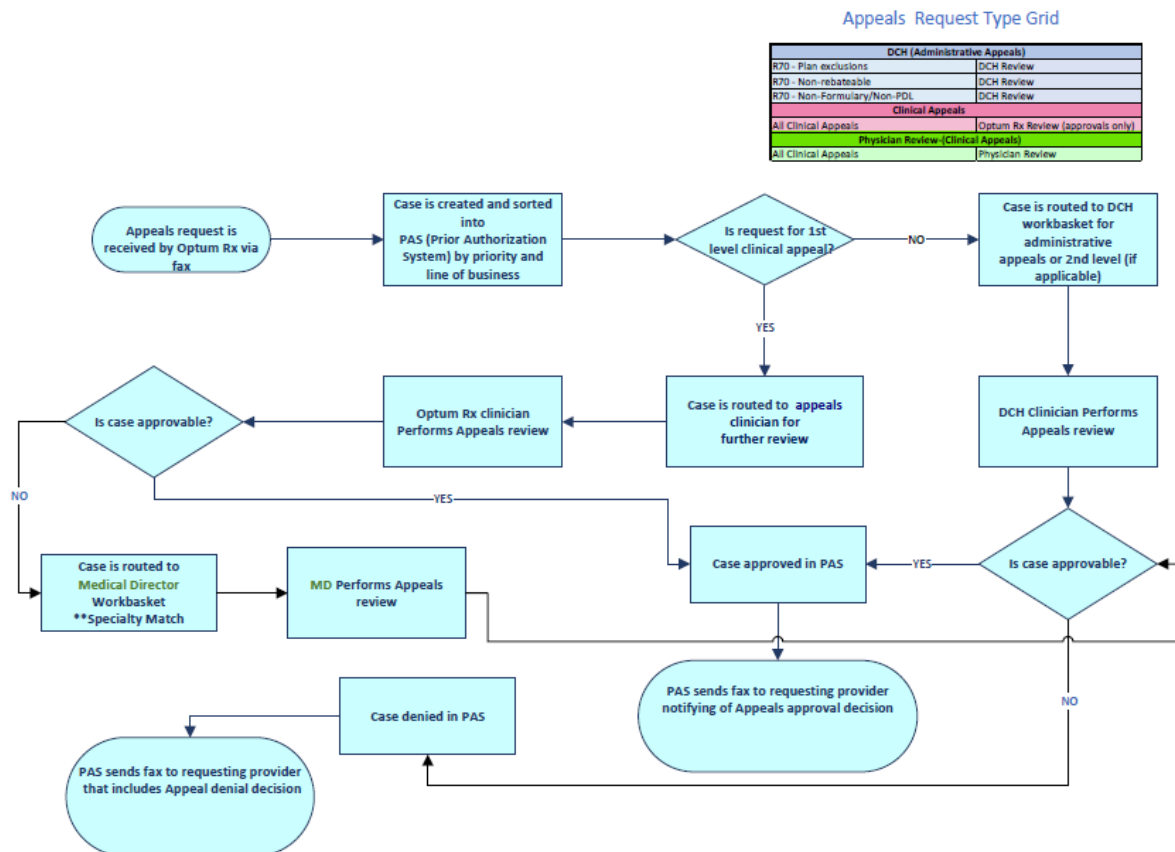


MSQ6.1 - Approach to Appeals

Below is a graphic representing our approach to appeals.

**CONFIDENTIAL, PROPRIETARY AND TRADE SECRET INFORMATION OF OPTUM
RX**

Appeals Workflow



Below are sample letters utilized in the initial denial and appeals process.

Optum Rx®  GEORGIA DEPARTMENT OF COMMUNITY HEALTH

INITIAL DENIAL NOTIFICATION

02/09/2024

John Doe
1110 ~~Medville~~ St
Atlanta, GA 30309

Fax: 6785393197

Regarding patient: Jane Smith
ID #: 000000000000
DOB: 01/01/1901

Reference# PA-12345678

Dear Dr. John Doe:

On behalf of the Georgia Department of Community Health, OptumRx® has received and reviewed a prior authorization request from you for the above referenced patient for coverage of the following medication:

Quipra

Based upon information provided and the Georgia Medicaid Pharmacy Program criteria for coverage of the above medication, the prior authorization has been denied due to the following reason(s):

Per your health plan's criteria, this drug is covered if you meet the following:
(1) You are experiencing a reduction in the number of monthly headache (migraine) days since starting the drug.
The information provided does not show that you meet the criteria listed above.
Reviewed by: ~~akil2, R, PA~~

The decision represents a coverage and reimbursement determination only for the requested medication and does not prohibit your clinical decision in the prescribing of the medication. Please consult the Georgia Medicaid Preferred Drug List (<https://dch.georgia.gov/preferred-drug-lists>) to obtain a listing of drugs that may be used in lieu of this medication that do not require prior authorization.

You have the right to appeal this decision. Please see the enclosed Georgia Medicaid Appeals form. This form should be completed and returned along with a written appeal that bears the physician's signature with accompanying documentation to support the medical necessity for this medication. These documents may be submitted via fax to 1-877-239-4565 or to the address below within 30 days of the date of this denial notification. Upon submission of the Georgia Medicaid Appeals Form AND a written appeal, a decision will be rendered within 3 business days. If you have additional question regarding this request, please contact us at 1-866-525-5827.

Sincerely,

OptumRx
Prior Authorization Department
c/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799
Fax: 1-877-239-4565

Reiterate the reason for denial

Educate prescriber on available online

Educate prescriber on Appeal rights and process

Fax number on the denial notification routes directly to Clinical Appeals for processing

This communication, including any attachments, may contain information that is confidential and may be privileged and exempt from disclosure under applicable law. It is intended solely for the use of the individual or entity to which it is addressed. If you are not the intended recipient, you are hereby notified that any use, disclosure, dissemination, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us by telephone at (866) 525-5827, discard, and destroy this document. Thank you for your cooperation.

Page 1 of 2

6V1003254 1 PA-12345678 



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

**Appeals Form prepopulated
with member, provider, and
drug information**

Georgia Medicaid Appeals Form

Member Information (required)			Provider Information (required)	
Member Name: Jane Smith			Provider Name: John Doe	
Insurance ID#: 000000000000			NPI#: 0000000000	Specialty:
Date of Birth: 01/01/1901			Office Phone: (678)000-0000	
Street Address: 343 Peach St			Office Fax: 6781111111	
City: Canton	State: GA	Zip: 30114	Office Street Address: 1110 Madville St	
Phone:			City: Atlanta	State: GA
			Zip: 30309	
Medication Information (required)				
Medication Name: Quilts		Strength: 80.00000	Dosage Form: Tabs	
Reference Number (optional)				
Reference #PA-12345678				
Appeal Information (required)				
*Date: _____			Please check one: ☐ 1 st Level Appeal	
*Number of pages enclosed: _____				
*Please place a check mark by the document(s) being submitted. This fax coversheet MUST be accompanied along with the additional documents.				
☐ Letter of Medical Necessity (LOMN) is <u>required</u> to be sent along with this form in order to process your appeal <i>LOMN must be signed by the prescriber on an official letterhead</i>				
☐ Supporting documentation (testing, lab work, medical history, etc.) if necessary				
☐ Other (please specify): _____				
<i>For initial prior authorization requests, please contact the Prior Authorization Department by telephone at 1-866-525-5827</i>				

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.

Office use only: GeorgiaAppealsForm_GAM_2019Aug