Chapter 5: Getting your outpatient prescription drugs and other covered medications through the plan

[The Plan should refer Participants to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1." An instruction [plan may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

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Introduction

This chapter explains rules for getting your *outpatient prescription drugs and other covered medications.* These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medicaid.

<Plan name> also covers the following drugs, although they will not be discussed in this chapter:

* Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
* Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Covered Items and Services Chart in Chapter 4 [the plan may insert reference, as applicable].

## Rules for the plan’s outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. A written prescription is required for both prescription and over-the-counter (OTC) drugs.
2. You generally must use a network pharmacy to fill your prescription unless <plan name> or your Interdisciplinary Team (IDT) has authorized you to use an out-of-network pharmacy.
3. Your prescribed drug must be on the plan’s *List of Covered Drugs*. We call it the “Drug List” for short.

* If it is not on the Drug List, we may be able to cover it by giving you an exception. See page <page number> [the plan may insert reference, as applicable] to learn about asking for an exception.

1. Your drug must be used for a *medically accepted indication.* This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books. [The plan should add definition of “medically accepted indication” as appropriate for Medicaid-covered drugs and items.]

# Getting your prescriptions filled

## Fill your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions *only* if they are filled at the plan’s network pharmacies. A *network pharmacy* is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

## Show your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription or over-the-counter (OTC) drug.

If you do not have your plan ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, *you may have to pay the full cost of the prescription when you pick it up.* You can then ask <plan name> to pay you back. If you cannot pay for the drug, contact Participant Services right away. We will do what we can to help.

To learn how to ask us to pay you back, see Chapter 7 [the plan may insert reference, as applicable].

If you need help getting a prescription filled, you can contact Participant Services or your Care Manager.

## What if you want to change to a different network pharmacy?

[The plan in which Participants do not need to take any action to change their pharmacies may delete the following sentence.] If you change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new pharmacy.

If you need help changing your network pharmacy, you can contact Participant Services or your Care Manager.

## What if the pharmacy you use leaves the network?

If the pharmacy you use leaves the plan’s network, you will have to find a new network pharmacy.

To find a new network pharmacy, you can look in the *Provider and* *Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

## What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a *specialized pharmacy.* Specialized pharmacies include:

* Pharmacies that supply drugs for home infusion therapy. [The plan may insert additional information about home infusion pharmacy services in the plan’s network.]
* Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing or intermediate care facility. Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility’s pharmacy. If your long-term care facility’s pharmacy is not in our network, or you have any difficulty accessing your drug benefits in a long-term care facility, please contact your Care Manager or Participant Services. [The plan may insert additional information about LTC pharmacy services in the plan’s network.]
* Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies. [The plan may insert additional information about I/T/U pharmacy services in the plan’s network.]
* Pharmacies that supply drugs requiring special handling and instructions on their use.

To find a specialized pharmacy, you can look in the *Provider and* *Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

## Can you use mail-order services to get your drugs?

This plan does not offer mail-order services.

**Can you get a long-term supply of drugs?**

[If the plan does not offer extended-day supplies, replace the information in this section with the following sentence: This plan does not offer long-term supplies of drugs.]

You can get a long-term supply of *maintenance drugs* on our plan’s Drug List. *Maintenance drugs* are drugs that you take on a regular basis, for a chronic or long-term medical condition.

[Delete if plan does not offer extended-day supplies through network pharmacies.] Some network pharmacies allow you to get a long-term supply of maintenance drugs. The *Provider and* *Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Participant Services or your Care Manager for more information.

## Can you use a pharmacy that is not in the plan’s network?

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. [Insert as applicable: We have network pharmacies outside of our service area where you can get your prescriptions filled as a Participant of our plan.]

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

* [The plan should insert a list of situations when they will cover prescriptions out of the network (e.g., during a declared disaster) and any limits on their out-of-network policies (e.g., day supply limits, use of mail-order during extended out-of-area travel, authorization or plan notification).]

In these cases, please check first with Participant Services to see if there is a network pharmacy nearby.

## Will the plan pay you back if you pay for a prescription at a pharmacy not in the plan’s network?

Sometimes a pharmacy that is not in the plan’s network will require you to pay the full cost for the drug and seek payment from us. You can ask <plan name> to pay you back.

To learn more about this, see Chapter 7 [plan may insert reference, as applicable].

# The plan’s Drug List

The plan has a *List of Covered Drugs.* We call it the “Drug List” for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan’s Drug List as long as you follow the rules explained in this chapter.

## What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs [insert if applicable: and items] covered under your Medicaid benefits.

The Drug List includes both brand-name and *generic* drugs.Generic drugs have the same active ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

Our plan also covers certain over-the-counter drugs [insert if applicable: and products]. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Participant Services or your Care Manager.

## How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the Drug List, you can:

* Check the most recent Drug List we sent you in the mail.
* Visit the plan’s website at <web address>. The Drug List on the website is always the most current one.
* Call Participant Services to find out if a drug is on the plan’s Drug List or to ask for a copy of the list.

[Plan may insert additional ways to find out if a drug is on the Drug List.]

## What is *not* on the Drug List?

The plan does not cover all prescription drugs or all over-the-counter (OTC) drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

[Plan should remove or modify language regarding benefit exclusions when the benefits are covered by the plan under the Medicaid program.]

<Plan name> will *not* pay for the drugs listed in this section [insert if applicable: except for certain drugs covered under our enhanced drug coverage]. These are called *excluded drugs.* If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9 [plan may insert reference, as applicable].)

Here are three general rules for excluded drugs:

* Our plan’s outpatient drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B. Drugs that would be covered under Medicare Part A or Part B are covered under our plan’s medical benefit.
* Our plan cannot cover a drug purchased outside the United States and its territories.
* [Plan may modify this paragraph to reflect the degree to which the Medicaid program wraps around non-Part D drugs.] The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called *off-label use.* Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid. [Plan should modify the list below and delete drugs that are covered by Medicaid or by the plan’s enhanced drug coverage.]

* Drugs used to promote fertility
* Drugs used for cosmetic purposes or to promote hair growth
* Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
* Drugs used for treatment of anorexia, weight loss, or weight gain
* Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

## What are tiers?

Every drug on the plan’s Drug List is in one of <number of tiers> tiers.

* [Plan should briefly describe each tier (e.g., Cost Sharing Tier 1 includes generic drugs). *Plan must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the CY 2016 Final Call Letter.* Indicate which is the lowest tier and which is the highest tier.]

To find out which tier your drug is in, look for the drug in the plan’s Drug List.

# Limits on coverage for some drugs

## Why do some drugs have limits?

For certain prescription and covered over-the-counter (OTC) drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plans expects your provider to prescribe the lower-cost drug.

**If there is a special rule for your drug, it usually means that the prescribing provider will have to give us or your Interdisciplinary Team (IDT) extra information, or you or your provider will have to take extra steps for us to cover the drug.** For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks the rule should not apply to your situation, you should ask <plan name> or your IDT to make an exception. <Plan name> or your IDT may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, see Chapter 9 [plan may insert reference, as applicable].

## What kinds of rules are there?

[Plan should include only the forms of utilization management used by the plan:]

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. [Insert as applicable: In most cases, if **or** If] there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider has told us or your IDT the medical reason that the generic drug and other covered drugs that treat the same condition will not work for you and has written “DAW” (Dispense as Written) on your prescription for a brand-name drug, then <plan name> or your IDT will approve the brand-name drug.

1. Getting plan or IDT approval in advance

For some drugs, you or your doctor must get approval from the plan or your IDT before you fill your prescription. If you don’t get approval, we may not cover the drug. Your IDT may approve drugs as part of your Life Plan (LP) or you can ask <plan name> for approval.

During the first [insert time period (must be at least 90 days)] days of your membership in the plan, you do not need the plan or your IDT to approve a refill request for an existing prescription, even if the drug is not on our Drug List or is limited in some way. See page <page number> for more information about getting a temporary supply.

1. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, <plan name>’s rules may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This is called *step therapy*.

1. Quantity limits

For some drugs, we limit the amount of the drug you can have. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

## Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the   
Drug List. For the most up-to-date information, call Participant Services or check our website at <web address>.

# Why your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

* **The drug you want to take is not covered by the plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
* **The drug is covered, but there are special rules or limits on coverage for that drug.** As explained in the section above [plan may insert reference, as applicable], some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask <plan name> or your Interdisciplinary Team (IDT) for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

## You can get a temporary supply

In some cases,the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask <plan name> or your IDT to approve the drug.

**To get a temporary supply of a drug, you must meet the two rules below:**

1. The drug you have been taking:

* is no longer on the plan’s Drug List, ***or***
* was never on the plan’s Drug List, ***or***
* is now limited in some way.

1. You must be in one of these situations:

* [Plan may omit this scenario if the plan allows current members to request formulary exceptions in advance for the following year. Plan may omit this scenario if the plan was not operating in the prior year.]**You were in the plan last year and do not live in a long-term care facility.**

We will cover a temporary supply (or supplies) of your drug **during the first** **[insert time period (must be at least 90 days)] days of the calendar year**. This temporary supply or supplies will be for up to [insert time period (must be at least 90 days)] days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of [insert time period (must be at least 90 days)] days of medication. You must fill the prescription at a network pharmacy.

* **You are new to the plan and do not live in a long-term care facility.**

We will cover a temporary supply (or supplies) of your drug **during the first [insert time period (must be at least 90 days)] days of your membership** in the plan. This temporary supply will be for up to [insert time period (must be at least 90 days)] days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of [insert time period (must be at least 90 days)] days of medication. You must fill the prescription at a network pharmacy.

* **You are new to the plan and live in a long-term care facility.**

We will cover a temporary supply (or supplies)of your drug **during the first** **[insert time period (must be at least 90 days)] days of your membership** in the plan. The total supply will be for up to [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)] days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of [insert time period (must be at least a 91 days)]daysof medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

* **You have been in the plan for more than** **[insert time period (must be at least 90 days)] days and live in a long-term care facility and need a supply right away.**

We will cover one [insert supply limit (must be at least a 31-day supply)]-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

* [If applicable: Plan must insert their transition policy for current members with changes to their level of care.]

To ask for a temporary supply of a drug, call Participant Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

* **You can change to another drug.**

There may be a different drug covered by the plan that works for you. You can call Participant Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

**OR**

* **You can ask for an exception.**

You and your provider can ask <plan name> or your IDT to make an exception. For example, you can ask <plan name> or your IDT to approve a drug even though it is not on the Drug List. Or you can ask <plan name> or your IDT to approve and cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

[Plan that does not allow current members to request an exception prior to the beginning of the following contract year may omit this paragraph:] If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year. We will tell you about any change in the coverage for your drug for next year. You can then ask us or your IDT to make an exception and cover the drug in the way you would like it to be covered for next year. <Plan name> or your IDT will answer your request for an exception within 72 hours after we receive your request (or your prescriber’s supporting statement).

To learn more about asking for an exception, see Chapter 9 [plan may insert reference, as applicable].

If you need help asking for an exception, you can contact Participant Services or your Care Manager.

# Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. The plan might:

* Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
* Remove drugs because they were recalled or because cheaper drugs work just as well.
* Add or remove a limit on coverage for a drug.
* Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

* We put a new limit on your use of the drug.
* We remove your drug from the Drug List, but not because of a recall or because a new generic drug has replaced it.

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. The changes will affect you on January 1 of the next year.

In the following cases, you *will* be affected by the coverage change before January 1:

* If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days’ notice about the change.
* The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
* You should work with your Care Manager or your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
* You and your Care Manager or your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9 [plans may insert reference, as applicable].
* If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
* Your Care Manager and your provider will also know about this change. He or she can work with you to find another drug for your condition.

If there is a change to coverage for a drug you are taking, **the plan will send you a notice.** Normally, the plan will let you know at least 60 days before the change.

# Drug coverage in special cases

## If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing or an intermediate care facility, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility’s pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility’s pharmacy is part of our network. If it is not, or if you need more information, please contact your Care Manager or Participant Services.

## If you are in a long-term care facility and become a new member of the plan

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply or multiple temporary supplies up to [insert time period (must be at least 91 and may be up to 98 days]days when you request a refill during the first *[insert time period (must be at least 90 days)*] of your membership.

If you have been a member of the plan for more than [insert time period (must be at least 90 days)] and you need a drug that is not on our Drug List, we will cover one [insert supply limit (must be at least a 31-day supply)]-day supply. We will also cover one [insert supply limit (must be at least a 31-day supply)]-day supply if the plan has a limit on the drug’s coverage. If your prescription is written for fewer than [insert supply limit] days, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your Care Manager or your provider to decide what to do when your supply runs out. A different drug covered by the plan might work just as well for you. Or you and your Care Manager or your provider can ask the plan to make an exception and cover the drug in the way you would like it to be covered.

To learn more about asking for exceptions, see Chapter 9 [plan may insert reference, as applicable].

## If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, see Chapter 4 [plan may insert reference, as applicable].

# Programs on drug safety and managing drugs

## Programs to help Participants use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

* Drug errors
* Drugs that may not be needed because you are taking another drug that does the same thing
* Drugs that may not be safe for your age or gender
* Drugs that could harm you if you take them at the same time
* Drugs that are made of things you are allergic to

If we see a possible problem in your use of prescription drugs, we will notify your Care Manager and have your Interdisciplinary Team (IDT) work with your provider to correct the problem.

## Programs to help Participants manage their drugs

If you take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

* How to get the most benefit from the drugs you take
* Any concerns you have, like medication costs and drug reactions
* How best to take your medications
* Any questions or problems you have about your prescription and over‑the‑counter medication

You’ll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You’ll also get a personal medication list that will include all the medications you’re taking and why you take them.

It’s a good idea to schedule your medication review before your yearly “Wellness” visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to Participants that qualify. If we have a program that fits your needs, your Interdisciplinary Team (IDT) will discuss whether you should enroll in the program.

If you have any questions about these programs, please contact Participant Services or your Care Manager.