# **2026 Part D Model Formulary (Abridged and Comprehensive)**

[Note*: Instructions for sponsors appear below in italicized text. Text in square brackets must be included if the text accurately describes the plan’s benefit structure. Carets are placeholders for variable fields that must be filled in accurately.*

*Below is a template that may be used for an abridged or comprehensive formulary except when noted as applicable to one form or the other. When indicated as “mandatory,” sponsors must provide the name by which their plan is known (HPMS Plan Name). In all other instances, sponsors may replace <plan name> as appropriate with “plan” or “our plan” and may use those terms interchangeably. Sponsors may also use the terms “we,” “us”, or “our,” to refer to themselves. Sponsors may also change references to Member Services and Pharmacy Directory with the appropriate name your plan uses.*

*This form may also be used for defined standard plans, whose marketing materials are required to reflect a single tier regardless of whether the formulary submitted to CMS is also associated with a multi-tier formulary.*

*Plans should also consult the most recent applicable chapters of the Prescription Drug Benefit Manual (PDBM) for more information on benefits and beneficiary protections, beneficiary communications, and formularies (these would include PDBM chapters 5 and 6), and 42 CFR Part 423 Subparts C (Benefits and Beneficiary Protections) and V (Part D Communication Requirements).*]

[*The following items must appear on the cover page:*]

## [ *insert mandatory* <Plan/Sponsor Name>]

## <Year> [<Abridged>] Formulary

## ([<Partial>] List of Covered Drugs or “Drug List”)

## PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION

## ABOUT [*insert the following when applicable*: <SOME OF>] THE DRUGS WE COVER IN THIS PLAN

[*Insert* <HPMS Approved Formulary File Submission ID>]

[*In the document footer, plans should provide the date the formulary was updated and available to enrollees. Dates used in the front and back of the formulary covers should be the same as the date of the last update in the footer.*]

[*The following information must appear on both the front and back covers of abridged formularies:* [*Insert one* <This abridged formulary was updated on <MM/DD/YYYY>.> *<*We have made no changes to this abridged formulary since MM/DD/YYYY.>] This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact [*Optional insert <*us*>,*] [*Insert mandatory* <plan /sponsor name>] [*Insert* <Customer/Member> Service at <phone number> (TTY users should call <TTY number>), <days/hours of operation>, or visit <web address>.]

[*The following information must appear on both the front and back covers of comprehensive formularies*. *Insert one* <This formulary was updated on <MM/DD/YYYY>.> *<*We have made no changes to this formulary since MM/DD/YYYY.>] [*Insert <*This formulary was updated on <MM/DD/YYYY>. For more recent information or other questions, please contact [*Optional insert <*us*>,*] [*Insert mandatory* <plan /sponsor name>] [*Insert* <Customer/Member> Service at <phone number> (TTY users should call <TTY number>), <days/hours of operation>, or visit <web address>.]]

[*The rest of the language need not appear on the cover page.*]

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this Drug List (formulary) refers to “we,” “us”, or “our,” it means [*Insert* <plan/sponsor name>]. When it refers to “plan” or “our plan,” it means [*Insert* <Plan Name>.]

This document includes [*For abridged formularies insert* <a partial>] Drug List (formulary) for our plan which is current as of [*Insert* <formulary revision date>.] [*For abridged formularies insert* <a complete,>] [*For comprehensive formularies insert* <an>] updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, [*Insert* <benefit year>], and from time to time during the year.

## What is the [*Insert mandatory* < plan/sponsor name>] [*Insert when applicable* <Abridged>] formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by [*Insert* <plan/sponsor name>] in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. [*Insert* <plan/sponsor>] will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a [*Insert* <plan/sponsor name>] network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

[*Insert for abridged formularies* <This document is a partial formulary and includes only some of the drugs covered by [*Insert* <plan/sponsor name>]. For a complete listing of all prescription drugs covered by [*Insert* <plan/sponsor name>], please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

## Can the formulary change?

Most changes in drug coverage happen on January 1, but [*Insert one* <we> <plan/sponsor name>] may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: [*Plan sponsors should insert URL showing website address with most recent version of the formulary.*].

Changes that can affect you this year***:*** In the below cases, you will be affected by coverage changes during the year: [*Plan sponsors that otherwise meet all requirements and want the option to make immediate substitutions (for instance, immediately replace brand name drugs with their new generic equivalents or immediately replace reference products with interchangeable biological products) must include advance general notice of changes in the bullet entitled “Immediate substitutions of certain new versions of brand name drugs and original biological products” below.*]

* + **Immediate substitutions of certain new versions of brand name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions [*plans that do not use tiers may omit* “on the same or lower cost-sharing tier and”]. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions [*plans that do not use tiers may omit* “different cost-sharing tier or”].

We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the [*Insert mandatory* < plan/sponsor name>]’s formulary?”]

Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”

* + **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.
  + **Other changes.** We may make other changes that affect members currently taking a drug. For instance, [Plan sponsors that are not choosing to make any immediate substitutions insert <we may add a new generic drug to replace a brand-name drug currently on the formulary, or add a new biosimilar to replace an original biological product currently on the formulary, or add new restrictions or move a drug we are keeping on the formulary to a higher cost-sharing tier or both after we add a corresponding drug.>] [Plan sponsors that otherwise meet requirements to make immediate substitutions insert <we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both.>] [*All plan sponsors insert* <We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier [Plan sponsors with one tier may remove “or move a drug to a higher cost-sharing tier” and insert an “formulary or” in place of “formulary,”], we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a [*Insert supply limit* (must be at least the number of days in the plan’s one month supply)]-day supply of the drug and notice of the change.>

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the [*Insert mandatory* <plan/sponsor name>]’s formulary?”

Changes that will not affect you if you are currently taking the drug**.** Generally, if you are taking a drug on our [*Insert* <contract year>] formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the [*Insert* < contract year>] coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of [*Insert* <last formulary update>. *Date should match the date used in the footer.*] To get updated information about the drugs covered by [*Insert* <plan/sponsor name>] please contact us. Our contact information appears on the front and back cover pages. [*Insert information about plan’s process for updating print formularies (e.g. via formulary errata sheets) in the event of mid-year non-maintenance formulary changes.*]

## How do I use the formulary?

There are two ways to find your drug within the formulary:

### Medical Condition

The formulary begins on page [*Insert* <table page number>]. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, [*Insert* <category name example>]. If you know what your drug is used for, look for the category name in the list that begins on [*Insert* < page number >]. Then look under the category name for your drug.

### Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page [*Insert* <index page number>]. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## What are generic drugs?

[*Insert* <plan/sponsor name>] covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug.  Generally, generic drugs work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

## What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

For discussion of drug types, please see the Evidence of Coverage, Chapter *[MA-PD insert <*5*>] [PDP insert <*3*>],* Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered.”*]*

## Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include: [*Plans may omit bullets as needed in order to reflect actual utilization management procedures used by the plan.*]

* Prior Authorization**:** [*Insert* <plan/sponsor name>] requires you [or your prescriber] to get prior authorization for certain drugs. This means that you will need to get approval from [*Insert* <plan/sponsor name>] before you fill your prescriptions. If you don’t get approval, [*Insert* <plan/sponsor name>] may not cover the drug.
* Quantity Limits**:** For certain drugs, [*Insert* <plan/sponsor name>] limits the amount of the drug that [*Insert* <plan/sponsor name>] will cover. For example, [*Insert* <plan/sponsor name>] provides <number of units> per prescription for <drug name>. This may be in addition to a standard one-month or three-month supply.
* Step Therapy**:** In some cases, [*Insert* <plan/sponsor name>] requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, [*Insert* <plan/sponsor name>] may not cover Drug B unless you try Drug A first. If Drug A does not work for you, [*Insert* <plan/sponsor name>] will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page [*Insert* <table page number>]. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. [*Plans/sponsors that apply prior authorization and/or step therapy insert the following with applicable information* <We have posted online [*Insert one* <a document><documents>] that explain our [*Insert when applicable <*prior authorization restriction> <step therapy restriction> <prior authorization and step therapy restrictions.>] You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask [*Insert* <plan/sponsor name>] to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the [*Insert* <plan/sponsor name>]’s formulary?” on page [*Insert* <exception page number>] for information about how to request an exception.

## What are over-the-counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. [*Insert* <plan/sponsor name>] pays for certain OTC drugs. *[Note: Include a list of OTC drugs the plan pays for with administrative funds.*] [*Insert* <plan/sponsor name>] will provide these OTC drugs at no cost to you. The cost to [*Insert* <plan/sponsor name>] of these OTC drugs will not count toward your total Part D drug costs.]

## What if my drug is not on the formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered. [*Insert for abridged formularies* <This document includes only a partial list of covered drugs, so [*Insert* <plan/sponsor name>] may cover your drug. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.>]

If you learn that [*Insert* <plan/sponsor name>] does not cover your drug, you have two options:

* You can ask Member Services for a list of similar drugs that are covered by [*Insert* <plan/sponsor name>.] When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by [*Insert* <plan/sponsor name>].
* You can ask [*Insert* <plan/sponsor name>] to make an exception and cover your drug. See below for information about how to request an exception.

## How do I request an exception to the [*Insert mandatory* <plan/sponsor name>]’s formulary?

You can ask [*Insert* <plan/sponsor name>] to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

* [You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.]
* You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, [*Insert* <plan/sponsor name>] limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.
* [*Insert if plan has multiple tiers with no specialty tier or has a specialty tier but does not exclude it from the exceptions process:* You can ask us to cover a formulary drug at a lower cost-sharing level.] [*Insert if plan has only one specialty tier and chooses to exclude this tier from the tier exceptions process:* You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier]. [*Insert if plan has two specialty tiers*: You can ask us to cover a formulary drug at a lower cost-sharing level unless the drug is on our lower cost sharing specialty tier. For formulary drugs that are on the higher cost sharing specialty tier, you can ask for coverage at the lower cost sharing specialty tier level.] If approved, this would lower the amount you must pay for your drug.]

Generally, [*Insert* <plan/sponsor name>] will only approve your request for an exception if the alternative drugs included on the plan’s formulary, [the lower cost-sharing drug,] or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a [*insert if plan has multiple tiers:* <tiering or,>] formulary exception, including an exception to a coverage restriction. When you request an exception, your prescriber will need to explain the medical reasons why you need the exception**.** Generally, we must make our decision within 72 hours of getting your prescriber’s supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber’s supporting statement.

## What can I do if my drug is not on the formulary or has a restriction?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first <*must be at least 90*> days you are a member of our plan.

For each of your drugs that is not on our formulary or has a coverage restriction, we will cover a temporary [*insert number of days that corresponds to the number of days designated as a month’s supply in the approved plan benefit package*]-day supply. If your prescription is written for fewer days, we’ll allow refills to provide up to a maximum [*insert supply limit - must be at least a one month supply based on approved plan benefit package*] day supply of medication. If coverage is not approved, after your first [*insert number of days that corresponds to the number of days designated as a month’s supply in the approved plan benefit package*]-day supply, we will not pay for these drugs, even if you have been a member of the plan less than <*must be at least 90*> days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first <*must be at least 90*> days of membership in our plan, we will cover a <*must be at least 31*>-day emergency supply of that drug while you pursue a formulary exception.

[Note***:*** *Plans must insert their transition policy for current enrollees with level of care changes, if applicable.*]

## For more information

For more detailed information about your [*Insert* <plan/sponsor name>] prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about [*Insert* <plan/sponsor name>], please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or visit http://www.medicare.gov.

## [*Insert* <plan/sponsor name>] formulary

The [*Insert for abridged formularies* <abridged>] formulary [*Insert as applicable* <below> <that begins on the next page>] provides coverage information about [*Insert for abridged formularies* <some of>] the drugs covered by [*Insert* <plan/sponsor name>]. If you have trouble finding your drug in the list, turn to the Index that begins on page [*Insert* <index page number>].

[*Insert the following paragraph for abridged formularies only <*Remember: This is only a partial list of drugs covered by [*Insert* <plan/sponsor name>]. If your prescription is not in this partial formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.>]

The first column of the chart lists the drug name. 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 Requirements/Limits column tells you if [*Insert* <plan/sponsor name>] has any special requirements for coverage of your drug.

[Note***:*** *Sponsors must provide information on the following items when applicable to specific drugs and define any symbols or abbreviations used to indicate their application: utilization management restrictions; drugs that are available via mail-order, drugs that are limited to a one month supply even when the drug is on a tier that otherwise allows for an extended day supply, excluded drugs that are covered by the plan; free first fill drugs; limited access drugs; and drugs covered under the medical benefit (for home infusion drugs only). While these symbols and abbreviations must appear whenever applicable, sponsors 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 where information is available, such as* page number *or* end [*or*] beginning of this table*.*]*”*

* *Plans that cover excluded drugs must use this column to indicate that certain drugs are available only through their benefit. Plans may indicate this with an asterisk/other symbol and a footnote that states:* “This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.” [Note*: Plans must insert any additional restrictions on this coverage, including any capped benefit limit.*]
* *Plans that offer generic-use incentive programs permitting zero (or reduced) cost sharing on first generic fills when a member agrees to use the generic rather than the brand name version of a medication must indicate the drugs to which this program applies. Plans may indicate this with an asterisk/other symbol and a footnote that states:* “This prescription drug will be provided at <zero>/<reduced> cost sharing the first time you fill it.”
* *Plans that restrict access to any drugs by limiting distribution to a subset of network pharmacies must indicate these drugs. Plans may indicate this with an asterisk/other symbol or footnote states:* “This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call [*Insert* <Customer/Member> Service at <phone number> (TTY users should call <TTY number>), <days/hours of operation>, or visit <web address>.].”
* *Plans that provide quantity limits for certain drugs must indicate the amount (days’ supply or amount dispensed).*
* *MA-PD or cost plans choosing to provide coverage for any Part D home infusion drugs as part of a bundled payment under a Part C supplemental benefit should indicate this with an asterisk/other symbol and a footnote that states,* “This prescription drug <is>/<may be> covered under our medical benefit. For more information, call [*Insert* <Customer/Member> Service at <phone number> (TTY users should call <TTY number>), <days/hours of operation>, or visit <web address>.]

Drug Table - Option 1

|  |  |  |
| --- | --- | --- |
| Drug Name | Drug Tier *[Column is optional for single tier formularies.]* | Requirements/Limits |
| **<Therapeutic Category Name 1> - [Optional: <Plain Language Description>]** | | |
| <Drug Name 1, Dosage Form A, Strength A> | <Tier 1> | <Util. Mgmt.> |
| <Drug Name 2, Dosage Form A, Strength A > | <Tier 1> | <Util. Mgmt.> |
| <Drug Name 2, Dosage Form B, Strength A > | <Tier 2> | <Util. Mgmt.> |
| <Drug Name 2, Dosage Form B, Strength B > | <Tier 3> | <Util. Mgmt.> |
| <Drug Name 3, Strength A> | <Tier 4> | <Util. Mgmt.> |
| **<Therapeutic Category Name 2> - [Optional: <Plain Language Description>]** | | |
| <Drug Name 3, Dosage Form A, Strength A > | <Tier> | <Util. Mgmt.> |
| <Drug Name 4> | <Tier> | <Util. Mgmt.> |

## Drug Table - Option 2

|  |  |  |
| --- | --- | --- |
| Drug Name | Drug Tier *[Column is optional for single tier formularies.]* | Requirements/Limits |
| **<Therapeutic Category Name 1> - [Optional: <Plain Language Description>]** | | |
| *<Therapeutic Class Name 1> - [Optional: <Plain Language Description>]* | | |
| <Drug Name 1> | <Tier 1> | <Util. Mgmt.> |
| <Drug Name 2, Dosage Form A, Strength A > | <Tier 1> | <Util. Mgmt.> |
| <Drug Name 2, Dosage Form B, Strength A > | <Tier 2> | <Util. Mgmt.> |
| <Drug Name 2, Dosage Form B, Strength B > | <Tier 3> | <Util. Mgmt.> |
| *<Therapeutic Class Name 2> - [Optional: <Plain Language Description>]* | | |
| <Drug Name 3> | <Tier 2> | <Util. Mgmt.> |
| <Drug Name 4 Dosage Form A, Strength B> | <Tier 1> | <Util. Mgmt.> |
| <Drug Name 4, Dosage Form A, Strength B > | <Tier 1> | <Util. Mgmt.> |
| <Drug Name 2, Dosage Form A, Strength C > | <Tier 2> | <Util. Mgmt.> |
| **<Therapeutic Category Name 2> - [Optional: <Plain Language Description>]** | | |
| *<Therapeutic Class Name 1> - [Optional: <Plain Language Description>]* | | |
| <Drug Name 5> | <Tier> | <Util. Mgmt.> |
| <Drug Name 6> | <Tier> | <Util. Mgmt.> |

## *General Drug Table instructions:*

*OTC drugs may not be included in the formulary table that lists drugs adjudicated at sale but must appear in a separate list or table.*

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

*For table sub-headings, plans have the option to use either the therapeutic category only (Table Option 1) or both the therapeutic category and therapeutic class (Table Option 2). The category or class names must be the same as those found on the CMS-approved formulary.*

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

*For Table Option 1, the therapeutic categories should be listed alphabetically within the table. The drugs should then be listed alphabetically under the appropriate therapeutic category; they should not be sorted by therapeutic class. For Table Option 2, 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.*

*For an abridged formulary, 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.*

## *Drug Name column instructions:*

*Brand name drugs should be capitalized, e.g., DRUG A. Generic drugs should be lower-case 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). Differences in dosage forms should be simplified, and abbreviations/acronyms defined for beneficiary understanding. The drug will be counted as a single drug when determining whether the plan has included two drugs within each therapeutic category/class.*

## *Drug Tier column instructions:*

*For plans that provide different levels of cost sharing for drugs depending on their tier, sponsors must include a column indicating the drug’s tier placement. For single tier plans (for instance, all defined standard plans), sponsors have the option to delete the column. Plans may choose from several methods to indicate the tier placement including tier numbers from your plan benefit package (e.g., 1/ 2/ 3), standard tier names from your plan benefit package (e.g., generic/ preferred brand/ other brand), copayment amounts (e.g., $10/$20/$35), or coinsurance percentages (e.g., 10%/25%). The latter two methods are preferred since they are generally easier for members to understand. If one of the two former methods are used, plans must provide an explanation before the table explaining the copayment amount or coinsurance percentage associated with each tier number or tier name. The above choices are also available to sponsors with single tier plans, in that plans would be expected to enter the same information in the column beside every drug listed (for instance, identifying all drugs as Tier 1 or subject to a 25% coinsurance).*

*Plans that have different copayment amounts or coinsurance percentages for retail and mail-order prescriptions may include both retail and mail order amounts within the same column or include separate columns for retail and mail order prescriptions.*

## *Requirements/Limits column instructions:*

*Part D Plans must indicate any applicable utilization management procedures (e.g., prior authorization, step therapy, quantity limits, etc.), special coverage rules, and/or mail-order procedures for each drug within the Requirement/Limits column.*

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

## Index of Drugs

[*Pursuant to 42 CFR §423.2267, applicable disclaimers must be included in this document.*]

*[BACK COVER]*

*[Please see the front cover for information that must also appear on the back cover.]*