11. PHARMACY

A. Formulary Management

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP ensures that the IEHP DualChoice Formulary is reviewed and updated no less than annually, is adequate and includes a range of drugs in a broad distribution of therapeutic categories and classes that does not substantially discourage enrollment by any group of beneficiaries.¹

PROCEDURES:

Formulary Management

A. On at least an annual basis, the IEHP P&T Subcommittee reviews for clinical appropriateness the practices and policies for formulary management activities, such as prior authorizations, step therapies, quantity limitations, generic substitutions, and other drug utilization activities that affect access.² For more information on the role and function of the P&T Subcommittee, please see Policy 2E, “Pharmacy and Therapeutics Subcommittee.”

B. Formulary management decisions are based on scientific evidence and may also be based on pharmacoeconomic considerations that achieve appropriate, safe, and cost-effective drug therapy.³ Factors related to optimal pharmacotherapy and considered in formulary deliberations include:

1. Pharmacologic considerations (e.g., drug class, similarity to existing drugs, side effect profile, mechanism of action, therapeutic indication, drug-drug interaction potential, and clinical advantages over other products in the specific drug class);

2. Unlabeled uses and their appropriateness;

3. Bioavailability data;

4. Pharmacokinetic data;

5. Dosage ranges by route and age;

6. Risks versus benefits regarding clinical efficacy and safety of a particular drug relative to other drugs with the same indication;

7. Patient risk factors relative to contraindications, warnings and precautions;

² Ibid.
³ Ibid.
11. PHARMACY

A. Formulary Management

8. Special monitoring or drug administration requirements;
9. Cost comparisons against other drugs available to treat the same medical condition(s);
10. Pharmacoeconomic data; and
11. Strength of scientific evidence and standards of practice (assessing peer-reviewed medical literature, pharmacoeconomic studies, outcome research data, and other such information as it determines appropriate).

C. The P&T Subcommittee meets quarterly or more frequently to update the Formulary by reviewing:
1. Medical literature including clinical trials;
2. Relevant findings of government agencies, medical and pharmaceutical associations, National Institutes of Health, and regulatory body publications;
3. Relevant patient utilization and experience;
4. Current therapeutic guidelines and the need for revised or new guidelines;
5. IEHP Provider and Practitioner recommendations for addition or deletion of drugs to the Formulary; and
6. The top ten (10) therapeutic classes and top ten (10) medications that were submitted for prior authorization. IEHP P&T Subcommittee determines if any of the medications or criteria need modifications to improve access, quality and safety of pharmaceutical care.

D. The P&T Subcommittee makes reasonable efforts to review a new drug product or indication approved by the United States Food and Drug Administration (FDA) within ninety (90) days of its release onto the market and makes a decision within one hundred eighty (180) days of its release onto the market, or a clinical justification will be provided if this timeframe is not met.4

E. IEHP Dual Choice Formulary includes all or substantially all drugs in the immunosuppressant (for prophylaxis of organ transplant rejection), antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes. “Substantially all” in this context means that all drugs and unique dosage forms in these categories are expected to be included in sponsor formularies, with the following exceptions:5
1. Multi-source brands of the identical molecular structure;
2. Extended release products when the immediate-release product is included;
3. Products that have the same active ingredient or moiety; and

5 Ibid.
11. PHARMACY

A. Formulary Management

4. Dosage forms that do not provide a unique route of administration (e.g., tablets and capsules versus tablets and transdermals).

F. In cases where generic (multi-source) drugs become available and the cost is comparable to similar Formulary drugs within the same class (plus or minus 10%), IEHP Clinical Pharmaceutical Services staff may approve the drug to be added to the IEHP Formulary. The following policy and procedure will be followed:

1. A generic drug that is cost neutral when comparing to another Formulary agent in the same class;

2. The drug was not voted off the Formulary previously because of drug safety concerns; and

3. The added generic drug will be reported back to the next P&T Subcommittee meeting.

G. The following CMS excluded drugs may be covered under the IEHP DualChoice expanded formulary:

1. Over-the-Counter Drugs;

2. Drugs to treat anorexia;

3. Weight loss agents;

4. Agents that are used for the symptomatic relief of cough and cold; and

5. Prescription vitamins and mineral products (except prenatal vitamins and fluoride).

H. In case of a Formulary change, IEHP submits the Formulary file to CMS for approval. IEHP also provides direct written notice to affected Members at least thirty (30) days prior to the effective date of the change; or may provide the Members with a month’s supply of the drugs under the same term as previously allowed and provide written notice of the Formulary change (See Attachments, “Notice of Formulary Change – English” and “Notice of Formulary Change – Spanish” in Section 11). The written notice shall contain the following information:

1. The name of the affected covered Part D Drug;

2. Describe the change of the Formulary status;

3. The reason for the change;

4. Alternative drugs in the same therapeutic category or class; and

5. The means by which Members may obtain a Coverage Determination or exception.

I. CMS may permit to account for new therapeutic uses and newly approved Part D drugs. IEHP shall not change the therapeutic categories and classes in a formulary other than at the

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6 Title 42, CFR §423.120(b)(5).
11. PHARMACY

A. Formulary Management

beginning of each plan year.\textsuperscript{7,8}

J. Except when the FDA deems a Part D drug unsafe or manufacturer removes a Part D drug from the market, IEHP shall not make any changes in the preferred or tiered cost-sharing status, nor remove a drug from the Formulary between the beginning of the annual coordinated election period and the end of the contract year.\textsuperscript{9}

K. IEHP notifies its Providers in writing about the Formulary additions, deletions, and modifications to policies and procedures.\textsuperscript{10} Monthly Formulary updates are posted online on the IEHP Provider website at www.iehp.org.

L. Requests for Formulary additions should be submitted in writing to the IEHP Pharmaceutical Services Staff for placement on the agenda for the next P&T Subcommittee meeting (see Attachment, “Request for Addition or Deletion of a Drug to the Formulary” in Section 11).

M. To ensure accuracy of claims adjudication and benefit logics (i.e. transition logics) at Point-Of-Sales (POS), IEHP conducts daily claims rejection review. The rejection review identifies any discrepancies or outliers by comparing CMS-approved formulary submission, patients’ enrollment status, claims submission condition and submitted claims information. All discrepancies shall be addressed immediately to minimize impact on Members.

Formulary Distribution

A. The IEHP Formulary and Treatment Guide is available on the IEHP website. A printed version is available to Members and Providers upon request. The IEHP Formulary and Treatment Guide is published in a booklet format annually and mailed to Providers.

B. All new IEHP Providers and pharmacists are informed, as part of their orientation materials, that formulary information is posted online on the IEHP Provider website.\textsuperscript{11}

C. On an annual basis, IEHP notifies the Members regarding the Formulary update schedule through the Member Newsletter. Members may also access the IEHP Website to obtain the latest Formulary changes.\textsuperscript{12}

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\textsuperscript{7} Title 42, CFR §423.120(b)(4).
\textsuperscript{8} Medicare Prescription Drug Benefit Manual, “Chapter 6 – Part D Drugs and Formulary Requirements,” Section 30.3.1.
\textsuperscript{9} Medicare Prescription Drug Benefit Manual, “Chapter 6 – Part D Drugs and Formulary Requirements,” Section 30.3.2.
\textsuperscript{10} Title 42, CFR, §423.120(b)(7).
\textsuperscript{11} Ibid.
\textsuperscript{12} Ibid.
11. PHARMACY

B. Coverage Determination

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP maintains procedures for making timely Coverage Determinations (CD), including requests for exceptions to a formulary, and addressing grievances and appeals that involve coverage determinations.¹

DEFINITIONS:

A. Coverage Determination (CD) - Any decision made by or on behalf of IEHP with regards the following:²
   1. A decision not to provide or pay for a Part D drug that is:
      a. Not on the IEHP DualChoice formulary;
      b. Determined not to be medically necessary;
      c. Furnished by an out-of-network pharmacy; or
      d. Otherwise excluded under Section 1862 (a) of the Social Security Act, if applied to Medicare Part D.³
   2. A decision to provide a CD in an expedited manner, when a delay would adversely affect the health of the Member;
   3. Whether a Member has or has not satisfied a prior authorization or other utilization management;
   4. A decision about a formulary exception request.
B. Exception request – A request to obtain a Part D drug that is not included in the IEHP DualChoice formulary, or to request to have a utilization management requirement waived (e.g., step therapy, prior authorization, quantity limit) for a formulary drug.⁴

¹ Title 42 Code of Federal Regulations (CFR) § 423.562.
³ Social Security Act Section § 1862.
11. PHARMACY

B. Coverage Determination

PROCEDURES:

Coverage Determination Requests
A. The following individuals may request a standard or expedited CD:5

1. A Member;

2. A Member’s appointed representative on behalf of the Member (See Attachments, “Appointment of Representative – CMS Form 1696 – English” and “Appointment of Representative – CMS Form 1696 - Spanish” in Section 11); or

3. A prescribing Physician or other prescriber on behalf of the Member.

B. CD and Exception requests may be submitted verbally or in writing, using the Coverage Determination or another form (See Attachments, “Coverage Determination – Provider & Member – English” and “Coverage Determination – Provider & Member – Spanish” in Section 11):6

1. A Member or their appointed representative may contact IEHP Member Services Department at (877) 273-IEHP (4347)/TTY (800) 718-4347 during normal business hours (8:00 a.m. to 8:00 p.m. Monday through Friday). The Member or their representative may leave a secure voice message after-hours.

2. A prescribing Physician or other prescriber may submit a CD or Exception request by phone at (909) 890-2049 or (888) 860-1297, by mail to IEHP at P.O. Box 1800, Rancho Cucamonga, CA 91729, through the secure IEHP Provider portal, or by fax to IEHP Pharmaceutical Services at (909) 890-2058. The prescribing Physician or other prescriber may leave a secure voice message after-hours. The Provider will be instructed by the voicemail message to provide all necessary information (e.g. Provider identification, Member identification, type of request and whether it is expedited or standard).

C. When a medication with prior authorization (PA) requirements is requested through the point-of-sale system, a message is transmitted to the Pharmacy indicating that the drug is not covered. The pharmacy should notify the Member, the Member’s appointed representative, the prescribing Physician or other prescriber to request a CD.7

D. Request for cash reimbursements are considered as CD requests. The request may be made up to one (1) year from the date of service. Please refer to Policy 11P, “Member Request for Pharmacy Reimbursement” for more information.

E. IEHP supplies all Providers with the CD Forms (See Attachments, “Coverage Determination - Provider & Member – English” and “Coverage Determination – Provider & Member –

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6 Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.12.

11. PHARMACY

B. Coverage Determination

Spanish” in Section 11) and instructions for their use. Forms may also be accessed through the website at www.iehp.org.

F. All CD requests must provide information that support the medical necessity or meet the criteria for prior authorization, as well as previous successful or failed therapies, any allergies, or any other clinical condition when applicable.

G. For information on review of drugs for inclusion and changes to the formulary, please see Policy 11A, “Formulary Management.”

Exception Requests

A. A prescribing Physician or other prescriber must provide supporting statement that the requested prescription drug is medically necessary to treat the Member’s disease or medical condition for the reasons listed below. If the supporting statement is provided orally, IEHP may require the prescribing Physician or other prescriber to subsequently provide a written supporting statement.²

1. All the covered Part D drugs on IEHP’s formulary for treatment for the same condition would not be as effective for the Member as the non-formulary drug, or could have adverse effects for the Member, or both;

2. The number of doses available under a dose restriction for the requested drug has been ineffective in the treatment of the Member’s disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the Member, and known characteristics of the regimen, is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance; or

3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements has been ineffective in the treatment of the Member’s disease or medical condition or, based on both sound clinical evidence and medical scientific evidence, the known relevant physical or mental characteristics of the Member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance.

B. IEHP may apply quantity limits on non-formulary drugs approved through the Exception request process that are based on safety-concerns. CMS permits the following safety-based quantity limits:³

1. Quantity limits based on maximum dosing limits, frequency and/or duration of therapy supported by the United States Food and Drug Administration;

2. Quantity limits on topical products in consideration of indication, directions for use, and

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² Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance”, Section 40.5.3.

11. PHARMACY

B. Coverage Determination

size of the area being treated; and

3. Quantity limits that support dose optimization that is intended to promote adherence and ensure safe and appropriate utilization.

Coverage Determination Timeframes

A. Standard CD Requests\(^{10}\)

1. Requests for drug benefits:
   a. IEHP notifies the Member, the Member’s appointed representative and the prescribing Physician or other prescriber as expeditiously as the Member’s health condition requires, but no later than seventy-two (72) hours (including weekends and holidays) after receipt of the request.
   b. For Exception requests, IEHP notifies the Member, the Member’s representative and the prescribing Physician or other prescriber within seventy-two (72) hours (including weekends and holidays) after receipt of the Physician’s supporting statement or fourteen (14) calendar days after receipt of the request, whichever occurs first.\(^{11}\)

2. Requests for Member reimbursement: Please see Policy 11M, “Member Request for Pharmacy Reimbursement” for more information, including processing timeframes.

B. Expedited Requests\(^{12}\)

1. IEHP will expedite a CD, as requested by the Member or the Member’s appointed representative, if the health plan determines that applying the standard timeframe may seriously jeopardize the Member’s life, health, or ability to regain maximum function.

2. IEHP will expedite a CD if the request is made or supported by a Physician, prescribing Physician, or other prescriber who indicates applying the standard timeframe may seriously jeopardize the Member’s life, health, or ability to regain maximum function.

3. Requests for reimbursement for covered Part D drugs that were already furnished to the Member may not be expedited.

4. IEHP will make a determination and notify the Member within twenty-four (24) hours of receipt of request (or for an Exception request, within twenty-four (24) hours of receipt of the physician’s supporting statement) if IEHP determines that the Member’s life or health will be seriously jeopardized by waiting for a standard decision.\(^{13}\)

\(^{10}\) Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance”, Section 40.5.3.

\(^{11}\) Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance”, Section 40.5.4.


\(^{13}\) Ibid.
11. PHARMACY

B. Coverage Determination

5. If IEHP denies a Member’s or a Member’s appointed representative’s request for an expedited CD, the request is processed using standard processing timeframes. IEHP:14
   a. Provides prompt oral notice to the Member, the Member’s appointed representative and the prescribing Physician or other prescriber that the request will be processed under the standard CD;
   b. Informs the Member of his or her right to have the prescribing Physician resubmit a request for an expedited CD;
   c. Informs the Member of his or her right to file an expedited grievance if he or she disagrees with IEHP’s decision not to expedite the CD;
   d. Provides instructions on IEHP’s grievance process and timeframes; and
   e. Mails a written confirmation to the Member within three (3) calendar days after the oral notification (See Attachments, “Notice of Right to an Expedited Grievance – Pharmacy – English” and “Notice of Right to an Expedited Grievance – Pharmacy - Spanish” in Section 11).

C. Failure to make a decision on a CD request and provide notice of the decision within the timeframe required by CMS constitutes an adverse CD. In this case, IEHP forwards the request to the Independent Review Entity (IRE) within twenty-four (24) hours of the expiration of the adjudication timeframe (See Attachments, “Notice of Case Status – English” and “Notice of Case Status - Spanish” in Section 11).15

Coverage Determination Review Process

A. All clinical criteria for prior authorization of medications are reviewed and updated at least annually or more often, as needed.

B. A CD will be made when a covered Part D drug is dispensed at a non-participating pharmacy if:16
   1. IEHP cannot reasonably expect the Member to obtain such drugs at a participating Pharmacy in a timely manner; and
   2. The Member does not access covered Part D drugs at non-participating pharmacies on a routine basis.

C. IEHP Clinical Pharmacists are responsible to review the initial CD. IEHP Clinical Pharmacists have current and unrestricted pharmacist license to practice in California.17

16 42 CFR § 423.124.
B. Coverage Determination

D. IEHP’s compensation plan for Clinical Pharmaceutical Services staff who provides utilization review services does not contain incentives, direct or indirect, for these individuals to deny, limit, or discontinue medically necessary services to any Member.¹⁸

E. IEHP Pharmaceutical Services staff reviews individual requests by thoroughly surveying the Member’s existing medication regimen, previous successful or failed therapies, any allergies, and any other clinical condition when applicable, and either approves, pends, withdraws, dismisses or denies the request.

1. **Approved:** Cases are approved for a twelve (12) month time span (or specific timeframe as dictated by the CMS-approved prior authorization criteria) which will allow for adjudication at Member’s Pharmacy. An approval notice is provided to the Member and the prescribing Physician or other prescriber, as appropriate.

2. **Pended:** There is insufficient information to make a determination on the appropriateness of the request. Additional information will be requested from the prescribing Physician or other prescriber. If no or insufficient information is received, a decision will be made within seventy-two (72) hours for standard request and twenty-four (24) hours for expedited request.¹⁹ For an Exception request, adjudication timeframe does not begin until the plan receives the prescribing Physician or other prescriber’s supporting statement.²⁰

3. **Withdrawn:** CD or Exception request was submitted to IEHP and subsequently withdrawn at the request of the Member, Member’s appointed representative, prescribing Physician or other prescriber.²¹

4. **Dismissed:** Exact duplication of an existing request or a request for a covered formulary medication.

5. **Denied:** Documentation provided did not meet approval guidelines. A denial notice will be provided to the prescribing Physician or other prescriber, and the Member.

F. If IEHP approves an Exception request, IEHP may not require the Member to request approval for a refill, or a new prescription to continue using the Part D prescription drug approved under the exception process for the remainder of the plan year, as long as:²²

1. The Member remains enrolled in IEHP;
2. The prescribing Physician or other prescriber continues to prescribe the drug; and
3. The drug continues to be considered safe for treating the disease or medical condition.

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¹⁸ CCI Three-Way Contract September 2019, Section 2.11.
²⁰ Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance”, Section 40.5.2.
²² Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance”, Section 40.5.5.
11. PHARMACY

B. Coverage Determination

G. If IEHP approves a CD, IEHP notifies the Member, the Member’s appointed representative and prescribing Provider or other prescriber within regulatory timeframes. The approval letter shall include conditions of the approval including, but not limited to:23

1. Duration of the approval;
2. Limitations associated with an approval; and/or
3. Any coverage rules applicable to subsequent refills.

H. The IEHP Clinical Pharmaceutical Services staff discusses the requests that are found to be medically unjustifiable with the Clinical Pharmacist prior to denying them. The IEHP Clinical Pharmacist reviews and signs all denied CDs.24

I. As part of the determination process, IEHP Clinical Pharmacist consults with appropriate Specialists for requests involving unusual or clinically complicated conditions.

J. Prior to denying a request, the IEHP Clinical Pharmaceutical Services staff consults with the prescribing Physician to offer an alternative pharmacotherapeutic regimen and to discuss the specific reason for the denial.

K. If IEHP denies a drug benefit, in whole or in part, a denial letter is issued to both Member or their appointed representative and the prescribing Physician or other prescriber25 (See Attachments, “Denial Letter – IEHP DualChoice – English,” “Denial Letter – IEHP DualChoice – Spanish,” “Notice of Redetermination – English,” and “Notice of Redetermination – Spanish” in Section 11). The denial letter shall include the following information:26

1. Denial notice language in a readable and understandable form;
2. The specific reason for the denial that takes into account the Member’s presenting medical condition, disabilities, and special language requirements, if any;
3. Criteria used in the review process;
4. Procedures for obtaining additional information about criteria used in the review process;
5. Information on the Member’s right to appoint a representative to file an appeal on the Member’s behalf;
6. Information on the Member’s right to a redetermination:

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11. PHARMACY

B. Coverage Determination

a. If IEHP denies drug coverage, a description of both the standard and expedited redetermination processes, including the conditions for obtaining an expedited redetermination and the appeals process.

b. If IEHP denies payment, the notice shall describe the standard redetermination process and the appeals process; and

7. Other notice requirements as specified by the Centers for Medicare & Medicaid Services (CMS).

L. The final authority for obtaining medications not included in the IEHP Formulary rests with IEHP Chief Medical Officer. All documents and written materials are forwarded to the Chief Medical Officer or Medical Director designee for review if an appeal is filed by the prescribing Physician or other prescriber, IPA, Pharmacist, Member, or Member’s appointed representative.

M. The Member, Member’s appointed representative, the prescribing Physician or other prescriber may request a redetermination if the Member has received an adverse CD. See Section 16, “Grievance and Appeal Resolution System” for more information.

N. A CD request that is submitted to the Pharmaceutical Services Department using a Coverage Determination form with the word “appeal” or there is a Part D denial case for the same requested medication with or without additional information in the past sixty (60) days will be deemed as redetermination and forwarded to the IEHP Grievance & Appeals Department for review.
11. PHARMACY

C. IEHP DualChoice Vaccine Coverage

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. Section 202(b) of the Tax Relief and Health Care Act of 2006 (TRHCA) established a permanent policy for payment by Medicare for administration of Part D covered vaccines beginning in 2008. Specifically, the policy states that, effective January 1st, 2008, the administration of a Part D covered vaccine is included in the definition of “covered Part D drug” under the Part D statute.¹

B. IEHP DualChoice Members receive both Part B and D vaccine coverage through IEHP. This policy however, does not apply to Part B covered vaccines.

C. The Part D vaccine program generally covers those vaccines not available under Part B. The following vaccines are covered under the Part B Program:

1. Pneumococcal pneumonia vaccine;
2. Influenza virus vaccine;
3. Hepatitis B vaccine for individuals at high or intermediate risk; and
4. Other vaccines (i.e. tetanus toxoid) when directly related to the treatment of an injury or direct exposure to a disease or condition.

D. All Part D covered vaccines are listed in the IEHP DualChoice Formulary. No prior authorization is required for covered Part D vaccines. All covered Part D vaccines are restricted to be used according to the latest Centers for Disease Control and Prevention (CDC) recommended Adult Immunization Schedule found online at http://www.cdc.gov/vaccines/schedules/hcp/adult.html.

PROCEDURES:

A. Members may receive Part D vaccine coverage through one (1) of the following options:

1. In-Network Vaccine Distribution – Retail Pharmacy
   a. Members could obtain a prescription from their PCP and bring it to a contracted IEHP Pharmacy provider for filling.
   b. IEHP Pharmacy Providers who register with the Pharmacy Benefit Manager (PBM) as vaccine Providers may provide service and submit claims online as a single claim (both the vaccine serum and the administration cost).

¹ Tax Relief and Health Care Act (TRHCA) § 202(b)
11. PHARMACY

C. IEHP DualChoice Vaccine Coverage

c. Pharmacy Providers should collect any applicable cost-sharing on the vaccine and its administration. No Member Reimbursement form is required. The Member’s deductible, coinsurance and co-pay will apply, if applicable.

2. Out-of-Network - IEHP reimburses the Members directly

a. Member receives and pays for a Part D covered vaccine through a doctor or other health care Provider (other than the Vaccine Network Pharmacy).

b. Member needs to bring the Member Reimbursement Form to the health care Provider, complete all the required information and send the Member Reimbursement Form along with the receipt to IEHP. The deductible, coinsurance and co-pay will apply. Please see Policy 11M, “Member Request for Pharmacy Reimbursement” for more information (See Attachments, “Member Request for Pharmacy Reimbursement – IEHP DualChoice – English” and “Member Request for Pharmacy Reimbursement – IEHP DualChoice- Spanish” in Section 11).

3. Out-of-Network - Receive vaccination through the physician provider

a. The Provider may submit claims on behalf of the Member when they provide Part D covered vaccines. The Member may also obtain the vaccine from the Pharmacy and transport the vaccine to the Physician’s office for administration. No Member Reimbursement form is required. The deductible, coinsurance and co-pay will apply.

B. One (1) cost-sharing amount should be applied to both the vaccine ingredient cost and the administration cost, resulting in one (1) co-pay for the Member, if the vaccines are distributed.

C. IEHP’s contracted PBM accepts Part D vaccine administration claims from participating pharmacies in the National Council for Prescription Drug Programs (NCPDP) approved format. IEHP reimburses any Pharmacy that has agreed to provide vaccine administration services.

E. IEHP and the contracted PBM will monitor the Part D vaccine claims. When administration is billed separately from the dispensing of the vaccine, IEHP and the contracted PBM will review existing claims for the presence of a vaccine charge. Should no vaccine charge be present in the claim’s history, IEHP will work with the Member to ensure the Member submits a paper receipt for the vaccine and that appropriate reimbursement has been paid.

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INLAND EMPIRE HEALTH PLAN

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2 Medicare Prescription Drug Manual, “Benefits and Beneficiary Protections,” Section 60.2.2.
11. PHARMACY

D. Claims for Drugs Prescribed or Dispensed by Sanctioned, Excluded and Precluded Providers

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP does not contract with, or otherwise pay for any amount for any covered service or item, other than emergency services furnished by:

1. A Provider at the medical direction or by prescription of the excluded provider when the Provider knew or had reason to know of the exclusion, or by an excluded provider to whom the Department of Health Care Services (DHCS) has failed to suspend payment while pending an investigation of a credible allegation of fraud; and

2. An individual or entity that is included on the preclusion list.

PROCEDURES:

A. IEHP’s contracted Pharmacy Benefit Manager (PBM) utilizes the reference file from the Office of Inspector General (OIG), United States General Services Administration (GSA) System for Award Management (SAM), the DHCS Medi-Cal Suspended & Ineligible (S&I) List and Preclusion list from the Centers for Medicare and Medicaid Services (CMS) to ensure the PBM claim system is updated to block claims submitted by sanctioned, excluded and precluded providers. Once updated, all claims related to the sanctioned or excluded Providers will be denied.

B. In collaboration with the PBM, IEHP notifies Members identified to be impacted by the Provider’s preclusion (See Attachments, “Part D Excluded Provider Letter – English” and “Part D Excluded Provider Letter - Spanish” in Section 11).

C. IEHP’s contracted PBM references the State Board licensing department to confirm the provider’s licensure and to receive notices of any actions related to termination, revocation or restriction of a Provider’s license to practice. Providers whose licenses are terminated, revoked, or suspended by the State of California are not eligible to write prescriptions for IEHP Members.

INLAND EMPIRE HEALTH PLAN

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1 Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.4
2 Social Security Act §1903(i)(2)
3 Title 42 Code of Federal Regulations (CFR) §422.222
11. PHARMACY

E. Pharmacy Access During a Federal Disaster or Other Public Health Emergency Declaration

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP ensures that Members’ access to medically necessary and covered drugs is not disrupted during a federal disaster or other public health emergency situations.¹

PROCEDURES:

A. IEHP monitors the Federal Emergency Management Agency (FEMA) for issuance of Presidential major disaster declarations and the Department of Health and Human Services (DHHS) website for public health emergency declarations.

B. IEHP will guarantee immediate refills of medications to any Members located in an “emergency area,” as defined by FEMA announcements.²

C. IEHP works in conjunction with the contracted Pharmacy Benefits Manager (PBM) to remove formulary restrictions and implement Formulary edits to allow full emergency access to medications for Members whose primary residence is located in the geographic area identified in the declarations, regardless of the location at which they are attempting to obtain a refill.³

D. At the end of the emergency declaration, IEHP will re-implement the edits and continue to work closely with Members who are displaced or otherwise impacted by the disaster. An emergency declaration ceases to exist when DHHS announces that the public health emergency no longer exists or upon the expiration of the ninety (90) day period beginning from the initial declaration; or when FEMA announces the closure of Presidential disaster declarations.⁴

INLAND EMPIRE HEALTH PLAN

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² Ibid.
³ Ibid
⁴ Ibid.
11. PHARMACY

F. Coverage Determination - Part B vs. D Determination

APPLIES TO:
A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

Policy:
A. IEHP ensures that drugs for which coverage may be available under Part B or Part D, as it is being prescribed or administered to the Member, are provided under the correct benefit coverage.

PROCEDURES:
A. IEHP’s Medicare Pharmacy staff will manage all prior authorizations for Part B vs. Part D Coverage Determinations (CDs) as follows:
1. IEHP’s Medicare Clinical Pharmacists will rely upon information submitted by the Pharmacy or Prescriber on the CD Form and medical information included with the prescription, if available, such as diagnosis information or the location where the medication is going to be administered (see Attachments, “Coverage Determination – Provider and Member – English” and “Coverage Determination – Provider and Member – Spanish” in Section 11).
2. IEHP’s Medicare Clinical Pharmacists may require the Pharmacy to share the information provided on the prescription to assist in the determination of Part B vs. Part D coverage. IEHP will make a Part B vs. Part D CD based on guidance set forth by the Centers for Medicare and Medicaid Services (CMS).

B. CDs and notifications to the Member or Member’s representative and prescribing Physician or other prescriber are made within regulatory timeframes, regardless of benefit determination. For more information on the CD process and requirements, please see Policy 11B, “Coverage Determination.”

C. Medications to be considered, and any additional parameters that must be taken into consideration to make a B vs. D Coverage Determination, are as follows:
1. Durable Medical Equipment Supply Drugs – Infusion Drugs
   a. Any agent administered in the home via intravenous (IV) drip or push injection would be covered under Medicare Part D.
   b. If the drug is administered using a CMS-approved infusion pump or meets durable medical equipment-maximum allowable cost (DME-MAC) Local Coverage Determination (LCD) criteria, it will be covered by Part B.
   c. The exception to this rule is if the Member resides in a long-term care (LTC) facility.

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1 Medicare Prescription Drug Benefit Manual, “Chapter 6 – Part D Drugs and Formulary Requirements,” Appendix C.
11. PHARMACY

F. Coverage Determination - Part B vs. D Determination

and the drug is administered via an infusion pump, then the medication is covered under Part D.

2. Durable Medical Equipment Supply Drugs – Respiratory Drugs
   a. Any agent administered in the home via a hand-held inhaler would be covered under Medicare Part D.
   b. If the drug’s approved administration is through a nebulizer in the home, it will be covered by Part B.
   c. The exception to this rule is if the Member resides in a LTC facility, and the drug is administered via a nebulizer, then the medication is covered under Part D.

3. Intravenous Immune Globulin (IVIG) provided in the home
   a. For individuals whose diagnosis is primary immune deficiency disease, IVIG are covered by Part B.
   b. Other indications as approved by IEHP’s Medicare Administrative Contractor (MAC) Part B carrier in its LCD will also be covered under Part D.
   c. All other medically accepted indications are covered by the Part D.

4. Parenteral Nutrition
   a. Part B coverage for parenteral nutrition is limited to individuals with a non-functioning digestive tract.
   b. For all other medically accepted indications, coverage would be under Part D.

5. Anti-neoplastic Drugs – ORAL
   a. Oral anti-neoplastics that have an IV formulation for the same indications are covered under Part B.
   b. All other oral anti-neoplastic agents are covered under Part D.

6. Anti-emetic Drugs – ORAL
   a. If a request for a Part B vs. D Coverage Determination is received, the Pharmacist will verify if the use is:
      1) Related to cancer treatment;
      2) A full replacement for intravenous administration; and
      3) Being administered within forty-eight (48) hours of cancer treatment.
      In such instances, the medication will be covered by Part B.
   b. Aprepitant (Emend®) will be covered under Part B when it is given prior to, during or right after chemotherapy. Otherwise, the medication will be covered under Part D. Oral anti-emetic drugs dispensed for use after the forty-eight (48) hours period, or any oral anti-emetic prescribed for conditions other than treatment of the effects of
11. PHARMACY

F. Coverage Determination - Part B vs. D Determination

cancer treatment, will be covered under Part D.

7. Immunosuppressant Drugs
   a. If a request for prior authorization is received, the Pharmaceutical Services Specialist will verify with the Clinical Pharmacist whether the Member’s transplant was covered by Medicare. If the Member had a Medicare-covered transplant, the medication will be covered under Part B; otherwise, the medication will be covered under Part D.

8. Injectables
   a. Coverage for B vs. D cannot generally be determined based solely on the drug itself. The IEHP Pharmaceutical Services staff will consider how the drug was “prescribed and dispensed or administered” with respect to the individual. The same drug may be covered under different circumstances either by IEHP’s Part D or Part B.
   b. IEHP will cover Part D eligible injectable drugs not covered by Medicare Part B. Most of these are generally self-administered (e.g., Imitrex).
   c. The fact that an injectable is covered under Part B if provided by and administered in a Physician’s office or Hospital outpatient setting does not mean IEHP can deny a claim from a Physician solely based on availability of Part B coverage for drugs given in the Physician’s office. If, however, a Member submits an out-of-network claim for an injectable drug administered in-office from a Physician’s supply, and this drug is covered in that setting by the Part B contractor for that area, such a claim will be denied under Part D by IEHP based on Part B coverage requirements.
   d. If the medication (including injectable) is being obtained at a retail pharmacy, it may be covered under Part D in accordance with the corresponding National Coverage Determination (NCD) or Local Coverage Determination (LCD). A Physician is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the Member will obtain the medication from a Pharmacy and have it in their possession until the Member delivers the medication to the Physician office for administration.

9. Hemophilia Clotting Factors
   a. Hemophilia clotting factors for hemophilia patients that are not competent to administer such factors to control bleeding without medical assistance, and items related to the administration of such factors, are covered under Part B.
   b. Hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors, are covered under Part D.

10. Pneumococcal Vaccine
   a. All vaccines must be dispensed and administered in compliance with California state law.
11. **PHARMACY**

F. **Coverage Determination - Part B vs. D Determination**

b. The vaccine and its administration to a Member are covered under Part B.

11. **Hepatitis B Vaccine**
   a. All vaccines must be dispensed and administered in compliance with California state law.
   b. The vaccine and its administration to a Member who is at high or intermediate risk of contracting Hepatitis B are covered under Part B.
   c. The vaccine prescribed to be administered prophylactically will be covered under Part D.

12. **Influenza Vaccine**
   a. All vaccines must be dispensed and administered in compliance with California state law.
   b. The vaccine and its administration to a Member are covered under Part B.

13. **Antigens**
   a. These formulations are usually prepared by a Physician (e.g., an allergist) for a specific patient. The Physician or Physician’s nurse generally administers these drugs in the Physician’s office. This would be covered under Part B.

14. **Erythropoietin (EPO)**
   a. For an end-stage renal disease (ESRD) patient undergoing dialysis in a facility the EPO claim must be submitted as part of their bundled payment, covered by Part B.
   b. For ESRD patients not receiving dialysis, the EPO prescription can be filled in the retail setting and covered under Part D.

D. **Long Term Care (LTC) Accessibility**

1. IEHP’s Medicare Clinical Pharmacists will approve coverage for medically necessary prescription drug treatments for Part D Members who reside in LTC facilities including dosage forms of drugs that are utilized in the LTC setting, such as unit dose products and liquid, chewable, and parenteral preparations.²

2. IEHP will also cover these dosage forms for Part D Members under circumstances in which Part B coverage is not available.³

E. **Denials**

1. If the decision is made by the Clinical Pharmacists that the medication will be covered under Medicare Part B, then the Part D Coverage Determination Request is denied as a “Non-Covered Benefit” in the medical management system. A notification will be sent

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² Medicare Prescription Drug Benefit Manual, “Chapter 6 – Part D Drugs and Formulary Requirements,” Section 30.2.3.
³ Ibid.
F. Coverage Determination - Part B vs. D Determination

to the Member or Member’s representative and prescribing Physician or other prescriber that the medication is denied under Part D but it is covered under Medicare Part B benefit (See Attachments, “Denial Letter – IEHP DualChoice – English,” “Denial Letter – IEHP DualChoice – Spanish,” “Notice of Redetermination – English,” and “Notice of Redetermination – Spanish” in Section 11).

F. IEHP applies beneficiary-level prior authorization requirements on four (4) categories of drugs that are always used for ESRD treatment (access management, anemia management, bone and mineral metabolism, cellular management). These four (4) drug categories are determined by CMS and do not include other drug categories, unless otherwise stated by CMS. If it is determined through routine utilization review or otherwise that a renal dialysis service drug has been inappropriately billed to Part D, IEHP and the ESRD facility will negotiate repayment.

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4 Health Plan Management System (HPMS) Memo, “Two Updates Pertaining to End-Stage Renal Disease (ESRD)-Related Drugs,” May 12, 2015.
11. PHARMACY

G. Coordination of Benefits

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP’s Coordination of Benefits (COB) program prevents duplication of payments for the same health care services and prevents Medicare from paying as the primary when it is the secondary payer.1

PROCEDURES:

COB Program

A. COB serves as a mechanism to:2
   1. Collect information from a Member regarding Other Health Coverage; and
   2. Support the tracking and calculating of beneficiaries’ “true out-of-pocket” (TrOOP) expenditures.

B. The COB program includes:3
   1. Enrollment file sharing;
   2. Claims processing and payment;
   3. Claims reconciliation reports;
   4. Third-party reimbursement of out-of-pocket costs;
   5. Application of protection against high out-of-pocket expenditures; and
   6. Other processes that CMS determines.

C. The National Council for Prescription Drug Programs (NCPDP) developed a set of transactions that provides a record of a payment, by a plan supplemental to Part D, to a Part D Plan. This is also known as Nx Transactions.

Member Responsibilities

A. Members are legally obligated to report information about Other Health Coverage or reimbursement for prescription drugs costs that they have or expect to receive under the Medicare Modernization Act (MMA).4

2 Ibid.
3 Ibid.
11. PHARMACY

G. Coordination of Benefits

B. Members or other payers have up to thirty-six (36) months from the date on which the prescription for a covered Part D drug was filled to seek reimbursement from IEHP.5

IEHP Responsibilities

A. IEHP and the contracted Pharmacy Benefit Manager (PBM) must comply with all administrative processes and requirements established by CMS to ensure effective exchange of information and coordination between IEHP and Other Health Coverage for:6

1. Payment of premiums and coverage; and
2. Payment for supplemental prescription drug benefits for Members enrolled in IEHP and an entity that provides other prescription drug coverage.

B. IEHP provides coordination of benefits with the PBM, CMS contracted COB Contractor, and the TrOOP Facilitators.

C. IEHP coordinates benefits with State pharmaceutical assistance programs, other payers, Members and others paying on the Members’ behalf for up to thirty-six (36) months from the date on which the prescription for a covered Part D drug was filled.7

D. When IEHP receives a Nx transaction but has no supplement payer information on file to identify the payer; IEHP shall attempt to make contact with the Member to identify the payer.8 IEHP sends the payer information to the COB Contractor via Electronic Correspondence Referral System (ECRS) verification. IEHP must report changes to the COB information and COB Contractor within thirty (30) days of receipt.9 IEHP shall maintain connectivity with CMS systems to allow direct access to Other Health Coverage status information.10

E. IEHP may impose user fees to Other Health Coverage for costs related to coordination of benefits between IEHP and Other Health Coverage under the provision of MMA. The user fees must be reasonable and related to the IEHP’s actual costs of COB with the Other Health Coverage.11

F. IEHP shall retroactively adjust claims and TrOOP balances based on prescription drugs event and claims records.12

G. IEHP’s PBM will process claims and track TrOOP in real time13.

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9 Medicare Prescription Drug Benefit Manual, “Chapter 14 – Coordination of Benefits,” Section 50.3.2.
13 Ibid.
11. PHARMACY

G. Coordination of Benefits
11. PHARMACY

H. Best Available Evidence

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP provides access to Part D drugs at the correct Low-Income Subsidy (LIS) cost-sharing level when presented with evidence of LIS eligibility, even if IEHP’s system and Centers for Medicare and Medicaid Services’ (CMS) systems do not yet reflect that eligibility.¹

DEFINITIONS:

A. Best Available Evidence – Documentation used by IEHP to support a favorable change to a low-income subsidy (LIS) eligible Member’s LIS status.²

PROCEDURES:

A. This process only applies to Members who are “deemed” eligible for LIS and may not be used for LIS applicants.

B. CMS defines an institutionalized individual as a Medicare Advantage (MA)-eligible who resides or is expected to reside continuously for ninety (90) days or longer in a long-term care facility that is either a skilled nursing facility (SNF), nursing facility (NF), or SNF/NF. These individuals are considered long-term institutional residents for purposes of determining who can enroll in a special needs plan. The payment for these SNF residents is made under Medicaid throughout a full calendar month. These Members remain deemed for zero co-pay throughout the remainder of the calendar year. IEHP accepts and uses BAE to substantiate the Member’s correct LIS cost-sharing level. The institutionalized Members have an indicator of 3 under the LIS level to return copay of zero.

C. IEHP accepts Best Available Evidence (BAE) at point-of-sale (POS) and updates the eligibility system within forty-eight to seventy-two (48-72) hours of the receipt of the documentation.

D. If the case is urgent, IEHP shall allow a minimum of seventy-two (72) hours’ worth of medications until the case is resolved.

1. IEHP accepts any one of the following documents to validate the correct LIS cost-sharing level and effective date for Members who should be deemed eligible for LIS 2 (full dual

¹ https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Best_Available_Evidence_Policy.
11. PHARMACY

H. Best Available Evidence

eligible). The document must show that the Member was eligible for Medicaid (IEHP Medi-Cal) during a month after June of the previous calendar year. 3

a. A copy of the Member’s Medicaid card which includes the Member’s name and eligibility date;

b. A copy of a state document that confirms active Medicaid status;

c. A print out from the State electronic enrollment file showing Medicaid status;

d. A screen print from the State’s Medicaid systems showing Medicaid status;

e. Other documentation provided by the State showing Medicaid status;

f. A report of contact, including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the State staff person who verified the Medicaid status;

g. A remittance from a long-term care facility showing Medicaid payment for a full calendar month for that individual; 4

h. A copy of a state document that confirms Medicaid payment to a long-term care facility for a full calendar month on behalf of the individual; 5

i. A screen print from the State’s Medicaid systems showing that individual’s institutional status based on at least a full calendar month’s stay for Medicaid payment purposes; 6

j. Supplemental Security Income (SSI) Notice of Award with an effective date;

k. An Important Information letter from the Social Security Administration (SSA) confirming that the beneficiary is automatically eligible for extra help; 7

l. An application filed by Deemed Eligible confirming that the beneficiary is “…automatically eligible for extra help…” (SSA publication HI 03094.605); or

m. A copy of the Deeming notice pub. No. 11166 (Purple Notice). 8

2. IEHP accepts any one of the following documents to validate the correct LIS cost-sharing level and effective date for Members who should be deemed eligible for LIS 3. The

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5 Ibid.

6 Ibid.


8 Ibid.
11. PHARMACY

H. Best Available Evidence

document must show that the Member was eligible for Medicaid (IEHP Medi-Cal) during a month after June of the previous calendar year.  

a. A remittance from the facility showing Medicaid payment for that individual;

b. A copy of a state Medicaid document showing the individual’s institutional status;

c. A screen-print from the State’s Medicaid systems showing the individual’s institutional status;

d. A copy of the Deeming notice – pub. No. 11166 (purple notice); 

e. A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary’s name and Home and Community-Based Services (HCBS) eligibility date;

f. A copy of a State-approved HCBS Service Plan that includes the beneficiary’s name and effective date;

g. A copy of a State-issued prior authorization approval letter for HCBS that includes the beneficiary’s name and effective date;

h. Other documentation provided by the State showing HCBS eligibility status; or

i. A State-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary’s name and the dates of HCBS.

E. IEHP updates the systems to reflect the LIS status indicated by the BAE and submits a request to CMS for manual update within sixty (60) days if routine reporting does not correct for deemed Members.

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11.   PHARMACY

I.   Transition Process

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP provides a transition process for Members whose current drug therapies may not be included in their new Part D plan’s formulary, and will effectuate a meaningful transition for the following:

1. New Members into IEHP DualChoice on January 1st of the new year following the previous year’s annual coordinated election period;
2. The transition of newly eligible Medicare beneficiaries from other coverage in the new year;
3. The transition of individuals who switch from one plan to another after January 1st of the new year;
4. Enrollees residing in Long-Term Care (LTC) facilities; and
5. Members affected by Formulary changes from one (1) contract year to the next.

PURPOSE:

A. To promote continuity of care and avoid interruptions in drug therapy while a switch to a therapeutically equivalent drug or the completion of an Exception request to maintain coverage of an existing drug based on medical necessity reasons can be effectuated.

PROCEDURES:

A. The following transition process and requirements apply to non-formulary drugs, meaning:

1. Part D drugs that are not on the IEHP DualChoice Formulary;
2. Part D drugs that were approved for coverage under an exception once the exception expires; and
3. Part D drugs that are on the IEHP DualChoice Formulary but require prior authorization, step therapy, or have an approved quantity limit lower than the beneficiary’s current dose, under IEHP utilization management rules.

3 Ibid.
11. PHARMACY

I. Transition Process

B. IEHP assures that all transition processes are applied to a brand-new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.4

C. IEHP provides a transition supply when the Member requests for a non-formulary drug within ninety (90) days of their enrollment with IEHP DualChoice. If the Member disenrolls from IEHP and re-enrolls during this ninety (90) day transition period, the transition period begins again with the new enrollment date.5

D. IEHP assures that in the outpatient (retail) setting, the transition fill of non-formulary Part D drug is for up to a total of thirty-one (31) days (unless the Member presents with a prescription written for less).6

E. IEHP assures that in the Long-Term Care (LTC) setting, such as nursing facility or sub-acute care facility, the transition supply of non-formulary Part D drug is for a thirty-one (31) day fill (unless the Member presents with a prescription written for less than thirty-one (31) days), with multiple refills as necessary (up to thirty-one (31) days).7

F. IEHP assures that in the Long-Term Care setting, after the ninety (90) days transition period has expired, the transition policy provides for a thirty-one (31)-day emergency supply of non-formulary Part D drugs (unless the Member presents with a prescription written for less than thirty-one (31) days) while an exception is being processed.8

G. Under circumstances where the transition policy does not apply, all non-formulary Part D drugs are subject to the coverage determination process. Please refer to Policy 11B, “Coverage Determination.”

H. Eligible claims will process and approve upon initial submission and messages will indicate when claims have paid under transition fill rules. The messages will be returned with paid transition fill claims so pharmacies can remind Members of actions that should be taken to ensure access to prescription drugs in accordance with Part D formularies and benefits.

I. Claims will automatically process if the Member and a drug are both eligible for transition.

J. If a transition claim fails to process and the Pharmacy believes the IEHP Member and the drug should be eligible under this policy, the Pharmacy should call the IEHP Pharmaceutical Services Department at (888) 860-1297 to request a temporary supply override.

11. PHARMACY

I. Transition Process

K. IEHP assures that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts.⁹

L. IEHP’s Pharmacy Benefit Manager (PBM) sends a written notice via U.S. mail to the Member within three (3) business days of adjudicating their first transition fill (See Attachments, “Prescription Transition Notice – English” and “Prescription Transition Notice - Spanish” in Section 11). IEHP ensures all reasonable efforts are made to notify Prescribers of a transition fill. This CMS Model Transition Notice includes:¹⁰

1. An explanation of the temporary nature of the transition supply the Member has received;
2. Instructions for working with IEHP and the Member’s prescriber to identify appropriate therapeutic alternatives that are on the plan’s formulary;
3. An explanation of the Member’s right to request a formulary exception;
4. A description of the procedures for requesting a Formulary exception; and
5. An explanation of the Member’s right to request an appeal if IEHP issues an unfavorable decision on a formulary exception.

M. IEHP ensures continued compliance with these requirements by routinely testing the efficacy of the PBM’s transition logic.

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11. PHARMACY

J. Pharmacy Access Standards

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

IEHP provides prescription drug coverage to its IEHP DualChoice Members utilizing a pharmacy network and formulary approved by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) in accordance with State, Federal and contractual access standards.¹

PROCEDURES:

A. IEHP ensures that the hours of operation of all Pharmacy Network Providers are convenient to the population served and do not discriminate against Members. Services are available twenty-four (24) hours a day, seven (7) days a week.

B. IEHP maintains a contracted pharmacy network consisting of retail pharmacies sufficient to ensure that the following access requirements are satisfied for IEHP DualChoice Members:²,³

1. At least 90% of Members, on average, in urban areas live within two (2) miles of a retail Pharmacy participating in the network;

2. At least 90% of Members, on average, in suburban areas live within five (5) miles of a retail Pharmacy participating in the network; and

3. At least 70% of Members, on average, in rural areas live within fifteen (15) miles of a retail Pharmacy participating in the network.

C. IEHP provides adequate access to home infusion pharmacies in accordance with requirements set by CMS. Members may receive home infusion pharmacy services for infusion drugs if a referral is made by a Physician and approved by IEHP.⁴,⁵

D. IEHP ensures convenient access to Long-Term Care (LTC) pharmacies for Members who reside in an LTC facility by contracting with any pharmacy willing to participate in its LTC pharmacy network so long as the pharmacy is capable of meeting the performance and service criteria set forth by CMS.⁶,⁷

² Title 42, Code of Federal Regulations (CFR) § 423.120.
⁵ 42 CFR § 423.120.
⁷ 42 CFR § 423.120.
11. PHARMACY

J. Pharmacy Access Standards

E. IEHP Members may receive ninety (90) day supply of the maintenance medications through retail Pharmacies or mail order Pharmacies.  

Mail Order Pharmacy Access

A. IEHP contracts with Mail Order Pharmacy to process mail order requests. Drugs that are on the Maintenance Lists are available through the Mail Order Pharmacy. All mail order requests must be for a ninety (90) day supply of the drug. The Mail Order Pharmacy is not meant for emergency refills. If an emergency refill is needed, the Member will need to refer to their local Pharmacy for the necessary medication.

Pharmacy Network

A. IEHP delegates all pharmacy contracting responsibilities to the Pharmacy Benefit Management (PBM) Company.

B. IEHP contracts with chain and independent Pharmacies, Long-Term Care Pharmacies, Home Infusion Pharmacies, and Specialty Pharmacies to provide various pharmacy services to IEHP Members.

C. IEHP allows and accepts any willing pharmacy that will accept IEHP’s standard contracting terms and conditions. IEHP’s PBM contracts on behalf of IEHP using standard contracting terms and conditions which include requirements, responsibilities, and reimbursement rates.

D. IEHP ensures Members have adequate access to covered Part D drugs dispensed at out-of-network pharmacies, when Members:
   1. Cannot reasonably be expected to obtain such drugs at a network pharmacy; and
   2. Do not access covered Part D drugs at an out-of-network pharmacy on a routine basis.

E. IEHP Members may go to any one of the Pharmacies in the IEHP Pharmacy network for pharmacy services. IEHP Members may call the IEHP’s Member Services Department at (877) 273-IEHP (4347) or access the IEHP Member Portal to find the nearest Pharmacy Provider in our network.

F. IEHP does not limit access of Part D drugs to a limited distribution through a subset of network pharmacies, except when necessary to meet Food and Drug Administration’s (FDA) limited distribution requirements or to ensure the appropriate dispensing of Part D drugs that require extraordinary requirements cannot be met by a network Pharmacy.

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8 42 CFR § 423.120.
11. PHARMACY

J. Pharmacy Access Standards

G. IEHP may specify, on a drug by drug basis, reasonable requirements for network Pharmacies to ensure appropriate handling and dispensing of a particular Part D drug that requires special attention.\(^{13}\)

H. IEHP may arrange delivery of medications from Specialty Pharmacies if a referral is made by a Physician and approved by IEHP. Member will be notified upon delivery by the Specialty Pharmacy.

I. IEHP shall notify CMS and the Department of Health Care Services (DHCS) in writing when material change is expected within IEHP Pharmacy network before the change is in effect.

Monitoring and Oversight

A. On an annual basis, IEHP assesses the Pharmacy Access Standards with our contracted PBM. If IEHP fails to meet the Pharmacy Access Standards, an investigation will be conducted to identify root cause. IEHP will work with the contracted PBM to remediate any deficiency identified.

B. IEHP assesses and analyzes Consumer Assessments of Healthcare Providers and Systems (CAHPS) score for Member satisfaction related to access; identifies trends, barriers, and improvement opportunities; develops interventions to address opportunities and evaluates outcome of actions tables.

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\(^{13}\) Medicare Prescription Drug Manual, “Chapter 5: Benefits and Beneficiary Protections,” Section 50.3.
11. PHARMACY

K. Medication Therapy Management Program

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP’s Medication Therapy Management (MTM) Program is designed to ensure that covered Part D drugs prescribed to targeted Members are appropriately used to optimize therapeutic outcomes through improved medication use. It is also designed to reduce the risk of adverse events, including adverse drug interactions, and to increase Member adherence with prescription medications.1

PROCEDURES:

Program Eligibility

A. IEHP’s MTM Program is available for Members who meet the following criteria set forth by the Centers for Medicare and Medicaid Services (CMS):2

1. Member is likely to incur costs (total drug costs) for Covered Part D drugs that exceed a predetermined level as specified by CMS;
2. Member has multiple chronic diseases, with three (3) chronic diseases being the maximum needed for enrollment; and
3. Member is taking multiple Part D drugs, with two (2) being the minimum and eight (8) being the maximum needed for enrollment.

B. On a quarterly basis, IEHP identifies and notifies qualified Members by mail or phone as potential candidates for the MTM Program.

Member Participation

A. All identified Members, including Members in Long-Term Care (LTC), who are qualified are enrolled into the MTM Program. Members may call IEHP’s Member Services Department to disenroll/opt-out3 from the program.

B. The MTM Program is voluntary. IEHP does not deny a Member access to prescription drugs based on the Member’s failure to participate in the MTM Program.

C. Members will be screened for eligibility for the MTM Program every year. IEHP will honor a Member’s desire to permanently opt-out of the MTM Program and not re-enroll the Member in future years; however, the Member may seek enrollment into the MTM Program at a later time.

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1 Title 42, Code of Federal Regulations (CFR) § 423.153(d).
2 Ibid.
3 Ibid.
11. PHARMACY

K. Medication Therapy Management Program

D. In the event that the Member no longer meets one (1) or more of the three (3) eligibility criteria for the program, the Member will remain enrolled in the program for the remainder of the calendar year. They will be reconsidered for eligibility at the beginning of the following calendar year.

IEHP’s MTM Program

A. The MTM Program was developed in cooperation with licensed and practicing pharmacists and physicians. Program services are furnished by pharmacists or other qualified Providers that have completed an appropriate training program as determined by IEHP.4

B. The MTM Program distinguishes between services in ambulatory and institutional settings.5

C. The MTM Program includes the following components:6

1. Annual Comprehensive Medication Review (CMR) Process:
   a. Medication review, at a minimum, on an annual basis;
   b. Interactive, person-to-person or telehealth consultation; and
   c. Individualized, written summary of consultation or recommended medication action plan.

   If the Member is offered annual CMR and is unable to accept the offer to participate, the pharmacist or other qualified Provider may perform the CMR with the Member’s prescriber, caregiver, or other authorized individual.

2. Quarterly Targeted Medication Review (TMR) Process:
   a. Individualized, written “take-away” materials such as personal medication record, reconciled medication list, action plan, recommendations for monitoring, education, or self-management; and
   b. Follow-up interventions as necessary after initial TMR.

3. Medication Therapy Review:
   a. Assesses the appropriateness of the current medication therapy;
   b. Interviews (i.e. phone, interactive, etc.) with Members to ensure the adherence and appropriateness of the dose and dosing regimen of each medication;
   c. Checks for therapeutic duplications;
   d. Interprets, monitors and assesses patient laboratory results;
   e. Checks for drug to disease interactions and drug-drug interactions;
   f. Checks for contraindications and adverse effects; and

4 42 CFR § 423.153(d).
5 Ibid.
6 Ibid.
11. PHARMACY

K. Medication Therapy Management Program

   g. Checks for over-utilization and under-utilization.

   4. The pharmacist or other qualified Provider reviews the Member’s medications, history and any information collected from the Member’s questionnaire. The pharmacist or other qualified Provider conducts interactive person-to-person or telehealth comprehensive medication review.

   5. A medication action plan:

      a. Develops a modification/recommendation plan based on the Member interviews, medication record evaluation and patient assessment.

   6. Intervention and referral:

      a. Provides education and training on the appropriate use of medications and monitoring devices;

      b. Emphasizes the importance of medication adherence and understanding of the treatment goals; and

      c. Communicates with the physician or other health care Providers on the findings when appropriate.

   7. Documentation and follow up:

      a. The pharmacist or other qualified Provider documents all interventions on the CMS MTM Standard form.

D. The MTM Programs are coordinated with the Member’s Individual Care Plan.

Monitoring and Oversight

A. The MTM Program and all mid-year changes to the program must be approved by CMS.

B. IEHP evaluates and measures the effectiveness of the MTM Program through:

   1. Statistics on individual Members according to the Member medication profiles- the adoption of recommended treatment regimen, the number of chronic medications, and projected annual pharmacy expenditures per Member;

   2. Statistics on the overall MTM Program- Number of changes in medication regimens, average number of chronic medications per Member, average projected annual pharmacy expenditures per Member;

   3. Financial impact – pharmacy cost changes; and

   4. Member satisfaction surveys.

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7 42 CFR § 423.153(d).
11. PHARMACY

K. Medication Therapy Management Program
11. PHARMACY

L. Insulin Administration Devices and Diabetes Testing Supplies

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP ensures coverage for the following as pharmacy benefit:
   1. Insulin and Glucagon Emergency Kits;
   2. Syringes and needles utilized as insulin administration devices;¹ ² and

B. Diabetes testing supplies are covered under both the IEHP pharmacy and medical benefit. This includes, but is not limited to, blood glucose meters, test strips, lancets, and ketone test strips.

PROCEDURES:

A. Requests for insulin pen devices for Members with special medical needs are subject to the Coverage Determination process. See Policy 11B, “Coverage Determination” for more information.

B. Diabetes testing supplies, including glucometer, test strips and lancets, may be obtained through retail Pharmacies.

C. IEHP covers diabetic testing supplies using the criteria approved by the IEHP Pharmacy and Therapeutics Subcommittee.

¹ Title 42 Code of Federal Regulations (CFR) § 423.100.
11. PHARMACY

M. Member Request for Pharmacy Reimbursement

APPLIES TO:
A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:
A. IEHP Members or their appointed representative, which may be the prescribing physician or other prescriber, may submit Direct Member Reimbursement (DMR) requests to IEHP for drugs that the Member believes he or she was incorrectly charged.\(^1\)

PROCEDURES:
A. All DMR requests are considered Coverage Determination (CD) requests and are subject to the same evaluation standards. All requests will be evaluated based on the medical necessity. Please see Policy 11B, “Coverage Determination” for more information.

B. Members must submit a written request for reimbursement and are encouraged to include proof of payment and other supporting documentation. The Member may, but is not required to, use the Pharmacy Reimbursement Request form (See Attachments, “Member Request for Pharmacy Reimbursement – IEHP DualChoice - English” and “Member Request for Pharmacy Reimbursement – IEHP DualChoice – Spanish” in Section 11).

C. The prescribing Physician may only submit the request if acting on behalf of the Member.

D. The DMR request must be submitted within one (1) year from the date of service.

E. Member requests for pharmacy reimbursement are subject to the Coverage Determination process. IEHP Clinical Pharmacy Staff will make reasonable and diligent efforts to obtain any missing supporting information within the fourteen (14) calendar day timeframe, including outreach to the Pharmacy and/or prescribing Physician, as applicable.

F. IEHP will notify the Member, or the Member’s representative, and the prescribing Physician, or other Prescriber (when applicable), of the decision no later than fourteen (14) calendar days of the date of receipt of the written request.\(^2\)

1. If the DMR request is denied by IEHP, the Member, or Member’s representative, and the prescribing Physician, or other Prescriber (when applicable), will receive a denial notification (See Attachments, “Denial Letter – IEHP DualChoice – English,” “Denial Letter – IEHP DualChoice - Spanish,” “Notice of Redetermination – English,” and “Notice of Redetermination – Spanish” in Section 11).

2. If the DMR request is approved, the Member, or Member’s representative, and the prescribing Physician, or other Prescriber (when applicable), will receive an approval

\(^1\) Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance”, Section 40.6.

\(^2\) Title 42 of Code of Federal Regulations (CFR) § 423.568(c).
11. PHARMACY

M. Member Request for Pharmacy Reimbursement

notification and the reimbursement check will be mailed directly to the Member by IEHP or its Pharmacy Benefit Manager within the fourteen (14) calendar day timeframe.

G. IEHP may also approve a payment request by approving drugs retrospectively or due to a decision by the Independent Review Entity (IRE), which must be authorized within seventy-two (72) hours.\(^3\) The Pharmacy processes the approved medication and provides refund to the Member. IEHP may approve payment directly to the Member if the Member is unable to return to the dispensing Pharmacy.
11. PHARMACY

N. Pharmacy Disease Therapy Management Program

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP’s Pharmacy Disease Therapy Management (DTM) program seeks to optimize treatment, increase the Member’s quality of life, and decrease overall medical cost by promoting drug adherence, appropriate use of drugs, and outcomes reporting.

PURPOSE:

A. To establish a Pharmacy Disease Therapy Management (DTM) Program for high cost or relevant disease states that provides specialized services including drug and disease management.

PROCEDURES:

DTM Specialty Pharmacy Providers

A. IEHP selects Specialty Pharmacy Providers to provide DTM and pharmacy services to IEHP Members who need specialty medications for the following conditions:

1. Crohn’s disease;
2. Growth Hormone Deficiency;
3. Hepatitis B;
4. Hepatitis C;
5. Hereditary Angioedema (HAE);
6. Hyperlipidemia (requiring PCSK9 inhibitors);
7. IVIG Therapy;
8. Multiple Sclerosis;
9. Cancer (Oral Chemotherapy);
10. Psoriasis;
11. Pulmonary Arterial Hypertension;
12. Respiratory Syncytial Virus;
13. Rheumatoid Arthritis;
14. Ulcerative Colitis; and
15. Conditions requiring home infusion therapies.
11.  PHARMACY

N.  Pharmacy Disease Therapy Management Program

B. A list of DTM Specialty Pharmacies and assigned drugs can be accessed online at www.iehp.org.

C. The DTM Specialty Pharmacies must meet or exceed IEHP’s DTM expectations and standards based on each disease management protocol and design.

D. The DTM Specialty Pharmacy shall be responsible for all drugs (pharmacy services) under the assigned disease state.

Member Participation

A. Medicare Members may utilize any pharmacy that can obtain the specialty drugs except for the following drugs and situation:
   1. Drugs listed on the Current Drug Shortages Index maintained by the Federal Drug Administration (FDA);
   2. Drugs not available at a network community pharmacy due to manufacturer’s instructions or restrictions;
   3. Drugs subject to risk evaluation or management strategies approved by the FDA; and/or
   4. A special shortage affecting IEHP’s Pharmacy network.

B. Within thirty (30) days of approving or dispensing the first fill of a DTM drug, the Member will be notified of their enrollment into a DTM program, their right to opt out, including the toll-free number and the opt out process.

C. Members may call IEHP Member Services Department at (877) 273-4347 to opt out of the DTM program. The opt out period will expire when the Member is disenrolled from IEHP.

Outcomes Reporting

A. The DTM Specialty Pharmacies collect clinical information and alert IEHP of any potential clinical issues and findings based on the disease management protocol. The DTM Specialty Pharmacy provides clinical reports on a quarterly basis detailing DTM-specific metrics.

B. IEHP Pharmaceutical Services communicates these findings with internal departments to proactively manage the Members’ conditions.

C. IEHP presents DTM Program reports to the IEHP Pharmacy & Therapeutics Subcommittee on an annual basis.
11. PHARMACY

O. Pharmacy Credentialing and Re-Credentialing

APPLIES TO:

A. This policy applies to all Pharmacies in the IEHP Pharmacy network.

POLICY:

A. IEHP delegates all pharmacy credentialing and re-credentialing activities to its contracted Pharmacy Benefit Manager (PBM), must have credentialing and re-credentialing policies and procedures that meet IEHP standards.

PROCEDURES:

A. The contracted PBM must credential all pharmacies prior to inclusion in the IEHP Pharmacy network and recredential every two (2) years thereafter.

B. The contracted PBM is responsible for ensuring that all network Pharmacies are qualified, properly licensed, and maintain appropriate levels of malpractice insurance.

C. The contracted PBM is also responsible for monitoring the performance of all IEHP network Pharmacy Providers. The PBM is also responsible for promptly notifying IEHP once the PBM becomes aware of any breach of the contracted Pharmacy’s obligations. The Medicare Advantage (MA) Organizations employing or contracting with health providers have a responsibility to check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. The MA organizations should check the Office of the Inspector General (OIG) Web site at https://oig.hhs.gov/exclusions/index.asp for the listing of excluded providers and entities. This includes, but is not limited to, the following:
   1. License surrender, revocation or suspension;
   2. Drug Enforcement Agency (DEA) license surrender, revocation or suspension; and
   3. Loss of malpractice insurance.

D. The PBM must notify IEHP when a pharmacy is terminated from the network (voluntarily or involuntarily) within sixty (60) days after termination.

E. Network Pharmacy Providers must update the credentialing information via IEHP online portal on a bi-annual basis.

INLAND EMPIRE HEALTH PLAN

<table>
<thead>
<tr>
<th>Chief Approval: Signature on file</th>
<th>Original Effective Date:</th>
<th>July 1, 2013</th>
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<tbody>
<tr>
<td>Chief Title: Chief Medical Officer</td>
<td>Revision Date:</td>
<td>January 1, 2021</td>
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## 11. PHARMACY

### Attachments

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<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
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<tbody>
<tr>
<td>Appointment of Representative - CMS Form 1696 – English</td>
<td>11B</td>
</tr>
<tr>
<td>Appointment of Representative – CMS Form 1696 – Spanish</td>
<td>11B</td>
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<tr>
<td>Coverage Determination Form - Provider and Member – English</td>
<td>11B, 11F</td>
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<td>Coverage Determination Form - Provider and Member – Spanish</td>
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<tr>
<td>Denial Letter – IEHP DualChoice - Spanish</td>
<td>11B, 11F, 11M</td>
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<tr>
<td>Member Request for Pharmacy Reimbursement – IEHP DualChoice – English</td>
<td>11C, 11M</td>
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<tr>
<td>Notice of Case Status - English</td>
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<td>Notice of Case Status - Spanish</td>
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<tr>
<td>Notice of Formulary Change – English</td>
<td>11A</td>
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<tr>
<td>Notice of Formulary Change – Spanish</td>
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<tr>
<td>Notice of Redetermination – English</td>
<td>11B, 11F, 11M</td>
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<td>Notice of Redetermination – Spanish</td>
<td>11B, 11F, 11M</td>
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<tr>
<td>Notice of Right to an Expedited Grievance – Pharmacy - English</td>
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<td>Notice of Right to an Expedited Grievance – Pharmacy - Spanish</td>
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<td>Request for Addition or Deletion of a Drug to the Formulary</td>
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# Appointment of Representative

<table>
<thead>
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<th>Name of Party</th>
<th>Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)</th>
</tr>
</thead>
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## Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, ______________________, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

<table>
<thead>
<tr>
<th>Signature of Party Seeking Representation</th>
<th>Date</th>
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<tbody>
<tr>
<td>Street Address</td>
<td>Phone Number (with Area Code)</td>
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<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Email Address (optional)</td>
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</tr>
</tbody>
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## Section 2: Acceptance of Appointment

To be completed by the representative:

I, ______________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party’s representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an ______________________

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

<table>
<thead>
<tr>
<th>Signature of Representative</th>
<th>Date</th>
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<tbody>
<tr>
<td>Street Address</td>
<td>Phone Number (with Area Code)</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Email Address (optional)</td>
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</tbody>
</table>

## Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing ______________________ before the Secretary of HHS.

<table>
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<th>Signature</th>
<th>Date</th>
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## Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

<table>
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<th>Signature</th>
<th>Date</th>
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</table>
Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, “Petition to Obtain Representative Fee” elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative’s fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you’ve been discriminated against. Visit https://www.cms.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-1696 (Rev 08/18)
### Sección 1: Nombramiento de un Representante

Para ser completada por la parte que busca representación (i.e., el beneficiario de Medicare, el proveedor o suplidor):

Yo nombro a __________________________ para actuar como representante en relación con mi reclamación o derecho en virtud del título XVIII de la Ley del Seguro Social (la Ley) y sus disposiciones relacionadas al título XI de la Ley. Autorizo a este individuo a realizar cualquier solicitud; presentar o obtener pruebas; obtener información sobre apelaciones; y recibir toda notificación sobre mi reclamación, apelación, queja o solicitud en mi representación. Entiendo que podría divulgarse la información médica personal sobre mi solicitud al representante indicado a continuación.

| Firma de la Parte Solicitando Representación | Fecha |
| Dirección | Número de teléfono (con código de área) |
| Ciudad | Estado | Código Postal |
| Correo electrónico (opcional) |

### Sección 2: Aceptación del Nombramiento

Para ser completado por el representante:

Yo, __________________________, acepto por la presente el nombramiento antes mencionado. Certifico que no se me ha descalificado, suspendido o prohibido mi desempeño profesional ante el Departamento de Salud y Servicios Humanos (HHS en inglés); que no estoy en calidad de empleado actual o anteriormente de los Estados Unidos, descalificado para actuar como representante del participante; y que reconozco que todo honorario podría estar sujeto a revisión y aprobación de la Secretaría.

Me desempeño como __________________________

(Situación profesional o relación con la parte, por ejemplo: abogado, pariente, etc.)

| Firma del representante | Fecha |
| Dirección | Número de teléfono (con código de área) |
| Ciudad | Estado | Código Postal |
| Correo electrónico (opcional) |

### Sección 3: Renuncia al Cobro de Honorarios por Representación

Instrucciones: El representante debe completar esta sección si se lo requieren o si renuncia al cobro de honorarios por representación. (Los proveedores o suplidores que representan a un beneficiario y le hayan brindado artículos o servicios no pueden cobrar honorarios por representación y deben completar esta sección).

Renuncio a mi derecho de cobrar un honorario por representar a __________________________ ante el Secretario(a) del HHS.

| Firma | Fecha |

### Sección 4: Renuncia al Pago por Artículos o Servicios en Cuestión

Instrucciones: Los proveedores o suplidores que actúan como representantes de beneficiarios a los que les brindaron artículos o servicios deben completar esta sección si la apelación involucra un tema de responsabilidad en virtud de la sección 1879(a)(2) de la Ley. (La sección 1879(a)(2) en general se aborda si un proveedor, suplidor o beneficiario no tenía conocimiento o no se podía esperar razonablemente que supiera que los artículos o servicios en cuestión no estarían cubiertos por Medicare).

| Firma | Fecha |
Renuncio a mi derecho de cobrar al beneficiario un honorario por los artículos o servicios en cuestión en esta apelación si está pendiente una determinación de responsabilidad bajo la sección 1879(a)(2) de la Ley.

Firma  
Fecha

Cobro de Honorarios por Representación de Beneficiarios ante el Secretario(a) del HHS

Un abogado u otro representante de un beneficiario, que desee cobrar un honorario por los servicios prestados en relación con una apelación ante el Secretario(a) del HHS (i.e., una audiencia con un Juez de Derecho Administrativo (ALJ en inglés) o la revisión de un abogado adjudicador por la Oficina de Audiencias y Apelaciones de Medicare (OMHA en inglés), una revisión con el Consejo de Apelaciones de Medicare o un proceso ante OMHA o el Consejo de Apelaciones de Medicare como resultado de una orden de remisión de la Corte de Distrito Federal) debe por ley obtener aprobación para recibir un honorario de acuerdo con 42 CFR §405.910(f).

Mediante este formulario, “Solicitud para Obtener un Honorario por Concepto de Representación” se obtiene la información necesaria para solicitar el pago de honorario. Debe ser completado por el representante y presentado con la solicitud para audiencia con el ALJ revisión de OMHA o revisión del Consejo de Apelaciones de Medicare. La aprobación de honorarios para el representante no es necesaria si: (1) el apelante es representado por un proveedor o suplidor; (2) prestados en calidad oficial como un tutor legal, comité o cargo similar representante designado por el tribunal y con la aprobación del tribunal en cuestión; (3) el honorario es por representación del beneficiario ante la corte de distrito federal; o (4) el representante desea renunciar al cobro de un honorario, puede hacerlo. La sección 3 en la primera página de este formulario puede usarse para ese propósito. En algunas instancias, según se indica en el formulario, no se cobrará el honorario por concepto de representación.

Aprobación de Honorarios

El requisito para la aprobación de honorarios garantiza que el representante recibirá una remuneración justa por los servicios prestados ante HHS en nombre de un beneficiario y brinda al beneficiario la seguridad de que los honorarios sean razonables. Para la aprobación de un honorario solicitado, OMHA o el Consejo de Apelaciones de Medicare considera la clase y el tipo de servicios prestados, la complejidad del caso, el nivel de pericia y capacidad necesaria para la prestación de servicios, la cantidad de tiempo dedicado al caso, los resultados alcanzados, el nivel de revisión administrativa al cual el representante llevó la apelación y el monto del honorario solicitado por el representante.

Conflicto de Interés

Las secciones 203, 205 y 207 del título XVIII del Código de Estados Unidos consideran como un delito penal cuando ciertos funcionarios, empleados y antiguos funcionarios y empleados de los Estados Unidos prestan ciertos servicios en temas que afectan al Gobierno, ayudan o asisten en el procesamiento de reclamaciones contra los Estados Unidos. Los individuos con un conflicto de interés quedarán excluidos de ser representantes de los beneficiarios ante HHS.

Dónde Enviar este Formulario

Envíe este formulario al mismo lugar que está enviando (o ha enviado) su: apelación si está solicitando una apelación, queja o protesta si está solicitando una queja o protesta, o determinación o decisión inicial si está solicitando una determinación o decisión inicial. Si necesita ayuda, comuníquese con 1-800-MEDICARE (1-800-633-4227) o con su plan de Medicare. Usuarios TTY debe llamar al 1-877-486-2048.

Usted tiene derecho a obtener la información de Medicare en un formato accesible, como en letra grande, Braille o audio. También tiene el derecho de presentar una queja si piensa que ha sido discriminado. Visite https://www.cms.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html o llame al 1-800-MEDICARE para más información.

De acuerdo con la Ley de Reducción de Papeleo de 1995, no se le requiere a ninguna persona responder a una recopilación de información a menos de que presente un número de control válido OMB. El número de OMB para esta recopilación es 0938-0950. El tiempo requerido para completar este formulario es de 15 minutos por notificación, incluyendo el tiempo necesario para seleccionar el formulario pre-impresso, completar y entregarlo al beneficiario. Si tiene comentarios sobre el tiempo estimado para completarlo o sugerencias para mejorar este formulario, favor de escribir a: CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, MD 21244-1850.
REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address: IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Fax Number: (909) 890-5877

You may also ask us for a coverage determination by phone at 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays (TTY) 1-800-718-4347 or through our website at www.iehp.org.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Member’s Information

<table>
<thead>
<tr>
<th>Member’s Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Member’s Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Phone

<table>
<thead>
<tr>
<th>Member’s Member ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Complete the following section ONLY if the person making this request is not the member or prescriber:

Requestor’s Name

<table>
<thead>
<tr>
<th>Requestor’s Relationship to Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tbody>
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<td></td>
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</tbody>
</table>

Phone

<table>
<thead>
<tr>
<th>Member’s Member ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Representation documentation for requests made by someone other than member or the member’s prescriber:

Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.
Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

<table>
<thead>
<tr>
<th>Type of Coverage Determination Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*</td>
</tr>
<tr>
<td>☐ I have been using a drug that was previously included on the plan’s list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*</td>
</tr>
<tr>
<td>☐ I request prior authorization for the drug my prescriber has prescribed.*</td>
</tr>
<tr>
<td>☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*</td>
</tr>
<tr>
<td>☐ I request an exception to the plan’s limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*</td>
</tr>
<tr>
<td>☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*</td>
</tr>
<tr>
<td>☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*</td>
</tr>
<tr>
<td>☐ My drug plan charged me a higher copayment for a drug than it should have.</td>
</tr>
<tr>
<td>☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.</td>
</tr>
</tbody>
</table>

*NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached “Supporting Information for an Exception Request or Prior Authorization” to support your request.

Additional information we should consider (attach any supporting documents):

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.
☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).

Signature: [ ]

Date: [ ]

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber’s supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

Prescriber’s Information

Name

Address

City

State

Zip Code

Office Phone

Fax

Prescriber’s Signature

Date

Diagnosis and Medical Information

Medication: [ ]

Strength and Route of Administration: [ ]

Frequency: [ ]

Date Started: [ ]

☑ NEW START

Expected Length of Therapy: [ ]

Quantity per 30 days

Height/Weight: [ ]

Drug Allergies: [ ]

DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes.

(If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)

ICD-10 Code(s)

Other RELEVANT DIAGNOSES:

ICD-10 Code(s)

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

DRUGS TRIED

(if quantity limit is an issue, list unit dose/total daily dose tried)

DATES of Drug Trials

RESULTS of previous drug trials

FAILURE vs INTOLERANCE (explain)

(Continued on next page)
<table>
<thead>
<tr>
<th>DRUGS TRIED</th>
<th>DATES of Drug Trials</th>
<th>RESULTS of previous drug trials</th>
</tr>
</thead>
<tbody>
<tr>
<td>(if quantity limit is an issue, list unit dose/total daily dose tried)</td>
<td></td>
<td>FAILURE vs INTOLERANCE (explain)</td>
</tr>
</tbody>
</table>

What is the member’s current drug regimen for the condition(s) requiring the requested drug?

### DRUG SAFETY

- Any FDA NOTED CONTRAINDICATIONS to the requested drug? □ YES □ NO
- Any concern for a DRUG INTERACTION with the addition of the requested drug to the member’s current drug regimen? □ YES □ NO

If the answer to either of the questions noted above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety.

### HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY

- If the member is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient? □ YES □ NO

### OPIOIDS – (please complete the following questions if the requested drug is an opioid)

- What is the daily cumulative Morphine Equivalent Dose (MED)? __________ mg/day
- Are you aware of other opioid prescribers for this member? □ YES □ NO
  - If so, please explain.

- Is the stated daily MED dose noted medically necessary? □ YES □ NO
- Would a lower total daily MED dose be insufficient to control the member’s pain? □ YES □ NO

### RATIONALE FOR REQUEST

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

- Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering), etc.

- Medical need for different dosage form and/or higher dosage [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]
☐ **Request for formulary tier exception** Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated

☐ **Other** (explain below)

**Required Explanation**
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
SOLICITUD DE DETERMINACIÓN DE COBERTURA DE MEDICAMENTOS RECETADOS DE MEDICARE

Puede enviarnos este formulario por correo o por fax:

Dirección: Número de Fax:
IEHP DualChoice (909) 890-5877
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Usted también puede solicitarnos una determinación de cobertura por teléfono al 1-877-273-IEHP (4347), 8am - 8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos (TTY) 1-800-718-4347), o a través de nuestro sitio web en www.iehp.org.

Quién Puede Realizar una Solicitud: El profesional que le receta medicamentos puede solicitarnos una determinación de cobertura en nombre de usted. Si desea que otra persona (como un familiar o un amigo) realice una solicitud por usted, esa persona debe ser su representante. Comuníquese con nosotros para obtener información sobre cómo designar a un representante.

Información del Miembro

<table>
<thead>
<tr>
<th>Nombre del Miembro</th>
<th>Fecha de Nacimiento</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dirección del Miembro</td>
<td></td>
</tr>
<tr>
<td>Ciudad</td>
<td>Estado</td>
</tr>
<tr>
<td>Teléfono</td>
<td>N.º de Identificación de Miembro del Miembro</td>
</tr>
</tbody>
</table>

Complete la siguiente sección ÚNICAMENTE si quien realiza esta solicitud no es el Miembro ni el profesional que receta medicamentos

<table>
<thead>
<tr>
<th>Nombre del Solicitante</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relación del Solicitante con el Miembro</td>
</tr>
<tr>
<td>Dirección</td>
</tr>
<tr>
<td>Ciudad</td>
</tr>
<tr>
<td>Teléfono</td>
</tr>
</tbody>
</table>

Documentación de representación para solicitudes realizadas por una persona que no sea el Miembro o el profesional que emite las recetas del Miembro:

Adjunte documentación que demuestre la autorización para representar al Miembro (un Formulario de Autorización de Representación CMS-1696 completado o un documento escrito equivalente). Para obtener más información sobre cómo designar a un representante, comuníquese con su plan o al 1-800-Medicare.
Nombre del medicamento con receta que solicita (si es posible, incluya la concentración y la cantidad solicitada por mes):

<table>
<thead>
<tr>
<th>Tipo de Solicitud de Determinación de Cobertura</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Necesito un medicamento que no está en la lista de medicamentos cubiertos del plan (excepción a la lista de medicamentos cubiertos).*</td>
</tr>
<tr>
<td>☐ Estuve usando un medicamento que anteriormente estaba incluido en la lista de medicamentos cubiertos del plan, pero se retirará o se retiró de esta lista durante el año del plan (excepción a la lista de medicamentos cubiertos).*</td>
</tr>
<tr>
<td>☐ Solicito la autorización previa para el medicamento que me recetó el profesional que emite las recetas médicas.*</td>
</tr>
<tr>
<td>☐ Solicito una excepción al requisito de que pruebe con otro medicamento antes de obtener el medicamento que me recetó el profesional que emite las recetas médicas (excepción a la lista de medicamentos cubiertos).*</td>
</tr>
<tr>
<td>☐ Solicito una excepción al límite del plan en la cantidad de pastillas (límite de cantidad) que puedo recibir para poder obtener la cantidad de pastillas que me recetó el profesional que emite recetas médicas (excepción a la lista de medicamentos cubiertos).*</td>
</tr>
<tr>
<td>☐ Mi plan de medicamentos cobra un copago más alto por el medicamento que me recetó el profesional que emite recetas médicas que el que cuesta otro medicamento que trata mi condición, y quiero pagar el copago más bajo (excepción al nivel).*</td>
</tr>
<tr>
<td>☐ Estuve usando un medicamento que anteriormente estaba incluido en un nivel de copago más bajo, pero que se pasará o ha pasado a un nivel de copago más alto (excepción al nivel).*</td>
</tr>
<tr>
<td>☐ Mi plan de medicamentos me cobró un copago más alto por un medicamento de lo que debería haber cobrado.</td>
</tr>
<tr>
<td>☐ Deseo que me reembolsen un medicamento recetado cubierto que pagué de mi bolsillo.</td>
</tr>
</tbody>
</table>

*NOTA: Si usted solicita una excepción a la lista de medicamentos cubiertos o al nivel, el profesional que le receta medicamentos DEBE proporcionar una declaración que respalde su solicitud. Las solicitudes que están sujetas a autorización previa (o a cualquier otro requisito de administración de la utilización) pueden requerir información de respaldo. El profesional que le receta medicamentos puede usar la “Información de Respaldo para una Solicitud de Excepción o Autorización Previa” adjunta para respaldar su solicitud.

Información adicional que debemos considerar (adjunte cualquier documento de respaldo):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Nota Importante: Decisiones Aceleradas

Si usted o el profesional que le receta medicamentos consideran que una espera de 72 horas para una decisión estándar podría afectar gravemente su vida, su salud o su capacidad para recuperar una función por completo, usted puede solicitar una decisión acelerada (rápida). Si el profesional que le receta medicamentos indica que una espera de 72 horas podría afectar gravemente su salud, automáticamente le informaremos de nuestra decisión dentro de las 24 horas. Si usted no obtiene la declaración de respaldo del profesional que le receta medicamentos para una solicitud acelerada, nosotros decidiremos si su caso requiere una decisión rápida. No puede solicitar una determinación de cobertura acelerada si nos pide que le reembolsemos un medicamento que ya recibió.

☐ MARQUE ESTA CASILLA SI CREE QUE NECESITA UNA DECISIÓN DENTRO DE LAS 24 HORAS (si tiene una declaración de respaldo del profesional que le receta medicamentos, adjúntela a esta solicitud).

Firma: Fecha:

Información de Respaldo para una Solicitud de Excepción o Autorización Previa

Las solicitudes de EXCEPCIÓN A LA LISTA DE MEDICAMENTOS CUBIERTOS y AL NIVEL no pueden procesarse sin una declaración de respaldo de un profesional que receta medicamentos. Las solicitudes de AUTORIZACIÓN PREVIA pueden requerir información de respaldo.

☐ SOLICITUD DE REVISIÓN ACELERADA: Al marcar esta casilla y firmar a continuación, certifico que aplicar el plazo de revisión estándar de 72 horas podría poner en grave peligro la vida o la salud del Miembro o la capacidad del Miembro de recuperar las funciones por completo.

Información sobre el Profesional que Receta Medicamentos

<table>
<thead>
<tr>
<th>Nombre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dirección</td>
</tr>
<tr>
<td>Ciudad</td>
</tr>
<tr>
<td>Teléfono del consultorio</td>
</tr>
<tr>
<td>Firma del Profesional que Receta Medicamentos</td>
</tr>
</tbody>
</table>

Diagnóstico e Información Médica

<table>
<thead>
<tr>
<th>Medicamentos:</th>
<th>Concentración y Vía de Administración:</th>
<th>Frecuencia:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fecha de Inicio:</td>
<td>Duración Prevista del Tratamiento:</td>
<td>Cantidad por 30 días</td>
</tr>
<tr>
<td>☐ NUEVO INICIO</td>
<td>Alergias a Medicamentos:</td>
<td></td>
</tr>
</tbody>
</table>
**DIAGNÓSTICO:** Por favor, indique todos los diagnósticos que se tratarán con el medicamento solicitado y los códigos de Clasificación Internacional de Enfermedades ICD-10 correspondientes. (Si la condición que se tratará con el medicamento solicitado es un síntoma, p. ej., anorexia, pérdida de peso, falta de aire, dolor en el pecho, náuseas, etc., proporcione el diagnóstico que causa el/los síntoma/s si es posible)

<table>
<thead>
<tr>
<th>Código/s ICD-10</th>
</tr>
</thead>
</table>

**Otros DIAGNÓSTICOS RELEVANTES:**

<table>
<thead>
<tr>
<th>Código/s ICD-10</th>
</tr>
</thead>
</table>

**HISTORIAL DE MEDICAMENTOS:** (para el tratamiento de la/s condición/condiciones que requieren el medicamento solicitado)

<table>
<thead>
<tr>
<th>MEDICAMENTOS PROBADOS</th>
<th>FECHAS de Pruebas de Medicamentos</th>
<th>RESULTADOS de pruebas de medicamentos anteriores</th>
<th>FALTA DE EFICACIA frente a INTOLERANCIA (explique)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
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</tr>
</tbody>
</table>

¿Cuál es el régimen actual de medicamentos del Miembro para la/s condición/condiciones que requiere/n el medicamento solicitado?

**SEGURIDAD DEL MEDICAMENTO**

¿Alguna CONTRAINDICACIÓN OBSERVADA POR LA FDA para el medicamento solicitado?  ☐ SÍ  ☐ NO

¿Alguna inquietud por una INTERACCIÓN DE MEDICAMENTOS al agregar el medicamento solicitado al régimen actual de medicamentos del Miembro?  ☐ SÍ  ☐ NO

Si la respuesta a cualquiera de las dos preguntas indicadas arriba es sí, por favor, 1) explique el problema, 2) analice los beneficios frente a los posibles riesgos a pesar de la inquietud indicada, y 3) el plan de control para garantizar la seguridad

**ADMINISTRACIÓN DE MEDICAMENTOS DE ALTO RIESGO EN ADULTOS MAYORES**

Si el Miembro tiene más de 65 años, ¿considera usted que los beneficios del tratamiento con el medicamento solicitado superan los posibles riesgos en este paciente adulto mayor?  ☐ SÍ  ☐ NO

**OPIOIDES – (por favor, complete las siguientes preguntas si el medicamento solicitado es un opioide)**

¿Cuál es la Dosis Equivalente de Morfina (Morphine Equivalent Dose, MED) acumulada?  

<table>
<thead>
<tr>
<th>mg/día</th>
</tr>
</thead>
</table>

¿Conoce a otros profesionales que recetan medicamentos opioides para este Miembro?  ☐ SÍ  ☐ NO

Si es así, por favor, explique.

¿La dosis MED diaria indicada es médicamente necesaria?  ☐ SÍ  ☐ NO
¿Una dosis MED diaria total más baja sería insuficiente para controlar el dolor que presenta el Miembro?  
☐ SÍ  ☐ NO

**FUNDAMENTO DE LA SOLICITUD**

☐ **Medicamento/s alternativo/s contraindicado/s o probado/s anteriormente, pero con resultado adverso, p. ej., toxicidad, alergia o falta de eficacia terapéutica** [Especifique a continuación si aún no se indicó en la sección HISTORIAL DE MEDICAMENTOS anterior en el formulario: (1) Medicamento/s probado/s y resultados de la/s prueba/s de medicamentos (2) si el resultado es adverso, enumere el/los medicamento/s y el resultado adverso de cada uno, (3) si se trata de falta de eficacia terapéutica, indique la dosis máxima y la duración del tratamiento para el/los medicamento/s probado/s, (4) si tiene contraindicaciones, por favor, indique el motivo específico por el que el/los medicamento/s preferido/s u otro/s medicamento/s de la lista de medicamentos cubiertos está/n contraindicado/s]

☐ **El paciente se encuentra estable con el/los medicamento/s actual/es; alto riesgo de resultado clínico adverso significativo con el cambio de medicamento** Se requiere una explicación específica de cualquier resultado clínico adverso significativo anticipado y por qué se esperaría un resultado adverso significativo, p. ej., la condición ha sido difícil de controlar (se probaron muchos medicamentos, se requieren múltiples medicamentos para controlar la condición), el paciente obtuvo un resultado adverso significativo cuando la condición no se controló previamente (p. ej., hospitalizaciones o visitas médicas frecuentes o para casos agudos, ataque cardíaco, derrame cerebral, caídas, limitación significativa del estado funcional, dolor excesivo y sufrimiento), etc.

☐ **Necesidad médica para una formulación diferente de la dosis y/o dosis más alta** [Especifique a continuación: (1) Formulación/Formulaciones de dosis y/o dosis probadas y resultado de la/s prueba/s de medicamentos; (2) explique el motivo médico (3) incluya por qué la dosis de menor frecuencia con una concentración más alta no es una opción —si existe una concentración más alta—]

☐ **Solicitud de excepción a la lista de medicamentos cubiertos o al nivel** Especifique a continuación si no se indicó en la sección HISTORIAL DE MEDICAMENTOS antes en el formulario: (1) medicamento/s preferido/s o de la lista de medicamentos cubiertos probado/s y resultados de la/s prueba/s de medicamentos (2) si el resultado es adverso, enumere el/los medicamento/s y el resultado adverso de cada uno, (3) si se trata de falta de eficacia terapéutica/no tan eficaz como el medicamento solicitado, indique la dosis máxima y la duración del tratamiento para el/los medicamento/s probado/s, (4) si tiene contraindicaciones, por favor, indique el motivo específico de por qué el/los medicamento/s preferido/s u otro/s medicamento/s de la lista de medicamentos cubiertos está/n contraindicado/s]

☐ **Otro** (explique a continuación)

**Explicación Requerida**

_____________________________________________________________________________

_____________________________________________________________________________
The notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

### NOTICE OF DENIAL OF MEDICARE PART D PRESCRIPTION DRUG COVERAGE

**Date:**

<table>
<thead>
<tr>
<th>Enrollee's Name:</th>
<th>Member Number:</th>
</tr>
</thead>
</table>

**Your request was denied**

We have denied coverage or payment under your Medicare Part D benefit for the following prescription drug(s) that you or your prescriber requested:

**Why did we deny your request?**

We denied this request under Medicare Part D because

*Provide specific rationale for the denial, including any applicable Medicare coverage rule or Part D plan policy. See instructions for additional detail.*

You should share a copy of this decision with your prescriber so you and your prescriber can discuss next steps. If your prescriber requested coverage on your behalf, we have shared this decision with your prescriber.

*Language to be inserted, as applicable, for prescription drugs that are or may be covered under Medicare Parts A or B:*

*Medicare Advantage plans that also provide Part D coverage (MA-PDs):*

{This request was denied under your Medicare Part D benefit; however, coverage/payment for the requested drug(s) has been approved under Medicare Part A/B {explain the conditions of approval in a readable and understandable format}. If you think Medicare Part D should cover this drug for you, you may appeal.}
What If I Don’t Agree With This Decision?

You have the right to appeal. If you want to appeal, you must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline. You have the right to ask us for a formulary exception if you believe you need a drug that is not on our list of covered drugs (formulary). You have the right to ask us for a coverage rule exception if you believe a rule such as prior authorization or a quantity limit should not apply to you. You can either provide information that shows that you meet the coverage rule that applies to the drug you are requesting or you can ask for a coverage rule exception. You can ask for a tiering exception if you believe you should get a drug at a lower cost-sharing amount. Your prescriber must provide a statement to support your exception request.

Who May Request an Appeal?

You, your prescriber, or your representative may request an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative.

You can call us at: 1-877-273-IEHP (4347); 8am – 8pm (PST) 7 days a week, including holidays, to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at TTY: 1-800-718-4347.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours): You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- If your prescriber asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, we will automatically expedite your appeal.

- If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal. If your appeal is for payment of a drug you’ve already received, we’ll give you a written decision within 14 days.

What Do I Include with My Appeal Request?

You should include your name, address, Member number, the reasons for appealing, and any evidence you wish to attach. Remember, your doctor must provide us with a supporting statement if you’re
requesting an exception to a coverage rule. You should include information about why the coverage rule should not apply to you because of your specific medical condition. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescriber must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

How Do I Request an Appeal?

For an Expedited Appeal: You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

Phone: Toll Free: 1-877-273-IEHP (4347); TTY users call: 1-800-718-4347
Fax: (909) 890-5748

For a Standard Appeal: You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

IEHP DualChoice
Grievance Department
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

What Happens Next?

If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Get help & more information

- IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)
  Toll Free: 1-877-273-IEHP (4347); TTY users call: 1-800-718-4347
  8am – 8pm (PST), 7 days a week, including holidays. Website: www.iehp.org
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116
- State Health Insurance Program National Technical Assistance Center: 1-877-839-2675

PRA Disclosure Statement  According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0976. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.
IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.
Importante: Este aviso le explica su derecho de apelar nuestra decisión. Lea este aviso cuidadosamente. Si necesita ayuda, puede llamar a uno de los números listados en la última página bajo el título “Obtenga ayuda y más información”.

AVISO DE DENEGACIÓN DE LA PARTE D DE MEDICARE COBERTURA DE MEDICAMENTOS RECETADOS

Fecha:

<table>
<thead>
<tr>
<th>Nombre del miembro:</th>
<th>Número de miembro:</th>
</tr>
</thead>
</table>

Su pedido fue denegado
Hemos denegado la cobertura o el pago de la Parte D de Medicare, del medicamento(s) que usted o su médico han solicitado:

¿Por qué denegamos su solicitud?
Hemos denegado su solicitud debido a {Provide specific rationale for denial including any applicable Medicare coverage rule or Part D plan policy.}:

Debe compartir una copia de esta decisión con su médico, para que puedan discutir los próximos pasos. Si su médico solicitó la cobertura en su nombre, hemos compartido esta decisión con su médico.

{Language to be inserted, as applicable, for prescription drugs that are or may be covered under Medicare Parts A or B}:

{Medicare Advantage plans that also provide Part D coverage (MA-PDs):} {La Parte D de Medicare le ha denegado su pedido; sin embargo, La Parte A/B de Medicare ha aprobado la cobertura/pago del medicamento(s) solicitado(s) {explain the conditions of approval in a readable and understandable format}. Si piensa que la Parte D de Medicare tendría que haberlo pagado, puede apelar la decisión.

Formulario CMS-10146-S
Aprobado por OMB No. 0938-0976 (Rev 01/2019)
H5355_HSRX_19004_S
¿Qué puedo hacer si no estoy de acuerdo con la decisión?

**Usted tiene el derecho de apelar.** Si desea hacerlo, tiene que apelar la decisión en un plazo de 60 días de la fecha de este aviso. Le podríamos otorgar más tiempo si tiene algún motivo válido para no cumplir con el plazo estipulado. Usted tiene el derecho a solicitar una excepción al formulario si cree que necesita un medicamento que no está en la lista de los medicamentos cubiertos (formulario). También tiene el derecho a solicitarnos una excepción a una norma de cobertura, si cree que dicha norma (como una autorización previa o un límite a la cantidad) no se aplica a su caso. Puede pedir una excepción de nivel si piensa que debería obtener un medicamento con un costo compartido menor. Su médico debe proporcionar una declaración que apoye su pedido de excepción.

¿Quién puede apelar?

Usted, su médico o su representante pueden solicitar una apelación (acelerada) o estándar. Usted puede nombrar a un familiar, amigo, médico, abogado u otra persona para que actúe como su representante legal. Otras personas ya podrían estar autorizadas por la Ley estatal para representarlo.


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**INFORMACIÓN IMPORTANTE SOBRE SUS DERECHOS DE APELACIÓN**

Hay dos tipos de apelación que puede solicitar:

**Acelerada (72 horas):** Usted, su médico o su representante pueden solicitar una apelación rápida (acelerada) si usted o su médico cree que esperar 7 días para que le notifiquen la decisión, podría poner su salud en peligro. Usted no puede pedir una apelación acelerada si es por un reembolso por un medicamento que ya recibió. Si le aceptan su pedido de apelación acelerada, le deben comunicar la decisión en las 72 horas siguientes a su apelación.

- **Si su médico** solicita o apoya su pedido de apelación acelerada e indica que si tiene que esperar 7 días hasta que se tome la decisión su salud puede ser seriamente afectada, **nosotros aceleraremos automáticamente su pedido de apelación**.

- **Si solicita** una apelación acelerada sin el apoyo de la declaración de su médico, entonces nosotros determinaremos si necesita una apelación acelerada. Si decidimos que no es necesario otorgarle una apelación acelerada, se lo comunicaremos y tomaremos una decisión en un plazo de 7 días.

**Estándar (7 días):** Usted, su médico o su representante pueden solicitar una apelación estándar y le daremos una respuesta en un plazo de 7 días después de haber recibido su apelación. Si su apelación es para el pago de un medicamento que ya recibió, le daremos una decisión por escrito dentro de los 14 días.
¿Qué debo incluir en mi solicitud de apelación?
Usted debe incluir su nombre, dirección, número de miembro, los motivos de su apelación y cualquier evidencia que desee adjuntar. Si está apelando por un medicamento que no es parte de nuestro formulario, su médico debe informarnos que ningún otro medicamento de cualquier otro nivel de nuestro formulario puede tratar su problema de salud eficazmente, como el medicamento que le ha recetado y que no está en el formulario, o que cualquier otro medicamento podría ser adverso para su salud.

¿Cómo apelo la decisión?

Para una apelación acelerada: Usted, su médico o su representante debe comunicarse con nosotros por teléfono o fax a los números siguientes:

Teléfono: 1-877-273-IEHP (4347); TTY users call: 1-800-718-4347

Fax: (909) 890-5748

Para una apelación estándar: Usted, su médico o su representante debe enviar por correo postal o entregar una solicitud de apelación por escrito a la dirección siguiente:

IEHP DualChoice
Grievance Department
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

¿Qué ocurre después?

Si usted apela, evaluaremos nuevamente su caso y tomaremos una decisión. Si la cobertura de cualquier medicamento que haya solicitado es denegada nuevamente, puede pedir que un revisor independiente que no pertenezca al plan Medicare de medicamentos recetados, evalúe su caso. Si aún no está de acuerdo con la decisión, podrá apelar al nivel siguiente. Si esto ocurre le informarán sobre sus derechos de apelación.

Obtenga ayuda y más información

- IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)
  Teléfono sin cargo: Toll Free: 1-877-273-IEHP (4347); Los usuarios de TTY deben llamar al: 1-800-718-4347, 8am a 8pm (Hora del Pacífico), los 7 días de la semana, incluidos días festivos. Website: www.iehp.org
- 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al: 1-877-486-2048
- Centro de los derechos de Medicare: 1-888-HMO-9050
- Localizador Eldercare: 1-800-677-1116
- Centro de Asistencia Técnica del Programa Estatal de Asistencia sobre Seguro Médico: 1-877-839-2675
Declaración sobre la Ley para la Reducción de Trámites

De acuerdo con la Ley para la Reducción de Trámites de 1995 (PRA en inglés), las personas no están obligadas a responder una recopilación de información a menos que se exhiba un número de control de la oficina de Gerencia y Presupuesto (OMB en inglés) válido. El número de control OMB válido para esta recopilación de información es 0938-0976. El tiempo necesario para responder esta recopilación de información es de aproximadamente 30 minutos por respuesta, incluido el tiempo para revisar instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un plan de salud que tiene contratos con Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.
Member Reimbursement Form

Use this form when you pay full price for a covered prescription drug. Complete the form and send it to IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) to request to be reimbursed. **Send the original prescription label(s) and receipt(s) with this form. Reimbursement is not guaranteed.**

Your claim receipt/Pharmacy print out must contain the following information in order to be processed for payment. If the information below is not received, your claim cannot be processed and will be denied for missing information.

- Pharmacy name, address, phone
- Medication name, strength and form
- Date of service (must be within 1 year)
- Prescriber full name
- Medication quantity
- Total amount paid for medication
- National Drug Code (NDC)

**Reason for Request**

<table>
<thead>
<tr>
<th>☐ No Identification Card Available</th>
<th>☐ Copayment Inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Out Of Network Pharmacy Used</td>
<td>☐ Pharmacy Unable To Process Claim Electronically</td>
</tr>
<tr>
<td>☐ Emergency – Please Describe</td>
<td>☐ Other – Please Describe</td>
</tr>
</tbody>
</table>

**Reason for other if applicable**

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

**Member Information**

Name: ____________________________ Date of Birth: ____________________________
ID Number: ____________________________ Phone Number: ____________________________
Street Address: ____________________________ Apt/Unit #: ____________________________
City: ____________________________ State: __________ Zip Code: ____________________________
For any questions regarding this form or the reimbursement process please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347), 8am – 8pm (PST), 7 days a week, including holidays. TTY users should call 1-800-718-4347.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.
Formulario de Reembolso del Miembro

Use este formulario cuando pague el precio total de un medicamento recetado cubierto. Llene el formulario y envíelo a IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) para solicitar el reembolso. Envíe las etiquetas y los recibos originales de los medicamentos con este formulario. El reembolso no está garantizado.

Su recibo de reclamación/impresión de la Farmacia debe contener la siguiente información para que pueda procesarse para el pago. Si no recibimos la siguiente información, no se podrá procesar su reclamación y ésta será denegada por falta de información.

- Nombre, domicilio y número de teléfono de la farmacia
- Nombre, concentración y presentación del medicamento
- Fecha del servicio (debe ser dentro de un plazo de 1 año)
- Nombre completo de la persona que receta
- Cantidad de medicamento
- Cantidad total que se pagó por el medicamento
- Código Nacional de Medicamentos (National Drug Code, NDC)

Razón de la Solicitud

- La Tarjeta de Identificación No Está Disponible
- Consulta sobre el Copago
- Se Usó una Farmacia fuera de la Red
- La Farmacia No Puede Procesar la Reclamación Vía Electrónica
- Emergencia: Por Favor, Describala
- Otra: Por Favor, Describala

Motivo de la otra razón proporcionada, si corresponde

____________________________________________________________________________
____________________________________________________________________________

Información del Miembro

Nombre: _________________________Fecha de Nacimiento: _________________________
Número de Identificación: _____________Número de Teléfono: _________________________
Domicilio: _________________________________________________________________
N.º de Apartamento/Unidad: _____________
Ciudad: _________________________Estado: __________Código Postal: ________________
Si tiene alguna pregunta acerca de este formulario o sobre el proceso de reembolso, por favor, llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347), de 8am-8pm (Hora del Pacífico), los 7 días de la semana, incluidos días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un Plan de Salud que tiene contratos con Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.
NOTICE OF CASE STATUS

<Date>

<Member Name>
<Street Address>
<City>, <State>, <Zip Code>

Member ID Number: <Member ID>
Case Number: <Case Number>

Dear <Member Name>:

This letter is to inform you that your request for a [“standard initial decision for benefits”] [“standard initial decision for reimbursement”] [“fast initial decision”] [“standard” appeal] [“fast” appeal] from IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) was forwarded to an independent organization for review on <insert date>.

[For a “standard initial decision” request [for benefits] [for reimbursement] Your case file was forwarded to an independent review organization because we did not provide you with an answer within [72 hours] [14 days] after receiving your request.]

[For a “fast initial decision” request: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 24 hours after receiving your request.]

[For a “standard” appeal: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 7 calendar days after receiving your appeal.]

[For a “fast” appeal: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 72 hours after receiving your appeal.]

The law requires us to forward your case file to an independent review organization within 24 hours if we do not provide you with an answer within the required time frame.

The independent review organization has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization. [Plans must indicate if there is a charge for the copy.].
You have the right to submit additional evidence about your case. If you choose to submit additional evidence, you should send it promptly to the independent review organization at

MAXIMUS Federal Services
Medicare Part D QIC
3750 Monroe Ave., Suite #702
Pittsford, NY 14534-1302
Fax: (585) 425-5301 Toll free fax: (866) 825-9507
Toll free customer service: (877) 456-5302

If you have any questions, or if you would like to request a copy of your case file, please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347), 8am – 8pm (PST), 7 days a week, including holidays. TTY users should call 1-800-718-4347.

Thank You,

The Appeal Team
IEHP DualChoice

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.
AVISO DEL ESTATUS DEL CASO

<Date>

<Member Name>
<Street Address>
<City>, <State>, <Zip Code>

Número de Identificación de Miembro: <Member ID>
Número de Caso: <Case Number>

Estimado/a <Member Name>:

El motivo de esta carta es informarle que su solicitud de [“decisión inicial estándar sobre beneficios”] [“decisión inicial estándar sobre reembolso”] [“decisión inicial rápida”] [apelación “estándar”] [apelación “rápida”] de IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) se envió a una organización independiente para su revisión el <insert date>.

[For a “standard initial decision” request [for benefits] [for reimbursement] El expediente de su caso se envió a una organización de revisión independiente porque no le proporcionamos una respuesta dentro de [las 72 horas] [los 14 días] posteriores a la recepción de su solicitud.]

[For a “fast initial decision” request: El expediente de su caso se envió a una organización de revisión independiente porque no le proporcionamos una respuesta dentro de las 24 horas posteriores a la recepción de su solicitud.]

[For a “standard” appeal: El expediente de su caso se envió a una organización de revisión independiente porque no le proporcionamos una respuesta dentro de siete días del calendario posteriores a la recepción de su apelación.]

[For a “fast” appeal: El expediente de su caso se envió a una organización de revisión independiente porque no le proporcionamos una respuesta dentro de las 72 horas posteriores a la recepción de su apelación.]

La ley nos exige enviar el expediente de su caso a una organización de revisión independiente dentro de las 24 horas si no le damos una respuesta dentro del plazo exigido.

La organización de revisión independiente tiene un contrato con los Centros de Servicios de Medicare y Medicaid (Centers for Medicare & Medicaid Services, CMS), la agencia del gobierno que administra el programa Medicare. La organización de revisión independiente no tiene relación alguna con nosotros. Usted tiene derecho a solicitarnos una copia del expediente de su caso que enviamos a esta organización. [Plans must indicate if there is a charge for the copy.].

H5355_MSGV_16009_S CMS Accepted
Usted tiene derecho a presentar pruebas adicionales sobre su caso. Si elige presentar pruebas adicionales, debe enviarlas lo antes posible a la organización de revisión independiente a:

MAXIMUS Federal Services  
Medicare Part D QIC  
3750 Monroe Ave., Suite #702  
Pittsford, NY 14534-1302  
Fax: (585) 425-5301 Línea gratuita de fax: (866) 825-9507  
Línea gratuita de servicio al cliente: (877) 456-5302

Si tiene alguna pregunta o si desea solicitar una copia del expediente de su caso, por favor, llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347), de 8am a 8pm (Hora del pacífico), los 7 días de la semana, incluidos los días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347.

Gracias,

El Equipo de Apelaciones de IEHP DualChoice

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un plan de salud que tiene contratos con Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.
Notice of Formulary Change

<Date>

<Member Name>
<Street Address>
<City, State Zip Code>

Member ID Number: <Insert Member ID>

Dear <insert name>:

This letter is to inform you of a change to IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) formulary.

Effective on <insert date>, <insert name of drug> is being removed from the formulary.

We are removing <insert name of drug> because the generic form of this drug is available.

You may be able to use another drug to treat your medical condition that is on our formulary. These drugs include <plan must indicate alternative drugs that are in the same therapeutic category/class or in the same cost-sharing tier.> You should ask your prescriber if one of these drugs is right for you. If your prescriber prescribes one of these drugs for you, your expected cost will be $0. For more information about copays, please refer to the IEHP DualChoice Member Handbook.

If your prescriber believes that none of the drugs listed above is right for you due to your medical condition, you may request an exception to our formulary. To file a request, please have your doctor submit a Coverage Determination request along with supporting documentation to IEHP DualChoice Pharmacy Department at 1-909-890-2049, or fax to 1-909-890-2058. Information regarding coverage determination and appeals can be found in Chapter 9 (What to do if you have a problem or complaint [coverage decisions, appeals, complaints]) of your IEHP DualChoice Member Handbook, or on our website, www.iehp.org, in the member plans and benefit section.

Or, you can call IEHP DualChoice Member Services at 1-877-273-IEHP (4347), 8am – 8pm (PST), 7 days a week, including holidays, for help in asking for this type of decision. TTY users should call 1-800-718-4347.

If you disagree with our decision to remove <insert name of drug>, you may also file a grievance with us. Please call us at 1-877-273-IEHP (4347) (TTY: 1-800-718-4347) if you want to file a grievance. You may also send your grievance to us in writing to:

IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Or visiting our website at www.iehp.org. You may also refer to Chapter 9, Section 10 of your IEHP DualChoice Member Handbook.
Thank you.

IEHP DualChoice

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

You can get this information for free in other languages. You can ask for this in other formats, such as large print, Braille and/or audio. Call 1-877-273-IEHP (4347), 8am – 8pm (PST) 7 days a week, including holidays. TTY users should call 1-800-718-4347. The call is free.

Usted puede obtener esta información gratis en otros idiomas. Usted puede solicitar esta información en formatos alternativos como tamaño de letra grande, Braille y/o audio. Llame al 1-877-273-IEHP (4347), 8am a 8pm (Hora del Pacífico), los 7 días de la semana, incluidos días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347. La llamada es gratuita.
Aviso de Cambio en la Lista de Medicamentos Cubiertos

<Date>

<Member Name>  
<Street Address>  
<City, State Zip Code>

Número de Identificación de Miembro: <Insert Member ID>

Estimado/a <insert name>:

Esta carta tiene la finalidad de informarle sobre un cambio a la lista de medicamentos cubiertos de IEHP DualChoice Cal Medi-Connect Plan (Medicare-Medicaid Plan).

Con vigencia a partir del <insert date>, <insert name of drug> se eliminará de la lista de medicamentos cubiertos.

Eliminaremos <insert name of drug> porque está disponible la forma genérica de este medicamento.

Quizás usted pueda usar otro medicamento para tratar su condición médica que esté en nuestra lista de medicamentos cubiertos. Estos medicamentos incluyen <plan must indicate alternative drugs that are in the same therapeutic category/class or in the same cost-sharing tier.> Debe preguntarle al profesional que le emite recetas médicas si uno de estos medicamentos es adecuado para usted. Si su profesional le receta uno de estos medicamentos, su costo previsto será de $0. Para obtener más información sobre copagos, consulte el Manual para Miembros de IEHP DualChoice.

Si el profesional que le receta medicamentos considera que ninguno de los medicamentos indicados más arriba es adecuado para usted debido a su condición médica, usted puede solicitar una excepción a nuestra lista de medicamentos cubiertos. Para presentar una solicitud, por favor, pida a su doctor que presente una solicitud de Determinación de Cobertura junto con los documentos de respaldo ante el Departamento de Farmacia de IEHP DualChoice al 1-909-890-2049, o que la envíe por fax al 1-909-890-2058. Puede encontrar la información sobre la determinación de cobertura y las apelaciones en el Capítulo 9 (Qué hacer si tiene un problema o una queja [decisiones sobre cobertura, apelaciones, quejas]) de su Manual para Miembros de IEHP DualChoice, o en nuestro sitio web, www.iehp.org, en la sección de planes y beneficios para Miembros.

O bien, puede llamar a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347), 8am – 8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos, para recibir ayuda con este tipo de decisiones. Los usuarios de TTY deben llamar al 1-800-718-4347.

Si no está de acuerdo con nuestra decisión de eliminar <insert name of drug>, también puede presentar una queja formal ante nosotros. Por favor, llámenos al 1-877-273-IEHP (4347) (TTY: 1-800-718-4347) si quiere presentar una queja formal. También puede enviarnos su queja formal por escrito a:

IEHP DualChoice  
P.O. Box 1800  
Rancho Cucamonga, CA 91729-1800

Gracias.

IEHP DualChoice

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un Plan de Salud que tiene contratos con Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.

You can get this information for free in other languages. You can ask for this in other formats, such as large print, Braille and/or audio. Call 1-877-273-IEHP (4347), 8am – 8pm (PST) 7 days a week, including holidays. TTY users should call 1-800-718-4347. The call is free.

Usted puede obtener esta información gratis en otros idiomas. Usted puede solicitar esta información en formatos alternativos como tamaño de letra grande, Braille y/o audio. Llame al 1-877-273-IEHP (4347), 8am – 8pm (Hora del Pacífico), los 7 días de la semana, incluidos días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347. La llamada es gratuita.
Request for Redetermination of Medicare Prescription Drug Denial

Because IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address: IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Fax Number: (909) 890-5866

You may also ask us for an appeal through our website at www.iehp.org.

Expedited appeal requests can be made by phone at 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays (TTY) 1-800-718-4347).

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.
## Member’s Information

Member’s Name __________________________ Date of Birth ________________

Member’s Address ________________________________

City __________________________ State _______ Zip Code ________________

Phone ________________________________

Member ID Number ________________________________

**Complete the following section ONLY if the person making this request is not the member:**

Requestor’s Name ________________________________

Requestor’s Relationship to Member ________________________________

Address ________________________________

City __________________________ State _______ Zip Code ________________

Phone ________________________________

### Representation documentation for appeal requests made by someone other than member or the member’s prescriber:

Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.

---

## Prescription drug you are requesting:

Name of drug: ____________________________ Strength/quantity/dose: ________________

Have you purchased the drug pending appeal?  □ Yes  □ No

If “Yes”:

Date purchased: ________________ Amount paid: $ _______ (attach copy of receipt)

Name and telephone number of pharmacy: ________________________________
Prescriber’s Information

Name ______________________________________________________________

Address ___________________________________________________________

City ___________________________ State _______ Zip Code _______________

Office Phone ___________________________ Fax ___________________________

Office Contact Person _____________________________________________

Important Note: Expedited Decisions
If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber’s support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS (if you have a supporting statement from your prescriber, attach it to this request).

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage and have your prescriber address the Plan’s coverage criteria, if available, as stated in the Plan’s denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan’s coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

________________________________________ Date: ________________

Signature of person requesting the appeal (the member or the representative):
Solicitud de Redeterminación de la Denegación de Medicamentos Recetados de Medicare

Debido a que IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) denegó su solicitud de cobertura (o de pago) de un medicamento recetado, usted tiene derecho a solicitarnos una redeterminación (apelación) de nuestra decisión. Tiene 60 días a partir de la fecha de nuestro Aviso de Denegación de la Cobertura de Medicamentos recetados de Medicare para solicitarnos una redeterminación. Puede enviarnos este formulario por correo o por fax:

Dirección: IEHP DualChoice
Núm. de Fax: (909) 890-5866
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

También puede solicitarnos una apelación a través de nuestro sitio web en www.iehp.org.

Las solicitudes de apelaciones aceleradas pueden realizarse por teléfono al 1-877-273-IEHP (4347), 8am - 8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos (TTY) 1-800-718-4347).

Quién Puede Realizar una Solicitud: El profesional que le receta medicamentos puede solicitarnos una apelación en su nombre. Si usted desea que otra persona (como un familiar o un amigo) solicite una apelación por usted, esa persona debe ser su representante. Comuníquese con nosotros para obtener información sobre cómo designar a un representante.
**Información del Miembro**

<table>
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<tr>
<th>Nombre del Miembro</th>
<th>Fecha de Nacimiento</th>
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<th>Dirección del Miembro</th>
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<tr>
<th>Ciudad</th>
<th>Estado</th>
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<th>Teléfono</th>
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Número de Identificación de Miembro ________________

**Complete la siguiente sección ÚNICAMENTE si quien realiza esta solicitud no es el Miembro:**

<table>
<thead>
<tr>
<th>Nombre del Solicitante</th>
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<th>Relación del Solicitante con el Miembro</th>
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<th>Teléfono</th>
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**Documentación de representación para solicitudes de apelación realizadas por una persona que no sea el Miembro o el profesional que receta los medicamentos del Miembro:**

Adjunte documentación que demuestre la autorización para representar al Miembro (un Formulario de Autorización de Representación CMS-1696 completado o un documento escrito equivalente) si dicha documentación no se presentó en el nivel de determinación de cobertura. Para obtener más información sobre cómo designar a un representante, comuníquese con su plan o al 1-800-Medicare.

**Medicamento recetado que solicita:**

<table>
<thead>
<tr>
<th>Nombre del medicamento:</th>
<th>Concentración/cantidad/dosis:</th>
</tr>
</thead>
</table>

¿Ya compró el medicamento que está en espera de la apelación? □ Sí □ No

Si la respuesta es “Sí”:

<table>
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<tr>
<th>Fecha en que lo compró:</th>
<th>Cantidad pagada: $ _______ (adjunte una copia del recibo)</th>
</tr>
</thead>
</table>

Nombre y número de teléfono de la farmacia: ________________________________
Información sobre el profesional que receta medicamentos

Nombre ____________________________________________________________
Dirección __________________________________________________________
Ciudad ___________________________ Estado _________ Código Postal _____________
Teléfono del Consultorio __________________________ Fax _________________
Persona de Contacto del Consultorio ______________________________________

Nota Importante: Decisiones Aceleradas
Si usted o el profesional que le receta medicamentos consideran que una espera de siete días para una decisión estándar podría afectar gravemente su vida, su salud o su capacidad para recuperar una función por completo, usted puede solicitar una decisión acelerada (rápida). Si su profesional que le receta medicamentos indica que una espera de siete días podría afectar gravemente su salud, automáticamente le informaremos de nuestra decisión dentro de las 72 horas. Si usted no obtiene la declaración de respaldo del profesional que le receta medicamentos para una apelación acelerada, nosotros decidiremos si su caso requiere una decisión rápida. No puede solicitar una apelación acelerada si nos pide que le reembolsemos un medicamento que ya recibió.

☐ MARQUE ESTA CASILLA SI CREE QUE NECESITA UNA DECISIÓN DENTRO DE LAS 72 HORAS (si tiene una declaración de respaldo del profesional que le receta medicamentos, adjúntela a esta solicitud).

Por favor, explique los motivos por los que presenta su apelación. Adjunte páginas adicionales si es necesario. Adjunte cualquier información adicional que considere que pueda ayudar con su caso, como una declaración de parte del profesional que le receta medicamentos y los registros médicos pertinentes. Le recomendamos que consulte la explicación que brindamos en el Aviso de Denegación de la Cobertura de Medicamentos Recetados de Medicare y que el profesional que le emite la receta médica satisfaga los criterios de cobertura del Plan, si corresponde, según lo indicado en la carta de denegación del Plan o en otros documentos del Plan. Se necesitará la opinión del profesional que le receta medicamentos para explicar por qué usted no puede cumplir con los criterios de cobertura del Plan y/o por qué los medicamentos requeridos por el Plan no son médicamente apropiados para usted.

__________________________________ __________________________
Firma de la persona que solicita la apelación (el Miembro o representante): Fecha: ______________
Date:

Patient Name: <Member Name> Patient ID Number: <Member ID>
<Member Address>

Notice of Right to an Expedited Grievance

_____ You are receiving this notice because we are denying your request to expedite (put on a fast track) your initial request for a Part D drug.

_____ You are receiving this notice because we are denying your request to expedite (put on a fast track) your appeal for a Part D drug.

Your request has been transferred to our regular processing time frame.

Initial requests will be processed no later than 72 hours and appeal requests will be processed no later than 7 calendar days from the day we received your request.

You may submit your request.

You may resubmit your request to expedite (put on a fast track) your initial request or appeal. If your prescribing physician or other prescriber tells us that applying the standard time frame could put your life or health at risk, we will automatically expedite your request.

You may file an expedited grievance.

If you disagree with our decision not to give you a fast decision, you may file an expedited grievance with us. We must decide within 24 hours if our decision to deny making a fast decision puts your life or health at risk.

If we determine that we should have expedited your request, we will do so immediately and notify you of our decision.

Please call us at 1-877-273-IEHP (4347) if you want to file an expedited grievance, or want more information.

You can also call 1-800-MEDICARE for more information about the expedited grievance process.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.
<DATE>

<MEMBER NAME>
<Address>
<CITY, STATE ZIP>

Dear <MEMBER NAME>:

This letter is to inform you that we can no longer cover prescription medications effective <Effective Date of OIG Exclusion> that are [Insert one <prescribed> <dispensed><distributed><manufactured>] by [Insert one <NAME OF PRESCRIBER> <NAME OF PHARMACY> <NAME OF DISTRIBUTOR><NAME OF MANUFACTURER>]. This includes new prescriptions, as well as any refills left on the prescriptions(s) you are currently taking.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) cannot cover medications [Insert one <prescribed> <dispensed><distributed> <manufactured>] by [Insert one <NAME OF PRESCRIBER> <NAME OF PHARMACY> <NAME OF DISTRIBUTOR><NAME OF MANUFACTURER>] because he/she/it has been excluded from participation in all federal health care programs as of <Effective Date of Exclusion>, including the Medicare program, by the U.S. Department of Health and Human Services’ Office of Inspector General (OIG). Medicare plans are prohibited from making payment for prescriptions prescribed, dispensed, or furnished by excluded individuals and entities. For more information about exclusions, you may visit the OIG’s website at http://oig.hhs.gov/fraud/exclusions.asp.

{Sponsors should insert at least one of the three sentences below.} [Please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347) (TTY users should call 1-800-718-4347) if you need assistance finding another <pharmacy>.]  [Please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347) (TTY users should call 1-800-718-4347) if you need assistance finding another provider in your area who can prescribe your medications.] [Please call your prescriber if you need assistance finding another medication.] If you have further questions regarding the status of your prescription(s), we are available from 8am – 8pm (PST) 7 days a week, including holidays. TTY users should call 1-800-718-4347. The call is free.

Sincerely,

<Plan Representative>

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

Last Updated <Date>
Estimado/a <MEMBER NAME>:

El motivo de esta carta es para informarle que, a partir del <Effective Date of OIG Exclusion> no podremos seguir cubriendo los medicamentos recetados que sean [Insert one <recetados> <despachados><distribuidos><fabricados>] por [Insert one <NAME OF PRESCRIBER> <NAME OF PHARMACY> <NAME OF DISTRIBUTOR><NAME OF MANUFACTURER>].

Tampoco podremos cubrir nuevas recetas ni resurtidos restantes de los medicamentos recetados que usted toma actualmente.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) no puede cubrir medicamentos [Insert one <recetados> <despachados><distribuidos><fabricados>] por [Insert one <NAME OF PRESCRIBER> <NAME OF PHARMACY> <NAME OF DISTRIBUTOR><NAME OF MANUFACTURER>] porque este/a ha sido excluido/a de participar en todos los programas federales de atención médica a partir del <Effective Date of Exclusion>, incluido el programa Medicare, por la Oficina del Inspector General (Office of Inspector General, OIG) del Departamento de Salud y Servicios Humanos de los Estados Unidos. Los planes de Medicare tienen prohibido hacer pagos por los medicamentos que sean recetados, despachados o suministrados por personas y entidades excluidas. Para obtener más información sobre las exclusiones, puede visitar el sitio web del OIG en http://oig.hhs.gov/fraud/exclusions.asp.

{Sponsors should insert at least one of the three sentences below.}

[Por favor, llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347) (los usuarios de TTY deben llamar al 1-800-718-4347) si necesita ayuda para encontrar otra <farmacia>.] [Por favor, llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347) (los usuarios de TTY deben llamar al 1-800-718-4347) si necesita ayuda para encontrar otro proveedor en su área que pueda recetarle sus medicamentos.] [Por favor, llame al profesional que le receta si necesita ayuda para encontrar otro medicamento.] Si tiene más preguntas sobre el estado de sus recetas, estamos disponibles de 8am-pm (Hora del Pacífico), los 7 días de la semana, incluidos días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347. La llamada es gratuita.

Atentamente,

<Plan Representative>
IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un Plan de Salud que tiene contratos con Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.

Última actualización: <Date>
YOUR DRUG(S) IS NOT ON OUR LIST OF COVERED DRUGS (FORMULARY) OR IS SUBJECT TO CERTAIN LIMITS

Dear <MEMBER NAME>:

We want to tell you that <IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) has provided you with a temporary supply of the following prescription[s]:

- <name of drug1>
- <name of drug2>
- <name of drug3>
- <name of drug4>
- <name of drug5>

This drug[s] is either not included on our list of covered drugs (called our formulary), or it’s included on the formulary but subject to certain limits, as described in more detail later in this letter. The Plan is required to provide you with a temporary supply of this drugs[s]. If your prescription is written for fewer than [insert number of days that corresponds to the number of days designated as a month’s supply in approved plan benefit package] days, we’ll allow multiple fills to provide up to a maximum of [insert supply limit - must be at least a one month supply based on approved plan benefit package] of medication.

It’s important to understand that this is a temporary supply of this drug(s). Well before you run out of this drug[s], you should speak to the Plan and/or the prescriber about:

- changing the drug[s] to another drug[s] that is on our formulary; or
- requesting approval for the drug[s] by demonstrating that you meet our criteria for coverage; or
- requesting an exception from our criteria for coverage.

When you request approval for coverage or an exception from coverage criteria, these are called coverage determinations. Don’t assume that any coverage determination, including any exception, you have requested or appealed has been approved just because you receive more fills of a drug. If we approve coverage, then we’ll send you another written notice.
If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, contact us at <1-877-273-4347>. TTY users should call <1-800-718-4347>. Live representatives are available from <8am - 8pm PST, 7 days/wk>. You can ask us for a coverage determination at any time. Instructions on how to change your current prescription[s], how to ask for a coverage determination, including an exception, and how to appeal a denial if you disagree with our coverage determination are discussed at the end of this letter.

The following is a specific explanation of why your drug[s] <is/are> not covered or <is/are> limited.

| Name of Drug: <name of drug>  
| Date Filled: <date filled>  
| Reason for Notification: This drug is not on our formulary. We will not continue to pay for this drug after you have received the maximum [insert number- must be at least a one month supply based on approved plan benefit package] days' temporary supply that we are required to cover, unless you obtain a formulary exception from us. |

| Name of Drug: <name of drug>  
| Date Filled: <date filled>  
| Reason for Notification: This drug is not on our formulary. In addition, we could not provide the full amount that was prescribed, because we limit the amount of this drug that we provide at one time. This is called a quantity limit and we impose such limits for safety reasons. In addition to imposing quantity limits as this drug is dispensed for safety reasons, we will not continue to pay for this drug after you have received the maximum [insert number- must be at least a one month supply based on approved plan benefit package] days' supply that we are required to cover unless you obtain a formulary exception from us. |

| Name of Drug: <name of drug>  
| Date Filled: <date filled>  
| Reason for Notification: This drug is on our formulary, but requires prior authorization. Unless you obtain prior authorization from us by showing us that you meet certain requirements, or we approve your request for an exception to the prior authorization requirements, we will not continue to pay for this drug after you have received the maximum [insert number- must be at least a one month supply based on approved plan benefit package] days' temporary supply that we are required to cover. |

| Name of Drug: <name of drug>  
| Date Filled: <date filled>  
| Reason for Notification: This drug is on our formulary. However, we will generally only pay for this drug if you first try other drug(s), specifically <Insert Step drug(s)> , as part of what we call a step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe, effective, and lower cost drug before progressing to other more costly drugs. Unless you try the other drug(s) on our formulary first, or we approve your request for an exception to the step therapy requirement, we will not continue to pay for this drug after you have received the maximum [insert number- must be at least a one month supply based on approved plan benefit package] days' temporary supply that we are required to cover. |

| Name of Drug: <name of drug>  
| Date Filled: <date filled>  
| Reason for Notification: This drug is on our formulary. However, we will generally only pay for this drug if you first try a generic version of this drug. Unless you try the generic drug on our formulary first, or we approve your request for an exception, we will not continue to pay for this drug after you have received the maximum [insert number- must be at least a one month supply based on approved plan benefit package] days temporary supply that we are required to cover. |

| Name of Drug: <name of drug>  
| Date Filled: <date filled>  
| Reason for Notification: This drug is on our formulary and is subject to a quantity (QL). We will not continue to provide more than what our QL permits unless you obtain an exception from the Plan. |
[Name of Drug: <name of drug>  
Date Filled: <date filled>  
Reason for Notification: This drug is not on our formulary. We will cover this drug for [insert number- must be at least a one month supply based on approved plan benefit package] while you seek to obtain a formulary exception from the Plan. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made.

[Name of Drug: <name of drug>  
Date Filled: <date filled>  
Reason for Notification: This drug is on our formulary and requires prior authorization. We will cover this drug for [insert number- must be at least a one month supply based on approved plan benefit package] days while you seek to obtain coverage by showing us that you meet the prior authorization requirements. You can also ask us for an exception to the prior authorization requirements if you believe they should not apply to you for medical reasons.

[Name of Drug: <name of drug>  
Date Filled: <date filled>  
Reason for Notification: This drug is on our formulary, but will generally be covered only if you first try certain other drugs as part of our step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. We will cover this drug for [insert number- must be at least a one month supply based on approved plan benefit package] days while you seek to obtain coverage by showing us that you meet the step therapy criteria. You can also ask us for an exception to the step therapy requirement if you believe it should not apply to you for medical reasons.

How do I change my prescription?

If your drug[s] is not on our formulary, or is on our formulary, but we have placed a limit on it, then you can ask us what other drug[s] used to treat your medical condition is on our formulary, ask us to approve coverage by showing that you meet our criteria, or ask us for an exception. We encourage you to ask your prescriber if this other drug[s] that we cover is an option for you. You have the right to request an exception from us to cover your drug[s] that was originally prescribed. If you ask for an exception, your prescriber will need to provide us with a statement explaining why a prior authorization, quantity limit, or other limit we have placed on your drug is not medically appropriate for you.

How do I request coverage determination, including an exception?

You or your prescriber may contact us to request a coverage determination, including an exception. <IEHP DualChoice>, <P. O. Box 1800>, <Rancho Cucamonga>, <CA> <91729-1800>. Fax <1-909-890-2058>, and <1-877-273-4347>.

If you are requesting coverage of a drug that is not on our formulary, or an exception to a coverage rule, your prescriber must provide a statement supporting your request. It may be helpful to bring this notice with you to the prescriber or send a copy to his or her office. If the exception request involves a drug that is not on our formulary, the prescriber’s statement must indicate that the requested drug is medically necessary for treating your condition, because all of the drugs on our formulary would be less effective as the requested drug or would have adverse effects for you. If the exception request involves a prior authorization or other coverage rule we have placed on a drug that is on our formulary, the prescriber’s statement must indicate that the coverage rule wouldn’t be appropriate for you given your condition or would have adverse effects for you.

We must notify you of our decision no later than 24 hours, if the request has been expedited, or no later than 72 hours, if the request is a standard request, from when we receive your request. For exceptions, the timeframe begins when we obtain your prescriber’s statement. Your request will be expedited if we determine, or your prescriber tells us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.
What if my request for coverage is denied?

If your request for coverage is denied, you have the right to appeal by asking for a review of the prior decision, which is called a redetermination. You must request this appeal within 60 calendar days from the date of our written decision on your coverage determination request. [Insert one: <You must file a standard request in writing.> or <We accept standard requests by phone and in writing.>] We accept expedited requests by phone and in writing. <IEHP DualChoice>, <P. O. Box 1800>, <Rancho Cucamonga>, <CA> <91729-1800>. Fax <1-909-890-2058>, and <1-877-273-4347>.

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, contact us at <1-877-273-4347> <8am - 8pm PST, 7 days/wk>. TTY users should call <1-800-718-4347>. Live representatives are available from <8am - 8pm PST, 7 days/wk> You can ask us for a coverage determination at any time. You can also visit our website at <www.iehp.org>.

Sincerely,

<IEHP Pharmaceutical Svcs Dept>

<IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.>

< H5355_HSRX_19002 >
SU MEDICAMENTO[S] RECETADO NO SE ENCUENTRA EN NUESTRA LISTA DE MEDICAMENTOS CON RECETA (FORMULARIO) O ESTÁ SOMETIDO A CIERTOS LÍMITES

Estimado <MEMBER NAME>:
Queremos decirle que <IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) le ha proporcionado un suministro temporal de la siguiente[s] receta:

- <name of drug1>
- <name of drug2>
- <name of drug3>
- <name of drug4>
- <name of drug5>

Este medicamento[s], o bien no está incluido en nuestra lista de medicamentos recetados cubiertos (llamada nuestro formulario), o está incluido[s] en el formulario pero sujeto a ciertos límites, como se describe más adelante en esta carta con más detalle. El Plan tiene obligación de proporcionarle un suministro temporal de este medicamento[s]. Si su medicamento se ha recetado para menos de [insértese el número de días que corresponda al número de días designados como suministro máximo para un mes en el paquete de prestaciones del Plan aprobado] días, permitiremos múltiples reposiciones hasta un máximo de [insertar límite de reposiciones - debe ser al menos un mes de suministro basado en el paquete de prestaciones del Plan aprobado] días de medicación.

Es importante que entienda que se trata de un suministro temporal de este medicamento[s]. Antes de que se le termine, usted debería hablar con el Plan o con el médico que se lo haya recetado sobre:

- cambiar el medicamento[s] a otro que sí esté en nuestro formulario; o
- solicitar permiso para el medicamento[s] demostrando que usted cumple nuestros criterios de cobertura; o
- solicitar una excepción a nuestros criterios de cobertura.

Cuando usted solicita permiso de cobertura o la cobertura de una excepción a los criterios de cobertura, ésto se llama determinaciones de cobertura. No asuma que cualquier determinación de cobertura, incluyendo cualquier excepción que usted haya solicitado o recurrido, ha sido aprobada, sólo porque usted reciba más reposiciones de una medicina. Si aprobamos la cobertura, le enviaremos otro aviso por escrito.
Si necesita asistencia para solicitar una determinación de cobertura, incluyendo una excepción, o si desea más información sobre cuándo cubriremos el suministro temporal de un medicamento, contacte con nosotros al <1-877-273-4347> Los usuarios de TTY deben llamar al <1-800-718-4347>. Representantes directos están disponibles de <<8am - 8pm PST, 7 days/wk>>. Usted nos puede pedir una determinación de cobertura en cualquier momento. Al final de esta carta encontrará instrucciones sobre cómo cambiar su receta[s] actual, la forma de solicitar una determinación de cobertura, incluyendo una excepción, y cómo apelar una denegación si no está de acuerdo con nuestra determinación.

Lo siguiente es una explicación concreta de por qué su medicamento[s] no está cubierto o tiene limitaciones.

**[Nombre del medicamento]:**<name of drug>
Fecha de suministro: <date filled>
**Motivo de la notificación:** Este medicamento no está en nuestro formulario. No seguiremos pagando este medicamento después de que usted haya recibido el máximo de los [insértese el número- debe ser al menos un mes de suministro basado en el paquete de prestaciones del Plan aprobado] días de suministro temporal que estamos obligados a cubrir, a menos que usted obtenga de nosotros una excepción al formulario.

**[Nombre del medicamento]:**<name of drug>
Fecha de suministro: <date filled>
**Motivo de la notificación:** Este medicamento no está en nuestro formulario. Además, no pudimos proporcionarle la cantidad total que estaba prescrita, porque limitamos la cantidad de este medicamento que podemos proporcionarle cada vez. Esto se llama cantidad límite e imponemos esos límites por razones de seguridad. Además de imponer límites de cantidad, como este medicamento se dispensa por razones de seguridad, no podremos seguir pagando este medicamento después de que usted haya recibido el máximo de los [insértese el número- debe ser al menos un mes de suministro basado en el paquete de prestaciones del Plan aprobado] días de suministro temporal que estamos obligados a cubrir, a menos que usted obtenga del Plan una excepción al formulario.

**[Nombre del medicamento]:**<name of drug>
Fecha de suministro: <date filled>
**Motivo de la notificación:** Este medicamento está en nuestro formulario, pero requiere autorización previa. A menos que usted obtenga autorización previa de nosotros demostrando que cumple ciertos requisitos, o que aprobemos su solicitud de excepción a los requisitos de autorización previa, no seguiremos pagando este medicamento después de que usted haya recibido el máximo de los [insértese el número- debe ser al menos un mes de suministro basado en el paquete de prestaciones del Plan aprobado] días de suministro temporal que estamos obligados a cubrir, a menos que usted obtenga del Plan una excepción al formulario.

**[Nombre del medicamento]:**<name of drug>
Fecha de suministro: <date filled>
**Motivo de la notificación:** Este medicamento está en nuestro formulario. Sin embargo, generalmente sólo podremos pagar este medicamento[s] si usted prueba primero otra droga[s], específicamente <Insert Step drug(s)>, como parte de lo que llamamos un programa de terapia escalonada. La terapia escalonada es la práctica de empezar una terapia de medicación con lo que consideramos ser un medicamento seguro, eficaz, y de menor costo antes de pasar a otros medicamentos más costosos. A menos que usted pruebe primero otro medicamento[s] de nuestro formulario, o que hayamos aprobado su solicitud de excepción al requisito de terapia escalonada, no seguiremos pagando este medicamento después de que usted haya recibido el máximo número de los [insértese el número- debe ser al menos un mes de suministro basado en el paquete de prestaciones del Plan aprobado] días de suministro temporal que estamos obligados a cubrir.

**[Nombre del medicamento]:**<name of drug>
Fecha de suministro: <date filled>
**Motivo de la notificación:** Este medicamento está en nuestro formulario. Sin embargo, nosotros generalmente sólo podremos pagar este medicamento si usted prueba primero una versión genérica del mismo. A menos que usted pruebe primero la versión genérica de nuestro formulario, o que hayamos...
aprobado su solicitud de excepción, no seguiremos pagando este medicamento después de que usted haya recibido el máximo número de los [insértese el número- debe ser al menos un mes de suministro basado en el paquete de prestaciones del Plan aprobado] días de suministro temporal que estamos obligados a cubrir.]

[Nombre del medicamento: <name of drug>  
Fecha de suministro: <date filled>  
Motivo de la notificación: Este medicamento está en nuestro formulario y está sujeto a un límite de cantidad (QL por sus siglas en inglés). No seguiremos proporcionándole más de lo que nuestra cantidad límite nos permite, a menos que obtenga del Plan una excepción.

[Nombre del medicamento: <name of drug>  
Fecha de suministro: <date filled>  
Motivo de la notificación: Este medicamento no está en nuestro formulario. Cubriremos este medicamento durante [insértese el número- debe ser al menos un mes de suministro basado en el paquete de prestaciones del Plan aprobado] días mientras usted trata de obtener una excepción de formulario del Plan. Si usted está procesando una excepción, consideraremos el permitir de continúe la cobertura hasta que se haya tomado una decisión.

[Nombre del medicamento: <name of drug>  
Fecha de suministro: <date filled>  
Motivo de la notificación: Este medicamento está en nuestro formulario, pero requiere autorización previa. Cubriremos este medicamento durante [insértese el número- debe ser al menos un mes de suministro basado en el paquete de prestaciones del Plan aprobado] días mientras usted trata de obtener cobertura demostrándonos que cumple los requisitos de autorización previa. También puede pedirnos una excepción a los requisitos de autorización previa si cree que no debe aplicársele a usted por razones médicas.

¿Cómo puedo cambiar mi receta?

Si su medicamento[s] no está en nuestro formulario, o lo está, pero sujeto a un límite, entonces usted puede preguntarnos qué otro fármaco utilizado para tratar su condición médica si lo está, pedirnos que aprobemos la cobertura demostrando que usted cumple nuestros criterios, o solicitar una excepción. Le animamos a que pregunte a su médico si esta droga[s] que podemos cubrir es una opción para usted. Usted tiene derecho a solicitar una excepción para cubrir el medicamento[s] que se le prescribió inicialmente. Si pide una excepción, su médico tendrá que proporcionarnos una declaración explicando por qué no es médicamente apropiadas para usted cualquier autorización previa, cantidad límite u otro límite que hayamos puesto a su medicamento.

¿Cómo puedo solicitar determinación de cobertura, incluyendo una excepción?

Usted o su médico podrán contactar con nosotros para solicitar una determinación de cobertura, incluyendo una excepción. <IEHP DualChoice>, <P. O. Box 1800>, <Rancho Cucamonga>, <CA> <91729-1800>, fax <1-909-890-2058>, y <1-877-273-4347>.

Si usted está solicitando la cobertura de un medicamento que no esté en nuestro formulario, o una excepción a una regla de cobertura, su médico debe proporcionar una declaración de apoyo a su solicitud. Puede serle
úttil llevarle este aviso a su médico o enviarle una copia a su oficina. Si la solicitud de excepción se refiere a un medicamento que no esté en nuestro formulario, el médico debe indicar en la declaración que el medicamento solicitado es clínicamente necesario para tratar su condición, porque todas las medicinas en nuestro formulario serían menos eficaces que el medicamento solicitado o tendrían efectos perjudiciales para usted. Si la solicitud de excepción incluye una autorización previa u otra regla de cobertura que hayamos impuesto a un medicamento en nuestro formulario, la declaración del médico debe indicar que la regla de cobertura no sería apropiada para usted dada su condición clínica o que tendría efectos perjudiciales para usted.

Estamos obligados a notificarle nuestra decisión en un plazo máximo de 24 horas, si la solicitud se ha agilizado, o de 72 horas, si la solicitud es estándar, desde el momento en el que hayamos recibido su petición. Para las excepciones, el plazo comienza cuando recibamos la declaración de su médico. Su solicitud será agilizada si determinamos, o su médico nos dice, que su vida, su salud o su capacidad para recobrar la función máxima podrían verse seriamente amenazadas por la espera de una decisión estándar.

¿Y si rechazan mi solicitud de cobertura?

Si se le rechaza su solicitud de cobertura, usted tiene derecho a apelar pidiendo una revisión de la decisión anterior, que se llama redeterminación. Usted debe solicitar esta apelación dentro de 60 días desde la fecha de nuestra carta de decisión sobre su petición de determinación de cobertura. [Insert one: <Usted debe presentar una solicitud estándar por escrito.> o <Aceptar peticiones estándar por teléfono y por escrito.> Aceptamos peticiones agilizadas por teléfono y por escrito. <IEHP DualChoice>, <P. O. Box 1800>, < Rancho Cucamonga>, <CA>, <91729-1800>, Fax <1-909-890-2058>, y teléfono <1-877-273-4347>.]

Si necesita asistencia para solicitar una determinación de cobertura, incluyendo una excepción, o si desea obtener más información acerca de cuándo cubriremos un suministro temporal de un medicamento, póngase en contacto con nosotros en el <1-877-273-4347> <8-8 PST, 7 días de la semana>. Los usuarios de TTY deben llamar al <1-800-718-4347>. Representantes directos están disponibles de <8-8 PST, 7 días de la semana>. Usted nos puede pedir una determinación de cobertura en cualquier momento. También puede visitar nuestro sitio web en < www.iehp.org >.

Atentamente,

<IEHP Pharmaceutical Svs Dept>

<IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un Plan de Salud que tiene un contrato con ambos Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados. >

<H5355_HSRX_19002_S>
REQUEST FOR ADDITION OR DELETION OF A DRUG TO THE FORMULARY

GENERIC NAME: ____________________________  BRAND NAME: ____________________________

MANUFACTURER(S): ____________________________

DOSAGE FORM: ____________________________

Pharmacological Classification: ____________________________

Indications: ____________________________

What similar drugs are currently available? ____________________________

What therapeutic advantage(s) does this drug have over the standard drug therapy? ____________________________

In how many patients do you expect this drug to be used during the next six months? ____________________________

What drug(s) currently used for this/these indications(s) may be deleted if this product is added to the formulary?

__________________________________________  ____________________________________________

__________________________________________  ____________________________________________

Should use of this drug be restricted to certain physicians or institutions because of the potential for misuse, high cost, or toxicity? ____________________________

REQUESTER’S NAME: ____________________________

ADDRESS & TELEPHONE: ____________________________

SIGNATURE OF REQUESTER: ____________________________  DATE: ____________________________