



Your Extended Family.

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

Dear <Member Name>,

There will be an important change to your Medicaid drug coverage starting <Date>.

Beginning <Date>, Molina Healthcare is making changes to your drug list (Formulary).

Our records show that you may be taking the following drug(s). These drug(s) will need prior approval beginning <date>:

<List impacted drug(s)>

The following are alternate drug(s) that do not need prior approval:

<List alternate drug(s)>

## What do I need to do?

You should talk to your doctor about these drugs before <Date> to make sure you have approval for the drugs you need.

It is important for you to contact your doctor as soon as possible before any prior approval requirements take effect. You and your doctor can discuss alternative drug(s) that do not need prior approval and if they are right for you. It will also give your doctor time to ask for prior approval if he or she wants to keep you on your current drug(s).

## Why am I getting this letter?

This letter is to inform you that you may have to change your current drugs or get prior approval to stay on your current drugs. This change will not cause you to lose your drug coverage.

## What is prior approval?

Prior approval (or prior authorization) means that our plan needs to approve a drug before you can use it. Your doctor can ask our plan for prior approval.

## **What drugs are on Molina Healthcare's preferred drug list (PDL)?**

To review the full list of covered drugs covered, please visit our website at [MolinaHealthcare.com](http://MolinaHealthcare.com) or log on to Molina's mobile app. You can contact Member Services for help at (XXX) XXX-XXXX (TTY 711) from 7 a.m. to 7 p.m. Eastern Time, Monday to Friday. You can also call your care manager, if you have one assigned to you.

## **Who can I call if I have questions?**

If you have any other questions about this notice, call Member Services at (XXX) XXX-XXXX (TTY 711)>, from X a.m. to X p.m. Monday to Friday or visit [MolinaHealthcare.com](http://MolinaHealthcare.com). The number is also listed on your Molina Healthcare member ID card.

Remember, you will not lose drug coverage. Molina Healthcare will work with your doctor to cover a drug that meets your needs.

Thank you,  
Molina Healthcare

If you have a problem reading or understanding this information, please contact Molina Healthcare Member Services for help, at no cost to you. We can explain this information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.

## Nondiscrimination Notice

Molina Healthcare of Kentucky (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
  - » Skilled sign language interpreters
  - » Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - » Skilled interpreters
  - » Written material translated in your language

If you need these services, contact Molina Member Services at (XXX) XXX-XXXX TTY 711.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person, by mail, fax, email, or through MyMolina.com, our secure member portal. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (XXX) XXX-XXXX, or TTY, 711. Mail your grievance to:

Civil Rights Coordinator  
200 Oceangate  
Long Beach, CA 90802

You can also email your grievance to [civil.rights@molinahealthcare.com](mailto:civil.rights@molinahealthcare.com). Or, fax your complaint to (XXX) XXX-XXXX.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can mail it to:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509E, HHH Building  
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. If you need help, call 1-XXX-XXX-XXXX; TTY XXX-XXX-XXXX.

**ATTENTION:** If English is not your first language, you can get language assistance services, free of charge. Call X-XXX-XXX-XXXX. If you are deaf or hard of hearing, call 711 for TTY.

**Spanish** – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al X-XXX-XXX-XXXX (TTY: 711).

**Chinese** – 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 X-XXX-XXX-XXXX (TTY: 711)。

**German** – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: X-XXX-XXX-XXXX (TTY: 711).

**Vietnamese** – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số X-XXX-XXX-XXXX (TTY: 711).

**Arabic** – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم X-XXX-XXX-XXXX (رقم هاتف الصم والبكم: 711).

**Serbo-Croatian** – OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite X-XXX-XXX-XXXX (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

**Japanese** – 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。X-XXX-XXX-XXXX (TTY: 711) まで、お電話にてご連絡ください。

**French** – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le X-XXX-XXX-XXXX (TTY : 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. X-XXX-XXX-XXXX (TTY: 711) 번으로 전화해 주십시오.

**Pennsylvanian Dutch** – Wann du Deutsch Pennsylvania German schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call X-XXX-XXX-XXXX (TTY: 711).

**Nepali** – ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् X-XXX-XXX-XXXX (टिटिवाइ: 711) ।

**Cushite** – XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa X-XXX-XXX-XXXX (TTY: 711).

**Russian** – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните X-XXX-XXX-XXXX (телетайп: 711).

**Tagalog** – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa X-XXX-XXX-XXXX (TTY: 711).

**Bantu** – ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona X-XXX-XXX-XXXX (TTY: 711).