<Logo File Name> <TF ONLY Second Logo File Name>

<RA Plan Name>

<RA Plan Address Line 1>

<RA Plan Address Line 2>

<RA Plan City, RA Plan State RA Plan Zip>

<Date>

<PRESCRIBER NAME>

<PRESCRIBER ADDRESS>

<PRESCRIBER CITY, STATE ZIP>

PRESCRIBER COPY – Your patient recently received this notice. This copy is provided for your information and follow-up.

This letter is intended only for the use of doctors of the individual listed in the letter and may contain confidential and/or proprietary information. If you are not the individual’s doctor, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please destroy this document immediately and contact us at <Customer Care Phone Number> for more information on Transition Fill.

Thank you.

<Plan Name>

**Your Drug iS Not on our List of Covered Drugs (FORMULARY)**

**OR IS SUBJECT TO CERTAIN LIMITS**

<DATE>

<MEMBER NAME> Member DOB: <MM/DD/YYYY> Member ID: <MBRID>

<MEMBER ADDRESS>

<MEMBER CITY, STATE ZIP>

Dear <Member Name>:

We want to tell you that <Plan Name with Plan Type> has provided you with a temporary supply of the following prescription: <name of drug>.

This drug is either not included on our list of covered drugs (called our formulary), or it’s included on the formulary 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 drug. If your prescription is written for fewer than <MonthSupply> days, we’ll allow multiple fills to provide up to a maximum <MonthSupply> days’ temporary supply of medication.

It’s important to understand that this is a temporary supply of this drug. Well before you run out of this drug, you should speak to <Plan Name> and/or the prescriber about:

* changing the drug to another drug that is on our formulary; or
* requesting approval for the drug 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 we approve coverage, then we’ll send you another written notice.

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, contact <Reference for group fielding calls from Member> at <Customer Care Phone Number>. TTY users should call <Customer Care TTY Number>. Live representatives are available <Customer Care Days and Hours of Operation>. You can ask us for a coverage determination at any time. You can also visit our website at <Websites Address>.

**Instructions on how to change your current prescription, 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(s) of why your drug is not covered or is limited.

**NOT IN FORMULARY TF REASON (N) 1A, 1B and 1C:**

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

**Date Filled**: <date filled>

**Reason for Notification**: This drug is not on our formulary. We will not continue to pay for this drug after you have received the maximum <MonthSupply> days’ temporary supply that we are required to cover unless you obtain a formulary exception from us.

**NOT IN FORMULARY WITH QUANTITY LIMIT TF REASON (NQ) 12A, 12B and 12C:**

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

**Date Filled**: <date filled>

**Reason for Notification**: This drug is not on our formulary and is subject to a quantity limit. We impose such limits for safety reasons. We will not continue to provide more than what our quantity limits permit and we will not continue to pay for this drug after you have received the maximum <MonthSupply> days’ temporary supply that we are required to cover unless you obtain a formulary exception from <Plan Name>.

**PRIOR AUTHORIZATION TF REASON (P) 2A, 2B and 2C:**

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

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our formulary, but requires prior authorization. Unless you obtain prior authorization from us by showing us that you meet certain requirements, or 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 the maximum <MonthSupply> days’ temporary supply that we are required to cover.

**STEP THERAPY TF REASON (S) 3A, 3B and 3C:**

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

**Date Filled**: <date filled>

**Reason for Notification**: This drug is on our formulary. However, we will generally only pay for this drug if you first try other drug(s), specifically <AltDrugsS>, 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 formulary first, or we approve your request for an exception to the step therapy requirement, we will not continue to pay for this drug after you have received the maximum <MonthSupply> days’ temporary supply that we are required to cover.

**QUANTITY LIMIT TF REASON (Q) 4A, 4B and 4C:**

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

**Date Filled**: <date filled>

**Reason for Notification**: This drug is subject to a quantity limit (QL). We will not continue to provide more than what our quantity limit permits, which is <AltDrugsQ>, unless you obtain an exception from <Plan Name>.

**How do I change my prescription?**

If your drug is not on our formulary, or is on our formulary, but we have placed a limit on it, then you can ask us what other drug is used to treat your medical condition that is on our formulary; 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 other drug that we cover is an option for you. You have the right to request an exception from us to cover your drug that was 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, your representative, or your prescriber on your behalf may contact us to request a coverage determination, including an exception. Contact us at: <CD Entity Name> <CD Street 1> <CD Street 2> <CD City>, <CD State> <CD Zip>; Phone: <CD Phone Number>; TTY: <CD TTY Number>; Fax: <CD Fax Number>; <CD Hours of Operation>.

If you are requesting coverage of a drug that is not on our formulary, 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 the prescriber’s office. If the exception request involves a drug that is not on our formulary, the prescriber’s statement must indicate that the requested drug is medically necessary for treating your condition because all of the drugs on our formulary 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 formulary, 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.

We must notify you of our 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 we determine, 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 request. We accept standard requests by phone and in writing. We accept expedited requests by phone and in writing. Contact us at: <Appeal Entity Name> <Appeal Street 1> <Appeal Street 2> <Appeal City>, <Appeal State> <Appeal Zip>; Phone: <Appeal Phone Number>; TTY: <Appeal TTY Number>; Fax: <Appeal Fax Number>; <Appeal Hours of Operation>.

Sincerely,

<Plan Name>

<Disclaimer #1>

<Disclaimer #2>

<Disclaimer #3>

<Disclaimer #4>

<Disclaimer #5>

<Disclaimer #6>