[*Instructions: Any FIDA-IDD plan that seeks a prescription transfer must use this model notice to request permission from a Participant to fill his/her prescription[s] at a different network pharmacy than the one the Participant is currently using. The FIDA-IDD plan may attach a written permission form to this letter for the Participant to fill out. The Participant may provide permission by either calling the plan or pharmacy or mailing/faxing the permission form. The model notice should only be used when the transfer of the prescription is not initiated by the Participant (or someone on his or her behalf). Unsolicited phone calls made by the pharmacy or FIDA-IDD plan seeking permission from Participants to transfer prescriptions are not permitted.*]

<DATE>

<PARTICIPANT NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <PARTICIPANT NAME>:

<Plan Name> has determined that the following medication[s] you are currently taking could be purchased through another [*insert one:* specialty, retail, *or* mail-order pharmacy].

<medication1><dosage>

<medication2><dosage>

<medication3><dosage>

[*Provide an explanation of the benefits realized by the Participant if he/she decides to transfer his/her prescription(s) to the different pharmacy.*]

If you want to continue to purchase your medications from your current pharmacy, you do not need to respond to this letter. Purchasing your medication from your current pharmacy will not affect your current coverage.

With your permission, we are able to fill your prescription[s] at <insert name of pharmacy>. We cannot change the way you fill your prescription[s] so that you can do so at this pharmacy until we have received permission from you. You may call your Care Manager to start the process of making this change.

If you want more information regarding how to transfer prescriptions, please call your Care Manager. You can also call Participant Services at <phone number>. TTY users should call <TTY number>. We are available from <hours of operations>.

Sincerely,

<Plan Representative>

<Plan’s legal or marketing name> is a managed care plan that contracts with Medicare, the New York State Department of Health (Medicaid) and the Office for People With Developmental Disabilities to provide benefits to Participants through the Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration.

Participants generally must use network pharmacies to access their prescription drug benefit.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

Benefits may change on January 1 of each year.

You can get this information for free in other languages. Call <toll-free number> and <TTY/TDD numbers> during <hours of operation>. The call is free. [*This disclaimer must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.*]

You can get this information for free in other formats, such as large print, braille, or audio. Call <toll-free number> and <TTY/TDD numbers> during <hours of operation>. The call is free.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 (TTY users, call 711) or online at icannys.org.