

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed under the section titled "Get help & more information."



NOTICE OF DENIAL OF MEDICARE PART D PRESCRIPTION DRUG COVERAGE

Date: 07/28/2023

Enrollee's Name: PHILIP RICE

Member Number: 101573439300

Your request was denied

We have denied coverage or payment under your Medicare Part D benefit for the following prescription drug(s) that you or your prescriber requested: HEPLISAV-B Soln Pref Syr

Why did we deny your request?

We denied this request under Medicare Part D because: We contacted your prescriber for information (per Part D Coverage Determination guidance Section 40.5), that is necessary to process your exception request and we did not receive any information from your prescriber to explain why you need this drug. This information is necessary for the plan to make a decision about paying for this drug. We have made multiple attempts to obtain the necessary information from your prescriber. Medicare Part D requires that we make a decision about your Medicare Part D drug plan's coverage of the drug within a certain time frame. If you want your Medicare Part D drug plan to consider this drug for coverage, please contact your prescriber and ask them to submit a supporting statement.

This supporting statement must contain the following information: An explanation of why the requested medication is a better choice than all of the formulary drugs used to treat the same condition. This should include whether these medications have already been tried, and if so, what the outcome was, and/or if these drugs would be likely to cause adverse events or would be less effective than the non-formulary drug. Please include the following:



Is the patient at high or intermediate risk of contracting hepatitis B? - High risk groups currently identified include but are not limited to: Individuals with ESRD (End Stage Renal Disease), Individuals with hemophilia who received Factor VIII or IX concentrates Clients of institutions for individuals with intellectual disabilities (IID), Persons who live in the same household as a hepatitis B virus carrier, Men who have sex with men, Illicit injectable drug abusers, Persons diagnosed with diabetes mellitus, - Intermediate risk groups currently identified include but are not limited to: Staff in institutions for individuals with intellectual disabilities (IID), Health care workers with frequent contact with blood or blood-derived body fluids during routine work

Current formulary alternatives include:

Prehevbrio suspension for injection (requires prior authorization)
Engerix-b prefilled syringe (requires prior authorization)
Recombivax hb prefilled syringe (requires prior authorization)
Engerix-b suspension for injection (requires prior authorization)
Recombivax hb suspension for injection (requires prior authorization)

You should share a copy of this decision with your prescriber so you and your prescriber can discuss next steps. If your prescriber requested coverage on your behalf, we have shared this decision with your prescriber.

What If I Don't Agree With This Decision?

You have the right to appeal. If you want to appeal, you must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline. You have the right to ask us for a **formulary exception** if you believe you need a drug that is not on our list of covered drugs (formulary). You have the right to ask us for a **coverage rule exception** if you believe a rule such as prior authorization or a quantity limit should not apply to you. You can either provide information that shows that you meet the coverage rule that applies to the drug you are requesting or you can ask for a coverage rule exception. You can ask for a **tiering exception** if you believe you should get a drug at a lower cost-sharing amount. Your prescriber must provide a statement to support your exception request.

Who May Request an Appeal?

You, your prescriber, or your representative may request an expedited (fast) or standard 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.

You can call us at: 1-800-414-2386 to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at TTY: 711.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours): You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If your prescriber** asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite**

How Do I Request an Appeal?

For an Expedited (Fast) Appeal: You, your prescriber, or your representative can file an appeal by telephone, by fax, through the plan's website, or by mail. **A verbal request by telephone is the fastest way to file an expedited (fast) request.**

Phone: 1-833-620-8808

TTY: 711

For a Standard Appeal: You, your prescriber, or your representative can file an appeal by telephone, by fax, through the plan's website, or by sending a letter to the mailing address listed below.

Phone: 1-833-620-8808

TTY: 711

Fax: 1-724-741-4954

Plan Website: www.aetnamedicare.com

Address: Aetna Medicare Part D Appeals
PO Box 14579
Lexington, KY 40512

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.

Get help & more information

- Aetna Medicare Premier Plus 1 (PPO) Toll Free: 1-833-620-8808
TTY users call: 711
24 hours a day, 7 days a week
www.aetnamedicare.com
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. 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
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

PRA Disclosure Statement 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

your appeal.

- If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal. If your appeal is for payment of a drug you've already received, we'll give you a written decision within 14 days.

What Do I Include with My Appeal Request?

You should include your name, address, Member number, the reasons for appealing, and any evidence you wish to attach. Remember, your doctor must provide us with a supporting statement if you're requesting an exception to a coverage rule. You should include information about why the coverage rule should not apply to you because of your specific medical condition. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescriber 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.





Request for Redetermination of Medicare Prescription Drug Denial

Because we, Aetna Medicare Premier Plus 1 (PPO), denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address:

Aetna Medicare Part D Appeals
PO Box 14579
Lexington, KY 40512

Fax Number:

1-724-741-4954

You may also ask us for an appeal through our website at www.aetnamedicare.com. Expedited appeal requests can be made by phone at 1-833-620-8808, TTY: 711, 24 hours a day, 7 days a week.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____

Enrollee's Member ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

valid OMB control number for this collection is 0938-0976. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any 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, Baltimore, Maryland 21244-1850.

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.



Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare, 24 hours a day, 7 days a week. TTY users call: 1-877-486-2048

Prescription drug you are requesting:

Name of Drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? Yes No

If "Yes": Date purchased: _____ Amount paid: \$ _____ (attach copy of receipt)

Name and telephone number of pharmacy: _____

Prescriber's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Office Contact Person _____

Important Note: Expedited Decisions

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. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

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).

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage and have your prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents. Input



from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

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

_____ **Date:** _____

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.