

Medicare Part D Drug Plans: What They Must, May, and Cannot Cover

Part D drug plans have a "formulary," or a list of the drugs, strengths, dosages, and routes of administration covered by the plan. Federal law requires plans to include *at least* two drugs from each class of drug category on their formulary. Generally, most plans cover far more than two in each category. In certain drug classes (see below), the Centers for Medicare & Medicaid Services (CMS) requires they include more.

Here we'll review *all* the formulary rules so you can better understand the rules and limitations on drug coverage to help your clients find the Part D plan that's best for them.

Must cover

There are six categories of drugs in which Part D Plans are generally required to cover "all or substantially all drugs." These categories are:

- HIV/AIDS treatments,
- Antidepressants,
- Antipsychotic medications,
- Anticonvulsive treatments for seizure disorders,
- Immunosuppressant medications, and
- Anticancer drugs (unless covered by Medicare Part B).

Part D plans also are required to cover all commercially available vaccines, including the shingles shot, except for those vaccines that are covered under Part B (e.g., annual flu shot, pneumococcal vaccine).

Part D plans also must cover a range of both generic and brand name drugs that are:

- Generally needed by populations on Medicare,
- Insulin preparations, even in states where a prescription is not required, and
- Available only by prescription.

May cover

Beneficiaries need to check their plan's formulary to see if their drugs are covered, but they can't stop there. It's just as important to check out how the cost-sharing structure works with the drugs they are taking and if there are any limitations. Most plans limit access to drugs by:

- **Using different cost-sharing tiers.** Plans can cover drugs in tiers with different levels of copayments or coinsurance. For example, Tier 1 (usually for generics) has the lowest cost-sharing amounts. Tiers 2-5 are for name-brand and specialty drugs and have higher out-of-pocket cost-sharing amounts.
- **Imposing utilization management requirements on covered drugs.**

1. Plans can use prior authorization rules, under which a provider must submit a request to the plan that the plan cover a drug and then the plan must approve a prescription before it can be filled;
2. Quantity limits, under which the plan establishes the maximum amount of the drug it will fill;
3. Step therapy, meaning that a plan can require a beneficiary to try another, lower cost drug up to 90 days. The plan will then review the provider's notes and decide whether or not they'll pay for the originally prescribed drug to limit access to certain drugs.

Cannot cover

There are certain types of drugs that standard Part D plans are generally not allowed to cover. That said, plans can have "enhanced alternative coverage." This means they can cover some of these excluded drugs. They would probably charge a higher premium for this additional benefit. These drugs include:

- Medications prescribed for:
 - Anorexia, weight loss, or weight gain (even if used for morbid obesity)
 - Symptomatic relief of cough and colds
 - Hair growth or cosmetic purposes
 - Fertility purposes
 - Prescription vitamins and mineral products EXCEPT for:
 - Niacin (when prescribed to treat a condition, not when used as a dietary supplement)
 - Prenatal vitamins
 - Fluoride
- Non-prescription drugs
- Drugs covered by Medicare Parts A or B
- Drugs used to treat sexual or erectile dysfunction
- Drugs only available from the manufacturer that require testing

Important note about barbiturates and benzodiazepines

Prior to 2013, benzodiazepines and barbiturates were on the Part D "excluded drugs" list. Benzodiazepines are drugs typically used to treat anxiety and insomnia, such as Diazepam (Valium). Beginning in 2013, standard plans were allowed to offer benzodiazepines, and certain barbiturates used in the treatment of epilepsy, cancer or a chronic mental disorder. Effective January 2014, benzodiazepines and barbiturates are covered under Part D for any medically accepted indication. With barbiturates, plans may require "prior authorization" (meaning your client's doctor must submit a request to the plan and get approval before the plan will provide coverage) to verify treatment.

How can beneficiaries get drugs NOT covered by their plan?

There are a few programs that may help beneficiaries get coverage for drugs not covered by their plan. Consider:

- Patient Assistance Programs (PAPs):
 - Search for PAPs by drug on [Medicare's website](#)
 - Check out the [Rx Assist Patient Center](#) and www.needymeds.org
 - Visit [BenefitsCheckUp®](#)
- State Medicaid programs for people with both Medicare and Medicaid
- Doctor office samples
- Alternative enhanced Part D plans that cover non-Part D drugs as a supplemental benefit

Formulary changes during the year

Part D plans can only make limited changes to how they cover drugs during the year. Plans can make such changes only after March 1 of each year, and only if they:

- Give notice to CMS, prescribing physicians, [State Pharmaceutical Assistance Programs](#) (SPAPs), network pharmacy/pharmacists, and affected plan members (at least 60 days prior to the change), and
- Continue to cover drugs for members who were stabilized on a drug that were:
 - Removed from the formulary (unless declared unsafe or ineffective by FDA),
 - “Tiered up” (or moved to a higher, more expensive cost-sharing tier), or
 - Imposed with new utilization management requirements.

Where do I find details about a drug plan's formulary?

You can help beneficiaries review a plan's formulary by using the online [Medicare Plan Finder](#) tool. The tool will show you which drugs are covered by each plan, if there are any utilization management requirements, and the cost-sharing amounts. The tool includes links to the plans' websites, where beneficiaries can learn more about the plans' transition policies for new plan members, and how to seek an exception or an appeal if the plan denies coverage of a certain drug.

References

See the Centers for Medicare & Medicaid Services (CMS) Medicare Prescription Drug Benefit Manual, [Chapter 6 – Part D Drugs and Formulary Requirements](#) for guidance on covered drugs, vaccine administration, excluded categories, and formulary requirements.

CMS also develops templates for Part D plans to use for their formulary list that must be available to members and those thinking about joining. Here you can [find the templates for the 2018 plan year](#) (click on 2018 Part D Models, and open the zip file to find model templates for an abridged formulary and a comprehensive formulary).

See the Centers for Medicare & Medicaid Services (CMS) [webpage](#) that contains contact info for the person or unit responsible for exceptions and appeals at every Part D plan.

See the Centers for Medicare & Medicaid Services (CMS) Guidance for Part D Sponsors titled [Transition to Part D Coverage of Benzodiazepines and Barbiturates Beginning in 2013 Memo](#) dated October 2, 2012.