

coverage that is not qualified prescription drug coverage under § 417.440(b)(2)(i) of this chapter.

(g) *Negotiated prices*—(1) *Access to negotiated prices.* A Part D sponsor is required to provide its Part D enrollees with access to negotiated prices for covered Part D drugs included in its Part D plan's formulary. Negotiated prices must be provided even if no benefits are payable to the beneficiary for covered Part D drugs because of the application of any deductible or 100 percent coinsurance requirement following satisfaction of any initial coverage limit.

(2) *Interaction with Medicaid best price.* Prices negotiated with a pharmaceutical manufacturer, including discounts, subsidies, rebates, and other price concessions, for covered Part D drugs by the following entities are not taken into account in establishing Medicaid's best price under section 1927(c)(1)(C) of the Act—

(i) A Part D plan, as defined in § 423.4; or

(iii) A qualified retiree prescription drug plan (as defined in § 423.882) for Part D eligible individuals.

(3) *Disclosure.* (i) A Part D sponsor is required to disclose to CMS data on aggregate negotiated price concessions obtained from pharmaceutical manufacturers, as well as data on aggregate negotiated price concessions obtained from pharmaceutical manufacturers that are passed through to beneficiaries, via pharmacies and other dispensers, in the form of lower subsidies paid by CMS on behalf of low-income individuals described in § 423.782, or in the form of lower monthly beneficiary premiums or lower covered Part D drug prices at the point of sale.

(ii) Information on negotiated prices disclosed to CMS under paragraph (g)(3) of this section is protected under the confidentiality provisions applicable under section 1927(b)(3)(D) of the Act.

(4) *Audits.* CMS and the Office of the Inspector General may conduct periodic audits of the financial statements and all records of Part D sponsors pertaining to any qualified prescription drug coverage they may offer under a Part D plan.

§ 423.112 Establishment of prescription drug plan service areas.

(a) *Service area for prescription drug plans.* The service area for a prescription drug plan other than a fallback prescription drug plan consists of one or more PDP regions as established under paragraphs (b) and (c) of this section.

(b) *Establishment of PDP regions*—(1) *General.* CMS establishes PDP regions in a manner consistent with the requirements for the establishment of MA regions as described at § 422.455 of this chapter.

(2) *Relation to MA regions.* To the extent practicable, PDP regions are the same as MA regions. CMS may establish PDP regions that are not the same as MA regions if CMS determines that the establishment of these regions improves access to prescription drug plan benefits for Part D eligible individuals.

(c) *Authority for territories.* CMS establishes a PDP region or regions for States that are not within the 50 States and the District of Columbia.

(d) *Revision of PDP regions.* CMS may revise the PDP regions established under paragraphs (b) and (c) of this section.

(e) *Regional or national plan.* Nothing in this section prevents a prescription drug plan from being offered in two or more PDP regions in their entirety or in all PDP regions in their entirety.

§ 423.120 Access to covered Part D drugs.

(a) *Assuring pharmacy access*—(1) *Standards for convenient access to network pharmacies.* Except as provided in paragraph (a)(7) of this section, a Part D plan must have a contracted pharmacy network consisting of retail pharmacies sufficient to ensure that for beneficiaries residing in each State in a prescription drug plan's service area (as defined in § 423.112(a)), each State in a regional MA-PD plan's service area (as defined in § 422.2 and § 422.455(a) of this chapter), a local MA-PD plan's service area (as defined in § 422.2 of this chapter), or a cost plan's geographic area (as defined in § 417.401 of this chapter), the following requirements are satisfied:

(i) At least 90 percent of Medicare beneficiaries, on average, in urban

areas served by the Part D plan live within 2 miles of a network pharmacy that is a retail pharmacy or a pharmacy described under paragraph (a)(2) of this section;

(ii) At least 90 percent of Medicare beneficiaries, on average, in suburban areas served by the Part D plan live within 5 miles of a network pharmacy that is a retail pharmacy or a pharmacy described under paragraph (a)(2) of this section; and

(iii) At least 70 percent of Medicare beneficiaries, on average, in rural areas served by the Part D plan live within 15 miles of a network pharmacy that is a retail pharmacy or a pharmacy described under paragraph (a)(2) of this section.

(2) *Applicability of some non-retail pharmacies to standards for convenient access.* Part D plans may count I/T/U pharmacies and pharmacies operated by Federally Qualified Health Centers and Rural Health Centers toward the standards for convenient access to network pharmacies in paragraph (a)(1) of this section.

(3) *Access to non-retail pharmacies.* A Part D plan's contracted pharmacy network may be supplemented by non-retail pharmacies, including pharmacies offering home delivery via mail-order and institutional pharmacies, provided the requirements of paragraph (a)(1) of this section are met.

(4) *Access to home infusion pharmacies.* A Part D plan's contracted pharmacy network must provide adequate access to home infusion pharmacies consistent with written policy guidelines and other CMS instructions.

(5) *Access to long-term care pharmacies.* A Part D plan must offer standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, to all long-term care pharmacies in its service area. The plan must provide convenient access to long-term care pharmacies consistent with written policy guidelines and other CMS instructions.

(6) *Access to I/T/U pharmacies.* A Part D plan must offer standard contracting terms and conditions conforming to the model addendum that CMS develops, to all I/T/U pharmacies in its service area. The plan must provide con-

venient access to I/T/U pharmacies consistent with written policy guidelines and other CMS instructions.

(7) *Waiver of pharmacy access requirements.* CMS waives the requirements under paragraph (a)(1) of this section in the case of—

(i) An MA-PD plan or cost plan (as described in section 1876(h) of the Act) that provides its enrollees with access to covered Part D drugs through pharmacies owned and operated by the MA organization or cost plan, provided the organization's or plan's pharmacy network meets the access standard set forth under § 422.112 of this chapter for an MA plan, or § 417.416(e) of this chapter for a cost plan.

(ii) An MA private fee-for-service plan described in § 422.4 of this chapter that—

(A) Offers qualified prescription drug coverage; and

(B) Provides plan enrollees with access to covered Part D drugs dispensed at all pharmacies, without regard to whether they are contracted network pharmacies and without charging cost-sharing in excess of that described in § 423.104(d)(2) and (d)(5).

(8) *Pharmacy network contracting requirements.* In establishing its contracted pharmacy network, a Part D sponsor offering qualified prescription drug coverage—

(i) Must contract with any pharmacy that meets the Part D plan's standard terms and conditions; and

(ii) May not require a pharmacy to accept insurance risk as a condition of participation in the Part D plan's contracted pharmacy network.

(9) *Differential cost-sharing for preferred pharmacies.* A Part D sponsor offering a Part D plan that provides coverage other than defined standard coverage may reduce copayments or coinsurance for covered Part D drugs obtained through a preferred pharmacy relative to the copayments or coinsurance applicable for such drugs when obtained through a non-preferred pharmacy. Such differentials are taken into account in determining whether the requirements under § 423.104(d)(2) and (d)(5) and § 423.104(e) are met. Any cost-sharing reduction under this section must not increase CMS payments to the Part D plan under § 423.329.

(10) *Level playing field between mail-order and network pharmacies.* A Part D sponsor must permit its Part D plan enrollees to receive benefits, which may include a 90-day supply of covered Part D drugs, at any of its network pharmacies that are retail pharmacies. A Part D plan may require an enrollee obtaining a covered Part D drug at a network pharmacy that is a retail pharmacy to pay any higher cost-sharing applicable to that covered Part D drug at the network pharmacy that is a retail pharmacy instead of the cost-sharing applicable to that covered Part D drug at the network pharmacy that is a mail-order pharmacy.

(b) *Formulary requirements.* A Part D sponsor that uses a formulary under its qualified prescription drug coverage must meet the following requirements—

(1) *Development and revision by a pharmacy and therapeutic committee.* A Part D sponsor's formulary must be developed and reviewed by a pharmacy and therapeutic committee that—

(i) Includes a majority of members who are practicing physicians and/or practicing pharmacists.

(ii) Includes at least one practicing physician and at least one practicing pharmacist who are independent and free of conflict relative to—

(A) The Part D sponsor and Part D plan; and

(B) Pharmaceutical manufacturers.

(iii) Includes at least one practicing physician and one practicing pharmacist who are experts regarding care of elderly or disabled individuals.

(iv) Bases clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmaco-economic studies, outcomes research data, and other such information as it determines appropriate.

(v) Considers whether the inclusion of a particular Part D drug in a formulary or formulary tier has any therapeutic advantages in terms of safety and efficacy.

(vi) Reviews policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, generic substitution, and therapeutic interchange.

(vii) Evaluates and analyzes treatment protocols and procedures related to the plan's formulary at least annually consistent with written policy guidelines and other CMS instructions.

(viii) Documents in writing its decisions regarding formulary development and revision and utilization management activities.

(ix) Meets other requirements consistent with written policy guidelines and other CMS instructions.

(2) Provision of an adequate benefit. A Part D plan's formulary must—

(i) Except as provided in paragraph (b)(2)(ii) of this section, include within each therapeutic category and class of Part D drugs at least two Part D drugs that are not therapeutically equivalent and bioequivalent, with different strengths and dosage forms available for each of those drugs, except that only one Part D drug must be included in a particular category or class of covered Part D drugs if the category or class includes only one Part D drug.

(ii) Include at least one Part D drug within a particular category or class of Part D drugs to the extent the Part D plan demonstrates, and CMS approves, the following—

(A) That only two drugs are available in that category or class of Part D drugs; and

(B) That one drug is clinically superior to the other drug in that category or class of Part D drugs.

(iii) Include adequate coverage of the types of drugs most commonly needed by Part D enrollees, as recognized in national treatment guidelines.

(iv) Be approved by CMS consistent with § 423.272(b)(2).

(3) *Transition Process.* A Part D sponsor must provide for an appropriate transition process for new enrollees prescribed Part D drugs that are not on its Part D plan's formulary. The transition policy must meet requirements consistent with written policy guidelines and other CMS instructions.

(4) *Limitation on changes in therapeutic classification.* Except as CMS may permit to account for new therapeutic uses and newly approved Part D drugs, a Part D sponsor may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year.

(5) *Provision of notice regarding formulary changes* (i) Prior to removing a covered Part D drug from its Part D plan's formulary, or making any change in the preferred or tiered cost-sharing status of a covered Part D drug, a Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (as defined in § 423.454), entities providing other prescription drug coverage (as described in § 423.464(f)(1)), authorized prescribers, network pharmacies, and pharmacists prior to the date such change becomes effective, and must either—

(A) Provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective; or

(B) At the time an affected enrollee requests a refill of the Part D drug, provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change.

(ii) The written notice must contain the following information—

(A) The name of the affected covered Part D drug;

(B) Whether the plan is removing the covered Part D drug from the formulary, or changing its preferred or tiered cost-sharing status;

(C) The reason why the plan is removing such covered Part D drug from the formulary, or changing its preferred or tiered cost-sharing status;

(D) Alternative drugs in the same therapeutic category or class or cost-sharing tier and expected cost-sharing for those drugs; and

(E) The means by which enrollees may obtain a coverage determination under § 423.566 or exception under § 423.578.

(iii) Part D sponsors may immediately remove from their Part D plan formularies covered Part D drugs deemed unsafe by the Food and Drug Administration or removed from the market by their manufacturer without meeting the requirements of paragraphs (b)(5)(i) of this section. Part D sponsors must provide retrospective notice of any such formulary changes to affected enrollees, CMS, State Pharmaceutical Assistance Programs (as defined in § 423.454), entities providing

other prescription drug coverage (as described in § 423.464(f)(1)), authorized prescribers, network pharmacies, and pharmacists consistent with the requirements of paragraphs (b)(5)(ii)(A), (b)(5)(ii)(B), (b)(5)(ii)(C), and (b)(5)(ii)(D) of this section.

(6) *Limitation on formulary changes prior to the beginning of a contract year.*

Except as provided under paragraph (b)(5)(iii) of this section, a Part D sponsor may not remove a covered Part D drug from its Part D plan's formulary, or make any change in the preferred or tiered cost-sharing status of a covered Part D drug on its plan's formulary, between the beginning of the annual coordinated election period described in § 423.38(b) and 60 days after the beginning of the contract year associated with that annual coordinated election period.

(7) *Provider and patient education.* A Part D sponsor must establish policies and procedures to educate and inform health care providers and enrollees concerning its formulary.

(c) *Use of standardized technology.* A Part D sponsor must issue and reissue, as necessary, a card or other type of technology that its enrollees may use to access negotiated prices for covered Part D drugs as provided under § 423.104(g). The card or other technology must comply with standards CMS establishes.

§ 423.124 Special rules for out-of-network access to covered Part D drugs at out-of-network pharmacies.

(a) *Out-of-network access to covered part D drugs.* (1) Out-of-network pharmacy access. A Part D sponsor must ensure that Part D enrollees have adequate access to covered Part D drugs dispensed at out-of-network pharmacies when the enrollees—

(i) Cannot reasonably be expected to obtain such drugs at a network pharmacy; and

(ii) Do not access covered Part D drugs at an out-of-network pharmacy on a routine basis.

(2) Physician's office access. A Part D sponsor must ensure that Part D enrollees have adequate access to vaccines and other covered Part D drugs