

Mail or fax completed Fair Hearing Request Form to:

Office of Public Assistance Appeal Hearings  
1317 Winewood Boulevard, Building 5  
Tallahassee, FL 32399-0700

FAX: 1-850-487-0662

Remember, you must contact your doctor (if prior authorization or pre-approval is required) AND the Ombudsman before requesting a hearing.

Incomplete Forms Will Be Returned And No Action Will Be Taken Until  
A Completed Form Is Received.

#### When can I NOT receive a fair hearing?

- If your prescription requires prior authorization and you have not contacted your doctor; OR
- Your doctor has not tried to get prior authorization; OR
- You came in too soon for a refill; OR
- The prescription has a problem that only the doctor can fix, and the doctor refuses to fix it.

#### If the pharmacist tells me Medicaid will not cover my prescription, when will I get a three (3) day supply of my medicine?

- If your prescription was for a refill of the exact prescription that Medicaid paid for last month; OR
- The pharmacist believes you should receive the medication to prevent serious or permanent harm to your health; OR
- The pharmacist believes that, if you do not receive your prescription, you could be hospitalized or need emergency treatment, or you have a serious contagious disease.

*Note: The three (3) day supply can be repeated one time.*

#### When is the three (3) day supply of refills not provided?

- If you already have the drug, or should still have some of your last prescription left; OR
- Your prescription may be harmful to your health; OR
- You are not a Medicaid recipient.

#### Can I keep my refill coverage after the three (3) day supply is gone and the problem has not been fixed?

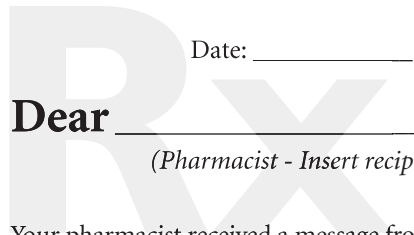
- Yes, if you have asked for a fair hearing **and** asked for ongoing coverage of your prescription **within ten (10) days after you get this pamphlet.**
- This refill coverage will continue until the Hearing Officer makes a decision about your request for a hearing.

04/27/04



# Important Information

about  
your  
**Florida  
Medicaid  
Prescription  
Drug  
Benefits**



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

Dear \_\_\_\_\_

(Pharmacist - Insert recipient's name)

Your pharmacist received a message from Medicaid or your Medicaid HMO that it will not cover your prescription for:

The reason given for not covering this prescription is:

This pamphlet has important information about:

- What you or your doctor must do to help you get medicine you need with your Medicaid.
- How to get help if your doctor cannot fix the problem.
- When you can request a fair hearing.
- When you can receive a three (3) business day supply of your prescription.
- Where to call if you have questions not answered in this pamphlet.

## Frequently Asked Questions and Answers

### What should I do if my prescription needs "prior authorization" or pre-approval?

- You must contact your doctor. Only your doctor or the doctor's staff can get prior authorization.
- If the drug needs prior authorization because you already have four (4) brand name prescriptions this month or the prescription is not on the state's preferred drug list, your doctor needs to contact Medicaid or your Medicaid HMO.

- If your prescription was not covered because there is a generic and your doctor believes you have had a bad reaction to the generic OR the brand drug is otherwise medically necessary, your doctor must fill out and submit a "Request for Multi-Source Brand Drug" form. The form is located on the AHCA website at: [www.fdhc.state.fl.us/Medicaid](http://www.fdhc.state.fl.us/Medicaid), choose "Pharmacy Services", then "Current Information", and then "Request for Multi-Source Brand Drug Form and Information".

### What if I cannot get my medicine for another reason? What if the pharmacist cannot fix the problem?

- You MUST contact the Ombudsman's Office at 1-866-490-1901 (TOLL FREE).

### What is the Ombudsman's Office?

Medicaid (and each Medicaid HMO) has an office to help fix certain prescription coverage problems. The name of the office is the "Ombudsman".

### What if the Ombudsman does not fix the problem and Medicaid or the HMO still does not cover my medicine?

You may be able to request a fair hearing if the Ombudsman cannot fix the problem.

### What are examples of when I can ask for a fair hearing?

- If you have made reasonable efforts to fix the problem; AND
- You have contacted the Ombudsman and they do not fix the problem within three (3) business days; AND
- You think Medicaid's reason for not covering the drug is wrong; OR
- The reason for not covering the drug is "lack of prior authorization", and you can show that your doctor tried to get it.

(continued)

## Fair Hearing Request Form

**Do not request a hearing unless you have contacted your doctor and the Ombudsman as described in this pamphlet.**

- (1) Medicaid refused to pay for my drug because \_\_\_\_\_ and I believe that reason is wrong. (Insert reason written on pamphlet or attach the pharmacy printout, if you were given one by your pharmacist.)
- (2) I want ongoing coverage of the prescription until my appeal is decided, since this is a refill and I am appealing within 10 days of the payment rejection notice. \_\_\_ Yes \_\_\_ No

**Circle the # of the paragraph(s) below that applies to you:**

- (3) If the reason in (1) is "no prior authorization", I want a hearing, because my doctor tried to get prior authorization and could not, or because the drug is not subject to prior authorization. **Evidence that my doctor tried to get prior authorization or that the drug does not require prior authorization is attached.**
- (4) If the reason in (1) is "too early", I request a hearing because that is wrong. I last filled this prescription on \_\_\_\_\_.
- (5) I request a hearing, because I contacted the Ombudsman and gave them all the information they asked for to fix my rejection, and they could not do so, or would not help me, or would not answer my calls.

I assert, under penalty of perjury, this \_\_\_ day of \_\_\_\_\_, 200 \_\_\_, that the foregoing is true and correct.

\_\_\_\_\_  
Recipient - Sign Name

\_\_\_\_\_  
Requestor - (If Not Recipient) Sign Name

\_\_\_\_\_  
Recipient's Medicaid ID Number

\_\_\_\_\_  
Requestor - (Relationship to Recipient)

I understand that I can represent myself or use legal counsel, a relative, friend or spokesperson in the hearing.

How can we contact you about your request for a hearing?

Name: \_\_\_\_\_  
*Print your name*

Mailing Address: \_\_\_\_\_  
*Street address*

\_\_\_\_\_  
*City* *Zip Code*

Phone number where we can contact you: \_\_\_\_\_  
*Area Code and Number*

If you have followed the steps outlined in this pamphlet, and you believe you are entitled to a hearing, you or your representative must fill out this form and mail or fax it to the address shown on the back. Be sure to include all the information requested and **circle** the paragraph(s) that explains the reason you are requesting a hearing.

Remember to enter your Medicaid ID# and print and sign your name.

**See Reverse Side for Mailing Instructions**

(Cut Along Dotted Line)