<Address Line 1>, <Address Line 2>
<City>, <State> <Zip>

Notice about Two Part D Coverage Issues
for Your <DRUG NAME(S)> Prescription(s)

<DATE>
<ENROLLEE NAME>
<ADDRESS>
<CITY, STATE ZIP>

Dear <ENROLLEE NAME>:

We want to tell you about 2 important coverage issues for the following prescription(s):

Name of Drug(s): <DRUG NAME(S)>
Date(s) Filled: <DATE FILLED>
Prescribed by: <PRESCRIBER NAME>

There are **2 separate issues** that both need your attention. To continue coverage for your prescription for <DRUG NAME(S)> from <PRESCRIBER NAME>, you'll need to address both of these issues:

Issue 1: This drug(s) is either not on our list of covered drugs (called our formulary) or it's included on the formulary, but subject to certain limits, as described in more detail later in this letter. <PLAN NAME> is required to provide you with a temporary supply of this drug(s). After you have received a <insert transition supply limit> days' temporary supply, we'll stop paying for this drug(s), unless you change to another drug(s) on our formulary, demonstrate you meet our criteria, or you are granted an exception. (See page <PAGE #> of this letter to find out what you can do about this issue.)

Issue 2: Your provider isn't enrolled in Medicare. Even if you change to another drug(s) on our formulary or get an approval for this drug(s), <PLAN NAME> can only cover prescriptions for this drug(s) from <PRESCRIBER NAME> up to a 3-month supply or until <DATE>, whichever comes first, unless <PRESCRIBER NAME> enrolls in Medicare. (See page <PAGE #> of this letter to find out what you can do about this issue 2.)

Read the following pages to find more information about each of these issues, and the steps you can take to fix them. After reading this letter, if you still have questions or need help, contact:

- <PLAN NAME> at <NUMBER> or NUMBER> (TTY users), on <DAYS> from <TIME> to <TIME> <TIME ZONE(S)>.
- The <STATE> State Health Insurance Program (SHIP) at <NUMBER> is also available to help Medicare beneficiaries.

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- Medicare at 1-800-MEDICARE (1-800-633-4227) is available anytime, 24 hours a day, 7 days a week to assist you. TTY users should call 1-877-486-2048.

Sincerely,

<PLAN NAME>

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ISSUE 1: YOUR DRUG(S) IS NOT ON OUR LIST OF COVERED DRUGS (FORMULARY) OR IS SUBJECT TO CERTAIN LIMITS

What is Issue 1?

We want to tell you that <PLAN NAME> has provided you with a temporary supply of the following prescription(s): <list medications[s] here>.

This drug[s] is either not included on our list of covered drugs (called our formulary), or it's included on the formulary but subject to certain limits, as described in more detail later in this letter. <PLAN NAME> is required to provide you with a temporary supply of this drug[s], as follows:

[*Insert for members who do not reside in an LTC facility*: < In the outpatient setting, we're required to provide a maximum of [*insert supply limit (must be at least a 30-day supply)*] of medication. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum [*insert supply limit (must be at least a 30-day supply)*] of medication.>. [*Insert for members who reside in an LTC facility*: <For a resident of a long-term care facility, we're required to provide a maximum of [*insert supply limit (must be at least a 91-day supply and may be up to a 98-day supply, depending on dispensing increment)*] of medication. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum [*insert supply limit (must be at least a 91-day supply and may be up to a 98-day supply)*] of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts to prevent waste).>]

It's important that you understand that this is a temporary supply of this drug(s). Well before you run out of this drug(s), you should speak to <PLAN NAME> and/or your prescriber about:

- changing to another drug(s) to another drug(s) that is on our formulary; or
- requesting approval for the drug(s) by demonstrating that you meet our criteria for coverage; or
- requesting an exception from our criteria for coverage.

When you request approval for coverage or an exception from coverage criteria, these are called coverage determinations. Don't assume that any coverage determination, including any exception you have requested or appealed has been approved just because you receive more fills of a drug. If we approve coverage, then we'll send you another written notice. **Instructions on how to change your current prescription[s], how to ask for a coverage determination, including an exception, and how to appeal a denial if you disagree with our coverage determination are discussed at the end of this letter.**

The following is a specific explanation of why your drug[s] <is/are> not covered or <is/are> limited.

***[Note**: Plans may include information about multiple temporary supplies in the same notice.]*

<WellCare® Health Plans / OHANA HEALTH PLAN / Easy Choice HEALTH PLAN A WellCare Company>

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<**Name of Drug**: *<name of drug>*
Date Filled: *<date filled>*
Reason for Notification: This drug is not on our formulary. [*Insert where applicable:* In addition, a prior exception you received for coverage of this drug has recently expired.] We will not continue to pay for this drug after you have received the maximum *[insert number]* days' temporary supply that we are required to cover, unless you obtain <a> <an additional> formulary exception from us.>

<**Name of Drug**: *<name of drug>*
Date Filled: *<date filled>*
Reason for Notification: This drug is not on our formulary. In addition, we could not provide the full amount that was prescribed, because we limit the amount of this drug that we provide at one time. This is called a quantity limit and we impose such a limit for safety reasons. In addition to imposing quantity limits as this drug is dispensed for safety reasons, we will not continue to pay for this drug after you have received the maximum *[insert number]* days' supply that we are required to cover 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 on our formulary, but requires prior authorization. Unless you obtain a prior authorization from us by showing us that you meet certain requirements, or we approve your request for an exception to the prior authorization requirements, we will not continue to pay for this drug after you have received the maximum [*insert number*] days' temporary supply that we are required to cover.>

<**Name of Drug**: *<name of drug>*
Date Filled: *<date filled>*
Reason for Notification: This drug is on our formulary. However, we will generally only pay for this drug if you first try other drug(s), specifically <Insert Step drug(s)>, as part of what we call a step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe, effective, and lower cost drug before progressing to other more costly drugs. Unless you try the other drug(s) on our formulary first, or we approve your request for an exception to the step therapy requirement, we will not continue to pay for this drug after you have received the maximum [*insert number*] days' temporary supply that we are required to cover.>

<Name of Drug: *<name of drug>*
Date Filled: *<date filled>*
Reason for Notification: This drug is on our formulary. However, we will generally only pay for this drug if you first try a generic version of this drug. Unless you try the generic drug on our

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formulary first, or we approve your request for an exception, we will not continue to pay for this drug after you have received the maximum [*insert number*] days' temporary supply that we are required to cover.>

<**Name of Drug**: *<name of drug>*
Date Filled: *<date filled>*
Reason for Notification: This drug is on our formulary and is subject to a quantity limit (QL). We will not continue to provide more than what our QL permits, which is <insert the QL>, unless you obtain an exception from <Plan Name>.>

***[Note**: The following choices are for Emergency Fill and Level of Care Change and are optional. However, we encourage plans to notify beneficiaries of Emergency Fill and Level of Care Change temporary supplies.]*

<**Name of Drug**: *<name of drug>*
Date Filled: *<date filled>*
Reason for Notification: This drug is not on our formulary. We will cover this drug for <days supply on filled claim – must be at least 31 days> while you seek to obtain a formulary exception from <Plan Name>. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made. >

<**Name of Drug**: *<name of drug>*
Date Filled: *<date filled>*
Reason for Notification: This drug is on our formulary and requires prior authorization. We will cover this drug for <days supply on filled claim – must be at least 31 days> while you seek to obtain coverage by showing us that you meet the prior authorization requirements. You can also ask us for an exception to the prior authorization requirements if you believe they should not apply to you for medical reasons. >

<**Name of Drug**: *<name of drug>*
Date Filled: *<date filled>*

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Reason for Notification: This drug is on our formulary, but will generally be covered only if you first try certain other drugs as part of our step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. We will cover this drug for <days supply on filled claim – must be at least 31 days> while you seek to obtain coverage by showing us that you meet the step therapy criteria. You can also ask us for an exception to the step therapy requirement if you believe they should not apply to you for medical reasons. >

What do I need to do about Issue 1?

You must ***either*** change to another drug(s) ***or*** obtain approval from <PLAN NAME> to continue receiving coverage of <DRUG NAME(s)>.

How do I change my prescription?

If your drug[s] is not on our formulary, or is on our formulary, but we have placed a limit on it, then you can ask us what other drug[s] used to treat your medical condition is on our formulary, ask us to approve coverage by showing that you meet our criteria, or ask us for an exception. We encourage you to ask your prescriber if this other drug[s] that we cover is an option for you. You have the right to request an exception from us to cover your drug [s] that was originally prescribed. If you ask for an exception, your prescriber will need to provide us with a statement explaining why a prior authorization, quantity limit, or other limit we have placed on your drug is not medically appropriate for you.

How do I request a coverage determination, including an exception?

You or your prescriber may contact us to request a coverage determination, including an exception. <PROVIDE THE NECESSARY ADDRESS, FAX NUMBER, AND PHONE NUMBER>.

If you are requesting coverage of a drug that is not on our formulary, or an exception to a coverage rule, your prescriber must provide a statement supporting your request. It may be helpful to bring this notice with you to the prescriber or send a copy to his or her office. If the exception request involves a drug that is not on our formulary, the prescriber's statement must indicate that the requested drug is medically necessary for treating your condition, because all of the drugs on our formulary would be less effective as the requested drug or would have adverse effects for you. If the exception request involves a prior authorization, or other coverage rule we have placed on a drug that is on our formulary, the prescriber's statement must indicate that the coverage rule, wouldn't be appropriate for you given your condition or would have adverse effects for you.

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We must notify you of our decision no later than 24 hours if the request has been expedited, or no later than 72 hours if the request is a standard request, from when we receive your request. For exceptions, the timeframe begins when we obtain your prescriber's statement. Your request will be expedited if we determine, or your prescriber tells us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.

What if my request for coverage is denied?

If your request for coverage is denied, you have the right to appeal by asking for a review of the prior decision, which is called a redetermination. You must request this appeal within 60 calendar days from the date of our written decision on your coverage determination. [*Insert one:* <You must file a standard request in writing.> or <We accept standard requests by phone and in writing.>] We accept expedited requests by phone and in writing. <PROVIDE THE NECESSARY ADDRESS, FAX NUMBER, AND PHONE NUMBER>.

What if I need help with Issue 1?

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary fill of a drug, contact us at <TOLL FREE NUMBER> <DAYS/HOURS OF OPERATION>. TTY users should call <TTY NUMBER>. Live representatives are available from <days/hours of operations when live representative take calls>. You can ask us for a coverage determination at any time. You can also visit our website at <insert web address>.

You must also take steps to address Issue 2. Go to the next page to learn more about this issue and what you can do.

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ISSUE 2: YOUR PRESCRIBER IS NOT ENROLLED IN MEDICARE

In addition to Issue 1 with your drug, there is an issue with <PLAN NAME> covering prescriptions from the prescriber. You must also address this problem in order to continue getting coverage for your prescription(s) for <DRUGS NAME(S)> from <PRESCRIBER NAME>.

What is Issue 2?

<PRESCRIBER NAME> hasn't enrolled in Medicare. Unless he/she does so, <PLAN NAME> can only cover prescriptions for <DRUG NAME(S)> from him/her up to a 3-month supply of each drug, or until <DATE>, whichever comes first. [*When prescriber is a contract provider, MAPDs and Cost plans, use this language:* <We're sending you this notice so that we can assist you in avoiding any interruption in your coverage for this prescription(s).>] [*When prescriber is a non-contract provider, MAPDs and Cost plans, and all other Part D plans, use this language:* <We're sending you this notice so you can take action to avoid an interruption in your coverage for this prescription(s)>.]

Medicare now requires doctors and most other providers who prescribe drugs to enroll in Medicare in order for their prescriptions to be covered under Medicare Part D. The purpose is to prevent Medicare fraud and improve the quality of care for people with Medicare. Most Part D prescribers are already enrolled; however, < PRESCRIBER NAME> isn't enrolled.

[*When prescriber is a contract provider, MAPDs and Cost plans use this language:*
<<PLAN NAME> will contact <PRESCRIBER NAME> immediately to ask if he/she will enroll in Medicare, so that your future prescriptions for <drug name(s)> from him/her can continue to be covered by <PLAN NAME>. Even if he/she doesn't want to accept Medicare for medical services, <PRESCRIBER NAME> can still enroll in Medicare just to prescribe. If <PRESCRIBER NAME> won't enroll in Medicare and you want your prescription(s) for <DRUG NAME(S)> to continue to be covered after <DATE>, we will help you find a different prescriber in <PLAN NAME>'s network who is enrolled in Medicare.>]

[*When prescriber is a non-contract provider, MAPDs and Cost plans, and all other Part D plans, use this language:*

<**What do I need to do about Issue 2?**

If you think you may need more prescriptions for <DRUG NAME(S)> from <PRESCRIBER NAME>, you have **3 main options**:

1) Contact <PRESCRIBER NAME> immediately and ask if he/she will enroll in Medicare Part D, so that your future prescriptions for <DRUG NAMES> from him/her can continue to be covered by <PLAN NAME>. Even if he/she doesn't want to accept Medicare for medical services, he/she can still enroll in Medicare just to

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prescribe**.** It's important that you talk with <PRESCRIBER NAME> right away, because the Part D enrollment process can take some time.

2) If <PRESCRIBER NAME> won't enroll in Medicare and you want your prescription(s) for <DRUG NAME(S)> to continue to be covered after <DATE>, you must find a different prescriber who is enrolled in Medicare. You will then need to contact the new prescriber as soon as possible to discuss this prescription(s).

3) If <PRESCRIBER NAME> won't enroll in Medicare and you still want to get your prescriptions for <DRUG NAME(S)> from him/her, you will have to pay the full cost out of pocket for the drug(s) in the future.>>

We want you to know that the Centers for Medicare & Medicaid Services (CMS) has been conducting an extensive outreach campaign for more than a year to try to make sure Part D prescribers are aware of this new requirement. <OPTIONAL: In addition, <PLAN NAME> contacted <PRESCRIBER NAME> about this new requirement <on <DATE(s)>> <in advance>.>However, according to the most recent available record, <PRESCRIBER NAME> isn't enrolled in Medicare.

What if I have questions or need help with Issue 2?

- Contact <PLAN NAME> at <NUMBER> or <NUMBER> (TTY users), on <DAYS> from <TIME> to <TIME> <TIME ZONE>. [*PDPs use this language:* <We can help you check your provider's most recent Medicare status.>]

- The <STATE> State Health Insurance Program (SHIP) at <PHONE> is also available to help Medicare beneficiaries.

- If you have any questions about Medicare's new requirement or need help finding a new provider who is enrolled in Medicare, please contact Medicare at 1-800-MEDICARE (1-800-633-4227), anytime, 24 hours a day/7 days a week. (TTY users should call 1-877-486-2048.) You can also visit https://www.medicare.gov/physiciancompare/search.html to look for a new provider. *Note:* Switching to a different Medicare Part D plan won't solve Issue #2, because <PRESCRIBER NAME> hasn't enrolled in Medicare.

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<'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.> <WellCare/Easy Choice Health Plan> (HMO) <, a WellCare company,> is a Medicare Advantage organization with a Medicare contract. Enrollment in <WellCare/'Ohana/EasyChoice> (HMO) depends on contract renewal.

<WellCare (PDP) is a Medicare-approved Part D sponsor. Enrollment in WellCare (PDP) depends on contract renewal.> This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-paymerns and restrictions may apply. <Benefits, premiums and/or co-payments/coinsurance> may change on January 1 of each year. The <formulary, pharmacy network, and/or provider network> may change at any time. You will receive notice when necessary. <WellCare/'Ohana/Easy Choice> uses a formulary. Please contact <WellCare/'Ohana/Easy Choice> for details.

†Other <pharmacies/physicians/providers> are available in our network.

<COMPANY> complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak <Spanish><or><Chinese>, language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)。