Instructions to Health Plans

* [If plans do not use the term “Member Services,” plans should replace it with the term the plan uses.]
* [Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]
* [Plans should note that the EOC is referred to as the “Member Handbook.” If plans do not use the term “Member Handbook,” plans should replace it with the term the plan uses.]
* [Plans should include all drugs/items covered under the Part D and Medicaid pharmacy benefits. This includes only those drugs on plans’ approved Part D formulary and approved Additional Demonstration Drug (ADD) file. Plans may not include OTC drugs and/or items offered as a plan supplemental benefit that are in excess of Medicaid-required OTC drugs and/or items.]
* [Plans may place a QR code on materials to provide an option for members to go online.]
* [Plans have the option of deleting the footer following the introduction (e.g., the footer is not necessary in the actual list of drugs.)]
* [Plans may add a Table of Contents to this document.]
* [*Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*
* *Format a section, chart, table, or block of text to fit onto a single page. In instances where* plan-customized information causes *an item or text* to *continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example,* similar to *the Benefits Chart in Chapter 4 of the Member Handbook, insert:* **This section is continued on the next page***)*.
* Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.
* *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
* *Spell out an acronym or abbreviations before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)).*
* *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
* *Avoid separating a heading or subheading from the text that follows when paginating the model.*
* *Use universal symbols or commonly understood pictorials.*
* *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
* *Consider using regionally appropriate terms or common dialects in translated models.*
* *Include instructions and navigational aids in translated models in the translated language rather than in English.*]

**<Plan Name> | <year> *List of Covered Drugs* (*Drug List* or Formulary)**

Introduction

[*Insert on the front cover the HPMS Approved Formulary File Submission ID, Version Number.*]

This document is called the *List of Covered Drugs* (also known as the *Drug List*).It tells you which prescription drugs [insert if applicable: and over-the-counter drugs] [insert if applicable: and items] are covered by <plan name>. The *Drug List* also tells you if there are any special rules or restrictions on any drugs covered by <plan name>. Key terms and their definitions appear in the last chapter of the *Member Handbook*.

[*In accordance with* CMS formulary guidance and the Prescription Drug Benefit Manual, *plans must indicate when the document was last updated by including either* “Updated on MM/DD/YYYY.” *or* “No changes made since MM/DD/YYYY”.

For more recent information or other questions, contact us at <toll-free phone and TTY numbers>, <days and hours of operation> or visit <URL>.” on both the front and back covers of this document. Plans may include the Material ID only on the front cover.]

[*Dates used in the front and back of the formulary covers should be the same as the footer of the document.*]

[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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1. Disclaimers

This is a list of drugs that members can get in <plan name>.

* [*Plans must include all applicable disclaimers as required in the State-specific Marketing Guidance.*]
* [*Plans may include either the current multi-language insert or provide a Notice of Availability. Plans that choose to use the current multi-language insert per 42 CFR §§ 422.2267(e)(31) and (e)(33) should include:* We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at <phone number>. Someone that speaks <language> can help you. This is a free service. [*This information must be included in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, Japanese, and any additional languages required by the state.*]

*OR*

*Per the final rule CMS 4205-F released on April 4, 2024, §§ 422.2267(e)(31) and 423.2267(e)(33), plans may choose to provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in Ohio and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.*]

* You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. [Plans must provide the information in alternate formats when a member asks for it or when the plan identifies a member who needs it.]
* [Plans that meet the 5% alternative language or Medicaid required language threshold insert: This document is available for free in [*insert* languages that meet the threshold *as described the “Standards for required materials and content section” of the Marketing Guidance for Ohio Medicare-Medicaid Plans.*]]
* [*Plans also must simply describe:*
  + *how they will request a member’s preferred language other than English and/or alternate format,*
  + *how they will keep the member’s information as a standing request for future mailings and communications so the member does not need to make a separate request each time,* ***and***
  + *how a member can change a standing request for preferred language and/or format.*]

1. Frequently Asked Questions (FAQ)

Find answers here to questions you have about this *List of Covered Drugs*. You can read all of the FAQ to learn more, or look for a question and answer. [*Plans that do not include B15, B16, and/or B18 must renumber remaining FAQs sequentially and update the Table of Contents accordingly.*]

B1. What prescription drugs are on the *List of Covered Drugs*? (We call the *List of Covered Drugs* the “*Drug List*” for short.)

The drugs on the *List of Covered Drugs* that starts in section <letter/number> are the drugs covered by <plan name>. These drugs are available at pharmacies within our network. A pharmacy is in our network if we have an agreement with them to work with us and provide you services. We refer to these pharmacies as “network pharmacies.”

* <Plan name> will cover all medically necessary drugs on the *Drug List* if:
* your doctor or other prescriber says you need them to get better or stay healthy, **and**
* you fill the prescription at a <plan name> network pharmacy.
* <Plan name> may have additional steps to access certain drugs (refer to question B4 below).

[*Plans that offer indication-based formulary design must include:* If we cover a drug only for some medical conditions, we clearly identify it on the *Drug List* along with the specific medical conditions that are covered.]

You can also refer to the up-to-date list of drugs that we cover on our website at <URL> or call Member Services at *<*phone number>.

B2. Does the *Drug List* ever change?

Yes, and <plan name> must follow Medicare and Medicaid rules when making changes. We may add or remove drugs on the *Drug List* during the year.

We may also change our rules about drugs. For example, we could:

* Decide to require or not require prior authorization (PA) or approval for a drug. (PA is permission from <plan name> before you can get a drug.)
* Add or change the amount of a drug you can get (called quantity limits).
* Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to question B4.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless:

* a new, cheaper drug comes on the market that works as well as a drug on the *Drug List* now, **or**
* we learn that a drug is not safe, **or**
* a drugis removed from the market.

Questions B3 and B6 below have more information on what happens when the *Drug List* changes.

* You can always check <plan name>’s up to date *Drug List* online at <URL>. Updates to the *Drug List* are posted on the website monthly.
* You can also call Member Services to check the current *Drug List* at <toll-free number>.

B3. What happens when there is a change to the *Drug List*?

Some changes to the *Drug List* will happen **immediately**. For example:

* [*Plans that otherwise meet all requirements and want the option to make immediate substitutions of certain new drugs (for instance, immediately replace brand name drugs with their generic equivalents or immediately replace reference products with interchangeable biological products) must provide the following advance general notice of changes:* **Substitutions of certain new version of drugs.**We may immediately remove the drugs from the *Drug List* if we replace them with certain new versions of that drug but your cost for the new drug will stay the same [*insert if applicable, for example, if the plan’s Drug List has differential cost-sharing for some generics:* or will be lower]. When we add the new generic drug, we may also decide to keep the brand name drug or original biological product on the list but change its coverage rules or limits.
* We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
  + We can make these changes only if the drug we are adding:
    - Is a new generic version of a brand name drug, or
    - Is a certain new biosimilar version of original biological products on the *Drug List* (for example, adding an interchangeable biosimilar that can be substituted for an original biological product without a new prescription).

Some of these drug types may be new to you. For more information, refer to Section B14.

* You or your provider can ask for an exception from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to question B10 for more information on exceptions.]
* **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or effective or the drug’s manufacturer takes a drug off the market, we may immediately take it off the *Drug List*. If you are taking the drug, we will send you a notice after we make the change. [*Plans should include information advising members what to do after they are notified (e.g., contact the prescribing provider, etc.).*]

**We may make other changes that affect the drugs you take.** We will tell you in advance about these other changes to the *Drug List*. These changes might happen if:

* The FDA provides new guidance or there are new clinical guidelines about a drug.
* [*Plans that want the option to immediately substitute a new generic drug, insert:* We remove a brand name drug from the *Drug List* when adding a generic drug that is notnew to the market, or
* we remove an original biological product when adding a biosimilar, or
* we change the coverage rules or limits for the brand name drug.]
* [*Plans that are not making immediate generic substitutions insert:* We add a generic drug and replace a brand name drug currently on the *Drug List*, or
* we add a new biosimilar to replace an original biological product currently on the *Drug List,* or
* we change the coverage rules or limits for the brand name drug.]

When these changes happen, we will:

* tell you at least 30 days before we make the change to the *Drug List* **or**
* let you know and give you a [*insert supply limit (must be at least the number of days in the plan’s one-month supply)*]-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

* if there is a similar drug on the *Drug List* you can take instead **or**
* whether to ask for an exception from these changes. To learn more about exceptions, refer to question B10.

B4. Are there any restrictions or limits on drug coverage or any required actions to take to get certain drugs?

Yes, some drugs have coverage rules or have limits on the amount you can get. In some cases you or your doctor or other prescriber must do something before you can get the drug. For example [*Plans should omit bullets as needed and reflect only those utilization management procedures actually used by the plan*]:

* **Prior Authorization (PA) or approval:** For some drugs, you or your doctor or other prescriber must get PA from <plan name> before you fill your prescription. <Plan name> may not cover the drug if you do not get approval.
* **Quantity limits:** Sometimes <plan name> limits the amount of a drug you can get.
* **Step therapy:** Sometimes <plan name> requires you to do step therapy. This means you will have to try drugs in a certain order for your medical condition. You might have to try one drug before we will cover another drug. If your doctor thinks the first drug doesn’t work for you, then we will cover the second.
* **Indication-based coverage:** If <plan name> covers a drug only for some medical conditions, we clearly identify it on the *Drug List* along with the specific medical conditions that are covered.

You can find out if your drug has any additional requirements or limits by looking in the tables in section <section letter/number>. You can also get more information by visiting our website at <URL>. [Plans that apply PA and/or step therapy insert the following with applicable information: We have posted online [insert: a document or documents] that [insert: explains or explain] our [insert as applicable: PA restriction **or** step therapy restriction **or** PA and step therapy restrictions].] You may also ask us to send you a copy.

You can ask for an exception from these limits. This will give you time to talk to your doctor or other prescriber. They can help you decide if there is a similar drug on the *Drug List* you can take instead or whether to ask for an exception. Please refer to questions B10-B12 for more information about exceptions.

B5. How will I know if the drug I want has limits or if there are required actions to take to get the drug?

The table of drugs in section <section letter/number> has a column labeled “Necessary actions, restrictions, or limits on use.”

B6. What happens if <plan name> changes their rules about some drugs (for example, PA or approval, quantity limits, and/or step therapy restrictions)?

[*Plans should omit information as needed and reflect only those utilization management procedures actually used by the plan*.] In some cases, we will tell you in advance if we add or change PA, quantity limits, and/or step therapy restrictions on a drug. Refer to question B3 for more information about this advance notice and situations where we may not be able to tell you in advance when our rules about drugs on the *Drug List* change.

B7. How can I find a drug on the *Drug List*?

There are two ways to find a drug:

* You can search alphabetically by the drug’s name, **or**
* You can search by medical condition.

To search **alphabetically**, refer to the Index of Covered Drugs section. You can find it [*give instructions*].

To search **by medical condition**, find the section labeled “Drugs Grouped by Medical Condition” in section <section letter/number>. The drugs in this section are grouped into categories depending on the type of medical conditions they are used to treat. For example, if you have a heart condition, you should look in the category, <therapeutic category name example>. That is where you will find drugs that treat heart conditions.

B8. What if the drug I want to take is not on the *Drug List*?

If you don’t find your drug on the *Drug List*, call Member Services at <toll-free number> and ask about it. If you learn that <plan name> will not cover the drug, you can do one of these things:

* Ask Member Services for a list of drugs like the one you want to take. Then show the list to your doctor or other prescriber. They can prescribe a drug on the *Drug List* that is like the one you want to take. **Or**
* You can ask the health plan to make an exception to cover your drug. Please refer to questions B10-B12 for more information about exceptions.

B9. What if I am a new <plan name> member and can’t find my drug on the *Drug List* or have a problem getting my drug?

We can help. We may cover a temporary [*insert supply limit (must be the number of days in plan’s one-month supply)*]-day supply of your drug during the first [*must be at least 90*] days you are a member of <plan name>. This will give you time to talk to your doctor or other prescriber. They can help you decide if there is a similar drug on the *Drug List* you can take instead or whether to ask for an exception.

If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of [*insert supply limit (must be the number of days in plan’s one-month supply)*] days of medication.

We will cover a [insert supply limit (must be the number of days in plan’s one-month supply)]-day supply of your drug if:

* you are taking a drug that is not on our *Drug List*, **or**
* health plan rules do not let you get the amount ordered by your prescriber, **or**
* the drug requires PA by <plan name>, **or**
* you are taking a drug that is part of a step therapy restriction.

If you are in a nursing home or other long-term care facility and need a drug that is not on the *Drug List* or if you cannot easily get the drug you need, we can help. If you have been in the plan for more than [insert time period (must be at least 90 days)] days, 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)] supply of the drug you need (unless you have a prescription for fewer days), whether or not you are a new <plan name> member.
* This is in addition to the temporary supply during the first [*must be at least 90*]days you are a member of <plan name>.

[If applicable, plans must insert a description of their transition policy for current members with changes to their level of care changes as specified in Chapter 6 of the Prescription Drug Benefit Manual.]

B10. Can I ask for an exception to cover my drug?

Yes. You can ask <plan name> to make an exception to cover a drug that is not on the *Drug List*.

You can also ask us to change the rules on your drug.

* For example, <plan name> may limit the amount of a drug we will cover. If your drug has a limit, you can ask us to change the limit and cover more.
* Other examples: You can ask us to drop step therapy restrictions or PA requirements.

B11. How can I ask for an exception?

To ask for an exception, call [plans should include information on the best person to call – e.g., your care manager, your care team, Member Services]. [Insert: Your care manager, Your care team or A Member Services representative] will work with you and your provider to help you ask for an exception. You can also read Chapter 9, [*plans may insert a reference, as applicable*], of the *Member Handbook* to learn more about exceptions.

B12. How long does it take to get an exception?

After we get a statement from your prescriber supporting your request for an exception, we will give you a decision within 72 hours. [*Plans include concise instructions about how and where plan members or their prescribers must send the statement.*]

If you or your prescriber think your health may be harmed if you have to wait 72 hours for a decision, you can ask for an expedited exception. This is a faster decision. If your prescriber supports your request, we will give you a decision within 24 hours of getting your prescriber’s supporting statement.

B13. What are generic drugs?

Generic drugs are made up of the same active ingredients as brand name drugs. They usually cost less than the brand name drug and generally work just as well. They usually don’t have well-known names. Generic drugs are approved by the Food and Drug Administration (FDA). There are generic drugs available for many brand name drugs. Generic drugs usually can be substituted for brand name drugs at the pharmacy without a new prescription—depending on state laws.

<Plan name> covers both brand name drugs and generic drugs.

B14. What are original biological products and how are they related to biosimilars?

When we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have forms that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilars alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

For more information on drug types, refer to Chapter 5 of the *Member Handbook.*

B15. What are OTC drugs?

[Only plans that cover OTC drugs should include question B15.]

OTC stands for “over-the-counter.” <Plan name> covers some OTC drugs when they are written as prescriptions by your provider.

You can read the <plan name> Drug List to find which OTC drugs are covered.

[Plans should include OTC drugs they pay for and that were included on the integrated formulary approved by CMS and the state in the Drug List. They should provide cost-sharing information there as well.]

B16. Does <plan name> cover non-drug OTC products?

[Only plans that cover non-drug OTC products should include question B16.]

<Plan name> covers some non-drug OTC products when they are written as prescriptions by your provider.

*[Plans should include the following language: Examples of non-drug OTC products include [insert examples of plan’s covered non-drug OTC products here].]*

You can read the <plan name> Drug List to find which non-drug OTC products are covered.

[*Plans should include non-drug OTC products they pay for in the Drug List. They should provide cost-sharing information there as well*.]

B17. What is my copay?

[Plans with no copays in any tier insert: As a <plan name> member, you have no copays for prescription and OTC drugs as long as you follow <plan name>’s rules.]

[Plans with copays in any tier insert: You can read the <plan name> Drug List to learn about the copay for each drug. <Plan name> members living in nursing homes or other long-term care facilities will have no copays. Some members getting long-term care in the community will also have no copays.]

[Plans with copays in any tier must also provide an explanation; refer to the example of tiered copays below. Plans should modify the explanation below consistent with their tier model, to include the range of applicable cost sharing amounts for each tier (and a statement that the copay varies depending on the person’s level of Medicaid eligibility), and a description of the types of drugs (e.g., generics, brands, and/or OTCs) on each tier. Plans 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 2016 Final Call Letter. If a plan has no copays for one or more tiers of drugs, the plan should modify the copay information accordingly.

Copays are listed by tiers. Tiers are groups of drugs with the same copay.

* Tier 1 drugs have the lowest copay. They are generic drugs. The copay is from <amount> to <amount>, depending on your income.
* Tier 2 drugs have a medium copay. They are brand name drugs. The copay is from <amount> to <amount>, depending on your income.
* Tier 3 drugs have the highest copay. They have a copay of <amount>.]

B18. What are drug tiers?

[Only plans with no copays in any tier should include question B18.

Tiers are groups of drugs on our Drug List.

Plans must provide a description of each of their drug tiers and the types of drugs (e.g., generic, brand, and/or OTC) in each tier.

Plans with no copays in any tier include tier examples such as the following:

* Tier 1 drugs are generic drugs.
* Tier 2 drugs are brand name drugs.

Plans must ensure the tier label or description of the types of drugs on each tier is consistent with their approved plan benefit package. Plans must also include a statement that all tiers have no copay.]

1. Drugs Grouped by Medical Condition

The drugs in this section are grouped into categories depending on the type of medical conditions they are used to treat. For example, if you have a heart condition, you should look in the category, <therapeutic category name example>. That is where you will find drugs that treat heart conditions.

The following list of covered drugs gives you information about the drugs covered by <plan name>. If you have trouble finding your drug in the list, turn to the Index of Covered Drugs that begins in section <section letter/number>. The index alphabetically lists all drugs covered by <plan name>.

The first column of the chart lists the name of the drug. Brand name drugs are capitalized (e.g., <BRAND NAME EXAMPLE>), and generic drugs are listed in lower-case italics (e.g., <*generic example*>).

The information in the necessary actions, restrictions, or limits on use column tells you if <plan name> has any rules for covering your drug.

[**Note**: Plans must provide information on the following items when applicable to specific drugs and define any symbols or abbreviations used to indicate their application: utilization management restrictions, drugs that are available via mail-order, free first fill drugs, limited access drugs, and drugs covered under the medical benefit (for home infusion drugs only). While the symbols and abbreviations must appear whenever applicable, plans are not required to provide associated explanations on every page. They must, however, provide a general footnote on every page stating: You can find information on what the symbols and abbreviations in this table mean by referring to [insert description of where information is available, such as section].]

[**Note**: Any OTC drugs or products on the plan’s approved integrated formulary must be included on the Drug List. For non-Part D drugs or OTC items that are covered by Medicaid, please place an asterisk (\*) or another symbol by the drug to indicate that the member may need to follow a different process for appeals.]

**Note:** The <symbol used by the plan> next to a drug means the drug is not a “Part D drug.” The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage).

* In addition, if you are getting Extra Help to pay for your prescriptions, you will not get any Extra Help to pay for these drugs. For more information on Extra Help, please refer to the call-out box below.

|  |
| --- |
| **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.” |

* These drugs also have different rules for appeals. An appeal is a formal way of asking us to review a coverage decision and to change it if you think we made a mistake. For example, we might decide that a drug that you want is not covered or is no longer covered by Medicare or Medicaid.
* If you or your prescriber disagrees with our decision, you can appeal. To ask for instructions on how to appeal, call Member Services at <toll-free number>. You can also read the Chapter 9 [plans may insert a reference, as applicable] of the *Member Handbook* to learn how to appeal a decision.

[*If plans use codes in the “Necessary actions, restrictions, or limits on use” column, they should include a key. Plans are not required to include a key on every page, but plans must provide a general footnote on every page stating:* You can find information on what the symbols and abbreviations in this table mean by referring to[*insert description of where information is available*]. *The key below is only an example; plans do not have to use the same abbreviations/codes:*]

| Here are the meanings of the codes used in the “Necessary actions, restrictions, or limits on use” column:  (g) = Only the generic version of this drug is covered. The brand name version is not covered.  M = The brand name version of this drug is in Tier 3. The generic version is in Tier 1.  PA = Prior authorization (approval): you must have approval from the plan before you can get this drug.  ST = Step therapy: you must try another drug before you can get this one. |
| --- |

[*Plans have the option to insert a table to illustrate drugs either by therapeutic category or by therapeutic category further divided into classes. An example of each type of table is presented below.*]

<Therapeutic Category> – [Optional: Plans are encouraged to insert a plain language description of the category. Plans include additional therapeutic categories as needed.]

| Name of drug | What the drug will cost you (tier level) | Necessary actions, restrictions, or limits on use |
| --- | --- | --- |
| <AZASAN> | <$0–$3 (Tier 3)> | <PA> |
|  |  |  |
|  |  |  |

or

<Therapeutic Category> – [Optional: Plans are encouraged to insert a plain language description of the category. Plans include additional therapeutic categories further divided into classes as needed.]

| Name of drug | What the drug will cost you (tier level) | Necessary actions, restrictions, or limits on use |
| --- | --- | --- |
| <Therapeutic Class Name 1> *–* [Optional: <Plain Language Description>] | | |
| <Drug Name 1> | <Tier Level> | <Util. Mgmt.> |
| <Drug Name 2> | <Tier Level> | <Util. Mgmt.> |
| <Therapeutic Class Name 2> – [Optional: <Plain Language Description>] | | |
| <Drug Name 1> | <Tier Level> | <Util. Mgmt.> |
| <Drug Name 2> | <Tier Level> | <Util. Mgmt.> |

[**General Drug Table instructions**:

Column headings should be repeated on each page of the table.

Plans should include OTC drugs they pay for and that were included on the integrated formulary approved by CMS and the state in the Drug List. They should provide copay information there as well.

Plans should include non-drug OTC products they pay for in the Drug List. They should provide cost-sharing information there as well.

Plans may include a “plain-language” description of the therapeutic category next to the name of each category. For example, instead of only including the category, “Dermatological Agents,” plans would include “Dermatological Agents – Drugs to treat skin conditions.”

List therapeutic categories alphabetically within the table, and list drugs alphabetically under the appropriate therapeutic category. If plans use the second option and further divide the categories into classes, the therapeutic categories should be listed alphabetically and the therapeutic classes listed alphabetically under the appropriate category. The drugs should then be listed alphabetically under the appropriate therapeutic class.

The chart must include at least two covered drugs for each therapeutic category/class except when only one drug exists in the category or class or when two drugs exist in the category or class but one is clinically superior to the other as per your CMS-approved formulary.]

[**“Name of Drug” column instructions:**

Brand name drugs should be capitalized (e.g., DRUG A). Generic drugs should be lowercase and italicized, e.g., penicillin. Plans may include the generic name of a drug next to the brand name.

If there are differences in formulary status, tier placement, quantity limit, PA, step therapy, or other restrictions or benefit offerings (e.g., available via mail order, etc.) for a drug based on its differing dosage forms or strengths, the formulary must clearly identify how it will treat the different formulations of that same drug. For instance, if a drug has a different tier placement depending on the dosage (e.g., 20 mg is in Tier 1 and 40 mg is in Tier 4), plans must include the drug twice within the table with the varying dosage listed next to the drug name (e.g., DRUG A, 20 mg and DRUG A, 40 mg). The drug will be counted as a single drug when determining whether the plan has included two drugs within each therapeutic category/class.]

[“**What the drug will cost you (tier level)” column instructions:**

Plans should put the appropriate tier level in parentheses next to the copay or range of copays as shown in the example above.]

[**Necessary actions, restrictions, or limits on use column instructions:**

Plans may include abbreviations within this column (e.g., QL for quantity limits) but must include an explanation at the beginning of the table explaining each abbreviation.

Plans must explain any symbols or abbreviations used to show use restrictions, drugs that are available via mail order, non-Part D drugs or OTC items that are covered by Medicaid, free-first-fill drugs, limited-access drugs, and drugs covered under the medical benefit (for home infusion drugs only and for plans that specifically request and are approved in the plan benefit package to bundle home infusion drugs and services under the medical benefit). Plans may also use abbreviations to show drugs that are not available via mail-order.

**Note**: Health plans may want to add this bullet if the plan offers generic use incentive programs permitting zero or reduced cost-sharing on first generic refills:

* We will provide this prescription drug at [insert as appropriate: no **or** a reduced] cost the first time you fill it.]

1. Index of Covered Drugs

[Plans must include an alphabetical listing of all drugs included in the formulary that indicates the page where members can find coverage information for that drug. Plans may use more than one column for the index listing. The inclusion of this list is required and should start on a separate page.]