*[****Note****: Optional language and guidance appears in bracketed and italicized text. All variable, required fields are denoted by carets and must be populated with Plan-specific information].*

*[All references to Member Services and Pharmacy Directory can be changed to the appropriate name your plan uses.]*

*[When indicated as “mandatory” sponsors must provide the name by which their plan is known (HPMS marketing name). In all other instances, sponsors may replace <plan name> as appropriate with “plan” or “our plan” and may use those terms interchangeably. Sponsors may also use the terms* “we,” “us”, or “our,” to refer to themselves*. Sponsors may correct plural and singular references as appropriate (such as pharmacy versus pharmacies). Sponsors should consult the Medicare Marketing Guidelines, as well as the most recent applicable chapters of the Prescription Drug Benefit Manual (PDBM) for more information on marketing, benefits and beneficiary protections, beneficiary communications, and formularies (these would include PDBM chapters 5 and 6).]*

*[COVER PAGE:*

*The following items must appear on the cover page:]*

**<*mandatory* Plan Name>**

### <Year> Pharmacy Directory

*The following contact and revision date information is expected to appear on both the front and back covers of the document:* [*Insert one*: <This pharmacy directory was updated on <MM/YYYY> .> *or <*We have made no changes to this pharmacy directory since MM/DD/YYYY.>] For more recent information or other questions, please contact [*optional* <us>,] <*mandatory* Plan or Sponsor Name> [*optional* <Member Services>,] at <Toll-free Number> or, for TTY users, <Toll-free TTY Number>, <Days/Hours of Operation>, or visit <insert web address>.

*[The rest of the language need not appear on the cover page.]*

Introduction

This booklet provides a list of <Plan Name>’s network pharmacies. To get a complete description of your prescription coverage, including how to fill your prescriptions, please review the Evidence of Coverage and <*mandatory* Plan Name>’s formulary.

[Optional: When this pharmacy directory refers to “we,” “us”, or “our,” it means <sponsor name>. When it refers to “plan” or “our plan,” it means <mandatory plan name>.]

We call the pharmacies on this list our “network pharmacies” because we have made arrangements with them to provide prescription drugs to Plan members. In most cases, your prescriptions are covered under <Plan Name> only if they are filled at a network pharmacy [or through our mail order pharmacy service]. Once you go to one pharmacy, you are not required to continue going to the same pharmacy to fill your prescription but can switch to any other of our network pharmacies. We will fill prescriptions at non-network pharmacies under certain circumstances as described in your Evidence of Coverage.

All network pharmacies may not be listed in this directory. Pharmacies may have been added or removed from the list after this directory was printed. This means the pharmacies listed here may no longer be in our network, or there may be newer pharmacies in our network that are not listed. This list is current as of <*insert date name*>. For the most current list, please contact us. Our contact information appears on the front and back cover pages.

*[Include if plan has network pharmacies that offer preferred cost-sharing :* “You can go to all the pharmacies on this list, but your costs for some drugs may be less at pharmacies in this list that offer preferred cost-sharing. We have marked these pharmacies with [insert identification method, such as asterisk (\*) or “P”, etc.]. to distinguish them from other pharmacies in our network that offer standard cost-sharing. *[Note: If applicable, describe restrictions imposed on members that use pharmacies that offer standard cost-sharing.]”]*

[*Include if plan has network pharmacies that offer mail order services:* You can get prescription drugs shipped to your home through our network mail order delivery program [*optional*“which is called *“*[*insert <*name>*.*]*”*For more information, please contact us or see the mail order section of this pharmacy directory.]

[*If this directory is a subset of a service area, sponsors must include the following:* “This directory is for <geographic area> which includes the area in which you live. However, we cover a larger service area, and there are more pharmacies where your prescriptions may be covered by our Plan. For information on more pharmacies in our plan network not listed in this directory [*insert contact information*.]”]

[*If a pharmacy directory lists pharmacies in its network that are outside of the service area, the sponsor must include the following*: “We also list pharmacies that are in our network but are outside <geographic area>, the area in which you live. You may also fill your prescriptions at these pharmacies. For more information, please see the section in this pharmacy directory on <Network Pharmacies outside the <geographic area> or [*insert contact information*.]”]

If you have questions about any of the above, please see the first and last cover pages of this directory for information on how to contact <us *or* Plan Name>.

***[Recommended organization:***

***Type of Pharmacy*** *(Retail, Mail Order, Home Infusion, LTC, I/T/U)*

***State*** *(Include only if directory includes multiple states)*

***County*** *(Listed alphabetically)*

***City*** *(Listed alphabetically)*

***Neighborhood/Zip Code*** *(Listed Numerically) Optional; For larger cities, pharmacies may be further subdivided by zip code or neighborhood)*

***Pharmacy*** *(Listed alphabetically)*

*[****Note:*** *Plans must indicate how types of pharmacies can be identified and located relative to organizational format.*]

[***Note:*** *Plans must indicate when a pharmacy is not available to all members. If symbols are used, a legend must be provided.]*

[***Note:*** *Plans must indicate when a pharmacy is a pharmacy that offers preferred cost-sharing . If symbols are used, a legend must be provided.]*

*[****Optional:*** *Plans may indicate network pharmacies that support electronic prescribing.]*

## [Retail Pharmacies, including Chain Pharmacies

<Pharmacy Name>

<Pharmacy Street Address, City, State, Zip Code>

<Phone Number>

*Note: Sponsors are expected to create one alphabetical list integrating both retail and chain pharmacies but the information supplied may vary for retail versus chain pharmacies.*

*Sponsors are required to provide the address and phone number for independent (non-chain) pharmacies.*

* *For chain pharmacies only, in lieu of providing addresses for all locations, sponsors may provide, as shown directly below, a toll-free customer service number and a TTY number that an enrollee can call to get the locations and phone numbers of the chain pharmacies nearest his or her home. If the chain pharmacy does not have a toll-free number, sponsors should include a central number for the pharmacy chain. If the chain pharmacy does not have a central number for enrollees to call, then sponsors must list each plan’s chain pharmacy and phone number in the directory. If the chain pharmacy does not have a TTY/ number, sponsors are instructed to list the TRS Relay number 711. A sponsor should not list its Member Services number as a pharmacy phone number or TTY/ number.*
* *Sponsors that choose to provide phone numbers for all the chains are expected to be consistent and also provide TTY phone numbers for independent retail pharmacies. This would include accessibility numbers; however, we do not require that sponsors research whether every retail pharmacy has a TTY or not, so long as the pharmacy directory clearly indicates for every retail pharmacy, including chains, a pathway for hearing impaired, which could be 711.*

*[****Optional:*** *<Web and e-mail addresses>]*

*[****Optional:*** <*Special Services:>]* *[****Note:*** *Examples of special services include: Home Delivery, Drive Thru, Compounds Prepared.]*

***[Note:*** *Indicate whether the pharmacy provides an extended day supply of medications]*

***[Optional:*** <*Days/Hours of Operation>] [****Note:*** *You may also indicate if a pharmacy is open 7 days per week and/or 24 hours per day.][****Optional:*** *Plans may indicate network pharmacies that support electronic prescribing.]*

*[****Note:*** *You may indicate special services/hours of operation with symbols, although text is preferred. If symbols are used, a legend must be provided. For example, you may use a clock to indicate that a pharmacy is open 24 hours per day, however, it is easier for readers if the directory simply states, “Open 24 hours.”*]

## Mail Order Pharmacy[ies]

## [optional: insert <Name of Mail Order Program>]

## <Pharmacy Name>

<Phone Number>

***[Optional:*** *Web and e-mail address >*]

*[****Optional:*** *Plans may indicate network pharmacies that support electronic prescribing.]*

*Sponsors of all plans offering mail order programs should insert the below language.*]

You can get prescription drugs shipped to your home through our network mail order delivery program [*optional*“which is called *“[insert <*name of program>*”].*

[S*ponsors of* *plans whose network mail order services received a CMS exception to deliver new prescriptions without obtaining prior beneficiary consent insert the following:*] If you have used mail order services with your current plan before, or if you opt in now, our pharmacy will automatically fill and shipnew prescriptions received directly from your doctors or other prescribers. You may opt out of automatic deliveries of new prescriptions at any time by contacting us [*optional insert contact information*].If you never had mail order delivery and/or decide to stop automatic fills of new prescriptions, we will contact you each time we get a new prescription from a provider, to see if you want the medication filled and shipped at that time. This will give you an opportunity to make sure that the correct drug (including strength, amount, and form) will be delivered, and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped.

*[Sponsors that do not offer a program that automatically process mail order refills, insert the following.]*

For refills of your mail order prescriptions, please contact us *[insert recommended number of days]* days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

*[Sponsors that offer a program that automatically processes mail order refills, insert the following.]*

For refills of your mail order prescriptions, you have the option to sign up for an automatic refill program [*optional: insert auto refill program name*]. Under this program, we will start to process your next refill automatically when our records show that you should be close to running out of your drug. We will contact you prior to shipping each refill to make sure you are in need of more medication. You can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use the auto refill program, please contact us *[insert recommended number of days]* before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time. To opt out of the automatic refill program, please contact us by *[insert instructions here].*

[*Sponsors of all plans offering mail order programs should insert the following sentences. Sponsors have the option to insert either*<business> *or <*calendar> *or neither in front of “****days****”.*]  Typically, you should expect to receive your prescription drugs[*sponsors have the option to insert either*“within [*insert “<*number> days”] *OR*“from[*insert <*number>] to [*insert<*number> days”]from the time that the mail order pharmacy receives the order.If you do not receive your prescription drug(s) within this time, please contact us at [*insert* *<*Toll-free number and TTY number/TRS Relay number 711*> and optionally other contact information*].

## Home Infusion Pharmacies

*<****Note:*** *Plans should provide any additional information on home infusion pharmacy services in their network and how enrollees can get more information.* >

<Pharmacy Name>

<Pharmacy Street Address, City, State, Zip Code>

<Phone Number>

***[Optional: <****Web and e-mail address>*]

*[****Optional:*** *Plans may indicate network pharmacies that support electronic prescribing.]*

## Long-Term Care Pharmacies

Residents of a long-term care facility may access their prescription drugs covered under <Plan Name> through the facility’s long-term care pharmacy or another network long-term care pharmacy.

*<****Note:*** *Plans should provide any additional information on long-term care pharmacy services in their network and how enrollees can get more information.* >

<Pharmacy/Long-Term Facility Name>

<Pharmacy Street Address, City, State, Zip Code>

<Phone Number>

***[Optional:*** *<Web and e-mail address>*]

*[****Optional:*** *Plans may indicate network pharmacies that support electronic prescribing.]*

## [Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through <Plan Name>’s pharmacy network. Those other than Native Americans and Alaskan Natives may be able to access these pharmacies under limited circumstances (e.g., emergencies).

*<****Note:*** *Plans should provide any additional information on I/T/U pharmacy services in their network and how enrollees can get more information>*

<Pharmacy Name>

<Pharmacy Street Address, City, State, Zip Code>

<Phone Number>

***[Optional:*** *<Web and e-mail address>*]

***[Optional:*** *<Special Services:>] [****Note:*** *This field is optional. Examples of special services include: Home Delivery, Drive Thru, Compounds Prepared].*

***[Optional:*** <*Days/Hours of Operation>] [****Note:*** *You may also indicate if a pharmacy is open 24 hours a day and/or 7 days per week.*]

*[****Optional:*** *Plans may indicate network pharmacies that support electronic prescribing.]*

**[Network Pharmacies outside the <Geographic Area>]**

[We have network pharmacies outside of the service area where you can get your drugs covered as a member of our plan.]

<Pharmacy Name>

<Pharmacy Street Address, City, State, Zip Code>

<Phone Number>

*[****Optional: <****Web and e-mail addresses >]*

*[****Optional:*** *Plans may indicate network pharmacies that support electronic prescribing.]]*

**[*Optional:* *Create categories for additional types of network pharmacies not encompassed in the categories above*]**

<Pharmacy Name>

<Pharmacy Street Address, City, State, Zip Code>

<Phone Number>

*[****Optional: <****Web and e-mail addresses >]*

*[****Optional:*** *Plans may indicate network pharmacies that support electronic prescribing.]]*

*[Appropriate language, including disclaimers, is expected to appear in this document on topics including: pharmacy disclaimers including mail order (MMG §50.15); Federal contracting (MMG §50.1); material ID Number (MMG §40.1); non-English translations (MMG §50.4); pharmacy directory (MMG §60.4).]*

*[BACK COVER]*

*[Please see the front cover for information that must also appear on the back cover.]*