***[Note:*** *Instructions for Plans are provided within 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]*

***[Note:*** *All references to Member Services and Pharmacy Directory can be changed to the appropriate name your plan uses.].*

**<Plan Name>**

### <Year> Formulary

### (List of Covered Drugs)

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN**

**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.

*Insert the following disclaimers:* Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, <XXXX>.

<Applicable Federal contracting disclaimer from Medicare Marketing Guidelines.>

<Phone number for beneficiary to receive material in alternate format or language>

<Material ID Number>

## [<HPMS Approved Formulary File Submission ID, Version Number>] What is the <plan name> Formulary?

A formulary is a list of covered drugs selected by <plan 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. <Plan name> will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a <plan name> network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

## Can the Formulary change?

Generally, if you are taking a drug on our <contract year> formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the <contract year> coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, [or] add prior authorization, quantity limits and/or step therapy restrictions on a drug [or move a drug to a higher cost-sharing tier], we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of <formulary date>. To get updated information about the drugs covered by <plan name>, please visit our Web site at <Web site address> or call Member Services at <toll-free number>, <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. *[Note: Insert information about plan’s process for updating print formularies (e.g., via 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 <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, < “category name example” >. If you know what your drug is used for, look for the category name in the list that begins < on page number / below / on the next page >. 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 <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?

<Plan 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 cost less than brand name drugs.

## 

## Are there any restrictions on my coverage?

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

* **Prior Authorization:** <Plan name> requires you [or your physician] to get prior authorization for certain drugs. This means that you will need to get approval from <plan name> before you fill your prescriptions. If you don’t get approval, <plan name> may not cover the drug.
* **Quantity Limits:** For certain drugs, <plan name> limits the amount of the drug that <plan name> will cover. For example, <plan 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, <plan 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, <plan name> may not cover Drug B unless you try Drug A first. If Drug A does not work for you, <plan 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 <table page number>. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site at <Web site address>.

You can ask <plan name> to make an exception to these restrictions or limits. See the section, “How do I request an exception to the <Plan Name’s> formulary?” on page <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. <Plan name> pays for certain OTC drugs. *[Note: Include a list of OTC drugs the plan pays for with administrative funds.*] <Plan name> will provide these OTC drugs at no cost to you. The cost to <plan name> of these OTC drugs will not count toward your total drug costs.]

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

If your drug is not included in this formulary, you should first contact Member Services and confirm that your drug is not covered. If you learn that <plan 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 <plan name>. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by <plan name>.
* You can ask <plan 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 <Plan Name’s> Formulary?**

You can ask <plan 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 your drug even if it is not on our formulary.
* You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, <plan name> limit 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 more.
* [You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our [non-preferred/highest tier subject to the tiering exceptions process] tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the [preferred/lowest tier subject to the tiering exceptions process] tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. *[****Note:*** *If the plan designated one of its tiers as a "high-cost/unique drug tier" and is exempting that tier from the exceptions process, include the following language*: “Also, you may not ask us to provide a higher level of coverage for drugs that are in the [tier designated as the high-cost/unique drug tier] tier.”]

Generally, <plan name> will only approve your request for an exception if the alternative drugs included on the plan’s formulary, [the lower-tiered drug] or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, [tiering] or utilization restriction exception. **When you are requesting a formulary, [tiering] or utilization restriction exception you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber’s or prescribing physician’s supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescriber’s or prescribing physician’s supporting statement.

**What do I do before I can talk to my doctor about changing my drugs or requesting an exception?**

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 your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to 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 if your ability to get your drugs is limited, we will cover a temporary <*must be at least 30*>-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. <After your first <*must be a least 30*>-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, we will allow you to refill your prescription until we have provided you with a <*must be at least 91 and may be up to 98*>-day transition supply, consistent with the dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first <*must be at least 90*> days you are a member of our plan. If 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 (unless you have a prescription for fewer days) 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 <plan name> prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about <plan name>, please call Member Services at <toll-free number>, <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.) Or visit <Web site address>.

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/TDD users should call 1-877-486-2048. Or, visit www.medicare.gov.

## <Plan Name’s> Formulary

The formulary <below/that begins on the next page> provides coverage information about some of the drugs covered by <plan name>. If you have trouble finding your drug in the list, turn to the Index that begins on page <index page number>.

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 <plan name> has any special requirements for coverage of your drug.

***[Note:*** *Plan must explain any symbols or abbreviations used to indicate utilization management restrictions, drugs that are available via mail-order, excluded drugs, free first fill drugs, limited access drugs, drugs covered in the coverage gap, and drugs covered under the medical benefit (for home infusion drugs only)]*

* *Plans that cover excluded Part D 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 at the bottom of the page 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 at the bottom of the page 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 at the bottom of the page that states:* “This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at <toll-free number>, <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.”
* *Plans that provide additional coverage for certain drugs in the coverage gap must indicate this with an asterisk/other symbol and a footnote at the bottom of the page that states*, “We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.”
* *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 at the bottom of the page that states,* “This prescription drug <is>/<may be> covered under our medical benefit. For more information, call Member Services at <toll-free number>, <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.”

*Drug Table - Option 1*

|  |  |  |
| --- | --- | --- |
| **Drug Name** | **Drug Tier** | **Requirements/Limits** |
| **<Therapeutic Category Name 1> - [Optional: <Plain Language Description>]** | | |
| <Drug Name 1> | <Tier> | <Util. Mgmt.> |
| <Drug Name 2> | <Tier> | <Util. Mgmt.> |
| **<Therapeutic Category Name 2> - [Optional: <Plain Language Description>]** | | |
| <Drug Name 1> | <Tier> | <Util. Mgmt.> |
| <Drug Name 2> | <Tier> | <Util. Mgmt.> |

*Drug Table - Option 2*

|  |  |  |
| --- | --- | --- |
| **Drug Name** | **Drug Tier** | **Requirements/ Limits** |
| **<Therapeutic Category Name 1> - [Optional: <Plain Language Description>]** | | |
| *<Therapeutic Class Name 1> - [Optional: <Plain Language Description>]* | | |
| <Drug Name 1> | <Tier> | <Util. Mgmt.> |
| <Drug Name 2> | <Tier> | <Util. Mgmt.> |
| *<Therapeutic Class Name 2> - [Optional: <Plain Language Description>]* | | |
| <Drug Name 1> | <Tier> | <Util. Mgmt.> |
| <Drug Name 2> | <Tier> | <Util. Mgmt.> |
| **<Therapeutic Category Name 2> - [Optional: <Plain Language Description>]** | | |
| *<Therapeutic Class Name 1> - [Optional: <Plain Language Description>]* | | |
| <Drug Name 1> | <Tier> | <Util. Mgmt.> |
| <Drug Name 2> | <Tier> | <Util. Mgmt.> |

General Drug Table instructions:

*OTC drugs may not be included in the 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).*

*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.*

*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 a drug has a different tier placement depending on the dosage (e.g., 20 mg has a $20 copayment and 40 mg has a $30 copayment), plans may 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*). 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:*

*Part D Plans that provide different levels of cost sharing for drugs depending on their tier must include a column indicating the drug’s tier placement.*

*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 co-insurance 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 is used, plans must provide an explanation before the table explaining the copayment amount or co-insurance percentage associated with each tier number or tier name.*

*Plans that have different copayment amounts or co-insurance 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

*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 may use more than one column for the index listing.*