[The below table has been created to auto-populate key terms throughout the document. For proper function, use of Microsoft 2007 or later is required. If using a previous version of Word, follow the instructions below for removing the bookmark table and related instructions.

**Populating the bookmark table.** To populate the table and auto-populate the terms throughout the document, use the following steps:

1. Update the values for each of the data fields in the table below by highlighting the text between the carets (< >) and typing the appropriate value. After entering the value, delete the carets.
2. Press Ctrl+A to select all text in the main document sections.
3. Press F9 to update the field references. If a box appears asking to update the Table of Contents, select “Update entire table” and press OK.
4. Double click on the header. Press Ctrl+A to select all header text.
5. Press F9 to update the field references in the header.
6. If the header does not populate throughout the document, steps 5 and 6 should be repeated for each header section in the document.
7. Double click on the footer, and press Ctrl+A to select all footer text.
8. Press F9 to update the field references in the footer.
9. If the footer does not populate throughout the document, steps 8 and 9 should be repeated for each footer section in the document.
10. To correct any issues with the Table of Contents, right-click on any line of the Table of Contents, ensuring that the whole table is highlighted in light gray, then click “Update Fields” followed by “Update entire table.”

| **Data Field (bookmarkName)** | **Value** |
| --- | --- |
| Plan name (planName) | <plan name> |
| Toll-free Number (tollFreeNumber) | <toll free number> |
| Days and hours of operation (daysAndHoursOfOperation) | <days and hours of operation> |
| Web Address (webAddress) | <web address> |
| Year (year) | 2019 |
| Plan's legal or marketing name (planLMName) | <Plan's legal or marketing name> |
| State Medicaid Program Name (medicaidName) | Rhode Island Medicaid |
| Member Services Name (memberServicesName) | <Member Services> |
| Person to call to ask for an exception (personForException) | <Your care coordinator, your care team, a Member Services representative> |
| Name for Care Coordinator (nameForCareCoordinator) | <Name for Care Coordinator> |
| Name of plan members (memberName) | Member |
| Member Services TTY/TDD Number (msTTYNumber) | <TTY/TDD Number> |

*Note: Plan should be cognizant of grammar and capitalization and review the document to ensure the populated bookmarks appear appropriately throughout.*

***Correcting error messages in the document.*** *If an error message appears in the document indicating that the source could not be found (shown below), a bookmark may have been deleted.*

""

*To recreate a bookmark, plan should use the following steps:*

1. *In the document, highlight the value that is not updating or the error message.*
2. *On the Insert ribbon tab, in the Links group, select Bookmark.*
3. *Find and select the bookmark name (found within parentheses next to the data field name in the bookmark table above) from the available list and click “Add.”*
4. *If the value does not appear in the list, enter the bookmark name exactly as written in the bookmark table into the “Bookmark name” field and press “Add.”*
5. Return to the instructions found before the bookmark table, beginning at Step 2, to update the bookmarks throughout the document.
6. *Repeat steps 1-5 for each additional value showing an error in the document.*

***Moving a tagged field.*** *To move a tagged field to another location within the document, use the following steps:*

1. Highlight the entire tagged field and any surrounding text you want to move or copy and press Ctrl+C to make a copy, leaving the original in place, or Ctrl+X to move the field, removing the original.
2. Place the cursor where the copied text should begin, and press Ctrl+V.
3. Ensure the field has remained intact by placing the cursor anywhere within the field. The entire field should have a light gray background.
4. If the field’s background is not light gray, press Ctrl+Z to undo the previous steps.
5. Repeat the previous steps, being careful to highlight the entire field before pressing either Ctrl+C or Ctrl+X

**Removing the bookmark table and related instructions.** Oversight and monitoring entities (such as MMCO or individual states) must **not** remove the bookmark table or any of the relevant plan instructions even after they have entered values. Instead, the MMP should utilize the following instructions to remove the bookmark table and plan instructions only after all information has been entered and the document is final or if the MMP chooses to manually populate the document:

1. Convert tagged fields into untagged text.
   1. Select all text within the body of the document by placing the cursor anywhere in the document and pressing Ctrl+A.
   2. Press Ctrl+F9 to convert all tagged fields in the main body of the document to untagged text.
      1. Note: After this step, changes made to the bookmarks will not update the tagged fields in the main body of the document.
   3. Double click within the header and press Ctrl+A to highlight all header text.
   4. Press Ctrl+F9 to convert all tagged fields in the header to untagged text. Steps c and d should be repeated for each header section in the document
      1. Note: After this step, changes made to the bookmarks will not update the tagged fields in the document’s header.
   5. Double click within the footer and press Ctrl+A to highlight all footer text.
   6. Press Ctrl+F9 to convert all tagged fields in the footer to untagged text. Steps e and f should be repeated for each footer section in the document.
      1. Note: After this step, changes made to the bookmarks will not update the tagged fields in the document’s footer.
2. Delete all plan instruction pages prior, including these instructions and the bookmark table.
3. Ensure that all text generated from the recently converted tagged fields has remained intact in the header, footer, and main body of the document.]

**Instructions to Health Plan**

* [*The plan is 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)*.*]
* [*Where the template instructs inclusion of a phone number, plan must ensure it is a toll-free number and include a toll-free TTY/TDD number and days and hours of operation*.]
* [*Plan should note that the EOC is referred to as the “Member Handbook”.   
  If plan does not use the term “Member Handbook,” plan should replace it with   
  the term the plan uses.*]
* [*Plan should include all drugs/items covered under the Part D and Medicaid pharmacy benefits. This includes only those drugs on plan’s’ approved Part D formulary and approved Additional Demonstration Drug (ADD) file. Plan may not include OTC drugs and/or items offered as a plan supplemental benefit that are in excess of Medicaid-required OTC drugs and/or items.*]
* [*Plan may place a QR code on materials to provide an option for members to go online.*]
* [*Plan has the option of deleting the footer following the introduction (e.g., the footer is not necessary in the actual list of drugs)]*
* [*Wherever possible, plan is encouraged to adopt good formatting practices that make information easier for English-speaking and non-English speaking enrollees 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 an item or text continues on to the following page, enter a blank return before right aligning with clear indication that the item continues (for example, as in the Benefits Chart in Chapter 4 of the Member Handbook, insert:* **This section is continued on the next page***).*
* *Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.*
* *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 dialect in translated models.*
* *Include instructions and navigational aids in translated models in the translated language rather than in English.*
* *Consider producing translated models in large print.*]

**<plan name>| 2019 *List of Covered Drugs* (Formulary)**

**Introduction**

This document is called the *List of Covered Drugs* (also known as the Drug List).It tells you which prescription drugs [*insert if applicable:* and over-the-counter] drugs [i*nsert if applicable:* and items] are covered by <plan name>. The Drug Listalso 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*.

[*In accordance with Section 60.4 of the Medicare Marketing Guidelines (MMG), plan must indicate when the document was last updated by including either* “Updated MM/YYYY” *or* “No changes made since MM/YYYY.”Plan must include their contact information on both the front and back cover in accordance with Section 60.4.1 of the MMG*.*]

[*Plan 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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1. Disclaimers

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

* [*Plan must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidelines and State-specific Marketing Guidance.*]
* You can always check <plan name>’s up-to-date *List of Covered Drugs* online at <web address>.
* ATTENTION: If you speak [*insert language of the disclaimer*], language assistance services, free of charge, are available to you. Call [insert Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation]. TTY users should call <TTY/TDD Number>. The call is free. [*This disclaimer must be included in Spanish and any other 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. Please call <member services name> at <toll-free number>, <days and hours of operation>. TTY users should call <TTY number>. The call is free.
* [*Plan must also describe how members can make a standing request to this document, now and in the future, in a language other than English or in an alternate format.*]

1. Frequently Asked Questions (FAQ)

Find answers here to questions you have about this *List of Covered Drugs*. 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 *List of Covered Drugs* that starts on page <insert page number> are the drugs covered by <plan name>. These 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, **and**
* you fill the prescription at a <plan name> network pharmacy.
* <plan name> may have additional steps to access certain drugs (see question B4 below).

You can also see an up-to-date list of drugs that we cover on our website at <web address> or call <Member Services> at .

B2. Does the Drug List ever change?

Yes. <plan name> 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 approval for a drug. (Prior approvalis 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 will cover another drug.)

For more information on these drug rules, see question B4.

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

* a new, cheaper drug comes along that works as well as a drug on the Drug List now, **or**
* we learn that a drug is not 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 <web address>.
* You can also call <Member Services> to check the current Drug List at .

**B3.** **What happens when there is a change to the Drug List?**

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

* [*Plan that otherwise meets all requirements and want the option to immediately replace brand name drugs with their generic equivalents must provide the following advance general notice of changes:* ***A new generic drug becomes available****. Sometimes, a new and cheaper drug comes* along that works as well as a drug on the Drug List now. When that happens, we may remove the current drug, but your cost for the new drug will stay the same [*insert if applicable, for example, if the plan’s Drug List has differential cost-sharing for some generics:* or will be lower]. When we add the new generic drug, we may also decide to keep the current drug on the list but change its coverage rules or limits.
  + We may not tell you before we make this change, but we will send you information about the specific change or changes we made.
  + You or your provider can ask for an exception from these changes. We will send you a notice with the steps you can take to ask for an exception. Please see question B10 for more information on exceptions.]
* **A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug’s manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. [*Plan should include information advising beneficiaries what to do after they are notified (e.g., contact the prescribing doctor, etc.).*]

**We may make other changes that affect the drugs you take.** We will 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.
* [*Plan that want the option to immediately substitute a new generic drug, insert:* We add a generic drug that is not new to the market **and**
  + Replace a brand name drug currently on the Drug List **or**
  + Change the coverage rules or limits for the brand name drug.]
* [*Plan that is not making immediate generic substitutions insert:* We add a generic drug **and** 
  + Replace a brand name drug currently on the Drug List **or**
  + Change the coverage rules or limits for the brand name drug.]

When these changes happen, we will tell you at least 30 days before we make the change to the Drug List **or** when you ask for a refill. This will give you time to talk to your doctor or other prescriber. He or she can help you decide if there is a similar drug on the Drug List you can take instead or whether to ask for an exception. Then you can:

* Get a [*insert supply limit (must be at least the number of days in the plan’s one month supply)*]-day supply of the drug before the change to the Drug List is made, or
* Ask for an exception from these changes. Please see question B10 for more information about exceptions.

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: [*Plan should omit bullets as needed and reflect only those utilization management procedures actually used by the plan*]:

* **Prior approval (or prior authorization):** For some drugs, you or your doctor or other prescriber must get approval from <plan name> before you fill your prescription. <plan name> may not cover the drug if you do not get approval.
* **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 will have to try drugs in a certain order for your medical condition. You might have to try one drug before we will cover another drug. If your doctor thinks the first drug doesn’t work for you, then we will cover the second.

You can find out if your drug has any additional requirements or limits by looking in the tables on pages <insert page numbers>. You can also get more information by visiting our web site at <web address>. [If the plan applies prior authorization and/or step therapy insert the following with applicable information: We have posted online [insert: a document or documents] that [insert: 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. He or she can help you decide if there is a similar drug on the Drug List you can take instead or whether to ask for an exception. Please see questions B10 – B12 for more information about exceptions.

B5. How will you know if the drug you want has limitations or if there are required actions to take to get the drug?

The *List of Covered Drugs* on page <insert page number> has a column labeled “Necessary actions, restrictions, or limits on use.”

B6. What happens if we change our rules about some drugs (for example, prior authorization (approval), quantity limits, and/or step therapy restrictions?

[*Plan should omit information as needed and reflect only those utilization management procedures actually used by the plan*]: In some cases, we will tell you in advance if we add or change prior approval, quantity limits, and/or step therapy restrictions on a drug. See 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 you find a drug on the Drug List?

There are two ways to find a drug:

* You can search alphabetically (if you know how to spell the drug), **or**

You can search by medical condition.

To search **alphabetically**, go to the Index of Covered Drugs section. You can find it [*give instructions*].

To search **by medical condition**, find the section labeled “List of drugs by medical condition” on page <insert page number>. The drugs in this section are grouped into categories depending on the type of medical conditions they are used to treat. For example, if you have a heart condition, you should look in the category, <therapeutic category name example>. That is where you will find drugs that treat heart conditions.

B8. What if the drug you want to take is not on the Drug List?

If you don’t see your drug on the Drug List, call <Member Services> at and ask about it. If you learn that <plan name> will not cover the drug, you can do one of these things:

* Ask for a list of drugs like the one you want to take. Then show the list to your doctor or other prescriber. He or she can prescribe a drug on the Drug List that is like the one you want to take. **Or**

You can ask the health plan to make an exception to cover your drug. Please see questions B10-B12 for more information about exceptions.

**B9. What if you are a new** <plan name> **member and can’t find your drug on the Drug List or have a problem getting your drug?**

We can help. We may cover a temporary [insert supply limit (*must be the number of days in plan’s one-month supply)*]-day supply of your Part D drug or [*must be at least 90*]-day [supply *or* supplies] of your Medicaid-covered drug during the first [*must be at least 90*] days you are a Member of <plan name>. This will give you time to talk to your doctor or other prescriber. He or she can help you decide if there is 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 will allow multiple fills to provide up to a maximum of [*insert supply limit (must be the number of days in plan’s one-month supply)*] days of medication.

We will cover a [*insert supply limit (must be the number of days in plan’s one-month supply)*]-day supply of your Part D drug or [*must be at least 90*]-day supply *or* supplies] of your Medicaid-covered drug if:

* you are taking a drug that is not on our Drug List, **or**
* health plan rules do not let you get the amount ordered by your prescriber, **or**
* the drug requires prior approval by <plan name>, **or**

you are taking a drug that is part of a step therapy restriction.

If you are in a nursing home or other long-term care facility and need a drug that is not on the Drug List or if you cannot easily get the drug you need, we can help. If you have been in the plan for more than [insert time period (must be at least 90 days)] days, live in a long- term care facility, and need a supply right away.

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

[*If applicable, the plan must insert a description of their transition policy for current members with changes to their level of care, as specified in section 30.4.7 of Chapter 6 of the* Prescription Drug Benefit Manual*.*]

B10. Can you ask for an exception to cover your drug?

Yes. You can ask <plan name> to make an exception to cover a drug that is not 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 will 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 approval requirements.

B11. How can you ask for an exception?

To ask for an exception, call [*plan should include information on the best person to call – e.g., your <Name for Care Coordinator>, your care team,* <Member Services>]. [*Insert*: *<Name for Care Coordinator>, your care team,* <Member Services>] will work with you and your provider to help you ask for an exception. You can also read Chapter 9, [*plan may insert a reference, as applicable*], of the *Member Handbook* to learn more about exceptions.

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

First, we must get a statement from your prescriber supporting your request for an   
exception. After we get the statement, we will give you a decision on your exception request within 72 hours.

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 will 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 usually don’t have well-known names. Generic drugs are approved by the Food and Drug Administration (FDA).

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

B14. What are OTC drugs? [*This question is optional. Plan should include this question only if the plan covers OTC drugs.*]

OTC stands for “over-the-counter.” <plan name> covers some OTC drugs when they are written as prescriptions by your provider.

You can read the <plan name> Drug List to see what OTC drugs are covered.

[*Plan should include OTC drugs they pay for and that were included on the integrated formulary approved by CMS and the state in the Drug List. They should provide cost-sharing information there as well.*]

B15. Does <plan name> cover OTC non-drug products? [*This question is optional. Plan should include this question only if the plan covers OTC non-drug products.*]

<plan name> covers some OTC non-drug products when they are written as prescriptions by your provider.[*Plan should include the following language*: Examples of OTC non-drug products include <*examples of plan’s covered OTC non-drug products>*.]

You can read the <plan name> Drug List to see what OTC non-drug products are covered.

[*Plan should include OTC non-drug products they pay for in the Drug List. They should provide cost-sharing information there as well.*]

B16. What is your copay?

[*Plan with no copays in any tier insert:* As a <plan name> member, you have no copays for prescription and OTC drugs as long as you follow <plan name>’s rules.]

[*Plan with copays in any tier insert:* You can read the <plan name> Drug List to learn about the copay for each drug. <plan name> members living in nursing homes or other long-term care facilities will have no copays. Some members getting long-term care in the community will also have no copays.]

[*Plan with copays in any tier must also provide an explanation; see the example of tiered copays below. Plan should modify the explanation below consistent with their tier model, to include the range of applicable cost sharing amounts for each tier (and a statement that the copay varies depending on the person’s level of Medicaid eligibility), and a description of the types of drugs (e.g., generics, brands, and/or OTCs) on each tier. Plan must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the CY 2016 Final Call Letter. If the plan has no copays for one or more tiers of drugs, the plan should modify the copay information accordingly.*

Copays are listed by tiers. Tiers are groups of drugs with the same copay.

* Tier 1 drugs have the lowest copay. They are generic drugs. The copay is from <amount> to <amount>, depending on your income.
* Tier 2 drugs have a medium copay. They are brand name drugs. The copay is from <amount> to <amount>, depending on your income.

Tier 3 drugs have the highest copay. They have a copay of <amount>.]

B17. What are drug tiers?

[*Only a plan with no copays in any tier should include question B17.*

Tiers are groups of drugs on our Drug List.

*Plan must provide* *a description of each of their drug tiers and the types of drugs (e.g., generic, brand, and/or OTC) in each tier.*

Plan with no copays in any tier include tier examples such as the following:

* Tier 1 drugs are generic drugs.
* Tier 2 drugs are brand name drugs.

*Plan must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the CY 2016 Final Call Letter and consistent with their approved plan benefit package*. *Plan must also include a statement that all tiers have no copay.*]

1. Overview of the *List of Covered Drugs*

The *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 on page <index page number>. The index alphabetically lists all drugs covered by <plan name>.

[***Note:*** *Plan must provide information on the following items when applicable to specific drugs and explain 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, plan is not 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 page number*].]

[***Note:*** *Any OTC drugs or products on the plan’s approved integrated formulary must be included on the Drug List. For non–Part D drugs or OTC items that are covered by Medicaid, please place an asterisk (\*) or another symbol by the drug to indicate that the beneficiary may need to follow a different process for appeals.*]

**Note:** The <symbol used by the plan*>* next to a drug means the drug is not a “Part D drug.” 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 getting Extra Help to pay for your prescriptions, you will not get any Extra Help to pay for these drugs. For more information on Extra Help, please see the call-out box [*plan insert*: below *or* on page <page number>].

Extra Help is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

* These drugs also have different rules for appeals. An appeal is a formal way of asking us to review a coverage decision and to change it if you think we made a mistake. For example, we might decide that a drug that you want is not covered or is no longer covered by Medicare or Medicaid.
* If you or your doctor disagrees with our decision, you can appeal. To ask for instructions on how to appeal, call <Member Services> at . You can also read Chapter 9, [*plan may insert a reference, as applicable*] of the *Member Handbook* to learn how to appeal a decision.

C1. List of Drugs by Medical Condition

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

[*If the plan uses codes in the “Necessary actions, restrictions, or limits on use” column, they should include a key. Plan is not required to include a key on every page, but plan must 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 page number*].** *The key below is only an example: Plan does not 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 is not covered.

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

PA = Prior authorization (approval): you must have approval 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 chart lists the name of the drug. 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 “Necessary actions, restrictions, or limits on use” column tells you if <plan name> has any rules for covering your drug.

[*Plan has 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>** – [*The plan may add/delete rows as needed but must leave no blank rows after populating table. Optional: The plan is encouraged to insert a plain language description of the category. The plan can include additional therapeutic categories as needed.*]

| 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> –** [*The plan may add/delete rows as needed but must leave no blank rows after populating table. Optional: The plan is encouraged to insert a plain language description of the category.* Plan can include additional therapeutic categories further divided into classes as needed.]

| 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.*

Plan should include OTC drugs they pay for and that were included on the integrated formulary approved by CMS and the state in the Drug List. They should provide cost-sharing information there as well.

Plan should include OTC non-drug products they pay for in the Drug List. They should provide cost-sharing information there as well.

*Plan may 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,” plan 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 plan uses the second option and further divide the categories into classes, 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.*]

[***“Name of Drug” column instructions****:*

*Brand name drugs should be capitalized (e.g., DRUG A). Generic drugs should be lowercase and italicized, e.g., penicillin. Plan may include the generic name of a drug next to the brand name.*

*If there are differences in formulary status, tier placement, quantity limit, prior authorization, step therapy, or other restrictions or benefit offerings (e.g., 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 (e.g., 20 mg is in Tier 1 and 40 mg is in Tier 4), plan must 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.*]

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

*Plan should put the appropriate tier level in parentheses next to the copay or range of copays as shown in the example above.*]

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

*Plan may include abbreviations within this column (e.g., QL for quantity limits) but must include an explanation at the beginning of the table explaining each abbreviation.*

*Plan 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 Medicaid, free-first-fill drugs, limited-access drugs, and drugs covered under the medical benefit (for home infusion drugs only and for a plan that specifically requests and is approved in the plan benefit package to bundle home infusion drugs and services under the medical benefit). Plan may also use abbreviations to show drugs that are not available via mail order.*

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

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

1. Index of Covered Drugs

[*Plan 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. Plan may use more than one column for the index listing. The inclusion of this list is required and should start on a separate page.*]