

Model Part D Transition Letter: FINAL CY2010

[Instructions: This model should be used to notify beneficiaries that they have received a transition supply of a drug because the drug is not on the plan's formulary, or it is subject to the following drug utilization management tools: prior authorization, step therapy, generic first fill, quantity limits (for safety or non-safety reasons). It can also be used when a member receives a transition fill across contract years.]

<DATE>

<MEMBER NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <MEMBER NAME>:

This letter is to inform you that <Plan Name> has provided you with a *[Insert one <temporary> <limited>]* supply, of the following prescription[s]: <list medication[s] here> .

This [These] drug[s] are either not included on our list of covered drugs (called our formulary) or included on the formulary, but subject to certain limits. As a *[Insert one <new enrollee> <current enrollee who has remained with our plan this year>]* <Plan Name> is required to provide at least a 30-day supply. *[Insert for members who reside in a LTC facility: As a resident of a long term care facility, <Plan Name> is required to provide at least a 31 day supply (unless the prescription is written for less) with refills provided, if needed, up to a 93 day supply.]*

It is important that you understand that this is a *[Insert one <temporary> or <limited>]* supply of this drug. Before this supply ends, you should speak to <Plan Name> and/or your physician regarding whether you should change the drug[s] you are currently taking, or request an exception from <Plan Name> to continue coverage of this [these] drug[s].

If you need assistance in requesting an exception, or for more information about our transition policy, please call <Customer/Member> Service at <phone number>. TTY users should call <TTYnumber>. We are happy to take your calls from <hours of operations>. Instructions on how to apply for an exception or how to change your current prescription[s] is [are] discussed at the end of the letter.

The following is an explanation of why your drug[s] is [are] not covered or is [are] limited under <Plan Name>.

[Note: Plans may include information about multiple transition supplies on the same notice.]

[Name of Drug: <name of drug>

Date Filled: <date filled>

Reason for Notification: This drug is not covered on our formulary. *[Insert for members who do not reside in a LTC facility: We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 30> day supply during your first <must be at least 90>days in*

<Plan name> unless you obtain a formulary exception from <Plan Name>.] [*Insert for members who reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least a 31 day supply (unless the prescription is written for less) with refills provided, if needed, up to a 93 day supply> during your first <must be at least 90> days in <Plan name> unless you obtain a formulary exception from <Plan Name>.]

[Name of Drug: <name of drug>

Date Filled: <date filled>

Reason for Notification: This drug is not covered on our formulary. In addition, we could not provide the full amount that was prescribed because we limit the amount of this drug that we provide at one time. This is called quantity limits and we impose such limits for safety reasons. [*Insert for members who do not reside in a LTC facility:* We will allow you to refill your <name of drug> prescription until we have provided you with a <must be at least 30> day supply, but we will not pay for it after that unless you obtain a formulary exception from <Plan Name>.] [*Insert for members who reside in a LTC facility:* We will allow you to refill the limited supply of your <name of drug> prescription but will stop providing additional fills after your first <must be at least 90> days in <Plan Name> unless you obtain a formulary exception from <Plan Name>.]

[Name of Drug: <name of drug>

Date Filled: <date filled>

Reason for Notification: This drug is covered on our formulary. However, we could not provide the full amount that was prescribed because of plan quantity limits. We will not provide more than what our quantity limits permit unless you obtain an exception from <Plan Name>. Please contact <Plan Name> to discuss the exception process. Our contact information is located below.

[Name of Drug: <name of drug>

Date Filled: <date filled>

Reason for Notification: This drug requires your doctor or other professional who prescribed this drug to ask us to satisfy certain requirements before you can fill this prescription at your pharmacy. This is called prior authorization. [*Insert for members who do not reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 30> day supply during your first <must be at least 90> days in <Plan name>, unless you obtain <Plan Name>'s prior authorization or you obtain an exception to the prior authorization from <Plan Name>.] [*Insert for members who reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a < must be at least a 31 day supply (unless the prescription is written for less) with refills provided, if needed, up to a 93 day supply> day supply during your first <must be at least 90> days in <Plan name> unless you obtain a prior authorization or you obtain an exception to the prior authorization from <Plan Name>.]

[Name of Drug: <name of drug>

Date Filled: <date filled>

Reason for Notification: This drug will be covered only if you first try certain other drugs, as part of what we call a step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. [*Insert for members who do not reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 30> day supply during your first <must be at least 90> days in <Plan name> unless you try other drugs on our formulary first or you

obtain an exception to the step therapy requirement from <Plan Name>.] *[Insert for members who reside in a LTC facility: We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a < must be at least a 31 day supply (unless the prescription is written for less) with refills provided, if needed, up to a 93 day supply > day supply during your first <must be at least 90> days in <Plan name> unless you try other drugs on our formulary first or you obtain an exception to the step therapy requirement from <Plan Name>.]*

Name of Drug: <name of drug>

Date Filled: <date filled>

Reason for Notification: This drug will be covered only if you first try a generic version of this drug. This drug will not be covered outside of the transition period because <Plan Name> would like you to try a generic of this drug before continuing to cover the brand drug. *[Insert for members who do not reside in a LTC facility: We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 30> day supply during your first <must be at least 90> days in <Plan name> unless you try other drugs on our formulary first or you obtain an exception to the step therapy requirement from <Plan Name>.]* *[Insert for members who reside in a LTC facility: We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a < must be at least a 31 day supply (unless the prescription is written for less) with refills provided, if needed, up to a 93 day supply> day supply during your first <must be at least 90> days in <Plan name> unless you try other drugs on our formulary first or you obtain an exception to the step therapy requirement from <Plan Name>.]* We will cover this drug only while you seek to obtain an exception to the generic first fill requirement. Please contact <Plan Name> to discuss the exception process. Our contact information is located below.]

Note: The following notice provision is optional to address the situation when a drug is non-formulary and has quantity limits that are not safety-related (plan imposed). While the non-formulary language is mandatory, plans may choose to also include quantity limit language in order to provide as much information as possible to the member.

[Name of Drug: <name of drug>

Date Filled: <date filled>

Reason for Notification: We could not provide the full amount that was prescribed because of plan quantity limits. We will not provide more than what our quantity limits permit unless you obtain an exception from <Plan Name>. Please contact <Plan Name> to discuss the exception process. Our contact information is located below.]

Note: The following notice provision is for Emergency Fill and Level of Care Change transitions and is optional. However, we encourage plans notify beneficiaries of Emergency Fill and Level of Care Change Transitions.

[Name of Drug: <name of drug>

Date Filled: <date filled>

Reason for Notification: This drug is not covered on our formulary. We will cover this drug for <days supply on filled claim –must be at least 31 days> while you seek to obtain a formulary exception from <Plan Name>. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made. Please contact <Plan Name> for more information regarding our exception process. Our contact information is located below.]

[Name of Drug: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug requires prior authorization. We will cover this drug for *<days supply on filled claim –must be at least 31 days>* while you seek to obtain an exception to the prior authorization from *<Plan Name>*. Please contact *<Plan Name>* to discuss the exemption process. Our contact information is located below.]

[Name of Drug: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug will be covered only if you first try certain other drugs as part of what we call our step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. We will cover this drug for *<days supply on filled claim –must be at least 31 days>* while you seek to obtain an exception to the step therapy requirement from *<Plan Name>*. Please contact *<Plan Name>* to discuss the exception process. Our contact information is located below.]

How do I change my prescription?

If your drug[s] is [are] not covered on our formulary, or is covered on our formulary but we have placed a prior authorization, step therapy, or quantity limit on it, you can ask us if we cover another drug used to treat your medical condition. If we cover another drug for your condition, we encourage you to ask your doctor if these drugs that we cover are an option for you. If your doctor tells you that none of the drugs we cover for treating your condition is medically appropriate, you have the right to request an exception from us. You also have the right to request an exception if your doctor tells you that a prior authorization, quantity limit, or other limit we have placed on a drug you are taking is not medically appropriate for treating your condition.

How do I request an exception?

The first step in requesting an exception is for you to ask your prescribing doctor to contact us. *<Provide the necessary address, fax number, and phone number>*.

Your doctor must submit a statement supporting your request. It may be helpful to take this notice with you to the doctor or submit it to his or her office. The doctor's statement must indicate that the requested drug is medically necessary for treating your condition because none of the drugs we cover would be as effective as the requested drug or would have adverse effects for you. If the exception involves a prior authorization, quantity limit, or other limit we have placed on that drug, the doctor's statement must indicate that the prior authorization, or limit, would not be appropriate given your condition or would have adverse effects for you.

Once the physician's statement is submitted, we must notify you of our decision no later than 24 hours, if the request has been expedited, or no later than 72 hours, if the request is a standard request. Your request will be expedited if we determine, or your doctor informs us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

What if my request is denied?

If your request is denied, you have the right to appeal by asking for a review of the prior decision. You must request this appeal within 60 calendar days from the date of our first decision. <You must file a standard request in writing/we accept standard requests by telephone and in writing. We accept expedited requests by telephone and in writing. Provide the necessary address, fax number, and phone number>.

If you need assistance in requesting an exception or for more information about our transition policy, please call <Customer/Member> Service at <phone number>. TTY users should call <TTY number>. We are available from <hours of operations>.

Sincerely,

<Plan Representative>

<Material ID>

[<CMS Approval Date >]

Last Updated <Date>