Technical Instructions for the Standardized Format for Part D Medication Therapy Management (MTM) Program Comprehensive Medication Review (CMR) Summary

FORM CMS-10396 (07/31/2025)

Updated: September 2024

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Section I: General Requirements

Introduction

An individualized, written summary in CMS' Standardized Format must be provided following each comprehensive medication review (CMR) performed under Part D Medication Therapy Management (MTM) programs in accordance with 42 CFR § 423.153(d).

Use of the Standardized Format is subject to all applicable rules, regulations, and industry standards, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and Section 508 of the Rehabilitation Act.

Purpose

These technical instructions supplement the Standardized Format ("Format") (Form CMS-10396, OMB Control Number 0938-1154) and do not change, alter, or add to the data collection. The purpose of this document is to provide detailed information and examples on how to complete the Format.

A blank version of the Format can be found in Appendix A. Completed samples of the Format are provided in Appendix B, followed by a Spanish version in Appendix C.

Components of the Format

The Format includes the following components:

- Cover Letter (CL)
- Recommended To-Do List (TDL) (also known as Medication Action Plan)
- Safe Disposal Information (optional template if provided in the CMR)
- Personal Medication List (PML)

The Format is not considered marketing material and should not include any marketing messages, marketing disclaimers, or other sales information.

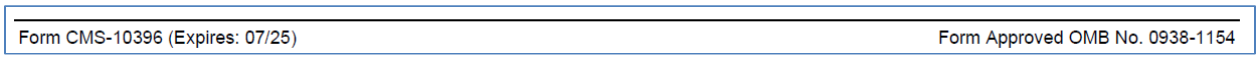
Limited Customization of the Format

The Format cannot be modified, but the specific content to populate the Format should be tailored to the beneficiary and sponsor's MTM program. Part D plan sponsors may provide supplemental materials in addition to the Format as needed to help beneficiaries manage their medication use. The enclosure notations or postscript of the CL may be used to list or describe the supplemental materials that will be included in the package with the Format. Technological marks (e.g., barcodes) or other form identifiers that do not interfere with the

required content of the CL, TDL, or PML may be included in the margins of the documents to facilitate the fulfillment process.

General Formatting Specifications

- ***Orientation:*** Portrait orientation is required for the CL and the TDL. The PML must be in landscape orientation.
- ***Paper stock***:
  - 8.5-inch by 11-inch standard letter-size paper stock.
  - Paper stock should be thick enough (20-22 lb.) to keep information on the back from showing through.
  - Different color paper stock may be used, as long as there is high-contrast combination of light paper and dark font color. CMS recommends black text on white or cream-colored non-glossy paper.
- ***Margins:*** 0.5 on top and bottom and 1 inch on the left and right sides.
- ***Font:*** 14-point font size is required except where another font size is specified below (e.g., section titles, headers, footers). Where a specific font is specified, an alternative, equivalent font with the same size, space, and serif specifications and appearance may be used (e.g., 7-pt Arial substituted for 7-pt Helvetica). Text sections, field entries, headings, and titles must be printed in Times New Roman, Verdana, Arial, Tahoma, Helvetica, or Calibri. Narrow, compressed, or condensed fonts are prohibited.
- ***Justification:*** All fields are left justified except headers, which are right justified.
- ***Header:*** Part D plan/MTM program identification should be consistent with other Medicare publications of Part D plans/MTM programs. A header with MTM provider/Part D plan identification may be included on the first page of the CL. The title of the summary section and the beneficiary's name and date of birth should be included on all other pages of the document.
- ***Footer:***



  - The **CMS form number and OMB approval number** must appear in the footer of every page of the CL, TDL, and PML. Use Helvetica or equivalent, 7-point font for the CMS-required footer.

- The **Paperwork Reduction Act (PRA) statement** must be included at the bottom of the Cover Letter or within the CMS-required footer. Use Helvetica or equivalent, 7-point font for the PRA statement.

> According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1154. The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850

- **Page Numbers***:* The CL, TDL, and PML forms have their own page numbers and should use 12-point serif font, the same font as the text sections of the documents. Page number sequences should restart at "Page **1** of **Y**" for each document.
- **Privacy Statement**: Part D plan-specific privacy statements, if desired, may be included on the last page of any or each document, above the CMS-required footer and also above the PRA statement on the CL. Use 14-point serif font to match the text portions of the documents.

- ***Form Sequencing:*** The forms must be prepared and delivered in the following order: the CL comes first, followed by the TDL, then the safe disposal page (if applicable), and last the PML. The TDL and PML forms are designed to be used alone or in conjunction with the other forms in the Format. The first page of each form must begin on a new sheet of paper, with page number sequences restarting at Page **1** of **Y**. Otherwise, the rest of the summary may be printed single-sided or double-sided.
- ***Instructions in the Format:*** Imbedded instructions for the MTM provider, shown as italicized text within < > symbols, should be deleted prior to distribution to beneficiaries. Icons such as the light bulb, exclamation point, and pencil are intended to draw focus to fields that may require action by the beneficiary and are required components of the Format. The image files are provided for download on the CMS.gov MTM webpage.
- ***Language:*** For ease of understanding, Part D plans and MTM providers are encouraged to use plain language, concrete nouns, and active voice and present the most important information first, where applicable, in each of the documents.

Cognitively Impaired Beneficiaries

Under 42 CFR § 423.153(d)(1)(vii)(B)(2), if the beneficiary is unable to accept the offer to participate in the CMR due to cognitive impairment, the MTM provider may perform the CMR with the beneficiary's prescriber, caregiver, or other authorized individual, such as a health care proxy or legal guardian. Throughout this instruction document, there are unique recommendations noted for the Format prepared for cognitively impaired beneficiaries.

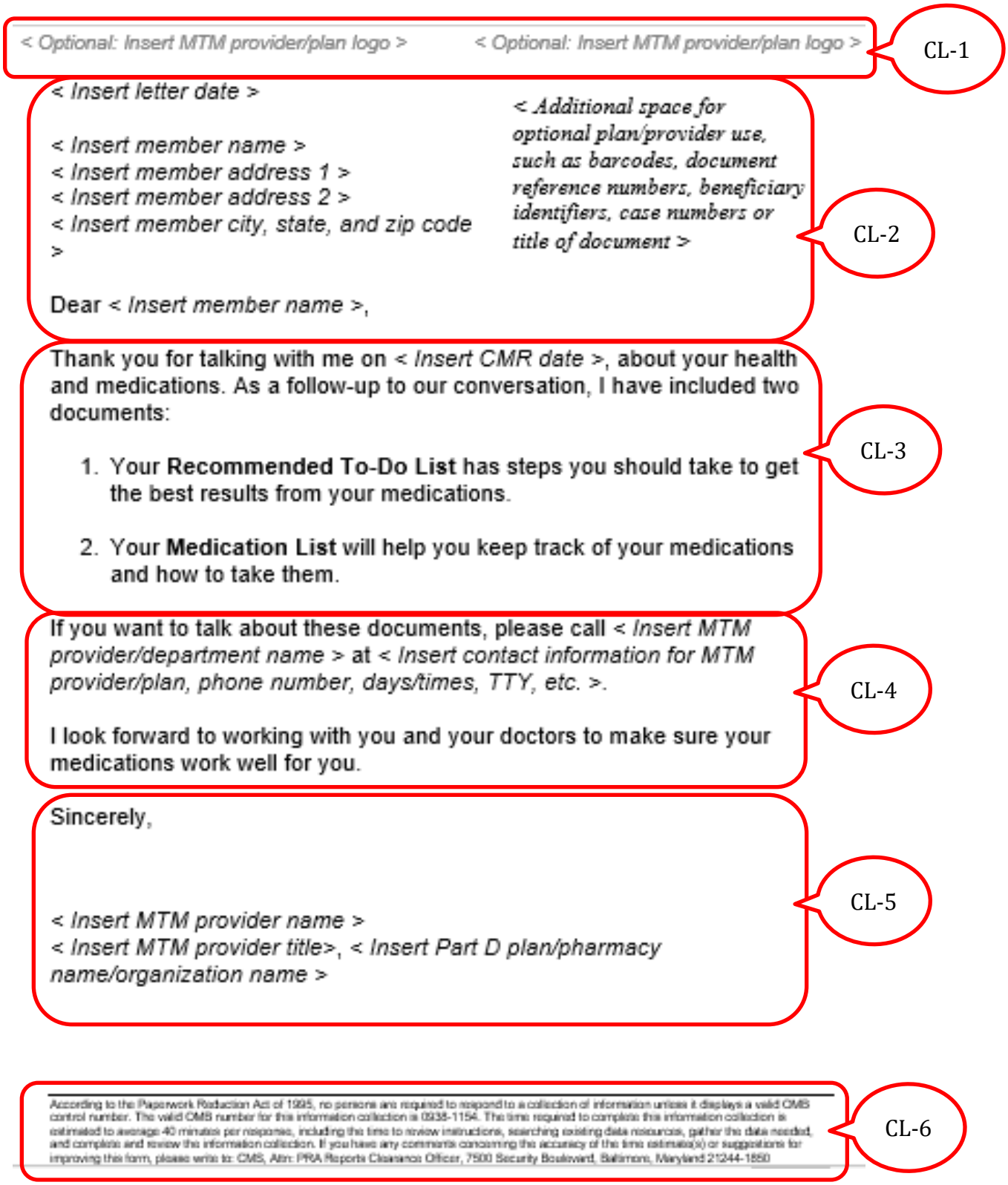
Completing the Format

The following pages provide accompanying instructions below each extracted section of the Format. Always remove the type in italics (e.g., < *insert date* >) prior to sending the summary to the beneficiary. Entries in the blanks may be typed (preferred) or hand-written by the MTM provider but should be large enough (i.e., approximately 14-point font) to allow ease in reading.

When completing the summary, CMS suggests a minimum look-back of 6 months to identify current prescriptions and prescribers, to reconcile and update information from the beneficiary, including current prescription medications, over-the-counter (OTC) medications, herbal therapies, and dietary supplements, and to capture beneficiary concerns. Although the PML may be initially populated with information from claims data, Electronic Medical Records (EMRs), or other data files, there should be a verification step by the MTM provider with the beneficiary. This step may also identify medication therapy problems to be addressed in the TDL.

Section II: Cover Letter (CL)

Cover Letter (CL)



< Optional: Insert MTM provider/plan logo > < Optional: Insert MTM provider/plan logo >

CL-1

< Insert letter date >

< Insert member name >
< Insert member address 1 >
< Insert member address 2 >
< Insert member city, state, and zip code >

< Additional space for optional plan/provider use, such as barcodes, document reference numbers, beneficiary identifiers, case numbers or title of document >

CL-2

Dear < Insert member name >,

Thank you for talking with me on < Insert CMR date >, about your health and medications. As a follow-up to our conversation, I have included two documents:

1. Your **Recommended To-Do List** has steps you should take to get the best results from your medications.

2. Your **Medication List** will help you keep track of your medications and how to take them.

CL-3

If you want to talk about these documents, please call < Insert MTM provider/department name > at < Insert contact information for MTM provider/plan, phone number, days/times, TTY, etc. >.

I look forward to working with you and your doctors to make sure your medications work well for you.

CL-4

Sincerely,

< Insert MTM provider name >
< Insert MTM provider title>, < Insert Part D plan/pharmacy name/organization name >

CL-5

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1154. The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850

CL-6

Purpose
The purpose of the cover letter (CL) is to remind the beneficiary of what occurred during the CMR, introduce the TDL and PML, and describe how the beneficiary can contact the MTM provider and/or plan.

Formatting Specifications
Length: The length of the CL is limited to one piece of paper if printed double-sided, or two pieces of paper if printed singled-sided.

CL-1:

< Optional: Insert MTM provider/plan logo >	*< Optional: Insert MTM provider/plan logo >*

- *< Optional: Insert MTM provider/plan logo >*: Sponsors may include the MTM provider's logo, if applicable, and/or include the plan or parent organization logo. Alternatively, this space may be blank on the CL. In addition, the sponsor has the option of which side of the header to place the MTM provider and/or plan logo. Remove the italics type in the fields that state "*< Optional: Insert MTM provider/plan logo >*".
- The *< Optional: Insert MTM provider/plan logo >* only appears on the first page of the CL.

CL-2:

< Insert letter date > *< Insert member name >* *< Insert member address 1 >* *< Insert member address 2 >* *< Insert member city, state, and zip code >* Dear *< Insert member name >*,	*< Additional space for optional plan/provider use, such as barcodes, document reference numbers, beneficiary identifiers, case numbers or title of document >*

Part D sponsors may customize and personalize the inside address, salutation, closing, and other fields within the body of the letter.

- *< Insert letter date >*: Enter the date the letter is prepared in month, day, year format (e.g., August 2, 2024). Remove the italics type in the field that states "*< Insert letter date >*".
- *< Insert member name>*: Enter beneficiary's name. Remove the italics type in the field that states "*< Insert name >*".
- *< Insert member address 1>*: Enter the first line of beneficiary's address. Remove the italics type in the field that states "*< Insert member address 1>*".
- *< Insert member address 2>*: Enter the second line of beneficiary's address if applicable. Remove the italics type in the field that states "*< Insert member address 2>*".
- *< Insert member city, state, and zip code>*: Enter beneficiary's city, state, and zip code. Remove the italics type in the field that states "*< Insert member city, state, and zip code >*".

  When the CMR is performed on the behalf of a cognitively impaired beneficiary with someone other than the beneficiary's legally authorized representative, such as a caregiver or prescriber, the MTM provider should discuss the delivery of the summary with the beneficiary's representative to determine to whom and where they should be sent. CMS expects the summary will be delivered to the beneficiary's authorized representative, if known. When sending the summary to the beneficiary's authorized representative, the inside address should include the beneficiary's name, c/o <name and address of their authorized representative>.
- *< Insert member name >*: Enter the greeting and beneficiary's name (e.g., "Dear John Smith"). Remove the italics type in the field that states "*< Insert member name >*".
- *< Additional space for optional plan/provider use… >*: Additional space to the right of the date/address/salutation area is optional for Part D plan/provider use. This area may be used as an extension of the header area for Part D plan information or used for items such as barcodes, document reference numbers, beneficiary identifiers, case numbers, or title of document. This area may also be left blank. Remove the italics type in the field that states "*< Additional space for optional plan/provider use… >*".

  When the CMR is performed with an authorized individual on the behalf of a cognitively impaired beneficiary, CMS recommends that sponsors include an explanatory note in the Additional Space section near the top right of the Cover Letter, such as the following:

NOTE: A review of your medications was done on <*date of CMR*> with <*name of beneficiary's representative*> who served on your behalf. Here is a summary of your medication review.

CL-3:

Thank you for talking with me on < *Insert CMR date* >, about your health and medications. As a follow-up to our conversation, I have included two documents:

1. Your **Recommended To-Do List** has steps you should take to get the best results from your medications.

2. Your **Medication List** will help you keep track of your medications and how to take them.

- < *Insert CMR date* >: Enter the date the CMR was performed in month, day, year format (e.g., August 1, 2024). Remove the italics type in the field that states "< *Insert CMR date* >".

CL-4:

If you want to talk about these documents, please call < *Insert MTM provider/department name* > at < *Insert contact information for MTM provider/plan, phone number, days/times, TTY, etc.* >.

I look forward to working with you and your doctors to make sure your medications work well for you.

- < *Insert MTM provider/department name* >: Enter the name of the MTM provider (or department of Part D plan if administered in-house), contact information and method as appropriate, periods of availability, and other applicable information. CMS recommends that the name and contact information of the individual who conducted the CMR be included, unless precluded by the Part D plan's MTM

program structure. Remove the italics type in the field that states "*< Insert MTM provider/department name >*".

- *< Insert contact information for MTM provider/plan, phone number, days/times, TTY, etc. >*: Enter contact information and method as appropriate, periods of availability, and other applicable information. Remove the italics type in the field that states "*< Insert contact information for MTM provider/plan, phone number, days/times, TTY, etc. >*".

CL-5:

Sincerely,

< Insert MTM provider name >
< Insert MTM provider title>, < Insert Part D plan/pharmacy name/organization name >

- *< Insert MTM provider name>*: Enter closing (e.g., "Sincerely,"). The letter should be signed with the signature, if possible, of the individual who performed the CMR with the beneficiary, with printed annotation of name in order to be understood. A cursive font is recommended if a printed name is used in lieu of the signature. Remove the italics type in the field that begins with "*< Insert MTM provider name>*".
- *< Insert MTM provider title* >, *< Insert Part D plan/pharmacy name/organization name* >: Enter MTM provider title (e.g., Clinical Pharmacist) and employer name. Remove the italics type in the field that begins with "*< Insert MTM provider title* >."

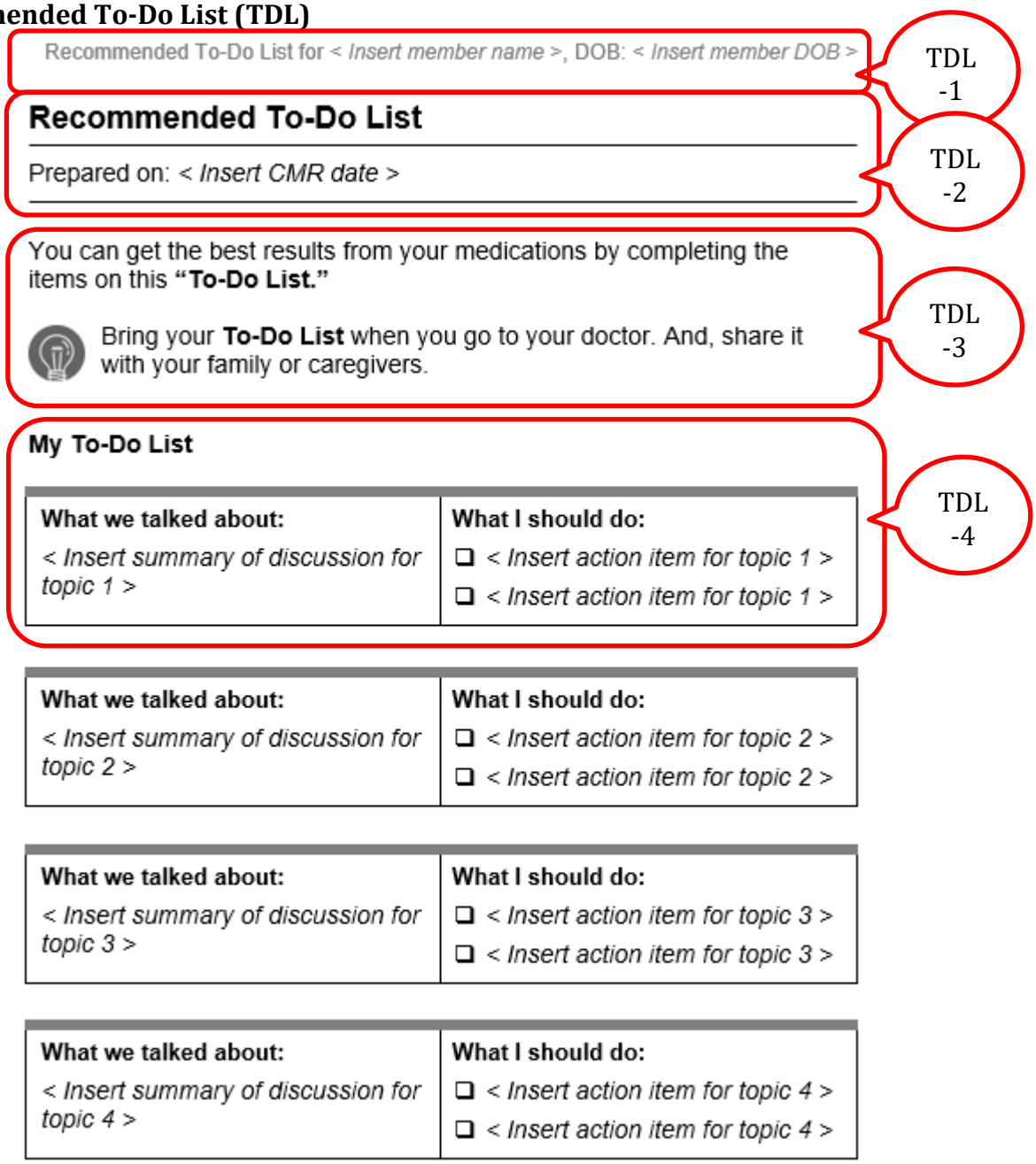
CL-6:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1154. The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850

Paperwork Reduction Act (PRA): The Paperwork Reduction Act (PRA) statement must be included at the bottom of the CL or within the CMS-required footer. Use Helvetica, 7-point font.

Section III: Recommended To-Do List (TDL)

Recommended To-Do List (TDL)



Purpose

The Recommended To-Do List (TDL) describes the medication action plan resulting from the CMR and beneficiary's responsibilities in the TDL. The TDL should not include detailed action plans of the MTM provider and is not intended to be a template for communications with other healthcare providers. The MTM provider should determine the most important action items for the beneficiary based on their concerns, needs, and ability to understand and complete the recommended activities.

There may be CMRs that do not identify current medication therapy problems or result in beneficiary-specific action items. The TDL allows sponsors to list other statements as appropriate for the beneficiary, such as reinforcing compliance, maintaining beneficiary's actions, and acknowledging beneficiary's success in their medication therapy. This provides a deliverable consistent with the Format for all beneficiaries, even if there are no new action items.

Formatting Specifications

Order of action items: Part D plans may select the sort order for the action items to be listed, such as alphabetically by medication involved or by health condition. CMS recommends that the most important action item be listed first.

Number of action items and length: The number of action items is based on beneficiary-specific needs as discussed during the CMR and the professional judgment of the MTM provider. CMS recommends no more than one piece of paper (either single or double-sided) for the TDL. Blank action item sections may be deleted. Part D plans and MTM providers are encouraged not to separate or break action item sections or rows across pages.

Sizes of border lines and divider lines:

- Narrow lines within rows are 0.5 pt.
- Top borders in the TDL sections are 6 pt.

Size and field descriptors: The number of characters in the fields within the Format is not limited to a maximum number of characters. Field sizes for Part D plan-reported information have a minimum height but may expand automatically, as necessary, to accommodate the information entered (see Table 1).

Table 1. Individual Field Descriptions for Recommended To-Do List (TDL)

Field title	Requirements for Row height/Cell width
What we talked about	Row height is at least 0.56 inch; cell width is 3.25 inches or less.
What I should do	Row height is at least 0.56 inch; cell width is 3.25 inches or less.

Spacing between sections of the TDL: The horizontal space between action plan sections of the TDL is 0.25 inch.

TDL-1:

Recommended To-Do List for < *Insert member name* >, DOB: < *Insert member DOB* >

- **Recommended To-Do List for:** This header is 12-point font and right justified.
- *< Insert member name>, < Insert member DOB >:* Enter the beneficiary's first and last names, and date of birth (DOB) in the format of *mm/dd/yyyy* (e.g., 03/04/1947) in 12-point font. Remove the italics type in the field that states "*< Insert member name*" and *< Insert member DOB >".*

TDL-2

Recommended To-Do List

Prepared on: < *Insert CMR date* >

- **Recommended To-Do List**: This field title is 18-point font.
- **Prepared on:** *< Insert CMR date >*: This field is 14-point font. Enter the date the CMR was performed in the format of *mm/dd/yyyy* (e.g., 08/01/2024). Remove the italics type in the field that states "*< Insert CMR date >".*
- **Size of border lines:** 0.5 pt, 6.49 inches wide, 0.5 inches apart vertically

TDL-3:

You can get the best results from your medications by completing the items on this **"To-Do List."**

Bring your **To-Do List** when you go to your doctor. And, share it with your family or caregivers.

- These instructions are in 14-point font.

TDL-4:

My To-Do List

What we talked about:	What I should do:
< Insert summary of discussion for topic 1 >	❑ *< Insert action item for topic 1 >* ❑ *< Insert action item for topic 1 >*

- **My To-Do List:** this field is 14-point font.
- **What we talked about:** *< Insert summary of discussion for topic X >*: The header row should be in 13-point bold font. The rest of the table should be in 14-point font. Enter a description of the topic that was discussed with the beneficiary, including the medication therapy problem to be resolved, the behavior to be encouraged, or the goal of therapy. The Part D plan sponsor or MTM provider has the discretion to choose how to refer to the issue, such as list the medication first in the box or add emphasis to that specific text. In some cases, it may be appropriate to tell the beneficiary that the MTM provider will follow up with the prescriber or other healthcare provider. Row height is at least 0.56 inch; cell width is up to 3.25 inches. Remove the italics type in the field that states "*< Insert summary of discussion for topic* X *>".*
- **What I should do:** *< Insert action items for topic X >*: The header row should be in 13-point bold font. The rest of the table should be in 14-point font. The "What I should do" fields in the TDL should include the checkboxes and list the relevant recommendation(s), action item(s), or reinforcing statement(s) for that topic for the beneficiary. Enter recommendations on what the beneficiary should be doing (e.g., "Check your blood pressure every morning. Record your blood pressure reading in your log book."). In some cases, it may be appropriate to tell the beneficiary to take no action pending outcome of the MTM provider's follow up with the prescriber or other healthcare provider. Although two items with checkboxes are shown in the template, plan sponsors may determine how many action items are needed for each topic. Beneficiaries may check off action items as they are completed. Row height is at least 0.56 inch; cell width is up to 3.25 inches. Remove the italics type in the field that states "*< Insert action item for topic X >".*

Section IV: How to Safely Dispose of Unused Prescription Medication

How to Safely Dispose of Unused Prescription Medications (optional)

Information on the safe disposal of unused prescription medications for < *Insert member name* >, DOB: < *Insert member DOB* >

SD-1

How to Safely Dispose of Unused Prescription Medications

Prepared on: < *Insert CMR date* >

SD-2

Purpose

The safe disposal template document is optional and should only be used by sponsors if the information about safe disposal of prescription drugs that are controlled substances, drug take back programs, in-home disposal and cost-effective means to safely dispose of such drugs is discussed with the beneficiary during the CMR.

Plans may also use their own template or include information in the TDL instead of using this provided page. CMS does not expect plans to duplicate any safe disposal information in the CMR summary if they have already provided it in a TMR, MTM enrollment/welcome letter, or other MTM correspondence or service. If using this page, plans should utilize these formatting specifications.

SD-1:

Information on the safe disposal of unused prescription medications for < *Insert member name* >, DOB: < *Insert member DOB* >

- **Information on the safe disposal of unused prescription medications for:** This header is 12-point font and right justified.
- < *Insert member name*>, < *Insert member DOB* >: Enter the beneficiary's first and last names, and date of birth (DOB) in the format of *mm/dd/yyyy* (e.g., 03/04/1947) in 12-point font. Remove the italics type in the field that states "< *Insert member name* > and < Insert member DOB >*".*

SD-2

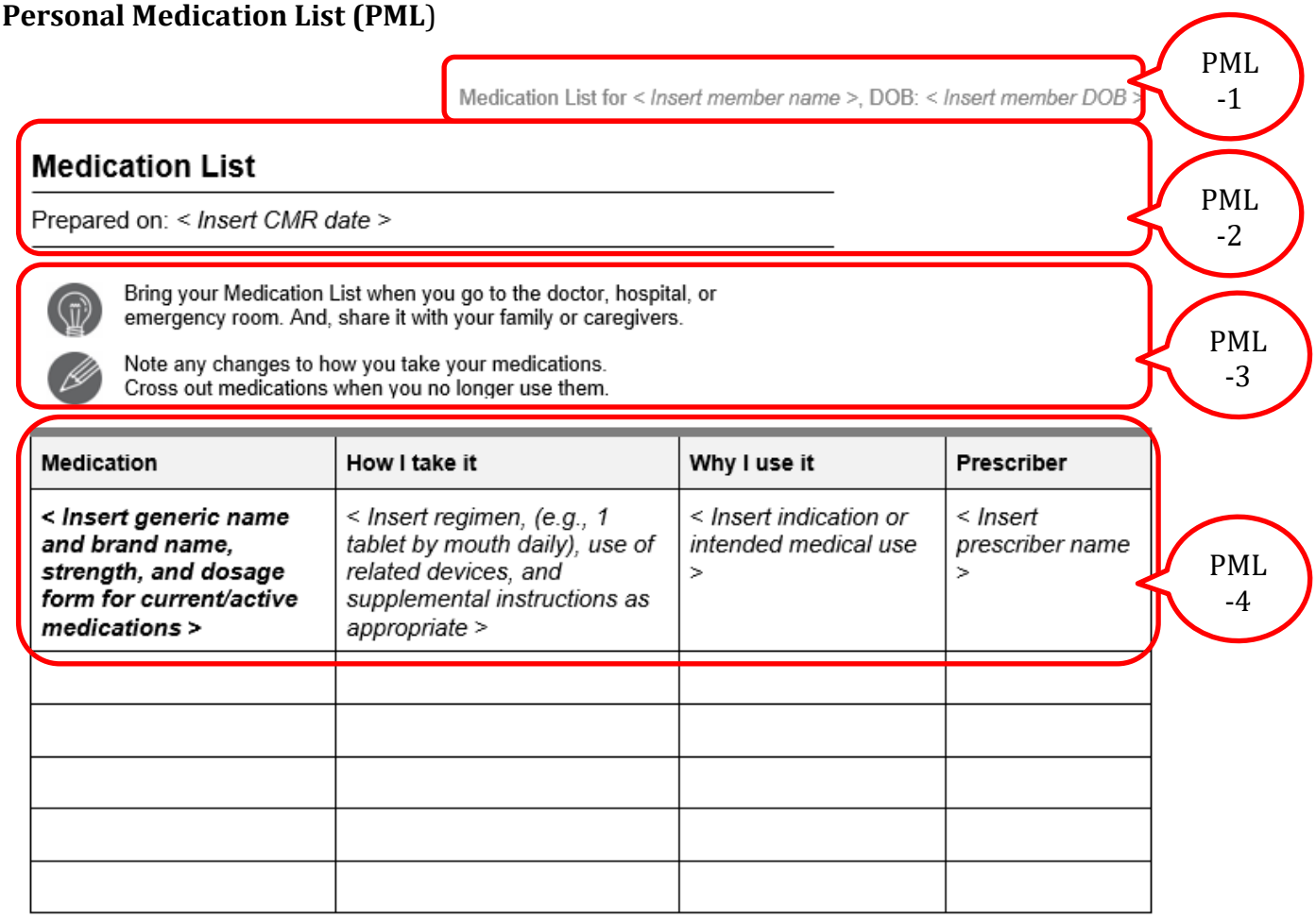
How to Safely Dispose of Unused Prescription Medications

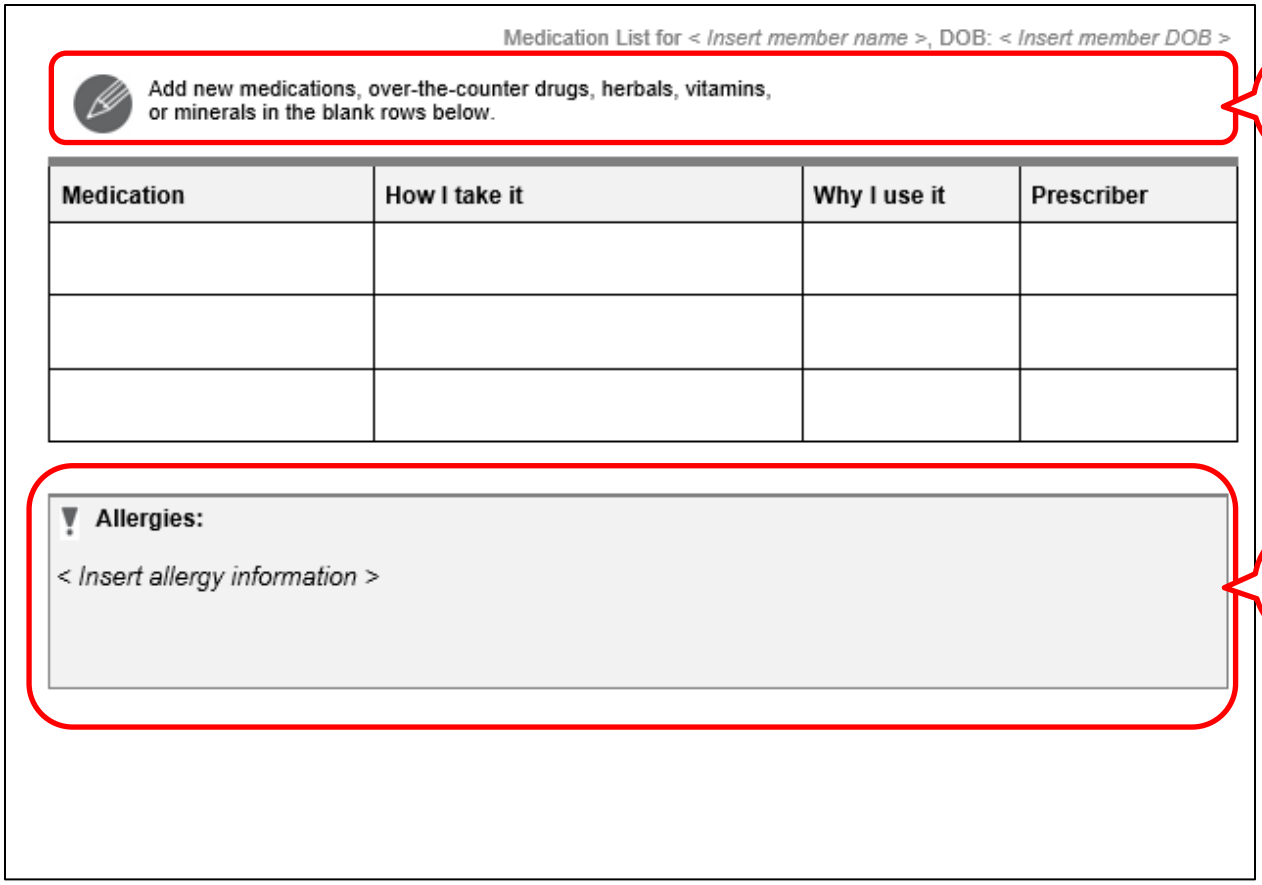
Prepared on: < *Insert CMR date* >

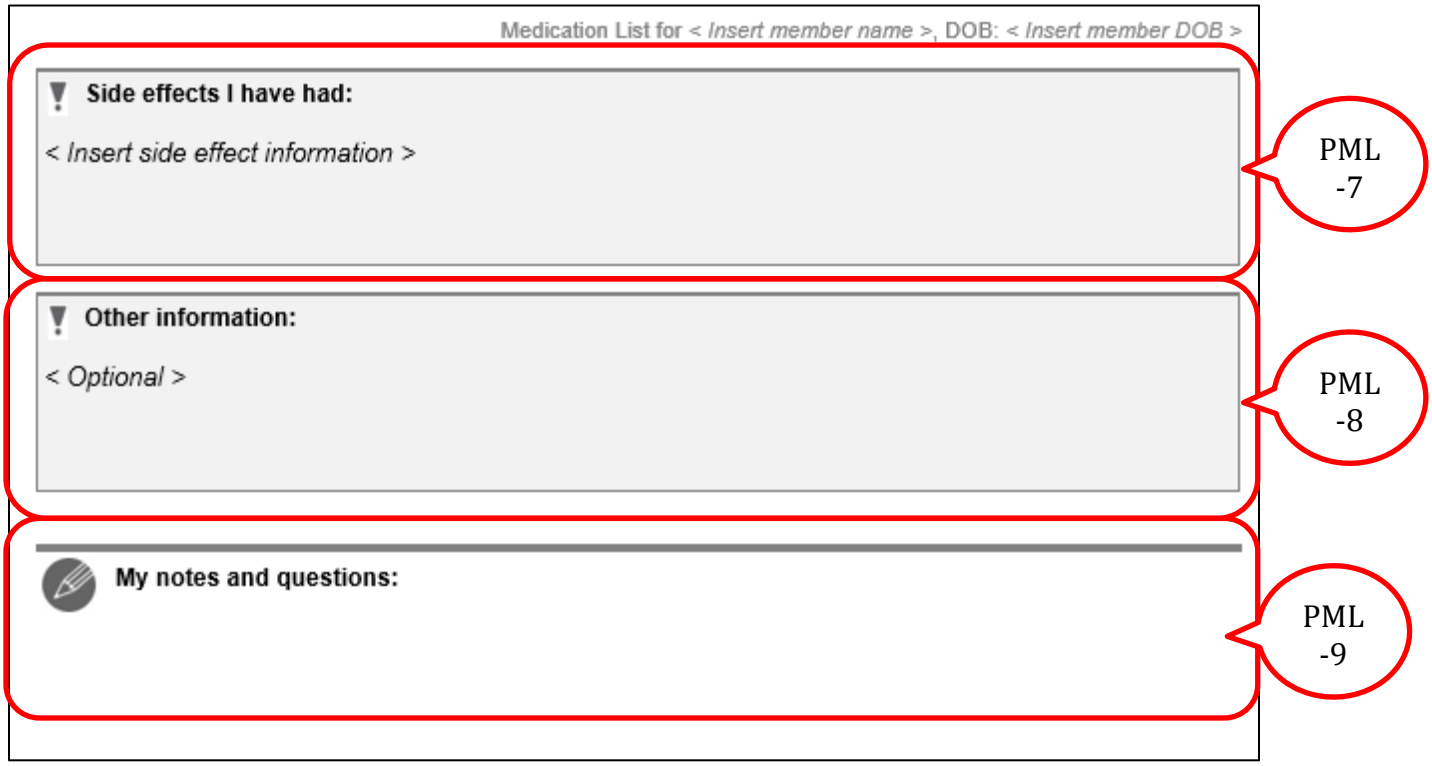
- **How to Safely Dispose of Unused Prescription Medications:** This field title is 18-point font
- **Prepared on:** < *Insert CMR date* >: Enter the date the CMR was performed in the format of *mm/dd/yyyy* (e.g., 08/01/2024). Remove the italics type in the field that states "< *Insert CMR date* >*".*
- **Size of border lines:** 6.49 inches wide, 0.5 inches apart vertically

Section V: Personal Medication List (PML)

Personal Medication List (PML)




Medication List for < Insert member name >, DOB: < Insert member DOB >
Add new medications, over-the-counter drugs, herbals, vitamins, or minerals in the blank rows below.
PML -5
Medication
How I take it
Why I use it
Prescriber
Allergies:
< Insert allergy information >
PML -6


Medication List for < Insert member name >, DOB: < Insert member DOB >
Side effects I have had:
< Insert side effect information >
PML -7
Other information:
< Optional >
PML -8
My notes and questions:
PML -9

Purpose

The Personal Medication List (PML) is a reconciled list of all the medications in use (i.e., active prescription medications, OTC medications, herbal therapies, and dietary supplements) by the beneficiary at the time of a CMR. CMS suggests a minimum look-back of 6 months to identify current prescriptions and prescribers. Information for this section may be pre-populated by the Part D plan with information from claims data, EMRs, or other data files and updated with information provided by the beneficiary and/or caregiver during the CMR. The use of OTC medications, herbals, vitamins or supplements is important for drug utilization review, should be captured during the CMR, and should be reported in the PML by the MTM provider. The PML assists the beneficiary with managing their medications by allowing the beneficiary to add new medications and redacting discontinued products.

Formatting Specifications

Orientation: The PML must be in landscape orientation.

Order of medications: Part D plans may select the sort order for the medications to be listed, such as alphabetically, by purpose, by prescriber, or by product type (e.g., prescription, OTC, dietary or herbal supplement).

Length: The number of pages of the PML is based upon the number of medications used by the beneficiary. The PML may be printed either single or double-sided. At least three blank medication sections or enough to fill the last page of the PML, whichever is greater, should be included for use by beneficiaries to update the PML. Part D plans and MTM providers are encouraged not to separate medication sections or rows across pages.

Sizes of border lines and divider lines:

- Narrow lines around PML titles, text box on PML, and within rows are 0.5 pt.
- The top border line of the PML table is 6 pt in the color gray.

Size and field descriptors: The header row should be in 13-point bold font. The rest of the table should be in 14-point font. The number of characters in the fields within the Format is not limited to a maximum number of characters. Field sizes for Part D plan-reported information have a minimum height but may expand automatically, as necessary, to accommodate the information entered. Fields for beneficiary-entered data have static height and width requirements. See individual field descriptions in Table 2.

Table 2. Individual Field Descriptions for Personal Medication List (PML)

Field title	Requirements for Row height/Cell width
Medication	Row height is at least 0.35 inch; cell width is 2.47 inches
How I take it	Row height is at least 0.35 inch; cell width 2.78 to 3.27 inches.
Why I use it	Row height is at least 0.35 inch; cell width is 1.66 to 2.14 inches.
Prescriber	Row height is at least 0.35 inch; cell width is 1.66 inches.
Allergies	Row height is at least 0.39 inch; cell width is 8.98 inches.
Side effects I have had	Row height is at least 0.39 inch; cell width is 8.98 inches.
Other Information	Row height is at least 0.39 inch; cell width is 8.98 inches.

Part D plans are also encouraged to post a blank PML on their Web site(s) or provide information to beneficiaries about how to obtain a blank copy.

PML-1:

Medication List for < *Insert member name* >, DOB: < *Insert member DOB* >

- **Medication List for:** This header is 12-point font and right justified.
- *< Insert member name > < Insert member DOB >*: Enter the beneficiary's first and last names and date of birth (DOB) in format of *mm/dd/yyyy* (e.g., 03/04/1947) in 12-point font. Remove the italics type in the field that states "*< Insert member name >* and *< Insert member DOB >".*

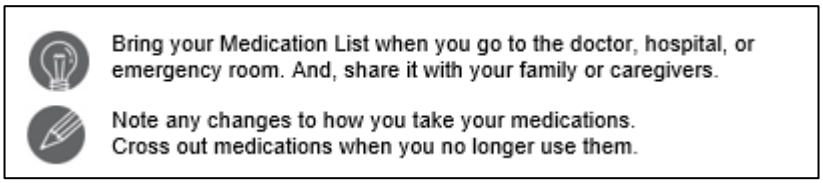
PML-2:

Medication List

Prepared on: < *Insert CMR date* >

- **Medication List:** This field title is 18-point bold font.
- **Prepared on:** *< Insert CMR date >*: Enter the date the CMR was performed in the format of *mm/dd/yyyy* (e.g., 08/01/2024). Remove the italics type in the field that states "*< Insert CMR date >*".
- **Size of border lines:** 6.49 inches wide, 0.5 inches apart vertically

PML-3:



- These instructions are in 12-point font.

PML-4:

Medication	How I take it	Why I use it	Prescriber
< Insert generic name and brand name, strength, and dosage form for current/active medications >	*< Insert regimen, (e.g., 1 tablet by mouth daily), use of related devices, and supplemental instructions as appropriate >*	*< Insert indication or intended medical use >*	*< Insert prescriber name >*

- **Medication:** Enter the medication's generic drug name (and brand name if applicable), strength, and dosage form for medications currently being used by the beneficiary, including starter supplies (e.g., samples), prescription medications, OTCs, dietary therapies, herbal supplements and vitamins. Each medication entry name should be bolded and in 14-point font.

  For brand drugs and branded generics, list both generic and brand names, such as "Generic Name (Brand Name)". An example is Furosemide (Lasix). For generic drugs, list the medication name as "Generic Name" (e.g., Furosemide). This would ensure a consistent format of: "Generic Name (Brand Name if applicable)".

  Information about medication-related devices should be included in the field for the applicable medication(s) in the "How I take it" field where appropriate. Row height is at least 0.35 inch; cell width is 2.47 inches. Remove the italics type in the field that states "*< Insert generic name and brand name, strength, and dosage form for current/active medications >*".

- **How I take it:** Enter the directions for use and supplemental instructions for using the medication. Directions should be specific and include the dose, frequency and route of administration (as ordered for prescribed products, or as being taken for self-selected products). MTM providers should document how the beneficiary is taking the medication and add any discrepancies from written or prescriber instructions to the "Other information" section as well as in the TDL.

For the dose that the beneficiary takes, it should, when appropriate and reasonable, include both the number of tablets/capsules/ teaspoonfuls, etc., and the strength (e.g., 3 teaspoonfuls (27mg) by mouth every 8 hours). For topical dosage forms, such as gels, creams, lotions, ointments, and drops, the dose strength does not need to be included in the directions (e.g., apply to affected area every 12 hours). For other non-oral dosage forms, such as injections, nasal and oral sprays, as well as transdermal patches, the MTM provider should include the strength of medication in a dose (e.g., apply 1 patch (5%) every 12 hours). Enter supplemental and device-related instructions (e.g., Shake the bottle for one minute prior to measuring the dose), if appropriate, or in the optional "*Other Information*" field. Row height is at least 0.35 inch; cell width is 2.78 to 3.27 inches. Remove the italics type in the field that states "< "*< Insert regimen, (e.g., 1 tablet by mouth daily), use of related devices, and supplemental instructions as appropriate >*".

- **Why I use it:** Enter the reason for use, indication, or intended purpose. It may be appropriate to include a lay term (e.g., high blood pressure) more easily understood by the beneficiary, rather than or in addition to the medical term (e.g., hypertension). The MTM provider may also describe the goal(s) of therapy in this field. Row height is at least 0.35 inch; cell width is 1.66 to 2.14 inches. Remove the italics type in the field that states "< *Insert indication or intended medical use >*".
- **Prescriber:** Enter the name of the authorized practitioner who ordered the medication for the beneficiary. This field may also include other prescriber data, such as designation of practitioner type (e.g., MD, PA, or NP), telephone number, address, site, etc., such as J. Johnson-Smith, NP. For non-prescribed OTCs, enter "self" or leave this field blank. Row height is at least 0.35 inch; cell width is 1.66 inches. Remove the italics type in the field that states "< *Insert prescriber name >*".

PML-5:

- These instructions are 12-point font.
- CMS recommends leaving at least 3 blank rows for the beneficiary to add new medications if needed.

PML-6:

- **Allergies:** This heading is 13-point font. Enter the beneficiary's allergies in this field in 14-point font. Record the allergen and note what happened to the beneficiary. The sponsor should also include significant non-drug allergies (such as anaphylactic reactions to shellfish or peanuts). Row height is at least 0.39 inch; cell width is 8.98 inches. Remove the italics type in the field that states "*< Insert allergy information >*".

PML-7:

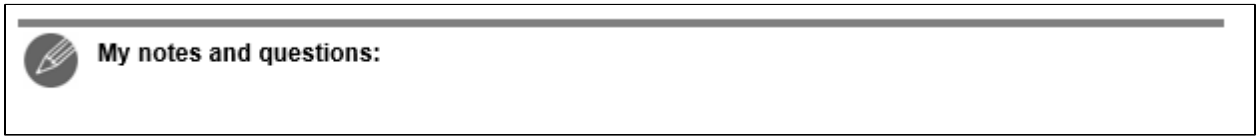
- **Side Effects I have had:** This heading is 13-point font. Enter the beneficiary's adverse drug reactions that are not true allergies in this field in 14-point font. Record the medication and note what happened to the beneficiary. Row height is at least 0.39 inch; cell width is 8.98 inches. Remove the italics type in the field that states "*< Insert side effect information >*".

PML-8:

- **Other Information:** This heading is 13-point font. This optional field may be personalized for the beneficiary, such as including a list of the beneficiary's medical conditions, primary care provider, primary pharmacy, or emergency contact

information. Row height is at least 0.39 inches; cell width is 8.98 inches. Remove the italics type in the field that says "< *Optional* >". This field may be deleted if no information is populated. Enter any information listed here in 14-point font.

PML-9:



- **My notes and questions:** This heading is 13-point font. This field is left blank for the beneficiary to use to write their own notes and questions for their prescriber or other health care professionals.

Appendix A: Medication Therapy Management Program Standardized Format – English Form CMS-10396 (Expires: 07/31/2025)

< *Optional: Insert MTM provider/plan logo* >

< *Optional: Insert MTM provider/plan logo* >

< *Insert letter date* >

< *Insert member name* >
< *Insert member address 1* >
< *Insert member address 2* >
< *Insert member city, state, and zip code* >

< *Additional space for optional plan/provider use, such as barcodes, document reference numbers, beneficiary identifiers, case numbers or title of document* >

Dear < *Insert member name* >,

Thank you for talking with me on < *Insert CMR date* >, about your health and medications. As a follow-up to our conversation, I have included two documents:

1. Your **Recommended To-Do List** has steps you should take to get the best results from your medications.

2. Your **Medication List** will help you keep track of your medications and how to take them.

If you want to talk about these documents, please call < *Insert MTM provider/department name* > at < *Insert contact information for MTM provider/plan, phone number, days/times, TTY, etc.* >.

I look forward to working with you and your doctors to make sure your medications work well for you.

Sincerely,

< *Insert MTM provider name* >
< *Insert MTM provider title* >, < *Insert Part D plan/pharmacy name/organization name* >

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1154. The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850

Recommended To-Do List

Prepared on: < *Insert CMR date* >

You can get the best results from your medications by completing the items on this **"To-Do List."**

Bring your **To-Do List** when you go to your doctor. And, share it with your family or caregivers.

My To-Do List

What we talked about:	**What I should do:**
< Insert summary of discussion for topic 1 >	❑ *< Insert action item for topic 1 >* ❑ *< Insert action item for topic 1 >*

What we talked about:	**What I should do:**
< Insert summary of discussion for topic 2 >	❑ *< Insert action item for topic 2 >* ❑ *< Insert action item for topic 2 >*

What we talked about:	**What I should do:**
< Insert summary of discussion for topic 3 >	❑ *< Insert action item for topic 3 >* ❑ *< Insert action item for topic 3 >*

What we talked about:	**What I should do:**
< Insert summary of discussion for topic 4 >	❑ *< Insert action item for topic 4 >* ❑ *< Insert action item for topic 4 >*

How to Safely Dispose of Unused Prescription Medications

Prepared on: < *Insert CMR date* >

Medication List

Prepared on: < *Insert CMR date* >

Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.

Note any changes to how you take your medications.
Cross out medications when you no longer use them.

Medication	How I take it	Why I use it	Prescriber
< Insert generic name and brand name, strength, and dosage form for current/active medications >	*< Insert regimen, (e.g., 1 tablet by mouth daily), use of related devices, and supplemental instructions as appropriate >*	*< Insert indication or intended medical use >*	*< Insert prescriber name >*

Add new medications, over-the-counter drugs, herbals, vitamins, or minerals in the blank rows below.

Medication	How I take it	Why I use it	Prescriber

Allergies:

< *Insert allergy information* >

Side effects I have had:

< *Insert side effect information* >

Other information:

< *Optional* >

My notes and questions:

Appendix B: Medication Therapy Management Program Standardized Format – Samples

Birchwood
Medicare Plus

August 2, 2024

Mr. John Smith
999 Common Ave.
Washington, DC 80008

Dear Mr. Smith,

Thank you for talking with me on August 1, 2024, about your health and medications. As a follow-up to our conversation, I have included two documents:

1. Your **Recommended To-Do List** has steps you should take to get the best results from your medications.

2. Your **Medication List** will help you keep track of your medications and how to take them.

If you want to talk about these documents, please call me, Sarah Cooper, at 1-800-222-3333.

I look forward to working with you and your doctors to make sure your medications work well for you.

Sincerely,

Sarah Cooper

Sarah Cooper
Pharmacist, Avenue Pharmacy

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1154. The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850

Recommended To-Do List

Prepared on: 08/01/2024

You can get the best results from your medications by completing the items on this **"To-Do List."**

Bring your **To-Do List** when you go to your doctor. And, share it with your family or caregivers.

My To-Do List

What we talked about:	**What I should do:**
You are at risk of a drug-food interaction by taking Lipitor and drinking grapefruit juice.	❑ Don't drink grapefruit juice or eat grapefruit while on Lipitor

What we talked about:	**What I should do:**
High Blood Pressure - at visit on 5/14/2024, it was 154/92 mmHg	❑ Check blood pressure at least 3 times a week and record on log. ❑ Maintain blood pressure less than 130/80 mmHg. ❑ Monitor salt in my diet and increase daily exercise. ❑ Make an appointment with doctor to have blood pressure rechecked and share log.

What we talked about:	What I should do:
There are 2 shingles vaccines currently available. One (Shingrix) has been shown to be more effective. The Shingrix vaccination will require 2 doses given 2 months apart.	❑ Talk to your doctor about getting a new vaccine, Shingrix Intramuscular Suspension Reconstituted 50 MCG ❑ Call Birchwood drug plan customer service to ask about reimbursement for the Shingrix vaccine

What we talked about:	What I should do:
You could lower your copayment by taking the generic version of Glucotrol.	❑ Talk to your doctor about changing to the generic version of Glucotrol (glipizide)

Medication List

Prepared on: 08/01/2024

Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.

Note any changes to how you take your medications.
Cross out medications when you no longer use them.

Medication	How I take it	Why I use it	Prescriber
Lisinopril 20 mg tablet	Take 1 tablet by mouth in the morning	High blood pressure	Dr. David Jones
Fluoxetine HCl 40 mg capsule	Take 1 capsule by mouth in the morning and with dinner	Major depressive disorder	Dr. Alka Aggarwal
Spironolactone 25 mg tablet	Take 1 tablet by mouth in the morning and at bedtime	Heart failure	Dr. David Jones
Atorvastatin (Lipitor) 20 mg tablet	Take 1 tablet by mouth with dinner	High cholesterol	Dr. Anne Parker
Gabapentin 800 mg tablet	Take 2 tablets by mouth at bedtime	Diabetic neuropathy	Dr. Alka Aggarwal

Medication	How I take it	Why I use it	Prescriber
Glipizide XL (Glucotrol) 5 mg tablet	Take 1 tablet by mouth with breakfast	Type 2 diabetes	Dr. Anne Parker
Metoprolol Succinate XL 25 mg tablet	Take 1 tablet by mouth at bedtime	Heart failure	Dr. David Jones
Acetaminophen 325 mg tablet	Take 1 tablet by mouth as needed for pain (3-4 tablets usually each day)	Knee pain	Self
Albuterol sulfate Inhalation Solution (Ventolin HFA)	Use 2 puffs every 6 hours as needed for shortness of breath	Breathing	Dr. Anne Parker

Add new medications, over-the-counter drugs, herbals, vitamins, or minerals in the blank rows below.

Medication	How I take it	Why I use it	Prescriber

Medication	How I take it	Why I use it	Prescriber

Allergies:

Penicillin – hives and difficulty swallowing

Side effects I have had:

Glucotrol XL caused low blood sugar when taken on an empty stomach. Eat within 30 minutes of taking Glucotrol XL.

My notes and questions:

Appendix C: Medication Therapy Management Program Standardized Format – Spanish Form CMS-10396 (Vence: 07/31/2025)

FORMATO ESTANDARIZADO PARA EL PROGRAMA DE CONTROL DE LA TERAPIA DE MEDICAMENTOS DE LA PARTE D DE MEDICARE

< Opcional: Ingrese MTM proveedor/plan logo > *< Opcional: Ingrese MTM proveedor/plan logo >*

< Ingrese la fecha >

< Ingrese el nombre del beneficiario >
< Ingrese la dirección del beneficiario 1 >
< Ingrese la dirección del beneficiario 2 >
< Ingrese la ciudad, estado, código postal del beneficiario >

< Espacio adicional para uso optativo del plan/proveedor para códigos de barra, número de referencia del documento, título o número del caso >

Saludo < *Ingrese el nombre del beneficiario* >,

Gracias por hablar conmigo el día < *Ingrese fecha de CMR* > acerca de su salud y medicamentos. Para hacer seguimiento a nuestra conversación, le adjunto dos documentos:

1. Su **Lista de Cosas Para Hacer** incluye los pasos que usted debe seguir para obtener los mejores resultados de sus medicamentos.

2. Su **Lista de Medicamentos** le ayudará a monitorear sus medicamentos y saber cuándo y cómo tomarlos.

Si usted quiere hablar acerca de estos documentos adjuntos, por favor llámme/nos < *Ingrese el nombre del proveedor del MTM/departamento* > al < *Ingrese la información de contacto del proveedor del MTM/plan, el número de teléfono, fechas/horas, TTY, etc.* >.

Espero poder trabajar con usted y sus doctores para asegurarnos que sus medicamentos son efectivos.

Muchas gracias por su atención,

< Ingrese el nombre del MTM proveedor >
< Ingrese el título del MTM proveedor >, *< Ingrese el nombre del plan de la Parte D/ la farmacia/ organización >*

De conformidad con la Ley de reducción de los trámites burocráticos de 1995, nadie estará obligado a responder a una solicitud de información a menos que se identifique con un número de control válido de la Oficina de Administración y Presupuesto. El número de control válido de la Oficina de Administración y Presupuesto para esta recolección de información es 0938-1154. El tiempo necesario para completar esta solicitud es en promedio, 40 minutos incluido el tiempo necesario para revisar las instrucciones, buscar en las fuentes de datos existentes, seleccionar los datos necesarios y completarla. Si tiene comentarios sobre el tiempo estimado para responder o sugerencias para mejorar este formulario, sírvase escribir a: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850

Lista de Cosas Por Hacer

Preparado el: < *Fecha de la Revisión Integral de Medicamentos (CMR)*>

Usted podrá obtener los mejores resultados de sus medicamentos completando todos los pasos en esta **"Lista de Cosas por Hacer."**

Lleve su **"Lista de Cosas por Hacer"** cuando visite su médico. Y compártala con su familia y cuidadores.

Mi Lista de Cosas por Hacer

Acerca de lo que hablamos:	**Lo que debo hacer:**
< Ingrese resumen de discusión para el tema 1 >	❑ *< Inserte acción a seguir para el tema 1 >* ❑ *< Inserte acción a seguir para el tema 1 >*

Acerca de lo que hablamos:	**Lo que debo hacer:**
< Ingrese resumen de discusión para el tema 2 >	❑ *< Inserte acción a seguir para el tema 2 >* ❑ *< Inserte acción a seguir para el tema 2 >*

Acerca de lo que hablamos:	**Lo que debo hacer:**
< Ingrese resumen de discusión para el tema 3 >	❑ *< Inserte acción a seguir para el tema 3 >* ❑ *< Inserte acción a seguir para el tema 3 >*

Acerca de lo que hablamos:	**Lo que debo hacer:**
< Ingrese resumen de discusión para el tema 4 >	❑ *< Inserte acción a seguir para el tema 4 >* ❑ *< Inserte acción a seguir para el tema 4 >*

Cómo desechar de forma segura los medicamentos recetados no utilizados

Preparado el: < *Fecha de la Revisión Integral de Medicamentos (CMR)* >

Lista de Medicamentos

Preparado el: < *Fecha de la Revisión Integral de Medicamentos (CMR)* >

Lleve su Lista de Medicamentos cuando vaya al médico, hospital, o sala de emergencia. Y compártala con su familia o cuidadores.

Anote cualquier cambio en la forma como toma sus medicamentos.
Tache los medicamentos que ya no toma.

Medicamento	**Cómo lo tomo**	**Por qué lo tomo**	**Médico**
< Ingrese el nombre genérico y de marca del medicamento, la potencia, y la dosis de los medicamentos que toma actualmente >	*< Ingrese la terapia que le ordenaron (por ejemplo, 1 tableta por vía oral diaria), los aparatos para usarla e instrucciones adicionales si correspondiera >*	*< Ingrese indicaciones o el uso médico >*	*< Ingrese nombre del médico >*

Añada nuevos medicamentos de receta, medicamentos de venta libre, productos herbarios, vitaminas, y minerales en las líneas en blanco abajo.

Medicamento	Cómo lo tomo	Por qué lo tomo	Médico

Alergias:

< *Ingrese información sobre alergias* >

Efectos secundarios que he tenido:

< *Ingrese información sobre efectos secundarios* >

Otra Información:

< *Opcional* >

Mis notas y preguntas: