

**This is important information about your Medicare Part D prescription drug coverage. Read this notice carefully.** For help, please contact us. Please see ways to contact us 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 your prior Medicare Part D plan, [Plan Name], had placed you in its drug management program with a limitation(s) on your access to prescription [insert as appropriate: {opioids} or {benzodiazepines} or {opioids and benzodiazepines}] for your safety. Based on our review, including information obtained from your previous plan, we have also placed you in our drug management program. }*

### What Action Have We Taken?

Effective [insert date] and continuing until [insert date], your access to medications 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 prescribers [MA-PDs insert if applicable: {even if the other prescriber is in our network}]. You can ask us to use a different prescriber by contacting 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 contacting 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 limitation(s) placed on the enrollee's access to frequently abused drugs under the drug management program. The rationale must include clinical criteria based on getting opioids from multiple prescribers or pharmacies and/or a recent history of an opioid overdose, 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 prescribers or pharmacies; when opioids are taken with certain other medications like benzodiazepines (commonly used for anxiety and sleep); and/or when a person taking opioids has a recent history of opioid overdose.

Visit [www.hhs.gov/opioids](http://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. Also visit Medicare's website about pain management at <https://www.medicare.gov/coverage/pain-management>.

[PACE organizations omit this section. 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 contacting 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 65 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 we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent 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]

[Insert plan mailing address]

[If the plan has a dedicated line (toll free), staff person, web portal, etc. for its DMP, that information may be included in this section, as applicable.]

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

---

**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-TBD. 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.

[Include the following form when the member has a pharmacy or prescriber limitation pending. This form is not required for point-of-sale edits.]

**{{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 (write in the information for up to two, in order of preference):

Choice #1

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Choice #2

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

I prefer to use the following prescriber (write in the information for up to two, in order of preference):

Choice #1

Prescriber Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Choice #2

Prescriber Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

}