Health Care Professional's Part D Fact Sheet

The new Medicare prescription drug program (Part D) is the single biggest change to Medicare in 40 years. Adding a benefit as significant as the new Medicare prescription drug program involves some start-up challenges. The Centers for Medicare & Medicaid Services has taken action to address these issues and make resources available to ensure that you—and your patients—get support. Listed below are steps to make it as easy as possible for you to help your Medicare patients get their medicines.

NEW ACTION TO ASSURE A SMOOTH TRANSITION:

Part D transition drug coverage is now **extended to March 31, 2006 for those individuals who were enrolled in the first few months of the program.** This extra time will help beneficiaries arrange for alternative medication, save more money or allow them to work out a way to continue their current drug if needed. Even after this extension expires, newly enrolled beneficiaries are always entitled to at least a 30-day transitional supply of non-formulary drugs.

WHAT'S COVERED, WHAT'S NOT:

Covered: All plans are required to have formularies that address all medically necessary drugs. Six drug classes of special concern have been specified in which all or substantially all drugs will be on a plan's formulary: anti-neoplastics, anti-HIV/AIDS drugs, immunosupressants, anti-psychotics, anti-depressants and anti-convulsants. **Not covered:** By law, there are certain types of drugs that Medicare must exclude from Part D: barbiturates; benzodiazepines; drugs used for anorexia, weight loss or weight gain; fertility drugs; drugs used for cosmetic purposes or hair growth; cough and cold medicines; prescription vitamins and minerals, and over-the-counter drugs. For your patients that have both Medicare and Medicaid, check with your state Medicaid program as most programs are continuing to cover all or some of these excluded drugs. Go to: www.cms.hhs.gov/States/EDC/list.asp#TopOfPage to check which states cover these excluded drugs.

RESOURCES THAT WILL HELP YOU HELP YOUR PATIENTS:

A **formulary finder** that provides an easy way to access each of the plan's formularies at: http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp

PDP formulary information on the Epocrates website. This familiar medical software company provides both tier and step therapy information, is updated constantly, and can be easily accessed by computer or downloaded to a PDA at: www.epocrates.com

Medicare Prescription Drug Coverage Provider Communication—Request for Prescription Information or Change form is a general fax form to expedite communications between pharmacists and physicians. www.cms.hhs.gov/center/provider.asp

MedicareRx
Prescription Drug Coverage

Clarification about Part B versus Part D drug coverage information and chart found at: www.cms.hhs.gov/pharmacy/downloads/partsbdcoverageissues.pdf

If your patients forget the plan they joined or still need to select a plan, go to www.medicare.gov and select the personal plan finder. Enter their Medicare information. If they have joined, it will display the name of the plan. If not, they can call 1-800-MEDICARE (1-800-633-4227) to get help joining.

Dedicated help for physicians. E-mail us at PRIT@cms.hhs.gov or join the regular conference call at 2 p.m. EST every Tuesday. Call 1-800-619-2457. Pass code: RBDML.

For personalized assistance for people with Medicare, **call 1-800-MEDICARE.** Phone lines are open 24/7.

For help on enrollment information encourage your patients to call 1-800-MEDICARE, go to www.medicare.gov to access the plan finder, or go to www.eldercare.gov to get information about local organizations that can help your patients with personalized counseling. If your patients have low incomes or limited assets and need additional financial help, encourage them to call the Social Security Administration at 1-800-772-1213 or go to www.socialsecurity.gov/prescriptionhelp **to fill out an application.**

GLOSSARY OF COMMON TERMS:

- **Coverage determinations:** The first decision made by a plan regarding the prescription drug benefits an enrollee may be entitled to receive, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request or a decision on the amount of cost sharing for a drug.
- **Exceptions:** A type of coverage determination request. Through the exceptions process an enrollee can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).
- **Appeals:** The process by which an enrollee may challenge a plan's coverage determination. There are five levels in the appeals process: redetermination by the plan, reconsideration by the Part D QIC (an independent review entity) an ALJ hearing, review by the Medicare Appeals Council and review by a federal district court. We expect most appeals to be resolved at the first two levels.

PRESCRIBING PHYSICIAN'S ROLE IN COVERAGE DETERMINATION, EXCEPTIONS AND APPEALS PROCESSES:

Short Decision Making Timeframes

CMS has directed every prescription drug plan to respond to requests without delay. Plans must communicate decisions on initial coverage determinations no later than 24 hours after receiving an expedited request, or 72 hours after receiving a standard request. If a prescribing physician requests a coverage determination on behalf of an enrollee, the physician also will receive notice of the decision from the plan. Coverage determinations include decisions on formulary and tiering exception requests. If the plan fails to meet the timeframe, the case goes to an independent review entity under contract with CMS for a decision on the case. The independent review entity is commonly referred to as the Part D qualified independent contractor (Part D QIC).

Requests Made by Prescribing Physicians

A coverage determination can be requested by a Part D plan enrollee, by an appointed representative or the prescribing physician on behalf of the enrollee. A prescribing physician can also request an **expedited redetermination** (first level of appeal) on behalf of the enrollee. Prescribing physicians cannot request a **standard redetermination** (first level of appeal) or a reconsideration (second level of appeal), unless they are the enrollee's appointed representative. Form CMS-1696 or an equivalent writing can be used to appoint a representative. Form CMS-1696 is available at www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage

Prescribing Physician Supporting Statements

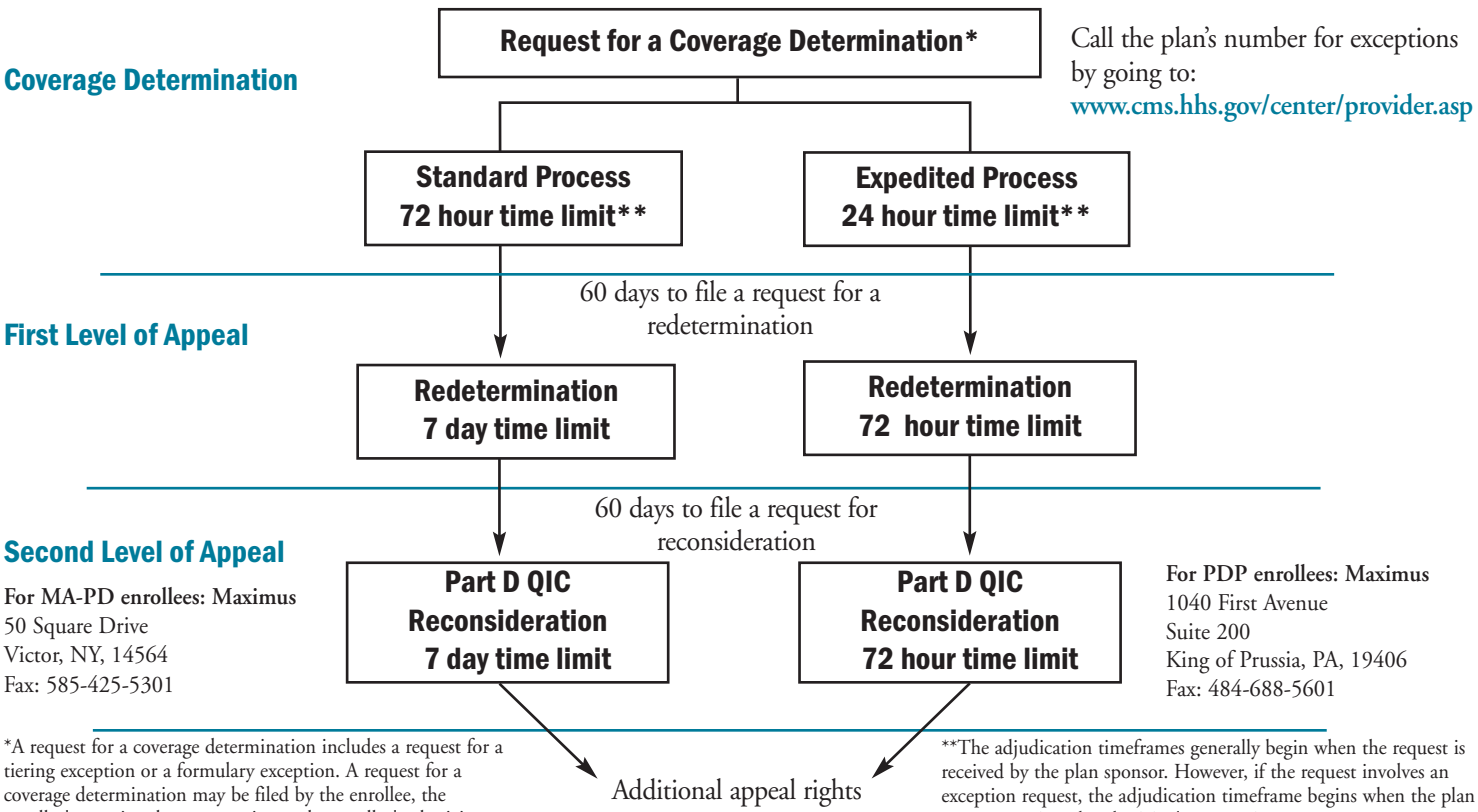
Prescribing physicians have an important role in the exceptions process. Whenever an enrollee requests a formulary or tiering exception, the prescribing physician must provide the Part D plan with an oral or written statement to support the exception request. Formulary exception requests include requests for exceptions to cost utilization management tools, such as step therapy or dose restrictions. The plan's timeframe for making a decision on an exception request does not begin until the prescribing physician's supporting statement is received by the plan. Anyone can go to our coverage determination site at: www.cms.hhs.gov/center/provider.asp to get contact numbers for the plans to facilitate the submission of the supporting statement.

Enrollee's Appeal Rights

If an enrollee doesn't agree with the initial coverage determination made by the plan, the enrollee has the right to appeal the coverage determination. As noted above, the prescribing physician can ask for an expedited first level appeal (redetermination) on behalf of the enrollee. The following chart describes the steps and the time limits of the process. For expedited redeterminations, a Part D plan must give the enrollee (and prescribing physician involved, as appropriate) notice of its decision no later than 72 hours after receiving the request. Decisions on standard redeterminations must be communicated to the enrollee in writing no later than 7 days after receiving the request. If a plan issues an adverse redetermination, the enrollee will receive a notice that includes information on how to request a reconsideration by the Part D QIC.

Medicare Prescription Drug Coverage: How to File a Complaint, Coverage Determination or Appeal
www.medicare.gov/Publications/Pubs/pdf/11112.pdf

CMS Part D Appeals Process



For MA-PD enrollees: Maximus
50 Square Drive
Victor, NY, 14564
Fax: 585-425-5301

For PDP enrollees: Maximus
1040 First Avenue
Suite 200
King of Prussia, PA, 19406
Fax: 484-688-5601

*A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative or the enrollee's physician.

**The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.