

[Part D Plan Logo]

**YOUR ACCESS TO CERTAIN PART D DRUGS WILL NOT BE LIMITED**

Date: [insert date]

Enrollee's Name: [insert name]

Member Number: [insert member ID]

On [Insert date of initial notice], we sent you a notice that we planned to limit your access to prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] through our drug management program.

After further review, we have decided that your access to these medications will NOT be limited under the drug management program. There are no changes to the way these medications are covered for you under our plan rules.

[Insert this section for Low Income Subsidy (LIS) beneficiaries:]

*{As of the date of this notice, you're eligible to use the quarterly Medicare Special Enrollment period because you receive Extra Help with your prescription drug costs. You can also change plans during other limited situations, such as if you move out of the plan's service area or you lose or have a change in your Extra Help. You can also change plans during the Annual Enrollment Period which occurs every year from October 15 – December 7.}*

If you have questions about this notice or our drug management program to help enrollees use prescription opioid medications safely, contact us at:

[Plan Name] Toll Free: [Insert phone number] TTY users: [Insert TTY]

[Insert call center hours of operation]

[Insert plan website]

[Insert plan mailing address]

[If the plan has a dedicated line (toll free), staff person, web portal, etc. for its DMP, that information may be included in this section, as applicable.]

If you have questions about your opioid pain medication or other prescription drugs you are taking, speak with your prescriber.

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