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How Medicare Prescription Drug Plans & Medicare Advantage Plans with Prescription Drug Coverage (MA-PDs) Use Pharmacies, Formularies, & Common Coverage Rules

Each Medicare Prescription Drug Plan and Medicare Advantage Plan with prescription drug coverage (MA-PD) must give at least a standard level of coverage set by Medicare. 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, like:

- Network pharmacies
- List of covered prescription drugs (formulary)
- Coverage rules

In this fact sheet, the term "Medicare drug plans" includes both Medicare Prescription Drug Plans and MA-PDs.

Network pharmacies

Medicare drug plans have contracts with pharmacies that are part of the plan's "network." If you go to a pharmacy that isn't in your plan's network, your plan may not cover your drugs. 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, you may save money by using them. Your prescription drug costs (like 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 may be a cost-effective and convenient way to fill prescriptions you take every day.
- **60- or 90-day retail pharmacy programs**
  Some retail pharmacies may also offer a 60- or 90-day supply of covered prescription drugs.

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List of covered prescription drugs (formulary)

Each Medicare drug plan has a list of prescription drugs (called a formulary) that it covers. Plans cover both generic and brand-name prescription drugs. The formulary must include a range of drugs in the most commonly prescribed categories and classes. This helps make sure that people with different medical conditions can get the prescription drugs they need. The formulary might not include your specific drug. However, in most cases, a similar drug should be available. If you or your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) believes none of the drugs on your plan's formulary will work for your condition, you can ask for an exception. See page 5 for more information on filing for an exception.

If your plan removes a drug you're taking from its formulary, in most cases, it must notify you at least 60 days in advance. You may have to change to another drug (that's similar to the one you're taking) on the plan's formulary or pay more to keep taking the drug. You can ask for an exception to continue using the drug that's being removed from your plan's drug list if none of the other drugs on the list will work for your condition. In some cases, if you're actively taking a drug on the formulary during the calendar year, you can continue taking that drug until the end of the year without paying more.

Note: A plan isn't required to tell you in advance when it removes a drug from its formulary if the Food and Drug Administration (FDA) takes the drug off the market for safety reasons, but your plan will let you know afterward.

Generally, using drugs on your plan's formulary will save you money. Using generics instead of brand-name drugs can also save you money.

- **Generic drugs**

  According to the FDA, generic drugs are the same as brand-name drugs in safety, strength, quality, the way they work, how they're taken, and the way they should be used. Generic prescription drugs use the same active ingredients as brand-name prescription drugs and work the same way. Generic prescription drug makers must prove to the FDA that their product works 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 prescriber.

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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.

Example of drug plan 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 (more expensive) tier and your prescriber 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. See page 5 for more information on filing for an exception.

Remember, the table above is only an example—your plan's tier structure may be different.

Coverage rules

Plans may have coverage rules to make sure certain drugs are used correctly and only when medically necessary. These rules may include prior authorization, step therapy, and quantity limits as described below and on page 4.

- **Prior authorization**
  Plans may require a "prior authorization" to make sure certain prescription drugs are used correctly and that only when medically necessary. This means before your plan will cover a certain drug, your prescriber must first contact your plan and show there's a medically necessary reason why you must use that particular prescription drug.

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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 are also approved for use for your condition before you can move up a "step" to a more expensive drug. For example, your plan may require you to first try a generic prescription drug (if available), then a less expensive brand-name prescription drug on its formulary, before it will cover a similar, more expensive brand-name prescription drug.

However, if you've already tried the similar, less expensive drugs and they didn't work, or if your prescriber believes your medical condition makes it medically necessary for you to be on the more expensive step therapy prescription drug, he or she can contact your plan to ask for an exception. See page 5 for more information on filing for an exception. If your prescriber's request is approved, your plan will cover the step therapy prescription drug.

Example of step therapy

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

Step 2—If Mr. Mason takes the generic sleeping pill but has side effects, Dr. Smith can use that information to ask the plan to approve a brand-name drug. If approved, Mr. Mason's Medicare drug plan will cover the brand-name drug for Mr. Mason.

- **Quantity limits**

For safety and cost reasons, plans may limit the amount of prescription drugs they cover over a certain period of time. For example, most people who are prescribed a 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. If you need more, you may need your prescriber's help to provide more information to the plan.

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

If you belong to a Medicare drug plan, you have the right to:

- Get a written explanation (called a "coverage determination") from your Medicare drug plan if your plan won't cover or pay for a certain prescription drug you need, or if you're asked to pay a higher share of the cost.
- Ask your Medicare drug plan for an exception (which is a type of coverage determination). If you ask for an exception, your doctor or other prescriber must give your drug plan a supporting statement that explains the medical reason for the request (like why similar drugs covered by your plan won't work or may be harmful to you). You can ask for an exception if:
  - You or your prescriber believes you need a drug that isn't on your drug plan's formulary.
  - You or your prescriber believes that a coverage rule (like step therapy) should be waived.
  - You believe you should get a non-preferred drug at a lower copayment because you can't take any of the alternative drugs on your drug plan's list of preferred drugs.

You or your prescriber must contact your plan to ask for a coverage determination. If your network pharmacy can't fill a prescription as written, the pharmacist will give or show you a notice that explains how to contact your Medicare drug plan so you can make your request.

A standard request for a coverage determination (including an exception) should be made in writing (unless your plan accepts requests by phone). You or your prescriber can also call or write your plan for an expedited (fast) request.

If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. Your plan's written decision will explain how to file an appeal. You should read this decision carefully, and call your plan if you have questions.

For more information on Medicare appeal rights, visit Medicare.gov/appeals. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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