



Revised January 2021

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.

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 might not cover your drugs. Along with retail pharmacies, your plan’s network might include preferred pharmacies, a mail-order program, or an option for retail pharmacies to supply a 2- or 3-month supply.

- **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 3-month 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 regularly.

- **2- or 3-month retail pharmacy programs**

Some retail pharmacies may also offer a 2- or 3-month 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 includes at least 2 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 plans can choose which specific drugs they cover. Plans are required to cover almost all drugs within these protected classes: antipsychotics, antidepressants, anticonvulsants, immunosuppressants, cancer drugs, and HIV/AIDS drugs.

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 7 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, or new medical information becomes available.

Plans may immediately remove drugs from their formularies after the Food and Drug Administration (FDA) considers them unsafe or if their manufacturer removes them from the market. Plans meeting certain requirements also can immediately remove brand name drugs from their formularies and replace them with new generic drugs, or they can change the cost or coverage rules for brand name drugs when adding new generic drugs. If you're currently taking any of these drugs, you'll get information about the specific changes made afterwards.

For other changes involving a drug you're currently taking that will affect you during the year, your plan must do one of these:

- Give you written notice at least **30 days** before the date the change becomes effective.
- At the time you request a refill, provide written notice of the change and at least a **month's supply** under the same plan rules as before the change.

You may need to change the drug you use or pay more for it. You can also ask for an exception (see page 7).

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 another 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 plan can divide its tiers in different ways. Each tier costs a different amount. Generally, a drug in a lower tier will cost you less than a drug in a higher tier.

Example of a drug plan’s tiers

- **Tier 1**—Most generic prescription drugs. Lowest copayment.
- **Tier 2**—Preferred, brand-name prescription drugs. Medium copayment.
- **Tier 3**—Non-preferred, brand-name prescription drugs. Higher copayment.
- **Specialty tier**—Very high cost prescription drugs. Highest copayment or coinsurance.

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 7 for more information on filing for an exception.

Remember, this 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**

You may need drugs that require prior authorization. This means before the plan will cover a particular drug, you must show the plan you meet certain criteria for you to have that particular drug. Plans also do this to be sure these drugs are used correctly. Contact your plan about its prior authorization requirements, and talk with your prescriber.

Plans may also use prior authorization when they cover a medication for certain medical conditions, but not all medical conditions for which a drug is approved. When this occurs, plans will likely have alternative medications on their formulary (drug list) for the other medical conditions, for which the drug can be prescribed.

However, if your prescriber believes it's medically necessary for you to be on that particular drug even though you don't meet the prior authorization criteria, you or your prescriber can contact the plan to request an exception. Your prescriber must give a statement supporting the request. If the request is approved, the plan will cover the particular drug, even if you didn't get prior authorization for the 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 7 for more information on filing for an exception.

Coverage rules (continued)

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 higher-cost ACE inhibitors covered by Mr. Mason’s Medicare drug plan. The plan rules require Mr. Mason to use a lower-cost ACE inhibitor first. For most people, the lower-cost drug works as well as the higher-cost drug.

Step 2—If Mr. Mason takes the lower-cost drug but has side effects or limited improvement, Dr. Smith can prescribe the higher-cost ACE inhibitor.

• 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.

• Opioid pain medication safety checks

Safety reviews at the pharmacy

When you fill a prescription at the pharmacy, Medicare drug plans and pharmacists routinely check to make sure the prescription is correct, that there are no interactions, and that the medication is appropriate for you. They also conduct safety reviews to monitor the safe use of opioids and other frequently abused medications. These reviews are especially important if you have more than one doctor who prescribes these drugs. In some cases, the Medicare drug plan or pharmacist may need to first talk to your doctor before the prescription can be filled.

Your drug plan or pharmacist may do a safety review when you fill a prescription if you:

- Take potentially unsafe opioid amounts as determined by the drug plan or pharmacist.
- Take opioids with benzodiazepines like Xanax®, Valium®, and Klonopin®.
- Are newly using opioids—you may be limited to an initial 7-day supply or less, to decrease the likelihood of addiction or long-term use.

Coverage rules (continued)

If your pharmacy can't fill your prescription as written, the pharmacist will give you a notice explaining how you or your doctor can call or write to your plan to ask for a coverage decision. If your health requires it, you can ask the plan for a fast coverage decision. You may also ask your plan for an exception to its rules before you go to the pharmacy, so you'll know if your plan will cover the medication. Visit [Medicare.gov/medicare-prescription-drug-coverage-appeals](https://www.Medicare.gov/medicare-prescription-drug-coverage-appeals) to learn how to ask for an exception.

Drug management programs

Some Medicare drug plans will have a drug management program to help patients who are at risk for prescription drug abuse. If you get opioids from multiple doctors or pharmacies, your plan may talk with your doctors to make sure you need these medications and that you're using them appropriately.

If your Medicare drug plan decides your use of prescription opioids and benzodiazepines may not be safe, the plan will send you a letter in advance. This letter will tell you if the plan will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a doctor or pharmacy that you select.

Before your Medicare drug plan places you in its drug management program, it will notify you by letter, and you'll be able to tell the plan which doctors or pharmacies you prefer to use. You and your doctor can appeal if you disagree with your plan's decision or think the plan made a mistake.

Note: The opioid safety reviews at the pharmacy and the drug management programs generally don't apply to you if you have cancer, get palliative or end-of-life care, are in hospice, or if you reside in a long-term care facility.

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 file 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.

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/claims-appeals/how-do-i-file-an-appeal](https://www.medicare.gov/claims-appeals/how-do-i-file-an-appeal). 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](https://www.Medicare.gov/medicare-and-you).
- Visit the Medicare Plan Finder at [Medicare.gov/plan-compare](https://www.Medicare.gov/plan-compare). 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](https://www.Medicare.gov/publications).
- Call your State Health Insurance Assistance Program (SHIP). Visit [shiptacenter.org](https://www.shiptacenter.org) or call 1-800-MEDICARE for the phone number of your SHIP.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you’ve been discriminated against. Visit [Medicare.gov/about-us/nondiscrimination/accessibility-nondiscrimination.html](https://www.Medicare.gov/about-us/nondiscrimination/accessibility-nondiscrimination.html), or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Paid for by the Department of Health & Human Services.

