DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

This is important information about your Medicare Part D prescription drug coverage.
Read this notice carefully. For help, call one of the numbers listed on the last page under "For More Information and Help with This Notice."

[Part D Plan Logo]

NOTICE OF INTENT TO LIMIT YOUR ACCESS TO CERTAIN PART D DRUGS

Date: [insert date]

Enrollee's Name: [insert name] Member Number: [insert member ID]

You are getting this notice because [Plan Name] believes your use of prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] may be unsafe. We plan to place you in our drug management program to better manage your use of these medications.

[Insert the following when at least one prescriber has responded:] {*Based on our review and communications with your prescribers(s),* [insert prescriber name(s)], *unless we receive additional information from you or your prescriber(s) that assures us that your use of these medications is safe and appropriate, your access to these medications will change on* [insert date 30 days from the date of this notice]. *The section "What If I Don't Agree?" tells you how to submit this information.*}

[Insert the following when no prescriber has responded:] {*We have contacted your prescriber(s),* [insert prescriber name(s)], *about your use of these medications but have not received a reply. Unless we receive information from you or your prescriber(s) that assures us that your use of these medications is safe and appropriate, your access to these medications will change on* [insert date 30 days from the date of this notice]. *The section "What If I Don't Agree?" tells you how to submit this information.*}

What Action Do We Intend To Take?

As of [insert date 30 days from the date of this notice], we will limit your access in the following way(s):

[Insert the following language as applicable:]

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following prescriber(s):*

[insert name, address and telephone number of prescriber(s)]

We will not cover these medications at the pharmacy when they are prescribed to you by other doctors [MA-PDs insert if applicable: {*even if the other doctor is in our network*}]. *You can ask us to use a different prescriber by calling us or by filling out the form at the end of this notice.*}

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following pharmacy(ies):*

[insert name, address and telephone number of pharmacy(ies)]

We will not cover these medications at another pharmacy, even if the other pharmacy is in the plan's network. You can ask us to use a different pharmacy by calling us or by filling out the form at the end of this notice.}

{*We will only cover the following prescription opioid pain medication(s):* [list medications and amounts, if applicable]

We will not cover any other prescription opioid medications, even if they are included on the plan's drug list.}

{*We will only cover the following amount of prescription opioid pain medication(s):* [describe level that plan will cover]}

{*We will not cover any prescription opioid pain medication, including* [insert beneficiary's opioid medication name(s)]. *This includes opioids that are on the plan's drug list.*}

{*We will only cover the following benzodiazepines:* [list medications and amounts, if applicable]

We will not cover any other benzodiazepines, even if they are included on the plan's drug list.}

{*We will not cover any benzodiazepines, including* [insert beneficiary's benzodiazepine name(s)]. *This includes benzodiazepines that are on the plan's drug list.*}

This change only affects your access to prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. Your access to other types of medications will not change.

[Insert this section for Low Income Subsidy (LIS) beneficiaries:]
{*Can I Change Plans?*
Generally no. As of [insert date of this notice], *you can only change plans during the year in very limited situations, such as if you move out of the plan's service area or you lose or have a change in your Extra Help with your prescription drug costs. You can also change plans during the Annual Enrollment Period which occurs every year from October 15 – December 7.*}

What Is A Drug Management Program?
[Plan Name] has a drug management program to help you use prescription opioids safely. Opioids are a class of drugs that include pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others. Opioid pain medications can help with certain types of pain, but have serious risks like addiction, overdose, and death. These risks are increased when opioids are obtained from multiple doctors or pharmacies, and when opioids are taken with certain other medications like benzodiazepines (commonly used for anxiety and sleep). If we determine that your use of prescription opioids is not safe, we may limit your access to them or to other medications like benzodiazepines.

What If I Don't Agree?
You have the right to give us any information you think is important to our decision about the safety of your medication use.

[Insert this language if prescriber(s) have been non-responsive:] {*If you don't think the limitation(s) described above should apply to you, you should talk to your prescriber(s) about this notice. We*

contacted your prescriber(s), [insert names of prescriber(s)], *about your use of these medications but have not received a reply. Your prescriber(s) can also give us information about why the limitation(s) should not apply to you.*}

[Insert this language if prescriber(s) have been responsive:] {*In making our decision, we got information from your prescriber(s),* [insert names of prescriber(s)]. *If you don't think the limitation(s) described above should apply to you, please tell us why. We have shared a copy of this notice with your prescriber(s). You should also talk to them about this notice and next steps.*}

If you or your prescriber has information you would like us to consider, you can contact us at:

[insert plan phone number, fax and address]

Note: We are not allowed to limit your access under the drug management program if you have cancer, you're in hospice or get palliative or end-of-life care, or you live in a long-term care facility. If you have information you would like us to consider, please call us at the number below within the next 30 days.

[Insert this section for pharmacy and/or prescriber limitation:]
{***What If I Want to Use a Different*** **[insert as appropriate: {*Pharmacy*} or {*Prescriber*}, or {*Pharmacy or Prescriber*}]*?***
If you don't want to use the [insert as appropriate: {*pharmacy*} or {*prescriber*} or {*pharmacy or prescriber*}] *we selected for you, you can ask to use a different one. You can give us this information by completing the last page of this notice and sending it to us, or by calling us at the phone number below.*}

What Happens Next?
We will review any information you send us. We will also review information from your prescriber(s). After we make a decision about whether you are safely using your medications, we will send you another notice within 60 days. If we decide you're at risk and limit your access to these drugs, we'll send you another notice explaining how you, your prescriber, or your representative can ask for an appeal. You will also receive a notice if we decide you're not at risk and will not limit your access to these drugs.

Note: If you change to a different Medicare drug plan, we can give your new plan information about your case and any limitations we place on your access under our drug management program. Your new plan may place you in its drug management program as well.

What Resources Are Available to Help Me Use My Medications Safely?
[MA-PDs insert a statement describing plan benefits related to treatment for prescription drug abuse, including medication assisted treatment, mental health and counseling services covered under the enrollee's Medicare benefit or as a supplemental benefit]
[MMPs insert a statement describing plan benefits related to treatment for prescription drug abuse, including medication assisted treatment, mental health and counseling services covered under the enrollee's Medicare benefit or as a supplemental benefit, as well as any coverage under the enrollee's Medicaid benefit]
[PDPs insert a statement describing plan benefits related to treatment for prescription drug abuse, including medication assisted treatment]

Visit **www.hhs.gov/opioids** for information about State and Federal public health resources that can help you learn more about opioid medications and how to use them safely, including information about mental health services and other counseling services.

For More Information and Help with This Notice
For more information about the drug management program or any of the information in this notice, please contact [Plan Name] at:

Toll Free: [Insert phone number] TTY users: [Insert TTY]
[Insert call center hours of operation]
[Insert plan website]

You may also contact one of the organizations listed below for assistance.

- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

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CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

[PLAN NAME] PHARMACY AND PRESCRIBER SELECTION FORM

Enrollee's Name: [insert name] Member Number: [insert member ID]

You can give us this information by calling us at [insert phone number], faxing this form to us at [insert fax number], or by sending the completed form to: [insert address].

I prefer to use the following pharmacy (choose two):

Choice #1

Pharmacy Name: _____

Address: _____

Telephone Number: _____

Choice #2

Pharmacy Name: _____

Address: _____

Telephone Number: _____

I prefer to use the following prescriber (choose two):

Choice #1

Prescriber Name: _____

Address: _____

Telephone Number: _____

Choice #2

Prescriber Name: _____

Address: _____

Telephone Number: _____