# Form Instructions
# "Medicare Prescription Drug Coverage and Your Rights"
# Pharmacy Notice

CMS-10147

A Medicare Part D plan must provide this notice to its network pharmacies for use in instructing enrollees to contact their Part D plan (Medicare drug plan) to obtain a coverage determination or ask for a formulary or tiering exception if the enrollee disagrees with the information provided by the pharmacist. This notice may be distributed to enrollees or conspicuously posted at the pharmacy. Posted notices must be at least as large as the individual notices that are distributed to enrollees, but larger dimensions and font size are permissible. This notice fulfills the requirements at 42 CFR §423.562(a) (3).

This is a standard notice. Part D plans may not deviate from the content of this notice. Please note that the OMB control number must be displayed in the upper right corner of the notice.

Heading
Logo not required. Pharmacies may elect to place their logo in the space above "Medicare Prescription Drug Coverage and Your Rights." In addition, a plan may elect to place the "MedicareRx" mark on the notice provided the plan is authorized to use this mark.

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 0938-0975. The time required to distribute this information collection once it has been completed is one minute per response, including the time to select the preprinted form and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

APPROVED OMB #0938-0975

# MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

You **have the right to get a written explanation** from your Medicare drug plan if:

- Your doctor or pharmacist tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed by your doctor.
- You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.

The Medicare drug plan's written explanation will give you the specific reasons why the prescription drug is not covered and will explain how to request an appeal if you disagree with the drug plan's decision.

You **also have the right to ask** your Medicare drug plan **for an exception** if:

- You believe you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;" or
- You believe you should get a drug you need at a lower cost-sharing amount.

**What you need to do:**

- Contact your Medicare drug plan to ask for a written explanation about why a prescription is not covered or to ask for an exception if you believe you need a drug that is not on your drug plan's formulary or believe you should get a drug you need at a lower cost-sharing amount.
- Refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.
- When you contact your Medicare drug plan, be ready to tell them:

    1. The prescription drug(s) that you believe you need.

    2. The name of the pharmacy or physician who told you that the prescription drug(s) is not covered.

    3. The date you were told that the prescription drug(s) is not covered.

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 0938-0975. The time required to distribute this information collection once it has been completed is one minute per response, including the time to select the preprinted form, and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

No. CMS-10147

**Form Instructions for the**
**"Notice of Denial of Medicare Prescription Drug Coverage"**
**CMS-10146**

A Part D plan must complete and issue this notice whenever it denies a Part D plan enrollee's request for prescription drugs. This is not model language. This is a standard form. Part D plans may not deviate from the content of the form provided. Please note that the OMB number must be displayed in the upper right corner of the notice.

## Heading

Logo—A logo is not required. Part D plans may elect to place their logo on the notice. If a plan elects to place its logo on the notice, the plan must also include the name, address, and telephone number of the Part D plan on the same page as the logo if not incorporated within the logo. Placement of the logo must not interfere with the content of the notice.

Date—Enter the month, day, and year that the notice is issued to the enrollee or the enrollee's appointed representative. Plans may also include the date the enrollee's request for a coverage determination was received, so long as the placement of that date does not interfere with the content of the notice.
Enrollee's Name—Enter the enrollee's full name. The enrollee's name and address may be placed on the notice in a manner that facilitates the use of a window envelope for mailing, so long as the placement does not interfere with the content of the notice.

Member's ID Number—Enter the enrollee's drug plan member ID number.

We have denied coverage of the following prescription drug(s) that you or your physician requested—List the denied prescription drug(s) that were requested by the enrollee or physician.

We denied this request because—The Part D plan must provide a specific and detailed explanation of why the prescription drug is being denied, including a description of any applicable Medicare coverage rule or any other applicable Part D plan policy upon which the denial decision was based. The plan's explanation must be written in a manner calculated to be understood by the enrollee.

**Section Titled: What If I Don't Agree With This Decision?**
No information is required to be completed.

**Section Titled: Who May Request an Appeal?**

In the spaces provided, the Part D plan is required to enter the Part D plan's telephone and TTY numbers that enrollees should use to obtain information or forms on how to name an appointed representative.

**Section Titled: There Are Two Kinds of Appeals You Can Request**

No information is required to be completed.

**Section Titled: What Do I Include with My Appeal?**

No information is required to be completed.

**Section Titled: How Do I Request an Appeal?**

Under the subsection "For an Expedited Appeal" –The Part D plan is required to enter the telephone or fax number that the enrollee or the enrollee's appointed representative can use to request an expedited (fast) appeal.

Under the subsection "For a Standard Appeal" –The Part D plan must provide the address (es) where the enrollee or the enrollee's appointed representative can mail or hand deliver a standard appeal request. If the Part D plan permits enrollees to make oral appeal requests, then it must provide the telephone number that may be used to request a standard appeal and must add the following italicized language to the text of the notice: "You or your appointed representative should *contact us at the number(s) below* or mail or deliver your written appeal request to the address (es) below."

**Section Titled: What Happens Next?**

No information is required to be completed.

**Section Titled: Contact Information**

In the spaces provided, the Part D plan is required to enter the Part D plan's telephone and TTY numbers that the enrollee or the enrollee's appointed representative can call if they need information or help.

**Section Titled: Other Resources to Help You**

No information is required to be completed.

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.

Approved OMB #0938-0976

# Notice of Denial of Medicare Prescription Drug Coverage

______________________________________________________________________

Date:

Enrollee's name: Member ID number:

______________________________________________________________________

We have denied coverage of the following prescription drug(s) that you or your physician requested:_______________________________________________________________

______________________________________________________________________

We denied this request because:_________________________________________

______________________________________________________________________

______________________________________________________________________

## 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 an exception** if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower cost-sharing amount. You can also ask for an exception to utilization management tools, such as a dose restriction or step therapy requirement. Your physician must provide a statement to support your exception request.

## Who May Request an Appeal?

You or someone you name to act for you (your **appointed representative**) may request an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others may already be authorized under State law to act for you.

You can call us at: (______)________________ to learn how to name your appointed representative. If you have a hearing or speech impairment, please call us at TTY (______)________________.

## IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

**For more information about your appeal rights, call us or see your Evidence of Coverage.**

**There Are Two Kinds of Appeals You Can Request**

**Expedited (72 hours) -** You can request an expedited (fast) appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If the doctor who prescribed the drug(s)** asks for an expedited appeal for you, or supports you in asking for one, and the doctor 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 a doctor, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

**Standard (7 days) -** You can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

**What Do I Include with My Appeal Request?**
You should include your name, address, Member ID number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescribing physician 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 or your appointed representative should contact us by telephone or fax at the numbers below:

Phone: (    ) ________________

Fax: (    )____________________

**For a Standard Appeal:** You or your appointed representative should mail or deliver your written appeal request to the address(es) below:

**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.

**Contact Information:**
If you need information or help, call **us** at:
Toll Free:
TTY:

**Other Resources To Help You:**
Medicare Rights Center
Toll Free: 1-888-HMO-9050
TTY:

Elder Care Locator
Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048