[*Instructions: Any Part D sponsor that seeks a prescription transfer must use this model notice to request permission from a member to fill his/her prescription[s] at a different network pharmacy than the one the member is currently using. The Part D sponsor may attach a written permission form to this letter for the member to fill out. The member may provide permission by either calling the plan or pharmacy or mailing/faxing the permission form. The model notice should only be used when the transfer of the prescription is not initiated by the member (or someone on his or her behalf). Unsolicited phone calls made by the pharmacy or Part D sponsor seeking permission from members to transfer prescriptions are not permitted.*]

<DATE>

<MEMBER NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <MEMBER NAME>:

[*Insert* <Plan Name>] has determined that the following medication(s) you are currently taking could be purchased through another [*Insert one* <specialty> <retail> <mail-order>] pharmacy.

[*Insert as applicable* <medication1> <dosage>

<medication2> <dosage>

<medication3> <dosage>]

[*Insert an explanation of the benefits realized by the plan member if he/she decides to transfer his/her prescription(s) to the different pharmacy*.]

If you want to continue to purchase your medications from your current pharmacy, you do not need to respond to this letter. Purchasing your medication from your current pharmacy will not affect your current coverage.

With your permission, we are able to fill your prescription(s) at [*Insert* <name of pharmacy>]. We cannot fill your prescription(s) at this pharmacy until we have received permission from you to do so. You may call [*Insert one* < Customer/Member Service> < name of pharmacy>] at [*Insert* <phone number> (TTY/TDD users should call <TTY/TDD number>)] if you would like this pharmacy to fill your prescription(s).

[*Optional insert* <You may also fill out the attached form granting permission to us to have us fill your prescription(s) at [*Insert* < name of pharmacy>]and fax it to [*Insert* <fax number>] or mail it to [*Insert* <mailing address>].

If you want more information regarding how to transfer prescriptions, please call [*Insert* <Customer/Member>] Service at [*Insert* <phone number>]. TTY/TDD users should call [*Insert* <TTY/TDD number>]. We are available from [*Insert* <days/hours of operations>].

Sincerely,

<Plan Representative>

<OPTIONAL: attachment>

Beneficiaries generally must use network pharmacies to access their prescription drug benefit.

[Pursuant to 42 CFR §423.2267, applicable disclaimers must be included in this letter.]