Chapter 5: Getting your outpatient prescription drugs   
through the plan

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1."   
An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

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# Introduction

This chapter explains rules for getting your *outpatient prescription drugs.* These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and MassHealth. [Plans with no cost sharing, delete the next sentence.] Chapter 6 [plans may insert reference, as applicable] tells you what you pay for these drugs*.*

<Plan name> also covers the following drugs, but they will **not** be discussed in this chapter:

* Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility;
* Drugs covered by Medicare Part B. These include:
  + Some chemotherapy drugs;
  + Some drug injections you get during an office visit with a doctor or other provider; and
  + Drugs you get at a dialysis clinic.

To learn more about which drugs are covered, see the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

## Rules for the plan’s outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section:

1. A doctor or other provider [insert if applicable: in our network] must write your prescription. This person often is your primary care provider (PCP). [Plans may modify or delete the next sentence as appropriate.] It could also be another [insert if applicable: network] provider if your primary care provider has referred you to that provider for care. [Insert if applicable: A *network provider* is a provider who works with our health plan.]
   * [Insert if applicable: The plan will cover prescriptions from out-of-network providers *only* in the following cases:
     + if the prescriptions are connected with emergency care that the plan pays for; or
     + if the prescriptions are connected with urgently needed care that the plan pays for when you cannot get to a network provider.
     + Plans should add any other situations when the plan will cover prescriptions written by out-of-network providers.]

[Insert if applicable: In other cases, you must first get approval from the plan if you want the plan to pay for a prescription from an out-of-network provider.]

1. You should use a network pharmacy to fill your prescription.
2. Your prescribed drug generally must be on the plan’s *List of Covered Drugs*. We call it the “Drug List” for short.
   * If it is not on the Drug List, we may be able to cover it by giving you an exception. See page <page number> [plans may insert reference, as applicable] to learn about asking for an exception.
3. Your drug must be used for a *medically accepted indication.* This means that the use of the drug is approved by the Food and Drug Administration (FDA) or supported by certain approved reference books. [Plans should add definition of “medically accepted indication” as appropriate for Medicaid-covered drugs and items.]

# Getting your prescriptions filled

## Fill your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions *only* if they are filled at the plan’s network pharmacies. A *network pharmacy* is a drugstore that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

* To find a network pharmacy, you can:
  + look in the *Provider and Pharmacy Network Directory*,
  + visit our website at <insert website>, or
  + contact Member Services at <member services phone number>
  + [insert if applicable: or your Care Coordinator]. [Plans should replace the term “care coordinator” with the term they use.]

## Show your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy will bill the plan for [plans with cost sharing, insert: our share of the cost of] your covered prescription drug. [Plans with no cost sharing, delete the next sentence:] You will need to pay the pharmacya co-pay when you pick up your prescription.

If you do not have your plan ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, or the pharmacy asks you to pay for the drug, contact [insert Member Services, your Care Coordinator, or other appropriate individual] right away. We will do what we can to help.

## What if you want to change to a different network pharmacy?

[Plans in which members do not need to take any action to change their pharmacies may delete the following sentence.] If you change pharmacies and need a refill of a prescription, you can [insert as applicable: either ask to have a new prescription written by a provider or] ask your pharmacy to transfer the prescription to the new pharmacy.

* If you need help changing your network pharmacy, you can contact Member Services at <member services phone number> [insert if applicable: or your Care Coordinator]. [Plans should replace the term “care coordinator” with the term they use.]

## What if the pharmacy you use leaves the network?

If the pharmacy you use leaves the plan’s network, you will have to find a new network pharmacy so that the plan continues to pay for your prescriptions.

* To find a new network pharmacy, you can look in the *Provider and* *Pharmacy Network Directory*, visit our website at <insert website>, or contact Member Services at <member services phone number> [insert if applicable: or your Care Coordinator]. [Plans should replace the term “Care Coordinator” with the term they use.]

## What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a *specialized pharmacy.* Specialized pharmacies include:

* pharmacies that supply drugs for home infusion therapy; [Plans may insert additional information about home infusion pharmacy services in the plan’s network.]
* pharmacies that supply drugs for residents of a long-term-care facility, such as a nursing facility. Usually, long-term-care facilities have their own pharmacies. Residents may get prescription drugs through a facility’s pharmacy as long as it is part of our network. If your long-term care facility’s pharmacy is not in our network, please contact Member Services; [Plans may insert additional information about LTC pharmacy services in the plan’s network.]
* pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies; and [Plans may insert additional information about I/T/U pharmacy services in the plan’s network.]
* pharmacies that supply drugs that require special handling and instructions on their use.

To find a specialized pharmacy, you can look in the *Provider and* *Pharmacy Network Directory*, visit our website, or contact Member Services at <Member Service phone number> [insert if applicable: or your Care Coordinator]. [Plans should replace the term “Care Coordinator” with the term they use.]

## Can you use mail-order services to get your drugs?

[Plans that do not offer mail-order services, replace the information in this section with the following sentence: No, this plan does not offer mail-order services.]

[Include the following information only if your mail-order service is limited to a subset of all formulary drugs, adapting terminology as needed: For certain kinds of drugs, you can use the plan’s network mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis for a chronic or long-term medical condition. [Insert if plan marks mail-order drugs in formulary: The drugs available through our plan’s mail-order service are marked as mail-order drugs in our Drug List.] [Insert if plan marks non-mail-order drugs in formulary: The drugs that are not available through the plan’s mail-order service are marked with [plans should indicate how these drugs are marked] in our Drug List.]

Our plan’s mail-order service [insert as appropriate: allows **or** requires] you to order [insert as appropriate: at least a <number of days>-day supply of the drug and no more than a <number of days>-day supply **or** up to a <number of days>-day supply **or** a <number of days>-day supply]. A <number of days>-day supply has the same co-pay as a one-month supply.

To get [insert if applicable: order forms and] information about filling your prescriptions by mail, [insert instructions].

Usually, a mail-order prescription will get to you within <number of days> days. [Insert plan’s process for members to get a prescription if the mail-order is delayed.]

[*For plans with automatic mail-order refills, include the following:*Our plan’s mail-order service provides members with mail-order drugs using an “automatic refill” service. If you used our “automatic refill” service in the past, we automatically sent you a refill of your drugs when our records indicated that you were about to run out. However, starting in January 2014, we will need to get your permission before we can send you a refill by mail. We will not need to get your permission to send your drugs by mail when you ask us for the refill or ask us for a new prescription.

This may be a change for you if you have always used mail order in the past and have not needed to tell us to send a refill of your prescription. But this change helps us to make sure you only get drugs you really need.

So that we can make sure that you want a refill, please tell us the best way to reach you. *[Plans: indicate how members should inform the plan of their communication preference.]* If we don’t know the best way to reach you, you might miss the chance to tell us whether you want a refill and you could run out of your prescription drugs. Remember, your drugs will not be automatically shipped unless you confirm you still want to receive the order. This new policy won’t affect refill reminder programs in which you go in person to pick up the prescription and it won’t apply to long–term care pharmacies that give out and deliver prescription drugs.]

## Can you get a long-term supply of drugs?

[Plans that do not offer extended-day supplies, replace the information in this section with the following sentence: This plan does not offer long-term supplies of drugs.]

You can get a long-term supply of *maintenance drugs* on our plan’s Drug List. *Maintenance drugs* are drugs that you take on a regular basis, for a chronic or long-term medical condition. [Insert if applicable: When you get a long-term supply of drugs, your co-pay may be lower.]

[Delete if plan does not offer extended-day supplies through network pharmacies.] Some network pharmacies allow you to get a long-term supply of maintenance drugs. A <number of days>-day supply has the same co-pay as a one-month supply. The *Provider and* *Pharmacy Network Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

[Delete if plan does not offer mail-order service.] [Insert as applicable: For certain kinds of drugs, you **or** You] can use the plan’s network mail-order services to get a long-term supply of maintenance drugs. See the section above [plans may insert reference, as applicable] to learn about mail-order services.

## Can you use a pharmacy that is not in the plan’s network?

You should always use a pharmacy in <plan name>’s network if you can. If you think you are not able to use a pharmacy in our network, call [insert Member Services, your Care Coordinator, or other appropriate individual] first.

We usually pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. [Insert as applicable: We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

* [Plans should insert a list of situations when they will cover prescriptions out of the network and any limits on their out-of-network policies (e.g., day supply limits, use of mail-order during extended out-of-area travel, authorization or plan notification). *The plan’s policies and procedures governing reasonable rules for limiting out-of-network access to Part D prescription drugs, including circumstances under which the plan will permit out-of-network access, must be consistent with Chapter 5 of the Prescription Drug Benefit Manual.*]

In these cases, please check first with Member Services to see if there is a network pharmacy nearby.

If you use an out-of-network pharmacy for some other reason, the pharmacy may ask you to pay for the full cost of your prescription. If this happens, call [insert Member Services, your Care Coordinator, or other appropriate individual] first.

If you pay the full cost [plans with cost sharing, insert: instead of a co-pay]when you get your prescription, you can ask us to pay you back [plans with cost sharing, insert: for our share of the cost].

To learn more about this, see Chapter 7 [plans may insert reference, as applicable].

# The plan’s Drug List

The plan has a *List of Covered Drugs.* We call it the “Drug List” for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will usually cover a drug on the plan’s Drug List as long as you follow the rules explained in this chapter.

## What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D, and some prescription and over-the-counter drugs [insert if applicable: and products] covered under your MassHealth benefits.

The Drug List includes both brand-name and *generic* drugs.Generic drugs have the same ingredients as brand-name drugs. They work just as well as brand-name drugs and usually cost less. Generic drugs are approved by the Food and Drug Administration (FDA).

We will usually cover drugs on the plan’s Drug List as long as you follow the rules explained in this chapter.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

## How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the Drug List, you can:

* Check the most recent Drug List that we sent to you in the mail;
* Visit the plan’s website at <web address>. The Drug List on the website is always the most current one; or
* You may also Call Member Services and ask for a copy of the list.

[Plans may insert additional ways to find out if a drug is on the Drug List.]

## What is *not* on the Drug List?

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

<Plan name> will *not* pay for the drugs listed in this section [insert if applicable: except for certain drugs covered under our enhanced drug coverage]. These are called *excluded drugs.* If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug in your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9 [plans may insert reference, as applicable].)

Here are three general rules for excluded drugs:

* Our plan’s outpatient drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by <plan> for free, but they are not part of your outpatient prescription drug benefits.
* Our plan cannot cover a drug purchased outside the United States and its territories.
* [Plans may modify this paragraph to reflect the degree to which the Medicaid program wraps around non-Part D drugs.] The use of the drug must be approved by the FDA or supported by certain approved reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though the drug was not approved to treat that condition. This is called *off-label use.* Our plan usually does not cover drugs when they are prescribed for off-label use.

By law, the types of drugs listed below are also not covered by Medicare or Medicaid. [Plans should modify the list below and delete drugs that are covered by the plan’s enhanced drug coverage.]

* Drugs used to promote fertility
* Drugs used for cosmetic purposes or to promote hair growth
* Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
* Drugs used for treatment of anorexia, weight loss, or weight gain
* Outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them

## What are cost-sharing tiers?

Every drug on the plan’s Drug List is in one of <number of tiers> cost sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

* [Plans should briefly describe each tier (e.g., Cost Sharing Tier 1 includes generic drugs). Indicate which is the lowest tier and which is the highest tier.]

To find out which cost-sharing tier your drug is in, look for the drug in the plan’s Drug List.

Chapter 6 [plans may insert additional reference] tells the amount you pay for drugs in each tier*.*

# Limits on coverage for some drugs

## Why do some drugs have limits?

There are special rules that limit how and when the plan covers certain prescription drugs. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plans expects your provider to use the lower-cost drug.

**If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug.** For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, you should ask us to make an exception. After review we may agree to let you use the drug without taking the extra steps.

* To learn more about asking for exceptions, see Chapter 9 [plans may insert reference, as applicable].

## What kinds of rules are there?

[Plans should include only the forms of utilization management used by the plan:]

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. [Insert as applicable: In most cases, if **or** If] there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider [insert as applicable: has told us the medical reason that the generic drug will not work for you **or** has written “No substitutions” on your prescription for a brand-name drug **or** has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you], then we will cover the brand-name drug. [Plans that offer all drugs at $0 cost sharing, delete the following sentence:] Your co-pay may be greater for the brand-name drug than for the generic drug.

1. Getting plan approval in advance

For some drugs, you or your doctor must get approval from <plan name> before you fill your prescription. This is called *prior approval* (or prior authorization). If you don’t get approval, <plan name> may not cover the drug.

1. Trying a different drug first (step therapy)

In general, the plan wants you to try lower-cost drugs (that often are just as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first. If Drug A does not work for you, then the plan will cover Drug B. This is called *step therapy*.

1. Quantity limits

For some drugs, we limit the amount of the drug you can have. For example, the plan   
might limit:

* how many refills you can get; ***or***
* how much of a drug you can get each time you fill your prescription.

## Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the   
Drug List. For the most up-to-date information, call Member Services at <member service phone number> or check our website at <web address>.

# Why your drug might not be covered

We try to make your drug coverage work well for you. But sometimes a drug might not be covered in the way that you would like it to be. For example:

* **The drug you want to take is not covered by the plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand-name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
* **The drug is covered, but there are extra rules or limits on coverage for that drug.** As explained in the section above [plans may insert reference, as applicable], some of the drugs covered by the plan have rules that limit their use. In some cases, you may want us to ignore the rule for you.

There are things you can do if your drug is not covered in the way that you would like it to be.

## You can get a temporary supply

In some cases,the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

If you are taking a Medicare Part D drug that <plan name> does not cover, you have the right to get a one-time, 72-hour supply of the drug. If the pharmacy is not able to bill <plan name> for this one-time supply, MassHealth will pay for it. This is required by Massachusetts law.

Also, you may be able to get a longer temporary supply of a Part D drug, or of a non-Part D drug that your MassHealth would cover. To find out how long <plan name> will provide a temporary supply of a drug, call Member Services at <Member Services phone number>.

**To get a temporary supply of a drug, you must meet the two rules below:**

1. The drug you have been taking:

* is no longer on the plan’s Drug List; ***or***
* was never on the plan’s Drug List; ***or***
* is now limited in some way.

1. You must be in one of these situations:

[Plans that offer an enhanced transition benefit allowing for more than one refill may edit the references to “one time only” as needed below.]

For Medicare Part D drugs:

* **You are new to the plan and do not live in a long-term care facility.**

We will cover a supply of your Medicare Part D drug **one time only during the first** [insert time period (must be at least 90 days)] **of your membership** in the plan. This supply will be for up to [insert supply limit (must be at least a 30-day supply)], or less if your prescription is written for fewer days. You must fill the prescription at a network pharmacy.

* **You are new to the plan and live in a long-term care facility.**

We will cover a supplyof your Medicare Part D drug **during the first** [insert time period (must be at least 90 days)] **of your membership** in the plan, until we have given you a [insert day supply range (must be at least 91 and may be up to 98)] supply consistent with the dispensing increment, or less if your prescription is written for fewer days.

* **You have been in the plan for more than** [insert time period (must be at least 90 days)] **and 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 your Medicare Part D drug, or less if your prescription is written for fewer days.

* [If applicable: Plans must insert their transition policy for current members with changes to their level of care.]

*For MassHealth drugs:*

* **You are new to the plan.**

We will cover a supply of your MassHealth drug for 90 days or until your Assessment and Personal Care Plan are complete, or less if your prescription is written for fewer days.

To ask for a temporary supply of a drug, call Member Services at <member service number>.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

* **You can change to another drug.**

There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

**OR**

* **You can ask for an exception.**

You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for an exception.

[Plans that allow current members to receive a temporary supply instead may omit this paragraph:] If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception. We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year. We will answer your request for an exception within 72 hours after we receive your request (or your prescriber’s supporting statement).

* To learn more about asking for an exception, see Chapter 9 [plans may insert reference, as applicable].
* If you need help asking for an exception, you can contact Member Services [insert if applicable: or your Care Coordinator]. [Plans should replace the term “Care Coordinator” with the term they use.]

# Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. Some of the things that the plan might do include:

* Add drugs because new drugs, including generic drugs, became available, or the government approved a new use for an existing drug;
* Remove drugs because they were recalled or because cheaper drugs work just as well;
* Move a drug to a higher or lower cost-sharing tier;
* Add or remove a limit on coverage for a drug; or
* Replace a brand-name drug with a generic drug.

If any of the following changes affect a drug you are taking, the change will not affect you until January 1 of the next year.

* We move your drug into a higher cost-sharing tier.
* We put a new limit on your use of the drug.
* We remove your drug from the Drug List, but *not* because of a recall or because a new generic drug has replaced it.

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. Those changes will not affect you until January 1 of the next year.

In the following cases, you *will* be affected by the coverage change before January 1.

* If a brand-name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days’ notice about the change.
  + The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
  + You should work with your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
  + You and your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9 [plans may insert reference, as applicable].
* If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
  + Your provider will also know about this change. He or she can work with you to find another drug for your condition.
  + If there is a change to coverage for a drug you are taking, **the plan will send you a notice.** Normally, the plan will let you know at least 60 days before the change.

# Drug coverage in special cases

## If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a co-pay. Once you leave the hospital or skilled nursing facility, the plan will continue to cover your drugs as long as the drugs meet all of our rules for coverage.

* [Plans with no cost sharing, delete this paragraph:] To learn more about drug coverage and what you pay, see Chapter 6 [plans may insert reference, as applicable].

## If you are in a long-term-care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term-care facility, you may get your prescription drugs through the facility’s pharmacy if it is part of our network.

Check your *Provider and Pharmacy Network Directory* to find out if your long-term-care facility’s pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

# Programs on drug safety and managing drugs

## Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

* Drug errors;
* Drugs that may not be needed because you are taking another drug that does the same thing;
* Drugs that may not be safe for your age or gender;
* Drugs that could harm you if you take them at the same time; or
* Drugs that are made of things that you are allergic to.

If we see a possible problem in your use of prescription drugs, we will work with your provider to fix the problem.

## Programs to help members manage their drugs

We have drug-management programs that might help you. If you meet certain requirements, we can help you keep track of your total covered drug costs. We can also keep track of your medical conditions and how many different drugs you take. These programs are called medication therapy management (MTM) programs.

A team of pharmacists and doctors developed the medication therapy management programs for us. The programs can help make sure our members are using the drugs that work best to treat their medical conditions. The programs also help members avoid possible drug-related problems.

Medication therapy management programs are voluntary and free to members. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

* If you have any questions about these programs, please contact Member Services [insert if applicable: or your Care Coordinator]. [Plans should replace the term “Care Coordinator” with the term they use.]