If your prescription is denied at the pharmacy, you may get a notice from the pharmacist called “Medicare Prescription Drug Coverage and Your Rights.” You have the right to appeal to your plan for coverage, but first you or your doctor need to get a written denial (coverage determination) from the plan.

Call the plan to find out why your drug was denied at the pharmacy and share that information with your doctor. It may have been denied because:

- The drug isn’t on your plan’s formulary (list of covered drugs), or
- The drug has restrictions on it (such as prior authorization, step therapy or quantity limits)

You or your doctor should then submit a formal, written request to the plan asking it to pay for the drug you need. This formal request is called an exception request because you’re asking the plan to make an exception to its coverage rules. If you submit the request, it will need to include a written statement from your doctor (see below). The plan must respond with a written decision, called a coverage determination.

Below are the steps you should follow to get a coverage determination from your plan. The process is the same whether you get your Part D coverage through a Medicare Advantage Plan with drug coverage (MA-PD) or a stand-alone Medicare private drug plan (PDP).

**Note:** Certain drugs are excluded from Medicare coverage by law. You can’t usually get coverage if you need one of these drugs. However, you may be able to ask for an exception if you can show that your doctor prescribed your drug for a use that is not explicitly excluded.

**Follow these steps to ask for a coverage determination:**

1. Get a written statement from your prescribing doctor.

You or your doctor can ask for a coverage determination (or exception), but either way you’ll need your doctor to fill out a Coverage Determination Request Form (attached). The attached document is a standard form your doctor can use, which all Part D plans must accept. However, your plan may have its own form it prefers you use. Check with your plan.

The form you submit must say that you’re requesting an exception to the plan’s formulary rules, and it must also say what kind of exception you need.
For example, your doctor will need to say that you’re requesting coverage of an off-formulary drug or an override of a specific restriction.

It must also say that the drug you were prescribed is medically necessary and:
- Other drugs/quantities on your plan's formulary are ineffective or harmful for you; or
- Other drugs/quantities on your plan's formulary are likely to be ineffective or harmful for you.

You don’t have to try other drugs if your doctor believes that they’re likely to be ineffective or harmful for you. Your doctor should give the medical reasons you can’t take other drugs or quantities on the plan’s formulary.

If it’s an emergency, your doctor can ask the plan to make a faster decision (*expedited exception request*). Your doctor should state that you need an expedited review because your life, health or ability to regain maximum function is at risk.

2. Find out where you should send your request for an exception.

Often, the doctor will send the request directly to the plan for you. If your doctor can’t do this, you can send it yourself. Call your plan or look at your plan’s website to find out where to fax or mail your request and the form your doctor filled out. Also ask whether you need to submit any other forms. All plans must accept the standard Coverage Determination Request Form (attached) but some plans may have their own specific forms that they prefer you use.

Plans must also let you request an exception through a toll-free phone number or the plan website, but even when you do this, the plan can still require that your doctor submit a written statement of support. The plan won’t start processing your request until your doctor has provided the requested information.

Keep proof, such as fax transmission reports or certified return receipts, of when you sent your exception request. You’ll need it if your plan doesn’t respond to your request on time.

3. Make sure your plan responds when it should.

Plans must respond within 72 hours of receiving your doctor's written statement. If it's an emergency, plans must respond to expedited requests within 24 hours. These are clock hours, not business hours. Your plan should send you a written coverage determination that says whether it will cover your drug. If you don’t hear from the plan in the proper timeframe, call and ask for the decision.
4. If the plan denies your exception request…

If a plan denies an exception request, you can appeal the plan's decision. Your plan should respond to you in writing with a letter titled "Notice of Denial of Medicare Prescription Drug Coverage." You’ll need this written notice in order to appeal, and the notice will include instructions on how to appeal. Appealing is also called requesting a redetermination from your plan.

5. If the plan doesn’t respond to your exception request within the required timeframe…

The lack of a decision is considered a denial. If this happens, you can send your request to the Independent Review Entity, a company that works with the federal government to review appeals. Your plan is supposed to do this, but it may not.

You can fax your request to the Independent Review Entity (a company called Maximus Federal Services) at 866-589-5241; or you can call Maximus at 877-240-6965.

Be sure to include a cover letter explaining that you submitted a request to your plan but received no response. You should also include proof of the date you submitted your appeal, such as a return receipt or fax transmission notice. You may also want to file a complaint with your plan.

6. If the plan approves your exception request…

If your plan approves your request, that means the plan will cover your drug. Make sure the plan approves coverage for the rest of the year. Normally, plans will approve a medication until the end of the calendar year (December 31).

To avoid having to appeal for the prescription each year, you can request prescription coverage extend beyond the current calendar year. Although it’s rare for plans to approve that request, plans may choose to cover a medication for more than one year, especially if you have an ongoing need and have won appeals for that drug in previous years.

If you aren’t sure for how long your plan has approved your medication, call and ask for that information in writing. It’s important to have this in case you have to ask for another exception.

For more information about the appeals process, call the Medicare Rights Center helpline at 800-333-4114.