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]

YOUR ACCESS TO CERTAIN PART D DRUGS IS LIMITED

Date: [insert date]

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

[Insert the following language UNLESS the plan is continuing an existing limitation from the enrollee's immediately prior plan:] {*On* [*insert date of initial notice*]*, we told you that we planned to limit your access to prescription* [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *through our drug management program. After completing our review, we have determined that your use of these drugs is unsafe.*}

[If the plan is continuing an existing limitation from the enrollee's immediately prior plan, insert the following language:] {*You are getting this notice because* [Plan Name] *has determined that the limitation(s) on your access to prescription* [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *is unsafe. Based on our review, including information obtained from your previous Medicare Part D plan, we have placed you in our drug management program.*}

What Action Have We Taken?
Effective immediately, your access is limited 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.

Why Did We Make This Decision?
[Provide specific rationale for the plan's decision that the enrollee is an at-risk beneficiary and the limit(s) placed on the enrollee's access to frequently abused drugs under the drug management program. The rationale must include any clinical criteria, Medicare coverage rule, Part D plan policy or other information on which the plan based its decision, including information obtained through case management or subsequent clinical contact with the enrollee's prescriber(s) of frequently abused drugs.

For decisions involving the continuation of a limitation under a drug management program from the enrollee's prior plan: the rationale must include an explanation, as applicable, that the plan's decision to continue the same limitation(s) as the prior plan was based in part on information obtained from the prior plan.]

[Plan Name]'s drug management program helps you use prescription opioids safely. 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).

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.

[Insert this section for Low Income Subsidy (LIS) beneficiaries:]
{*Can I Change Plans?*
Generally no. As of [insert date of initial notice], *you can only change plans during the year in very limited situations, such as 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.*}

[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 If I Don't Agree With This Decision?
You have the right to appeal. You can appeal our decision to limit your access to prescription [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}], as well as any coverage determination made under a drug management program.

If you change to a new Medicare plan, we can give your new plan information about your case and the limits we have put on your access to prescription [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. You also have the right to appeal our sharing of this information with the new plan.

If you want to appeal, **you must request your appeal by [insert date 60 calendar days after the date of this notice].** We can give you more time if you have a good reason for missing the deadline.

Who May Request an Appeal?
You, your prescriber, or your representative may request an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative.

You can call us at [insert toll free plan phone number] to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at TTY [insert TTY].

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours): You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If your prescriber** asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite your appeal.**

- If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an

expedited appeal and we will decide your appeal within 7 days.

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

What Do I Include with My Appeal Request?
You should include your name, address, Member number, the reasons for appealing, and any information you'd like us to consider. You may wish to talk with your prescriber about your appeal.

How Do I Request an Appeal?

For an Expedited Appeal: You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

Phone: [insert toll free phone number]

Fax: [insert fax number]

For a Standard Appeal: You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

[Insert address]

What Happens Next?
If you appeal, we will review your case and give you a decision. If you disagree with any part of our decision, you can request an independent review of your case by a reviewer outside of our plan. If you disagree with that decision, you will have the right to another appeal. You will be notified of your appeal rights if this happens.

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: _____