What if your drug is not on the formulary?

If your prescription drug is not listed on the formulary, you should first contact Member Service at the number on your identification card to be sure it is not covered. If Member Service confirms that we do not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by us.
- You can ask us to make an exception to cover your drug.
- You can pay out-of-pocket for the drug and request us to reimburse you by requesting a formulary exception. This does not obligate us to reimburse you if the exception request is not approved.

A decision about whether we will cover a Part D prescription drug can be a “standard” coverage determination that is made within 72 hours, or it can be a “fast” coverage determination that is made typically within 24 hours. You can ask for a fast decision only if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.

Asking for a standard decision

Requests for non-formulary drugs will be decided within 72 hours after we have received your doctor’s “supporting statement”, which explains why the drug you are asking for is medically necessary. You should always submit your prescribing doctor’s supporting statement with the request, if possible. A link is provided for the Medication Request Form. Your doctor can complete this form to provide his “supporting statement”. To ask for a standard decision, you can:

Phone member service at the number on your identification card.

-or-

Mail your request to: Highmark Inc. Pharmacy Affairs
PO Box 279
Pittsburgh, PA 15230

-or-

Fax your request to: Highmark Inc. Pharmacy Affairs
1-412-544-7546

Asking for a fast decision

Requests for a non-formulary drug will be decided within 24 hours of receiving your doctor's "supporting statement", which explains why the drug you are asking for is medically necessary. You should always submit your prescribing doctor's supporting statement with the request, if possible.

To ask for a fast decision, you can:

Phone member service at the number on your identification card.

Be sure to ask for a "fast", "expedited" or "24 hour" review.

-or-

Mail your request to: Highmark Inc. Pharmacy Affairs
PO Box 279
Pittsburgh, PA 15230

-or-

Fax your request to: Highmark Inc. Pharmacy Affairs
1-412-544-7546

For more information on the coverage determination process, please refer to your Evidence of Coverage. Your Evidence of Coverage can be found on your plan Website's Home Page. If you have any questions on the coverage determination process or want to check on the status of a coverage determination filed on your behalf, please call the Member Service toll-free number on your identification card. Hearing-impaired users should call the TTY telephone number also located on the identification card.

If we deny all or part of your request in our coverage determination, you may ask us to reconsider our decision. This is called an appeal or request for redetermination.

Important Information About Your Appeal Rights.

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours) -You can request an expedited (fast) appeal if you or your doctor believes 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: (800) 485-9610

Fax: (800) 894-7947

For a Standard Appeal: You or your appointed representative should contact us by:

Written appeal request to the address below:

Medicare Prescription Drug
Appeals Department
PO Box 535047
Pittsburgh, PA 15253-5047

-or-

Fax your request to:
Medicare Appeals Department
412-544-1513

-or-

Calling member service at the number on your identification card

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.

For more information on the appeals process, please refer to your Evidence of Coverage. If you have any questions about the appeals process or want to check on the status of an appeal filed on your behalf, please call the Member Service toll-free number on your identification card. Hearing-impaired users should call the TTY telephone number also located on the identification card.

What to do if you have complaints

We encourage you to let us know right away if you have any questions, concerns or problems related to your prescription drug coverage. A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

If you have a grievance, we encourage you to first call the Member Service toll- free number on your identification card. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. You should send your written grievance to:

Medicare Prescription Drug Appeals Department PO Box 535047
Pittsburgh, PA 15253-5047

-or-

Fax your request to: Medicare Appeals Department 412-544-1513

Whether you file your grievance orally or in writing, will respond to your complaint within 30 days or as quickly as the case requires.

For more information on the grievance process, please refer to your Evidence of Coverage. If you have any questions about the grievance process or want to check on the status of a grievance filed on your behalf, please call the Member Service toll-free number on your identification card. Hearing-impaired users should call the TTY telephone number also located on the identification card.

Who may ask for a coverage determination, an appeal or a grievance?

You can ask us for a coverage determination, an appeal or a grievance yourself, or your prescribing doctor or someone you name may do it for you. The person you name would be your appointed representative. You can name a relative, a friend, advocate, doctor, attorney or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. Prescribing physicians and other prescribers, upon giving you notice, may request a standard or expedited appeal on your behalf without having been appointed your representative.

A link to the form to appoint a representative is provided on the Formulary Plan Policy web page. Once this form is complete, you can mail or fax the information to the addresses provided above, depending on your request. Please refer to your Evidence of Coverage on how to appoint a representative. You can also call the Member Service toll-free number on your identification card for information on how to appoint a representative. Hearing-impaired users should call the TTY telephone number also located on the identification card.

For Physicians Only:

Physicians that have questions on the coverage determination process or want to check on the status of a coverage determinations filed on behalf of their patients can call 1-800-600-2227. Only physician calls will be handled by this phone number. Hearing-impaired providers (or physicians) should call the TTY relay number in the state in which they are located. Members must call the Member Service toll-free number on their identification card to check on the status of a coverage determination.

Physicians that would like to request an expedited coverage determination can call 1-800-656-2485. Only physician calls will be handled by this phone number. Hearing-impaired providers (or physicians) should call the TTY relay number in the state in which they are located. Members must call the Member Service toll-free number on their identification card to request an expedited coverage determination.

Y0037_11_0110 CMS Approval (02/24/2011)