<DATE>

<MEMBER NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <MEMBER NAME>:

This letter is to inform you that we have provided you with a temporary supply of the following prescription[s]:

***Note**: Plans may include information about multiple transition supplies on the same notice.*

[**Name of Drug**: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug is not covered on our formulary. [*Insert for members who do not reside in a LTC facility:* "We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 30> day supply during your first <must be at least 90>days in <Plan name> unless you obtain a formulary exception from <Plan Name>."] [*Insert for members who reside in a LTC facility:* "We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 93 day supply> during your first <must be at least 90> days in <Plan name> unless you obtain a formulary exception from <Plan Name>."]

[**Name of Drug**: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug is not covered on our formulary. In addition, we could not provide the full amount that was prescribed because of quantity limits for safety reasons. [*Insert for members who do not reside in a LTC facility:* "We will allow you to refill your *<name of drug>* prescription until we have provided you with a *<must be at least 30>* day supply, but we will not pay for it after that unless you obtain a formulary exception from <Plan Name>.] [*Insert for members who reside in a LTC facility:* "We will allow you to refill your *<name of drug>* prescription but will stop providing additional fills after your first <must be at least 90> days in <Plan Name> unless you obtain a formulary exception from <Plan Name>.]

[**Name of Drug**: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug requires prior authorization. [*Insert for members who do not reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days

supply allowed is a <must be at least 30> day supply during your first <must be at least 90> days in <Plan name>, unless you obtain <Plan Name>'s prior authorization or you obtain an exception to the prior authorization from <Plan Name>."] [*Insert for members who reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 93> day supply during your first <must be at least 90> days in <Plan name> unless you obtain a prior authorization or you obtain an exception to the prior authorization from <Plan Name>."]

[**Name of Drug**: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug will be covered only if you first try certain other drugs on our formulary, as part of a step therapy program. [*Insert for members who do not reside in a LTC facility:* "We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 30> day supply during your first <must be at least 90> days in <Plan name> unless you try other drugs on our formulary first or you obtain an exception to the step therapy requirement from <Plan Name>."] [*Insert for members who reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 93> day supply during your first <must be at least 90> days in <Plan name> unless you try other drugs on our formulary first or you obtain an exception to the step therapy requirement from <Plan Name>."]

***Note**: The following notice provision for Emergency Fill and Level of Care Change transitions is optional. However, we encourage plans notify beneficiaries of Emergency Fill and Level of Care Change Transitions.*

[**Name of Drug**: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug requires prior authorization. We will cover this drug only while you seek to obtain an exception to the prior authorization from <Plan Name>.]

[**Name of Drug**: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug will be covered only if you first try certain other drugs on our formulary, as part of a step therapy program. We will cover this drug only while you seek to obtain an exception to the step therapy requirement from <Plan Name>.]

[**Name of Drug**: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug is not covered on our formulary. In addition, we could not provide the full amount that was prescribed because of quantity limits for safety reasons. We will cover this drug only while you seek to obtain a formulary exception from <Plan Name>.]

[**Name of Drug**: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug is not covered on our formulary. We will cover this drug only while you seek to obtain a formulary exception from <Plan Name>."]]

***Note**: The following notice provision is optional, as it technically falls outside the definition of a transition fill. However, we encourage plans to notify beneficiaries of partial fills due to quantity limits for formulary drugs.*

[**Name of Drug**: *<name of drug>*

Date Filled: *<date filled>*

Reason for Notification: This drug is covered on our formulary. However, we could not provide the full amount that was prescribed because of plan quantity limits. We will not provide more than our quantity limits permit unless you obtain a formulary exception from <Plan Name>.]

How do I change my prescription?

If your drug is not covered on our formulary or is covered on our formulary but we have placed a prior authorization, quantity limit, or other limit on it, you can ask us if we cover another drug used to treat your medical condition. If we cover another drug for your condition, we strongly encourage you to ask your doctor if any of these drugs is an option for you. If your doctor tells you that none of the drugs we cover for treating your condition is medically appropriate for treating your condition, you have the right to request a formulary exception from us. You also have the right to request a formulary exception if your doctor tells you that a prior authorization, quantity limit, or other limit we have placed on a drug you are taking is not medically appropriate for treating your condition.

How do I request an exception?

The first step in requesting an exception is for you or your prescribing doctor to contact us. <Provide the necessary address, fax number, and phone number>.

Your doctor must submit a statement supporting your request. The doctor's statement must indicate that the requested drug is medically necessary for treating your condition because none of the drugs we cover for treating your condition would be as effective as the requested drug or would have adverse effects for you. If the exception involves a prior authorization, quantity limit, or other limit we have placed on a drug you are taking, the doctor's statement must indicate that the prior authorization or limit would not be appropriate given your condition or would have adverse effects for you.

Once the physician's statement is submitted, we must notify you of our decision no later than 24 or 72 hours, depending on whether the request is an expedited request or a standard request. Your request will be expedited if we determine, or your doctor tells us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

What if my request is denied?

If your request is denied, you have the right to appeal by asking us to review our decision. You must request this appeal within 60 calendar days from the date of our first decision. <You must file a standard request in writing/we accept standard requests by telephone and in writing. We accept expedited requests by telephone and in writing. Provide the necessary address, fax number, and phone number>.

If you need help to ask for a formulary exception or for more information about our transition policy, please call <Customer/Member> Service at <phone number>. TTY/TDD users should call <TTY/TDD number>. We are available from <hours of operations>.

Sincerely,

<Plan Representative>