MEDICARE PART D
MEDICATION THERAPY MANAGEMENT PROGRAM
STANDARDIZED FORMAT

FORM CMS-10396 (07/14)

Last updated: July 15, 2014

Instructions for Implementing the Standardized Format

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Section 1: General Requirements

Introduction

The Medicare Part D Medication Therapy Management (MTM) Program Standardized Format (Format) is a written summary of a comprehensive medication review (CMR). A CMR is an interactive, person-to-person or telehealth medication review and consultation of a beneficiary's medications (including prescriptions, over-the-counter (OTC) medications, herbal therapies, and dietary supplements) by a pharmacist or qualified provider that is intended to aid in assessing medication therapy and optimizing patient outcomes. Part D sponsors must, at a minimum, offer a CMR annually for targeted beneficiaries and provide written summaries. The summaries must comply with requirements as specified by CMS for the Format as of January 1, 2013 and any subsequent revisions.

Background

Section 10328 of the Affordable Care Act amended section 1860D-4(c)(2)(ii) of the Act to require prescription drug plan sponsors to offer, at a minimum, an annual comprehensive medication review (CMR) that may be furnished person-to-person or via telehealth technologies. The CMR must include a review of the individual's medications, which may result in the creation of a recommended medication action plan with a written or printed summary of the results of the review provided to the targeted individual. The Act further required the development of a standardized format for the action plan and summary. Standardization of the format of these documents is expected to improve the quality of the MTM program services and provide consistency in beneficiary communications across differing Medicare Part D programs.

As noted above, a CMR is an interactive, person-to-person or telehealth medication review and consultation of a beneficiary's medications (including prescriptions, over-the-counter (OTC) medications, herbal therapies, and dietary supplements) by a pharmacist or qualified provider that is intended to aid in assessing medication therapy and optimizing patient outcomes. Refer to Chapter 7 of the Prescription Drug Benefit Manual, Medication Therapy Management and Quality Improvement Program (http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter7.pdf) and other related guidance about Part D MTM programs (http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html).

Use of the 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

The purpose of this publication is to provide detailed instructions and examples on how to complete the MTM Program Standardized Format (Form CMS-10396 (07/14), Form Approved OMB No. 0938-1154), which at this time is provided in both English and Spanish.

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 of the Format in Appendix C. A summary of revisions to the Format is available in Appendix D.

Components of the Format

The Format for the written summary given to beneficiaries after a CMR includes three documents:

- CMR Cover Letter (CL)
- Medication Action Plan (MAP)
- 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 provides a template for the written summary after a CMR. The Format cannot be modified, but the specific content to populate the Format must be tailored to the beneficiary and customized for the Part D plan and MTM program. There is limited variability in the Format for Part D plans to provide additional information, such as supplemental instructions and goals of therapy. This limited variability is provided to meet the unique needs of each beneficiary beyond the requirements of the basic Format and to promote innovation.

The Format should be considered a foundation upon which to innovate to improve healthcare outcomes of beneficiaries, increase quality, reduce costs, and implement new standards for healthcare technology. Part D plans are encouraged to provide supplemental materials in addition to the Format as needed to help beneficiaries manage their healthcare

needs. The enclosure notations or postscript of the CL may be used to list or describe 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, MAP, or PML may be included in the margins of the documents to facilitate the fulfillment process.

Communicating with the Beneficiary

Pharmacists or other qualified providers who conduct CMRs are encouraged to explain to beneficiaries that the Format, namely the Medication Action Plan (MAP) and Personal Medication List (PML), was developed to help beneficiaries understand their medications and use them safely, as well as assist with keeping track of their medications.

The CMR provider should discuss the delivery options for the Format with the beneficiary, such as postal delivery service, transmission by email, or access through a secure Web site. Part D plans may provide the Standardized Format to a beneficiary immediately following a CMR, or, if distributed separately, materials must be sent out within 14 calendar days.

Based on stakeholders' feedback and changing demographics of Medicare beneficiaries, there is a Standardized Format available in Spanish. Throughout the instructions booklet, there are unique requirements noted for this version.

General Formatting Specifications

- ***Orientation:*** Portrait orientation is required for all documents of the Format.
- ***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:*** 0.9 to 1 inch on all sides.
- ***Font:*** 14-point font size is required except where another font size is specified below (e.g., **DATE PREPARED** field, 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 and field entries must be printed with a serif font, such as Times New Roman or Cambria. Headings and titles are printed in bold font, and a sans serif font, such as Arial or Calibri, may be used. Narrow, compressed, or condensed fonts are prohibited.

- ***Justification:*** All fields are left justified except where specified below (e.g., **DATE PREPARED** field on the MAP and PML is 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 must be included on the first page of the CL, MAP, and PML and must not appear on the other pages.
- ***Footer:***

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  - The **CMS form number and OMB approval number** must appear in the footer of every page of the CL, MAP, 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 last page of the PML above 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, MAP, 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 must 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 PML. 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 MAP, and then the PML. The MAP 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**.
- ***Instructions in the Format:*** Imbedded instructions shown as italicized text within < > symbols must be deleted prior to distribution to beneficiaries.
- ***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

Part D Plans are required to offer a CMR to all beneficiaries, regardless of setting. In the event the beneficiary is cognitively impaired and cannot make decisions regarding his or her medical needs, CMS recommends that the MTM provider reach out to the beneficiary's prescriber, caregiver, or other authorized individual, such as the beneficiary's health care proxy or legal guardian, to take part in the CMR. Throughout this instructions booklet, there are unique recommendations noted for the CMR summary prepared for cognitively impaired beneficiaries.

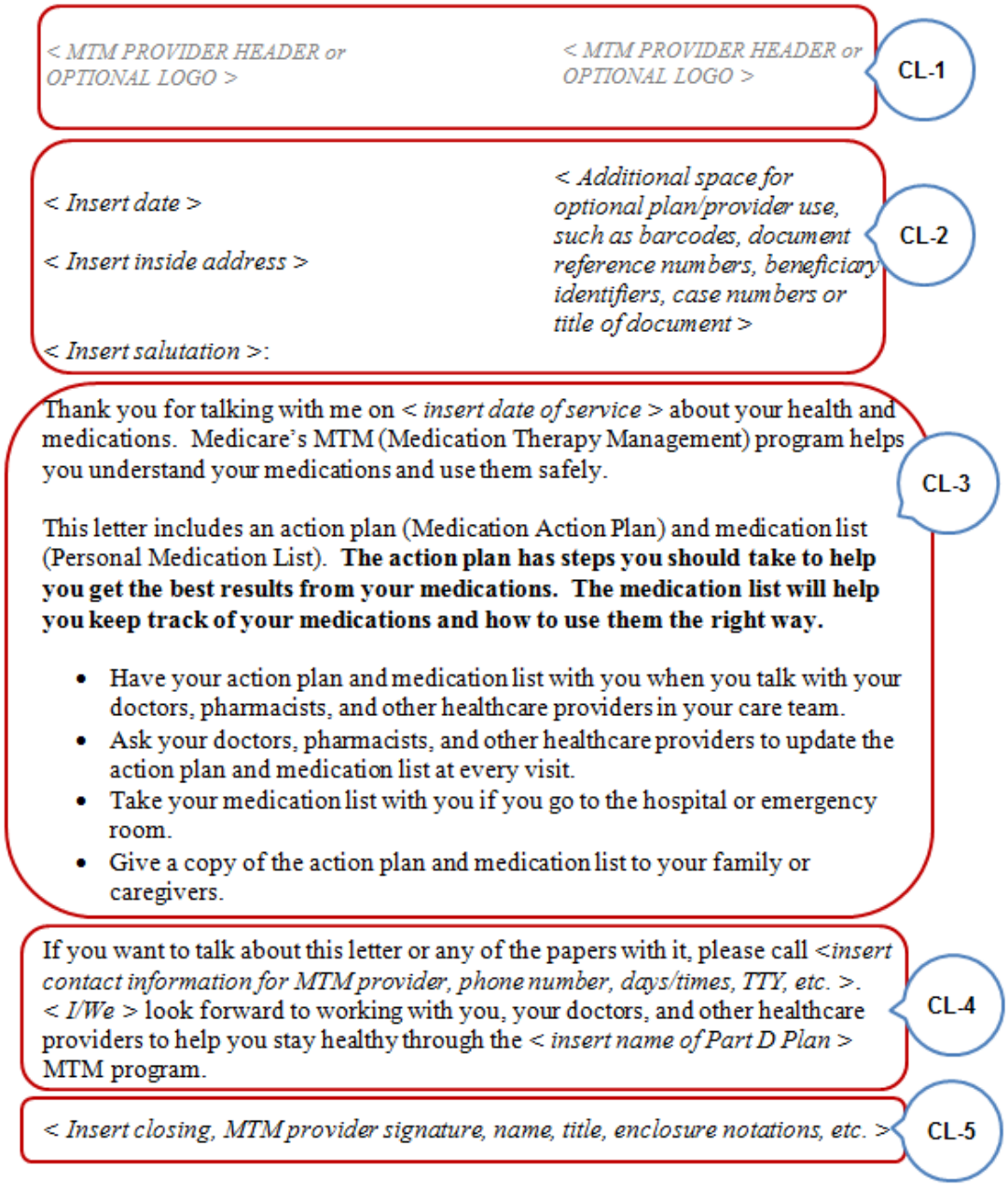
Completing the Format

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 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 conducting a CMR, CMS suggests a minimum look-back of 6 months to identify current medications and prescribers and for utilization review. Regardless of the look-back period or availability of historical data, the interactive CMR is an opportunity to capture, reconcile, and update data from the beneficiary, including current medications, OTCs, other unreported medications, and beneficiary concerns. Although the PML may be initially populated with information from claims data, EMRs, or other data files, there should be a verification step by the MTM provider with the beneficiary. This step may also identify adherence concerns to be addressed in the MAP.

Section II: Cover Letter (CL)

Cover Letter (CL)



< *MTM PROVIDER HEADER or OPTIONAL LOGO* >

< *MTM PROVIDER HEADER or OPTIONAL LOGO* >

CL-1

< *Insert date* >

< *Insert inside address* >

< *Insert salutation* >:

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

CL-2

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.

CL-3

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 healthcare 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.

CL-4

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

CL-5

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Purpose

The purpose of the cover letter (CL) is to remind the beneficiary of what occurred during the CMR, introduce the MAP and PML, and describe how the beneficiary can contact the MTM program.

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

Formatting Specifications

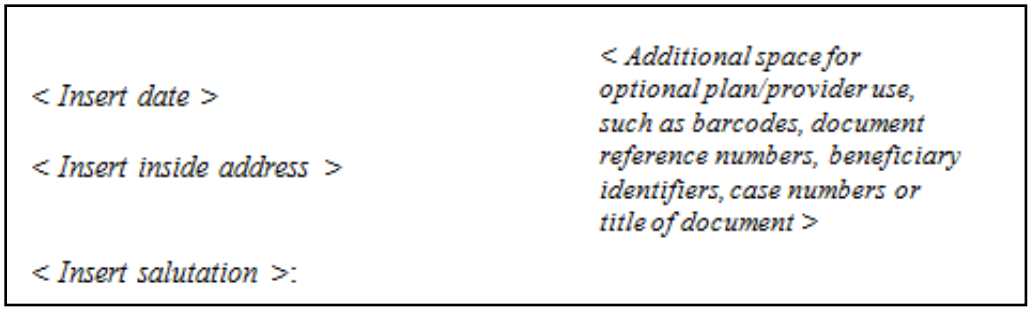
Length: The length of the CL is limited to one piece of paper if printed double-sided, or two pieces of paper if printed singled-sided.

CL-1:

< MTM PROVIDER HEADER or OPTIONAL LOGO >	*< MTM PROVIDER HEADER or OPTIONAL LOGO >*

- *< MTM PROVIDER HEADER or OPTIONAL LOGO >*: Include the MTM provider's identification information unless precluded by the structure of the Part D plan's MTM program, such as if MTM services are provided by in-house staff. At the discretion of the Part D plan sponsor, the logo space may be blank on the CL, or the sponsor may choose which logo to include, such as the logo of the parent organization, Part D plan, or MTM provider. In addition, the plan sponsor has the option of which side of the header to place the MTM provider information and whichever logo to sponsor selects. One can be on the left side and one can be on the right side. Remove the italics type in the fields that state "*< MTM PROVIDER HEADER or OPTIONAL LOGO >*".
- The *< MTM PROVIDER HEADER or OPTIONAL LOGO >* only appears on the first page of the CL.

CL-2:



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

- *< Insert date >*: Enter the date the letter is prepared in month, day, year format (e.g., April 12, 2013). Remove the italics type in the field that states "*< Insert date >*".
- *< Insert inside address >*: Enter beneficiary's name and mailing address. Remove the italics type in the field that states "*< Insert inside address >*".

  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 summary materials with the beneficiary's representative to determine to whom and where they should be sent. CMS expects the CMR summary will be delivered to the beneficiary's authorized representative, such as the health care power of attorney, if known. When sending the CMR summary to the beneficiary's legally designated authorized representative, the inside address should include the beneficiary's name, c/o <name and address of their authorized representative>.
- *< Insert salutation >*: Enter the greeting and beneficiary's name (e.g., "Dear Mr. Smith"). Remove the italics type in the field that states "*< Insert salutation >*".
- *< 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 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 healthcare 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.

- < *insert date of service* >: Enter the date the beneficiary interacted with the MTM provider in month, day, year format (e.g., April 12, 2013). Remove the italics type in the field that states "< *insert date of service* >".

CL-4:

> 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 contact information for MTM provider, phone number, days/times, TTY, etc. >*: Enter the name of the MTM provider (or 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 contact information for MTM provider, phone number, days/times, TTY, etc. >*".
- *< I/We >*: Choose *I* or *We* as appropriate and remove the italics font. Remove the non-selected pronoun and "< >" symbols.
- *< insert name of Part D Plan >*: Enter name of the Part D plan. Remove the italics type in the field that states "*< insert name of Part D Plan >*".

CL-5:

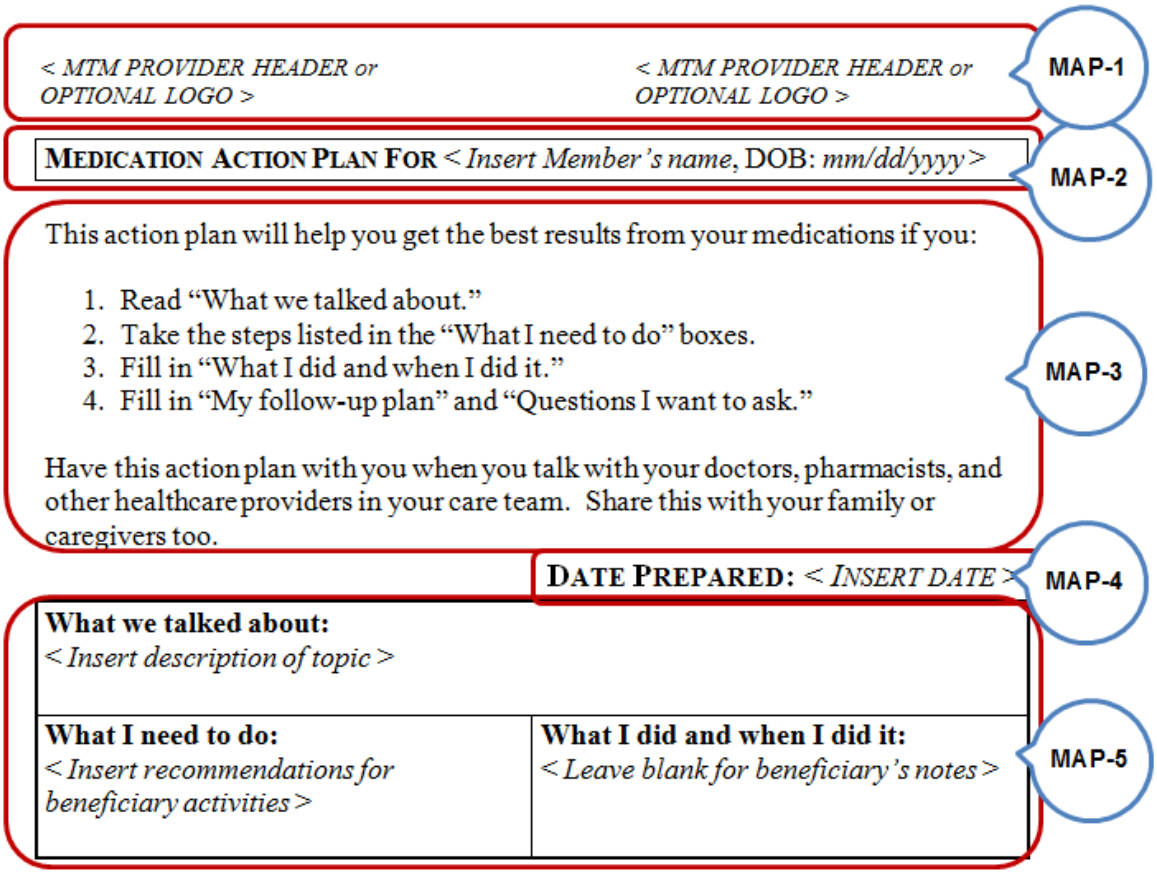
< Insert closing, MTM provider signature, name, title, enclosure notations, etc. >

- *< Insert closing, signature, name, title, enclosure notations, etc. >*: Enter closing (e.g., "Sincerely,"). The letter should be signed with a cursive signature, if possible, of the individual who performed the interactive 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. Enclosure notations, if appropriate, can be placed below the printed annotation. The postscript of the CL may be used to describe the availability of the materials by alternative methods, such as text telephones, Braille, or alternative languages, and the availability of language translation services. Remove the italics type in the field that states "*< Insert closing, signature, name, title, enclosure notations, etc. >*".

  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 summary may also be Cc:d to the beneficiary's proxy who participated in the CMR, if appropriate for treatment purposes.

Section III: Medication Action Plan (MAP)

Medication Action Plan (MAP)



< *MTM PROVIDER HEADER or OPTIONAL LOGO* >

< *MTM PROVIDER HEADER or OPTIONAL LOGO* >

MAP-1

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

MAP-2

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."

MAP-3

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* >

MAP-4

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* >

MAP-5

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:**

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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 >

MAP-6

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

MAP-7

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

MAP-8

Purpose

The Medication Action Plan (MAP) describes the specific action items resulting from the interactive CMR consultation, the beneficiary's responsibilities in the MAP, and healthcare provider activities that may affect the beneficiary's tasks.

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

The MAP is a plan to assist the beneficiary with resolving issues of current drug therapy and to help achieve the goals of medication treatment. It may also include acknowledgement and reinforcement of favorable behaviors. The MAP 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 activities for the beneficiary based on the beneficiary's concerns, the therapeutic need, and the beneficiary's ability to understand and complete the recommended activities.

There may be CMRs that do not identify issues of current drug therapy or beneficiary-specific action items. The Format allows plan sponsors to enter other statements into a new MAP as appropriate for the beneficiary, such as reinforcing compliance, maintaining beneficiary's actions, and acknowledging beneficiary success in his/her medication therapy. Beneficiaries will best understand a consistent deliverable after their CMRs, including the medication action plan, even if there are no new beneficiary-specific action steps.

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 presented first.

Number of action items and length: The number of action items is based on the needs of the beneficiary that were 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 MAP. 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 around MAP titles and within rows are 0.5 pt.
- Wide lines around sections of the MAP are 2.25 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. Fields for beneficiary-entered data have static height and width requirements. See individual field descriptions in Table 1.

Table 1. Individual Field Descriptions

	Requirements for Row height/Cell width
Medication Action Plan (MAP)	
What we talked about	Row height is at least 0.70 inch; cell width is 6.5 to 6.7 inches.
What I need to do	Row height is at least 0.90 inch; cell width is 3.25 to 3.35 inches.
What I did and when I did it	Row height is at least 0.90 inch; cell width is 3.25 to 3.35 inches.
My follow-up plan	Row height is 1.15 inches; cell width is 6.5 to 6.7 inches.
Questions I want to ask	Row height is 1.15 inches; cell width is 6.5 to 6.7 inches.

Spacing between sections of the MAP: The horizontal space between action plan sections of the MAP is 0.20 inch.

MAP-1:

< MTM PROVIDER HEADER or OPTIONAL LOGO >	*< MTM PROVIDER HEADER or OPTIONAL LOGO >*

- *< MTM PROVIDER HEADER or OPTIONAL LOGO >:* Include the MTM provider's identification information unless precluded by the structure of the Part D plan's MTM program, such as if MTM services are provided by in-house staff. At the discretion of the Part D plan sponsor, the logo space may be blank on the MAP, or the sponsor may choose which logo to include, such as the logo of the parent organization, Part D plan, or MTM provider. In addition, the plan sponsor has the

option of which side of the header to place the MTM provider information and whichever logo the sponsor selects. One can be on the left side and one can be on the right side. Remove the italics type in the fields that state "*< MTM PROVIDER HEADER or OPTIONAL LOGO >*".

- The *< MTM PROVIDER HEADER or OPTIONAL LOGO >* only appears on the first page of the MAP.

MAP-2:

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

- **MEDICATION ACTION PLAN FOR:** This field title is 14-point bold font with small caps.
- *< Insert Member's name,* DOB: *mm/dd/yyyy >*: Enter the beneficiary's first and last names, and date of birth (DOB) in the format of *mm/dd/yyyy* (e.g., 11/15/1925) in 14-point font. Remove the italics type in the field that states "*< Insert Member's name*" and "*mm/dd/yyyy >".*

MAP-3:

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.

- During the CMR, the MTM provider should discuss these MAP instructions with the beneficiary.

MAP-4:

DATE PREPARED: < *Insert date* >

- **Date Prepared:** *< Insert date >*: Enter the date the MAP (Medication Action Plan) was prepared in the format of *mm/dd/yyyy* (e.g., 12/14/2013). This date may be different from the date the beneficiary interacted with the MTM provider. This field is right-justified, with 16-point, bold font and small caps for field title and date. Remove the italics type in the field that states "*< Insert date >*".

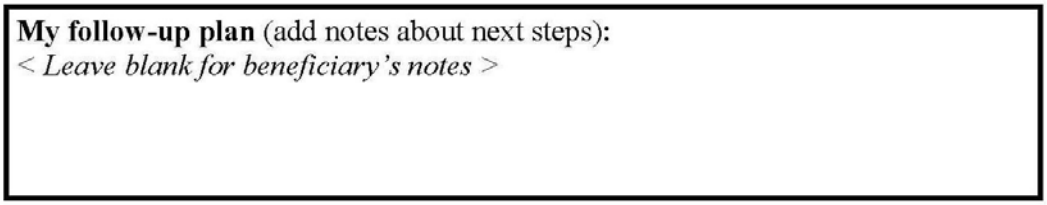
MAP-5:

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:** *< Insert description of topic >*: Enter a description of the topic that was discussed with the beneficiary, including the medication or care issue to be resolved or the behavior to be encouraged. The Part D plan or MTM provider has the discretion to choose how to make reference to the medication or care issue, such as to 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 physician or other practitioner or to include goals of therapy. Row height is at least 0.70 inch; cell width is 6.5 to 6.7 inches. Remove the italics type in the field that states "*< Insert description of topic >*".
- **What I need to do:** *< Insert recommendations for beneficiary activities >*: 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 physician or other practitioner. Row height is at least 0.90 inch; cell width is 3.25 to 3.35 inches. Remove the italics type in the field that states "*< Insert recommendations for beneficiary activities >*".
- **What I did and when I did it:** This field is for the beneficiary to use after the CMR is complete. Remove the italics type in the field that says to "*< Leave blank for beneficiary's notes >*". Discuss with the beneficiary that the box is for his/her use and to write in this box as appropriate. For example, the MTM provider may educate the beneficiary to take the medication with a meal to increase absorption

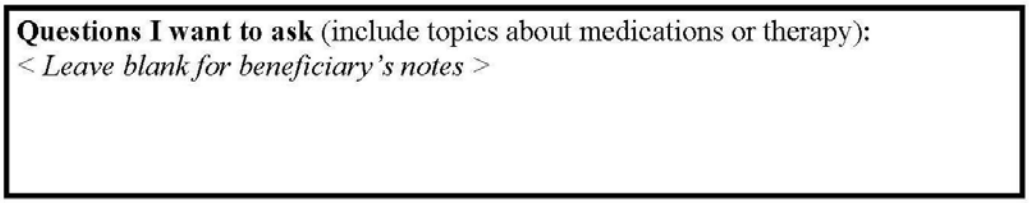
(e.g., calcium carbonate) and then the beneficiary can note when they started doing this and the effects if any. Row height is at least 0.90 inch; cell width is 3.25 to 3.35 inches.

MAP-6:



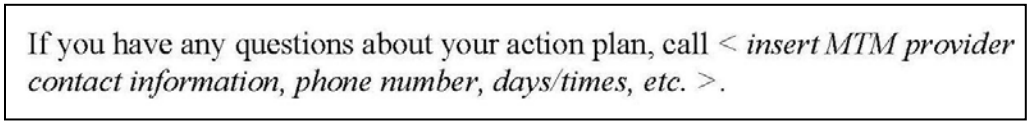
- **My follow-up plan** (add notes about next steps)**:** This field is for the beneficiary's use. Discuss with the beneficiary that the box is for his/her use and to write in this box as appropriate. Row height is 1.15 inches; cell width is 6.5 to 6.7 inches. Remove the italics type that says to "*< Leave blank for beneficiary's notes >".*

MAP-7:



- **Questions I want to ask** (include topics about medications or therapy)**:** Discuss with the beneficiary that the box is for his/her use and to write in this box as appropriate. For example, the beneficiary may want to know if a symptom he/she is experiencing could be a side effect of a medication. Row height is 1.15 inches; cell width is 6.5 to 6.7 inches. Remove the italics type that says to "*< Leave blank for beneficiary's notes >".*

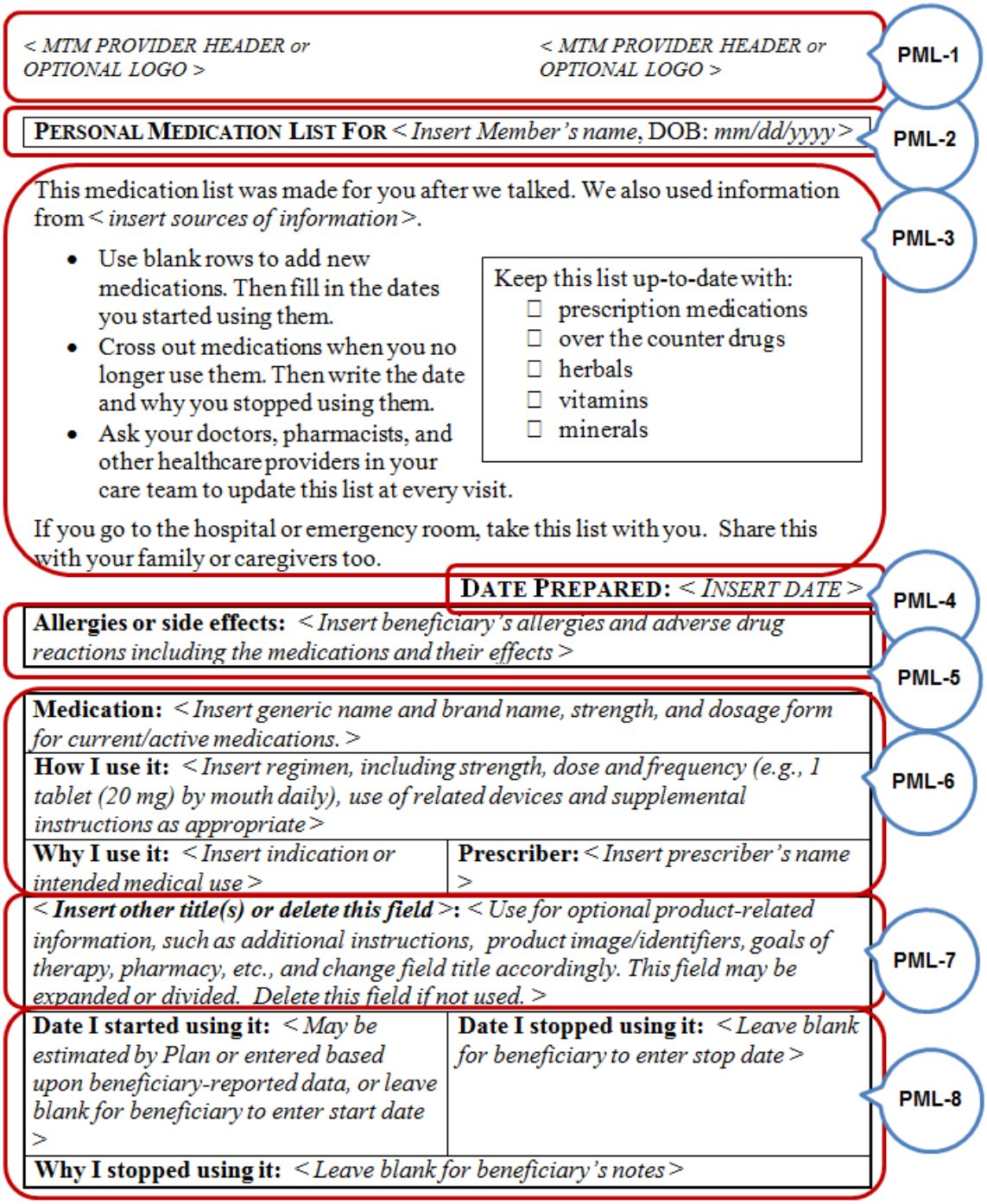
MAP-8:



- *< insert contact information for MTM provider, phone number, days/times, TTY, etc. >*: Enter the name of the MTM provider (or 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 contact information for MTM provider, phone number, days/times, TTY, etc. >*".

Section IV: Personal Medication List (PML)

Personal Medication List (PML)



< *MTM PROVIDER HEADER or OPTIONAL LOGO* >

< *MTM PROVIDER HEADER or OPTIONAL LOGO* >

PML-1

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

PML-2

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

PML-3

- 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* >

PML-4

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

PML-5

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* >

PML-6

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.* >

PML-7

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* >

PML-8

Why I stopped using it: < *Leave blank for beneficiary's notes* >

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Page **1** of **3**

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:

PML-9

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

PML-10

Purpose

The Personal Medication List (PML) is a reconciled list of all the medications in use (i.e., active medications) by the beneficiary at the time of a CMR. Information for this section may be pre-populated by the Part D plan and must be completed and updated with information provided by the beneficiary and/or caregiver during the consultation. Part D plans must also collect and report the purpose and instructions for the beneficiary's use of his/her medications. The use of over-the-counter medications is important for drug utilization review and should be captured during the interactive CMR and reported in the PML by the Part D plan.

The PML is intended to help beneficiaries understand their medications and how they relate to their treatment plans; to engage beneficiaries in the management of their drug therapy; and to improve both communication about medications and tracking of all medications, including self-prescribed medicines, with their healthcare providers. The PML assists the beneficiary with managing his/her medications by allowing the beneficiary to add new medications and their start dates, redacting discontinued products, and indicating the stop dates and reasons for stopping.

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

The PML is not a wallet card. Some MTM programs may also provide supplemental wallet cards, such as AHRQ's sample wallet card (http://www.ahrq.gov/consumer/safemeds/walletform.pdf).

Formatting Specifications

Order of medications: MTM programs 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, vitamin, 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, must 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.
- Wide lines around sections of the PML are 2.25 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. Fields for beneficiary-entered data have static height and width requirements. See individual field descriptions in Table 2.

Table 2. Individual Field Descriptions

	Requirements for Row height/Cell width
Personal Medication List (PML)	
Allergies or side effects	Row height is at least 0.45 inch; cell width is 6.5 to 6.7 inches.
Medication	Row height is at least 0.23 inch; cell width is 6.5 to 6.7 inches
How I use it	Row height is at least 0.23 inch; cell width is 6.5 to 6.7 inches.
Why I use it	Row height is at least 0.23 inch; cell width is 3.25 to 3.35 inches.
Prescriber	Row height is at least 0.23 inch; cell width is 3.25 to 3.35 inches.
< Insert other titles or delete this field >	This field may be expanded or divided. Delete this field if it is not used. Row height is at least 0.23 inch; cell width is 6.5 to 6.7 inches.
Date I started using it	Row height is 0.23 inch; cell width is 3.25 to 3.35 inches. [Allow 0.45 inch height for Spanish Format.]
Date I stopped using it	Row height is 0.23 inch; cell width is 3.25 to 3.35 inches. [Allow 0.45 inch height for Spanish Format.]
Why I stopped using it	Row height is 0.23 inch; cell width is 6.5 to 6.7 inches.
Other Information	Row height is 1.15 inches; cell width is 6.5 to 6.7 inches.

Spacing between sections of the PML: The horizontal space between medication sections of the PML is 0.20 inch.

Paperwork Reduction Act (PRA): The Paperwork Reduction Act (PRA) statement must be included at the bottom of the last page of the PML above or within the footer. Use Helvetica, 7-point font.

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

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:

< MTM PROVIDER HEADER or OPTIONAL LOGO >	*< MTM PROVIDER HEADER or OPTIONAL LOGO >*

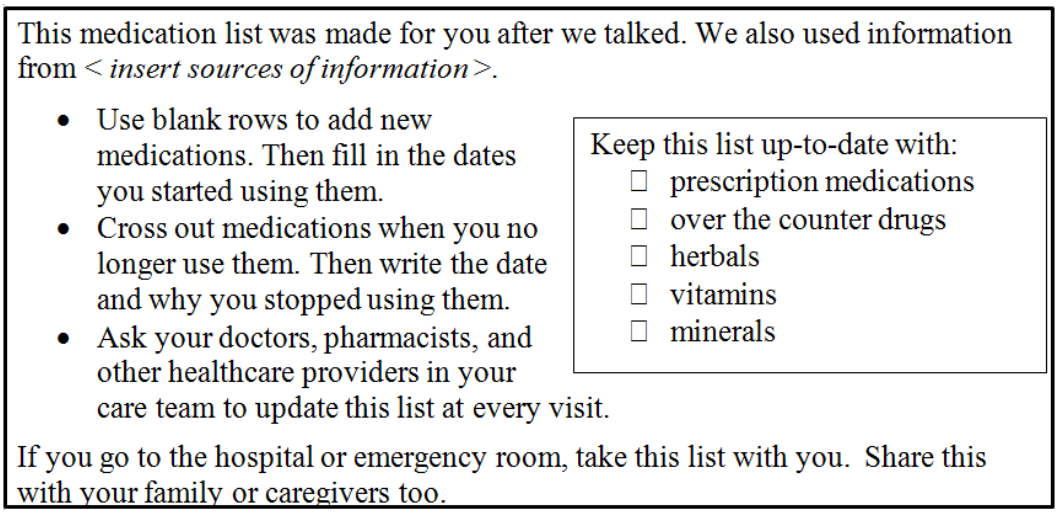
- *< MTM PROVIDER HEADER or OPTIONAL LOGO >:* Include the MTM provider's identification information unless precluded by the structure of the Part D plan's MTM program, such as if MTM services are provided by in-house staff. At the discretion of the Part D plan sponsor, the logo space may be blank on the PML, or the sponsor may choose which logo to include, such as the logo of the parent organization, Part D plan, or MTM provider. In addition, the plan sponsor has the option of which side of the header to place the MTM provider information and whichever logo the sponsor selects. One can be on the left side and one can be on the right side. Remove the italics type in the fields that state "*< MTM PROVIDER HEADER or OPTIONAL LOGO >*".
- The *< MTM PROVIDER HEADER or OPTIONAL LOGO >* only appears on the first page of the PML.

PML-2:

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

- **PERSONAL MEDICATION LIST FOR:** This field title is 14-point bold font with small caps.
- *< Insert Member's name,* DOB: *mm/dd/yyyy >*: Enter the beneficiary's first and last names and date of birth (DOB) in format of *mm/dd/yyyy* (e.g., 11/15/1925) in 14-point font. Remove the italics type in the field that states "*< Insert Member's name*" and "*mm/dd/yyyy >".*

PML-3:


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.

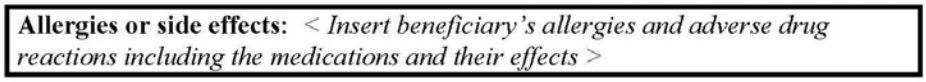
- *< insert sources of information >*: Enter sources of information, such as prescription claims information, electronic medical records, pharmacy records, doctor or caregiver, etc. If doctor or caregiver, such as for a CMR of a cognitively impaired beneficiary, include the name of the person. Patients may also self-report their prescription and OTC medications. Remove the italics type in the field that states "*< insert sources of information >*".

PML-4:


DATE PREPARED: < *Insert date* >

- **Date Prepared:** *< Insert date >*: Enter the date the PML (Personal Medication List) was prepared in the format of *mm/dd/yyyy* (e.g., 12/14/2013). This date may be different from the date that the beneficiary interacted with the MTM provider. This field is right-justified, with 16-point, bold font and small caps for field title and date. Remove the italics type in the field that states "*< Insert date >*".

PML-5:


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

- **Allergies or Side Effects:** Enter the beneficiary's allergies and adverse drug reactions in this field. There is only one section for this information and it is not separated by allergic versus adverse drug reaction. Record the medication and note

what happened to the beneficiary. If the MTM provider is able to distinguish between allergy and adverse event, the MTM provider may label true allergies with the text "allergy" after the medication. Row height is at least 0.45 inch; cell width is 6.5 to 6.7 inches. Remove the italics type in the field that states "*< Insert beneficiary's allergies and adverse drug reactions including the medications and their effects >*".

PML-6:

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 >*

- **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, over-the-counter (OTC) drugs, herbal products, vitamins, and minerals.

  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) where appropriate. Row height is at least 0.23 inch; cell width is 6.5 to 6.7 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 use it:** Enter the directions for use and supplemental instructions for using the medication. Directions must be specific and include the dose, frequency and route of administration (as ordered for prescribed products, or as being taken for self-selected products). 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). 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 "*insert other titles*…" field. Row height is at least 0.23 inch; cell width is 6.5 to 6.7 inches. Remove the italics type in the field that states "< *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:** 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 0.23 inch; cell width is 3.25 to 3.35 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 0.23 inch; cell width is 3.25 to 3.35 inches. Remove the italics type in the field that states "< *Insert prescriber's name >".*

PML-7:

< ***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.* >

- ***< Insert other titles or delete this field >*:** This is an optional field that can be used as appropriate by the Part D plan or MTM provider. This field is intended to capture other medication-related information that Part D plans and MTM providers prefer to include consistently in a medication list, such as images of medications, goals of therapy, other product identifiers, supplemental instructions, or comments. Therefore, the name of this field and its content are determined by the Part D plan or MTM program. Change the field title as appropriate for the information being provided in this customizable field. Row height is at least 0.23 inch; cell width is 6.5 to 6.7 inches. Remove the italics type that states "< *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. >". Font, size, and emphasis should match the other field titles. This field may be expanded or divided. Delete this field if it is not used.

- In the blank medication sections for the beneficiaries to use, this ***< Insert other titles…>*** field must be re-titled or deleted consistent with the completed medication sections of the PML, or given a title that is useful for self-entry by the beneficiary, such as "**Notes:**".

PML-8:

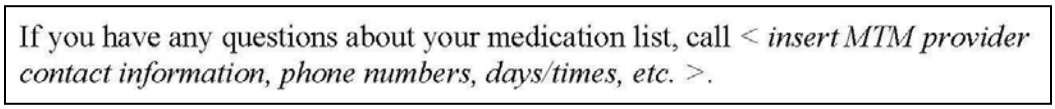
Date I started using it: *< May be estimated by Plan or entered based upon beneficiary-reported data, or leave blank for beneficiary to enter start date >*	**Date I stopped using it:** *< Leave blank for beneficiary to enter stop date >*
Why I stopped using it: *< Leave blank for beneficiary's notes >*	

- **Date I started using it:** The medication start date may be entered by the Part D plan if known or reasonably estimated, or entered based upon beneficiary-reported data; or the field may be left blank for the beneficiary to complete. The last prescription fill date should not be entered in this field. Row height is 0.23 inch; cell width is 3.25 to 3.35 inches. Remove the italics type in the field that states "< *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:** This field allows the beneficiary to record the date he/she stops using the medication. Remove the italics type that states "< *Leave blank for beneficiary to enter stop date >".* Leave this field blank for the beneficiary to enter the stop date. Discuss with the beneficiary that when a medication is no longer being taken, he/she should write the date that the medication was stopped and the reason why the medication was stopped. Row height is 0.23 inch; cell width is 3.25 to 3.35 inches.
- **Why I stopped using it:** This field allows the beneficiary to record the reason he/she stops using the medication. Remove the italics type that states "< *Leave blank for beneficiary's notes >".* Leave this field blank for the beneficiary's notes. Discuss with the beneficiary that when a medication is no longer being taken, he/she should write the date that the medication was stopped and the reason why the medication was stopped. Row height is 0.23 inch; cell width is 6.5 to 6.7 inches.

PML-9:

- **Other Information:** This field may be personalized for the beneficiary, such as including a list of the beneficiary's medical conditions, primary care provider, primary pharmacy provider, or emergency contact information. Row height is 1.15 inches; cell width is 6.5 to 6.7 inches.

PML-10:



- *< insert contact information for MTM provider, phone number, days/times, TTY, etc. >*: Enter the name of the MTM provider (or 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 contact information for MTM provider, phone number, days/times, TTY, etc. >*".

Appendix A: Medication Therapy Management Program Standardized Format – Blank Version

< MTM PROVIDER HEADER or OPTIONAL LOGO >

< MTM PROVIDER HEADER or OPTIONAL LOGO >

< Insert date >

< Insert inside address >

< Insert salutation >:

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

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.* >.

Appendix B: Medication Therapy Management Program Standardized Format – Samples

Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood
Medicare Plus

January 30, 2013

Mr. John Smith
999 Straight Road
Washington, DC 80008

Dear Mr. Smith:

Thank you for talking with me on January 14, 2013 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 healthcare 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 Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday. I look forward to working with you, your doctors, and other healthcare providers to help you stay healthy through the Birchwood Medicare Plus MTM program.

Sincerely,
Jane Doe
Jane Doe, PharmD
Pharmacy Manager

Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood Medicare Plus

MEDICATION ACTION PLAN FOR Mr. John Smith, DOB: 07/04/1940

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: 01/14/2013

What we talked about: • High Cholesterol	
What I need to do: • Monitor diet; eat fewer high cholesterol foods (see dietary handout for healthier options). • Get your cholesterol checked.	**What I did and when I did it:**

What we talked about: • High Blood Pressure - at visit on 1/14/2013 it was 154/92 mmHg	
What I need to do: • 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 physician to have blood pressure rechecked and share log.	**What I did and when I did it:**

What we talked about: • Diabetes	
What I need to do: • Continue to check blood sugar once a day. • Maintain fasting blood sugar less than 120 and greater than 70. • Make an appointment to see the podiatrist within one month.	**What I did and when I did it:**

What we talked about: • How to use your Metered Dose Inhaler - Albuterol	
What I need to do: • Refer to the attached handout on proper inhaler technique. • Always use spacer with inhaler. • Keep this medication with me at all times – "rescue inhaler".	**What I did and when I did it:**

My follow-up plan (add notes about next steps)**:**

Questions I want to ask (include topics about medications or therapy)**:**

If you have any questions about your action plan, call Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday.

Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood Medicare Plus

PERSONAL MEDICATION LIST FOR Mr. John Smith, DOB: 07/04/1940

This medication list was made for you after we talked. We also used information from Medicare Part D claims data.

- 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: 01/14/2013

Allergies or side effects: Penicillin - hives and difficulty swallowing

Medication: Simvastatin 20 mg tablet	
How I use it: Take one tablet (20 mg) by mouth every night	
Why I use it: High Cholesterol	**Prescriber:** Dr. Joe Anne
Goals: • LDL (Low Density Lipoproteins) < 100 mg/dL • HDL (High Density Lipoproteins) > 40 mg/dL	
Date I started using it: January 2009	**Date I stopped using it:**
Why I stopped using it:	

Medication: Glipizide XL (Glucotrol XL) 5 mg tablet	
How I use it: Take one tablet (5mg) by mouth once daily	
Why I use it: Type 2 Diabetes	**Prescriber:** Dr. Joe Anne
Date I started using it: June 2010	**Date I stopped using it:**
Why I stopped using it:	

PERSONAL MEDICATION LIST FOR Mr. John Smith, DOB: 07/04/1940

(Continued)

Medication: Acetaminophen 325 mg tablet	
How I use it: Take one tablet (325 mg) by mouth as needed for pain (3-4 tablets usually each day)	
Why I use it: Knee Pain	**Prescriber:** Self
Reminder: • Taking more than 3000mg of Acetaminophen a day can increase your chance of liver toxicity. • Do not drink alcohol with this medication. It can increase your risk of liver problems.	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication: Albuterol Sulfate Inhalation Solution (Ventolin HFA)	
How I use it: Use 2 puffs every 6 hours as needed for shortness of breath	
Why I use it: Breathing	**Prescriber:** Dr. Joe Anne
Reminder: • Refer to leaflet on proper technique. • Keep with you at all times – "rescue inhaler."	
Date I started using it: Early 2011	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
Notes:	
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:**
Notes:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

PERSONAL MEDICATION LIST FOR Mr. John Smith, DOB: 07/04/1940

(Continued)

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
Notes:	
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:**
Notes:	
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:**
Notes:	
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 Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday.

Appendix C: Medication Therapy Management Program Standardized Format – Spanish Version

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

< MTM HEADER PROVEEDOR o LOGO OPCIONAL >

< MTM HEADER PROVEEDOR o LOGO OPCIONAL >

< Fecha >

< Dirección >

< Saludo >:

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

Le agradezco por el tiempo que me dedicó el < ingrese la fecha > para hablar sobre su salud y sus medicamentos. El Programa de Control de la Terapia de Medicamentos de Medicare (MTM en inglés) le ayuda a entender sus medicamentos y a utilizarlos con seguridad.

Esta carta incluye un plan de acción (Plan de medicamentos) y una lista de los medicamentos (Lista personal de medicamentos). El plan de acción le indica los pasos que debe seguir para obtener los mejores resultados de su terapia de medicamentos. La lista de medicamentos le ayudará a monitorear sus medicamentos y le explicará cómo tomarlos correctamente.

- Cuando hable con sus médicos, farmacéuticos y otros profesionales de la salud de su equipo de atención médica, tenga a mano su plan de acción y la lista de medicamentos.
- Pídale a sus médicos, farmacéuticos y otros profesionales de la salud que actualicen el plan de acción y la lista de medicamentos en cada visita.
- Si tiene que ir a la sala de emergencia o al hospital lleve su lista de medicamentos.
- Entréguele a sus familiares y a la persona que lo cuida una copia del plan de acción y de la lista de medicamentos.

Si tiene preguntas sobre esta carta o los documentos adjuntos, llame a <*ingrese la información de contacto del proveedor del MTM, el número de teléfono, fechas/horas, TTY, etc.* >. <*Espero/amos*> trabajar con usted, sus médicos, y otros proveedores de atención médica a través de < *nombre del plan de la Parte D* > del programa MTM, para mantenerlo saludable.

< Ingrese el párrafo de despedida, la firma del proveedor del programa MTM, el nombre, título, adjuntos, etc. >

< MTM HEADER PROVEEDOR o LOGO OPCIONAL >

< MTM HEADER PROVEEDOR o LOGO OPCIONAL >

PLAN DE ACCIÓN PARA *< Nombre del beneficiario, fecha de nacimiento: mes/día/año >*

Este plan de acción le permitirá obtener los mejores resultados si:

1. Lee "Acerca de lo que hablamos."
2. Sigue los pasos mencionados en "Lo que debo hacer".
3. Anota "Lo que hice y cuándo lo hice."
4. Anota "Mi plan de seguimiento" y "Las preguntas que quiero hacer."

Cuando hable con sus médicos, farmacéuticos y otros profesionales de la salud de su equipo de atención médica, tenga a mano su plan de acción. Compártalo también con sus familiares y con la persona que lo cuida.

PREPARADO EL: *< FECHA >*

Acerca de lo que hablamos: *< Describa el tema tratado >*	
Lo que debo hacer: *< Las actividades recomendadas al beneficiario >*	**Lo que hice y cuándo lo hice:** *< Deje el espacio en blanco para que lo use el beneficiario >*

Acerca de lo que hablamos:	
Lo que debo hacer:	**Lo que hice y cuándo lo hice:**

Acerca de lo que hablamos:	
Lo que debo hacer:	**Lo que hice y cuándo lo hice:**

Acerca de lo que hablamos:	
Lo que debo hacer:	**Lo que hice y cuándo lo hice:**

Acerca de lo que hablamos:	
Lo que debo hacer:	**Lo que hice y cuándo lo hice:**

Mi plan de seguimiento (escriba los pasos próximos)**:**
< Deje el espacio en blanco, es para uso del beneficiario >

Las preguntas que quiero hacer (preguntas sobre los medicamentos o la terapia)**:**
< Deje el espacio en blanco, es para uso del beneficiario >

Si tiene preguntas sobre el plan de acción, llame a *<ingrese la información de contacto del proveedor del MTM, el número de teléfono, fechas/horas, TTY, etc. >*

< MTM HEADER PROVEEDOR o LOGO OPCIONAL >

< MTM HEADER PROVEEDOR o LOGO OPCIONAL >

LISTA PERSONAL DE MEDICAMENTOS PARA *< Nombre del beneficiario, fecha de nacimiento: mes/día/año >*

Después de hablar con usted preparamos esta lista de medicamentos. Para hacerlo también usamos la información de *< mencione las fuentes de información >*.

- Use las líneas en blanco para agregar medicamentos nuevos y ponga las fechas en las que comenzó a tomarlos.
- Tache los medicamentos que ya no toma, ponga las fechas y el motivo por el que dejó de tomarlos.
- Pídale a sus médicos, farmacéuticos y otros proveedores de la salud de su equipo de atención médica que actualicen la lista de medicamentos en cada visita.

Actualice la lista incluyendo:

- ☐ Los medicamentos recetados
- ☐ Los de venta libre
- ☐ Hierbas
- ☐ Vitaminas
- ☐ Minerales

Si tiene que atenderse en la sala de emergencia o en el hospital, lleve con usted su lista de medicamentos. Compártala con sus familiares y con quien lo cuida.

PREPARADO EL: *< FECHA >*

Alergias o efectos secundarios: *< Mencione las alergias del beneficiario así como los medicamentos que toma y los efectos secundarios >*

Medicamento: *< Ingrese el nombre genérico y de marca del medicamento(s)que toma, la potencia y la dosis. >*	
Cómo lo toma: *< La terapia que le ordenaron, incluya la potencia, dosis y frecuencia (por ejemplo, 1 píldora (20 mg) diaria por boca), los aparatos para usarla e instrucciones adicionales si correspondiera >*	
Para qué lo toma: *< Mencione las indicaciones o el uso médico >*	**Proveedor:** *< Nombre del médico >*
< Ponga otro título(s) o borre este casillero >*: *< Ingrese información opcional sobre el medicamento, instrucciones adicionales, identificadores del producto, objetivos de la terapia, la farmacia, etc. y cambie el título de este casillero según sea apropiado. Si no usa este casillero, bórrelo. >	
Fecha en la que comencé a tomarlo: *< Tal vez sea una fecha estimada por el plan o informada por el beneficiario. Puede dejarlo en blanco para que lo llene el beneficiario >*	**Fecha en la que dejé de tomarlo:** *< déjelo en blanco para que lo llene el beneficiario >*
Dejé de tomarlo por: *< Déjelo en blanco para que lo llene el beneficiario >*	

LISTA PERSONAL DE MEDICAMENTOS PARA < *Nombre del beneficiario, fecha de nacimiento: mes/día/año* > (Continuación)

Medicamento:	
Cómo lo toma:	
Para qué lo toma:	**Proveedor:**
< *Ponga otro título(s) o borre este casillero*>:	
Fecha en la que comencé a tomarlo:	**Fecha en la que dejé de tomarlo:**
Dejé de tomarlo por:	

Medicamento:	
Cómo lo toma:	
Para qué lo toma:	**Proveedor:**
< *Ponga otro título(s) o borre este casillero*>:	
Fecha en la que comencé a tomarlo:	**Fecha en la que dejé de tomarlo:**
Dejé de tomarlo por:	

Medicamento:	
Cómo lo toma:	
Para qué lo toma:	**Proveedor:**
< *Ponga otro título(s) o borre este casillero*>:	
Fecha en la que comencé a tomarlo:	**Fecha en la que dejé de tomarlo:**
Dejé de tomarlo por:	

Medicamento:	
Cómo lo toma:	
Para qué lo toma:	**Proveedor:**
< *Ponga otro título(s) o borre este casillero*>:	
Fecha en la que comencé a tomarlo:	**Fecha en la que dejé de tomarlo:**
Dejé de tomarlo por:	

LISTA PERSONAL DE MEDICAMENTOS PARA < *Nombre del beneficiario, fecha de nacimiento: mes/día/año* > (Continuación)

Medicamento:	
Cómo lo toma:	
Para qué lo toma:	**Proveedor:**
< *Ponga otro título(s) o borre este casillero*>:	
Fecha en la que comencé a tomarlo:	**Fecha en la que dejé de tomarlo:**
Dejé de tomarlo por:	

Medicamento:	
Cómo lo toma:	
Para qué lo toma:	**Proveedor:**
< *Ponga otro título(s) o borre este casillero*>:	
Fecha en la que comencé a tomarlo:	**Fecha en la que dejé de tomarlo:**
Dejé de tomarlo por:	

Medicamento:	
Cómo lo toma:	
Para qué lo toma:	**Proveedor:**
< *Ponga otro título(s) o borre este casillero*>:	
Fecha en la que comencé a tomarlo:	**Fecha en la que dejé de tomarlo:**
Dejé de tomarlo por:	

Otra Información:

Para preguntas sobre la lista de medicamentos, llame a <*ingrese la información de contacto del proveedor del MTM, el número de teléfono, fechas/horas, TTY, etc.* >

Appendix D: Change History

DATE OF REVISION	CHANGE DESCRIPTION
07/15/2014	REVISIONS BASED ON OMB APPROVAL AND EXTENSION ON 07/03/2014, EFFECTIVE NO LATER THAN 01/01/2015. 1. The contents of the headers were revised on the CL, MAP and PML, including the choice of location for the MTM provider information and an optional logo. 2. The margins of the CL, MAP, and PML may be used for technological marks (e.g., barcodes) to facilitate the fulfillment process, if the technological marks do not interfere with the required content of the Standardized Format. 3. Text in the CL was revised in several locations, and references to "your care team" were added to the CL, MAP, and PML. 4. The footers of the CL, MAP, and PML were revised to show the new approval date (07/14) of Form CMS-10396. 5. In the PRA statement on the last page of the PML, the average minutes per response was changed to 40.
01/29/2013	1. Numeric bullets added to the instructions in the sample Medication Action Plan on page 44.
08/15/2012	1. Recommendations for using the Standardized Format for summaries of CMRs performed for cognitively impaired beneficiaries are described on pages 5, 9, 11, and 27. a. The requirement to offer CMRs to all beneficiaries, regardless of setting, is described on page 5. b. Content for the *Inside Address* and the *Additional Space* fields are described on page 9. c. Use of the carbon-copy field is described on page 11. d. Adding the name of the person who represented the beneficiary as a data source in the PML is described on page 27. 2. Changes related to the Spanish translation appear in Appendix C. a. Added an accent to the word "cómo" in second paragraph of the Cover Letter. b. Adjusted the text to properly display small caps for the Titles and Date Prepared fields in the Medication Action Plan and Personal Medication List. c. Deleted the second occurrence of the word "la" in the third bullet of the instructions in the Personal Medication List. d. Added additional spacing within the instruction section in the Personal Medication List. e. Changed both words to title case in "Otra Información" in the Personal Medication List.
07/02/2012	1. The enclosure notations or postscript of the Cover Letter may be used to list or describe supplemental materials that will be included in the package with the Format (P.3.). 2. ***Margins:*** 0.9 to 1 inch on all sides (P.3.). 3. ***Font:*** Where a specific font is specified, an alternative, equivalent font with the same size, space, serif specifications and appearance may be used (e.g., 7-pt Arial substituted for 7-pt Helvetica) (P.3.). Also see page 4 for the font description of the footer and Paperwork Reduction Act statement. 4. The length of the Cover Letter is limited to one piece of paper if printed double-sided, or two pieces

DATE OF REVISION	CHANGE DESCRIPTION
	of paper if printed single-sided (P.8). 5. A cursive font is recommended if a printed name is used in lieu of the signature on the Cover Letter (P.11). 6. Row and cell widths are specified as a range rather than specific widths in the tables of the Medication Action Plan and Personal Medication List (P.16 to 31). 7. The Personal Medication List may be printed either single or double-sided (P.24). 8. Miscellaneous corrections to the footer and fonts in the blank format, sample, and Spanish translation (Appendices).