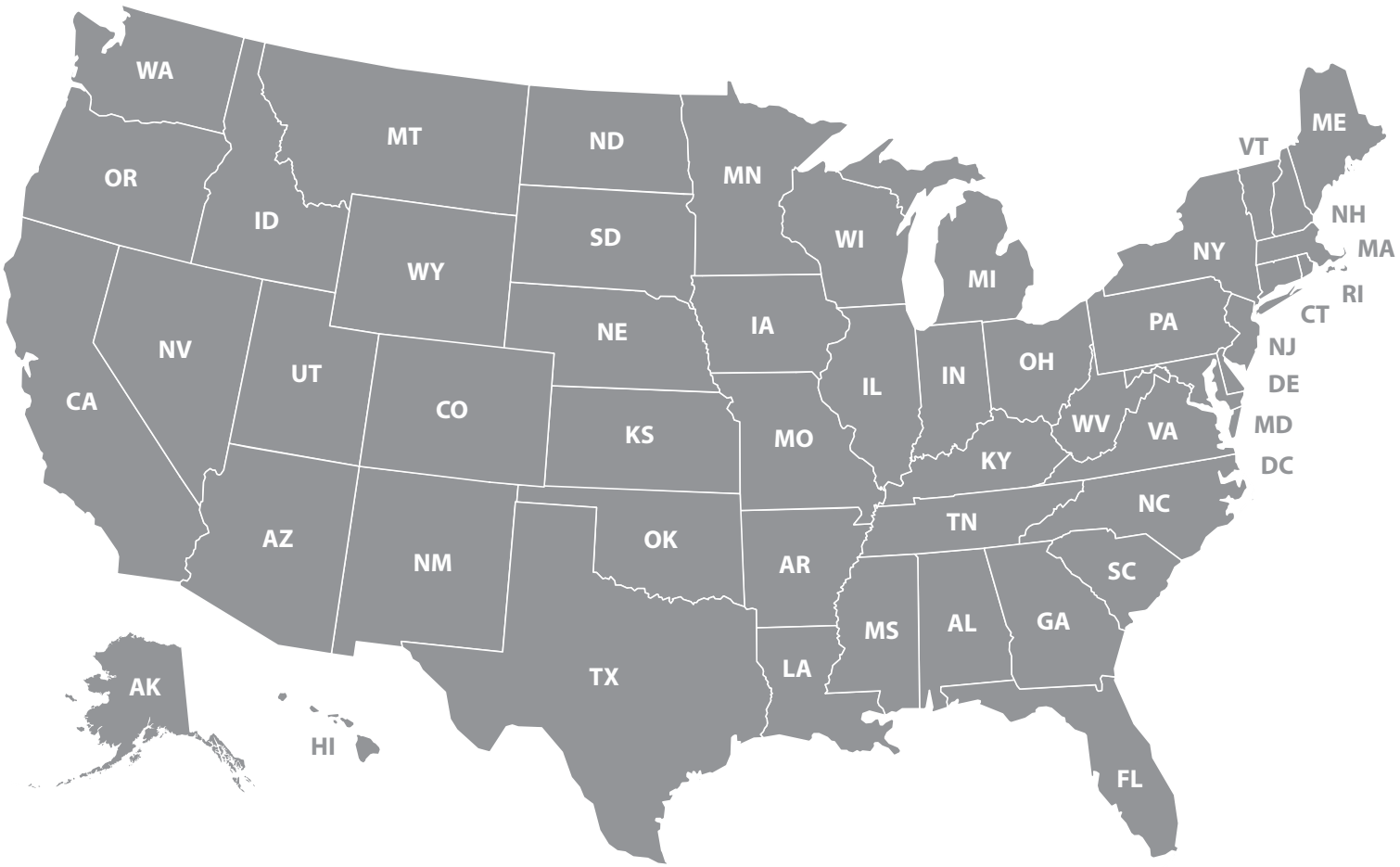
MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS

NAVIGATION MAP

Please select your state below:



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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 1: MAINE, NEW HAMPSHIRE

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- CIGNA Medicare Rx Plan One
- PrescribaRx Bronze
- WellCare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 2: CONNECTICUT, MASSACHUSETTS, RHODE ISLAND, VERMONT

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Advantage Star Plan by RxAmerica
- Aetna Medicare Rx Essentials
- BravoRx
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- Health Net Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 2
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- SilverScript Value
- WellCare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 3: NEW YORK

Please click on a plan to view detailed exceptions information

- Advantage Star Plan by RxAmerica
- BravoRx
- CIGNA Medicare Rx Plan One
- EnvisionRx Plus Silver
- GHI Medicare Prescription Drug Plan
- HIP Part D New York
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- SilverScript Value
- WellCare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 4: NEW JERSEY

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Advantage Star Plan by RxAmerica
- CIGNA Medicare Rx Plan One
- EnvisionRx Plus Silver
- Medco Medicare Prescription Plan – Value
- SilverScript Value

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 5: DISTRICT OF COLUMBIA, DELAWARE, MARYLAND

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- HealthSpring Prescription Drug Plan – Reg 5
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- UA Medicare Part D Rx Covg – Silver Plan
- WellCare Classic

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 6: PENNSYLVANIA, WEST VIRGINIA

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Advantage Star Plan by RxAmerica
- AmeriHealth Advantage
- BravoRx
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- Health Net Orange Option 1
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- SilverScript Value

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 7: VIRGINIA

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- EnvisionRx Plus Silver
- First Health Part D – Premier
- Health Net Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 7
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- WellCare Classic

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1, 2]

REGION 8: NORTH CAROLINA

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 9: SOUTH CAROLINA

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- BravoRx
- CIGNA Medicare Rx Plan One
- CIGNA Medicare Rx Plan Two
- Community CCRx Basic
- First Health Part D – Premier
- Health Net Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 9
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- WellCare Classic
- Windsor Rx

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 10: GEORGIA

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- PrescribaRx Bronze
- WellCare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 11: FLORIDA

Please click on a plan to view detailed exceptions information

- Advantage Star Plan by RxAmerica
- Envision Rx Plus Silver
- Health Net Orange Option 1
- PrescribaRx Bronze

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 12: ALABAMA, TENNESSEE

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- HealthSpring Prescription Drug Plan – Reg 12
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- Windsor Rx

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 13: MICHIGAN

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- BravoRx
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- HealthSpring Prescription Drug Plan – Reg 13
- PrescribaRx Bronze
- WellCare Classic

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 14: OHIO

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- HealthSpring Prescription Drug Plan – Reg 14

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 15: INDIANA, KENTUCKY

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- HealthSpring Prescription Drug Plan – Reg 15
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 16: WISCONSIN

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- BravoRx
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- Health Net Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 16
- PrescribaRx Bronze
- SilverScript Value

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 17: ILLINOIS

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- BravoRx
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- HealthSpring Prescription Drug Plan – Reg 17
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 18: MISSOURI

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- BravoRx
- CIGNA Medicare Rx Plan Two
- Community CCRx Basic
- Envision Rx Plus Silver
- HealthNet Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 18
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- SilverScript Value
- WellCare Classic

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 19: ARKANSAS

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- HealthNet Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 19
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- UA Medicare Part D Rx Covg – Silver Plan
- WellCare Classic
- Windsor Rx

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 20: MISSISSIPPI

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- Health Net Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 20
- PrescribaRx Bronze
- WellCare Classic
- Windsor Rx

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 21: LOUISIANA

Please click on a plan to view detailed exceptions information

- Advantage Star Plan by RxAmerica
- BravoRx
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- First Health Part D – Premier
- Health Net Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 21
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- SilverScript Value
- Health Net Orange Option 1
- Wellcare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 22: TEXAS

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- BravoRx
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- EnvisionRx Plus Silver
- First Health Part D – Premier
- HealthSpring Prescription Drug Plan – Reg 22
- PrescribaRx Bronze
- UnitedHealthcare MedicareRx
- WellCare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 23: OKLAHOMA

Please click on a plan to view detailed exceptions information

- Advantage Star Plan by RxAmerica
- Aetna Medicare Rx Essentials
- Community CCRx Basic
- Health Net Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 23
- Humana Basic – S5884-122
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- WellCare Classic

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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 24: KANSAS

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- Community CCRx Basic
- First Health Part D – Premier
- HealthSpring Prescription Drug Plan – Reg 24
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 25: IOWA, MINNESOTA, MONTANA, NEBRASKA, NORTH DAKOTA, SOUTH DAKOTA, WYOMING

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- BravoRx
- Community CCRx Basic
- First Health Part D – Premier
- HealthSpring Prescription Drug Plan – Reg 25
- PrescribaRx Bronze
- SilverScript Value

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1, 2]

REGION 26: NEW MEXICO

Please click on a plan to view detailed exceptions information

- Advantage Star Plan by RxAmerica
- Health Net Orange Option 1
- Humana Basic – S5884-123
- PrescribaRx Bronze
- SilverScript Value
- WellCare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 27: COLORADO

Please click on a plan to view detailed exceptions information

- First Health Part D – Premier
- HealthSpring Prescription Drug Plan – Reg 27
- PrescribaRx Bronze
- UnitedHealthcare MedicareRx
- WellCare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 28: ARIZONA

Please click on a plan to view detailed exceptions information

- BravoRx
- Community CCRx Basic
- Health Net Orange Option 1
- Humana Basic – S5884-124
- UnitedHealthcare MedicareRx
- WellCare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 29: NEVADA

Please click on a plan to view detailed exceptions information

- BravoRx
- Community CCRx Basic
- Health Net Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 29

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 30: OREGON, WASHINGTON

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Aetna Medicare Rx Essentials
- Community CCRx Basic
- First Health Part D – Premier
- Health Net Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 30
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- SilverScript Value

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 31: IDAHO, UTAH

Please click on a plan to view detailed exceptions information

- BravoRx
- CIGNA Medicare Rx Plan One
- Community CCRx Basic
- Health Net Orange Option 1
- HealthSpring Prescription Drug Plan – Reg 31
- Medco Medicare Prescription Plan – Value
- PrescribaRx Bronze
- SilverScript Value
- UnitedHealthcare MedicareRx

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 32: CALIFORNIA

Please click on a plan to view detailed exceptions information

- Advantage Star Plan by RxAmerica
- BravoRx
- First Health Part D – Premier
- Health Net Orange Option 1
- WellCare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 33: HAWAII

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- Advantage Star Plan by RxAmerica
- AdvantraRx Premier
- Aetna Medicare Rx Essentials
- HealthSpring Prescription Drug Plan – Reg 33
- SilverScript Value

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2]

REGION 34: ALASKA

Please click on a plan to view detailed exceptions information

- AARP MedicareRx Saver
- CIGNA Medicare Rx Plan One
- First Health Part D – Premier
- HealthSpring Prescription Drug Plan – Reg 34
- WellCare Classic

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

AARP MEDICARERx SAVER

Sponsor	UnitedHealthcare
Exceptions Process	Providers requesting an exception should complete and submit the Medicare Part D Coverage Determination Request Form. Members requesting an exception should submit the Request For Medicare Prescription Drug Coverage Determination Form. When members request a formulary or tiering exception, they should submit a statement from their provider supporting their request. Generally, the coverage decision will be made within 72 hours after the payer receives the provider's supporting statement. Members can request an expedited (fast) exception if they, or their provider, believes that the member's health could be seriously harmed by waiting up to 72 hours for a decision. If a request to expedite is granted, the payer must give a decision no later than 24 hours after receiving the provider's supporting statement. If the member is requesting an exception, they will need the following information ready when calling: • Member date of birth • Member ID number • Name of the medication • Provider's phone number • Provider fax number (if available)
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(888) 867-5575 (members) (800) 711-4555 (providers)
Notification	The plan's decision on the exception request will be provided to the member by telephone or mail. In addition, the provider will be notified by telephone or fax. If a member would like to inquire about the status of the coverage determination, he/she may call the UnitedHealthcare Customer Care line.
Prior Authorization Process	Members or providers can initiate a prior authorization by contacting UnitedHealthcare. Providers may contact the Prior Authorization Department directly by phone or fax in a Prior Authorization Request Form. Fax: (800) 527-0531
Forms Accepted	Plan-specific form
Phone Number for Prior Authorizations	(888) 867-5575 (members) (800) 711-4555 (providers)
Notification	The plan's decision on the prior authorization request will be provided to the member by telephone or mail. In addition, the provider will be notified by telephone or fax. If a member would like to inquire about the status of the coverage determination, he/she may call the UnitedHealthcare Customer Care line.
Plan Link	https://www.aarpmedicarerx.com/
Exceptions Link	https://www.aarpmedicareplans.com/health-plans/prescription-drug-plans/pdp-medicare-forms/medicare-appeals.html
Prior Authorization Link	https://www.aarpmedicareplans.com/health-plans/prescription-drug-plans/pdp-medicare-forms

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

ADVANTAGE STAR PLAN BY RxAMERICA

Sponsor	**RxAmerica, LLC**
Exceptions Process	Members have the right to ask for an exception for a drug that is not on the formulary or if the member wants a lower co-payment. For a formulary exception, the provider must provide a statement to support the request. The provider must submit the request on the RxAmerica Medicare Part D Formulary Exception/Prior Authorization Form. The plan is required to issue a decision no later than 72 hours after obtaining the request or sooner if the member's health condition requires it. If an expedited review is requested, the payer will issue a decision within 24 hours. Members may mail a written request to: RxAmerica Medicare Attn: Coverage Determination 221 North Charles Lindbergh Dr. Salt Lake City, UT 84116 Fax: (866) 855-2676
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(800) 429-6686
Notification	Members may call (800) 429-6686, option 4 to use the automated line to check the status of a prior authorization or exception request. Notifications are mailed to members and faxed to the provider's office within 1 to 3 days. The notification will indicate an approval or a denial and will include the reasons for the denial.
Prior Authorization Process	The provider must submit the request on the RxAmerica Medicare Part D Formulary Exception/Prior Authorization Form.
Forms Accepted	Plan-specific form
Phone Number for Prior Authorizations	(800) 429-6686
Notification	Members may call (800) 429-6686, option 4 to check the status of a prior authorization or exception request. Notifications are mailed to members and faxed to the provider's office within 1-3 days. The notification will indicate an approval or a denial and will include the reasons for the denial.
Plan Link	http://www.meds4medicare.com/
Exceptions Link	http://www.rxamerica.com/meds4medicare/exceptions_appeals.html
Prior Authorization Link	http://www.rxamerica.com/meds4medicare/exceptions_appeals.html

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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

ADVANTRARx PREMIER

Sponsor	**Coventry AdvantraRx**
Exceptions Process	Under the Medicare Part D prescription drug benefit program, a Part D plan beneficiary can request a coverage determination regarding the drug benefits they are entitled to receive. When Coventry makes a coverage determination, they are making a decision whether or not to provide or pay for a Part D drug and what the beneficiary's share of the cost is for the drug. A Part D plan beneficiary may also request a cost-share tiering or formulary exception. A request can also be made on behalf of the beneficiary by the beneficiary's appointed representative or the beneficiary's prescribing physician. To request a coverage determination, complete the formulary exception/prior authorization form. The timeframe for a coverage determination is dependent upon the medical situation surrounding the request. A request for an expedited coverage determination can be made orally by calling a Customer Service Representative at 800-882-3822 , 24 hours a day, 7 days a week. A request for a standard coverage determination must be made in writing and faxed to: (800) 639-9158 or mailed to: Medicare Prescription Drug Plan 4300 Cox Road Glen Allen, VA 23060
Forms Accepted	Plan specific
Phone Number for Exceptions	Phone: (800) 882-3822 Fax: (800) 639-9158
Notification	A written notice is sent to the member, faxed notifications are sent to providers.

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Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

ADVANTRARx PREMIER

(Continued from previous page)

Prior Authorization Process	For drugs that require prior authorization, your doctor must complete the necessary form(s) below and include any clinical information and supporting documentation with the form(s). All forms require a physician's signature. Forms submitted without a physician's signature cannot be accepted. The prior authorization forms found below must be either mailed or faxed. Request by mail: Medicare Prescription Drug Plan 4300 Cox Road Glen Allen, VA 23060 Request by fax: Forms can also be faxed to: (800) 639-9158
Forms Accepted	General Prior Authorization form; or product-specific form
Phone Number for Prior Authorizations	Phone: (800) 882-3822 Fax: (800) 639-9158
Notification	A written notice is sent to the member, faxed notifications are sent to providers.
Plan Link	http://coventry-medicare.coventryhealthcare.com/advantrarx/index.htm
Exceptions Link	http://coventry-medicare.coventryhealthcare.com/prescription-drug-benefits/prior-authorization/index.htm
Prior Authorization Link	http://coventry-medicare.coventryhealthcare.com/prescription-drug-benefits/prior-authorization/index.htm

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The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

AETNA MEDICARE Rx ESSENTIALS

Sponsor	Aetna Life Insurance Company
Exceptions Process	To initiate a coverage determination or exception request, the Aetna Medical Exception/Precertification Request for Prescription Medications Form must be completed by the member and provider and then can be mailed or faxed to Aetna at: Aetna Pharmacy Management Precertification Unit 300 Highway 169 South, Suite 500 Minneapolis, MN 55426 Pharmacy Precertification (Phone): (800) 414-2386 Pharmacy Precertification (Fax): (800) 408-2386 The provider may also contact Aetna directly at the toll-free number indicated on the form. A request for an expedited determination for drug coverage is available for a member who thinks that applying the standard coverage determination process could jeopardize the member's health.
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(877) 238-6211 (member services) (800) 414-2386 (providers)
Notification	If the exception is phoned in, the caller (member or provider) is aware of the determination by the end of the call. In addition, a letter is mailed to the member and a fax is also sent to the provider. If the exception is done by fax, a letter is mailed to the member and a fax is sent to the provider with notification.
Prior Authorization Process	Providers can call directly to initiate a verbal request by calling (800) 414-2386, or providers may fax in the Exception/Precertification Request for Prescription Medications Form for medications requiring a prior authorization.
Forms Accepted	Plan-specific form
Phone Number for Prior Authorizations	(800) 414-2386
Notification	If the prior authorization is phoned in, the caller is aware of the determination by the end of the call. In addition, a letter is mailed to the member and a fax is also sent to the provider. If the prior authorization is done via fax, a letter is mailed to the member and a fax is sent to the provider with notification.
Plan Link	http://www.aetnamedicare.com/plan_choices/aetna_medicare_rx.jsp
Exceptions Link	http://www.aetnamedicare.com/plan_choices/rx_exceptions_appeals.jsp
Prior Authorization Link	http://www.aetnamedicare.com/help_and_resources/downloadable_forms.jsp

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

AMERIHEALTH ADVANTAGE

Sponsor	QCC Insurance Company DBA AmeriHealth Insurance Company
Exceptions Process	To ask for a standard decision for a Part D drug, the member or provider or the member's appointed representative should call, fax, or write the plan at the numbers or address listed under Part D Coverage Determinations (for appeals about Part D drugs) in Section 5.2 of the 2010 Evidence of Coverage (EOC) publication. Members may ask for a fast decision only if their provider believes that waiting for a standard decision could seriously harm the member's health or the member's ability to function. (Fast decisions apply only to requests for benefits that the member has not yet received. If the member is requesting a Part D drug that they have not yet received, the member, the provider, or the member's representative may ask the plan to give the member a fast decision by calling, faxing, or writing the plan at the numbers or address listed under Part D Coverage Determinations (for appeals about Part D drugs) in Section 5.2 of the 2010 Evidence of Coverage (EOC) publication.
Forms Accepted	CMS-specific (member) and plan-specific (provider) forms
Phone Number for Exceptions	(888) 567-9129 or (866) 369-6037
Notification	For a standard initial determination about a Part D drug (including a request to pay the member back for a Part D drug that the member may have already received), usually a decision will be made no later than 72 hours after receipt of the exception request, but the plan will make it sooner if the request is for a Part D drug that the member has not received yet and their health condition requires it. However, if the request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as prior authorization, dosage limits, quantity limits, or step therapy requirements), a decision will be provided no later than 72 hours after receipt of the member's provider "supporting statement" explaining why the drug is medically necessary. If a response is not received within 72 hours after receipt (or the provider's supporting statement if request involves an exception), the request will automatically go to Appeal Level 2. For a fast initial determination about a Part D drug that the member or provider has not yet received, if the plan gives the member a fast review, then the plan will provide their decision within 24 hours after the member or provider asked for a fast review. The plan will provide the decision sooner if the member's health condition requires them to. If the member's or provider's request involves a request for an exception, the plan will provide their decision no later than 24 hours after they have received the provider's "supporting statement," which explains why the requested drug is medically necessary. If the plan decides the request is eligible for a fast review and the member or the provider have not received an answer from them within 24 hours after receiving the request (or the provider's supporting statement if the request involves an exception), the request will automatically go to Appeal Level 2.

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Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

AMERIHEALTH ADVANTAGE (continued)

(Continued from previous page)

Prior Authorization Process	When filling out a prior authorization form, all requested information must be supplied. Incomplete requests will be faxed back to the provider's office for completion, which will delay the review process. • Fax completed forms to the FutureScripts® Secure for review. Make sure to include your office telephone and fax number. • The provider will be notified by fax if the request is approved. The provider and patient will receive a denial letter if the request is denied. • If the provider has not received a response after two business days from submitting complete information, contact the Provider Services Department.
Forms Accepted	Plan-specific, class and drug-specific forms
Phone Number for Prior Authorizations	(888) 567-9129 (866) 369-6037
Notification	Communication is generally by fax to the provider's office. The plan can provide the determination if the member or provider calls back . If the request is denied, the prescribing provider is notified of the denial by fax. A mailed denial letter is sent to the member.
Plan Link	http://www.amerihealth.com/amerihealth65/2009/rx_pa_wv/index.html
Exceptions Link	http://www.amerihealthmedicare.com/medical_plans/quick_links/exceptions_appeals.html
Prior Authorization Link	http://www.amerihealthmedicare.com/find_a_drug/ahrx_prior_authorization/index.html

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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

BRAVORx

Sponsor	Bravo Health Insurance Company, Inc.
Exceptions Process	Under the Medicare Part D prescription drug benefit program, a Part D plan member can request a coverage determination, including a request for a tiering or formulary exception. A request can also be made on behalf of the member by the member's appointed representative or the member's prescribing provider. A request for a standard coverage determination is generally made in writing, but a plan can choose to accept oral requests. A request for an expedited coverage determination can be made orally or in writing. An authorization for the drug needs to be completed first and if this authorization is denied, then the member or provider can submit an exception by faxing a letter in writing to: For Standard Coverage Decisions fax: (866) 464-0709 For Expedited Coverage Decisions fax: (877) 712-3028 or mailing it to: Bravo Health, Prior Authorization Unit 3601 O'Donnell Street Baltimore, MD 21224
Forms Accepted	CMS-specific form
Phone Number for Exceptions	(877) 504-7252
Notification	The member and provider are both notified by letter.
Prior Authorization Process	Providers can check to see if there is a drug-specific prior authorization form, a class-specific form, or a general form to complete. This form is then faxed into Bravo at (866) 464-0709.
Forms Accepted	Plan-specific, drug and class-specific forms
Phone Number for Prior Authorizations	(877) 504-7252
Notification	The provider is notified by fax. Nothing is sent to the member.
Plan Link	http://www.mybravohealth.com/PDP/
Exceptions Link	http://www.mybravohealth.com/Resources/Important-Info/
Prior Authorization Link	http://www.bravohealth.com/Providers/PrescriptionDrug/PA.aspx

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The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

CIGNA MEDICARE Rx PLAN ONE & PLAN TWO

Sponsor	Connecticut General Life Insurance Company
Exceptions Process	After determining that a prescribed drug is not covered, members or their providers should contact the plan before trying to fill a prescription at a pharmacy. The member's provider must provide a statement to support the exception request. For any additional questions on how to obtain an exception to the CIGNA Medicare Rx Prescription drug plan formulary, members or providers should contact CIGNA Medicare Rx Customer Service at (800) 735-1459, 8:00 a.m. to 8:00 p.m. local time, 7 days a week. Providers can submit a completed CIGNA Medication Coverage Determination Form by faxing it to (866) 249-1172.
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(800) 558-9363
Notification	The member is notified (or the provider, if the member has completed the appointment of representative form) by mail.
Prior Authorization Process	Providers should complete the Cigna Medication Coverage Determination Form and fax it in to (866) 249-1172. Prior authorizations may also be done over the phone by calling (800) 558-9363. Standard response time is 72 hours. If the request is urgent, it is important to call CIGNA Pharmacy Management to expedite the request. Urgent requests can be handled within 24 hours.
Forms Accepted	Plan-specific form
Phone Number for Prior Authorizations	(800) 558-9363
Notification	A fax is sent to the provider and the plan's outreach team calls the member to notify them of determination.
Plan Link	http://www.cigna.com/sites/cignamedicare/your_cigna_choices/medicarerx/index.html
Exceptions Link	http://www.cigna.com/sites/cignamedicare/medicarerx_grievances.html
Prior Authorization Link	http://www.cigna.com/sites/cignamedicare/forms.html

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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

COMMUNITY CCRx BASIC

Sponsor	Universal American
Exceptions Process	Community CCRx will only approve a member's request for an exception if the alternative drugs included on the plan's formulary, the preferred-brand drug or additional utilization restrictions would not be as effective in treating their condition and/or would cause the member to have adverse medical effects. Members should contact the payer to ask for an initial coverage decision for a formulary, tiering, or utilization restriction exception. Both the member and provider should complete the Request for Coverage of a Non-Formulary Drug Form. When requesting a formulary, tiering, or utilization restriction exception, the member should submit a statement from their provider supporting the request. The provider is asked to list previous drugs and doses attempted for the member, condition and dates or approximate dates or duration of treatment (if known), and to document adverse effects requiring discontinuation and/or reason for perceived ineffectiveness. The payer must make a decision within 72 hours of getting the prescribing provider's supporting statement. Members and providers can request an expedited (fast) exception if they believe that the member's health could be seriously harmed by waiting up to 72 hours for a decision. If the request to expedite is granted, the payer must issue a decision no later than 24 hours after receiving the prescribing provider's supporting statement. **Note:** If the formulary exception is approved, it will be reimbursed at a Tier 3 co-payment for the calendar year.
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(866) 566-8741 (members) (866) 316-6049 (providers)
Notification	All determinations are mailed to members and if the request was denied, the payer's notification will contain an explanation for the denial. If an initial determination does not give the member all that they requested, they have the right to appeal the decision.
Prior Authorization Process	Members may call to initiate a prior authorization. Providers should submit the drug specific form available on the payer Web site, or may call to request a prior authorization.
Forms Accepted	Plan-specific, drug-specific forms
Phone Number for Prior Authorizations	(866) 566-8741 (members) (866) 316-6049 (providers)
Notification	A written notice is sent to the member, faxed notifications are sent to providers.
Plan Link	http://www.universal-american-medicare.com/Plans/communityccrx/default.aspx
Exceptions Link	http://www.universal-american-medicare.com/Plans/communityccrx/exceptions-and-prior-authorizations.aspx
Prior Authorization Link	http://www.universal-american-medicare.com/Plans/communityccrx/exceptions-and-prior-authorizations.aspx

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

ENVISIONRx PLUS SILVER

Sponsor	Envision Insurance Company
Exceptions Process	EnvisionRx Plus has both a standard and a fast (sometimes called expedited) procedure in place for making coverage determinations. The plan defines a coverage decision as one of the following: • A decision concerning an exception request for a plan's tiered cost-sharing structure. • A decision concerning an exception request involving a non-formulary drug. • A decision on the amount of cost-sharing for a drug. When requesting a coverage determination, the member should use a prior authorization form, exception request form, or coverage determination form. A decision about whether the plan will cover a Medicare prescription drug can be a "standard decision" that is made within the standard timeframe (typically within 72 hours). To ask for a standard decision, the member, their provider or appointed representative should mail or fax the request in writing to: EnvisionRx Plus Attn: Appeals/Coverage Determinations P.O. Box 1298 Twinsburg, OH 44087 Fax: (866) 250-5178 A decision about whether the plan will cover a Medicare prescription drug can be a "fast decision" that is made more quickly (typically within 24 hours). The member or provider can ask for a "fast" decision by calling (866) 250-2005 or by submitting a written request to the address or fax number for the Appeals/Coverage Determinations department listed above.
Forms Accepted	Plan-specific forms
Phone Number for Exceptions	(866) 250-2005
Notification	EnvisionRx Plus will notify the member or authorized representative, and the provider, as appropriate, of the decision regarding the member's request for coverage determination as expeditiously as the health condition requires, but no later than 24 hours from the receipt of the request, or receipt of the provider's supporting statement, if provided. The member will receive oral notification and provider will receive written approval notification, if the provider provided a supporting statement.
Prior Authorization Process	A member or provider can call (330) 405-8080 to initiate the prior authorization. Providers can fax the prior authorization form to (330) 405-8081.
Forms Accepted	Plan-specific, drug-specific forms
Phone Number for Prior Authorizations	(330) 405-8080
Notification	If a prior authorization is phoned in, a determination can be given over the phone immediately, otherwise a fax is sent to the provider's office within 24 hours.
Plan Link	http://www.envisionrxplus.com/
Exceptions Link	http://www.envisionrxplus.com/grievance.aspx#coverage
Prior Authorization Link	http://www.envisionrxplus.com/pdl.aspx#1

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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

FIRST HEALTH PART D - PREMIER

Sponsor	First Health Life and Health Insurance Company
Exceptions Process	Members may request a coverage determination, which includes request for an exception. The member has the right to ask for an "exception" if their provider believes a drug is needed that is not on the plan's list of covered drugs (formulary) or believes that the member should get a drug at a lower co-payment. If an exception is requested, the provider must issue a statement to support the request. The member should contact the plan if they would like to request a coverage determination by completing the Formulary Exception/Prior Authorization Form. Complete the form and fax it to (800) 639-9158 or mail to: Medicare Prescription Drug Plan 4300 Cox Road Glen Allen, VA 23060
Forms Accepted	Plan-specific forms
Phone Number for Exceptions	(800) 551-2694
Notification	Member is notified by mail and the provider is notified by fax.
Prior Authorization Process	The member or their provider has the ability to fax a completed, signed form to Coventry Health Care (800) 639-9158 in order to expedite processing. These forms can also be sent by mail to: Medicare Prescription Drug Plan 4300 Cox Road Glen Allen, VA 23060 Providers may call in the prior authorization, and a determination can be given over the phone.
Forms Accepted	Plan-specific, drug-specific forms
Phone Number for Prior Authorizations	(800) 639-9158
Notification	The member is notified by mail, and the provider is notified by fax if the provider sends in the request via fax.
Plan Link	http://firsthealthpremier.coventryhealthcare.com/MedicareRx/index.htm
Exceptions Link	http://www.firsthealthpremier.com/templates/editorial.asp?itemID=15328&link=child&Community=Provider
Prior Authorization Link	http://www.firsthealthpremier.com/templates/editorial.asp?itemID=13834

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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

GHI MEDICARE PRESCRIPTION DRUG PLAN

Sponsor	**GHI (Group Health Incorporated)**
Exceptions Process	The Drug Coverage Determination Form and Exception Request Form should indicate that the request is for an exception. Members can print the form and request their provider sends it in. The provider should submit the form via fax to (646) 447-3061. For immediate or expedited service, the provider can call (877) 444-7241 for a coverage determination and information may be provided verbally by the provider. If expedited service is requested, a response will be provided by the plan within 24 hours.
Forms Accepted	Plan-specific form or CMS-specific form
Phone Number for Exceptions	(877) 444-7241 or (800) 447-0829
Notification	If the provider calls for the exception, many times an answer is given over the phone. When the request is faxed in, the provider will receive a fax back to the office within 24-48 hours regarding the determination. Nothing is mailed to the member.
Prior Authorization Process	The Drug Coverage Determination Form and Exception Request Form should indicate that the request is for a prior authorization request. Members can print the form and request their provider sends it in. The provider should submit the form via fax to (646) 447-3061. For immediate or expedited service the provider can call (877) 444-7241 for a coverage determination and information may be provided verbally by the provider. If expedited service is requested, a response will be provided by the plan within 24 hours.
Forms Accepted	Plan-specific form
Phone Number for Prior Authorizations	(877) 444-7241 or (800) 447-0829
Notification	If the provider calls for the exception, an answer may be given over the phone. When the request is faxed in, the provider will receive a fax back to the office within 24-48 hours regarding the determination. Nothing is mailed to the member.
Plan Link	http://www.ghi.com/default.aspx?Page=3024
Exceptions Link	http://www.ghi.com/default.aspx?Page=3026
Prior Authorization Link	http://www.ghi.com/default.aspx?Page=3026

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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

HEALTH NET ORANGE OPTION 1

Sponsor	Health Net Life Insurance Company/Health Net Insurance of NY, Inc.
Exceptions Process	Members may ask for an exception if they believe they need a drug that is not on the plan's list of covered drugs or believe they should get a non-preferred drug at a lower out-of-pocket cost. Exception to cost utilization rules, such as a limit on the quantity of a drug, can also be done. The member's provider must provide a statement to support the exception request. If the plan denies coverage, the member can appeal and ask the plan to review the decision. The plan may issue a standard decision, which is a decision that is made within the standard time frame, or a fast decision which is also called an "expedited" decision. All requests for a standard decision received after business hours are handled the next business day. Members requesting a fast or expedited decision may only do so if the healthcare provider or member believes that waiting for a standard decision could seriously harm the member's health or ability to function. Members or their provider may submit the completed exception form by faxing it to (800) 977-8226.
Forms Accepted	Plan-specific and CMS-specific form
Phone Number for Exceptions	(800) 806-8811
Notification	A fax is sent to the pharmacy and provider. A letter is sent to the member.
Prior Authorization Process	Provider calls in to request form or can print it off the Internet. Members or providers may submit the completed form and fax it to (800) 977-8226. Turn around time is 24-72 hours. Requests may be mailed to: Health Net HNPS Prior Auth Dept. 10540 White Rock Road, Suite 280 Rancho Cordova, CA 95670
Forms Accepted	Plan-specific form
Phone Number for Prior Authorizations	(800) 867-6564
Notification	A fax is sent to the pharmacy and provider. A letter is sent to the member.
Plan Link	https://www.healthnet.com/portal/medicare/home.do
Exceptions Link	https://www.healthnet.com/portal/medicare/findADrug.do For plan specific guidance – enter state and then zip code to identify forms and instructions.
Prior Authorization Link	https://www.healthnet.com/portal/medicare/findADrug.do

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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

HEALTHSPRING PRESCRIPTION DRUG PLAN

Sponsor	HealthSpring Inc./HealthSpring of Alabama, Inc.
Exceptions Process	For information on how to obtain an exception to the HealthSpring Medicare Prescription Drug Plan Formulary, the member may contact HealthSpring Member Service at (800) 331-6293, 8 a.m. to 8 p.m., CST, 7 days a week. The plan will only approve a request for an exception if the alternative drugs included on the plan's formulary would not be as effective in treating the member's condition and/or would cause the member to have adverse medical effects. Urgent requests may be faxed to the plan, and supportive documentation from the provider should be included in the fax. Faxes for urgent requests may be sent to (866) 593-4407 and will be processed within 24 hours. Non-urgent requests will be reviewed within 72 hours.
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(800) 331-6293
Notification	The provider is sent a fax and the member is mailed a letter regarding the determination.
Prior Authorization Process	Members or providers may submit the prior authorization request by fax to (866) 845-7267. Allow up to 72 hours for review of non-urgent prior authorization requests; urgent requests will be processed within 24 hours.
Forms Accepted	Plan-specific form
Phone Number for Prior Authorizations	(800) 331-6293
Notification	The provider is sent a fax and the member is mailed a letter regarding the determination.
Plan Link	https://www.healthspring.com/default.aspx?id=3038
Exceptions Link	https://www.healthspring.com/default.aspx?id=3060
Prior Authorization Link	https://www.healthspring.com/default.aspx?id=3060

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2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

HIP PART D NEW YORK

Sponsor	HIP Health Plan of New York (HIP)
Exceptions Process	If a medication is not included in the formulary, the member should contact HIP Customer Service and ask if it is covered. If the plan does not cover it, the member can ask the plan to make an exception. Members should contact HIP Customer Service to ask for an initial coverage decision for a formulary, tiering, or utilization restriction exception. Initial coverage determination means the plan's decision to provide or pay for a Part D drug. If the medication is still not available, members should complete the HIP Medicare Prescription Drug Coverage Determination Form. When requesting a formulary, tiering, or utilization restriction exception, the member should submit a statement from the provider supporting the request. Generally, HIP must make a decision within 72 hours of getting the prescribing provider's supporting statement. Members can request an expedited exception if the provider believes that the member's health could be seriously harmed by waiting up to 72 hours for a decision. Note that certain high-cost drugs may not be eligible for the exception process.
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(800) 447-8255
Notification	For requests for standard coverage determinations, HIP will notify the member (and prescribing provider as appropriate) of the determination as expeditiously as possible but no later than 72 hours after receipt of the request for the coverage determination, or for an exception request, the provider's supporting statement (if one is provided). If an expedited request is granted, HIP will provide notice to the member (and prescribing provider as appropriate) within 24 hours of receiving the request (or for an exception request in which a non-formulary drug is requested) or within 24 hours of receiving the provider's supporting statement. If the expedited request is denied, HIP will make the determination within 72 hours of request of provider's statement and give prompt oral notice of the denial of the expedited request, which (1) explains HIP's standard process; (2) informs the member of the right to file expedited grievance; (3) informs the member of the right to resubmit the request with a provider's supporting documentation; and (4) provides instructions about HIP's grievance process and its timeframes. HIP will also send a written notice within 3 calendar days after verbal notification of the denial.

(Continued on following page)

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2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
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MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

HIP PART D NEW YORK (continued)

(Continued from previous page)

Prior Authorization Process	Providers should call the respective Department of Pharmacy Services to discuss clinical parameters for issuance of a provider prior approval (PPA) number for drugs not included in the HIP Drug Formulary for members whose benefit does not provide for a 3-tier non-formulary option. This should be done before sending the member to the pharmacy. It is important to remember that each new prescription for a medication requires a new PPA number. Providers should be prepared to answer the following questions: • Provider name and license number • Name of the member and HIP Identification number • The name and strength of the drug • Quantity to be dispensed and days' supply • Diagnosis • Reason member can't utilize the therapeutically equivalent formulary agent If a provider PPA number is not obtained by the prescriber prior to the member going to fill the prescription, the pharmacist will contact the prescriber. At all other times, pharmacists will be instructed to dispense a 2 to 5 day supply of medication. This will avoid interruption of the prescribed course of therapy. In addition, pharmacists will be directed to contact Pharmacy Services on the next business day to obtain prior approval. At that time, applicable policy will be reviewed with the pharmacy.
Forms Accepted	Plan-specific, drug-specific forms
Phone Number for Prior Authorizations	(800) 992-6227 (providers) (800) 447-8255 (members)
Notification	The plan will only notify the provider by fax or phone of the coverage determination; the plan does not contact members or mail updates to members on the status of prior authorization requests. Members may call the plan for a status update on the prior authorization.
Plan Link	http://www.hipusa.com/medicare/pdp_drug_plan.asp
Exceptions Link	http://www.hipusa.com/medicare/exception_appeals.asp
Prior Authorization Link	Physician Prior Approval Protocol: https://www.hipusa.com/Pharmacy/prior_approval_protocol.asp Formulary Products Requiring Prior Approval: https://www.hipusa.com/Pharmacy/req_prior_approval.asp Information on Coverage Determinations, Prior Authorization, Exceptions, Step Therapy Requirements, and Redeterminations (Appeals): http://www.hipusa.com/medicare/formulary_info.asp

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2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

HUMANA BASIC

Sponsor	Humana Insurance Company
Exceptions Process	To ask for a standard decision, beneficiaries, physicians, or an appointed representative should call Humana Clinical Pharmacy Review (HCPR) at (800)-555-CLIN (2546), or you can deliver a written request to: Humana Clinical Pharmacy Review 1951 Bishop Lane Suite 500 Louisville, KY 40218 Request forms may also be faxed to (877)-486-2621 Generally, Humana Clinical Pharmacy Review (HCPR) must provide a decision no later than 72 hours after receiving the request, but will make it sooner if the member's health condition requires. However, if the request involves a formulary exception, a drug placement exception, or an utilization management exception – such as dosage or quantity limits or step therapy requirements – Humana must make a decision no later than 72 hours after receiving the doctor's supporting statement. This statement explains why the requested drug is medically necessary. Members requesting an exception should submit their prescribing doctor's supporting statement with the request, if possible.
Forms Accepted	Plan-specific; Provider and/or beneficiary form
Phone Number for Exceptions	Phone: (800) 555-2546 Fax: (877) 486-2621
Notification	Humana will provide written notice of their decision under the timeframe explained above. If they do not approve the request, they must explain why and tell the member about his or her right to appeal their decision. If an answer is not received within 72 hours after receiving the request, the request will automatically go to Appeal Level 2, where an independent organization will review the case.
Prior Authorization Process	Doctors can submit their requests to the Humana Clinical Pharmacy Review (HCPR) through the following method. Complete the applicable drug specific request form or non-formulary drug authorization form and fax to 1-877-486-2621. To obtain the status on a prior request or for general information, you may contact HCPR by calling 1-800-555-CLIN (2546) Monday through Friday, 8:00 a.m. to 6:00 p.m. local time.
Forms Accepted	Plan-specific, drug-specific forms
Phone Number for Prior Authorizations	Phone: (800) 555-2546 Fax: (877) 486-2621
Notification	A written notice is sent to the member, faxed notifications are sent to providers
Plan Link	http://www.humana-medicare.com/
Exceptions Link	http://www.humana.com/providers/tools/prescription_tools/exceptions_appeals.asp
Prior Authorization Link	http://www.humana.com/providers/tools/prescription_tools/prior_authorization.asp

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2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

MEDCO MEDICARE PRESCRIPTION PLAN - VALUE

Sponsor	**Medco Containment Insurance Company of New York**
Exceptions Process	To initiate a Medicare coverage review, members, or providers may download the appropriate coverage review fax form for prior authorization or an exception. Clearly fill out the member, prescription, and prescriber sections and fax the completed form back to (800) 837-0959. Use the Exception Request Form to request coverage for a non-formulary drug or to request that a non-preferred drug be covered at a lower co-payment. The following requests for a lower co-payment are not permitted: Requests to cover a non-preferred brand (Tier 3) or preferred brand (Tier 2) at the generic co-payment (Tier 1); requests to cover a specialty/high-cost drug (Tier 5) at a lower co-payment (Tier 3, 2, or 1); or requests to cover an approved non-formulary drug (now covered at a Tier-3 co-payment) at a lower co-payment (Tier 2 or 1).
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(800) 935-6103
Notification	Once the completed form is received, a coverage decision will be made and faxed to the provider, generally within 24 hours of receipt of all information requested. In addition, a letter that confirms or denies coverage approval will be sent to both provider and member.
Prior Authorization Process	Medco maintains a specific list of drugs that require a prior authorization. The member, pharmacist, or provider can call to initiate the prior authorization, and Medco will fax the necessary prior authorization form to the provider's office. Medco will need to determine from the provider that the medication requiring prior authorization is being prescribed according to the criteria specified by Medco. The provider must complete the drug-specific prior authorization request form and fax it to (800) 837-0959. If the drug-specific prior authorization request form is not available, the provider may fax in the Coverage Review Request Form to (800) 837-0959, and indicate the specific medication.
Forms Accepted	Plan-specific, drug-specific forms
Phone Number for Prior Authorizations	(800) 753-2851
Notification	Once the completed form is received, a coverage decision will be made and faxed to the provider, generally within 24 hours of receipt of all information requested. In addition, a letter that confirms or denies coverage approval will be sent to both provider and the member.
Plan Link	http://www.medcohealth.com/medco/corporate/home.jsp?BV_SessionID=@@@@1401581046.1261414627-mm410337291214@@@@&BV_EngineID=ccfiadejehdlmmdcfklcgffdghfdfih.0&articleID=CorpYOURxExitPage
Exceptions Link	http://www.medcohealth.com/medco/corporate/home.jsp?BV_SessionID=@@@@0973935091.1248381964-mm301665556826@@@@&BV_EngineID=ccfiadehlgkgeldcfklcgffdghfdfih.0&articleID=CorpPhysMedicare
Prior Authorization Link	http://www.medcohealth.com/medco/corporate/home.jsp?BV_SessionID=@@@@0973935091.1248381964-mm301665556826@@@@&BV_EngineID=ccfiadehlgkgeldcfklcgffdghfdfih.0&articleID=CorpPhysMedicare

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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

PRESCRIBARx BRONZE

Sponsor	Universal American
Exceptions Process	PrescribaRx Bronze will only approve a member's request for an exception if the alternative drugs included on the plan's formulary, the preferred-brand drug or additional utilization restrictions would not be as effective in treating their condition and/or would cause the member to have adverse medical effects. Members should contact the payer to ask for an initial coverage decision for a formulary, tiering, or utilization restriction exception. Both the member and provider should complete the Request for Coverage of a Non-Formulary Drug Form. When requesting a formulary, tiering or utilization restriction exception the member should submit a statement from their provider supporting the request. The provider is asked to list previous drugs and doses attempted for the member, condition and dates or approximate dates or duration of treatment (if known), and to document adverse effects requiring discontinuation and/or reason for perceived ineffectiveness. The payer must make a decision within 72 hours of getting the prescribing provider's supporting statement. Members and providers can request an expedited (fast) exception if they believe that the member's health could be seriously harmed by waiting up to 72 hours for a decision. If the request to expedite is granted, the payer must issue a decision no later than 24 hours after receiving the prescribing provider's supporting statement. Note: If the formulary exception is approved, it will be reimbursed at a Tier 3 co-payment for the calendar year.
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(866) 316-6049 (providers) (866) 566–8741 (members)
Notification	All determinations are mailed to members and if the request was denied, the payer's notification will contain an explanation for the denial. If an initial determination does not give the member all that they requested, they have the right to appeal the decision.
Prior Authorization Process	Members may call to initiate a prior authorization. Providers should submit the drug specific form available on the payer Web site, or may call to request a prior authorization.

(Continued on following page)

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1, 2, 3]

PRESCRIBARx BRONZE (continued)

(Continued from previous page)

Forms Accepted	Plan-specific, drug-specific forms
Phone Number for Prior Authorizations	(866) 316-6049 (providers) (866) 566-8741 (members)
Notification	All determinations are mailed to members and if the request was denied, the payer's notification will contain an explanation for the denial. If an initial determination does not give the member all that they requested, they have the right to appeal the decision.
Plan Link	http://www.universal-american-medicare.com/prescribarx/default.aspx
Exceptions Link	http://www.universal-american-medicare.com/prescribarx/exceptions-and-prior-authorizations.aspx
Prior Authorization Link	http://www.universal-american-medicare.com/prescribarx/exceptions-and-prior-authorizations.aspx

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The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

SILVERSCRIPT VALUE

Sponsor	SilverScript Insurance Company
Exceptions Process	Members may mail in the Coverage Determination Request Form, which can be downloaded from the plan Web site, or may request their provider download the Provider Coverage Determination Form from the Web site. For a standard coverage determination, including requests for payment for a drug the member has already received, SilverScript is required to provide a decision no later than 72 hours after obtaining the request. SilverScript will make it sooner if the member's health condition requires it. However, if the request is for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules), SilverScript must make a decision no later than 72 hours after obtaining the provider's supporting statement, which explains why the drug is medically necessary. If the member qualifies for a fast coverage determination about a Part D drug, SilverScript will give a decision within 24 hours or sooner if the member's health requires it. If the member is requesting a fast exception, SilverScript is required to make a decision no later than 24 hours after getting a supporting statement (Coverage Determination Form) from the provider, explaining why the non-formulary or non-preferred drug is medically necessary. Members may mail request to: SilverScript Appeals Department – MC109 P.O. Box 52000 Phoenix, AZ 85072-2000
Forms Accepted	Plan-specific form (for use by providers) CMS-specific form (for use by members)
Phone Number for Exceptions	(866) 235-5660
Notification	SilverScript will give the member a decision in writing and fax a notice to the provider. If SilverScript does not approve the request, the payer will explain why, and advise the member of their right to appeal the decision. If the payer denies the request, the payer will send out a written explanation to the member.
Prior Authorization Process	Members and providers may search the formulary to see if a medication is covered or if a prior authorization is required. Members can initiate the prior authorization process by faxing or mailing in the Prior Authorization Criteria Request Form to SilverScript. Once received, SilverScript will fax the drug-specific form to the provider's office for completion.
Forms Accepted	Plan-specific form
Phone Number for Prior Authorizations	(866) 235-5660
Notification	If the request is denied, the provider and member will be sent a notification and reason for the denial. If approved, the pharmacy will be notified with an override, allowing the claim to be reprocessed.
Plan Link	http://www.silverscript.com/en-US/new_default.aspx
Exceptions Link	http://www.silverscript.com/en-US/coverage-determination-process.aspx
Prior Authorization Link	http://www.silverscript.com/en-US/prior_auth.aspx

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

UA MEDICARE PART D Rx COVERAGE – SILVER PLAN

Sponsor	United American Insurance Company
Exceptions Process	To initiate a coverage review for the member, providers may fax the Coverage Review Request Form. Upon receipt of this completed form, the plan will fax the provider the appropriate questionnaire. If the provider's request is faxed from 8:00 a.m. to 9:00 p.m., ET, Monday through Friday, the provider can expect the questionnaire faxed within 24 hours of the request. If the request is received outside of these timeframes, the questionnaire will be faxed the next business day. Alternately, providers can call to initiate the review. The plan will fax a form to the provider to fill out and return by fax to (800) 711-5673. Members requesting a formulary exception or a prior authorization are advised to first call their plan to discuss different options. If a member and their provider decide that an exception is still needed, the member may complete the Request for Medicare Prescription Drug Coverage Determination Form and send it to the program by mail or fax. The provider must also fax the plan a statement to support the medical necessity, or attach it to the form if it is being mailed in. Mailing Address: United American Insurance Company Attn: Medicare Part D P.O. Box 8080 McKinney, TX 75070 Fax: (800) 711-5673
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(800) 753-2851 (providers) (866) 299-3406 (members)
Notification	If initiated by fax, once the completed questionnaire is returned, a coverage decision will be faxed back, usually within 1 business day. In addition, a letter that confirms or denies coverage approval will be sent to both the provider and the member. If initiated by phone, the plan will send the provider and member a letter that confirms or denies coverage approval (usually within 2 business days of receiving the necessary information). If coverage is not approved, the letter will provide the denial reason, and the member will be responsible for the entire cost of the medication.
Prior Authorization Process	The member can initiate a prior authorization by calling the plan; the plan will then fax the necessary forms to the provider to complete. Providers may call the plan to initiate the prior authorization or fax the Coverage Review Request Form to the plan to initiate the prior authorization. The plan will then contact the provider for any additional information and will fax the appropriate prior authorization form to the provider to complete. The plan will only provide coverage after it determines that the drug is being prescribed according to the criteria specified. Fax: (800) 711-5673
Forms Accepted	Plan-specific form
Phone Number for Prior Authorizations	(800) 753-2851 (providers) (866) 299-3406 (members)

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Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

UA MEDICARE PART D Rx COVERAGE – SILVER PLAN (continued)

(Continued from previous page)

Notification	If initiated by fax, once the completed questionnaire is returned, a coverage decision will be faxed back, usually within 1 business day. In addition, a letter that confirms or denies coverage approval will be sent to both the provider and the member. If initiated by phone, the plan will send the provider and member a letter that confirms or denies coverage approval (usually within 2 business days of receiving the necessary information). If coverage is not approved, the letter will provide the denial reason, and the member will be responsible for the entire cost of the medication.
Plan Link	http://www.uamedicarepartd.com/premiums_silver.asp
Exceptions Link	http://www.uamedicarepartd.com/appeals_silver.asp
Prior Authorization Link	http://www.uamedicarepartd.com/formulary_silver.asp

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The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

UNITEDHEALTHCARE MEDICARERx

Sponsor	UnitedHealthcare
Exceptions Process	A coverage determination allows plan members to request an exception to waive coverage restrictions or limits. A coverage determination applies to prior authorization, step therapy, quantity limits, and Medicare Part B and Medicare Part D. Members and/or providers can initiate a coverage determination. If an exception is approved for a non-formulary drug, members would receive the prescription drug at the Tier 3 co-pay level. Generally, a request for an exception will be approved only if the alternative drugs included on the plan's formulary or the lower-tiered drug would not be as effective in treating a member's condition or would cause a member to have adverse medical effects. When requesting a formulary or tiering exception, a statement from the prescribing provider supporting the request is required. Usually, a coverage decision will be made within 72 hours. Members can request an expedited (fast) exception if they or their provider believe that their health could be seriously harmed by waiting up to 72 hours for a decision. If an expedited request is granted, a decision will be made no later than 24 hours once the provider's supporting statement is received. Providers may submit exception requests using the plan-specific form or by calling the plan directly to request an expedited request. Members must have the following information ready when making a request by phone: • Member name • Member date of birth • Member ID number • Name of the medication • Provider's phone number • Provider's fax number (if available)
Forms Accepted	Plan-specific authorization and exceptions forms (providers) CMS model form for exceptions (members)
Phone Number for Exceptions	(866) 498-9693 (members) (800) 711-4555 (providers)
Notification	Decisions for exceptions requests will be provided by phone or mail. The initiator of the request will be notified by telephone or fax. If the request was denied, the payer's notification will contain an explanation for the denial. If an initial determination does not give the member all that they requested, they have the right to appeal the decision.
Prior Authorization Process	Members may call to initiate a prior authorization. Providers should submit the plan-specific form available on the payer Web site, call to request a prior authorization, or submit online through the payer's Web site.
Forms Accepted	Plan-specific authorization form CMS-model form

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

UNITEDHEALTHCARE MEDICARERx (continued)

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Phone Number for Prior Authorizations	(866) 498-9693 (members) (800) 711-4555 (providers) Online requests for providers only: http://www.rxsolutions.com
Fax Number for Prior Authorizations	(800) 527-0531 (providers)
Notification	The plan's decision on exceptions request will be provided by phone or mail. The initiator of the request will be notified by telephone or fax.
Plan Link	https://www.uhcmedicarerx.com/
Exceptions Link	**Providers**: https://www.uhcmedicarerx.com/online_documents/ovation/pdf/pdp/en/2010/Medication%20Prior%20Authorization%20Request%20Form_2010.pdf **Patients:** http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/ModelCoverageDeterminationRequestForm.pdf
Prior Authorization Link	https://www.uhcmedicarerx.com/online_documents/ovation/pdf/pdp/en/2010/Medication%20Prior%20Authorization%20Request%20Form_2010.pdf

Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

WELLCARE CLASSIC

Sponsor	WellCare
Exceptions Process	If a drug is not included in the formulary, members and providers may request an exception. Generally, WellCare Classic will only approve a request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating the member's condition and/or would cause the member to have adverse medical effects. Members should contact the plan to ask for an initial coverage decision for a formulary, tiering, or utilization restriction exception. When requesting a formulary, tiering, or utilization restriction exception, members should submit a statement from their provider supporting the request. Generally, the plan must make a decision within 72 hours of getting the prescribing provider's supporting statement. Members can request an expedited (fast) exception if they or the provider believes that the member's health could be seriously harmed by waiting up to 72 hours for a decision. If the request to expedite is granted, the plan must give a decision no later than 24 hours after receiving the prescribing provider's supporting statement. The member can call to initiate the exception request, the provider's office can fax in the Medicare Coverage Determination Request Form, or the provider's office may call in exception request. Some additional documentation may be requested. Members can mail request to: WellCare Health Plans Attention: Pharmacy Department P.O. Box 31577 Tampa, FL 33631-3577 Fax: (866) 388-1767
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(888) 517-5252
Notification	A letter with a coverage decision will be mailed to the member and faxed to the provider's office. If it is a denial, the letter will provide a reason for the denial and include steps to initiate an appeal.
Prior Authorization Process	The member can call to initiate the prior authorization, the provider's office can fax in the Medicare Coverage Determination Request Form, or the provider's office can call in the prior authorization request. Some additional documentation may be requested. Members mail request to: WellCare Health Plans Attention: Pharmacy Department P.O. Box 31577 Tampa, FL 33631-3577 Fax: (866) 388-1767
Forms Accepted	Plan-specific form

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Collected on December 16, 2009. Please note, not all dual eligible plans are listed, due to plan restrictions.
The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

WELLCARE CLASSIC (continued)

(Continued from previous page)

Phone Number for Prior Authorizations	(888) 517-5252
Notification	A letter with a coverage decision will be mailed to the member and faxed to the provider's office. If it is a denial, the letter will provide a reason for the denial and include steps to initiate an appeal.
Plan Link	http://www.wellcarepdp.com/plan_comparison/find_pdp_states
Exceptions Link	http://www.wellcarepdp.com/member_rights/default
Prior Authorization Link	http://www.wellcarepdp.com/medication_guide/default

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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

WINDSOR Rx

Sponsor	Windsor Health Plan, Inc.
Exceptions Process	Members may call the Windsor Pharmacy Department and request an exception. Providers should complete the Windsor Coverage Determination Form, and return it by fax to (801) 245-3862. If a Coverage Determination Form is not readily available for the provider, the provider may provide the information verbally. Members may also request a formulary exception, but they will not be processed until the member's prescribing provider submits the form with a written supporting statement or documentation. After receiving the required information, the Coverage Determination Form will be reviewed by Windsor. If the request meets the established clinical criteria approval, payment will be granted by Windsor. Windsor must make a decision within 72 hours of getting the prescribing provider's supporting statement. Members can request an expedited (fast) exception if they or their provider believe that the member's health could be seriously harmed by waiting up to 72 hours for a decision. For all expedited decisions, Windsor must give the member a decision no later than 24 hours after getting the prescribing provider's supporting statement.
Forms Accepted	Plan-specific form
Phone Number for Exceptions	(800) 264-1587
Notification	If the exception is approved, then the name of the medication approved, date, and length of the approval are faxed back to the prescriber and mailed to the member. An override is then entered into the pharmacy claims processing system or the medical claims processing system depending on the delivery of the medication. If the exception is denied, notification will be mailed to the prescriber and member. The letter of non-coverage of the requested drug is generated and includes the following: the name of the denied medication, the specific clinical reasons that coverage was denied, a statement that the clinical criteria is available upon request and free of charge, the notice of the right to file an appeal, and whom to contact for more information. The appeals process is available for any denial.
Prior Authorization Process	Members may call the Windsor Pharmacy Department and request a coverage determination for a prior authorization. A provider must use the Windsor Coverage Determination Form, and indicate on the form that the request is for a prior authorization. If requesting a prior authorization in which a member would suffer adverse effects if he or she were required to satisfy the prior authorization requirement, the prescribing provider must provide a written supporting statement or documentation to Windsor. If a Coverage Determination Form is not readily available for the provider, the provider may provide the information orally. After receiving the required information, the Coverage Determination Form will be reviewed by Windsor. If the request meets the established clinical criteria, approval of payment will be granted by Windsor.
Forms Accepted	Plan-specific form

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1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.

MEDICARE PDP PLANS FOR DUAL-ELIGIBLE PATIENTS[1,2,3]

WINDSOR Rx (continued)

(Continued from previous page)

Phone Number for Prior Authorizations	(800) 264-1587
Notification	If approved, then the name of the medication approved, date, and length of the approval are faxed back to the prescriber and mailed to the member. An override is then entered into the pharmacy claims processing system or the medical claims processing system depending on the delivery of the medication. If denied, notification will be mailed to the prescriber and member. The letter of non-coverage of the requested drug is generated and includes the following: the name of the denied medication, the specific clinical reasons that coverage was denied, a statement that the clinical criteria is available upon request and free of charge, the notice of the right to file an appeal, and whom to contact for more information. The appeals process is available for any denial.
Plan Link	http://www.windsorrx.com/
Exceptions Link	http://www.windsorrx.com/members/coverage.html
Prior Authorization Link	http://www.windsorrx.com/members/quality.html

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The information provided is not a guarantee of coverage or payment (partial or full). Actual benefits are determined by each Part D plan administrator in accordance with its respective policy and procedures. Please refer to www.medicare.gov or contact the plan for more information about coverage or any restrictions or prerequisites that may apply. All information is subject to change.

1. http://www.medicare.gov; December 2009.
2. 2010 Prescription Drug Plans identified as No Premium with Full Low-Income Subsidy. Complete plan lists for each state can be accessed at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.
3. Data on file. Ortho-McNeil-Janssen Pharmaceuticals, Inc.