

5018 - Model Part D Prescription Transfer Letter: FINAL CY2010

[Instructions: This model should be used by Part D sponsors to request permission from a member to fill his/her prescription[s] at a different network pharmacy than the one the member is currently using. The beneficiary may provide permission by calling the plan or pharmacy, or via mail. The Part D sponsor may attach a form to this letter requesting the member's permission to switch the prescription to a different pharmacy. This model does not need to be used if the change in pharmacies is initiated by the beneficiary.]

<DATE>

<MEMBER NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <MEMBER NAME>:

<Plan Name> has determined that the following medication [s] you are currently taking could be purchased through another *<insert one: specialty, retail or mail-order pharmacy>*.

<medication1><dosage>

<medication2><dosage>

<medication3><dosage>

[Provide an explanation of the benefits realized by the plan member if he/she decides to transfer his/her prescription(s) to the different pharmacy.]

If you do not want to receive your medication[s] from <insert name of pharmacy>, you do not need to do anything in response to this notification. You may continue purchasing your medications at your pharmacy and your coverage will remain the same.

With your permission, we are able to fill your prescription[s] at <insert name of pharmacy>. We cannot fill your prescription[s] at this pharmacy until we have received permission from you to do so. You may call *[Insert one: <us at Customer/Member Service> <insert name of pharmacy>]* at <phone number> (TTY users should call <TTY number>) if you would like this pharmacy to fill your prescription[s]. [OPTIONAL: You may also fill out the attached form granting permission to us to have us fill your prescription[s] at <insert name of pharmacy> and fax it to <phone number> or mail it to <insert address>].

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If you want more information regarding how to transfer prescriptions, please call <Customer/Member> Service at <phone number>. TTY users should call <TTY number>. We are available from <hours of operations>.

Sincerely,

<Plan Representative>

<OPTIONAL: attachment>

<Material ID>
[<CMS Approval Date >]

Last Updated <Date>

Checklist for the 2010 Model Part D Prescription Transfer Letter

Instructions

- The Model Part D Pharmacy Transfer Letter should be used by Part D sponsors when they want to transfer a member's prescription to a different network pharmacy than the one the member is currently using.
- This model does not need to be used if the change in pharmacies is initiated by the beneficiary.
- The beneficiary may provide permission by calling the plan or pharmacy, or via mail.
- Complete the checklist and submit it with your Model letter which you will transmit via the HPMS PDP Marketing Module.

Requirements

___ All required and relevant information is included in the Model letter.

___ Marketing material ID is included.

___ Materials are in 12 point font.

___ Customer service number(s), TTY/TDD number, and days/hours of operation are identified.

___ If applicable, pharmacy phone numbers, including TTY/TDD number for the receiving pharmacy.

___ Explanation of benefits realized by plan member if he/she decides to transfer from his/her current pharmacy to the recommended pharmacy.

___ Medications impacted.

___ OPTIONAL – Form to be filled out by member granting permission to transfer prescriptions from one pharmacy to another.

___ Applicable disclaimers.

Based on my best knowledge, information, and belief, all information submitted to CMS in these documents are accurate, complete, and truthful. Our organization has performed a second quality review of the materials before submitting them to CMS for review and approval.

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(Name & Title of preparer of materials/ Date)

(Name & Title of second Quality Reviewer/Date)

On behalf of

(NAME OF ORGANIZATION)