Chapter 5: Getting your outpatient prescription drugs and other covered medications through the plan

Introduction

This chapter explains rules for getting your outpatient prescription drugs and other covered medications.These are drugs that your provider orders for you that you get from a pharmacy [insert if applicable: or by mail-order]. They include drugs covered under Medicare Part D and Medicaid. Key terms and their definitions appear in alphabetical order in the last chapter of the Participant Handbook.

<Plan name> also covers the following drugs, although 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 given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Covered Items and Services Chart in Chapter 4 [the plan 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. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. A written prescription is required for both prescription and over-the-counter (OTC) drugs.
2. Your prescriber must not be on Medicare’s Exclusion or Preclusion Lists.
3. You generally must use a network pharmacy to fill your prescription unless <plan name> or your Interdisciplinary Team (IDT) has authorized you to use an out-of-network pharmacy. [Insert if applicable: Or you can fill your prescription through the plan’s mail-order service.]
4. Your prescribed drug must be on the plan’s *List of Covered Drugs* (*Drug List*). (Refer to section B of this chapter.)

* If it is not on the *Drug List*, we may be able to cover it by giving you an exception.
* Refer to Chapter 9 [the plan may insert reference, as applicable] to learn about asking for an exception.

1. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. [The plan should add definition of “medically accepted indication” as appropriate for Medicaid-covered drugs and items.]
2. Your drug may require approval before we will cover it. Refer to Section C.

[The plan should refer Participants to other parts of the handbook using the appropriate chapter number and section. For example, "refer to Chapter 9, Section A." An instruction [plan may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

[The 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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# Getting your prescriptions filled

## A1. Filling 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 drug store that has agreed to fill prescriptions for our plan Participants. You may use any of our network pharmacies.

To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

## A2. Using your Participant ID Card when you fill a prescription

To fill your prescription, **show your Participant ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription or OTC drug.

If you do not have your Participant 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, you may have to pay the full cost of the prescription when you pick it up.** You can then ask <plan name> to pay you back. If you cannot pay for the drug, contact Participant Services right away. We will do what we can to help.

* To learn how to ask us to pay you back, refer to Chapter 7 [the plan may insert reference, as applicable].
* If you need help getting a prescription filled, you can contact Participant Services or your Care Manager.

## A3. What to do if you change to a different network pharmacy

[The plan in which Participants 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 ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, you can contact Participant Services or your Care Manager.

## A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves the plan’s network, you will have to find a new network pharmacy.

To find a new network pharmacy, you can look in the *Provider and* *Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

## A5. Using a specialized pharmacy

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

* Pharmacies that supply drugs for home infusion therapy. [The plan 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 or intermediate care facility (ICF).
  + Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility’s pharmacy.
  + If your long-term care facility’s pharmacy is not in our network, or you have any difficulty accessing your drug benefits in a long-term care facility, please contact your Care Manager or Participant Services. [The plan 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. [The plan may insert additional information about I/T/U pharmacy services in the plan’s network.]
* Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, you can look in the *Provider and* *Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

## A6. Using mail-order services to get your drugs

[If the plan does not offer mail-order services, replace the information in this section with the following sentence: This plan does not offer mail-order services.]

## A7. Getting a long-term supply of drugs

[If the plan does 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.

[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. The *Provider and* *Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Participant Services or your Care Manager for more information.

## A8. Using a pharmacy that is not in the plan’s network

Generally, we 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 Participant of our plan.] In these cases, please check first with Member Services to find out if there is a network pharmacy nearby. [Insert if applicable: You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.]

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

[The plan should insert a list of situations when they will cover prescriptions out of the network (e.g., during a declared disaster) 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).]

## A9. Paying you back if you pay for a prescription

Sometimes a pharmacy that is not in the plan’s network will require you to pay the full cost for the drug and seek payment from us. You can ask <plan name> to pay you back.

To learn more about this, refer to Chapter 7 [plan 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 generally cover a drug on the plan’s *Drug List* as long as you follow the rules explained in this chapter.

[*A plan that offers indication-based formulary design must include:* If we cover a drug only for some medical conditions, it is clearly identified on our *Drug List* and in Medicare Plan Finder along with the specific medical conditions that are covered.]

## B1. Drugs on the *Drug List*

The *Drug List* includes the drugs covered under Medicare Part D and some prescription and OTC drugs [insert if applicable: and items] covered under your Medicaid benefits.

[Insert if offering indication-based formulary design: Certain drugs may be covered for some medical conditions but are considered non-formulary for other medical conditions. These drugs will be identified on our Drug List and in Medicare Plan Finder, along with the specific medical condition that they cover.]

The *Drug List* includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the *Drug List*, when we refer to “drugs,” this could mean a drug or a biological product such as vaccines or insulin.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as brand name drugs orbiological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternativesfor some biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to Chapter 12 for definitions of the types of drugs that may be on the Drug List.

Our plan also covers certain OTC drugs [insert if applicable: and products]. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Participant Services or your Care Manager.

## B2. How to find a drug 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* we sent you in the mail.
* Visit the plan’s website at <URL>. The *Drug List* on the website is always the most current one.
* Call Participant Services to find out if a drug is on the plan’s *Drug List* or to ask for a copy of the list.
* Use our “Real Time Benefit Tool” at <URL> or call [insert if applicable: your care coordinator or] Participant Services. With this tool you can search for drugs on the *Drug List* to get an estimate of what you will pay and if there are alternative drugs on the *Drug List* that could treat the same condition. [Plans may insert additional information about the Real Time Benefit Tool such as rewards and incentives which may be offered to enrollees who use the “Real Time Benefit Tool.”]

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

## B3. Drugs that are not on the *Drug List*

The plan does not cover all prescription drugs or all OTC 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 should remove or modify language regarding benefit exclusions when the benefits are covered by the plan under the Medicaid program.]

<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 because of your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9 [plan may insert reference, as applicable].)

Here are three general rules for excluded drugs:

1. Our plan’s outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by <plan name> for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. [The plan 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 either approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid. [Plan should modify the list below and delete drugs that are covered by Medicaid or 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

## B4. *Drug List* tiers

Every drug on the plan’s *Drug List* is in one of <number of tiers> tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs).

[Plan must briefly describe each tier (e.g., Tier 1 includes generic 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 2016 Final Call Letter. Indicate which is the lowest tier and which is the highest tier.]

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

# Limits on some drugs

For certain prescription and covered OTC drugs, special rules limit how and when the plan covers them. 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 plan expects your provider to prescribe the lower-cost drug.

**If there is a special rule for your drug, it usually means that the prescribing provider will have to give us or your IDT extra information, or 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 the rule should not apply to your situation, you should ask <plan name> or your IDT to make an exception. <Plan name> or your IDT may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to Chapter 9 [plan may insert reference, as applicable].

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

1. Limiting use of a brand name drug [insert as applicable: or original biological products] when [insert as applicable: , respectively,] a generic [insert as applicable: or interchangeable biosimilar] 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 [insert as applicable: , respectively,] the generic version.

* We usually will not pay for the brand name drug when there is a generic version.
* However, if your provider has told us or your IDT the medical reason that the generic drug and other covered drugs that treat the same condition will not work for you and has written “DAW” (Dispense as Written) on your prescription for a brand name drug, then <plan name> or your IDT will approve the brand name drug.

1. Getting plan or IDT approval in advance

For some drugs, you or your prescriber must get approval from the plan or your IDT, based on specific rules, before you fill your prescription. If you don’t get approval, we may not cover the drug. Your IDT may approve drugs as part of your Life Plan or you can ask <plan name> for approval.

During the first [insert time period (must be at least 90 days)] days of your participation in the plan, you do not need the plan or your IDT to approve when you ask for a refill for an existing prescription, even if the drug is not on our *Drug List* or is limited in some way. Refer to section <section letter> for more information about getting a temporary supply.

1. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are 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, <plan name>’s rules may require you to try Drug A first.

If Drug A does not work for you, the plan will then cover Drug B. This is called step therapy.

1. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

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 Participant Services or check our website at <URL>.

# Reasons 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 special rules or limits on coverage for that drug**.** As explained in the section above [plan may insert reference, as applicable], some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask <plan name> or your IDT for an exception to a rule.

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

## D1. Getting 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 <plan name> or your IDT to approve the drug.

**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:

* [Plan may omit this scenario if the plan allows current Participants to ask for formulary exceptions in advance for the following year. Plan may omit this scenario if the plan was not operating in the prior year.]You were in the plan last year.
  + We will cover a temporary supply (or supplies) of your drug **during the first** [**insert time period (must be at least 90 days)**] **days of the calendar year**.
  + This temporary supply (or supplies) will be for up to [insert supply limit (must be the number of days in the plan’s one-month supply)] days.
  + If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of [insert supply limit (must be the number of days in the plan’s one-month supply)] days of medication. You must fill the prescription at a network pharmacy.
  + Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
* You are new to the plan.
  + We will cover a temporary supply of your drug during the first [**insert time period (must be at least 90 days)**] days of your participation in the plan.
  + This temporary supply will be for up to [insert supply limit (must be the number of days in the plan’s one-month supply)] days.
  + If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of [insert supply limit (must be the number of days in the plan’s one-month supply)] days of medication. You must fill the prescription at a network pharmacy.
  + Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
* You have been in the plan for more than [insert time period (must be at least 90 days)] 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)]-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
* [If applicable: Plan must insert their transition policy for current Participants with changes to their level of care.]
  + To ask for a temporary supply of a drug, call Participant Services.

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 Participant 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 <plan name> or your IDT to make an exception. For example, you can ask <plan name> or your IDT to approve a drug even though it is not on the *Drug List*. Or you can ask <plan name> or your IDT to approve and cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

[Plan that does not allow current Participants to ask for an exception prior to the beginning of the following contract year 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 before next year.

* We will tell you about any change in the coverage for your drug for next year. You can then ask us or your IDT to make an exception and cover the drug in the way you would like it to be covered for next year.
* <Plan name> or your IDT will answer when you ask for an exception within 72 hours after we get your request (or your prescriber’s supporting statement).

To learn more about asking for an exception, refer to Chapter 9 [plan may insert reference, as applicable].

If you need help asking for an exception, you can contact Participant Services or your Care Manager.

# Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but <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 (PA) for a drug. (PAis 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, refer to Section C earlier in this chapter.

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 on the market 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.

**What happens if coverage changes for a drug you are taking?**

To get more information on what happens when the *Drug List* changes, you can always:

* Check <plan name>’s up to date *Drug List* online at <URL> **or**
* Call <Participant Services> to check the current *Drug List* at <toll-free number>.

**Changes we may make to the *Drug List* that affect you during the current plan year**

**[*Advance General Notice that plans may make certain immediate generic and biosimilar substitutions:*** *In order to immediately replace brand name drugs or biological products with, respectively, new therapeutically equivalent or new authorized generic drugs or new interchangeable biological products or new unbranded biological products (or to change the tiering or the restrictions, or both, applied if the related drug remains on the formulary), plans that otherwise meet the requirements must provide the following advance general notice of changes:*

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

* **A new generic drug becomes available.** Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the Drug List now. When that happens, we may remove the brand name drug and add the new generic 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 brand name 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 we made once it happens.
* 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 refer to Chapter 9 of this handbook for more information on exceptions.]

[Plans that will not be making any immediate substitutions of new generic drugs should insert the following:

Some changes to the Drug List may include:

* **A new generic drug** [insert as applicable: **or interchangeable biosimilar**] **becomes available.** Sometimes, a new generic drug [insert as applicable: or an interchangeable biosimilar version of the same biological product] comes on the market that works as well as a brand name drug [insert as applicable: or original biological product] on the Drug List now. When that happens, we may remove the brand name drug [insert as applicable: or original biological product] and add the new generic drug [insert as applicable: or an interchangeable biosimilar version of the same biological product], but your cost for the new drug [insert as applicable: or an interchangeable biosimilar] 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 brand name drug [insert as applicable: or original biological product] on the list but change its coverage rules or limits.

When these changes happen, we will:

* + Tell you at least 30 days before we make the change to the Drug List or
  + Let you know and give you a [insert supply limit (must be at least the number of days in the plan’s one-month supply)]-day supply of the brand name drug [insert as applicable: or original biological product] after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

* + If you should switch to the generic [insert as applicable: or interchangeable biosimilar] or if there is a similar drug on the Drug List you can take instead, or
  + Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9 [plans may insert reference, as applicable].]
* **A drug is taken off the market.** If the FDA says a drug you are taking is not safe or effective or the drug’s manufacturer takes a drug off the market, we may immediately take it off the *Drug List*. If you are taking the drug, we will send you a notice after we make the change. [The plan should include information advising Participants what to do after they are notified (e.g., contact the prescribing provider, 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.

When these changes happen, we will:

* Tell you at least 30 days before we make the change to the *Drug List* **or**
* Let you know and give you a [*supply limit (must be at least the number of days in the plan’s one-month supply)*]-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They 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 from these changes to continue covering the drug or the version of the drug you have been taking. To learn more about asking for exceptions, refer to Chapter 9 [plan may insert reference, as applicable].

**Changes to the *Drug List* that do not affect you during the current plan year**

We may make changes to the drugs you take that are not described above and do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking [*insert if applicable:* ,increase what you pay for the drug,] or limit its use, then the change will not affect your use of the drug [*insert if applicable:* or what you pay for the drug] for the rest of the year.

If any of these changes happen for a drug you are taking (except for the changes noted in the section above), the change won’t affect your use until January 1 of the next year.

We will not tell you above these types of changes directly during the current year. You will need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.

# Drug coverage in special cases

## F1. If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing facility or an ICF, 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 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 your Care Manager or Participant Services.

## F2. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

* If you are enrolled in a Medicare hospice and require certain drugs (e.g., pain medication, anti-nausea drugs, laxative, or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
* To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. Refer to the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, refer to Chapter 4 [plan may insert reference, as applicable].

# Programs on drug safety and managing drugs

## G1. Programs to help Participants use drugs safely

Each time you fill a prescription, we look for possible problems, such as drugs errors or drugs that:

* may not be needed because you are taking another similar drug that does the same thing
* may not be safe for your age or gender
* could harm you if you take them at the same time
* have ingredients that you are or may be allergic to
* have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we will notify your Care Manager and have your IDT work with your provider to correct the problem.

## G2. Programs to help Participants manage their drugs

If you take medications for different medical conditions and/or you are in a Drug Management Program to help you use your opioid medications safely, you may be eligible to get services, at no cost to you, through a Medication Therapy Management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

* how to get the most benefit from the drugs you take
* any concerns you have, like medication costs and drug reactions
* how best to take your medications
* any questions or problems you have about your prescription and over‑the‑counter medication

You’ll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You’ll also get a personal medication list that will include all the medications you’re taking and why you take them. In addition, you’ll get information about safe disposal of prescription medications that are controlled substances.

It’s a good idea to schedule your medication review before your yearly “Wellness” visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to Participants that qualify. If we have a program that fits your needs, your IDT will discuss whether you should enroll in the program.

If you have any questions about these programs, please contact Participant Services or your Care Manager.

## G3. Drug management program (DMP) to help Participants safely use their opioid medications

<Plan name> has a program that can help Participants safely use their prescription opioid medications and other medications that are frequently misused. This program is called a DMP.

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, if we decide your use of prescription opioid [insert if applicable: or benzodiazepine] medications is not safe, we may limit how you can get those medications. Limitations may include:

* Requiring you to get all prescriptions for those medications **from <a certain pharmacy** ***or*****certain pharmacies>** and/or **from <a certain prescriber *or*****certain prescribers>**
* **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you’ll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

**You will have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know.** If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9 [The plan may insert reference, as applicable].)

The DMP may not apply to you if you:

* have certain medical conditions, such as cancer or sickle cell disease,
* are getting hospice, palliative, or end-of-life care, **or**
* live in a long-term care facility.