



<MONTHDATE, YEAR>

<FIRST NAME> <LAST NAME>  
<ADDRESS LINE 1>  
<ADDRESS LINE 2>  
<CITY>, <STATE> <ZIP>

<Subscriber ID>

Dear <FIRST NAME> <LAST NAME>:

This letter is to inform you that <PLAN NAME> has provided you with a <temporary/limited> supply of the following <prescription/prescriptions>: <MEDICATIONLIST>.

<This drug is/These drugs are> either not included on our list of covered drugs (called our formulary) or included on the formulary, but subject to certain limits, as described in more detail further below. Our records indicate that you are a <new enrollee/current enrollee> affected by formulary changes implemented this year by <PLAN NAME> and that you are within your first 90 days of coverage for this plan year. <Insert for members who do not reside in an LTC facility: Therefore, in the outpatient setting, <PLAN NAME> is required to provide at least a 30-day supply unless the prescription is written for less and does not provide for refills.> <Insert for members who reside in a LTC facility: For a resident of a long-term care facility, <PLAN NAME> is required to provide at least a 91-day supply and maybe up to a 98-day supply, consistent with the dispensing increment, with refills provided, if needed (unless the prescription is written for less).>

It is important that you understand that this is a <temporary/limited> supply of <this drug/these drugs.> Before this supply ends, you should speak to <PLAN NAME> and/or your physician regarding whether you should change the <drug/drugs> you are currently taking, or request an exception from <PLAN NAME> to continue coverage of <this drug/these drugs>.

If you need assistance in requesting an exception, or for more information about our transition policy, please call <Customer Service/Member Services> at <PHONE NUMBER>. TTY users should call <TTY/TDD NUMBER>. We are happy to take your calls from <HOURS OF OPERATION>. Instructions on how to apply for an exception or how to change your current <prescription/prescriptions> are discussed at the end of the letter.

The following is an explanation of why your <drug is/drugs are> not covered or <is/are> limited under<PLAN NAME>.

<Name of Drug: <DRUG NAME>

Date Filled: <DATE FILLED>

**Reason for Notification:** This drug is not covered on our formulary. Because you are within your first 93 days of coverage with <PLAN NAME> for this plan year, *<Insert for members who do not reside in a LTC facility>*: we have provided you with a <DAYS SUPPLY>-day supply. The maximum days supply allowed is a 31-day supply, and we will not pay for the drug after the maximum days supply is used 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 prescription until we have provided you with a 93-day supply (unless the prescription is written for less). Unless you obtain a formulary exception from <PLAN NAME>, we will not pay for the drug after the maximum days supply is used.>>

<Name of Drug: <DRUG NAME>

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 we limit the amount of this drug that we provide at one time. This is called quantity limits and we impose such limits for safety reasons. Because you are within your first 90 days of coverage with <PLAN NAME> for this plan year, *<Insert for members who do not reside in a LTC facility>*: we will allow you to refill your prescription until we have provided you with a 31-day supply, but we will not pay for the drug after this maximum days supply is used 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 prescription until we have provided you with a 93-day supply (unless the prescription is written for less). Unless you obtain a formulary exception from <PLAN NAME>, we will not pay for the drug after the maximum days supply is used.>>

<Name of Drug: <DRUG NAME>

Date Filled: <DATE FILLED>

**Reason for Notification:** This drug requires your doctor or other professional who prescribed this drug to satisfy certain requirements before you can fill this prescription at your pharmacy. This is called prior authorization. Because you are within your first 93 days of coverage with <PLAN NAME> for this plan year, *<Insert for members who do not reside in a LTC facility>*: we have provided you with a <DAYS SUPPLY>-day supply. The maximum days supply allowed is a 31-day supply, and we will not pay for the drug after the maximum days supply is used 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 will allow you to refill your prescription until we have provided you with a 93-day supply (unless the prescription is written for less). Unless you obtain a prior authorization from <PLAN NAME>, we will not pay for the drug after the maximum days supply is used.>>

<Name of Drug: <DRUG NAME>

Date Filled: <DATE FILLED>

**Reason for Notification:** This drug will be covered only if you first try certain other drugs, 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 and effective, lower-cost drug before progressing to other more costly drugs. Because you are within your first 93 days of coverage with <PLAN NAME> for this plan year, *<Insert for members who do not reside in a LTC facility>*: we have provided you with a <DAYS SUPPLY>-day supply. The maximum days supply allowed is a 31-day supply, and we will not pay for the drug after the maximum days supply is used 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 will allow you to refill your prescription

until we have provided you with a 93-day supply (unless the prescription is written for less). Unless you try other drugs on our formulary first or you obtain an exception to the step therapy requirement from <PLAN NAME>, we will not pay for the drug after the maximum days supply is used.>>

**<Name of Drug:** <DRUG NAME>

**Date Filled:** <DATE FILLED>

**Reason for Notification:** This drug will be covered only if you first try a generic version of this drug. Because you are within your first 93 days of coverage with <PLAN NAME> for this plan year, *<Insert for members who do not reside in a LTC facility>* we have provided you with a <DAYS SUPPLY>-day supply. The maximum days supply allowed is a 31-day supply, and we will not pay for the drug after the maximum days supply is used unless you try the generic drug 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 will allow you to refill your prescription until we have provided you with a 93-day supply (unless the prescription is written for less). Unless you try the generic drug on our formulary first, or you obtain an exception from <PLAN NAME>, we will not pay for the drug after the maximum days supply is used.>>

**<Name of Drug:** <DRUG NAME>

**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 what our quantity limits permit unless you obtain an exception from <PLAN NAME>. Please contact <PLAN NAME> to discuss the exception process. Our contact information is located below.>

**<Name of Drug:** <DRUG NAME>

**Date Filled:** <DATE FILLED>

**Reason for Notification:** We could not provide the full amount that was prescribed because of plan quantity limits. We will not provide more than what our quantity limits permit unless you obtain an exception from <PLAN NAME>. Please contact <PLAN NAME> to discuss the exception process. Our contact information is located below.>

**<Name of Drug:** <DRUG NAME>

**Date Filled:** <DATE FILLED>

**Reason for Notification:** This drug is not covered on our formulary. We will cover this drug for a <DAYSSUPPLY>-day supply 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. Please contact <PLAN NAME> for more information regarding our exception process. Our contact information is located below.>

<Name of Drug: <DRUG NAME>

Date Filled: <DATE FILLED>

**Reason for Notification:** This drug requires prior authorization. We will cover this drug for a <DAYSSUPPLY>-day supply while you seek to obtain an exception to the prior authorization from <PLAN NAME>. Please contact <PLAN NAME> to discuss the exemption process. Our contact information is located below.>

<Name of Drug: <DRUG NAME>

Date Filled: <DATE FILLED>

**Reason for Notification:** This drug will be covered only if you first try certain other drugs as part of what we call 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 a <DAYSSUPPLY>-day supply while you seek to obtain an exception to the step therapy requirement from <PLAN NAME>. Please contact <PLAN NAME> to discuss the exception process. Our contact information is located below.>

### How do I change my prescription?

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

<CLIENT NAME>

<EX ADDRESS LINE 1>

<EX ADDRESS LINE 2>

<EX CITY>, <EX STATE> <EX ZIP>

Phone: <EX PHONE NUMBER>

Fax: <EX FAX NUMBER>

Your doctor must submit a statement supporting your request. It may be helpful to take this notice with you to the doctor or submit it to his or her office. The doctor's statement must indicate that the requested drug is medically necessary for treating your condition because none of the drugs we cover 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 that drug, 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 hours, if the request has been expedited, or no later than 72 hours, if the request is a standard request. Your request will be expedited if we determine, or your doctor informs 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 for a review of the prior 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.>

<CLIENT NAME>

<EX ADDRESS LINE 1>

<EX ADDRESS LINE 2>

<EX CITY>, <EX STATE> <EX ZIP>

Phone: <EX PHONE NUMBER>

Fax: <EX FAX NUMBER>

If you need assistance in requesting an exception or for more information about our transition policy (including alternate format or languages regarding this policy), please call <Customer Service/Member Services> at <PHONE NUMBER>. TTY users should call <TTY/TDDNumber>. We are available from <HOURS OF OPERATION>.

Sincerely,

<PLANREPRESENTATIVE>

< 'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.> < WellCare is a Coordinated Care Plan with a Medicare Advantage contract.> <A Medicare-approved Part D sponsor.>

*Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or co-payments/coinsurance may change on January 1, <2013>.*

This document is available in alternate languages. Please call Customer Service at the number listed above for alternate languages available in your area.