Information partners can use on:

Drug Coverage under Different Parts of Medicare

This tip sheet provides an overview of drug coverage under Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), Medicare Advantage Plans with prescription drug coverage, and Medicare Prescription Drug Plans.

Which drugs does Part A cover?

People with Medicare may get drugs as part of their inpatient treatment during a covered stay in a hospital or skilled nursing facility (SNF). Generally, Part A payments made to the hospital, SNF, or other inpatient setting cover all drugs provided during a covered stay. If you get hospice care, Part A will cover drugs you get for symptom control or pain relief.

Which drugs does Part B cover?

Generally, Part B covers drugs that usually aren't self-administered. These drugs can be given in a doctor's office as part of their service. In a hospital outpatient department, coverage generally is limited to drugs that are given by infusion or injection. If the injection usually is self-administered or isn't given as part of a doctor's service, Part B generally won't cover it, but a person's Medicare drug plan (Part D) **may** cover these drugs under certain circumstances.

In most cases, the yearly Part B deductible applies to these drugs. This means that people with Medicare may have to pay the Part B deductible amount before Medicare pays its share. You pay 20% of the Medicare-approved amount for covered Part B prescription drugs that you get in a doctor's office or pharmacy. In a hospital outpatient setting, you pay a copayment of 20%. Part B also covers:

- **Certain shots (vaccinations):**
  - **Flu shots:** In general, one flu shot per flu season. Flu shots typically are given before the start of the flu season, in the late summer, fall, or winter, but some people may get the shot in the spring. This means people with Medicare can sometimes get this preventive shot twice in the same calendar year.

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Which drugs does Part B cover? (continued)

- **Certain shots (vaccinations): (continued)**
  - **Pneumococcal shots:** Two shots to help prevent pneumococcal infections (like certain types of pneumonia). The two shots protect against different strains of the bacteria. Part B covers the first shot at any time, and also covers a different second shot if it's given one year (or later) after the first shot. People with Medicare should talk with their doctor or other health care provider to see if they need one or both of the pneumococcal shots.
  - **Hepatitis B shots:** A series of shots covered only for people at high or medium risk for Hepatitis B. A person's risk for Hepatitis B increases if the person has hemophilia, End-Stage Renal Disease (ESRD)—permanent kidney failure requiring dialysis or a kidney transplant—or certain conditions that increase the person's risk for infection. Other factors may also increase a person's risk for Hepatitis B. To determine if they're eligible for coverage, people with Medicare should check with their doctor to see if they're at high or medium risk for Hepatitis B.
  - **Other shots:** Some other vaccines when they're directly related to the treatment of an injury or illness (like a tetanus shot after stepping on a nail).
- **Durable Medical Equipment (DME) supply drugs:** Medicare covers drugs administered through a covered item of DME, like an infusion pump or a nebulizer.
- **Injectable and infused drugs:** Medicare covers most injectable and infused drugs given by a licensed medical provider if the drug is considered reasonable and necessary for treatment and usually isn't self-administered.
- **Injectable osteoporosis drugs:** Medicare covers an injectible drug for women with osteoporosis who meet the coverage criteria for the Medicare home health benefit and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. A doctor must certify that the woman is unable to learn to give herself the drug by injection. The home health nurse or aide won't be covered to provide the injection unless family and/or caregivers are unable or unwilling to give the drug by injection.
- **Some antigens:** Medicare helps pay for antigens if they're prepared by a doctor and given by a properly instructed person (who could be the patient) under appropriate supervision.
- **Erythropoiesis stimulating agents:** Medicare will help pay for erythropoietin by injection if a person with Medicare has ESRD and needs this drug to treat anemia. Medicare may also cover these drugs to treat anemia for people who don't have ESRD.

Which drugs does Part B cover? (continued)

- **Blood clotting factors:** If a person with Medicare has hemophilia, Medicare helps pay for clotting factors they give themselves by injection.
- **Immunosuppressive drugs:** Medicare covers immunosuppressive drug therapy for people who received an organ transplant for which Medicare made payments.
  - If a person is entitled to Medicare only because of permanent kidney failure, their Medicare coverage will end 36 months after the month of the transplant. Medicare won't pay for any services or items, including immunosuppressive drugs, for patients who aren't entitled to Medicare.
  - A person with ESRD and Original Medicare may join a Medicare drug plan (Part D). Part D may cover other immunosuppressive drugs not covered by Part B, even if Medicare didn't pay for the transplant.
- **Oral cancer drugs:** Medicare helps pay for some cancer drugs you take by mouth if the same drug is available in injectable form or is a prodrug of the injectable drug. A prodrug is an oral form of a drug that when ingested breaks down into the same active ingredient found in the injectable form of the drug.
- **Oral anti-nausea drugs:** Medicare helps pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered immediately before, at, or within 48 hours after chemotherapy, and must be used as a full therapeutic replacement for an intravenous anti-nausea drug.
- **Parenteral and enteral nutrition (intravenous and tube feeding):** Medicare helps pay for certain nutrients for people who can't absorb nutrition through their intestinal tracts or can't take food by mouth.
- **Intravenous Immune Globulin (IVIG) provided in the home:** Medicare helps pay for IVIG for people with a diagnosis of primary immune deficiency disease. A doctor must decide that it's medically appropriate for the IVIG to be given in the patient's home. Part B covers the IVIG itself, but doesn't pay for other items and services related to the patient getting the IVIG in his or her home.
- **Insulin used with insulin pumps:** Insulin pumps worn outside the body (external), including the insulin used with the pump, may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. Certain insulin pumps are considered durable medical equipment. If you need to use an insulin pump, your doctor will prescribe it for you.

Does Part B cover self-administered drugs given in an outpatient setting, like an emergency department or hospital observation unit?

Generally, no. A person's Medicare drug plan (Part D) **may** cover these drugs under certain circumstances. A person might need to pay out-of-pocket for these drugs and submit a claim to their Part D plan to get paid back. He or she should call the plan for more information.

You can also view the fact sheet "How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings" by visiting Medicare.gov/publications.

Which drugs do Medicare Advantage Plans cover?

Medicare Advantage Plans must cover the drugs that are covered under Part A and Part B. A person in a Medicare Advantage Plan will usually get their Medicare prescription drug coverage from their plan. They should contact their plan to see if it offers prescription drug coverage. In most Medicare Advantage Plans, if a person wants Medicare prescription drug coverage and their plan offers it, they must get it from their Medicare Advantage Plan. A person can't be enrolled in both a Medicare Advantage Plan and a Medicare Prescription Drug Plan.

Which drugs do Medicare Prescription Drug Plans cover under Part D?

A Medicare Prescription Drug Plan offers comprehensive prescription drug coverage to people with Original Medicare (Part A and Part B). In general, a Part D-covered drug must meet all of these conditions:

- Available only by prescription
- Approved by the Food and Drug Administration (FDA)
- Used and sold in the U.S.
- Used for a medically accepted indication, as defined under the Social Security Act
- Not covered under Part A or Part B
- Included on the plan's Part D drug list or coverage approved through the exceptions or appeals process

Do Medicare drug plans cover shots (vaccinations) under Part D?

Yes. All Medicare drug plans must include on their drug formularies all commercially available vaccines, like the shingles shot. Part D doesn't cover vaccines covered under Part B, like the flu or pneumococcal shot (see pages 1–2). The plan member or provider can contact the Medicare drug plan for more information about coverage.

Are there certain drugs that Medicare drug plans don't cover under Part D?

Yes. By law, Part D can't pay for drugs when they would be covered under Part A or Part B. In addition, these drugs can't be included in basic Part D coverage:

- Drugs when used for weight loss or gain
- Drugs when used for treatment of sexual or erectile dysfunction, unless these drugs are used to treat a condition other than sexual or erectile dysfunction, for which the drugs have been approved by the FDA
- Drugs when used for symptomatic relief of cough and colds
- Non-prescription drugs
- Drugs when used for cosmetic purposes or hair growth
- Drugs when used to promote fertility
- Prescription vitamins and minerals, except prenatal vitamins and fluoride preparation products

Some Medicare drug plans may choose to cover these drugs as part of the plan's supplemental benefits. However, any amount spent for these drugs isn't counted toward the person's out-of-pocket limit.

Can people appeal a drug coverage decision?

Yes. People with Medicare have certain guaranteed rights. One of these is the right to a fair process to appeal decisions about coverage or payment of health care services. How people file an appeal will depend on which part of Medicare is involved. People with Medicare should review their coverage decision notices carefully for instructions on how to file an appeal.

Where can people get more information or help?

- Visit Medicare.gov.
  - Look for more information on appeals at Medicare.gov/appeals.
  - Look for more information on Medicare drug coverage in the "Drug Coverage (Part D)" section. Select "Find health & drug plans."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Contact a State Health Insurance Assistance Program (SHIP) to get free personalized health insurance counseling. To get the phone number for a particular state, visit shiptacenter.org, or call 1-800-MEDICARE.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

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