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How Medicare Drug Plans Use Pharmacies, Formularies, & Common Coverage Rules

Each Medicare drug plan must give at least a standard level of coverage set by Medicare. Plans can vary on pharmacies they use, 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 Medicare Advantage Plans with prescription drug coverage (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.

List of covered prescription drugs (formulary)

Most Medicare drug plans have their own list of covered drugs, called a formulary. 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. All Medicare drug plans generally must cover at least 2 drugs per drug category, but the plans can choose which specific drugs they cover.

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.

A Medicare drug plan can make some changes to its drug list during the year if it follows guidelines set by Medicare. Your plan may change its drug list during the year because drug therapies change, new drugs are released, and new medical information becomes available.

If the change involves a drug you're currently taking, your plan must do one of these:

- Give you notice in writing at least 60 days before the date the change becomes effective.
- At the time you request a refill, provide written notice of the change and a 60-day supply of the drug under the same plan rules as before the change.

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 it'll let you know afterward.

You may need to change the drug you use or pay more for it. In some cases, you can keep taking the drug until the end of the year. You can also ask for an exception. See page 5.

Generally, using drugs on your plan's formulary will save you money. If you use a drug that isn't on your plan's drug list, you'll have to pay full price instead of a copayment or coinsurance, unless you qualify for a formulary exception. All Medicare drug plans have negotiated to get lower prices for the drugs on their drug lists, so using those drugs will generally save you money. Also, using generic drugs instead of brand-name drugs may save you money.

List of covered prescription drugs (formulary) (continued)

- **Generic drugs**
  The FDA says generic drugs are copies of brand-name drugs and are the same as those brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. Generic drugs use the same active ingredients as brand-name prescription drugs. Generic drug makers must prove to the FDA that their product works the same way as the brand-name prescription drug. In some cases, there may not be a generic drug the same as the brand-name drug you take, but there may be a generic drug that will work as well for you. Talk to your doctor or other prescriber.
- **Tiers**
  To lower costs, many plans place drugs into different "tiers" on their formularies. Each tier costs a different amount. A drug in a lower tier will cost you less than a drug in a higher tier. Each plan can divide its tiers in different ways.

Example of a drug plan's 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 tiers 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 5.

- **Prior authorization**

  Plans may require a "prior authorization" to make sure certain prescription drugs are used correctly and only when medically necessary. This means before your plan will cover a certain drug, you must show the plan you meet certain criteria for you to have that particular drug.

  Step therapy

  Step therapy is a type of prior authorization. In most cases, you must first try a certain less-expensive drug on the plan's formulary that's been proven effective for most people with your condition before you can move up a "step" to a more expensive drug. For instance, some plans may require you first try a generic drug (if available), then a less expensive brand-name drug on their drug list before you can get a similar, more expensive, brand-name drug covered.

  However, if your prescriber believes that because of your medical condition it's medically necessary for you to be on a more expensive step therapy drug without trying the less expensive drug first, you or your prescriber can contact the plan to request an exception.

  Your prescriber can also request an exception if he or she believes you'll have adverse health effects if you take the less expensive drug, or if your prescriber believes the less expensive drug would be less effective. Your prescriber must give a statement supporting the request. If the request is approved, the plan will cover the more expensive drug, even if you didn't try the less expensive drug first. See page 5 for more information on filing for an exception.

  Example of step therapy

  Step 1—Dr. Smith wants to prescribe an ACE inhibitor to treat Mr. Mason's heart failure. There's more than one type of ACE inhibitor. Some of the drugs Dr. Smith considers prescribing are brand-name drugs covered by Mr. Mason's Medicare drug plan. The plan rules require Mr. Mason to use a generic drug first. For most people, the generic drug works as well as the brand-name drugs.

Coverage rules (continued)

Step 2—If Mr. Mason takes the generic drug but has side effects or limited improvement, Dr. Smith can provide that information to the plan to request approval to cover a brand-name drug that Dr. Smith wants to prescribe. If approved, Mr. Mason's Medicare drug plan will then cover the requested brand-name drug.

- **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 prescribed heartburn medication take 1 tablet per day for 4 weeks. Therefore, a plan may cover only an initial 30-day supply of the heartburn medication.

  If your prescriber believes that, because of your medical condition, a quantity limit isn't medically appropriate (for example, your doctor believes you need a higher dosage of 2 tablets per day), you or your prescriber can contact the plan to ask for an exception.

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.

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

You or your prescriber must ask your plan 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 can call 1-877-486-2048.

Where can I go for more information?

- Contact your Medicare drug plan. The contact information is in your member materials or on your membership card.
- Read the "Medicare & You" handbook. It includes information about Medicare drug plans in your area. You can view or print the handbook at Medicare.gov/medicare-and-you.
- Visit the Medicare Plan Finder at Medicare.gov/find-a-plan. The Medicare Plan Finder allows you to search for and compare coverage options available in your area.
- Read the "Your Guide to Medicare Prescription Drug Coverage" booklet. You can view or print the booklet at Medicare.gov/publications.
- Call your State Health Insurance Assistance Program (SHIP). Visit shiptacenter.org or call 1-800-MEDICARE for the phone number of your SHIP.
- Call 1-800-MEDICARE.

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Notes

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