[*Instructions: The FIDA-IDD Plan that seeks a prescription transfer must use this model notice to ask for permission from a Participant to fill their prescription(s) at a different network pharmacy than the one the Participant is currently using. The FIDA-IDD Plan may attach a written permission form to this letter for the Participant to fill out. The Participant may provide permission by either calling the plan or pharmacy or mailing/faxing the permission form. The FIDA-IDD Plan should only use this model notice when the transfer of the prescription is not initiated by the Participant (or someone on their behalf). Unsolicited phone calls made by the pharmacy or FIDA-IDD Plan seeking permission from Participants to transfer prescriptions are not permitted.*]

<DATE>

<PARTICIPANT NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <PARTICIPANT NAME>:

<Plan name> Participants generally must use network pharmacies to access their prescription drug benefit. <Plan name> has determined that the following medication(s) you are currently taking could be purchased through another [*insert one:* specialty, retail, *or* mail-order pharmacy].

<medication1><dosage>

<medication2><dosage>

<medication3><dosage>

[*Provide an explanation of the benefits realized by the Participant if they decide to transfer their prescription(s) to the different pharmacy.*]

If you want to continue to purchase your medications from your current pharmacy, you do not need to respond to this letter. Purchasing your medication from your current pharmacy will not affect your current coverage.

With your permission, we are able to fill your prescription(s) at [*insert name of pharmacy*]. We cannot fill your prescription(s) at this pharmacy until we have gotten permission from you. You may call your Care Manager to start the process of making this change.

If you want more information about how to transfer prescriptions, please call your Care Manager. You can also call Participant Services at <toll-free phone number>. TTY users should call <toll-free TTY number>. We are available from <days and hours of operations>.

Sincerely,

<Plan Representative>

[*The plan must insert a reference to the attachment here if using a written permission form as mentioned in plan instructions at the beginning of the letter.*]

[*The plan must include all applicable disclaimers as required in the State-specific Marketing Guidance.*]

[*The plan is subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to* [*www.hhs.gov/civil-rights/for-individuals/section-1557*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)*.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.