CENTERS FOR MEDICARE & MEDICAID SERVICES

How Medicare Drug Plans Use Pharmacies, Formularies, and Common Coverage Rules

Medicare drug plans provide access to high-quality prescription drug coverage. When you get Medicare prescription drug coverage (Part D), you pay part of the costs, and Medicare pays part of the costs. People with limited income and resources may qualify for extra help that can lower or even eliminate out-of-pocket costs for this coverage.

Each plan must provide at least a standard level of coverage set by Medicare. However, plans can vary on which pharmacies they use, which prescription drugs they cover, and how much they charge. Plans design their prescription drug coverage using different methods. Some of these methods are listed below. Becoming familiar with these terms will help you make choices about your coverage:

- Network Pharmacies
- List of covered prescription drugs (Formulary)
- Coverage Rules

Network Pharmacies

Medicare drug plans have contracts with a number of pharmacies that are part of the plan's "network." Your plan may not cover your prescription if you don't go to a network pharmacy. Along with retail pharmacies, your plan's network may include preferred pharmacies, a mail-order program, and a 60 or 90-day retail pharmacy program.

- **Preferred Pharmacies**
  If your plan has preferred pharmacies, it may be in your best interest to use them. Your prescription drug costs (such as a copayment or coinsurance) may be less at a preferred pharmacy because it has agreed with your plan to charge less.
- **Mail-Order Programs**
  Some plans may offer a mail-order program that allows you to get up to a 90-day supply of your covered prescription drugs sent directly to your home. This is usually a cost-effective and convenient way to fill your prescriptions.

Network Pharmacies (continued)

- **60 or 90-Day Retail Pharmacy Programs**
  Some retail pharmacies may also offer a 60 or 90-day supply of covered prescription drugs similar to mail order.

List of covered prescription drugs (Formulary)

Each Medicare drug plan will have a list of prescription drugs that it covers. Plans cover both generic and brand-name prescription drugs. The drug lists must include a range of drugs in the most commonly prescribed categories and classes. This makes sure that people with different medical conditions can get the treatment they need.

The prescription drug list may not include your specific drug. However, in most cases, a similar drug should be available. If you or your doctor don't believe any of the drugs on your plan's drug list are appropriate, you can ask for an exception (See "What do I do if a plan won't cover a drug I need?" on page 5 for more information about your options).

If a plan removes a drug you are taking from their drug list, your plan must notify you at least 60 days in advance. You may have to change the drug you use or pay more for it or file an exception. In most cases, if you are actively taking a drug on their drug list during the calendar year, you will be permitted to continue taking the drug until the end of the year.

Using drugs on your plan's list will generally save you money. Using generics instead of brand-name drugs can also save you money.

- **Generic Drugs**
  According to the Food and Drug Administration (FDA), a generic prescription drug is the same as a brand-name prescription drug in safety, strength, quality, the way it works, how it's taken, how much should be taken, and the way it should be used. Generic prescription drugs use the same active ingredients as brand-name prescription drugs and work the same way. Generic prescription drugs have similar risks and benefits as brand-name prescription drugs. Generic prescription drug makers must prove to the FDA that their product performs in the same way as the brand-name prescription drug. Today, almost half of all prescriptions are filled with generics. In some cases, there may not be a generic prescription drug available for the brand-name prescription drug you take. Talk to your doctor.

List of covered prescription drugs (Formulary) (continued)

- **Tiers**

  Many Medicare drug plans place drugs into different "tiers." Drugs in each tier have a different cost. Some plans may have more tiers and some may have less. The chart below is an example of tiers.

Tier	You Pay	What's Covered?
1	Lowest copayment	Most generic prescription drugs
2	Medium copayment	Preferred, brand-name prescription drugs
3	Higher copayment	Non-preferred, brand-name prescription drugs
Specialty Tier	Highest copayment or coinsurance	Unique, very high-cost prescription drugs

  In some cases, if your drug is in a higher tier and your doctor thinks you need that drug instead of a similar drug on a lower tier, you can file an exception and ask your plan for a lower copayment.

Coverage Rules

Plans may have coverage rules to make sure that certain drugs are used correctly and only when necessary. These rules may include prior authorization, step therapy, and quantity limits as described below.

- **Prior Authorization**

  Some prescription drugs are more expensive than others even though some less expensive prescription drugs work just as well. Other prescription drugs may have more side effects, or have restrictions on how long they can be taken. To be sure certain prescription drugs are used correctly and only when truly necessary, plans may require a "prior authorization." This means before the plan will cover these prescriptions, your doctor must first contact the plan and show there is a medically-necessary reason why you must use that particular prescription drug for it to be covered.

Coverage Rules (continued)

- **Step Therapy**

  Step therapy is a type of prior authorization. With step therapy, in most cases, you must first try certain less expensive drugs that have been proven effective for most people with your condition. For instance, some plans may require you to first try a generic prescription drug (if available), then a less expensive brand-name prescription drug on their drug list, before you can get a similar, more expensive brand-name prescription drug covered.

  However, if you have already tried the similar, less expensive drugs and they didn't work, or if your doctor believes that your medical condition makes it medically necessary for you to be on the more expensive step-therapy prescription drug, he or she can contact the plan to request an exception. If your doctor's request is approved, the step-therapy prescription drug will be covered.

  Example of step therapy:

  Step 1—Dr. Smith wants to prescribe a new sleeping pill to treat Mr. Mason's occasional insomnia. There is more than one type of sleeping pill available. Some of the drugs Dr. Smith considers prescribing are brand-name only prescription drugs covered by Mr. Mason's Medicare drug plan. The plan rules require Mr. Mason to use the generic prescription drug zolpidem first. For most people, zolpidem works as well as brand-name prescription drugs.

  Step 2—If Mr. Mason takes zolpidem but has side effects, his doctor can provide that information to the plan to seek approval to prescribe a brand-name drug. If approved, Mr. Mason's Medicare drug plan will now cover the drug.

- **Quantity Limits**

  For safety and cost reasons, plans may limit the quantity of prescription drugs that they cover over a certain period of time. For example, some people prescribed heartburn medication take 1 capsule per day for 4 weeks. Therefore, a plan may cover only an initial 30-day supply of the heartburn medication. Should you need more medication, you may need your doctor's help in providing more information to extend the therapy.

What do I do if my plan won't cover a prescription drug I need?

If your pharmacist tells you that your Medicare drug plan won't cover a drug you think should be covered, or it will cover the drug at a higher cost than you think you are required to pay, you have the right to the following:

What do I do if my plan won't cover a prescription drug I need? (continued)

- Request a coverage determination from your plan.
- Pay for the prescription, save your receipt, and ask the plan to pay you back by requesting a coverage determination.
- Request a coverage determination if your plan requires you to try another drug before it pays for the drug prescribed for you, or there is a limit on the quantity or dose of the drug prescribed for you and you disagree with the requirement or limit.

You, your doctor, or someone you ask to act on your behalf can call or write to your plan to request that the plan cover the prescription you need. Once your plan receives the request, it has 72 hours (for a standard request) or 24 hours (for an expedited (fast) request) to make its decision.

Note: For some types of coverage determinations called exceptions, you will need a supporting statement from your doctor that explains why you need a certain prescription drug. Check with your plan to find out if a supporting statement is required. Once your plan receives the statement, its decision-making period begins.

If the plan decides not to cover your prescription drug, you can appeal the decision. When you enroll in a Medicare drug plan, the plan will send you information about the plan's appeal process. Read the information carefully and call the plan if you have questions.

Where can I go for more information?

- Contact your Medicare drug plan. The contact information should be in your member materials or on your membership card.
- Read the "Medicare & You" handbook. It includes information about Medicare Prescription Drug Plans in your area.
- Visit www.medicare.gov on the web. Under "Search Tools," select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area." You can also view or download a copy of "Your Guide to Medicare Prescription Drug Coverage" by selecting "Find a Medicare Publication" under "Search Tools."
- Call your State Health Insurance Assistance Program. For their telephone number, look at your "Medicare & You" handbook.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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