

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

[Part D Plan Logo]

Date: [insert date]

Enrollee's Name: [insert name]

Member Number: [insert member ID]

On [Insert date of initial notice], we sent you a notice 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 further review, we have decided that your access to these medications will NOT be limited under the drug management program. There are no changes to the way these medications are covered for you under our plan rules.

[Insert this section for Low Income Subsidy (LIS) beneficiaries:]  
*{As of the date of this notice, you're eligible to use the quarterly Medicare Special Enrollment period because you receive Extra Help with your prescription drug costs. You can also change plans during other 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. You can also change plans during the Annual Enrollment Period which occurs every year from October 15 – December 7.}*

If you have questions about this notice or our drug management program to help enrollees use prescription opioid medications safely, contact us at:

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

If you have questions about your opioid pain medication or other prescription drugs you are taking, speak with your prescriber.

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**PRA Disclosure Statement** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0964. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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.