DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Revisions to the Medicare Part D Medication Therapy Management Program Standardized Format

On July 3, 2014, in accordance with the Paperwork Reduction Act, the Office of Management and Budget (OMB) approved without change the final revisions that CMS proposed for the Medicare Part D Medication Therapy Management Standardized Format, Form CMS-10396, OMB Control Number 0938-1154, through July 31, 2017. A description of the revisions appears below, followed by the revised Standardized Format. The individualized, written summaries of comprehensive medication reviews provided to beneficiaries must comply with the revised Standardized Format, Form CMS-10396 (07/14), no later than January 1, 2015.

A. All Documents

A.1. The inclusion of a logo in the header on the first page of the Cover Letter, Medication Action Plan, or Personal Medication list is optional. At the discretion of the Part D plan sponsor, the logo space may be blank on any or all of these three forms, or the sponsor may choose which logo to include, such as the logo of the parent organization, Part D plan, or MTM provider. In addition, the plan sponsor has the option of which side of the header to place the MTM provider information and the sponsor logo. One can be on the left side and one can be on the right side.

A.2. Technological marks (e.g., barcodes) that do not interfere with the required content of the Standardized Format may be included in the margins of the Cover Letter, Medication Action Plan, or Personal Medication List to facilitate the fulfillment process.

A.3. Change the footers as follows:

From: “Form CMS-10396 (01/12)”

To: “Form CMS-10396 (07/14)”

B. Cover Letter

B.1. In the Cover Letter, change the second sentence in the first paragraph:

From: “Medicare’s MTM (Medication Therapy Management) program helps you to make sure that your medications are working.”

To: “Medicare’s MTM (Medication Therapy Management) program helps you understand your medications and use them safely.”

B.2. In the Cover Letter, change the first sentence of the second paragraph:

From: "Along with this letter are an action plan (Medication Action Plan) and a medication list (Personal Medication List)."

To: "This letter includes an action plan (Medication Action Plan) and medication list (Personal Medication List)."

B.3. In the Cover Letter, change the first bullet below the second paragraph to make reference to a care team, such as in a long term care (LTC) facility:

From: "Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other health care providers."

To: "Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team."

B.4. In the Cover Letter, change the second bullet below the second paragraph as follows:

From: "Ask your doctors, pharmacists, and other healthcare providers to update them at every visit."

To: "Ask your doctors, pharmacists, and other healthcare providers to update the action plan and medication list at every visit."

B.5. In the Cover Letter, change the last sentence in the last paragraph:

From: "*< I/We >* look forward to working with you and your doctors to help you stay healthy through the *< insert name of Part D Plan >* MTM program."

To: "*< I/We >* look forward to working with you, your doctors, and other healthcare providers to help you stay healthy through the *< insert name of Part D Plan >* MTM program."

C. Medication Action Plan

C.1. In the Medication Action Plan, change the first sentence in the paragraph below the instruction bullets to make reference to a care team, such as in a LTC facility:

From: "Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers."

To: "Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team."

D. Personal Medication List

D.1. In the Personal Medication List, change the third bullet of the instructions as follows:

From: “Ask your doctors, pharmacists, and other healthcare providers to update this list at every visit.”

To: “Ask your doctors, pharmacists, and other healthcare providers in your care team to update this list at every visit.”

D.2. In the Paperwork Reduction Act statement at the end of the Personal Medication List, change the average minutes per response as follows:

From: “average 37.76 minutes per response”

To: “average 40 minutes per response”

Medicare Part D
Medication Therapy Management Program
Standardized Format – English
July 2014
(Effective no later than January 1, 2015)

< MTM PROVIDER HEADER or OPTIONAL LOGO >

< MTM PROVIDER HEADER or OPTIONAL LOGO >

< Insert date >

< Insert inside address >

< Additional space for optional plan/provider use, such as barcodes, document reference numbers, beneficiary identifiers, case numbers or title of document >

< Insert salutation >:

Thank you for talking with me on *< insert date of service >* about your health and medications. Medicare's MTM (Medication Therapy Management) program helps you understand your medications and use them safely.

This letter includes an action plan (Medication Action Plan) and medication list (Personal Medication List). **The action plan has steps you should take to help you get the best results from your medications. The medication list will help you keep track of your medications and how to use them the right way.**

- Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team.
- Ask your doctors, pharmacists, and other healthcare providers to update the action plan and medication list at every visit.
- Take your medication list with you if you go to the hospital or emergency room.
- Give a copy of the action plan and medication list to your family or caregivers.

If you want to talk about this letter or any of the papers with it, please call *<insert contact information for MTM provider, phone number, days/times, TTY, etc. >*. *< I/We >* look forward to working with you, your doctors, and other healthcare providers to help you stay healthy through the *< insert name of Part D Plan >* MTM program.

< Insert closing, MTM provider signature, name, title, enclosure notations, etc. >

< MTM PROVIDER HEADER or OPTIONAL LOGO >

MEDICATION ACTION PLAN FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* >

This action plan will help you get the best results from your medications if you:

1. Read "What we talked about."
2. Take the steps listed in the "What I need to do" boxes.
3. Fill in "What I did and when I did it."
4. Fill in "My follow-up plan" and "Questions I want to ask."

Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team. Share this with your family or caregivers too.

DATE PREPARED: < *INSERT DATE* >

What we talked about: *< Insert description of topic >*	
What I need to do: *< Insert recommendations for beneficiary activities >*	**What I did and when I did it:** *< Leave blank for beneficiary's notes >*

What we talked about:	
What I need to do:	**What I did and when I did it:**

What we talked about:	
What I need to do:	**What I did and when I did it:**

What we talked about:	
What I need to do:	**What I did and when I did it:**

What we talked about:	
What I need to do:	**What I did and when I did it:**

My follow-up plan (add notes about next steps)**:**
< Leave blank for beneficiary's notes >

Questions I want to ask (include topics about medications or therapy)**:**
< Leave blank for beneficiary's notes >

If you have any questions about your action plan, call *< insert MTM provider contact information, phone number, days/times, etc. >*.

< MTM PROVIDER HEADER or OPTIONAL LOGO >

PERSONAL MEDICATION LIST FOR < *Insert Member's name,* DOB: *mm/dd/yyyy* >

This medication list was made for you after we talked. We also used information from < *insert sources of information* >.

- Use blank rows to add new medications. Then fill in the dates you started using them.
- Cross out medications when you no longer use them. Then write the date and why you stopped using them.
- Ask your doctors, pharmacists, and other healthcare providers in your care team to update this list at every visit.

Keep this list up-to-date with:

- ☐ prescription medications
- ☐ over the counter drugs
- ☐ herbals
- ☐ vitamins
- ☐ minerals

If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

DATE PREPARED: < *INSERT DATE* >

Allergies or side effects: *< Insert beneficiary's allergies and adverse drug reactions including the medications and their effects >*

Medication: *< Insert generic name and brand name, strength, and dosage form for current/active medications. >*	
How I use it: *< Insert regimen, including strength, dose and frequency (e.g., 1 tablet (20 mg) by mouth daily), use of related devices and supplemental instructions as appropriate >*	
Why I use it: *< Insert indication or intended medical use >*	**Prescriber:** *< Insert prescriber's name >*
***< Insert other title(s) or delete this field >*:** *< Use for optional product-related information, such as additional instructions, product image/identifiers, goals of therapy, pharmacy, etc., and change field title accordingly. This field may be expanded or divided. Delete this field if not used. >*	
Date I started using it: *< May be estimated by Plan or entered based upon beneficiary-reported data, or leave blank for beneficiary to enter start date >*	**Date I stopped using it:** *< Leave blank for beneficiary to enter stop date >*
Why I stopped using it: *< Leave blank for beneficiary's notes >*	

PERSONAL MEDICATION LIST FOR < *Insert Member's name,* DOB: *mm/dd/yyyy* >

(Continued)

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

PERSONAL MEDICATION LIST FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* > (Continued)

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Other Information:

If you have any questions about your medication list, call < *insert MTM provider contact information, phone numbers, days/times, etc.* >.