[*Instructions: This model should be used to notify Participants within 3 business days after adjudication of the first temporary fill that they have received a transition supply of a drug because the Part D transition requirements apply.*

*The FIDA-IDD Plan may replace <Plan name> with either “the Plan”, “our Plan”, or “your plan” throughout notice. The FIDA-IDD Plan should use the term “compound” in <list medications here> or <name of drug> when a transition supply applies to a compound.*]

<DATE>

<PARTICIPANT NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <PARTICIPANT NAME>:

This letter is to inform you that <plan name> has provided you with a [*Insert one:* <temporary> *or* <limited>] supply of the following prescription[s]: <list medication[s] here>.

<This/These> drug[s] <is/are> either not included on our List of Covered Drugs (called our formulary, or also the Drug List for short) or included on the Drug List, but subject to certain limits, as described in more detail further below. Our records indicate that you are a [*Insert one:* <new Participant> *or* <current Participant>] affected by Drug List changes implemented this year by <plan name> and that you are within your first 90 days of coverage for this plan year. [*Insert for members who do not reside in an LTC facility:* Therefore, in the outpatient setting, <plan name> is required to provide up to <must be at least 90> days of medication. If your prescription is written for fewer than <must be at least 90> days, we will allow multiple fills to provide up to <must be at least 90> days of medication.] [*Insert for Participants who reside in a LTC facility:* Therefore, for a resident of a long term care facility, <plan name> is required to provide a maximum of [*insert supply limit (must be at least a 91-day supply and may be up to a 98-day supply, depending on the dispensing increment)*] of medication. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum [*insert supply limit (must be at least a 91-day supply and may be up to a 98-day supply*)] of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste).]

It is important that you understand that this is a [*Insert one:* <temporary> *or* <limited>] supply of this drug.

Well before this supply ends, you should speak to <plan name>, your physician, and/or your Interdisciplinary Team (IDT) regarding whether you should change the drug[s] you are currently taking, or request an exception from <plan name> or your IDT to continue coverage of <this/these> drug[s]. You should not assume that any exception you have requested or appealed has been approved just because you get more fills of a drug. When <plan name> or your IDT approves exceptions, we send you written notice.

Contact <plan name> Participant Services or your Care Manager to request an exception. Instructions on how to change your current prescription[s], apply for an exception, and appeal a denial are discussed at the end of the letter.

The following is an explanation of why your drug[s] <is/are> not covered or <is/are> limited under <plan name>.

**[*Note****: Plans may include information about multiple transition supplies on the same notice.*]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is not on our Drug List. We will not continue to pay for this drug after you have received up to <must be at least 90> days of medication that we are required to cover unless you obtain a Drug List exception from <plan name> or your IDT.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is not on our Drug List. In addition, we could not provide the full amount that was prescribed, because we limit the amount of this drug that we provide at one time. This is called quantity limits and we impose such limits for safety reasons. In addition to imposing quantity limits as this drug is dispensed for safety reasons, we will not continue to pay for this drug after you have received up to <must be at least 90> days of medication that we are required to cover unless you obtain a Drug List exception from <plan name> or your IDT.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List, but requires your doctor or other professional who prescribed this drug to satisfy certain requirements before we pay for this drug. This is called prior authorization. Unless you obtain a prior authorization from <plan name> or your IDT, we will not continue to pay for this drug after you have received up to <must be at least 90> days of medication that we are required to cover.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List. However, we will only pay for this drug if you first try other drug(s), specifically <Insert Step 1 drug(s)*>,* as part of what we call a step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. Unless you try the other drug(s) on our Drug List first or you obtain an exception to the step therapy requirement from <plan name> or your IDT, we will not continue to pay for this drug after you have received up to <must be at least 90> days of medication that we are required to cover.]

**[Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List. However, we will only pay for this drug if you first try a generic version of this drug. Unless you try the generic drug on our Drug List first, or you obtain an exception from <plan name> or your IDT, we will not continue to pay for this drug after you have received up to <must be at least 90> days of medication that we are required to cover.]

[***Note****: The following notice is optional, as it technically falls outside the definition of a transition fill. However, we encourage plans to include this in their transition notifications.*]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List. However, we could not provide the full amount that was prescribed because of plan quantity limits. We will not provide more than what our quantity limits permit, which is <insert the QL>, unless you obtain an exception from <plan name> or your IDT. Please contact Participant Services or your Care Manager to discuss the exception process. Our contact information is located below.]

[***Note****: The following notice is for Emergency Fill and Level of Care Change transitions and is optional. However, we encourage plans to notify beneficiaries of Emergency Fill and Level of Care Change Transitions.*]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is not on our Drug List. We will cover this drug for <days supply on filled claim – must be at least 31 days> while you seek to obtain a Drug List exception from <plan name> or your IDT. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made. Please contact Participant Services or your Care Manager for more information regarding our exception process. Our contact information is located below.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List and requires prior authorization. We will cover this drug for <days supply on filled claim –must be at least 31 days> while you seek to obtain an exception to the prior authorization from <plan name> or your IDT. Please contact Participant Services or your Care Manager to discuss the exception process. Our contact information is located below.]

[**Name of Drug**: <name of drug>

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List, but will be covered only if you first try certain other drugs as part of what we call our step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. We will cover this drug for <days supply on filled claim – must be at least 31 days> while you seek to obtain an exception to the step therapy requirement from <Plan name> or your IDT. Please contact <plan name> or your Care Manager to discuss the exception process. Our contact information is located below.]

**How do I change my prescription?**

If your drug[s] <is/are> not on our Drug List, or is on our Drug List, but we have placed a prior authorization, step therapy, or quantity limit on it, you can ask us if we cover another drug used to treat your medical condition and whether that other drug is an option for you. If we cover another drug for your condition, we encourage you to ask your doctor if these drugs that we cover are an option for you. If your doctor tells you that none of the drugs we cover for treating your condition is medically appropriate, you have the right to request an exception from us to cover the drug that was originally prescribed. You also have the right to request an exception if your doctor tells you that a prior authorization, quantity limit, or other limit we have placed on a drug you are taking is not medically appropriate for treating your condition.

**How do I request an exception?**

The first step in requesting an exception to our coverage rules is for you to ask your prescribing doctor to contact us. [*Provide the necessary address, fax number, and phone number*]. Your Care Manager can help you with this.

Your doctor must submit a statement supporting your request. It may be helpful to take this notice with you to the doctor or submit it to his or her office. The doctor’s statement must indicate that the requested drug is medically necessary for treating your condition, because none of the drugs on our Drug List would be as effective as the requested drug or would have adverse effects for you. If the exception request involves a prior authorization, quantity limit, or other limit <plan name> has placed on a Drug List drug, the doctor’s statement must indicate that the prior authorization, or limit, would not be appropriate given your condition or would have adverse effects for you.

Once the physician's statement is submitted, <plan name> or your IDT must notify you of its decision no later than 24 hours, if the request has been expedited, or no later than 72 hours, if the request is a standard request. Your request will be expedited if <plan name> or your IDT determines, or your doctor indicates, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

**What if my request is denied?**

If your request is denied, you have the right to appeal by asking for a review of the prior decision. You must request this appeal within 60 calendar days from the date of our first decision. <You must file a standard request in writing/we accept standard requests by telephone and in writing. We accept expedited requests by telephone and in writing. Provide the necessary address, fax number, and phone number>. Instructions for filing an appeal are in Chapter 9 of your Participant Handbook or can be provided to you by your Care Manager, Participant Services, or by the FIDA-IDD Participant Ombudsman.

If you need assistance in requesting an exception or for more information about our transition policy (including alternate format or languages regarding this policy), please contact Participant Servicesat <plan name>, at <Toll-free Number> or *<*Toll-free TTY Number>, <Days/Hours of Operation>, or visit <insert web address>.

Sincerely,

<Plan Representative>

<Plan’s legal or marketing name> is a managed care plan that contracts with Medicare, the New York State Department of Health (Medicaid) and the Office for People With Developmental Disabilities to provide benefits to Participants through the Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

Benefits may change on January 1 of each year.

You can get this information for free in other languages. Call <toll-free number> and <TTY/TDD numbers> during <hours of operation>. The call is free. [*This disclaimer must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.*]

You can get this information for free in other formats, such as large print, braille, or audio. Call <toll-free number> and <TTY/TDD numbers> during <hours of operation>. The call is free.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 (TTY users, call 711) or online at icannys.org.