**Instructions to Health Plans**

* [*If plans do not use the term “Member Services,” plans should replace it with the term the plan uses.*]
* [*Plans should also consult the most recent applicable chapters of the Prescription Drug Benefit Manual (PDBM) for more information on benefits and beneficiary protections, beneficiary communications, and formularies (these would include PDBM chapters 5 and 6), and 42 CFR Part 423 Subpart V (Part D Communication Requirements).*]
* [*Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation*.]
* [*Plans may place a QR code on materials to provide an option for members to go online.*]
* [*Plans have the option of deleting the footer following the introduction (for example, the footer is not necessary in the actual list of drugs).*]
* [*Plans may insert an effective date on the first page of the document.*]
* [*Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*
* *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes the Table of Contents or any item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, insert:* **This section is continued on the next page***).*
* *Ensure plan-customized text is in plain language and complies with member reading level requirements.*
* *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples, as applicable.*
* *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Managed Long Term Services and Supports (MLTSS)).*
* *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
* *Avoid separating a heading or subheading from the text that follows when paginating the model.*
* *Use universal symbols or commonly understood pictorials.*
* *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
* *Consider using regionally appropriate terms or common dialects in translated models.*
* *Include instructions and navigational aids in translated models in the translated language rather than in English.*]

[*The following items must appear on the cover page:*

**<Plan name, Plan type> | <year>** ***List of Covered Drugs* (*Formulary*)**

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN**

[*Insert on the front cover the HPMS Approved Formulary File Submission ID, Version Number*.]

[*The following information must appear on both the front and back covers of comprehensive formularies: Insert one* This formulary was updated on <MM/DD/YYYY>. *or* We have made no changes to the Drug List since <MM/DD/YYYY>. For more recent information or other questions, contact us at <toll-free phone and TTY numbers>, <days and hours of operation> or visit <web address>.]

[*Dates used in the front and back of the formulary covers should be the same as the footer of the document.*]

**Introduction**

This document is called the *List of Covered Drugs* (also known as the Drug List).It tells you which prescription drugs [insert if applicable: and over-the-counter (OTC) drugs] [insert if applicable: and items]are covered by <plan name>. The Drug Listalso tells you if there are any special rules or restrictions on any drugs covered by <plan name>. Key terms and their definitions appear in the last chapter of the *Evidence of Coverage*.

[In accordance with CMS formulary guidance and the Prescription Drug Benefit Manual, plans must indicate when the document was last updated by including either “Updated on MM/DD/YYYY” or “No changes made since MM/DD/YYYY” *along with* “For more recent information or other questions, contact us at <toll-free phone and TTY numbers>, <days and hours of operation> or visit <Internet address>” on both the front and back covers of this document*.* Plans may include the Material ID only on the front cover.]

[*Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.*]

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1. Disclaimers

This is a list of drugs that members can get in <plan name>.

* [*Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V) and included in any state-specific guidance provided by New Jersey’s Division of Medical Assistance and Health Services (DMAHS).*]
* [*As required at 42 CFR § 438.10(d)(2), all disclaimers and taglines that explain the availability of alternate formats using auxiliary aids and services or oral interpretation services and the toll-free telephone number of the entity providing choice counseling services as required by § 438.71(a), must be in conspicuously visible font.*]
* You can always check <plan name>’s up-to-date *List of Covered Drugs* online at <URL> or call Member Services [*plans insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document]. This call is free.
* You can get this document for free in other formats, such as large print, braille, or audio. Call Member Services [*plans insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document]. This call is free. [*The text of this bullet point must be in print no smaller than 18 point font.*]
* [*Plans may include either the current multi-language insert or provide a Notice of Availability. Plans that choose to use the current multi-language insert per 42 CFR §§ 422.2267(e)(31) and (e)(33) should include:* We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at <phone number>. Someone that speaks <language> can help you. This is a free service. [*This information must be included in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, Japanese, and any additional languages required by the state*.]

*OR*

*Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31) and 423.2267(e)(33), plans may choose to provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in <State> and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.*]

* [*Plans that meet the Medicare 5 percent alternative language threshold per 42 CFR §§ 422.2267(a) and 423.2267(a) or Medicaid required language threshold insert:* This document is available for free in <languages that meet the threshold requirement>.]
* [Plans also must simply describe:
* how they will request a member’s preferred language other than English and/or alternate format,
* how they will keep the member’s information as a standing request for future mailings and communications so the member does not need to make a separate request each time, and
* how a member can change a standing request for preferred language and/or format.]

1. Frequently Asked Questions (FAQ)

Find answers to questions you have about this *List of Covered Drugs*. You can read all of the FAQ to learn more or look for a question and answer.

B1. What prescription drugs are on the *List of Covered Drugs*? (We call the *List of Covered Drugs* the “Drug List” for short.)

The drugs on the Drug List that starts in section <section letter> are the drugs covered by <plan name>. These drugs are available at pharmacies within our network. A pharmacy is in our network if we have an agreement with them to work with us and provide you services. We refer to these pharmacies as “network pharmacies.”

* <Plan name> will cover all medically necessary drugs on the Drug List if:
* your doctor or other prescriber says you need them to get better or stay healthy, **and**
* you fill the prescription at a <plan name> network pharmacy.
* <Plan name> may have additional steps to access certain drugs. Refer to question B4 for more information.

[*Plans that offer indication-based formulary design must include:* If we cover a drug only for some medical conditions, we clearly identify it on the Drug List along with the specific medical conditions that are covered.]

You can also find an up-to-date list of drugs we cover on our website at <Internet address> or call Member Services [*plans may insert reference for reader:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document].

B2. Does the Drug List ever change?

Yes, and <plan name> must follow Medicare and Medicaid rules when making changes. We may add or remove drugs on the Drug List during the year.

We may also change our rules about drugs. For example, we could:

* Decide to require or not require prior authorization for a drug. (Prior authorizationis permission from <plan name> before you can get a drug.)
* Add or change the amount of a drug you can get (called quantity limits).
* Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to question B4.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless:

* a new, cheaper drug comes on the market that works as well as a drug on the Drug List now, **or**
* we learn that a drug is not safe, **or**
* a drug is removed from the market.

Questions B3 and B6 have more information on what happens when the Drug List changes.

* You can always check <plan name>’s current Drug List online at <Internet address>. Updates to the *Drug List* are posted on the website monthly.
* You can also call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] to check the current Drug List.

B3. What happens when there is a change to the Drug List?

Some changes to the Drug List will happen **immediately**. For example:

* [*Plans that otherwise meet all requirements and want the option to make immediate substitutions of certain new drugs (for instance, immediately replace brand name drugs with their generic equivalents or immediately replace reference products with interchangeable biological products) must provide the following advance general notice of changes:* **Substitutions of certain new versions of drugs.**We may immediately remove the drugs from the *Drug List* if we replace them with certain new versions of that drug. When we add a new version of a drug, we may also decide to keep the brand name drug or original biological product on the list but change its coverage rules or limits.
* We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
* We can make these changes only if the drug we are adding:
  + is a new generic version of a brand name drug, or
  + is a certain new biosimilar version of original biological products on the Drug List (for example, adding an interchangeable biosimilar that can be substituted for an original biological product without a new prescription).
  + Some of these drug types may be new to you. For more information, refer to Section B14.
* You or your provider can ask for an exception from these changes. We will send you a notice with the steps you can take to ask for an exception. Refer to questions B10-B12 for more information on exceptions.]
* **A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or effective or the drug’s manufacturer takes a drug off the market, we may immediately take it off the Drug List. If you are taking the drug, we will send you a notice after we make the change. [*Plans should include information advising members what to do after they are notified (for example, contact the prescribing doctor, etc.).*]

**We may make other changes that affect the drugs you take.** We will tell you in advance about these other changes to the Drug List. These changes might happen if:

* The FDA provides new guidance or there are new clinical guidelines about a drug.
* [*Plans that meet the requirements for the option to immediately substitute a new generic drug, insert:* We remove a brand name drug from the *Drug List* when adding a generic drug that is not new to the market **or**
* we remove an original biological product when adding a biosimilar, or
* we change the coverage rules or limits for the brand name drug.]
* [*Plans that are not making immediate generic substitutions insert:* We add a generic drug and replace a brand name drug currently on the *Drug List*, or
* we add a new biosimilar to replace an original biological product currently on the *Drug List,* or
* we change the coverage rules or limits for the brand name drug.]

When these changes happen, we will:

* Tell you at least 30 days before we make the change to the Drug List or
* Let you know and give you a <*supply limit (must be at least the number of days in the plan’s one-month supply)*>-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

* if there is a similar drug on the Drug List you can take instead or
* whether to ask for an exception from these changes. To learn more about exceptions, refer to questions B10-B12 for more information.

B4. Are there any restrictions or limits on drug coverage or any required actions to take to get certain drugs?

Yes. Some drugs have coverage rules or have limits on the amount you can get. In some cases you, your doctor, or other prescriber must do something before you can get the drug. [*Plans should omit bullets as needed and reflect only those utilization management procedures actually used by the plan.*] For example:

* **Prior authorization:** For some drugs, you, your doctor, or other prescriber must get authorization from <plan name> before you fill your prescription. Prior authorization is different from a referral. <Plan name> may not cover the drug if you do not get authorization.
* **Quantity limits:** Sometimes <plan name> limits the amount of a drug you can get.
* **Step therapy:** Sometimes <plan name> requires you to do step therapy. This means you will have to try drugs in a certain order for your medical condition. You might have to try one drug before we will cover another drug. If your prescriber thinks the first drug doesn’t work for you, then we will cover the second.
* **Indication-based coverage:** If <plan name> covers a drug only for some medical conditions, we clearly identify it on the Drug List along with the specific medical conditions that are covered.

You can find out if your drug has any additional requirements or limits by looking in the key/legend in section <section letter/number>. You can also get more information by visiting our website at <URL>. [Plans that apply prior authorization and/or step therapy insert the following with applicable information: We have posted online [a document **or** documents] that [explains **or** explain] our [insert as applicable: prior authorization restriction **or** step therapy restriction **or** prior authorization and step therapy restrictions].]You may also ask us to send you a copy.

You can ask for an exception to these limits. This will give you time to talk to your doctor or other prescriber. They can help you decide if there is a similar drug on the Drug List you can take instead or whether to ask for an exception. Refer to questions B10-B12 for more information about exceptions.

B5. How will I know if the drug I want has limits or if there are any actions required to get the drug?

The List of Drugs by <medical condition/drug type> has a column labeled “Necessary actions, restrictions, or limits on use.”

B6. What happens if <plan name> changes their rules about how they cover some drugs (for example, prior authorization, quantity limits, and/or step therapy restrictions)?

[*Plans should omit information as needed and reflect only those utilization management procedures actually used by the plan.*] In some cases, we will tell you in advance if we add or change prior authorization, quantity limits, and/or step therapy restrictions on a drug. Refer to question B3 for more information about this advance notice and situations where we may not be able to tell you in advance when our rules about drugs on the Drug List change.

B7. How can I find a drug on the Drug List?

There are two ways to find a drug:

* you can search alphabetically by the drug’s name, **or**
* you can search by <medical condition *or* drug type>.

To search **alphabetically**, use the Index of Covered Drugs section. You can find it [*give instructions*]. The Index of Covered Drugs is an alphabetical list of all of the drugs included in the Drug List. Brand name drugs and generic drugs [*insert if applicable*: as well as over-the-counter (OTC) drugs] are listed in the index.

[Plans insert one of the following paragraphs depending on whether drugs are organized by **medical condition** or **drug type** in the drug listings:

To search **by medical condition**, find section <letter/number> labeled “List of Drugs by <Medical Condition>”. The drugs in this section are grouped into categories depending on the type of medical conditions they are used to treat. For example, if you have a heart condition, you should look in that category. That is where you will find drugs that treat heart conditions.

*or*

To search **by drug type**, find the section <letter/number> labeled “List of Drugs by <Drug Type>”. The drugs in this section are grouped into categories by type. For example, if you are taking a medicine for migraines, you should look in the “Antimigraine Agents” category. That is where you will find drugs that treat migraines.]

B8. What if the drug I want to take is not on the Drug List?

If you don’t find your drug on the Drug List, call Member Services [*plans insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] and ask about it. If you learn that <plan name> will not cover the drug, you can do one of these things:

* Ask Member Services for a list of drugs like the one you want to take. Then show the list to your doctor or other prescriber. They can prescribe a drug on the Drug List that is like the one you want to take. **Or**

You can ask the health plan to make an exception to cover your drug. Refer to questions B10-B12 for more information about exceptions.

B9. What if I am a new <plan name> member and can’t find my drug on the Drug List or have a problem getting my drug?

We can help. We may cover a temporary <supply limit *(must* *be the number of days in plan’s one-month supply)*>-day supply of your drug during the first [*must be at least 90*] days you are a member of <plan name>. This will give you time to talk to your doctor or other prescriber. They can help you decide if there is a similar drug on the Drug List you can take instead, or whether to ask for an exception.

If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of <supply limit *(must be the number of days in plan’s one-month supply)*> days of medication.

We will cover a <supply limit *(must be the number of days in plan’s one-month supply)*>-day supply of your drug if:

* you are taking a drug that is not on our Drug List, **or**
* health plan rules do not let you get the amount ordered by your prescriber, **or**
* the drug requires prior authorization by <plan name>, **or**
* you are taking a drug that is part of a step therapy restriction.

[*Include if the following coverage is provided by the Medicaid program: If you are taking a drug that <plan name> does not consider to be a Part D drug, you have the right to get a one-time, 72-hour supply of the drug.*]

If you are in a nursing home or other long-term care facility and need a drug that is not on the Drug List or if you cannot easily get the drug you need, we can help. If you have been in the plan for more than <time period (must be at least 90 days)>days, live in a long-term care facility, and need a supply right away:

* We will cover one <supply limit *(must be at least a 31-day supply)*>supply of the drug you need (unless you have a prescription for fewer days), whether or not you are a new <plan name> member.
* This is in addition to the temporary supply during the first <time period (*must be at least 90)*> days you are a member of <plan name>.

[*Note: If applicable, plans must insert a description of their transition policy for current members with changes to their level of care, as specified in section 30.4.7 of Chapter 6 of the Prescription Drug Benefit Manual.*]

B10. Can I ask for an exception to cover my drug?

Yes. You can ask <plan name> to make an exception to cover a drug that is not on the Drug List.

You can also ask us to change the rules on your drug.

* For example, <plan name> may limit the amount of a drug we will cover. If your drug has a limit, you can ask us to change the limit and cover more.
* Other examples: You can ask us to drop step therapy restrictions or prior authorization requirements.

B11. How can I ask for an exception?

To ask for an exception, call [*plans should include information on the best person to call – for example,* *your Care Manager or Member Services*]. [*Insert*: Your Care Manager *or* A Member Services representative] will work with you and your provider to help you ask for an exception. You can also read Chapter 9 section <section letter/number> of the *Evidence of Coverage* to learn more about exceptions.

B12. How long does it take to get an exception?

After we get a statement from your prescriber supporting your request for an exception, we will give you a decision within 72 hours. [*Plans include concise instructions about how and where plan members or their prescribers must send the statement.*]

If you or your prescriber think your health may be harmed if you have to wait 72 hours for a decision, you can ask for an expedited exception. This is a faster decision. If your prescriber supports your request, we will give you a decision within 24 hours of getting your prescriber’s supporting statement.

B13. What are generic drugs?

Generic drugs are made up of the same active ingredients as brand name drugs. They usually cost less than the brand name drug and generally work just as well. They usually don’t have well-known names. Generic drugs are approved by the Food and Drug Administration (FDA). There are generic drugs available for many brand name drugs. Generic drugs usually can be substituted for brand name drugs at the pharmacy without a new prescription.

<Plan name> covers both brand name drugs and generic drugs.

**B14. What are original biological products and how are they related to biosimilars?**

When we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have forms that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

For more information on drug types, refer to Chapter 5 of the *Evidence of Coverage*.

B15. What are over-the-counter (OTC) drugs?

OTC stands for “over-the-counter.” <Plan name> offers some OTC drugs through the NJ FamilyCare (Medicaid) portion of the plan’s coverage at no cost to you. You need a prescription for OTC drugs to be covered. These OTC drugs are listed in this Drug List in section <section letter/number>.

B16. Does <plan name> cover non-drug OTC products?

Yes. <Plan name> covers **some** non-drug OTC products when they are prescribed for you by your provider. These non-drug OTC products are listed in this Drug List in section <section letter/ number>.

[*Plans should include the following language*: Examples of non-drug OTC products include <examples of plan’s covered non-drug OTC products>.]

B17. Can I get my drugs through <Mail-Order/Long-Term Supply>?

[*Plans should include only if they offer extended-day supplies. Plans should modify the section title and language below to reflect their specific plan as needed, consistent with their approved extended-day benefit. If included, plans should begin their response with* “Yes.”]

* [Mail-Order Program. We offer a mail-order program that allows you to get up to a <number>-day supply of your prescription drugs sent directly to your home.]
* [Long-Term Supply. We offer a way to get a long-term supply of “maintenance” drugs on our plan’s Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)]

[For more information about getting drugs through mail-order or long-term supply, call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document].]

B18. What is my [copayment/copay]?

<Plan name> members have no [copayments/copays] for prescription and over-the-counter (OTC) drugs and non-drug products as long as the member follows the plan’s rules. Refer to questions B14 and B15 for more information about OTC drugs and non-drug products.

Tiers are groups of drugs on our Drug List.

[*Plans should modify the explanation below consistent with their tier model, to include a description of the types of drugs (for example, generic, brand name) on each tier. Plans must include tier examples such as the following:*

* Tier 1 Generic drugs have $0 [copayment/copay].
* Tier 1 Brand name drugs have $0 [copayment/copay]]

[*Plans must ensure the tier label or description of the types of drugs on each tier is consistent with their approved plan benefit package*. *Plans must also include a statement that all tiers have no copayment/copay.*]

OTCs have a $0 [copayment/copay].

If you have questions, call Member Services [*plans insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document].

1. Overview of the *List of Covered Drugs*

The *List of Covered Drugs* gives you information about the drugs covered by <plan name>. If you have trouble finding your drug in the list, turn to the Index of Covered Drugs that begins in section <section letter/number>. The index alphabetically lists all drugs covered by <plan name>.

[***Note:*** *Plans must provide information on the following items when applicable to specific drugs and explain any symbols or abbreviations used to indicate their application: utilization management restrictions, drugs that are available via mail-order, limited-access drugs, and drugs covered under the medical benefit (for home infusion drugs only). While the symbols and abbreviations must appear whenever applicable, plans are not required to provide associated explanations on every page. They must, however, provide a general footnote on every page stating:* You can find information on what the symbols and abbreviations in this table mean by referring to[*insert description of where information is available, such as section*].]

C1*.* List of Drugs by <Medical Condition/Drug Type>

[Plans insert one of the following paragraphs depending on whether drugs are organized by **medical condition** or **drug type** in the drug listings:

The drugs in this section are grouped into categories depending on the type of medical conditions they are used to treat. For example, if you have a heart condition, you should look in the category, <therapeutic category name>. That is where you will find drugs that treat heart conditions.

*or*

The drugs in this section are grouped into categories by type. For example, if you are taking a medicine for migraines, you should look in the “Antimigraine Agents” category. That is where you will find drugs that treat migraines.]

[*If plans use codes in the “Necessary actions, restrictions, or limits on use” column, they should include a key. Plans are not required to include a key on every page, but plans must provide a general footnote, in the same font size plans use in this document, on every page stating:* **You can find information on what the symbols and abbreviations in this table mean by referring to[*insert description of where information is available*]**. *The following key is only an example. Plans do not have to use the same abbreviations/codes.*]

Here are the meanings of the codes used in the “Necessary actions, restrictions, or limits on use” column:

(g) = Only the generic version of this drug is covered. The brand name version is not covered.

M = The brand name version of this drug is in Tier 3. The generic version is in Tier 1.

PA = Prior authorization (approval): you must have approval from the plan before you can get this drug.

ST = Step therapy: you must try another drug before you can get this one.

The first column of the table lists the name of the drug. Generic drugs are listed in lower-case italics (for example, <*generic example*>), brand name drugs are capitalized (for example, <BRAND NAME EXAMPLE>), and OTC drugs and products are listed in lower case (for example, <otc example>). The information in the “Necessary actions, restrictions, or limits on use” column tells you if <plan name> has any rules for covering your drug.

[*Plans have the option to insert a table to illustrate drugs either by therapeutic category or by therapeutic category further divided into classes. An example of each type of table is presented below.*]

<Therapeutic Category> – [*Optional:* *Plans are encouraged to insert a plain language description of the category. Plans include additional therapeutic categories as needed.*]

| Name of drug | What the drug will cost you (tier level) | Necessary actions, restrictions, or limits on use |
| --- | --- | --- |
| <AZASAN> | $0 (<Tier level>) | <PA> |
|  |  |  |
|  |  |  |

*or*

**<Therapeutic Category> –** [*Optional:* *Plans are encouraged to insert a plain language description of the category.* Plans include additional therapeutic categories further divided into classes as needed.]

| Name of drug | What the drug will cost you (tier level) | Necessary actions, restrictions, or limits on use |
| --- | --- | --- |
| *<Therapeutic Class Name 1> -* [*Optional: <Plain Language Description>*] | | |
| <Drug Name 1> | $0 (<Tier level>) | <Util. Mgmt.> |
| <Drug Name 2> | $0 (<Tier level>) | <Util. Mgmt.> |
| *<Therapeutic Class Name 2> -* [*Optional: <Plain Language Description>*] | | |
| <Drug Name 1> | $0 (<Tier level>) | <Util. Mgmt.> |
| <Drug Name 2> | $0 (<Tier level>) | <Util. Mgmt.> |

**[*General Drug Table instructions:***

*Column headings should be repeated on each page of the table.*

*Plans can include a “plain-language” description of the therapeutic category next to the name of each category. For example, instead of only including the category, “Dermatological Agents,” plans would include “Dermatological Agents – Drugs to treat skin conditions.”*

*List therapeutic categories alphabetically within the table, and list drugs alphabetically under the appropriate therapeutic category. If plans use the second option and further divide the categories into classes, the therapeutic categories should be listed alphabetically and the therapeutic classes listed alphabetically under the appropriate category. The drugs should then be listed alphabetically under the appropriate therapeutic class.*

*The table must include at least two covered drugs for each therapeutic category/class except when only one drug exists in the category or class or when two drugs exist in the category or class but one is clinically superior to the other as per your CMS-approved formulary.*]

**[*“Name of Drug” column instructions:***

*Brand name drugs should be capitalized (for example,* DRUG A*). Generic drugs should be lower case and italicized (for example, penicillin). OTC drugs and products should be lower case (for example,* aspirin*). Plans may include the generic name of a drug next to the brand name. For purposes of this section, OTCs, regardless of brand name or generic, should be listed in lower case. Proper nouns should still have an initial capital.*

*If there are differences in formulary status, quantity limit, prior authorization, step therapy, or other restrictions or benefit offerings (for example, available via mail order, etc.) for a drug based on its differing dosage forms or strengths, the formulary must clearly identify how it will treat the different formulations of that same drug.* *Differences in dosage forms should be simplified, and abbreviations/acronyms defined for beneficiary understanding.*]

**[*“<What the drug will cost you> (tier level)” column instructions:***

*Plans should put the appropriate tier level in parentheses next to the copayment/copay as shown in the example above.*]

**[*Necessary actions, restrictions, or limits on use column instructions:***

*Plans may include abbreviations within this column (for example, QL for quantity limits) but must include a key at the beginning of the table explaining each abbreviation.*

*Plans must explain any symbols or abbreviations used to show use restrictions, drugs that are available via mail order, non-Part D drugs or OTC items that are covered by Medicaid, limited-access drugs, and drugs covered under the medical benefit (for home infusion drugs only and for plans that specifically ask and are approved in the plan benefit package to bundle home infusion drugs and services under the medical benefit). Plans may also use abbreviations to show drugs that are not available via mail-order.*]

D. Index of Covered Drugs

In this section, you can find a drug by searching for its name alphabetically. This will tell you the page number where you can find additional coverage information for your drug.

[*Plans must include an alphabetical listing of all drugs included in the formulary that indicates the page where members can find coverage information for that drug. Plans may use more than one column for the index listing. The inclusion of this list is required and should start on a separate page.*]