Instructions to Health Plans

* [Below is a template which can be used for an abridged or comprehensive formulary except when noted as applicable to one form or the other. When indicated as “mandatory,” provide the name by which the plan is known (HPMS plan name). In all other instances, replace <plan name> as appropriate with “plan” or “our plan” and use those terms interchangeably.]
* [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).]
* [Plans should use the term “care coordinator,” and shouldn’t replace it with similar terms such as “care manager” or others.]
* [Plans should use the term “Member Services,” and shouldn’t replace it with similar terms.]
* [Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]
* [Plans can place a QR code on materials to provide an option for members to go online.]
* [The footer should appear on every other page. Plans have the option of deleting the footer following the introduction (for example, the footer isn’t necessary in the actual list of drugs).]
* [Wherever possible, plans are encouraged to adopt formatting practices that make information easier for English-speaking and non-English-speaking members to read and understand. The following are based on input from beneficiary interviews:
* *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes the Table of Contents or any item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, insert: This section is continued on the next page*).
* *Ensure plan-customized text is in plain language and complies with member reading level requirements.*
* *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable*.
* *Spell out an acronym or abbreviations before its first use in a document or on a page (for example, Long-term Services and Supports (LTSS) or low-income subsidy (LIS)).*
* *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
* *Avoid separating a heading or subheading from the text that follows when paginating the model.*
* *Use universal symbols or commonly understood pictorials.*
* *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
* *Consider using regionally appropriate terms or common dialects in translated models.*
* *Include instructions and navigational aids in translated models in the translated language rather than in English*.]

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

<Plan name, Plan type>

<Year> <Abridged> List of Covered Drugs (*Drug List* or Formulary)

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT** [*insert the following when applicable*: <**SOME OF>**] **THE DRUGS WE COVER IN THIS PLAN**

[*Insert on the front cover the HPMS Approved Formulary File Submission ID, Version Number*.]

[*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>. *Or* We have made no changes to the *Drug List* since <MM/DD/YYYY>. This isn’t a complete list of drugs covered by our plan. For a complete listing of drugs or other questions, contact us at <toll-free phone and TTY numbers>, <days and hours of operation> or visit <URL>.]

[*The following information must appear on both the front and back covers of comprehensive formularies: Insert one* This *Drug List* was updated on <MM/DD/YYYY>. *or* We have made no changes to the *Drug List* since <MM/DD/YYYY>. For more recent information or other questions, contact us at <toll-free phone and TTY numbers>, <days and hours of operation> or visit <URL>.]

[*Dates used in the front and back of the formulary covers should be the same as the footer of the document.*]]

Introduction

This document is called the *List of Covered Drugs* (also known as the *Drug List*).It tells you which drugs [*insert if applicable*: and over-the-counter (OTC) drugs and non-drug products] [*insert if applicable*: and items] are covered by <plan name>. The *Drug List* also tells you if there are any special rules or restrictions on any drugs covered by <plan name>. Key terms and their definitions appear in the last chapter of the *Member Handbook*.

[*For abridged formularies, plans should insert the following:* This document is a partial (or abridged) *Drug List* and includes only some of the drugs covered by <plan name>. For a complete listing of all drugs covered by <plan name>, please visit our website or call us.]

[*Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.*]

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# Disclaimers

This is a list of drugs that members can get in *<*plan name*>*.

[*Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V) and included in any state-specific guidance provided by <Medicaid program name>.*]

[*As required at 42 CFR § 438.10(d)(2), all disclaimers and taglines that explain the availability of alternate formats using auxiliary aids and services or oral interpretation services and the toll-free telephone number of the entity providing choice counseling services as required by § 438.71(a), must be in conspicuously visible font*.]

* You can always check <plan name>’s up-to-date List of Covered Drugs online at <URL> or by calling Member Services [plans insert reference: at <toll-free phone and TTY numbers>, <days and hours of operation>, or at the numbers listed at the bottom of this page or at the numbers in the footer of this document]. This call is free.
* You can get this document for free in other formats, such as large print, braille, or audio. Call Member Services [plans insert reference: at <toll-free phone and TTY numbers>, <days and hours of operation>, or at the numbers listed at the bottom of this page or at the numbers in the footer of this document.]. This call is free. [Plans must meet any state font size requirements.]
* [Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31)(ii) and 423.2267(e)(33)(ii), plans must provide a Notice of Availability of language assistance services and auxiliary aids and services that, at a minimum, states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in South Carolina and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.]
* [Plans that meet the Medicare 5 percent alternative language threshold per 42 CFR §§ 422.2267(a) and 423.2267(a) or Medicaid required language threshold insert: This document is available for free in <languages that meet the threshold requirement.>]
* [Plans also must describe:
* *how they’ll request a member’s preferred language other than English and/or alternate format,*
* *how they’ll keep the member’s information as a standing request for future mailings and communications so the member doesn’t need to make a separate request each time, and*
* *how a member can change a standing request for preferred language and/or format*.]

# Frequently Asked Questions (FAQ)

Find answers here to questions you have about this *List of Covered Drugs* (*Drug List*). You can read all of the FAQ to learn more, or look for a question and answer.

## B1. 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 <abridged> *Drug List* that starts in **Section <section letter>** are the drugs covered by <plan name>. The 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 medically necessary drugs on the *Drug List* if:
* your doctor or other prescriber says you need them to get better or stay healthy,
* <plan name> agrees that the drug is medically necessary for you, **and**
* you fill the prescription at a <plan name> network pharmacy.
* In some cases, you have to do something before you can get a drug. Refer to question B4 for more information.

[*Plans that offer indication-based formulary design must include:* If we cover a drug only for some medical conditions, we clearly identify it on the *Drug List* along with the specific medical conditions that are covered.]

You can also find an up-to-date list of drugs that we cover on our website at <URL> or call Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers and days/hours of operation> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document].

[*For abridged formularies, plans should insert the following:* This document is a partial *Drug List* and includes only some of the drugs covered by <plan name>. For a complete listing of all drugs covered by <plan name>, please visit our website or call us. Our contact information, along with the date we last updated the *Drug List*, appears on the front and back cover pages.]

## B2. Does the *Drug List* ever change?

Yes, and <plan name> must follow Medicare and South Carolina Healthy Connections Medicaid rules when making changes. We may add or remove drugs on the *Drug List* during the year.

We may also change our rules about drugs. For example, we could:

* Decide to require or not require prior authorization for a drug. (Prior authorization is permission from <plan name> 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’ll cover another drug.)

For more information on these drug rules, refer to question B4.

If you’re taking a drug that was covered at the **beginning** of the year, we’ll generally not remove or change coverage of that drug **during the rest of the year** unless:

* a new, cheaper drug comes on the market that works as well as a drug on the *Drug List* now, **or**
* we learn that a drug isn’t safe, **or**
* a drug is removed from the market.

Questions B3 and B6 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 <URL>. Updates to the *Drug List* are posted on the website monthly.
* You can also call Member Services [*plans can insert reference, for example:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] to check the current *Drug List*.

## B3. What happens when there’s a change to the *Drug List*?

Some changes to the *Drug List* will happen **immediately**. For example:

* [*Plans that otherwise meet all requirements and want the option to make immediate substitutions of certain new drugs (for instance, immediately replace brand name drugs with their generic equivalents or immediately replace reference products with interchangeable biological products) must provide the following advance general notice of changes*: **Substitutions of certain new versions of drugs.** We may immediately remove the drugs from the *Drug List* if we replace them with certain new versions of that drug, but your cost for the new drug will [*Plans should include an accurate description of the change such as:* remain $0 with the same or fewer restrictions or appear on the same or lower cost-sharing tier with the same or fewer restrictions.] When we add a new version of a drug, we may also decide to keep the brand name drug or original biological product on the list but change its coverage rules or limits.
* We may not tell you before we make this change, but we’ll send you information about the specific change we made once it happens.
* We can make these changes only if the drug we’re adding:
* is a new generic version of a brand name drug, or
* is a certain new biosimilar version of original biological products on the *Drug List* (for example, adding an interchangeable biosimilar that can be substituted for an original biological product without a new prescription).
* Some of these drug types may be new to you. For more information, refer to **Section B14**.
* You or your provider can ask for an exception from these changes. We’ll send you a notice with the steps you can take to ask for an exception. Please refer to questions B10-B12 for more information on exceptions.]
* **Remove unsafe drugs and other drugs that are taken off the market.** Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off the *Drug List*. If you’re taking the drug, we’ll send you a notice after we make the change. [*Plans should include information advising members what to do after they’re notified (for example, contact the prescribing doctor, etc.).*]

**We may make other changes that affect the drugs you take.** We’ll tell you in advance about these other changes to the *Drug List*. These changes might happen if:

* The FDA provides new guidance or there are new clinical guidelines about a drug.
* [*Plans that meet the requirements for the option to immediately substitute a new generic drug, insert:* We remove a brand name drug from the *Drug List* when adding a generic drug that isn’t new to the market, or
* we remove an original biological product when adding a biosimilar, or
* we change the coverage rules or limits for the brand name drug.]
* [*Plans that aren’t making immediate generic substitutions insert:* We add a generic drug and replace a brand name drug currently on the *Drug List*, or
* we add a new biosimilar to replace an original biological product currently on the *Drug List,* or
* we change the coverage rules or limits for the brand name drug.]

When these changes happen, we’ll:

* tell you at least 30 days before we make the change to the *Drug List* **or**
* let you know and give you a <supply limit (must be at least the number of days in the plan’s one-month supply)>-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

* if there’s a similar drug on the *Drug List* you can take instead **or**
* whether to ask for an exception from these changes. To learn more about exceptions, refer to questions B10-B12.

## B4. Are there any restrictions or limits on drug coverage or any required actions to take 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 authorization:** For some drugs, you or your doctor or other prescriber must get authorization from <plan name> before you fill your prescription. Prior authorization is different from a referral. <Plan name> may not cover the drug if you don’t get prior authorization.
* **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’ll have to try drugs in a certain order for your medical condition. You might have to try one drug before we’ll cover another drug. If your prescriber thinks the first drug doesn’t work for you, then we’ll cover the second.
* **Indication-based coverage:** If <plan name> covers a drug only for some medical conditions, we clearly identify it on the *Drug List* along with the specific medical conditions that are covered.

You can find out if your drug has any additional requirements or limits by looking in the tables in **Section <section letter/number>**. You can also get more information by visiting our website at <URL>. [*Plans that apply prior authorization and/or step therapy insert the following with applicable information:* We have posted online [a document *or* documents]that [explains *or* 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.** This will give you time to talk to your doctor or other prescriber. They can help you decide if there’s a similar drug on the *Drug List* you can take instead or whether to ask for an exception. Refer to questions B10-B12 for more information about exceptions.

## B5. How will I know if the drug I want has limits or if there are required actions to take to get the drug?

The table in the section titled “<Abridged> List of Drugs by <Medical Condition/Drug Type>” has a column labeled “Necessary actions, restrictions, or limits on use.”

## B6. What happens if <plan name> changes their rules about how they cover some drugs (for example, prior authorization, quantity limits, and/or step therapy restrictions)?

[*Plans should omit information as needed and reflect only those utilization management procedures actually used by the plan.*] In some cases, we’ll tell you in advance if we add or change prior authorization, quantity limits, and/or step therapy restrictions on a drug. Refer to question B3 for more information about this advance notice and situations where we may not be able to tell you in advance when our rules about drugs on the *Drug List* change.

## B7. How can I find a drug on the *Drug List*?

There are two ways to find a drug:

* you can search alphabetically, **or**
* you can search by <medical condition *or* drug type>.

To search **alphabetically**, look for your drug in the Index of Covered Drugs section. You can find it [*plans should provide instructions*]. The Index of Covered Drugs is an alphabetical list of all of the drugs included in the *Drug List*. Brand name drugs and generic drugs [*insert if applicable*: as well as over-the-counter (OTC) drugs] are listed in the index.

[*Plans insert one of the following paragraphs depending on whether drugs are organized by medical condition or drug type in the drug listings*:

To search by medical condition, find **Section <letter/number>** labeled “List of Drugs by <Medical Condition>.” The drugs in this section are grouped into categories depending on the type of medical conditions they’re used to treat. For example, if you have a heart condition, you should look in <category description> category. That’s where you’ll find drugs that treat heart conditions.

*or*

To search by drug type, find the **Section <letter/number>** labeled “List of Drugs by <Drug Type>.” The drugs in this section are grouped into categories by type. For example, if you’re taking a medicine for migraines, you should look in the <category description> category. That’s where you’ll find drugs that treat migraines.]

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

## B8. What if the drug I want to take isn’t on the *Drug List*?

If you don’t find your drug on the *Drug List*, call Member Services [*plans insert reference:* at <toll-free phone and TTY numbers and days/hours of operation> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] and ask about it. If you learn that <plan name> won’t cover the drug, you can do one of these things:

* Ask [*plans should insert either* Member Services *or* your Care Coordinator as appropriate] for a list of drugs like the one you want to take. Then show the list to your doctor or other prescriber. They can prescribe a drug on the *Drug List* that’s like the one you want to take. **Or**
* Ask <plan name> to make an exception to cover your drug. Refer to questions B10-B12 for more information about exceptions.

## B9. What if I’m a new <plan name> member and can’t find my drug on the *Drug List* or have a problem getting my drug?

We can help. We may cover a temporary <supply limit (must be the number of days in plan’s one-month supply)>-day supplyofyour drug during the first <must be at least 90> days you’re a member of <plan name>. This will give you time to talk to your doctor or other prescriber. They can help you decide if there’s a similar drug on the *Drug List* you can take instead or whether to ask for an exception.

If your prescription is written for fewer days, we’ll allow multiple refills to provide up to a maximum of <supply limit (must be the number of days in plan’s one-month supply)> days of medication.

We’ll cover a <supply limit (must be the number of days in plan’s one-month supply)>-day supplyof your drug if:

* you’re taking a drug that isn’t on our *Drug List*,**or**
* our plan rules don’t let you get the amount ordered by your prescriber, **or**
* the drug requires prior authorization by <plan name>, **or**
* you’re taking a drug that’s part of a step therapy restriction.

If you’re in a nursing home or other long-term care facility and need a drug that isn’t on the *Drug List* or if you can’t easily get the drug you need, we can help. If you’ve been in the plan for more than <time period (must be at least 90 days)> days, live in a long-term care facility, and need a supply right away:

* We’ll cover one <supply limit (must be at least a 31-day supply)>-daysupply of the drug you need (unless you have a prescription for fewer days), whether or not you’re a new <plan name> member.
* This is in addition to the temporary supply during the first <time period (must be at least 90)>days you’re a member of <plan name>.

[***Note****: If applicable, plans must insert a description of their transition policy for current members with changes to their level of care, as specified in Chapter 6 of the Prescription Drug Benefit Manua*l*.*]

## B10. Can I ask for an exception to cover my drug?

Yes. You can ask <plan name> to make an exception to cover a drug that isn’t on the *Drug List*.

You can also ask us to change the rules on your drug.

* For example, <plan name> may limit the amount of a drug we’ll cover. If your drug has a limit, you can ask us to change the limit and cover more.
* Other examples: You can ask us to drop step therapy restrictions or prior authorization requirements.

## B11. How can I ask for an exception?

To ask for an exception, call [*plans should include information on the best person to call – for example, your care coordinator or Member Services*]. [*Insert*: Your care coordinator *or* A member services representative] will work with you and your prescriber to help you ask for an exception. You can also read **Chapter 9** **Section <section letter/number>** of the *Member Handbook* to learn more about exceptions.

## B12. How long does it take to get an exception?

After we get a statement from your prescriber supporting your request for an exception, we’ll give you a decision within 72 hours. [*Plans should include concise instructions about how and where plan members or their prescribers must send the statement.*]

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, we’ll give you a decision within 24 hours of getting your prescriber’s supporting statement.

## B13. What are generic drugs?

Generic drugs are made up of the same active ingredients as brand name drugs. They usually cost less than the brand name drug and generally work just as well. They usually don’t have well-known names. Generic drugs are approved by the Food and Drug Administration (FDA). There are generic drugs available for many brand name drugs. Generic drugs usually can be substituted for brand name drugs at the pharmacy without a new prescription—depending on state laws.

<Plan name> covers both brand name drugs and generic drugs.

## B14. What are original biological products and how are they related to biosimilars?

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 forms 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 more information on drug types, refer to **Chapter 5** of the *Member Handbook*.

## B15. What are OTC drugs?

OTC stands for “over-the-counter”. [*Plans insert as applicable:* <Plan name> covers some OTC drugs when they’re written as prescriptions by your provider.

You can read the <plan name> *Drug List* to find out what OTC drugs are covered.]

[*If a plan doesn’t cover OTC drugs they can omit this section and renumber the sections as appropriate. Plans should include OTC drugs they pay for and that were included on the formularies approved by CMS and the state in the Drug List. Plans that offer OTC drugs or products as Part C supplemental benefits should not include those drugs or products in the Drug List but in this section can refer members to the description of these benefits in* ***Chapter 4*** *of the Member Handbook*.]

## B16. Does <plan name> cover non-drug OTC products?

[*Plans should include this section if they cover non-drug OTC products*:<Plan name> covers some non-drug OTC products when they’re written as prescriptions by your provider.

Examples of non-drug OTC products include <examples of plan’s covered non-drug OTC products>. You can read the <plan name> *Drug List* to find out what non-drug OTC products are covered.]

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

## B17. Does <plan name> cover long-term supplies of prescriptions?

[*Plans should include only if they offer extended-day supplies at any pharmacy location. Plans should modify the language below as needed, consistent with their approved extended-day supply benefits*:

* **Mail-Order Programs**. We offer a mail-order program that allows you to get up to a <number>-day supply of your drugs sent directly to your home. A <number>-day supply has the same copay as a one-month supply.
* <number>**-Day Retail Pharmacy Programs**. Some retail pharmacies may also offer up to a <number>-day supply of covered drugs. A <number>-day supply has the same copay as a one-month supply.]

## B18. Can I get prescriptions delivered to my home from my local pharmacy?

[*Plans should include this section only if they contract with pharmacies that offer home delivery*:

Your local pharmacy may be able to deliver your prescription to your home. You can call your pharmacy to find out if they offer home delivery.]

## B19. What’s my copay?

<Plan name> members have [*plans should insert description of any copays, if applicable*] for prescription [*if applicable:* and OTC drugs and non-drug products] as long as the member follows the plan’s rules. Refer to questions B15 and B16 for more information about OTC drugs and non-drug products.

Tiers are groups of drugs on our *Drug List*.

[*Plans should modify the explanation below consistent with their tier model, to include a description of the types of drugs (for example, generic, brand name) on each tier and any copays. Plans must include tier examples such as the following:*

* *Tier 1 Generic drugs have $0 copay.*
* *Tier 1 Brand name drugs have $0 copay*.]

[*Plans must ensure the tier label or description of the types of drugs on each tier is consistent with their approved plan benefit package. Plans must also include a statement that all tiers have no copay, if applicable*.]

[*Plans that have no copay for OTC drugs should insert: OTCs have a $0 copay*.]

If you have questions, call Member Services [*plans insert reference*: at <toll-free phone and TTY numbers and days/hours of operation> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document].

# Overview of the <Abridged> *List of Covered Drugs*

The <Abridged> *List of Covered Drugs* gives you information about the drugs covered by <plan name>. If you have trouble finding your drug in the list, turn to the Index of Covered Drugs that begins in **Section <section letter/number>**. The index alphabetically lists all drugs covered by <plan name>.

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

[*Note: Plans 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, 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 aren’t 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 in this table mean by going to[*insert description of where information is available, such as section*].]

[*Note: For non–Part D drugs or OTC items that are covered by* Healthy Connections Medicaid *, plans should place an asterisk (\*) or another symbol by the drug to indicate that the member may need to follow a different process for appeals and include the following text.*

**Note**: The <symbol used by the plan> next to a drug means the drug isn’t a “Part D drug.” These drugs have different rules for appeals.

* An appeal is a formal way of asking us to review a decision we made about your coverage and to change it if you think we made a mistake.
* For example, we might decide that a drug that you want isn’t covered or is no longer covered by Medicare or Healthy Connections Medicaid. f
* If you or your prescriber disagrees with our decision, you can appeal. If you ever have a question, call Member Services [*plans insert reference*: at <toll-free phone and TTY numbers and days/hours of operation> *or* at the numbers listed at the bottom of this page or at the numbers in the footer of this document].
* You can also read **Chapter 9** of the *Member Handbook* to learn how to appeal a decision.]

## C1. <Abridged> List of Drugs by <*insert term* Medical Condition *or* Drug Type>

[*Plans insert one of the following paragraphs depending on whether drugs are organized by* ***medical condition*** *or* ***drug type*** *in the drug listings*:

The drugs in this section are grouped into categories depending on the type of medical conditions they’re used to treat. For example, if you have a heart condition, you should look in the category, <therapeutic category name>. That’s where you’ll find drugs that treat heart conditions.

*or*

The drugs in this section are grouped into categories by type. For example, if you’re taking a medicine for migraines, you should look in the <category description> category. That’s where you’ll find drugs that treat migraines.]

[*If plans use codes in the “Necessary actions, restrictions, or limits on use” column, they should include a key. Plans aren’t required to include a key on every page, but plans must provide a general footnote, in the same font size plans use in this document, 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]. The key below is only an example; plans don’t 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 isn’t covered.

M = The brand name version of this drug is in Tier 3. The generic version is in Tier 1.

PA = Prior authorization: you must have authorization from the plan before you can get this drug.

ST = Step therapy: you must try another drug before you can get this one.

The first column of the table lists the name of the drug. Generic drugs are listed in lower-case italics (for example, <*generic example*>), brand name drugs are capitalized (for example, <BRAND NAME EXAMPLE>), [*insert if applicable:* and OTC drugs and non-drug products are listed in lower case (for example, <OTC 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.

[*Plans have the option to insert a table to illustrate drugs either by therapeutic category or by therapeutic category further divided into classes. An example of each type of table is presented below.*]

<Therapeutic Category> – [*Plans can add/delete rows as needed but must leave no blank rows after populating table. Optional: Plans can insert a plain language description of the category.*]

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

*or*

<Therapeutic Category> - [*Plans can add/delete rows as needed but must leave no blank rows after populating table. Optional: Plans can insert a plain language description of the category.*]

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

**[*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 Part D formulary approved by CMS or by* Healthy Connections Medicaid *in the Drug List. Plans should provide cost-sharing information, including $0 cost sharing, there as well.*

*Plans should include non-drug OTC products they pay for and that were included on the Part D formulary approved by CMS or by* Healthy Connections Medicaid *in the Drug List. Plans should provide cost-sharing information, including $0 cost sharing, there as well.*

*Plans can 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 of further dividing the categories into classes, the therapeutic classes should be listed alphabetically under the appropriate category. The drugs should then be listed alphabetically under the appropriate therapeutic class.*

*The table 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 (for example, DRUG A). Generic drugs should be lowercase and italicized (for example, penicillin). Plans can include the generic name of a drug next to the brand name. For purposes of this section, OTCs, regardless of brand name or generic, should be listed in lower case. Proper nouns should still have an initial capital.*

*If there are differences in formulary status, tier placement, quantity limit, prior authorization, step therapy, or other restrictions or benefit offerings (for example, 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 (for example, 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 (for example, 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.*]

**[“*What the drug will cost you (tier level)” column instructions*:**

*Plans should put the appropriate tier level in parentheses next to the copay as shown in the example above.*]

**[*Necessary actions, restrictions, or limits on use column instructions***

*Plans can include abbreviations within this column (for example, QL for quantity limits) but must include a key 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* Healthy Connections 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 ask for and are approved in the plan benefit package to bundle home infusion drugs and services under the medical benefit). Plans can also use abbreviations to show drugs that aren’t available via mail-order.*

*Note: Health plans can add this bullet if the plan offers generic use incentive programs permitting zero or reduced cost-sharing on first generic refills:*

* We’ll provide this drug at [*insert as appropriate:* no or a reduced] cost the first time you fill it.]

# Index of Covered Drugs

In this section, you can find a drug by searching for its name alphabetically. This will tell you the page number where you can find additional coverage information for your drug.

[*Plans must include an alphabetical listing of all drugs included in the formulary that indicates the page where members can find coverage information for that drug. Plans can use more than one column for the index listing. The inclusion of this list is required and should start on a separate page.*]