**Instructions to Health Plans**

* [*If the state does not use the word “Medicaid”, plans should replace it with the name the state uses.*]
* [*If plans do not use the term “Member Services”, plans should replace it with   
  the term the plan uses.*]
* [*Plans should note that the EOC is referred to as the “Member Handbook”.   
  If plans do not use the term “Member Handbook,” plans should replace it with   
  the term the plan uses.*]
* [*Plans should include all drugs/items covered under the Part D and Medicaid pharmacy benefits. This may include Part D excluded drugs and over the counter drugs and/or items.*]
* [*Plans may place a QR code on materials to provide an option for members to go online.*]
* [*Plans have the option of deleting the footer following the introduction (e.g., the footer is not necessary in the actual list of drugs).*]

**<Plan Name>** | <year> List of Covered Drugs (Formulary)

[*Plans should include the version date of this issuance* and the plan contact information on both the front and back cover*.*]

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

* <Plan’s legal or marketing name> is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.
* Benefits, List of Covered Drugs, [and] pharmacy and provider networks [, and/or copayments] may change from time to time throughout the year and on January 1 of each year.
* You can always check <plan name>’s up-to-date List of Covered Drugs online at <web address>.
* Limitations [insert as appropriate: , co-payments] and restrictions may apply. For more information, call <plan name> <Member Services> or read the <plan name> Member Handbook.
* [*Plans that charge $0 copays for all Part D drugs may delete this disclaimer.*] Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.

You can ask for this information in other formats, such as audio, Braille or large print. Call <toll-free number>. The call is free. [Plans must provide the handbook in alternate formats when a Member requests it or when the plan identifies a Member who needs it.]

* You can get this information for free in other languages. Call <toll-free number>. The call is free. [Plans must provide the handbook in all non-English languages that meet the Medicare and state thresholds for translation when a Member requests it or when the plan identifies a Member who needs it. *The preceding sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.*]

**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.

1. 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 #5 below).

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

1. Does the Drug List ever change?

Yes. <Plan name> may add or remove drugs on the Drug List during the year. Generally, the   
Drug List will only change if:

* a 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.

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

* Decide to require or not require prior approval for a drug. (*Prior approval* 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 will cover another drug.)

(For more information on these drug rules, see page <page number>.)

We will tell you when a Medicare Part D drug you are taking is removed from the Drug List. We will also tell you when we change our rules for covering a Medicare Part D drug. Questions 3, 4, and 7 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 <toll-free number>.

1. What happens when a cheaper drug comes along that works as well as a drug on the Drug List now?

If you are taking a Medicare Part D drug that is removed because a cheaper drug that works just as well comes along, we will tell you. We will tell you at least 60 days before we remove it from the Drug List ***or*** when you ask for a refill. Then you can get a 60-day supply of the drug before the change to the Drug List is made. [*Plans should explain how beneficiaries will receive this notification.*]

1. What happens when we find out a drug is not safe?

If the Food and Drug Administration (FDA) says a drug you are taking is not safe, we will take it off the Drug List right away. We will also send you a letter telling you that. [*Plans should include information advising beneficiaries what to do after they receive this letter (e.g., contact the prescribing doctor, etc.).*]

1. Are there any restrictions or limits on drug coverage? Or are there any required actions to take in order to get certain drugs?

Yes, some drugs have coverage rules or have limits on the amount you can get. In some cases you must do something before you can get the drug. For example:

* **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. If you don’t get approval, <plan name> may not cover the drug.
* **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 <page numbers>. You can also get more information by visiting our web site at <web address>. [Plans that apply prior authorization and/or step therapy insert the following with applicable information: We have posted online [a document or documents] that 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. Please see question 11 for more information on exceptions.

* 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. We will cover a [*must be at least 31*]-day emergency 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 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 request an exception. Please see question 11 for more information about exceptions.

1. 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 <page number> has a column labeled “Necessary actions, restrictions, or limits on use.”

1. What happens if we change our rules on how we cover some drugs? For example, if we add prior authorization (approval), quantity limits, and/or step therapy restrictions on a drug.

We will tell you if we add prior approval, quantity limits, and/or step therapy restrictions on a drug. We will tell you at least 60 days before the restriction is added or when you next ask for a refill. Then, you can get a 60-day supply of the drug before the change to the Drug List is made. This gives you time to talk to your doctor or other prescriber about what to do next.

1. 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 Alphabetical Listing section. You can find it [*give instructions*].

To search **by medical condition**, find the section labeled “List of drugs by medical condition” on page <page number>. Then find your medical condition. For example, if you have a heart condition, you should look in that category. That is where you will find drugs that treat heart conditions.

1. 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 <toll-free number> and ask about it. If you learn that <plan name> will not cover the drug, you can do one of these things:

* Ask Member Services 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 question 11 for more information about exceptions.

1. 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 [*must be at least 30*]-day [supply or supplies] of your 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 request an exception.

We will cover a [*must be at least 30*]-day supply of your 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 live in a nursing home or other long-term care facility, you may refill your prescription   
for as long as [*must be at least 91 and may be up to 98*]days. You may refill the drug multiple times during the [*must be at least 90*]days. This gives your prescriber time to change your drugs to ones on the Drug List or ask for an exception.

[*Note: Plans must insert their transition policy for current enrollee with level-of-care changes, if applicable, as specified in section 30.4.7 of Chapter 6 of the* Prescription Drug Benefit Manual*.*]

1. 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.

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

First, we must receive a statement from your prescriber supporting your request for an   
exception. After we receive 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 receiving your prescriber’s supporting statement.

1. How can you ask for an exception?

To ask for an exception, call [*plans should include information on the best person to call – e.g., your service coordinator, your service coordination team, Member Services*]. <*Your service coordinator, your service team, a Member Services representative>* will work with you and your provider to help you ask for an exception.

1. 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.

1. What are 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.

[*Plans 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.*]

1. Does <plan name> cover OTC non-drug products? [*This question is optional. Plans 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.

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

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

1. What is your copay?

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.

[*If a plan has copays, they should provide an explanation; see the example of tiered copays below. Plans 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. If a plan has no copays for any drugs or 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 will be from <amount> to <amount>, depending on your level of Medicaid eligibility.
* Tier 2 drugs have a medium copay. They are brand name drugs. The copay will be from <amount> to <amount>, depending on your level of Medicaid eligibility.

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

List of Covered Drugs

The list of covered drugs <below/that begins on the next page> gives you information about 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 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.

[***Note:*** *Plans 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, plans are 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 receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs. 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 <toll-free number>. You can also read the Member Handbook to learn how to appeal a decision.

|  |  |  |
| --- | --- | --- |
| <Treatment Category 1> – [*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> |
|  |  |  |
|  |  |  |

[*If plans use codes in the “Necessary actions, restrictions, or limits on use” column, they should include a key. Plans are not required to include a key on every page, but plans 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; plans do 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.

|  |  |  |
| --- | --- | --- |
| <Treatment Category 2> – [*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 |
|  |  |  |
|  |  |  |
|  |  |  |

[*If plans use codes in the “Necessary actions, restrictions, or limits on use” column, they should include a key. Plans are not required to include a key on every page, but plans 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; plans do not have to use the same abbreviations/codes:*]

[*Plans also have the option to further divide the therapeutic categories into classes as shown below:*]

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.

|  |  |  |
| --- | --- | --- |
| <Treatment Category 1> – [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> | <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.> |

[*Even if a plan uses this option, if plans use codes in the “Necessary actions, restrictions, or limits on use” column, they should include a key. Plans are not required to include a key on every page, but plans 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*].]

[*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 integrated formulary approved by CMS and the state in the Drug List. They should provide cost-sharing information there as well.

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

*Plans may include a “plain-language” description of the treatment 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 treatment categories alphabetically within the table, and list drugs alphabetically under the appropriate treatment category. If plans use 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. Plans 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), plans 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:*

*Plans 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*

*Plans 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.*

*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 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 request and are approved in the plan benefit package to bundle home infusion drugs and services under the medical benefit). Plans may also use abbreviations to show drugs that are not available via mail-order.*

***Note:*** *Health plans 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.]

[*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. The inclusion of this list is required and should start on   
a separate page.*]