



TRIBUTE[®] HMO SNP

P.O. Box 740444
Houston, TX 77274

THIS IS A SAMPLE TRANSITION FILL LETTER

This letter is to inform you that Tribute HMO SNP has provided you with a *temporary and/or limited* supply, of the following prescription[s]:

This/These drug[s] is/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 and/or current enrollee* affected by formulary changes implemented this year by Tribute HMO SNP and that you are within your first 90 days of coverage for this plan year.

Insert for members who do not reside in a Long Term Care (LTC) facility:

Therefore, in the outpatient setting, Tribute HMO SNP 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 Long Term Care (LTC) facility:

For a resident of a long term care facility, Tribute HMO SNP is required to provide at least a 91 day supply and may be 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 and/or limited* supply of this drug. Before this supply ends, you should speak to Tribute HMO SNP and/or your physician regarding whether you should change the drug[s] you are currently taking, or request an exception from Tribute HMO SNP to continue coverage of *this/these drug[s]*.

If you need assistance in requesting an exception, or for more information about our transition policy, please call Customer Service at **1-800-817-3515**. TTY users should call **1-800-958-2692**. We are happy to take your calls from 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week. Instructions on how to apply for an exception or how to change your current prescription[s] are discussed at the end of the letter.

The following is an explanation of why your drug[s] *is/are* not covered or *is/are* limited under Tribute HMO SNP. *Reasons for notification below will be member specific.*

Name of Drug: *name of drug*

Date Filled: *date filled*

Reason for Notification: This drug is not covered on our formulary. Because you are within your first **90 days** of coverage with Tribute HMO SNP for this plan year,

Insert for members who do not reside in a Long Term Care (LTC) facility:

we have provided you with a *days supply on filled claim or day supply*. The maximum days supply allowed is a **30 day supply**, and we will not pay for the drug after the maximum days supply is used unless you obtain a formulary exception from Tribute HMO SNP.

Insert for members who reside in a Long Term Care (LTC) facility:

we will allow you to refill your prescription until we have provided you with a **98 day supply** (unless the prescription is written for less). Unless you obtain a formulary exception from Tribute HMO SNP, we will not pay for the drug after the maximum days supply is used.

Name of Drug: *name of drug*

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 Tribute HMO SNP for this plan year,

Insert for members who do not reside in a Long Term Care (LTC) facility:

we will allow you to refill your prescription until we have provided you with a **30 day supply**, but we will not pay for the drug after this maximum days supply is used unless you obtain a formulary exception from Tribute HMO SNP.

Insert for members who reside in a Long Term Care (LTC) facility:

we will allow you to refill your prescription until we have provided you with a **98 day supply** (unless the prescription is written for less). Unless you obtain a formulary exception from Tribute HMO SNP, we will not pay for the drug after the maximum days supply is used.

Name of Drug: *name of drug*

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 **90 days** of coverage with Tribute HMO SNP for this plan year,

Insert for members who do not reside in a Long Term Care (LTC) facility:

we have provided you with a *days supply on filled claim or day supply*. The maximum days supply allowed is a **30 day supply**, and we will not pay for the drug after the maximum days supply is used unless you obtain Tribute HMO SNP's prior authorization or you obtain an exception to the prior authorization from Tribute HMO SNP.

Insert for members who reside in a Long Term Care (LTC) facility:

we will allow you to refill your prescription until we have provided you with a **98 day supply** (unless the prescription is written for less). Unless you obtain a prior authorization from Tribute HMO SNP, we will not pay for the drug after the maximum days supply is used.

Name of Drug: *name of drug*

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 **90 days** of coverage with Tribute HMO SNP for this plan year,

Insert for members who do not reside in a Long Term Care (LTC) facility:

we have provided you with a *days supply on filled claim or day supply*. The maximum days supply allowed is a 30 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 Tribute HMO SNP.

Insert for members who reside in a Long Term Care (LTC) facility:

we will allow you to refill your prescription until we have provided you with a **98 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 Tribute HMO SNP, we will not pay for the drug after the maximum days supply is used.

Name of Drug: *name of drug*

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 **90 days** of coverage with Tribute HMO SNP for this plan year,

Insert for members who do not reside in a Long Term Care (LTC) facility:

we have provided you with a *days supply on filled claim or day supply*. The maximum days supply allowed is a **30** 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 Tribute HMO SNP.

Insert for members who reside in a Long Term Care (LTC) facility:

we will allow you to refill your prescription until we have provided you with a **98 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 Tribute HMO SNP, we will not pay for the drug after the maximum days supply is used.

Name of Drug: *name of drug*

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

¹ Other Pharmacies are Available in our Network

our quantity limits permit unless you obtain an exception from Tribute HMO SNP. Please contact Tribute HMO SNP to discuss the exception process. Our contact information is located below.

For emergency fills and Level of Care changes:

Name of Drug: *name of drug*

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 Tribute HMO SNP. Please contact Tribute HMO SNP to discuss the exception process. Our contact information is located below.

Name of Drug: *name of drug*

Date Filled: *date filled*

Reason for Notification: This drug is not covered on our formulary. We will cover this drug for **34 days** while you seek to obtain a formulary exception from Tribute HMO SNP. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made. Please contact Tribute HMO SNP for more information regarding our exception process. Our contact information is located below.

Name of Drug: *name of drug*

Date Filled: *date filled*

Reason for Notification: This drug requires prior authorization. We will cover this drug for **34 days** while you seek to obtain an exception to the prior authorization from Tribute HMO SNP. Please contact Tribute HMO SNP to discuss the exemption process. Our contact information is located below.

Name of Drug: *name of drug*

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 **34 days** while you seek to obtain an exception to the step therapy requirement from Tribute HMO SNP. Please contact Tribute HMO SNP to discuss the exception process. Our contact information is located below.

How do I change my prescription?

If your drug[s] *is/are* not covered on our formulary, or is covered on our formulary but we have placed a prior authorization, step therapy, or quantity limit on it, 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. You can contact us or mail your request to:

¹ Other Pharmacies are Available in our Network

Tribute HMO SNP
Attention: Appeals /Coverage Determinations
P.O. Box 391197
Solon, Ohio 44139-3911

Phone: 1-866-316-6049 (TTY) 1-866- 684-5351
Fax: 1-866-868-0858

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. We accept standard and expedited requests by telephone and in writing.

Tribute HMO SNP
Attention: Appeals /Coverage Determinations
P.O. Box 391197
Solon, Ohio 44139-3911

Phone: 1-866-316-6049 (TTY) 1-866-684-5351
Fax: 1-866-868-0858

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 at **1-800-817-3515**. TTY users should call **1-800-958-2692**. We are available from 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.

Sincerely,

Tribute HMO SNP

¹ Other Pharmacies are Available in our Network

Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2013.

A health plan with a Medicare contract.

Tribute® HMO SNP is offered by the following organization that contracts with the Federal government: SelectCare of Oklahoma, Inc., a member of the Universal American family of companies.

Please contact Customer Service 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week, at 1-800-817-3515 to request materials in an alternate format or language. TTY users should call 1-800-958-2692.