DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

This is important information about your Medicare Part D prescription drug coverage. Read this notice carefully. For help, please contact us. Please see methods to contact us on the last page under "For More Information and Help with This Notice."

[Part D Plan Logo]

NOTICE OF INTENT TO LIMIT YOUR ACCESS TO CERTAIN PART D DRUGS

Date: [insert date]

Enrollee's Name: [insert name] Member Number: [insert member ID]

You are getting this notice because [Plan Name] believes your use of prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] may be unsafe. We plan to place you in our drug management program to better manage your use of these medications.

[Insert the following when at least one prescriber has responded:] {*Based on our review and communications with your prescribers(s),* [insert prescriber name(s)]*, unless we receive additional information from you or your prescriber(s) that assures us that your use of these medications is safe and appropriate, your access to these medications will change as early as* [insert date 30 days from the date of this notice]. *The section "What If I Don't Agree?" tells you how to submit this information.*}

[Insert the following when no prescriber has responded:] {*We have contacted your prescriber(s),* [insert prescriber name(s)]*, about your use of these medications but have not received a reply. Unless we receive information from you or your prescriber(s) that assures us that your use of these medications is safe and appropriate, your access to these medications will change as early as* [insert date 30 days from the date of this notice]. *The section "What If I Don't Agree?" tells you how to submit this information.*}

What Action Do We Intend To Take?

Based on information available at the time of our review, we intend to limit your drug access in the following way(s), unless you provide us with information that changes our decision within 30 days of this notice:

[Insert the following language as applicable:]

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following prescriber(s):*

[insert name, address and telephone number of prescriber(s)]

We will not cover these medications at the pharmacy when they are prescribed to you by other doctors [MA-PDs insert if applicable: {*even if the other doctor is in our network*}]. *You can ask us to use a different prescriber by contacting us or by filling out the form at the end of this notice.*}

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following pharmacy(ies):*

[insert name, address and telephone number of pharmacy(ies)]

We will not cover these medications at another pharmacy, even if the other pharmacy is in the plan's network. You can ask us to use a different pharmacy by contacting us or by filling out the form at the end of this notice.}

{*We will only cover the following prescription opioid pain medication(s):* [list medications and amounts, if applicable]

We will not cover any other prescription opioid medications, even if they are included on the plan's drug list.}

{*We will only cover the following amount of prescription opioid pain medication(s):* [describe level that plan will cover]}

{*We will not cover any prescription opioid pain medication, including* [insert beneficiary's opioid medication name(s)]. *This includes opioids that are on the plan's drug list.*}

{*We will only cover the following benzodiazepines:* [list medications and amounts, if applicable]

We will not cover any other benzodiazepines, even if they are included on the plan's drug list.}

{*We will not cover any benzodiazepines, including* [insert beneficiary's benzodiazepine name(s)]. *This includes benzodiazepines that are on the plan's drug list.*}

This change only affects your access to prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. Your access to other types of medications will not change.

[PACE organizations omit this section. Insert this section for Low Income Subsidy (LIS) beneficiaries:]
{***Can I Change Plans?***
Generally, no. As of [insert date of this notice]*, you can only change plans during the year in very limited situations, such as if you move out of the plan's service area or you lose or have a change in your Extra Help with your prescription drug costs. You can also change plans during the Annual Enrollment Period which occurs every year from October 15 – December 7.*}

What Is A Drug Management Program?
[Plan Name] has a drug management program to help you use prescription opioids safely. Opioids are a class of drugs that include pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others. Opioid pain medications can help with certain types of pain, but have serious risks like addiction, overdose, and death. These risks are increased when opioids are obtained from multiple doctors or pharmacies; when opioids are taken with certain other medications like benzodiazepines (commonly used for anxiety and sleep); and/or when a person taking opioids has a recent history of opioid overdose. If we determine that your use of prescription opioids is not safe, we may limit your access to them or to other medications like benzodiazepines under our drug management program.

What If I Don't Agree?
You have the right to give us any information you think is important to our decision about the safety of your medication use.
[Insert this language if prescriber(s) have been non-responsive:] {*If you don't think the limitation(s)*

described above should apply to you, you should talk to your prescriber(s) about this notice. We contacted your prescriber(s), [insert names of prescriber(s)]*, about your use of these medications but have not received a reply. Your prescriber(s) can also give us information about why the limitation(s) should not apply to you.*}

[Insert this language if prescriber(s) have been responsive:] {*In making our decision, we got information from your prescriber(s),* [insert names of prescriber(s)]. *If you don't think the limitation(s) described above should apply to you, please tell us why. We have shared a copy of this notice with your prescriber(s). You should also talk to them about this notice and next steps.*}

If you or your prescriber has information you would like us to consider, you can contact us at:

[insert plan phone number, fax and address]

Note: We are not allowed to limit your access under the drug management program if you are being treated for active cancer-related pain or have sickle cell disease, you're in hospice or get palliative or end-of-life care, or you live in a long-term care facility. If any of these apply to you or you have any other information you would like us to consider, please contact us within the next 30 days. See options to contact us in the section For More Information and Help with This Notice below.

[Insert this section for pharmacy and/or prescriber limitation:]
{***What If I Want to Use a Different*** **[insert as appropriate: {*Pharmacy*} or {*Prescriber*}, or {*Pharmacy or Prescriber*}]*?***
If you don't want to use the [insert as appropriate: {*pharmacy*} or {*prescriber*} or {*pharmacy or prescriber*}] *we selected for you, you can ask to use a different one. You can give us this information by completing the last page of this notice and sending it to us, or by contacting us at the phone number below.*}

What Happens Next?
We will review any information you send us. We will also review any new information from your prescriber(s). After we make a decision about whether you are safely using your medications, we will send you another notice within 60 days. You will receive another notice if we decide you're not at risk and will not limit your access to these drugs. You will also receive another notice if we decide you're at risk and limit your access to these drugs. This notice will explain how you, your prescriber, or your representative can ask for an appeal and, if you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan.

Note: If you change to a different Medicare drug plan, we can give your new plan information about your case and any limitations we place on your drug access under our drug management program. Your new plan may place you in its drug management program as well.

What Resources Are Available to Help Me Use My Medications Safely?
[MA-PDs insert a statement describing plan benefits related to treatment for prescription drug abuse, including medication assisted treatment, mental health and counseling services covered under the enrollee's Medicare benefit or as a supplemental benefit]
[MMPs insert a statement describing plan benefits related to treatment for prescription drug abuse, including medication assisted treatment, mental health and counseling services covered under the enrollee's Medicare benefit or as a supplemental benefit, as well as any coverage under the enrollee's Medicaid benefit]
[PDPs insert a statement describing plan benefits related to treatment for prescription drug abuse, including medication assisted treatment]

Visit **www.hhs.gov/opioids** for information about State and Federal public health resources that can help you learn more about opioid medications and how to use them safely, including information about mental health services and other counseling services. Also visit Medicare's webpage **www.medicare.gov/coverage/pain-management** for information about Medicare's coverage of other pain treatments.

FOR MORE INFORMATION AND HELP WITH THIS NOTICE

For more information about the drug management program or any of the information in this notice, please contact [Plan Name] at:

Toll Free: [Insert phone number] TTY users: [Insert TTY]
[Insert call center hours of operation]
[Insert plan website]
[Insert plan mailing address]
[If the plan has a dedicated line (toll free), staff person, web portal, etc. for its DMP, that information may be included in this section, as applicable.]

You may also contact one of the organizations listed below for assistance.

- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users:1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

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CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

[Include the following form when the member has a pharmacy or prescriber limitation pending. This form is not required when only medications are to be limited]

{[PLAN NAME] PHARMACY AND PRESCRIBER SELECTION FORM

Enrollee's Name: [insert name] *Member Number: [insert member ID]*

You can give us this information by calling us at [insert phone number], faxing this form to us at [insert fax number], or by sending the completed form to: [insert address].

I prefer to use the following pharmacy (write in the information for up to two, in order of preference):

Choice #1

Pharmacy Name: _____

Address: _____

Telephone Number: _____

Choice #2

Pharmacy Name: _____

Address: _____

Telephone Number: _____

I prefer to use the following prescriber (write in the information for up to two, in order of preference):

Choice #1

Prescriber Name: _____

Address: _____

Telephone Number: _____

Choice #2

Prescriber Name: _____

Address: _____

Telephone Number: _____

}