

## Request for Redetermination of Medicare Prescription Drug Denial

We denied your request for coverage of (or payment for) \_\_\_\_\_. You have the right to ask us for a redetermination (appeal) of our decision. Use this form to appeal this decision.

A You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.

A You can also file an appeal through our website at [www.optumrx.com](http://www.optumrx.com).

A Expedited appeal requests can be made by phone at 1 888 403 3398.

Your prescriber can ask for an appeal on your behalf. If you want another person (like a family member or friend) to file an appeal for you, that person must be your representative. Call us at 1 888 403 3398 to learn how to name a representative.

### Plan enrollee information \_\_\_\_\_

Enrollee name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Date of birth (MM/DD/YYYY): \_\_\_\_\_

Mailing address: \_\_\_\_\_

City, State, ZIP code: \_\_\_\_\_

Phone: \_\_\_\_\_

### Prescription & prescriber information \_\_\_\_\_

Name of drug you asked for: \_\_\_\_\_

Strength/quantity/dose: \_\_\_\_\_

Prescriber name: \_\_\_\_\_

Office address: \_\_\_\_\_

City, State, ZIP code: \_\_\_\_\_

Office phone: \_\_\_\_\_ Office fax: \_\_\_\_\_

Office contact person: \_\_\_\_\_

Did you already purchase this drug? ☐ Yes ☐ No

If YES:

Date purchased: \_\_\_\_\_ Amount paid: \_\_\_\_\_ (attach copy of receipt)

Pharmacy name: \_\_\_\_\_

Pharmacy phone number: \_\_\_\_\_

Do you need an expedited (fast) decision? ☐ Check this box if you believe you need a decision within 72 hours. If you have a supporting statement from your prescriber, attach it to this request.

A If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision.

A If your prescriber indicates that waiting 7 days could seriously harm your health, we'll automatically give you a decision within 72 hours. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already got.

A If you don't get your prescriber's support for an expedited appeal, we'll decide if your case requires a fast decision.

Explain why you think this drug should be covered \_\_\_\_\_

A Attach any additional information you think may help your case, like statement from your prescriber or medical records.

A Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage

A Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't medically appropriate for you.

A Other information we should consider: \_\_\_\_\_  
\_\_\_\_\_

Representative information \_\_\_\_\_

Complete this section ONLY if the person making this request is not the enrollee or the enrollee's prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed Form CMS 1696 or a written equivalent) if it wasn't submitted at the coverage determination level. For more information on appointing a representative, Call us at 1 844 515 0250.

Representative name: \_\_\_\_\_

Relationship to enrollee: \_\_\_\_\_

Street address: \_\_\_\_\_

City, State, ZIP code: \_\_\_\_\_

Phone: \_\_\_\_\_

Sign & submit this form \_\_\_\_\_

Signature of person requesting the appeal (the enrollee, prescriber or representative):

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Fax or mail your completed form and any supporting information to:

Address:

Fax Number:

Optum Rx

1 877 239 4565

c/o Appeals Coordinator

P.O. Box 2975

Mission, KS 66201