Drugs Available Under the Medicare Drug Benefit

Key Points

- Formularies are required to provide all the necessary medications for Medicare beneficiaries, and CMS has evaluated each formulary to assure that Medicare prescription drug plans do not discourage enrollment by beneficiaries with certain conditions.
- CMS expects that best-practice formularies will contain all or substantially all drugs within six key therapeutic classes.
- Plans can establish limits on the medications that prescribers can access through the use of formularies, cost-sharing levels, step therapy, and prior authorization.
- Plans must notify enrollees of any changes to their formularies or cost-sharing levels at least 60 days in advance of such change taking effect.
- The Medicare Modernization Act excludes certain medications from Medicare prescription drug benefit coverage based on their class and use.
- For drugs not on a plan's formulary, there is an exceptions process for prescribers and beneficiaries to request access to the drug or to reduce the cost-sharing associated with the drug.

Formularies

Each plan will have a formulary that has been approved by CMS. The formulary will likely vary from plan to plan. Plans will provide information about their formularies during the marketing period in October 2005, and upon request. Any management tools, such as different levels of copayments, step therapy, and prior authorization, are permitted, subject to CMS review. In addition, CMS requires plans to include all or substantially all of the drugs in six therapeutic classes on the plan's formulary: antidepressants, antipsychotics, anticonvulsants, HIV/AIDS drugs, immunosuppressants, and anti-cancer drugs. CMS will also monitor the exceptions and appeals filed by beneficiaries.

Formulary Change Notification

Plans must notify enrollees of any changes to their formularies or cost-sharing levels at least 60 days in advance of such changes taking effect. If the plan does not provide the enrollee with such notice, it must provide the enrollee with a 60-day supply of the drug and the notice of change when the enrollee requests a refill of the drug affected by the change. This requirement provides time for enrollees to request an exception and file an appeal, if needed.

Special packaging for institutionalized residents of LTC facilities will be accommodated through inclusion of qualified long-term pharmacy providers, who currently utilize special packaging as part of a medication distribution system.

Drugs NOT Covered under the Medicare Prescription Drug Benefit

- Benzodiazepines
- Barbiturates
- Nonprescription drugs*
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Agents used for symptomatic relief of cough and colds
- Agents used for cosmetic purposes or hair growth
- Agents used to promote fertility
- Agents used for anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.
- Any drug for which, as prescribed and dispensed or administered to an individual, payment would be available under Medicare Parts A or B for that individual.

(Source: Medicare Modernization Act of 2003)

*Plans will be permitted to use certain over-the-counter (OTC) drugs as part of step therapy. The cost of the OTC drug will be borne under the Plan's administrative costs.

Exceptions and Appeals

Beneficiaries and prescribers may request exceptions to the plan's formulary to gain access to non-formulary drugs or to reduce the cost-sharing for the needed drug. (For more information, see the Exceptions and Appeals section).

For additional information contact:

Medicare: 1-800-MEDICARE (1-800-633-4227); TTY 1-877-486-2048

or

www.medicare.gov

Social Security Administration: 1-800-772-1213; TTY 1-800-325-0778

or

www.socialsecurity.gov or www.SSA.gov

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