[*Instructions: This model should be used to notify Participants within 3 business days after adjudication of the first temporary fill that they have received a transition supply of a drug because the Part D transition requirements apply.*

*The FIDA Plan should include the appropriate specific explanation(s) for the limited coverage from the choices below. The FIDA Plan may replace <Plan name> with either “the Plan”, “our Plan”, or “your plan” throughout notice. The FIDA Plan should use the term “compound” in <list medications here> or <name of drug> when a transition supply applies to a compound.*

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

**YOUR DRUG(s) <IS/ARE> NOT ON OUR LIST OF COVERED DRUGS (FORMULARY)**

**OR <IS/ARE> SUBJECT TO CERTAIN LIMITS**

<DATE>

<PARTICIPANT NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <PARTICIPANT NAME>:

We want to tell you that <plan name> has provided you with a temporary supply of the following prescription(s): <list medication(s) here>.

<This/These> drug(s) <is/are> either not included on our List of Covered Drugs (called our formulary, or also the Drug List for short) or included on the Drug List, but subject to certain limits, as described in more detail later in this letter. <Plan name> is required to provide you with a temporary supply of <this/these> drug(s). If your prescription is written for fewer than [*insert number of days that corresponds to the number of days designated as a month’s supply in approved plan benefit package*] days, we’ll allow multiple fills to provide up to a maximum of [*insert supply limit - must be at least a one-month supply based on approved plan benefit package*] days of medication.

It’s important to understand that this is a temporary supply of <this/these> drug(s). Well before you run out of <this/these> drug(s), you should speak to <plan name>, the prescriber, and/or your Interdisciplinary Team (IDT) about:

* changing the drug(s) to <another/other> drug(s) that <is/are> on our Drug List; or
* requesting approval for the drug(s) by demonstrating that you meet our criteria for coverage; or
* requesting an exception from our criteria for coverage.

When you request approval for coverage or an exception from coverage criteria, these are called coverage determinations. Don’t assume that any coverage determination, including any exception, you have requested or appealed has been approved just because you receive more fills of a drug. If <plan name> or your IDT approves coverage, then we’ll send you another written notice.

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, contact <plan name> Participant Services or your Care Manager at <toll-free number>. TTY users should call <toll-free TTY number>. Live representatives are available from <days and hours of operation when live representatives take calls>. You can ask for a coverage determination at any time. **Instructions on how to change your current prescription(s), how to ask for a coverage determination, including an exception, and how to appeal a denial if you disagree with our coverage determination are discussed at the end of this letter.**

The following is a specific explanation of why your drug(s) <is/are> not covered or <is/are> limited.

**[*Note****: FIDA Plans may include information about multiple temporary supplies in the same notice.*]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is not on our Drug List. [*Insert where applicable:* In addition, a prior exception you received for coverage of this drug has recently expired.] We will not continue to pay for this drug after you have received up to [*insert supply limit (must be at least the number of days in the plan’s one-month supply)*] days’ temporary supply that we are required to cover unless you obtain <a/an additional> Drug List exception from <plan name> or your IDT.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is not on our Drug List. In addition, we could not provide the full amount that was prescribed, because we limit the amount of this drug that we provide at one time. This is called a quantity limit and we impose such limits for safety reasons. In addition to imposing quantity limits for safety reasons as this drug is dispensed, we will not continue to pay for this drug after you have received up to [*insert supply limit (must be at least the number of days in the plan’s one-month supply)*] days’ supply that we are required to cover unless you obtain a Drug List exception from <plan name> or your IDT.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List, but requires prior authorization. Unless you obtain prior authorization from <plan name> or your IDT by showing us that you meet certain requirements or unless we approve your request for an exception to the prior authorization requirements, we will not continue to pay for this drug after you have received up to [*insert supply limit (must be at least the number of days in the plan’s one-month supply)*] days’ temporary supply that we are required to cover.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List. However, we will generally only pay for this drug if you first try <another/other> drug(s), specifically <insert step drug(s)*>,* as part of what we call a step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe, effective, and lower cost drug before progressing to other more costly drugs. Unless you try the other drug(s) on our Drug List first or unless we or your IDT approve your request for an exception to the step therapy requirement, we will not continue to pay for this drug after you have received up to [*insert supply limit (must be at least the number of days in the plan’s one-month supply)*] days’ temporary supply that we are required to cover.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List. However, we will generally only pay for this drug if you first try a generic version of this drug. Unless you try the generic drug on our Drug List first or unless we or your IDT approve your request for an exception, we will not continue to pay for this drug after you have received up to [*insert supply limit (must be at least the number of days in the plan’s one-month supply)*] days’ temporary supply that we are required to cover.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List and is subject to a quantity limit (QL). We will not continue to provide more than what our QL permits, which is <insert the QL>, unless you obtain an exception from <plan name> or your IDT.]

[***Note****: The following choices are for Emergency Fill and Level of Care Changes and are optional. However, we encourage the plan to notify Participants of Emergency Fill and Level of Care Change temporary supplies.*]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is not on our Drug List. We will cover this drug for <days’ supply on filled claim – must be at least 31 days> while you seek to obtain a Drug List exception from <plan name> or your IDT. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List and requires prior authorization. We will cover this drug for <days’ supply on filled claim – must be at least 31 days> while you seek to obtain coverage by showing us that you meet the prior authorization requirements. You can also ask us for an exception to the prior authorization requirements if you believe they should not apply to you for medical reasons.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List but will generally be covered only if you first try certain other drugs as part of our step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. We will cover this drug for <days’ supply on filled claim – must be at least 31 days> while you seek to obtain coverage by showing us that you meet the step therapy criteria. You can also ask us for an exception to the step therapy requirement if you believe it should not apply to you for medical reasons.]

# How do I change my prescription?

If your drug(s) <is/are> not on our Drug List, or <is/are> on our Drug List, but we have placed a limit on <it/them>, then you can ask us what other drug(s) used to treat your medical condition <is/are> on our Drug List, ask us to approve coverage by showing that you meet our criteria, or ask us for an exception. We encourage you to ask your prescriber if <this/these> other drug(s) that we cover <is/are> an option for you. You have the right to request an exception from us to cover your drug(s) that <was/were> originally prescribed. If you ask for an exception, your prescriber will need to provide us with a statement explaining why a prior authorization, quantity limit, or other limit we have placed on your drug is not medically appropriate for you.

# How do I request a coverage determination, including an exception?

You or your prescriber may contact us to request a coverage determination, including an exception. [*Provide the necessary address, fax number, and phone number*]. Your Care Manager can help you with this.

If you are requesting coverage of a drug that is not on our Drug List or an exception to a coverage rule, your prescriber must provide a statement supporting your request. It may be helpful to bring this notice with you to the prescriber or send a copy to his or her office. If the exception request involves a drug that is not on our Drug List, the prescriber’s statement must indicate that the requested drug is medically necessary for treating your condition, because all of the drugs on our Drug List would be less effective than the requested drug or would have adverse effects for you. If the exception request involves a prior authorization or other coverage rule we have placed on a drug that is on our Drug List, the prescriber’s statement must indicate that the coverage rule wouldn’t be appropriate for you given your condition or would have adverse effects for you.

<Plan name> or your IDT must notify you of its decision no later than 24 hours, if the request has been expedited, or no later than 72 hours, if the request is a standard request, from when we receive your request. For exceptions, the timeframe begins when we obtain your prescriber’s statement. Your request will be expedited if <plan name> or your IDT determines, or your prescriber tells us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.

# What if my request coverage is denied?

If your request for coverage is denied, you have the right to appeal by asking for a review of the prior decision, which is called a redetermination. You must request this appeal within 60 calendar days from the date of our written decision on your coverage determination request. [*Insert one:* You must file a standard request in writing *or* We accept standard requests by phone and in writing]. We accept expedited requests by phone and in writing. [*Provide the necessary address, fax number, and phone number*]. Instructions for filing an appeal are in Chapter 9 of your Participant Handbook or can be provided to you by your Care Manager, Participant Services, or by the FIDA Participant Ombudsman.

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, please contact Participant Servicesat <plan name>, at <toll-free number> or *<*toll-free TTY/TDD numbers>. Live representatives are available from <days and hours of operation when live representatives take calls>. You can ask us for a coverage determination at any time. You can also visit our website at <insert web address>.

Sincerely,

<Plan Representative>

[*Plans must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidelines and State-specific Marketing Guidance.*]

ATTENTION: If you speak [*insert language of the* disclaimer], language assistance services, free of charge, are available to you. Call [*insert Participant Services toll-free phone and TTY/TDD numbers and days and hours of operation*]. The call is free. [*This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation.*]

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