<Client LOGO>

<Date>

<Member Name>

<ADDRESS>

<CITY, STATE ZIP>

Case Number: DUR-ES-xxxxxxxx

Dear <Member Name>,

You are getting this notice because [Plan Name] has received your request for an alternate pharmacy and/or prescriber to better manage your use of prescription [insert as appropriate: {opioids} *or* {benzodiazepines} *or* {opioids and benzodiazepines}].

[*Insert the following when at least one prescriber has responded, and request is Approved:*] {Based on our review and communications with your selected prescribers(s), [*insert prescriber name(s)*], your request for alternate prescriber(s) is approved.

[*Insert the following when at least one pharmacy has responded, and request is Approved:*] {Based on our review and communications with your selected pharmacy(ies), your request for alternate pharmacy(ies) is approved.

[*Insert the following when no prescriber has responded, or prescriber has declined to be alternate, so request is Denied:*] {We have contacted your selected prescriber(s), [insert prescriber name(s)], about your use of these medications. Your request for alternate prescriber(s) is denied

1. due to no response from the prescriber(s).
2. due to prescriber(s) declined the request.
3. due to multiple preference requests.

[*Insert the following when alternate pharmacy request is Denied:*] {We have contacted your selected pharmacy(ies) about your use of these medications. Your request for alternate pharmacy(ies) is denied

1. due to no response from the pharmacy(ies).
2. due to pharmacy(ies) declined the request.
3. due to pharmacy sanctions.
4. due to multiple preference requests.

**What Action Do We Intend To Take?**

As of [*insert date 30 days from the date of this notice*], we will limit your access in the following way(s):

[*Insert the following language as applicable:*]

{You will be required to get your prescription [*insert as applicable:* {opioids} *or* {benzodiazepines} *or* {opioids and benzodiazepines}] from the following prescriber(s):

[*insert name, address and telephone number of prescriber(s)*]

We will not cover these medications at the pharmacy when they are prescribed to you by other doctors [*MA-PDs insert if applicable:* {even if the other doctor is in our network}]. You can ask us to use a different prescriber by calling us or by filling out the form at the end of this notice.}

{You will be required to get your prescription [*insert as applicable:* {opioids} *or* {benzodiazepines} *or* {opioids and benzodiazepines}] from the following pharmacy(ies):

[*insert name, address and telephone number of pharmacy(ies)*]

We will not cover these medications at another pharmacy, even if the other pharmacy is in the plan’s network. You can ask us to use a different pharmacy by calling us or by filling out the form at the end of this notice.}

{We will only cover the following prescription opioid pain medication(s): [*list medications and amounts, if applicable*]

We will not cover any other prescription opioid medications, even if they are included on the plan’s drug list.}

{We will only cover the following amount of prescription opioid pain medication(s): [*describe level that plan will cover*]}

{We will not cover any prescription opioid pain medication, including [*insert beneficiary’s opioid medication name(s)*]*.* This includes opioids that are on the plan’s drug list.}

{We will only cover the following benzodiazepines: [*list medications and amounts, if applicable*]

We will not cover any other benzodiazepines, even if they are included on the plan’s drug list.}

{We will not cover any benzodiazepines, including [*insert beneficiary’s benzodiazepine name(s)*]. This includes benzodiazepines that are on the plan’s drug list.}

This change only affects your access to prescription [*insert as appropriate:* {opioids} *or* {benzodiazepines} *or* {opioids and benzodiazepines}]. Your access to other types of medications will not change.

{**What If I Want to Use a Different [*insert as appropriate:* {Pharmacy} *or* {Prescriber} *or* {Pharmacy or Prescriber}]?**

If you don’t want to use the [*insert as appropriate:* {pharmacy} *or* {prescriber} *or* {pharmacy or prescriber}]we selected for you, you can ask to use a different one. You can give us this information by completing the last page of this notice and sending it to us, or by calling us at the phone number below.}

## What Happens Next?

We will review any information you send us. We will also review information from your prescriber(s). After we make a decision about whether you are safely using your medications, we will send you another notice within 60 days. If we decide you’re at risk and limit your access to these drugs, we’ll send you another notice explaining how you, your prescriber, or your representative can ask for an appeal. You will also receive a notice if we decide you’re not at risk and will not limit your access to these drugs.

Note: If you change to a different Medicare drug plan, we can give your new plan information about your case and any limitations we place on your access under our drug management program. Your new plan may place you in its drug management program as well.

If you have any questions, please call [Plan Name] at [Customer Care Phone Number], [Hours of Operation]. TTY users can call [TTY Number].

Sincerely,

[Plan Name]

[Insert appropriate disclaimers]

**[PLAN NAME] PHARMACY AND PRESCRIBER SELECTION FORM**

Enrollee’s Name: [insert name] Member Number: [insert member ID]

You can give us this information by calling us at [insert phone number], faxing this form to us at [insert fax number], or by sending the completed form to: [insert address].

I prefer to use the following pharmacy (choose two):

Choice #1

|  |  |
| --- | --- |
| Pharmacy Name: |  |
| Address: |  |
| Telephone Number: |  |

Choice #2

|  |  |
| --- | --- |
| Pharmacy Name: |  |
| Address: |  |
| Telephone Number: |  |

I prefer to use the following prescriber (choose two):

Choice #1

|  |  |
| --- | --- |
| Prescriber Name: |  |
| Address: |  |
| Telephone Number: |  |

Choice #2

|  |  |
| --- | --- |
| Prescriber Name: |  |
| Address: |  |
| Telephone Number: |  |