OPTUMRx®

Coverage Determination

Coverage determination is a coverage decision we make about your benefits and coverage, or about the amount we will pay for your prescription drugs. We make a coverage decision for you whenever you fill a prescription at a pharmacy.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. Usually, there is no problem. We decide the drug is covered and pay our share of the cost. But in some cases we might decide the drug is not covered or is no longer covered by Medicare for you. When we make a coverage determination, we are applying your plan benefits to your specific situation. If you disagree with this coverage decision, you can submit an appeal. Please refer to the separate instructions for submitting a coverage redetermination or appeal.

There is one form a member or a physician can complete for a coverage determination:

- Prior Authorization Form (access form on **optumrx.com/calpers**)

Examples of Coverage Determination requests include:

- Asking us to cover a Part D drug that is not on the plan's List of Covered Drugs.
- Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get).
- Asking to pay a lower cost-sharing amount for a covered non-preferred drug.
- Asking us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's List of Covered Drugs but we require you to get approval from us before we will cover it for you.)
- Asking us to reimburse you for a prescription drug you already paid for. This is a request for a payment determination. You should file your paper claim using the Direct Member Reimbursement Form available on your member website. Please follow the instructions on the form and mail to the address provided.

What types of benefit coverage requests are there?

There are two different types of coverage determination requests: standard coverage decision request and an expedited (fast) request.

For a standard benefit coverage decision request, we generally are required to give you our decision no later than 72 hours after we receive your request and supporting information from your doctor. We will make it sooner if your health condition requires.

If we have not given you a decision within 72 hours after receiving your request, your request will automatically be forwarded to C2C, an Independent Review Entity, to review your case.

If you request a fast coverage decision about a Part D drug you have not received, we will give you our decision within 24 hours — sooner if your health requires us to. If you are requesting a fast exception, we are required to make our decision no later than 24 hours after we get a supporting statement (use the Prior Authorization Form) from your doctor.

We will give you and your doctor our decision in writing. If we do not approve your request we will explain why, and tell you of your right to appeal our decision.

To file a benefit coverage determination request, you must complete and submit the Prior Authorization Form to:

OptumRx
Prior Auth Department
CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

If you prefer you may fax the form to: 1-877-239-4565

If you want a fast decision or oral request, call OptumRx Member Services, 24 hours a day, 7 days a week at the number located on the back of your prescription ID card. TTY users should call 711.

What happens if my benefit coverage request is denied?

If we deny your request, we will send you a written explanation. We may decide completely or only partly against your request. If a coverage decision does not give you all you requested, you have the right to appeal the decision.