Using Your Medicare Drug Plan: *What to Do if Your Medicine Isn't Covered*

SPRING 2007

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Your Medicare prescription drug plan may not automatically cover every medicine prescribed by your **health care provider**. If you find yourself in this situation, you have options. With a little persistence, you can often get your plan to cover the medicine you need. Read on to find out when and how to request coverage from your Medicare plan.

Throughout this guide, you'll see words in **bold letters** that you may not know. These words are often used in health insurance materials, so learning them will help you understand the information you get from Medicare and from your plan. We've included definitions of these terms for you on the edge of the page.

How does it work?

First you must formally ask your plan to cover your medicine. This request is called a **coverage determination**. Some kinds of coverage determinations, called **exceptions**, require a statement from your health care provider explaining why the medicine you are seeking is medically necessary. After the coverage determination, Medicare has a formal **appeal process** that you can use to ask your Medicare drug plan to re-evaluate a **denial** of coverage. It's important to use the specific terms that Medicare uses for each step in the process. You can learn more about the coverage determination and the specific steps in the Medicare appeal process on page 5 of this booklet.

TIP: Tip: If your plan has a deductible, your plan may not pay anything toward the cost of a medicine until you have met your deductible – even if the medicine is covered (on your plan's formulary). Before you request coverage, be sure to ask your pharmacist why your plan did not pay.

Health care provider: When requesting coverage, you will need to work with the person who prescribed the medicine in question. This could be a doctor, nurse practitioner, physician assistant, dentist, psychiatrist or other medical professional.

Coverage determination: The first decision made by a plan about the benefits you may be allowed.

Exception: A request that your plan pay for a medicine that it wouldn't normally pay for. An exception request usually must include a statement from your health care provider.

Appeal process: Steps you can take to ask your Medicare drug plan to re-evaluate a decision made about your coverage.

Denial: When you are told that your plan will not pay anything toward the cost of a particular medicine any time during the year.

When should I request coverage?

Requesting coverage when your medicine is not covered can help you get the medicines you need to stay healthy. It can also help you control your costs. You can start the process and then wait for approval to get a medicine that is not covered. Or, if you need the medicine right away, you can pay for the medicine yourself and then start the process to ask the plan to pay you back.

Formulary: A plan's list of which medicines it covers and at what level of co-payment.

Prior authorization: A type of coverage determination that requires your health care provider to get approval from the plan before it will pay for a medicine.

Co-pay (or co-payment): A fixed amount, for example $10, that an insured person pays for health services or medicines, regardless of the actual cost of that service or medicine.

The information in this booklet relates to situations when you may want to request coverage because the medication your health care provider prescribed is not on your plan's **formulary**, so it is not covered by your plan.

You also may want to request coverage if:

- You made a request for **prior authorization** that was denied.
- Your plan requires you to try a lower cost medicine first but you have already tried that medicine unsuccessfully, or your health care provider knows that you cannot take it for some reason.
- Your plan limits the number of pills you can have of a particular medicine.
- Your medicine has a high **co-pay** and you want to ask for a lower co-pay because similar medicines with a lower co-pay do not work for you or your health care provider knows that you cannot take them for some reason.

In these situations the steps in the process are similar, but they are not described in this guide. For more information, call 1-800-MEDICARE (1-800-633-4227).

TIP: If your prescription is denied the first time you use a new Medicare drug plan to refill a medicine you have been taking, you, your pharmacist, or your health care provider should ask the plan for a "transitional supply." This gives you and your health care provider 30 days to decide if you should switch to a medicine that is covered or request coverage from your plan. Be sure to take action, or your medication may not be covered at your next refill!

How do I know if my medicine is covered?

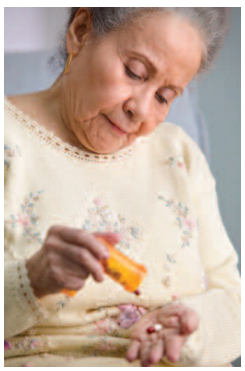
Medicare drug plans all have a formulary. The medicines on the formulary are grouped into **co-pay tiers**, or preferred drug levels. There are often tiers for generic drugs, preferred brand name drugs, non-preferred brand name drugs, and specialty drugs. The tier a medicine is on determines how much your co-pay will be.

Co-pay tiers: Groups of medicines with the same co-payment. Plans assign each medicine on the formulary to a tier. There can be 2, 3, or more tiers, each with a different co-payment amount.

If your medicine is not on the formulary, coverage will be denied. Your plan can also:

- set limits on how many pills of a certain medicine you can get in a month or a year,
- require prior authorization or,
- require you to try a less expensive medicine before agreeing to pay for the one your health care provider originally prescribed.

Your plan can make changes to its formulary, like adding or removing medications or changing tier assignments, any time during the year. If a plan decides to remove a medication you are taking from the formulary or change it to a different tier mid-year, the plan must tell you 60 days before it makes the change.



Unless a medicine you take is removed from the formulary because (1) a generic version of the medicine has become available or (2) there is a safety reason, *the plan must continue to cover it for you until the end of the plan year*. This is to give you and your health care provider time to determine:

- whether another medicine that the plan covers will work for you,
- whether you want to request a coverage determination, or
- whether you want to join a different plan next year – one that will cover the medication you need.

You usually cannot switch to a new plan until the annual open enrollment period, even if your current plan takes your medication off its formulary mid-year.

Who can request coverage?

If you have Medicare, you have a right to request a coverage determination and use the Medicare appeal process. In some cases, you may need information from your health care provider or other kinds of help in order to make your request. Medicare beneficiaries may appoint a representative who can act on their behalf in the Medicare appeal process.

To name an appointed representative, call the member services number on the back of your pharmacy benefit ID card and ask to have the appropriate form sent to you, or download one from the Centers for Medicare & Medicaid Services at: www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf. You and your appointed representative must both sign the form before you send it back to the plan. An appointed representative may do anything that a Medicare beneficiary can do in the Medicare appeal process, including filing a request, submitting evidence, and receiving notices from your plan.

Your appointed representative may be any willing person you choose, including a:

- relative
- friend
- doctor, pharmacist, or other health care professional
- lawyer

You may have a different appointed representative for each medicine. Medicare beneficiaries who cannot make their own medical decisions may have a court-appointed guardian or conservator act on their behalf, according to state laws.

TIP: Your health care provider is not automatically your appointed representative. If you want your health care provider to help you with the Medicare appeal process, you must file a form to designate him or her, just as if you were designating a friend or relative.

Requesting coverage: step by step

If you and your health care provider agree that you need a medicine that is not covered, you can request coverage. Most requests will be settled at the first step of the process, called the *coverage determination.* When requesting coverage because a medicine you need is not on your plan's formulary, you must request a specific type of coverage determination called a *formulary exception*. If your request for coverage is denied you may appeal to the next level using the Medicare appeal process. Each time you appeal to a higher level and your request for coverage is denied your plan must send you a written notice including information about why your request for coverage was denied and how to take the next step in the Medicare appeal process.

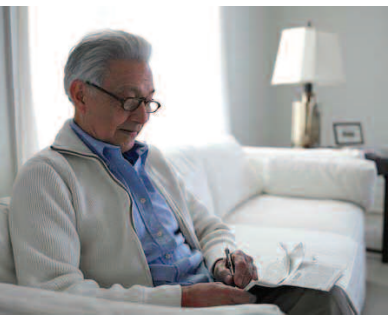
TIP: You can usually find the formulary on your plan's Web site or by calling the member services phone number on the back of your pharmacy benefit ID card. You can also use the Formulary Finder at www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to find plans in your state that cover the medications you need.

Step 1: Request a *formulary exception* (a type of coverage determination). In this step your plan makes a formal decision about whether or not to cover your medication.

- How to Request: You, your appointed representative, or your health care provider may make this request by phone or in writing to your plan. No matter who does this, your plan must receive a statement from your health care provider explaining the medical reason you need the specific drug.
- Timeframe: You may make this request at any time.
- Decision: A decision must be made and sent to you as soon as your clinical condition requires, but no later than 72 hours (24 hours for an **expedited request**) after your health care provider's statement is received.

Expedited request: A faster review of your request because your health care provider told your plan that your life or health will be seriously jeopardized if you must wait 72 hours for the medicine.

Step 2: If your formulary exception request is denied, request a *redetermination*. In this step a doctor at your plan who was not involved in the original denial must review the case again.



- How to Request: You or your appointed representative must make this request in writing to your plan. The letter you received from your plan in response to your formulary exception request will tell you where to send your request. There is no special form to use. A simple letter saying that you want to appeal further should be enough. For a sample letter, see page 9. Your health care provider is not allowed to do this for you unless he or she is your appointed representative.
- Timeframe: You must request a redetermination within 60 days of receiving a denial of your formulary exception request.
- Decision: A decision must be made and sent to you as soon as your clinical condition requires, but no later than 7 days (72 hours for an expedited request).

Step 3: If your request for coverage is not granted after a redetermination, request a *reconsideration***.** In this step, an independent entity will review the case and make its own decision.

- How to Request: You or your appointed representative must make this request in writing to the "Independent Review Entity" (IRE). The letter you received in response to your redetermination request will give you the address and instructions on how to write to the IRE.
- Timeframe: You must make this request within 60 days of receiving a denial of your request for coverage under the redetermination.
- Decision: A decision must be made by the IRE and sent to you as soon as your clinical condition requires, but no later than 7 days (72 hours for an expedited request).

If your request for coverage is denied under the reconsideration and you wish to appeal further, you may want help from a lawyer. (If you need help finding a lawyer, contact the Eldercare Locator by calling 1-800-677-1116 or visiting www.eldercare.gov.) You will get information about how to appeal further when you are told that your request for coverage has been denied under the reconsideration. For more information about additional steps in the Medicare appeal process, see www.MedicareDrugAppeals.org.

Requesting coverage: the process at a glance

Step:	*How to Request:*	*Do This Within:*	*Decision Within:*
Request a coverage determination (specifically: formulary exception)	Call or write to your plan. Your health care provider must explain why you need the specific medicine.	No time requirement	72 hours of receiving health care provider's statement (24 hours for expedited request)
Request a redetermination	Write to your plan and request a redetermination.	60 days of formulary exception denial	7 days (72 hours for expedited request)
Request a reconsideration	Write to the independent review entity (IRE) noted in your redetermination denial letter.	60 days of denial of redetermination request for coverage	7 days (72 hours for expedited request)
Appeal to the Administrative Law Judge (ALJ)	Follow steps in reconsideration letter.	60 days of denial of reconsideration request for coverage	No time requirement
Appeal to the Medicare Appeals Council (MAC)	Follow steps in ALJ letter.	60 days of denial from the ALJ	No time requirement
File suit in Federal District Court	Follow steps in MAC letter.	60 days of denial from the MAC	Depends on court schedule

Writing a letter of appeal

If your request for a formulary exception has been denied, you will need to write a letter in order to request a redetermination. This letter can be very simple; however, it is probably good to include all of the following information in the letter so that you establish a written record.

- Your name, address, phone number, and Medicare ID number
- The date you are writing the letter
- The date you tried to fill the prescription
- The name and address of the pharmacy where you tried to fill the prescription
- The name, address, and phone number of the health care provider who wrote the prescription

You should also:

- Clearly state that you wish to request a redetermination.
- Include a copy of either the receipt, if you paid already, or the prescription, if you didn't. If you don't have either of these items, list the exact name and dosage of the medication prescribed.
- State that the plan has permission to contact your health care provider if additional medical information is needed. (It would also be good to talk to your health care provider about how to respond to the reasons why the plan denied your benefit and to let your health care provider know that you are filing an appeal and that he/she may get a call.)
- Indicate that you expect the plan to tell you everything you need to do so that your appeal can be processed. Also ask them to tell you how you can appeal further if they deny this appeal.
- Respond to the reasons the plan gave for denial in the letter denying your formulary exception request. For example, if the plan wants you to try a different medicine first, but you have a bad reaction to that medicine, you should explain this.
- Make a copy of your letter for yourself before you mail it.

Sample appeal letter*

[Your Name]
[Your Address]
[City, State ZIP]
[Your Phone Number]
[Your ID Number]
DOB: [Your Date of Birth]

Date

Medicare Prescription Drug Plan Name
Plan Address
City, State ZIP

To Whom It May Concern:

I am writing to request a redetermination. I am covered under your plan and my ID number is [ID number]. On [date], I attempted to fill a prescription for [name of medicine] at the [pharmacy name] Pharmacy located at [pharmacy address]. I requested an exception and was denied. Your coverage determination letter said you were denying my claim because [reason for denial]. I need this medication because [reason why you need this specific medicine].

[I have already paid for the medication and want to be reimbursed. OR I cannot afford to pay for this medication myself and need you to cover it as soon as possible, since I am currently going without it.]

My contact information is above, and contact information for [name of health care provider who wrote prescription], is listed below.

[Name of Health Care Provider Who Wrote Prescription]
[Health Care Provider Address]
[City, State ZIP]
[Health Care Provider Phone Number]

[Name of health care provider who] wrote the prescription, and you may contact him/her if medical information is needed for consideration of my appeal. I have included a copy of the [prescription or receipt] for your consideration.

Please provide me with a written explanation of any additional steps I must take for you to process my appeal, as well as a written explanation of the basis for your decision about my claim.

Sincerely,
[Your Name]

You can find this information on the back of your pharmacy benefit ID card - the one you use when you pick up your prescriptions.

Your ID number is on the front of your pharmacy benefit ID card.

You may need to ask your health care provider to provide information explaining why the medicine is "medically necessary."

If you don't have a copy of the written prescription or the pharmacy receipt, list the name of the medication and the dose that you were prescribed. Double check with your pharmacist to make sure that you have spelled everything correctly since the names of many medications are similar.

* This sample appeal letter is provided for informational purposes only. Every plan has different rules and procedures for appeals, and this sample letter may not meet the requirements of your plan. DO NOT USE THIS LETTER WITHOUT FIRST CHECKING THE SPECIFIC PROCEDURES OF YOUR PLAN FOR APPEAL LETTERS.

Additional Resources

- Visit www.YourPharmacyBenefit.org for information about the appeal process and links to forms.
- Visit www.Medicare.gov/basics/appeals.asp for information about your right to appeal.
- See the publication Medicare Prescription Drug Coverage: How to File a Complaint, Coverage Determination, or Appeal, available by calling 1-800-MEDICARE (1-800-633-4227) and asking for publication #11112, or online at http://www.medicare.gov/Publications/Pubs/pdf/11112.pdf.
- Contact the Office of the Medicare Ombudsman, responsible for assisting you with grievances and appeals, at 1-800-MEDICARE (1-800-633-4227) or online at http://www.cms.hhs.gov/center/ombudsman.asp.
- Contact your local Area Agency on Aging. You can find information for your local Area Agency on Aging by calling 1-800-677-1116, at www.eldercare.gov, or in the blue pages of your phone book.

The U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services has reviewed this publication, which is produced by YourPharmacyBenefit.org. YourPharmacyBenefit.org is a collaborative effort among non-profit organizations representing consumers, physicians, pharmacy, and pharmaceutical companies that strives to educate consumers to make informed decisions when choosing and using their pharmacy benefits, thus empowering them to access the medicines their health care providers prescribe. This publication may be reprinted for educational and nonprofit purposes.

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