

2018 年 D 部分處方藥一覽表範本（簡明和綜合版）

[Note: Instructions for sponsors appear below in italicized text. Text in square brackets must be included if the text accurately describes the plan's benefit structure. Carets are placeholders for variable fields that must be filled in accurately.]

Below is a template which may be used for an abridged or comprehensive formulary except when noted as applicable to one form or the other. 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 also change references to Member Services and Pharmacy Directory with to the appropriate name your plan uses.

This form may also be used for defined standard plans, whose marketing materials are required to reflect a single tier regardless of whether the formulary submitted to CMS is also associated with a multi-tier formulary.

Plans should also consult 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 3, 5, and 6).]

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

<mandatory Plan Name>

<Year> 年[<簡明>]處方藥一覽表

([<部分>]承保藥物清單)

請閱讀：本文件包含

關於[insert the following if applicable: <部分>]本計劃承保藥物的資訊

[<HPMS Approved Formulary File Submission ID, Version Number>]

[The following information must appear on both the front and back covers of abridged formularies: "[Insert one: <本簡明處方藥一覽表更新於 <MM/DD/YYYY>。>or <本簡明處方藥一覽表上次修訂日期為 MM/DD/YYYY。>]本一覽表並非計劃承保藥物的完整清單。如需完整清單或有其他問題，請聯絡 [optional <我們>], <mandatory Plan or Sponsor Name> [optional <會員服務部>]，電話：<Toll-free Number> 或聽障專線：<Toll-free TTY Number>，服務時間為：<Days/Hours of Operation>，或瀏覽 <insert web address>。]

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[The following information must appear on both the front and back covers of comprehensive formularies: [Insert one: <本處方藥一覽表更新於 <MM/DD/YYYY>。> or <本處方藥一覽表上次修訂日期為 MM/DD/YYYY。>] 本處方藥一覽表更新於 <xx/xx/xxxx>。更多最新資訊或如有其他疑問，請聯絡 [optional <我們>，] <mandatory Plan or Sponsor Name> [optional <會員服務部>，] 電話：<Toll-free Number> 或聽障專線：<Toll-free TTY Number>，服務時間為：<Days/Hours of Operation>，或瀏覽<insert web address>。]

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

現有會員請注意：本處方藥一覽表自去年已變更。請閱讀本文件，確保本處方藥一覽表仍然包含您服用的藥物。

本藥物清單（處方藥一覽表）中，凡提述「我們」或「我們的」均指 <insert Sponsor Name>。出現「計劃」或「我們的計劃」時，是指 <insert 2018 Plan Name>。

本文件載有我們計劃截至 <formulary revision date> 的 [insert if abridged<部分>] 的藥物清單（處方藥一覽表）。如需 [insert for abridged 完整>] [insert for comprehensive <an>] 的最新處方藥一覽表，請與我們聯絡。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。

一般而言，您必須使用網絡內藥房才能享用處方藥福利。自 <XXXX> 年 1 月 1 日起，福利、處方藥一覽表、藥房網絡和/或定額手續費/共同保險在年內可能會不時有所調整。

什麼是<mandatory Plan Name> <簡明>處方藥一覽表？

處方藥一覽表是 <Plan Name> 透過諮詢醫療提供者團隊所選出的承保藥物清單，是高品質治療計劃中不可或缺的處方藥治療。只要具有醫療必要性，且於 <Plan Name> 的網絡內藥房配藥，並遵守其他計劃規則，<Plan Name> 通常會承保列於處方藥一覽表中的藥物。要瞭解有關如何按您的處方配藥的更多資訊，請查閱您的「承保範圍說明書」。

[For abridged] 本文件為處方藥一覽表的一部分，僅載有 <Plan Name> 的部分承保藥物。如需 <Plan Name> 所有承保處方藥的完整清單，請瀏覽我們的網站或致電聯絡我們。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。

處方藥一覽表（藥物清單）是否會變更？

一般而言，若您正在使用年初享受承保的 <contract year> 年處方藥一覽表上的藥物，我們不會在 <contract year> 年承保年度中終止或減少此藥物的承保，除非有更低價的新副廠藥推出，或者出現有關藥物安全性或有效性的最新不利資訊。其他類型的處方藥一覽表變更（例如從處方藥一覽表中刪除某種藥物）不會對目前正在服用此藥物的會員產生影響。在承保年度剩餘時間內，將以相同的分攤費用向服用此藥物的會員提供此藥物。我們認為，讓您能夠在承保年度的剩餘時間繼續獲得在您

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選擇我們的計劃時可用的處方藥一覽表上的藥物十分重要，除非是能夠為您節省更多費用或確保您的安全。

我們若從處方藥一覽表中刪除藥物、或新增對某種藥物的事先授權、數量限制和/或階段療法限制 [*insert if plan has multiple tiers: 或提高某種藥物的分攤費用等級*]，我們必須在變更生效前至少 60 天或在會員要求再次配藥時向受變更影響的會員發出通知，會員可在再次配藥時配取 60 天的藥量。若美國食品及藥物管理局認為我們處方藥一覽表上的某種藥物不安全，或藥物製造商從市場中撤除該藥物，我們會立即從我們的處方藥一覽表上刪除該藥物，並向服用該藥物的會員發出通知。隨附的處方藥一覽表更新於 <formulary date>。若要取得有關 <Plan Name> 承保藥物的最新資訊，請聯絡我們。我們的聯絡資訊載於封面和封底。 [*Note: Insert information about plan's process for updating print formularies (e.g., via errata sheets) in the event of mid-year non-maintenance formulary changes.*]

如何使用處方藥一覽表？

有兩種方法在處方藥一覽表中查找您所需的藥物：

病症

處方藥一覽表從第 <table page number> 頁開始。本處方藥一覽表中的藥物按照所治療的病症類型分類。例如，用於治療心臟病的藥物列於「<category name example>」類別之下。若您瞭解藥物的用途，在 <第 on page number 頁/下面/下一頁> 開始的清單中查找類別名稱。然後，在此類別名稱下查找所需的藥物。

按字母順序排列的清單

若您不確定應查找哪一個類別，則應在開始於第 <index page number> 頁的索引中查找所需的藥物。該索引提供一份按字母順序排列的清單，其中有本文件包含的所有藥物。該索引中列有原廠藥和副廠藥。請在該索引中查找所需的藥物。藥物旁邊註有頁碼，您可以在該頁查找承保範圍資訊。轉到該索引中所列的頁碼，在清單的第一欄即可找到所需的藥物名稱。

什麼是副廠藥？

<Plan Name> 同時承保原廠藥和副廠藥。副廠藥是一種由 FDA 核准，具有與原廠藥相同活性成分的藥物。通常，副廠藥的費用較原廠藥低。

對於我享受的承保範圍是否有任何限制？

某些承保藥物可能有其他要求或承保範圍限制。這些要求和限制可能包括： [*Note: Plans may omit bullets as needed in order to reflect actual utilization management procedures used by the plan.*]

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- **事先授權：**對於某些藥物，<Plan Name> 要求您[或您的醫師]取得事先授權。這表示您將需要在配藥前取得 <Plan Name> 的批准。若您未取得批准，<Plan Name> 可能不會承保該藥物。
- **數量限制：**對於某些藥物，<Plan Name> 限制了藥物承保數量。例如，<Plan Name> 對於 <drug name> 的每份處方提供 <number of units> 的藥量。這可以另外附加在標準的一個月或三個月的藥量上。
- **階段療法：**某些情況下，<Plan Name> 會要求您先嘗試使用某些藥物治療您的病症後，才會承保您使用另外一種藥物。例如：若藥物 A 和藥物 B 皆可治療您的病症，則 <Plan Name> 可能不會承保藥物 B，除非您先嘗試使用藥物 A。如果藥物 A 對您無效，則 <Plan Name> 將會承保藥物 B。

您可以透過第 <table page number> 頁開始的處方藥一覽表查詢您的藥物是否有額外的要求或限制。您也可以透過瀏覽我們的網站，取得更多關於特定承保藥物適用之限制的資訊。[*Sponsors that apply prior authorization and/or step therapy insert the following with applicable information:* 我們已在線上刊載[文件 or 相關文件]，解釋我們[insert as applicable 事先授權限制 or 階段療法限制 or 事先授權和階段療法的限制。]您也可以要求我們寄一份給您。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。

您可以要求 <Plan Name> 對此類限制或使用上限作出例外處理，或索取可能治療您的病症的其他相似藥物清單。請參閱第 <exception page number> 頁的「如何申請 <Plan Name's> 的處方藥一覽表例外處理？」章節，以瞭解如何申請例外處理的相關資訊。

[什麼是非處方 (OTC) 藥？

OTC 藥物是 Medicare 處方藥計劃通常不承保的非處方藥。<Plan Name> 可為某些非處方藥付費。[*Note: Include a list of OTC drugs the plan pays for with administrative funds.*] <Plan Name> 將免費為您提供這些非處方藥。<plan name> 為這些非處方藥支付的費用將不計入您的 D 部分藥物總費用（即您支付的金額不計入達到承保範圍缺口的金額。）]

若我的藥物不在處方藥一覽表上，該怎麼辦？

若您的藥物不在此處方藥一覽表（承保藥物清單）上，那麼您首先應該聯絡會員服務部，詢問您的藥物是否在承保範圍內。[*Insert for abridged formularies:* 本文件僅包含承保藥物的部分清單，因此 <Plan Name> 可能會承保您的藥物。要瞭解更多資訊，請聯絡我們。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。]

若您得知 <Plan Name> 並未承保您的藥物，則您有兩種選擇：

- 您可向會員服務部索取一份由 <Plan Name> 承保的相似藥物清單。當您收到該清單後，請拿給您的醫生看，並要求醫生開立由 <Plan Name> 承保的相似藥物。
- 您可以要求 <Plan Name> 作出例外處理，並承保您的藥物。請查看以下關於如何申請例外處理的資訊。

如何申請 <mandatory Plan Name's> 的處方藥一覽表例外處理？

您可以要求 <Plan Name> 對我們的承保規則作出例外處理。您可以向我們提出數種例外處理申請。

- [您可以要求我們承保一種藥物，即使它不在我們的處方藥一覽表上。如獲批准，此藥物將按預定分攤費用等級獲得承保，但您不得要求我們以更低的分攤費用等級提供此藥物。
- [*Insert if plan has multiple tiers:* [如果不屬於特殊藥物，]您可要求我們按更低的分攤費用等級承保處方藥一覽表上的藥物。如獲批准，這會減少您必須為藥物支付的金額。]
- 您可以要求我們撤銷對您的藥物的承保限制。例如：對於某些藥物，<Plan Name> 限制了藥物的承保數量。若您的藥物有數量限制，您可以要求我們撤銷限制並承保更多數量。

通常只有在替代藥物包含在計劃的處方藥一覽表中時，[較低的分攤費用藥物]或額外的使用限制對於治療您的病症無法達到相同的效果時，和/或可能造成副作用時，<Plan Name> 才會批准您的例外處理申請。

您應當與我們聯絡，要求我們做出針對處方藥一覽表、[*insert if plan has multiple tiers*] 或使用限制例外處理的初始承保決定。在提出針對處方藥一覽表、[*insert if plan has multiple tiers*]或使用限制例外處理申請時，您應提交一份處方醫師或醫師的聲明以支持您的申請。通常，我們在收到處方醫師的支持聲明後，必須在 72 小時內做出決定。若您或您的醫師認為等候 72 小時再做出決定會對您的健康造成嚴重傷害，您可以申請加急（快速）例外處理。如果您的加急申請獲得批准，我們在收到您的醫師或其他處方醫師的支持聲明後，必須在 24 小時內為您做出決定。

在向醫師提出變更藥物請求或提交例外處理申請之前，我應該做什麼？

無論是我們計劃的新會員還是老會員，您可能正在使用我們處方藥一覽表上沒有的藥物。或者，您正在使用一種在我們處方藥一覽表上的藥物，但您在獲取該藥物時受到限制。例如，您在配藥前可能要獲得我們的事先授權。您應當先和您的醫師談談，以決定您是否應該換用我們承保的適當藥物，

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或提出處方藥一覽表例外處理申請以使我們承保您使用的藥物。在您與醫師討論以確定何種措施對您適合的時候，我們會在您成為我們計劃會員後的前 *must be at least 90* 天內針對某些情況為您的藥物提供承保。

對於所有不在我們處方藥一覽表上的藥物，或如果您在獲取藥物時受到限制，在您去網絡內藥房配藥時，我們將承保 *must be at least 30* 天的臨時供藥（除非您的處方寫明更少天數）。在提供前 *must be at least 30* 天藥量之後，我們將不再為您支付這些藥物的費用，即使您成為計劃會員還不足 *must be at least 90* 天。

若您居住在長期護理機構中，我們將會允許您重新配藥，直到我們提供為您與配藥增量一致的 *must be at least 91 and may be up to a 98* 天份量的過渡期藥物（除非您的處方寫明更少天數）。在您成為我們計劃會員後的前 *must be at least 90* 天內，我們將為您承保這些藥物的多次重新配取。若您需要非處方藥一覽表的藥物，或您獲取藥物的能力受到限制，但您成為我們計劃會員已超過 *must be at least 90* 天，則在您尋求處方藥一覽表例外處理時，我們將會對該藥物承保 *must be at least 31* 天份量的緊急藥量（除非您處方的天數較少）。

<Note: Plans must insert their transition policy for current enrollees with level of care changes, if applicable.>

瞭解更多資訊

更多關於 *<Plan Name>* 處方藥承保的詳細資訊，請參閱您的「承保範圍說明書」及其他計劃資料。

若您對 *<Plan Name>* 有任何疑問，請聯絡我們。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。

若您對 Medicare 處方藥承保範圍有任何疑問，請致電 Medicare，電話：1-800-MEDICARE (1-800-633-4227)（全天候開通）。聽障人士應致電 1-877-486-2048。或瀏覽 <http://www.medicare.gov>。

<Plan Name's> 處方藥一覽表

*<下面的/從下一頁開始的><簡明>*處方藥一覽表介紹了 *<Plan Name>* 承保的*<部分>*藥物的承保資訊。若您難以在清單中找到所需的藥物，請轉到第 *<index page number>* 頁開始的索引。

*[Insert the following paragraph for abridged formulary only:*請記住：本一覽表僅列出 *<Plan Name>* 承保的部分藥物。若您的處方藥未列於本簡要一覽表中，請聯絡我們。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。*]*

表格的第一欄列出了藥物名稱。原廠藥用大寫字母表示（如 *<BRAND NAME EXAMPLE>*），副廠藥則用小寫斜體字母表示（如 *<generic example>*）。

要求/限制欄中的資訊表示 *<Plan Name>* 對於承保您的藥物是否有任何特殊的要求。

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[Note: Sponsors must provide information on the following items when applicable to specific drugs and explain any symbols or abbreviations used to indicate their application: utilization management restrictions; drugs that are available via mail-order, excluded drugs that are covered by the plan; free first fill drugs; limited access drugs' drugs covered in the coverage gap; and drugs covered under the medical benefit (for home infusion drugs only). While these symbols and abbreviations must appear whenever applicable, sponsors are not required to provide associated explanations on every page. They must, however, provide a general footnote on every page stating 「您可以在 [insert of description where information is available, such as 第 page number 頁 or 本表格的末尾[or]開頭找到本表中的符號和縮寫詞含義的相關資訊。]」

- *Plans that cover excluded Part D drugs must use this column to indicate that certain drugs are available only through their benefit. Plans may indicate this with an asterisk/other symbol and a footnote that states: 「Medicare 處方藥計劃通常不承保此處方藥。」您在配取此類處方藥時所支付的金額不計入您的總藥費（即您支付的金額不會計入使您符合災難承保階段資格的金額）。此外，若您正在領取額外補助以支付您的處方藥費用，您將無法為該藥物取得任何額外補助。[Note: Plans must insert any additional restrictions on this coverage, including any capped benefit limit.]」*
- *Plans that offer generic-use incentive programs permitting zero (or reduced) cost-sharing on first generic fills when a member agrees to use the generic rather than the brand name version of a medication must indicate the drugs to which this program applies. Plans may indicate this with an asterisk/other symbol and a footnote that states: 「首次配取時，將以<零>/<較低的>」分攤費用為您提供此處方藥。*
- *Plans that restrict access to any drugs by limiting distribution to a subset of network pharmacies must indicate these drugs. Plans may indicate this with an asterisk/other symbol or footnote states: 「本處方藥可能僅在某些藥房提供。更多資訊，請查閱您的藥房目錄或聯絡會員服務部，電話：<toll-free number>，服務時間為：<days and hours of operation>。聽障人士可致電 <toll-free TTY number>。」*
- *Plans that provide additional coverage for certain drugs in the coverage gap must indicate this with an asterisk/other symbol and a footnote that states, 「我們為達到承保範圍缺口的該處方藥提供額外承保。請參閱承保範圍說明書，瞭解更多關於承保的資訊。」*
- *Plans that provide quantity limits for certain drugs must indicate the amount (days' supply or amount dispensed).*
- *MA-PD or cost plans choosing to provide coverage for any Part D home infusion drugs as part of a bundled payment under a Part C supplemental benefit should indicate this with an asterisk/other symbol and a footnote that states, 「該處方藥<受>/<可能受>我們的醫療福利承保。如需更多資訊，請致電會員服務部，電話：<toll-free number>，服務時間為：<days and hours of operation>。聽障人士可致電 <toll-free TTY number>。」*

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藥物表- 選項 1

藥物名稱	藥物等級 <i>[Column is optional for single tier formularies.]</i>	要求/限制
<Therapeutic Category Name 1> - [Optional:<Plain Language Description>]		
<Drug Name 1, Dosage Form A, Strength A>	<Tier 1>	<Util.Mgmt.>
<Drug Name 2, Dosage Form A, Strength A >	<Tier 1>	<Util.Mgmt.>
<Drug Name 2, Dosage Form B, Strength A >	<Tier 2>	<Util.Mgmt.>
<Drug Name 2, Dosage Form B, Strength B >	<Tier 3>	<Util.Mgmt.>
<Drug Name 3, Strength A>	<Tier 4>	<Util.Mgmt.>
<Therapeutic Category Name 2> - [Optional:<Plain Language Description>]		
<Drug Name 3, Dosage Form A, Strength A >	<Tier>	<Util.Mgmt.>
<Drug Name 4>	<Tier>	<Util.Mgmt.>

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藥物表 - 選項 2

藥物名稱	藥物等級 <i>[Column is optional for single tier formularies.]</i>	要求/限制
<Therapeutic Category Name 1> - [Optional:<Plain Language Description>]		
<Therapeutic Class Name 1> - [Optional:<Plain Language Description>]		
<Drug Name 1>	<Tier 1>	<Util. Mgmt.>
<Drug Name 2, Dosage Form A, Strength A >	<Tier 1>	<Util. Mgmt.>
<Drug Name 2, Dosage Form B, Strength A >	<Tier 2>	<Util. Mgmt.>
<Drug Name 2, Dosage Form B, Strength B >	<Tier 3>	<Util. Mgmt.>
<Therapeutic Class Name 2> - [Optional:<Plain Language Description>]		
<Drug Name 3>	<Tier 2>	<Util. Mgmt.>
<Drug Name 4 Dosage Form A, Strength B>	<Tier 1>	<Util. Mgmt.>
<Drug Name 4, Dosage Form A, Strength B >	<Tier 1>	<Util. Mgmt.>
<Drug Name 2, Dosage Form A, Strength C >	<Tier 2>	<Util. Mgmt.>
<Therapeutic Category Name 2> - [Optional:<Plain Language Description>]		
<Therapeutic Class Name 1> - [Optional:<Plain Language Description>]		
<Drug Name 5>	<Tier>	<Util. Mgmt.>
<Drug Name 6>	<Tier>	<Util. Mgmt.>

General Drug Table instructions:

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OTC drugs may not be included in the formulary table that lists drugs adjudicated at sale but must appear in a separate list or table.

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

For table sub-headings, plans have the option to use either the therapeutic category only (Table Option 1) or both the therapeutic category and therapeutic class (Table Option 2). The category or class names must be the same as those found on the CMS-approved formulary.

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

For Table Option 1, the therapeutic categories should be listed alphabetically within the table. The drugs should then be listed alphabetically under the appropriate therapeutic category; they should not be sorted by therapeutic class. For Table Option 2, 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.

For an abridged formulary, 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.

Drug Name column instructions:

Brand name drugs should be capitalized, e.g., DRUG A. Generic drugs should be lower-case 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, prior authorization, 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.

Drug Tier column instructions:

For plans that provide different levels of cost sharing for drugs depending on their tier, sponsors must include a column indicating the drug’s tier placement. For single tier plans (for instance, all defined standard plans), sponsors have the option to delete the column. Plans may choose from several methods to indicate the tier placement including tier numbers from your plan benefit package (e.g., 1/ 2/ 3), standard tier names from your plan benefit package (e.g., generic/ preferred brand/ other brand), copayment amounts (e.g., \$10/\$20/\$35), or co-insurance percentages (e.g., 10%/25%). The latter two methods are preferred since they are generally easier for members to understand. If one of the two former methods is used, plans must provide an explanation before the table explaining the copayment amount or co-insurance percentage associated with each tier number or tier name. The above choices are also available to sponsors with single tier plans, in that plans would be expected to enter the same

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information in the column beside every drug listed (for instance, identifying all drugs as Tier 1 or subject to a 25% coinsurance).

Plans that have different copayment amounts or co-insurance percentages for retail and mail-order prescriptions may include both retail and mail order amounts within the same column or include separate columns for retail and mail order prescriptions.

Requirements/Limits column instructions:

Part D Plans must indicate any applicable utilization management procedures (e.g., prior authorization, step therapy, quantity limits, etc.), special coverage rules, and/or mail-order procedures for each drug within the Requirement/Limits column.

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

藥物索引

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[Appropriate language, including disclaimers, is expected to appear in this document on topics including: material ID Number (MMG §40.1); Federal contracting (MMG §50.1); non-English translations (MMG §50.4); formulary (MMG § 60.5).]

[BACK COVER]

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