Mail or fax completed Fair Hearing Request Form to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

(877) 254-1055 (toll-free)
239-338-2642 (fax)

MedicaidHearingUnit@ahca.myflorida.com

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 to fill 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 getting my drug covered by Medicaid 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 coverage will continue until the Hearing Officer makes a decision about your request for a hearing.

3/10/17

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) 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" because it is not on the "Preferred Drug List" (PDL)?

Generally, you must first try the drugs that are on the PDL (this is called "step therapy"), unless there are special circumstances that your doctor can justify for using the non-PDL drug.

For drugs not on the PDL or that require "prior authorization" for other reasons - such as off-label use - you must first contact your doctor. Only your doctor or the doctor's staff can get prior authorization.

What if I need to fill my current medication, but it is no longer on the PDL or is not covered for some other reason?

Generally, you should get at least a three (3) day supply of your current medication from the pharmacist, and you should contact your doctor right away. If your pharmacist is unable to assist you, contact your Ombudsman at the number below to see if you qualify for a three (3) day supply of your current medication.

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 have 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 verify that your doctor tried to get prior authorization. This information is available either through your physician's office or the Ombudsman office.

(continued)

(Cut Along Dotted Line)

Fair Hearing Request Form

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

(1) On _____ Medicaid refused to pay for my drug _____
(Date) (Name of 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 request for coverage of a medication I am currently taking and I am appealing within 10 days of getting this pamphlet. __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, (a) because my doctor tried to get prior authorization and could not, or (b) because the drug I need does not require prior authorization. **I verified my physician's request for prior authorization with (check one) ___ my physician or ___the Ombudsman's office.**

(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