**2018 MSHO [and SNBC] List of Covered Drugs (Formulary)**

**Instructions to Health Plans**

* [*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557*.]
* [*If plans do not use the term “Member Services”, plans should replace it with   
  the term the plan uses.*]
* [*Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY/TDD number and days and hours of operation*.]
* [*Plans may place a QR code on materials to provide an option for members to go online.*]
* [*When the term “prior <approval/authorization>” appears, plans should use one version or the other (i.e., “prior approval”* ***or*** *“prior authorization”).*]
* [*Plans have the option of deleting the footer following the introduction (e.g., the footer is not necessary in the actual list of drugs).*]
* [*Plans should insert the Marketing Material ID on the first page.*]
* [*Plans may add a Table of Contents to this document*.]

**<Plan Name>** | <year> List of Covered Drugs (Formulary)

[*In accordance with Section 60.4 of the Medicare Marketing Guidelines (MMG), plans must include the applicable HPMS approved formulary file submission ID number, which is the HPMS formulary submission ID number of the approved formulary that is being marketed, and version number* *and indicate when the document was last updated by including either* “Updated MM/YYYY” *or* “No changes made since MM/YYYY.”Plans must also include their contact information on both the front and back cover in accordance with Section 60.4.1 of the MMG*.*]

This is a list of drugs that members can get in <plan name>.

* <Plan’s legal or marketing name> is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in <Plan’s legal or marketing name> depends on contract renewal.
* The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.
* Benefits [and/or copayments/copays] may change on January 1 of each year.
* You can always check <plan name>’s up-to-date List of Covered Drugs online at <Internet address>.
* Limitations [, [copayments/copays],] and restrictions may apply. For more information, call <plan name> <Member/Customer> Services at the number listed at the bottom of this page or read the <plan name> Member Handbook <or Evidence of Coverage for SNBC>.
* [*Plans that charge $0 copays for all Part D drugs may delete this disclaimer.*] [Copayments/Copays] for prescription drugs may vary based on the level of Extra Help you get. Please contact the plan for more details.
* If you speak [*insert language of the disclaimer*], language assistance services, free of charge, are available to you. Call <plan name> <Member/Customer> Services at the number listed at the bottom of this page. The call is free. [*This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation of written materials. If the plan doesn’t meet either the Medicare or state thresholds for translation of written materials, the above disclaimer should not be included.*]
* You can get this document for free in other formats, such as large print, braille, or audio. Call <Member/Customer> Services at the number listed at the bottom of this page.
* [*Plans must also describe how members can make a standing request to get this document, now and in the future, in a language other than English or in an alternate format*.]

**Inside front cover:**

**<American Indian Language>**

**[<NCQA Disclaimer>]**

**Frequently Asked Questions (FAQ)**

Find answers to questions you have about this List of Covered Drugs. You can read all of the FAQ to learn more, or look for a question and answer.

1. What prescription drugs are on the List of Covered Drugs?   
   (We call the List of Covered Drugs the “Drug List” for short.)

The drugs on the Drug List that starts on page <insert page number> are the drugs covered by <plan name>. These drugs are available at pharmacies within our network. A pharmacy is in our network if we have an agreement with them to work with us and provide you services. We refer to these pharmacies as “network pharmacies.”

* <Plan name> will cover all medically necessary drugs on the Drug List if:
* your doctor or other prescriber says you need them to get better or stay healthy, ***and***
* you fill the prescription at a <plan name> network pharmacy.
* <Plan name> may have additional steps to access certain drugs (see question 5 below).

You can also see an up-to-date list of drugs we cover on our website at <insert website> or call <Member/Customer> Services at the number listed at the bottom of this page.

1. Does the Drug List ever change?

Yes. <Plan name> may add or remove drugs on the Drug List during the year. Generally, the   
Drug List will only change if:

* a cheaper drug comes along that works as well as a drug on the Drug List now, ***or***

we learn that a drug is not safe.

We may also change our rules about drugs. For example, we could:

* Decide to require or not require prior <approval/authorization> for a drug. (*Prior <approval/authorization>* is permission from <plan name> before you can get a drug.)
* Add or change the amount of a drug you can get (called *quantity limits*).

Add or change step therapy restrictions on a drug. (*Step therapy* means you must try one drug before we will cover another drug.)

(For more information on these drug rules, see questions 5, 6, and 7.)

* We will tell you when a drug you are taking is removed from the Drug List. We will also tell you when we change our rules for covering a drug. Questions 3, 4, and 7 have more information on what happens when the Drug List changes. You can always check <plan name>’s current Drug List online at <Internet address>. You can also call <Member/Customer> Services at the number listed at the bottom of this page to check the current Drug List.

1. What happens when a cheaper drug comes along that works as well as a drug on the Drug List now?

If you are taking a drug that is removed from the Drug List because a cheaper drug that works just as well comes along, we will tell you. We will tell you at least 60 days before we remove it from the Drug List ***or*** when you ask for a refill. Then you can get a 60-day supply of the drug before the change to the Drug List is made. [*Plans should explain how beneficiaries will get this notification.*]

1. What happens when we find out a drug is not safe?

If the Food and Drug Administration (FDA) says a drug you are taking is not safe, we will take it off the Drug List right away. We will also send you a letter telling you that. [*Plans should include information advising beneficiaries what to do after they get this letter (e.g., contact the prescribing doctor, etc.).*]

1. Are there any restrictions or limits on drug coverage? Or are there any actions required to get certain drugs?

Yes, some drugs have coverage rules or have limits on the amount you can get. In some cases you, your doctor, or other prescriber must do something before you can get the drug. [*Plans should omit bullets as needed and reflect only those utilization management procedures actually used by the plan.*] For example:

* **Prior <approval/authorization>:** For some drugs, you, your doctor, or other prescriber must get <approval/authorization> from <plan name> before you fill your prescription. If you don’t get <approval/authorization>, <plan name> may not cover the drug.
* **Quantity limits:** Sometimes <plan name> limits the amount of a drug you can get.

**Step therapy:** Sometimes <plan name> requires you to do step therapy. This means you will have to try drugs in a certain order for your medical condition. You might have to try one drug before we will cover another drug. If your doctor or other prescriber thinks the first drug doesn’t work for you, then we will cover the second.

You can find out if your drug has any additional requirements or limits by looking in the tables on pages <page numbers>. You can also get more information by visiting our website at <Internet address>. [Plans that apply prior authorization/approval and/or step therapy insert the following with applicable information: We have posted online [a document **or** documents] that explain[s] our [insert as applicable: prior <authorization/approval> restriction **or** step therapy restriction **or** prior <authorization/approval> and step therapy restrictions.]]You may also ask us to send you a copy.

You can ask for an “exception” to these limits. Please see questions 9 - 13 for more information on exceptions.

* If you are in a nursing home or other long-term care facility and need a drug that is not on the Drug List, or if you cannot easily get the drug you need, we can help. We will cover a [*must be at least 31*]-day emergency supply of the drug you need (unless you have a prescription for fewer days), whether or not you are a new <plan name> member. This will give you time to talk to your doctor or other prescriber. He or she can help you decide if there is a similar drug on the Drug List you can take instead or whether to ask for an exception. Please see questions 9 - 13 for more information about exceptions.

1. How will you know if the drug you want has limitations or if there are any actions required to get the drug?

The Drug List on page <page number> has a column labeled “Necessary actions, restrictions, or limits on use.”

1. What happens if we change our rules on how we cover some drugs? For example, if we add prior <approval/authorization>, quantity limits, and/or step therapy restrictions on a drug.

[*Plans should omit information as needed and reflect only those utilization management procedures actually used by the plan*]: We will tell you if we add prior <approval/authorization>, quantity limits, and/or step therapy restrictions on a drug. We will tell you at least 60 days before the restriction is added or when you next ask for a refill. Then you can get a 60-day supply of the drug before the change to the Drug List is made. This gives you time to talk to your doctor or other provider about what to do next.

1. How can you find a drug on the Drug List?

There are two ways to find a drug:

* You can search alphabetically (if you know how to spell the drug), ***or***

You can search by <medical condition/drug type>.

To search **alphabetically**, go to the *Index*. You can find it [*give instructions*]. The *Index* is an alphabetical list of all of the drugs included in the Drug List. Both brand name drugs and generic drugs are listed in the *Index*.

[Plans insert one of the following paragraphs depending on whether drugs are organized by **medical condition** or **drug type** in the drug listings:

<To search **by medical condition**, find the section labeled “List of drugs by medical condition” on page <page number>. The drugs in this section are grouped into categories depending on the type of medical conditions they are used to treat. For example, if you have a heart condition, you should look in that category. That is where you will find drugs that treat heart conditions.

OR

<To search **by drug type**, find the section labeled “List of drugs by drug type” on page <page number>. The drugs in this section are grouped into categories by type. For example, if you are taking a medicine for migraines, you should look in the “Antimigraine Agents” category. That is where you will find drugs that treat migraines.>]

1. What if the drug you want to take is not on the Drug List?

If you don’t see your drug on the Drug List, call <Member/Customer> Services at the number listed at the bottom of this page and ask about it. If you learn that <plan name> will not cover the drug, you can do one of these things:

* Ask <Member/Customer> Services for a list of drugs like the one you want to take. Then show the list to your doctor or other prescriber. He or she can prescribe a drug on the Drug List that is like the one you want to take. ***Or***

You can ask the health plan to make an exception to cover your drug. Please see questions 10-13 for more information about exceptions.

1. What if you are a new <plan name> member and can’t find your drug on the Drug List or have a problem getting your drug?

We can help. We may cover a temporary [must be at least 30]-day [supply/supplies] of your drug during the first [*must be at least 90*] days you are a member of <plan name>. This will give you time to talk to your doctor or other prescriber. He or she can help you decide if there is a similar drug on the Drug List you can take instead, or whether to ask for an exception.

We will cover a [*must be at least 30*]-day supply of your drug if:

* you are taking a drug that is not on our Drug List, ***or***
* health plan rules do not let you get the amount ordered by your prescriber, ***or***
* the drug requires prior <approval/authorization> by <plan name>, ***or***

you are taking a drug that is part of a step therapy restriction.

If you live in a nursing home or other long-term care facility, you may refill your prescription   
for as long as [*must be at least 91 and may be up to 98*]days. You may refill the drug multiple times during your first [*must be at least 90*]days. This gives your prescriber time to change your drugs to ones on the Drug List or ask for an exception.

[*Note: Plans must insert their transition policy for current enrollee with level-of-care changes, if applicable, as specified in section 30.4.7 of Chapter 6 of the* Prescription Drug Benefit Manual*.*]

1. Can you ask for an exception to cover your drug?

Yes. You can ask <plan name> to make an exception to cover a drug that is not on the Drug List.

You can also ask us to change the rules on your drug.

* For example, <plan name> may limit the amount of a drug we will cover. If your drug has   
  a limit, you can ask us to change the limit and cover more.
* Other examples: You can ask us to drop step therapy restrictions or prior <approval/authorization> requirements.

1. How long does it take to get an exception?

First, we must get a statement from your prescriber supporting your request for an   
exception. After we get the statement, we will give you a decision on your exception request within 72 hours.

If you or your prescriber think your health may be harmed if you have to wait 72 hours for a decision, you can ask for an expedited exception. This is a faster decision. If your prescriber supports your request, we will give you a decision within 24 hours of getting your prescriber’s supporting statement.

1. How can you ask for an exception?

To ask for an exception, call [*plans should include information on the best person to call – e.g., your care coordinator, your care team, <Member/Customer> Services*]. [*Insert:* Your care coordinator ***or*** Your care team ***or*** A <Member/Customer> Services representative] will work with you and your provider to help you ask for an exception.

1. What are generic drugs?

*Generic drugs* are made up of the same active ingredients as brand name drugs. They usually cost less than the brand name drug and usually don’t have well-known names. Generic drugs are approved by the Food and Drug Administration (FDA).

<Plan name> covers both brand name drugs and generic drugs.

1. What are OTC drugs?

*OTC* stands for “over-the-counter.” <Plan name> offers some OTC drugs through Medical Assistance (Medicaid) at no cost to you. You need a prescription for OTC drugs to be covered. These OTC drugs are listed in this Drug List [starting on page <page #>.]

1. Does <plan name> cover non-drug OTC products?

<Plan name> covers some non-drug OTC products through Medical Assistance (Medicaid). These non-drug OTC products are listed in this Drug List [starting on page <page #>.]

17. [Can I get my drugs through <Mail-Order/Long-Term Supply>?

[*Plans should include only if they offer extended-day supplies. Plans should modify the section title and language below to reflect their specific plan as needed, consistent with their approved extended-day benefit.*]

* [Mail-Order Program. We offer a mail-order program that allows you to get up to a <number>-day supply of your prescription drugs sent directly to your home. A <number>-day supply has the same [copayment/copay] as a <number>-month supply.]
* [Long-Term Supply. We offer a way to get a long-term supply of “maintenance” drugs on our plan’s Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)]

[For more information about getting drugs through mail-order or long-term supply, please call <Member/Customer> Services at the number listed at the bottom of this page.]

1. What is your [copayment/copay]?

You can read the <plan name> Drug List to learn about the [copayment/copay] for each drug.

A [copayment/copay] is an amount you may be required to pay as your share of the cost of a prescription drug. A [copayment/copay] is usually a set amount, rather than a percentage. For example, you might pay <insert sample copay amount or range> for a prescription drug.

<Plan name> members living in nursing homes or other long-term care facilities will have no [copayment/copay]s. Some members getting long-term care in the community will also have no [copayment/copay]s.

[*If a plan has copays, it must provide an explanation; see the example of tiered copays below. Plans should modify the explanation below consistent with their tier model, to include the range of applicable cost-sharing amounts for each tier (and a statement that the copay varies depending on the person’s level of Medicaid eligibility), and a description of the types of drugs (e.g., generics, brands, and/or OTCs) on each tier. Plans must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the CY 2016 Final Call Letter. If a plan has no copays for any drugs or for one or more tiers of drugs, the plan should modify the copay information accordingly.*

The Drug List includes [copayment/copay] listed by tiers.

* Tier 1 Generic drugs have the lowest <copayment/copay>. The <copayment/copay> is from <amount> to <amount>, depending on your income and level of Medical Assistance (Medicaid) eligibility.
* Tier 1 Brand drugs have a higher <copayment/copay>. The <copayment/copay> is from <amount> to <amount>, depending on your income and level of Medical Assistance (Medicaid) eligibility.]
* OTCs have a $0 [copayment/copay].]

**List of Covered Drugs**

The list of covered drugs <below/that begins on the next page> gives you information about the drugs covered by <plan name>. If you have trouble finding your drug in the list, turn to the *Index* that begins on page <index page number>.

The first column of the table lists the name of the drug. Generic drugs are listed in lower-case italics (e.g., <*generic example*>), brand name drugs are capitalized (e.g., <BRAND NAME EXAMPLE>, and OTC drugs and products are listed in lower case (e.g., <otc example>). The information in the “Necessary actions, restrictions, or limits on use” column tells you if <plan name> has any rules for covering your drug.

[***Note:*** *Plans must provide information on the following items when applicable to specific drugs and explain any symbols or abbreviations used to indicate their application: utilization management restrictions, drugs that are available via mail-order, free-first-fill drugs, limited-access drugs, and drugs covered under the medical benefit (for home infusion drugs only). While the symbols and abbreviations must appear whenever applicable, plans are not required to provide associated explanations on every page. They must, however, provide a general footnote on every page stating:* You can find information on what the symbols and abbreviations in this table mean by going to[*insert description of where information is available, such as page number*].]

[*If plans use codes in the “Necessary actions, restrictions, or limits on use” column, they should include a key. Plans are not required to include a key on every page, but plans must provide a general footnote on every page stating:* You can find information on what the symbols and abbreviations in this table mean by going to[*insert description of where information is available, such as page number*]. *The key below is only an example; plans do not have to use the same abbreviations/codes:*]

Here are the meanings of the codes used in the “Necessary actions, restrictions, or limits on use” column:

(g) = Only the generic version of this drug is covered. The brand name version is not covered.

M = The brand name version of this drug is in Tier 3. The generic version is in Tier 1.

PA = Prior authorization (approval): you must have approval from the plan before you can get this drug.

ST = Step therapy: you must try another drug before you can get this one.

**List of Drugs by <Medical Condition/Drug Type>**

[Plans insert one of the following paragraphs depending on whether drugs are organized by **medical condition** or **drug type** in the drug listings:

<The drugs in this section are grouped into categories depending on the type of medical conditions they are used to treat. For example, if you have a heart condition, you should look in the category, <therapeutic category name example>. That is where you will find drugs that treat heart conditions.>

***or***

<The drugs in this section are grouped into categories by type. For example, if you are taking a medicine for migraines, you should look in the “Antimigraine Agents” category. That is where you will find drugs that treat migraines.>]

<Therapeutic Category 1/Drug Type 1> – [Optional: *Plans can insert a plain language description of the category.*]

| Name of drug | What the drug will cost you (tier level) | Necessary actions, restrictions, or limits on use |
| --- | --- | --- |
| <*azathioprine*>  *or*  <AZASAN>  *or*  <aspirin> | <$0/$1.25/$3.35 (Tier 1 – Generic)>  *or*  <$0/$3.70/$8.35 (Tier 1 – Brand)>  *or*  <$0 (OTC)> | <PA>  <PA> |
|  |  |  |
|  |  |  |

<Therapeutic Category 2/Drug Type 2> – [Optional: *Plans can insert a plain language description of the category.*]

| Name of drug | What the drug will cost you (tier level) | Necessary actions, restrictions, or limits on use |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

[*Plans also have the option to further divide the therapeutic categories into classes as shown below:*]

## <Therapeutic Category 1/Drug Type 1> - [Optional: Plans can insert a plain language description of the category.]

| Name of drug | What the drug will cost you (tier level) | Necessary actions, restrictions, or limits on use |
| --- | --- | --- |
| *<Therapeutic Class Name 1> -* [*Optional: <Plain Language Description>*] | | |
| <Drug Name 1> | <Tier Level> | <Util. Mgmt.> |
| <Drug Name 2> | <Tier Level> | <Util. Mgmt.> |
| *<Therapeutic Class Name 2> -* [*Optional: <Plain Language Description>*] | | |
| <Drug Name 1> | <Tier Level> | <Util. Mgmt.> |
| <Drug Name 2> | <Tier Level> | <Util. Mgmt.> |

[*General Drug Table instructions:*

*Column headings should be repeated on each page of the table.*

*Plans may include a “plain-language” description of the therapeutic category next to the name of each category. For example, instead of only including the category, “Dermatological Agents,” plans would include “Dermatological Agents – Drugs to treat skin conditions.”*

*List therapeutic categories alphabetically within the table, and list drugs alphabetically under the appropriate therapeutic category. If plans use the second option and further divide the categories into classes, the therapeutic categories should be listed alphabetically and the therapeutic classes listed alphabetically under the appropriate category. The drugs should then be listed alphabetically under the appropriate therapeutic class.*

*The table must include at least two covered drugs for each therapeutic category/class except when only one drug exists in the category or class or when two drugs exist in the category or class but one is clinically superior to the other as per your CMS-approved formulary.*]

[*“Name of Drug” column instructions:*

*Brand name drugs should be capitalized (e.g., DRUG A). Generic drugs should be lower case and italicized, e.g., penicillin. OTC drugs and products should be lower case, e.g., aspirin. Plans may include the generic name of a drug next to the brand name. For purposes of this section, OTCs, regardless of brand or generic, should be listed in lower case. Proper nouns should still have an initial capital.*]

*If there are differences in formulary status, tier placement, quantity limit, prior authorization, step therapy, or other restrictions or benefit offerings (e.g., available via mail order, etc.) for a drug based on its differing dosage forms or strengths, the formulary must clearly identify how it will treat the different formulations of that same drug. For instance, if a drug has a different tier placement depending on the dosage (e.g., 20 mg is in Tier 1 and 40 mg is in Tier 4), plans must include the drug twice within the table with the varying dosage listed next to the drug name (e.g., DRUG A, 20 mg and DRUG A, 40 mg). The drug will be counted as a single drug when determining whether the plan has included two drugs within each therapeutic category/class.*]

[*“<What the drug will cost you> (tier level)” column instructions:*

*Plans should put the appropriate tier level in parentheses next to the copay or range of copays as shown in the example above.*]

**[*Necessary actions, restrictions, or limits on use column instructions***

*Plans may include abbreviations within this column (e.g., QL for quantity limits) but must include an explanation at the beginning of the table explaining each abbreviation.*

*Plans must explain any symbols or abbreviations used to show use restrictions, drugs that are available via mail order, non-Part D drugs or OTC items that are covered by Medicaid, free-first-fill drugs, limited-access drugs, and drugs covered under the medical benefit (for home infusion drugs only and for plans that specifically ask and are approved in the plan benefit package to bundle home infusion drugs and services under the medical benefit). Plans may also use abbreviations to show drugs that are not available via mail-order.*

***Note:*** *Health plans may want to add this bullet if the plan offers generic use incentive programs permitting zero or reduced cost-sharing on first generic refills:*

We will provide this prescription drug at [*insert as appropriate:* no***or*** *a reduced*] cost the first time you fill it.]

[*Index of Drugs*

*Plans must include an alphabetical listing of all drugs included in the formulary that indicates the page where members can find coverage information for that drug. Plans may use more than one column for the index listing. The inclusion of this list is required and should start on a separate page.*]