

MEDICAID PRESCRIPTION DRUG DENIAL: CLIENT INTAKE SCREENING FORM

NAME OF CLIENT: _____

DATE OF DENIAL: _____

DATE OF INTAKE: _____

1. Has client contacted Ombudsman Project and given all required information?

Yes No (If "no," advise client to do so, and provide self-help letter (Attachment A))

2. If client has contacted Ombudsman's office and provided all required information, has client submitted fair hearing request?

Yes No (If "no," advise client how to submit complete and proper request, and to return to legal services/legal aid office if hearing scheduled or if hearing request returned as incomplete.)

3. If reason for denial is due to lack of prior authorization, did client contact doctor or doctor's office?

Yes No (If "no," advise client to do so, and advise that only the doctor or doctor's staff can request prior authorization.)

MEDICAID PRESCRIPTION DRUG DENIAL: CLIENT INTERVIEW CHECKLIST

NOTE: If client has not yet: (1) contacted doctor if reason for denial due to lack of prior authorization, or (2) contacted Ombudsman Project, and given it three days to resolve problem, or (3) submitted a hearing request, then **give client self-help letter.**

NAME OF CLIENT: _____

DATE OF DENIAL: _____ REASON FOR DENIAL: _____

1. **Is client in an HMO?** Yes No

1.1 If "yes," name of HMO: _____

2. **If reason for denial is due to lack of prior authorization ("PA"), did doctor try to get PA?**

Yes No

2.1 If "yes," what happened? _____

2.1.1 If doctor tried and was unable to get PA, can client get statement from doctor or doctor's staff documenting unsuccessful attempt(s) to receive prior authorization (see attached draft statement)?

Yes No

2.1.2 _____
(doctor's name and contact information)

2.2 If "no," why? _____
(e.g., did not know number to call; hold time was too long. If doctor did not know whom to call, advise to call the toll-free ombudsman line.)

3. **If reason for denial is due to lack of PA, was drug subject to PA?**

3.1 Is drug not on the Preferred Drug List?¹ Yes No

3.2 Does drug exceed 4 brand names in the month? Yes No

3.3 Is drug a "protocol" drug?² Yes No

NOTE: If answer to any of the above is "yes," then reason for denial due to proper authorization is valid, unless exception 3.4, below, applies.

¹ The Florida Medicaid Preferred Drug List (updated 4/12/04), can be found at:
http://www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml.

² The list of protocol drugs can be found at:
http://www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/pharm_thera/paforms.shtml.

- 3.4 Is drug exempt from prior authorization (e.g. generic, drug used to treat serious mental illness³, antiviral drug used to treat HIV)? Yes No
4. **Is reason for denial (for a reason other than lack of prior authorization) factually accurate?**
- 4.1 If “yes,” explain: _____
 (e.g. reason was “early refill,” even though last refill was over 30 days ago.)
5. **Why did the Ombudsman not resolve the problem?**
- 5.1 Ombudsman did not respond within 3 business days? Yes No
- 5.2 Client was unable to contact Ombudsman Project? Yes No
- 5.2.1 If “yes,” why? _____
 (e.g. no answer, line busy, no translator)
6. **Was client denied prescription for a refill (i.e., exact prescription same drug Medicaid or Medicaid HMO paid for the month before)?**
- 6.1 If “yes,” did client get 3-day supply? Yes No
- 6.2 If “no,” did reason for denial indicate:
- 6.2.1 Client already had drug? Yes No
- 6.2.2 Client not eligible for Medicaid? Yes No
- 6.2.3 Drug may cause adverse medical reaction? Yes No
7. **Has hearing been scheduled?** Yes No
- 7.1 If “yes,” _____
 (Hearing date)
- 7.2 If “no,” was hearing request returned? Yes No
- 7.2.1 If “no,” does client have valid reason⁴ for request? Yes No

³ See Attachment B, list of drugs used to treat serious mental illness.

⁴ See Attachment C, Hearing Review Checklist

MEDICAID PRESCRIPTION DRUG DENIAL: SELF-HELP LETTER

[Insert Program Letterhead]

Dear Medicaid Client,

You requested assistance because your prescription drug was denied coverage, but you had not yet contacted the Ombudsman Project for Medicaid or your Medicaid HMO. You need to give the Ombudsman or your Medicaid HMO three business days to fix your prescription drug problem. Also, if the reason for denial was “lack of prior authorization,” you need to ask your doctor to call for prior authorization. If he or she does not know the number to call, tell them to call the toll-free Ombudsman number at 1/866-490-1901.

If the Ombudsman is unable to help you, and your doctor has tried to get prior authorization (if that is the reason for denial), you can request a fair hearing. You should fill out the form on the back of the pamphlet you received at the pharmacy and be sure to follow all the directions on the pamphlet. Also, be sure to sign the request.

If you were denied a refill of the exact prescription you had the month before which Medicaid or your HMO did pay for, be sure to check Box #2 on the fair hearing request form. Doing so indicates that you want to keep getting your medication until the hearing officer makes a decision. You must then **fax the hearing request to the Ombudsman and send it to the address on the form.** The Ombudsman fax number is: 1/866-490-1902. Be sure to keep a copy of the confirmed fax transmission for your records.

Please feel free to re-contact this office if: (1) your fair hearing is scheduled; (2) your request is sent back as incomplete; (3) your prescription was for a refill and you cannot get the medication; or (4) if you have any other questions. I am also giving you a brochure that may answer more of your questions.

Sincerely,

Attachment A

Drugs Used to Treat Severe Mental Illness Which Should be Exempt From Prior Authorization

Generic Name	Brand Name
Aripiprazole	Abilify
Chlorpromazine	Thorazine
Chlorpromazine	Generic
Clozapine	Generic
Clozapine	Clozaril
Fluphenazine	Generic
Fluphenazine	Permitil, Prolixin
Haloperidol	Haldol
Haloperidol	Generic
Loxapine	Generic
Loxapine	Loxitane
Mesoridazine	Serentil
Molindone	Moban
Olanzapine	Zyprexa, Zydis
Perphenazine	Generic
Perphenazine	Trilafon
Pimozide	Orap
Prochlorperazine	Generic
Prochlorperazine	Compazine
Quetiapine	Seroquel
Risperidone	Risperdal
Thioridazine	Generic
Thioridazine	Mellaril
Thiothixene	Generic
Thiothixene	Navane
Trifluoperazine	Generic
Trifluoperazine	Stelazine
Ziprasidone	Geodone

FAIR HEARING REQUEST FORM REVIEW CHECKLIST

1. Has the recipient either filled in the blank indicating the reason(s) the prescription was denied, or attached a computer printout from the pharmacy indicating the denial reason(s)?

yes _____ no _____

If “no”, send recipient the Notice of Fair Hearing Request Rejection form, and as reason for rejection of hearing request state: *“No reason provided for denial of drug coverage”*

2. Has the recipient circled either number 3, number 4, or number 5?

yes _____ no _____

If “no”, send recipient the Notice of Fair Hearing Request Rejection form, and as reason for rejection of hearing request state: *“Did not indicate appropriate reason for hearing request by circling either number 3, 4, or 5”*

3. Did the recipient circle only number 3?

yes _____ no _____

If yes, did the recipient attach any of the following:

- a) A statement from the prescribing physician or a member of the physician’s staff stating that he or she called or faxed the prior authorization request and was either unable to get through or provided the requested information; or
- b) A statement that the drug does not require prior authorization because the reason for rejection received from Medicaid is “drug requires prior authorization because recipient already received four brand name drugs this month” and the recipient states that she or he has not received four brand name prescriptions this month; or
- c) A statement that the drug does not require prior authorization because the reason for rejection received from Medicaid is “drug requires prior authorization because not on the preferred drug list (PDL)”, and the recipient states that the drug is on the PDL or is a generic; or
- d) A statement that the drug does not require prior authorization because recipient states that the drug is used to treat mental illness or is an anti-viral drug used to treat H.I.V.

yes _____ no _____

If “no”, send recipient the Notice of Fair Hearing Request Rejection form, and as reason for rejection of hearing request state: *“Did not attach evidence that your doctor tried to get prior authorization or that the drug is not subject to prior authorization.”*

4. Did recipient or recipient’s authorized representative sign the form in the blank for signature? (If signed by the recipient’s authorized representative, the recipient’s signature is not required.)

yes _____ no _____

If “no”, send recipient the Notice of Fair Hearing Request Rejection form, and as reason for rejection of hearing request state: *“Did not sign hearing request under penalty of perjury.”*

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