Tera Gorecki
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Great Falls , MT 59401

Cigna Medicare Rx® (PDP)

Medicare Part D Prescription Drug Plans

Cigna Medicare Rx (PDP)
P.O. Box 42005
Phoenix, AZ 85080-2005
1-800-222-6700

NOTICE OF DENIAL OF MEDICARE PRESCRIPTION DRUG COVERAGE

Date

04/23/2013

Enrollee's name	Member number
MERIAM NAGEL	000000013804154601

We have denied coverage or payment for the following prescription drug or drugs that you or your prescriber requested:

LIPITOR 20 MG TABLET

We denied this request because:

The drug that you or the enrollee has requested, Lipitor, is not on our formulary. Instead, the drug atorvastatin is on our formulary and is indicated for treating the enrollee's condition. Prior to being approved for coverage of Lipitor, the enrollee must have experienced failure or intolerance to atorvastatin or have a good medical reason why the enrollee cannot try atorvastatin. You have not submitted any documentation or medical records supporting the medical necessity for receiving Lipitor instead of atorvastatin. Therefore, we are denying your request to cover Lipitor. However, the enrollee may obtain a prescription for atorvastatin.

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 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, the enrollee, or the enrollee's representative may request an expedited (fast) or standard appeal. The enrollee can name a relative, friend, advocate, attorney, doctor, or someone else to be their representative. Others may already be authorized under State law to be their representative.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can request:

1. **Expedited (72 hours):** You, the enrollee, or the enrollee's representative can request an expedited (fast) appeal if you or the enrollee believe that the enrollee's 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 the enrollee back for a prescription drug they 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 you ask for an expedited appeal for the enrollee, or support the enrollee in asking for one, and you indicate that waiting for 7 days could seriously harm the enrollee's health, **we will automatically expedite your appeal**.
    - If the enrollee asks for an expedited appeal without support from you, we will decide if the enrollee's health requires an expedited appeal. We will notify the enrollee if we do not grant an expedited appeal and we will decide the enrollee's appeal within 7 days.

2. **Standard (7 days):** You, the enrollee, or the enrollee's representative can request a standard appeal. We must give the enrollee a decision no later than 7 days after we get the appeal.

What do I include with my appeal request?

You should include the enrollee's name, address, member 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, you must indicate that all the drugs on any tier of our formulary would not be as effective to treat the enrollee's condition as the requested off-formulary drug or would harm the enrollee's health.

How do I request an appeal?

For an Expedited Appeal: You, the enrollee's, or the enrollee's representative should contact us by telephone or fax at the numbers below:

Phone	Fax
1-800-222-6700	1-866-945-4631

For a Standard Appeal: You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

Cigna Pharmacy Services
Attention: Medicare Rx (PDP) Appeals
PO Box 42005
Phoenix, AZ 85080-2005

What happens next?

If you or the enrollee appeal, we will review the enrollee's case and give them a decision. If any of the prescription drugs requested are still denied, the enrollee can request an independent review of their case by a reviewer outside of their Medicare Drug Plan. If the enrollee disagrees with that decision, they will have the right to further appeal. The enrollee will be notified of their appeal rights if this happens.

Contact information:

If you need information or help, call us at:

Toll Free	TTY
1-800-222-6700	1-800-322-1451

Other resources to help you:

Medicare Rights Center
Toll Free: 1-888-HMO-9050

Medicare
Toll Free: 1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048

Elder Care Locator

Cigna Medicare Rx® (PDP)

Medicare Part D Prescription Drug Plans

Request for Redetermination of Medicare Prescription Drug Denial

Because we Cigna Medicare Rx® (PDP) 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:	Fax Number:
Cigna Pharmacy Services	1-866-945-4631
Attn: Medicare Rx (PDP) Appeals	
PO Box 42005	
Phoenix, AZ 85080-2005	

You may also ask us for an appeal through our website at www.Cignamedicarerx.com.
Expedited appeal requests can be made by phone at 800-222-6700

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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.

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Medicare Part D Prescription Drug Plans

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 _____

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.

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Medicare Part D Prescription Drug Plans

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).**

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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.

Signature of person requesting the appeal (the enrollee, or the enrollee's prescriber or representative): _____ **Date:** _____