

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

[Logo]

## **Notice of Denial of Medicare Part D Drug Coverage**

Date:

Enrollee Name:

Member Number:

### **Coverage of your drug was denied**

We denied coverage under Medicare Part D for the following drug(s) you or your prescribing provider asked for:

## **Why was coverage for this drug denied?**

We denied coverage for this drug because {Provide specific rationale for the denial, including any applicable Medicare coverage rule or Part D plan policy. See instructions for additional detail.}:

Share this notice with your prescribing provider and discuss next steps. If your prescribing provider asked for coverage for this drug on your behalf, we already shared this denial notice with them.

[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 Medicare Part D; 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 can appeal.}

## **You have the right to appeal this decision**

You have the right to ask us to review our decision by asking us for an appeal within 65 calendar days of the date of this notice. If you ask for an appeal after 65 days, you must explain why your appeal is late.

You or your prescribing provider have the right to ask us for a special type of appeal called an **“exception.”** Your prescribing provider must provide a statement to support your exception request. Examples of an exception are:

- **Formulary exception:** you need a drug that’s not on our list of our covered drugs (formulary).
- **Coverage rule exception:** you think a coverage rule (like prior authorization or a quantity limit) shouldn’t apply to you for medical reasons.

- **Tiering Exception:** you need to take a non-preferred drug that's on a higher cost-sharing tier, and you want our plan to cover the drug at a lower cost-sharing amount.

## **Who can ask for an appeal?**

You, your prescribing provider, or your representative can ask for an 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. To learn how to appoint a representative, call us at: ( ) \_\_\_\_\_.  
TTY users call: ( ) \_\_\_\_\_.

# **Important Information About Your Appeal Rights**

**There are 2 kinds of appeals: standard or expedited (fast)**

**Standard appeal:** you'll get a written decision within 7 days (or 14 days if your appeal is about a payment for a drug you already received).

**Expedited appeal (fast):** you'll get a written decision within 72 hours.

- You can ask for an expedited (fast) appeal when you or your prescribing provider believe that your health could be seriously harmed by waiting for a standard decision.
- You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already received.
- We'll automatically expedite your appeal if your prescribing provider asks for one for you (or supports your request) and indicates that waiting for a standard decision could seriously harm your health. If you ask for an expedited appeal without support from your

prescribing provider, we'll decide if your health requires an expedited appeal. If we don't give you an expedited appeal, we'll process a standard appeal.

## **How to ask for an appeal**

For an **expedited** (fast) appeal, phone is the fastest way to ask:

Phone:

TTY:

For a **standard** appeal: [For plans that accept verbal standard requests:] {You can file an appeal by phone, by fax, online, or by mailing a letter to the address below.}

[For plans that don't accept verbal standard requests:] {You can file an appeal by fax, online, or by mailing a letter to address below.}

[For plans that don't accept verbal standard requests, omit the plan phone number and TTY]

{Phone:}

{TTY:}

Fax:

Online:

Address:

## **What to include with your appeal request**

- Your name, address and member number
- The reasons you're appealing
- Any evidence you want to attach to support your case
- Supporting statement from your prescribing provider

## **What happens next**

After you appeal, we'll review your case and give you a decision. If any of the drugs you asked for are still denied, you can ask for the next level of appeal, which is an

independent review of your case by a reviewer outside of our plan. If you disagree with that decision, you'll have the right to further appeal. You'll be notified of your appeal rights if this happens.

## **Get help & more information**

- **{Plan Name}** Toll Free: TTY users call:  
    {Insert call center hours of operation}  
    {Insert plan website}
- **1-800-MEDICARE** (1-800-633-4227), TTY users call:  
1-877-486-2048
- **Medicare Rights Center:** 1-888-HMO-9050 (1-888-466-9050)
- **Elder Care Locator:** 1-800-677-1116 or  
[Eldercare.acl.gov/Public/Index.aspx](http://Eldercare.acl.gov/Public/Index.aspx) to find help in your community
- **State Health Insurance Program:** call your State Health Insurance Assistance Program for free, personalized health insurance counseling. Visit

SHIPhelp.org or call 1-877-839-2675 to get the number for your local SHIP.

## **Get information in another format**

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 feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

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 0938-0976. This information collection is for the notice Medicare drug plans must provide when a request for a drug is denied in whole or in part. The time required to complete this information collection is

estimated to average less than 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1860D-4(g)(h) of the Act and the regulatory authority set in Subpart M of Part 423 at 42 CFR 423.568 and 423.572. If you have 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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS-10146

OMB Approval No. 0938-0976 (Expires 11/30/2027)