**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.*]
* [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 should note that the EOC is referred to as the “Participant Handbook”.   
  Plans must use the term “Participant Handbook”.]
* [Plans should include in the Drug List all drugs/items covered under the Part D and Medicaid pharmacy benefits. *This includes only those drugs on plans’ approved Part D formulary and approved Additional Demonstration Drug (ADD) file. Plans may not include in the Drug List any OTC drugs and/or items offered as a plan supplemental benefit that are in excess of Medicaid-required OTC drugs and/or items.* However, under question number 16 in the introductory FAQ section, plans may include language briefly describing any plan-covered supplemental OTC benefits they provide in addition to the OTC drugs and/or items required to be covered on the ADD File. Plans must include a reference to Chapter 4 of the Participant Handbook where the Participant can get additional information about the supplemental OTC benefit.]
* [Plans may place a QR code on materials to provide an option for Participants to go online.]
* [The footer following the introduction (i.e., the footer in the actual list of drugs) must appear at the bottom of every other 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 indicate when the document was last updated by including either “*Updated MM/YYYY” *or* “No changes made since MM/YYYY.”Plans must 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 Participants can get in <plan name>.

* <Plan’s legal or marketing name> is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.
* 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 may change on January 1 of each year.
* You can always check <plan name>’s up-to-date List of Covered Drugs online at <web address> or by calling <plan name> Participant Services at <toll-free number>.
* Limitations and restrictions may apply. For more information, call <plan name> Participant Services or read the <plan name> Participant Handbook. This means that you need to follow certain rules to have <plan name> pay for your services.
* There are no copays for any covered drugs*.*
* If you speak [*insert language of the disclaimer*], language assistance services, free of charge, are available to you. Call [insert Participant Services toll-free phone and TTY/TDD numbers and days and hours of operation]. The call is free. [*This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation.*]
* You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY/TDD numbers>, <days and hours of operation>. The call is free.
* [*Plans must simply describe how they will request a Participant’s preferred language and/or format and keep the information as a standing request for future mailings and communications. Plans must also describe how a Participant can change a standing request for preferred language and/or format*.]
* The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

Frequently Asked Questions (FAQ)

Find answers here 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 List of Covered Drugs 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 drugs on the Drug List if:
* your doctor or other prescriber says you need them to get better or stay healthy,
* the drug is medically necessary for your condition, ***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). In some cases, you may have to do something before you can get a drug, like try other drugs first.

You can also see an up-to-date list of drugs that we cover on our website at <insert website address> or call Participant Services at <insert phone number>.

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 new 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 for a drug. (*Prior approval* is permission from <plan name> or your Interdisciplinary Team (IDT) 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 page <page number>.)

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 below have more information on what happens when the Drug List changes.

* You can always check <plan name>’s up to date Drug List online at <web address>.   
  You can also call Participant Services to check the current Drug List at <toll-free number>.

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

If a cheaper drug becomes available that works as well as a drug on the Drug List now:

Your pharmacist may give you the cheaper drug the next time you fill your prescription. If you and your provider decide that the cheaper drug is not right for you, your provider can tell the pharmacist to continue to give you the drug you take now.

<Plan name> may decide to take the more expensive drug off of the Drug List. If you are taking a drug that we remove from the Drug List because a cheaper drug that works just as well comes along, 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 Participants 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 and call you to tell you that the unsafe drug was taken off the Drug List. [*Plans should include information advising Participants what to do after they get this letter and call (e.g., contact the prescribing doctor, etc.).*]

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

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

* **Prior approval (or prior authorization):** For some drugs, you or your doctor or other prescriber must get approval from <plan name> or your Interdisciplinary Team (IDT) before you fill your prescription. If you don’t get approval, <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 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 beginning on pages <page numbers>. You can also get more information by visiting our web site at <web address>. [Plans that apply prior authorization and/or step therapy insert the following with applicable information: We have posted online [a document or documents] that explain our [insert as applicable: prior authorization restriction **or** step therapy restriction **or** prior authorization and step therapy restrictions.] You may also ask us to send you a copy.

You can ask for an “exception” from these limits. Please see question 11 for more information on exceptions.

* If you are in a nursing facility 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> Participant. 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 question 11 for more information about exceptions.

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

The List of Covered Drugs 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 authorization (approval), 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, 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 prescriber 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.

To search **alphabetically**, go to the Alphabetical Listing section on page <page number>. Then look for the name of your drug in the list.

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 the category, <therapeutic category name example>. That is where you will find drugs that treat heart conditions.

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 Participant Services at <toll-free number> and ask about it. If you learn that <plan name> will not cover the drug, you can do one of these things:

* Ask Participant 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 plan or your Interdisciplinary Team (IDT) to make an exception to cover your drug. Please see question 11 for more information about exceptions.

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

We can help. We must cover up to 90 days of temporary supplies of your drug, as needed, during the first 90 days you are a Participant 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 up to 90 days of temporary supplies 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 by <plan name> or your Interdisciplinary Team (IDT), ***or***
* you are taking a drug that is part of a step therapy restriction.

If you live in a nursing facility 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 in the plan. 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> or your Interdisciplinary Team (IDT) to make an exception to cover a drug that is not on the Drug List.

You can also ask <plan name> or your IDT 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 or your IDT to change the limit and cover more.
* Other examples: You can ask us or your IDT to drop step therapy restrictions or prior approval requirements.

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

First, <plan name> or your Interdisciplinary Team (IDT) must receive a statement from your prescriber supporting your request for an exception. After we get the statement, you will get 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, you will get 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 your Care Manager. Your Care Manager 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 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> covers some OTC drugs when they are written as prescriptions by your provider.

You can read the <plan name> Drug List to see what OTC drugs are covered.

[Plans should include OTC drugs they pay for and that were included on the integrated formulary approved by CMS and New York State in the Drug List.]

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

<Plan name> covers some OTC non-drug products when they are written as prescriptions by your provider. [*Plans should provide examples of non-drug OTC products (e.g., band-aids, etc.).*]

You can read the <plan name> Drug List to see what OTC non-drug products are covered.

[Plans should include OTC non-drug products they pay for in the Drug List.]

[Optional: Plans may include language briefly describing any plan-covered supplemental OTC benefits they provide in addition to the OTC drugs and/or items required to be covered on the Additional Demonstration Drug (ADD) File.  Plans must include a reference to Chapter 4 of the Participant Handbook where the Participant can get additional information about the supplemental OTC benefit.]

1. What is your copay?

You will not be charged a copay for drugs on the Drug List.

1. What are drug tiers?

Tiers are groups of drugs on our Drug List.

[*Plans must provide* *a description of each of their drug tiers and the types of drugs (e.g., generics, brands, and/or OTCs) in each tier.*

*Plans must include tier examples such as the following:*

* Tier 1 drugs are generic drugs.
* Tier 2 drugs are brand name drugs.

*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 and consistent with their approved plan benefit package. Plans must also* *include a statement that all tiers have no 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 chart lists the name of the drug. Brand name drugs are capitalized (e.g., <BRAND NAME EXAMPLE>) and generic drugs are listed in lower-case italics (e.g., <*generic 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 on this table mean by going to[*insert of description of where information is available, such as page number*].]

[***Note:***Any OTC drugs or products on the plan’s approved integrated formulary must be included on the Drug List. For non–Part D drugs or OTC items that are covered by Medicaid, please place an asterisk (\*) or another symbol by the drug to indicate that the beneficiary may need to follow a different process for appeals.]

**Note:** The <symbol used by the plan*>* next to a drug means the drug is not a “Part D drug.” These drugs have different rules for appeals. An *appeal* is a formal way of asking for a review of and change to a coverage decision if you think there was a mistake. For example, <plan name> or your Interdisciplinary Team (IDT) might decide that a drug that you want is not covered or is no longer covered by Medicare or Medicaid. If you or your doctor or other prescriber disagrees with the decision, you can appeal. To ask for instructions on how to appeal, call Participant Services at <toll-free number> or the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800. (TTY users call 711, then follow the prompts to dial 844-614-8800.) You can also read the Participant Handbook to learn how to appeal a decision.

**List of Drugs by Medical Condition**

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.

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

| Name of drug | Tier level | What the drug will cost you | Necessary actions, restrictions, or limits on use |
| --- | --- | --- | --- |
| <AZASAN> | <1-3> | $0 | <PA> |
|  |  |  |  |
|  |  |  |  |

[*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.

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

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

[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.

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

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

| Name of drug | Tier level | What the drug will cost you | Necessary actions, restrictions, or limits on use |
| --- | --- | --- | --- |
| *<Therapeutic Class Name 1> -* [*Optional: <Plain Language Description>*] | | | |
| <Drug Name 1> | <Tier Level> | $0 | <Util. Mgmt.> |
| <Drug Name 2> | <Tier Level> | $0 | <Util. Mgmt.> |
| *<Therapeutic Class Name 2> -* [*Optional: <Plain Language Description>*] | | | |
| <Drug Name 1> | <Tier Level> | $0 | <Util. Mgmt.> |
| <Drug Name 2> | <Tier Level> | $0 | <Util. Mgmt.> |

[Even if a plan uses this option, 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*].]

[**General Drug Table instructions:**

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

Plans should include OTC drugs they pay for and that were included on the integrated formulary approved by CMS and the state in the Drug List.

Plans should include OTC non-drug products they pay for in the Drug List.

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 chart 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 lowercase and italicized, e.g., penicillin. Plans may include the generic name of a drug next to the brand name.]

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.]

[**“Tier level” column instructions:**

Plans should enter the appropriate tier level as a numerical value (i.e., 1, 2, 3, etc).]

[**“What the drug will cost you” column instructions:**

Plans should enter $0 as the copay for all drugs.]

[**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 request 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.]

[**Index of Drugs**

Plans must include an alphabetical listing of all drugs included in the formulary that indicates   
the page where Participants 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.]