[*Instructions:**This model should be used when a Participant is entitled to a provisional supply and the transition requirement is also triggered.*

*The FIDA Plan may replace <Plan name> with either “the Plan”, “our Plan”, or “your plan” throughout notice. The FIDA Plan should use the term “compound” in <DRUG NAME(s)> when a provisional supply applies to a compound.*]

**Notice about Two Part D Coverage Issues**

**for Your <DRUG NAME(s)> Prescription(s)**

<DATE>

<PARTICIPANT NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <PARTICIPANT NAME>:

We want to tell you about 2 important coverage issues for the following prescription(s):

**Name of Drug(s)**: <DRUG NAME(s)>

**Date(s) Filled**: <DATE FILLED>

**Prescribed by**: <PRESCRIBER NAME>

There are **2 separate issues** that both need your attention. To continue coverage for your prescription for <DRUG NAME(s)> from <PRESCRIBER NAME>, you’ll need to address both of these issues:

**Issue 1: <This/These> drug(s) <is/are> either not on our list of covered drugs (called our formulary or also the Drug List for short) or <it’s/they’re> included on the Drug List, but subject to certain limits, as described in more detail later in this letter.** <PLAN NAME> is required to provide you with a temporary supply of <this/these> drug(s). After you have received a <transition supply limit, must be at least 90> days’ temporary supply, we’ll stop paying for <this/these> drug(s), unless you change to <another/other> drug(s) on our Drug List, demonstrate you meet our criteria, or are granted an exception. (See page <PAGE #> of this letter to find out what you can do about this issue.)

**Issue 2: Your provider isn’t enrolled in Medicare.** Even if you change to <another/other> drug(s) on our Drug List or get an approval for <this/these> drug(s), <PLAN NAME> can only cover prescriptions for <this/these> drug(s) from <PRESCRIBER NAME> up to a 3-month supply or until <**DATE**>, whichever comes first, unless <PRESCRIBER NAME> enrolls in Medicare. (See page <PAGE #> of this letter to find out what you can do about this issue.)

Read the following pages to find more information about each of these issues, and the steps you can take to fix them. After reading this letter, if you still have questions or need help, contact:

* <PLAN NAME> Participant Services at <toll-free phone and TTY/TDD numbers>, <days and hours of operation>.
* The Independent Consumer Advocacy Network (ICAN) toll-free at 1-844-614-8800 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)
* Medicare at 1-800-MEDICARE (1-800-633-4227), anytime, 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.

Sincerely,

<Plan Representative>

**ISSUE 1: Your Drug(s) <is/ARE> Not on our DRUG LIST OR <IS/ARE> SUBJECT TO CERTAIN LIMITS**

**What is Issue 1?**

We want to tell you that <PLAN NAME> has provided you with a temporary supply of the following prescription(s): <list medications(s) here>.

<This/These> drug(s) <is/are> either not included on our Drug List or <it’s/they’re> included on the Drug List but subject to certain limits, as described in more detail later in this letter. <PLAN NAME> is required to provide you with a temporary supply of <this/these> drug(s), as follows:

[*Insert for Participants who do not reside in an LTC facility*: In the outpatient setting, we’re required to provide up to <must be at least 90> days of medication. If your prescription is written for fewer days, we’ll allow multiple fills to provide up to <must be at least 90> days of medication.].

[*Insert for Participants who reside in an LTC facility*: For a resident of a long-term care facility, we’re 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 dispensing increment)*] of medication. If your prescription is written for fewer days, we’ll 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 to prevent waste).]

It’s important that you understand that this is a temporary supply of <this/these> drug(s). Well before you run out of <this/these> drug(s), you should speak to <PLAN NAME>, the prescriber, and/or your Interdisciplinary Team (IDT) about:

* changing the drug(s) to <another/other> drug(s) that <is/are> on our Drug List; or
* requesting approval for the drug(s) by demonstrating that you meet our criteria for coverage; or
* requesting an exception from our criteria for coverage.

When you request approval for coverage or an exception from coverage criteria, these are called coverage determinations. Don’t assume that any coverage determination, including any exception you have requested or appealed has been approved just because you receive more fills of a drug. If <plan name> or your IDT approves coverage, then we’ll send you another written notice. **Instructions on how to change your current prescription(s), how to ask for a coverage determination, including an exception, and how to appeal a denial if you disagree with our coverage determination are discussed at the end of this letter.**

The following is a specific explanation of why your drug(s) <is/are> not covered or <is/are> limited.

[***Note****: FIDA Plans may include information about multiple temporary supplies in the same notice.*]

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

**Date Filled**: <date filled>

**Reason for Notification**: This drug is not on our Drug List. [*Insert where applicable:* In addition, a prior exception you received for coverage of this drug has recently expired.] We will not continue to pay for this drug after you have received up to <must be at least 90> days’ temporary supply that we are required to cover unless you obtain <a/an additional> 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 a quantity limit and we impose such limits for safety reasons. In addition to imposing quantity limits for safety reasons as this drug is dispensed, we will not continue to pay for this drug after you have received up to <must be at least 90> days’ supply 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 prior authorization. Unless you obtain prior authorization from <plan name> or your IDT by showing us that you meet certain requirements or unless we approve your request for an exception to the prior authorization requirements, we will not continue to pay for this drug after you have received up to <must be at least 90> days’ temporary supply 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 generally only pay for this drug if you first try <another/other> drug(s), specifically <insert step 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, effective, and lower cost drug before progressing to other more costly drugs. Unless you try the other drug(s) on our Drug List first or unless we or your IDT approve your request for an exception to the step therapy requirement, we will not continue to pay for this drug after you have received up to <must be at least 90> days’ temporary supply 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 generally 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 unless we or your IDT approve your request for an exception, we will not continue to pay for this drug after you have received up to <must be at least 90> days’ temporary supply 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 and is subject to a quantity limit (QL). We will not continue to provide more than what our QL permits, which is <insert the QL>, unless you obtain an exception from <plan name> or your IDT.]

[***Note****: The following choices are for Emergency Fill and Level of Care Changes and are optional. However, we encourage the plan to notify Participants of Emergency Fill and Level of Care Change temporary supplies.*]

[**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.]

[**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 coverage by showing us that you meet the prior authorization requirements. You can also ask us for an exception to the prior authorization requirements if you believe they should not apply to you for medical reasons.]

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

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our Drug List but will generally be covered only if you first try certain other drugs as part of 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 coverage by showing us that you meet the step therapy criteria. You can also ask us for an exception to the step therapy requirement if you believe it should not apply to you for medical reasons.]

**What do I need to do about Issue 1?**

You must ***either*** change to <another/other> drug(s) ***or*** obtain approval from <PLAN NAME> or your IDT to continue receiving coverage of <DRUG NAME(s)>.

**How do I change my prescription?**

If your drug(s) <is/are> not on our Drug List, or <is/are> on our Drug List, but we have placed a limit on <it/them>, then you can ask us what other drug(s) used to treat your medical condition <is/are> on our Drug List, ask us to approve coverage by showing that you meet our criteria, or ask us for an exception. We encourage you to ask your prescriber if <this/these> other drug(s) that we cover <is/are> an option for you. You have the right to request an exception from us to cover your drug(s) that <was/were> originally prescribed. If you ask for an exception, your prescriber will need to provide us with a statement explaining why a prior authorization, quantity limit, or other limit we have placed on your drug is not medically appropriate for you.

**How do I request a coverage determination, including an exception?**

You or your prescriber may contact us to request a coverage determination, including an exception. [*Provide the necessary address, fax number, and phone number*]. Your Care Manager can help you with this.

If you are requesting coverage of a drug that is not on our Drug List or an exception to a coverage rule, your prescriber must provide a statement supporting your request. It may be helpful to bring this notice with you to the prescriber or send a copy to his or her office. If the exception request involves a drug that is not on our Drug List, the prescriber’s statement must indicate that the requested drug is medically necessary for treating your condition, because all of the drugs on our Drug List would be less effective than the requested drug or would have adverse effects for you. If the exception request involves a prior authorization or other coverage rule we have placed on a drug that is on our Drug List, the prescriber’s statement must indicate that the coverage rule wouldn’t be appropriate for you given your condition or would have adverse effects for you.

<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, from when we receive your request. For exceptions, the timeframe begins when we obtain your prescriber’s statement. Your request will be expedited if <plan name> or your IDT determines, or your prescriber tells us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.

**What if my request for coverage is denied***?*

If your request for coverage is denied, you have the right to appeal by asking for a review of the prior decision, which is called a redetermination. You must request this appeal within 60 calendar days from the date of our written decision on your coverage determination.

[*Insert one:* You must file a standard request in writing *or* We accept standard requests by phone and in writing]. We accept expedited requests by phone 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 Participant Ombudsman.

**What if I have questions or need help with Issue 1?**

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, please contact Participant Servicesat <plan name>, at <toll-free number> or *<*toll-free TTY/TDD numbers>. Live representatives are available from <days and hours of operation when live representatives take calls>. You can ask us for a coverage determination at any time. You can also visit our website at <web address>.

**You must also take steps to address Issue 2. Go to the next page to learn more about this issue and what you can do.**

**ISSUE 2: Your Prescriber is not enrolled in medicare**

In addition to Issue 1 with your drug, there is an issue with <PLAN NAME> covering prescriptions from the prescriber. You must also address this problem in order to continue getting coverage for your prescription(s) for <DRUGS NAME(s)> from <PRESCRIBER NAME>.

**What is Issue 2?**

<PRESCRIBER NAME> hasn’t enrolled in Medicare. Unless he/she does so, <PLAN NAME> can only cover prescriptions for <DRUG NAME(s)> from him/her up to a 3-month supply of each drug, or until <**DATE**>, whichever comes first. [*When prescriber is a contract provider, insert this language:* We’re sending you this notice so we can assist you in avoiding any interruption in your coverage for <this/these> prescription(s).] [*When prescriber is a non-contract provider, insert this language:* We’re sending you this notice so you can take action to avoid an interruption in your coverage for <this/these> prescription(s).] Medicare now requires doctors and most other providers who prescribe drugs to enroll in Medicare in order for their prescriptions to be covered under Medicare Part D. The purpose is to prevent Medicare fraud and improve the quality of care for people with Medicare. Most Part D prescribers are already enrolled; however, <PRESCRIBER NAME> isn’t enrolled.

[*When prescriber is a contract provider, insert this language:*

<PLAN NAME> will contact <PRESCRIBER NAME> immediately to ask if he/she will enroll in Medicare, so that your future prescriptions for <drug name(s)> from him/her can continue to be covered by <PLAN NAME>. Even if he/she doesn’t want to accept Medicare for medical services, <PRESCRIBER NAME> can still enroll in Medicare just to prescribe. If <PRESCRIBER NAME> won’t enroll in Medicare and you want your prescription(s) for <DRUG NAME(s)> to continue to be covered after <**DATE**>, we will help you find a different prescriber in <PLAN NAME>’s network who is enrolled in Medicare.]

[*When prescriber is a non-contract provider, insert this language:*

**What do I need to do about Issue 2?**

If you think you may need more prescriptions for <DRUG NAME(s)> from <PRESCRIBER NAME>, <PLAN NAME> Participant Services or your Care Manager can help you with your **3 main options**:

1. Contact <PRESCRIBER NAME> immediately and ask if he/she will enroll in Medicare Part D, so that your future prescriptions for <DRUG NAME(s)> from him/her can continue to be covered by <PLAN NAME>. Even if he/she doesn’t want to accept Medicare for medical services, he/she can still enroll in Medicare just to prescribe**.** It’s important that you talk with <PRESCRIBER NAME> right away, because the Part D enrollment process can take some time.
2. If <PRESCRIBER NAME> won’t enroll in Medicare and you want your prescription(s) for <DRUG NAME(s)> to continue to be covered after <**DATE**>, you must find a different prescriber who is enrolled in Medicare. You will then need to contact the new prescriber as soon as possible to discuss <this/these> prescription(s).
3. If <PRESCRIBER NAME> won’t enroll in Medicare and you still want to get your prescriptions for <DRUG NAME(s)> from him/her, you will have to pay the full cost out of pocket for the drug(s) in the future.]

We want you to know that the Centers for Medicare & Medicaid Services (CMS) has been conducting an extensive outreach campaign for more than a year to try to make sure Part D prescribers are aware of this new requirement. [*Optional*: In addition, <PLAN NAME> contacted <PRESCRIBER NAME> about this new rule [*either* <on <**DATE**(s)> *or* in advance]. However, according to the most recent available record, <PRESCRIBER NAME> isn’t enrolled in Medicare.

**What if I have questions or need help with Issue 2?**

* Contact <PLAN NAME> Participant Services at <toll-free phone and TTY/TDD numbers>, <days and hours of operation>.
* Contact the Independent Consumer Advocacy Network (ICAN) toll-free at 1-844-614-8800 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)
* Contact Medicare at 1-800-MEDICARE (1-800-633-4227), anytime, 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.

<Plan’s legal or marketing name> is a managed care plan that contracts with both Medicare and New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) 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 phone and TTY/TDD numbers>, <days and 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 phone and TTY/TDD numbers>, <days and 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 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)