Valor Health Plan

Insurance focused on you.
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North Canton, Ohio 44720
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Medication Therapy Management Program (MTM program) - 2022

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

A team of pharmacists and doctors developed the program for us. This program can help make sure you get the most benefit from the drugs you take such as including increasing your awareness regarding your medications and preventing or minimizing drug-rated risk. This program is free of charge and is open only to those who qualify. The MTM program is a clinical program provided by our Plan and is not considered a plan benefit.

Who qualifies for the MTM program?

We will automatically enroll you in the Plan's Medication Therapy Management Program at no cost to you if all three (3) conditions apply:

1. You take eight (8) or more Medicare Part D covered drugs
2. You have three (3) or more of these long-term health conditions: Alzheimer 's Disease, Diabetes, Dyslipidemia, Hypertension, or Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD).
3. You incurred drug cost of at least $4,696 per year, or $1,174 in the previous three months

How will I be contacted if I qualify for the MTM program?

We review for qualified members each quarter. If you qualify for the program, you will receive an initial letter indicating you are enrolled in the MTM program along with a personal medication record (PMR). The PMR contains a list of drugs covered by the Plan in the previous 4 months of the calendar year.

What services are included in the MTM program?

1. Comprehensive Medication Review (CMR): In the initial letter you receive, you will be offered a telephonic CMR with a member of our clinical staff. During the CMR, the personal medication record mailed initially to you will be verified and you can

talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications.

Upon completion of the CMR, and individualized written summary in the CMS standard format will be provided within 14 days of the CMR. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You will also get a personal medication list that will include all the medications you are taking and why you take them. You can review a blank copy of the medication list at the end of this document.

MTM enrollees may receive follow-up mailings on a quarterly basis to remind them of their opportunity for the CMR and to provide general member education materials.

2. Targeted Medication Review (TMR): A TMR is where we review your claims on a quarterly basis to identify therapy care gap and mail or fax suggestions to the healthcare professional that prescribed the medication. Prescribers will be re-notified regarding any unresolved therapy care gaps no more frequently than every 6 months. As always, your prescribing doctor will decide whether to consider our suggestions. Your prescription drugs will not change unless you and your doctor decide to change them.

How can I get more information about the MTM program?

If you would like additional information about this program, would like to receive copies of MTM materials, or you do not wish to take part in the MTMP, please call us at the number on the back of your Member ID card.

Medication Therapy Management Program Standardized Format – English
Form CMS-10396 (02/24)

< MTM PROVIDER HEADER or OPTIONAL LOGO >

< MTM PROVIDER HEADER or OPTIONAL LOGO >

< Insert date >

< Insert inside address >

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

< Insert salutation >:

Thank you for talking with me on *< insert date of service >* about your health and medications. Medicare's MTM (Medication Therapy Management) program helps you understand your medications and use them safely.

This letter includes an action plan (Medication Action Plan) and medication list (Personal Medication List). **The action plan has steps you should take to help you get the best results from your medications. The medication list will help you keep track of your medications and how to use them the right way.**

- Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other health care providers in your care team.
- Ask your doctors, pharmacists, and other healthcare providers to update the action plan and medication list at every visit.
- Take your medication list with you if you go to the hospital or emergency room.
- Give a copy of the action plan and medication list to your family or caregivers.

If you want to talk about this letter or any of the papers with it, please call *<insert contact information for MTM provider, phone number, days/times, TTY, etc. >*. *< I/We >* look forward to working with you, your doctors, and other healthcare providers to help you stay healthy through the *< insert name of Part D Plan >* MTM program.

< Insert closing, MTM provider signature, name, title, enclosure notations, etc. >

< MTM PROVIDER HEADER or OPTIONAL LOGO >

< MTM PROVIDER HEADER or OPTIONAL LOGO >

MEDICATION ACTION PLAN FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* >

This action plan will help you get the best results from your medications if you:

1. Read "What we talked about."
2. Take the steps listed in the "What I need to do" boxes.
3. Fill in "What I did and when I did it."
4. Fill in "My follow-up plan" and "Questions I want to ask."

Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team. Share this with your family or caregivers too.

DATE PREPARED: < *INSERT DATE* >

What we talked about: *< Insert description of topic >*	
What I need to do: *< Insert recommendations for beneficiary activities >*	**What I did and when I did it:** *< Leave blank for beneficiary's notes >*

What we talked about:	
What I need to do:	**What I did and when I did it:**

What we talked about:	
What I need to do:	**What I did and when I did it:**

What we talked about:	
What I need to do:	**What I did and when I did it:**

What we talked about:	
What I need to do:	**What I did and when I did it:**

My follow-up plan (add notes about next steps)**:**
< Leave blank for beneficiary's notes >

Questions I want to ask (include topics about medications or therapy)**:**
< Leave blank for beneficiary's notes >

If you have any questions about your action plan, call *< insert MTM provider contact information, phone number, days/times, etc. >*.

< *MTM PROVIDER HEADER or OPTIONAL LOGO* >

< *MTM PROVIDER HEADER or OPTIONAL LOGO* >

PERSONAL MEDICATION LIST FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* >

This medication list was made for you after we talked. We also used information from < *insert sources of information* >.

- Use blank rows to add new medications. Then fill in the dates you started using them.
- Cross out medications when you no longer use them. Then write the date and why you stopped using them.
- Ask your doctors, pharmacists, and other healthcare providers in your care team to update this list at every visit.

Keep this list up-to-date with:

- ☐ prescription medications
- ☐ over the counter drugs
- ☐ herbals
- ☐ vitamins
- ☐ minerals

If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

DATE PREPARED: < *INSERT DATE* >

Allergies or side effects: < *Insert beneficiary's allergies and adverse drug reactions including the medications and their effects* >

Medication: < *Insert generic name and brand name, strength, and dosage form for current/active medications.* >	
How I use it: < *Insert regimen, including strength, dose and frequency (e.g., 1 tablet (20 mg) by mouth daily), use of related devices and supplemental instructions as appropriate* >	
Why I use it: < *Insert indication or intended medical use* >	**Prescriber:** < *Insert prescriber's name* >
***< Insert other title(s) or delete this field >*:** < *Use for optional product-related information, such as additional instructions, product image/identifiers, goals of therapy, pharmacy, etc., and change field title accordingly. This field may be expanded or divided. Delete this field if not used.* >	
Date I started using it: < *May be estimated by Plan or entered based upon beneficiary-reported data, or leave blank for beneficiary to enter start date* >	**Date I stopped using it:** < *Leave blank for beneficiary to enter stop date* >
Why I stopped using it: < *Leave blank for beneficiary's notes* >	

PERSONAL MEDICATION LIST FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* >

(Continued)

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

PERSONAL MEDICATION LIST FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* >

(Continued)

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Other Information:

If you have any questions about your medication list, call < *insert MTM provider contact information, phone numbers, days/times, etc.* >.