

Understanding the Medicare Part D Appeals Process

What to do when you can't get your prescriptions filled: A Step-By-Step Guide

Why can't you fill your prescription?

At some point, your Medicare prescription drug plan may decide not to cover some of your prescriptions. ***You have the right to appeal your plan's decision.*** Understanding the reasons behind your plan's denial of coverage is the first step in any decision to file an appeal.

There are several reasons why your plan may not cover your drug:

1. Your plan decided the medication wasn't medically necessary for you.
2. Your plan's formulary doesn't include the drug you want, or the dosage or form (i.e. liquid vs. pill form) of the drug you want.
3. You didn't go through a "step therapy" protocol.
4. You can't afford the co-pays or cost-sharing amounts that your plan requires.
5. Your doctor prescribed a "unique" medication, such as a genomic or biotech product, that your plan doesn't cover or charges too much for you.
6. Your plan removed the drug your doctor prescribed for you from its formulary in the middle of the year, and you can't change to another plan.
7. The pharmacy you went to wasn't in your plan's network.

What can you do in these different situations?

1) **If your plan decided the medication wasn't medically necessary:**

- First, you must make a *written* request for a *Coverage Determination* – an official decision from your plan about whether the prescribed medication is necessary for you.
- Your plan must tell you (and your prescribing physician if s/he requested the coverage determination) what the plan's Coverage Determination is no more than 72 hours (3 calendar days) after they receive your request.
 - ⇒ If 72 hours is too long to wait for the prescribed medication, you can request an *Expedited Coverage Determination* within 24 hours of the time the plan receives the request.
- If your plan denies your request, they must give you a written notice within 72 hours explaining why, and informing you how you can appeal their decision.

2) **If the prescribed medication is not in your drug plan's formulary:**

- If your doctor believes that you must have medication that is not in your plan's formulary, you will need to request a *Formulary Exception* from your plan.
- Your doctor needs to submit a written statement to your drug plan stating that none of the drugs used to treat your condition in your plan's formulary would be as effective in treating you, and/or all of the drugs in your plan's formulary for your condition would give you bad side effects.

Note: A *Formulary Exception* lasts for the rest of your plan year. If you renew your enrollment in the same plan for the next year, the plan can decide not to continue to cover the prescribed drug that was

approved through a *Formulary Exception*. If they decide not to continue to cover the drug, you may be required to submit a new *Formulary Exception* request for the new plan year.

3) If you didn't go through a "step therapy" protocol:

Step therapy refers to procedures your plan establishes to reduce costs. These procedures include:

- ↪ Substituting a less costly type of drug
- ↪ Experimenting with dosage limitations (i.e., giving you 30 pills a month instead of the usual 60)
- ↪ Requiring that your doctor gets prior approval from your plan before s/he prescribes certain medications.

If you or your doctor believes that you must have a medication or a dosage that is not in your plan's formulary, you will need to request a *Formulary Exception*. (See situation 2.)

4) If you can't afford the cost-sharing amounts your Medicare Prescription Drug Plan imposes on the drug your doctor prescribed:

- See if there is an equivalent drug that is less expensive on your plan's formulary.
- If you or your doctor believes you must have the drug previously prescribed, you will have to request a *Formulary Exception* to the plan's tiered cost-sharing structure. (See situation 2.)

5) If your doctor prescribed a "unique" or very expensive medication such as a genomic or biotech product that you cannot afford:

- If the drug is not in your plan's formulary you can try to get a *Formulary Exception*. (See situation 2.)

Note: You may not be able to get a *Formulary Exception* to lower your out-of-pocket costs for these drugs.

6) If your plan removed the drug your doctor prescribed from the plan formulary or increased the amount you must pay for your medication in the middle of the year and you can't change plans:

- Your plan must give you a written notice at least 60 days before the change becomes effective.
- *If you do not get the prior written notice, your plan must give you a 60-day supply of the prescribed medication on the same terms as if the plan had not changed its rules.* The plan must also see to it that you get a *written* notice when you fill our prescription.
- If your doctor believes that you must have the medication that is not in your plan's formulary, you will need to request a *Formulary Exception*. (See situation 2.)

7) If the pharmacy you went to wasn't in your Plan's network:

- You are allowed to get your prescribed drug from a pharmacy that does not participate in your plan's network *only if* you could not reasonably have been expected to get to a participating in-network pharmacy.

Note: If you go to an out-of-network pharmacy you will not be able to request a *Formulary Exception* or file an appeal.

Are there any drugs that your plan is not required to cover?

Yes, there are. Your plan is required to cover most, but not all, medications. The types of drugs that your plan is not required to cover include:

1. Weight-loss and weight-gain drugs
2. Drugs for symptomatic relief of coughs and colds
3. Prescription vitamins, with the exception of prenatal vitamins and fluoride
4. Over-the-counter drugs, with the exception of insulin
5. Drugs to promote hair growth
6. Fertility drugs
7. Cosmetic drugs
8. Drugs that must be monitored by testing services that only the manufacturer provides, such as certain anti-psychotic medications,
9. Barbiturates (drugs used to control seizures or used for sedation or anesthesia such as Phenobarbital or Nembutal®)
10. Benzodiazepines, often referred to as minor tranquilizers, used to treat anxiety or insomnia (such as Xanax®, Valium® and Ativan®)

You may have to pay out-of-pocket for some or all of these drugs (or look for alternate coverage). Check with your plan.

Who can help me get medication when my plan has said it won't cover it?

- You can ask anyone you want to help you with your Medicare Prescription Drug Plan. If this person agrees to help you in this way, s/he is your *Authorized Representative*.
 - ⇒ Your *Authorized Representative* can be someone appointed to make decisions for you, such as a guardian or a “conservator” of the person. It can be your prescribing physician. It can also be your SHIP (State Health Insurance Plan) program.

What if I lose my *Coverage Determination* or *Formulary Exception*?

1. If your request for a *Formulary Exception* is denied, you can ask for a *Redetermination*. You have 60 days from the date of the notice of your plan's denial to write and ask for a *Redetermination*. A *Redetermination* must be decided within 7 days. If 7 days is too long for you to wait, your doctor can request an *Expedited Redetermination*, which must be decided in 72 hours or less.
2. If your *Redetermination* is denied, you can ask for a *Reconsideration*. *Reconsiderations* are processed by Independent Review Entities (IREs) that contract with CMS, and must be requested within 60 days of the date on the notice of *Redetermination* your plan sends to you. The IRE must ask your physician for a written statement explaining your need for the specific medication. (See situation 2.)
3. If you disagree with the *Reconsideration* decision, and if the cost of the drug at issue is at least \$100, you can ask for a hearing before an *Administrative Law Judge (ALJ)*. You must request your hearing within 60 days of the date on the notice from the IRE about your *Reconsideration* decision.
4. If you disagree with the decision of the *ALJ*, you can ask the *Medicare Appeals Council* to review the decision of the *ALJ*.
5. If you disagree with the *Medicare Appeals Council* review, and if the cost of the drug at issue is at least \$1,050, you can take your case to federal court.