



VOQUEZNA[®]
(vonoprazan) tablets ^{10mg}_{20mg}

Guide to Medicare Part D Coverage

Key information for healthcare
providers and practices

Learn more about the Medicare Part D program and
new information about the 2026 benefit design.

MEDICARE OVERVIEW

Parts A and B are known as original Medicare. Patients usually get drug coverage under Part C (Medicare Advantage) or by purchasing a Part D plan.^{1,2}

Eligibility requirements (must meet one of the following)¹



65 years old



Have collected Social Security disability insurance for 24 consecutive months



Diagnosed with end-stage renal disease

Original Medicare Components²

PART A:
Hospital Insurance

- In-patient care
- Stays in nursing facilities
- Home healthcare
- Hospice care

PART B:
Medical Insurance

- Durable medical equipment (DME)
- Healthcare professional (HCP) services
- Preventive care
- Home health services
- Mental health services
- Provider-administered prescription medications (injections or infusions)

PART C:
Medicare Advantage

- Bundled plans (parts A + B, sometimes D) offered through private companies
- Offers services beyond original Medicare

PART D:
Prescriptions

- Certain prescription medications that are not covered under Part B and are self-administered (eg, oral, topical, self-injected), medical supplies, and vaccines



Prescription drug coverage for retail pharmacy medications would be covered under a Medicare Advantage Plan (Part C) or Part D²

TYPES OF PART D BENEFITS

STAND-ALONE MEDICARE PART D PRESCRIPTION DRUG PLAN (PDP)

Patients with original Medicare (Parts A and B) can add coverage for prescription drugs by purchasing a PDP. PDP plans typically have higher premiums than Medicare Advantage plans.^{2,3}

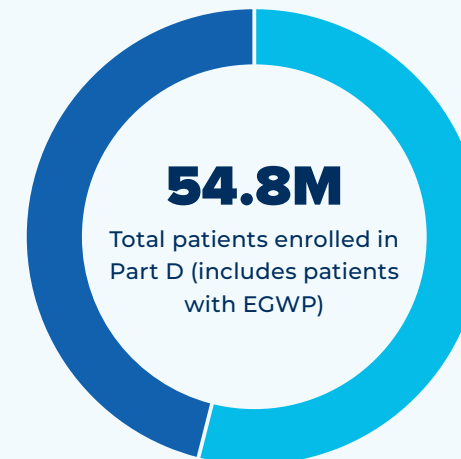
MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLAN

For 43% of patients enrolled in an MA-PD, the median copayment for non-preferred drugs is \$100.^{2,4}

EMPLOYER GROUP WAIVER PLAN (EGWP)

EGWPs are employer-sponsored Medicare Advantage plans for retired employees or union members. Patients may have an employer-sponsored MA-PD plan or PDP.⁵

2025 Enrollment Snapshot⁶



46% Patients covered under PDPs

54% Patients covered under MA-PD plans

In 2025, EGWP plans accounted for ~17% of Medicare Advantage enrollees⁷

UNDERSTANDING MEDICARE PART D OUT-OF-POCKET (OOP) COSTS

DEDUCTIBLE^{2,8}

- A deductible, which is separate from the premium, is an amount that the patient needs to pay toward their healthcare costs before the patient's Medicare plan begins to pay
- The patient must pay 100% of the deductible for their covered prescription drug costs before Part D kicks in
- Deductibles depend on the Part D plan but would not be more than \$615

INITIAL COVERAGE PHASE⁸

- Once the deductible has been reached, the patient will pay a copayment or coinsurance (based on the plan design) and Medicare Part D will pay the rest
- The initial coverage phase ends when you spend \$2100 on prescription drugs

CATASTROPHIC COVERAGE PHASE⁸

- The combined deductible and OOP costs of \$2100 is the maximum amount a patient will be responsible to pay for covered outpatient prescription drugs during the calendar year. Once the patient hits the maximum, Medicare Part D will cover the full cost of the prescription for the rest of the year



A Patients Maximum OOP cost for covered prescription drugs under Part D will depend on the plan, but will be **no more than \$2100²**

AFFORDABILITY PROGRAMS

LOW-INCOME SUBSIDY (LIS) EXTRA HELP²

LIS may assist low-income households with paying the Medicare Part D monthly premium, any yearly deductible, coinsurance, and copayments through the Extra Help program.

Call 1-800-772-1213, visit ssa.gov/medicare/part-d-extra-help, or go to a local social security administration office to apply.

DUAL ELIGIBILITY²

Patients who qualify for coverage from both Medicare and Medicaid are considered "dual eligible." Medicare and Medicaid work together to lower healthcare costs for dual-eligible individuals.

For more information on dual eligibility, visit cms.gov/medicare/medicaid-coordination/about.

STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP)²

SHIP provides unbiased help to Medicare beneficiaries, their families, and caregivers. SHIP counselors are members of your community who have been screened, trained, and certified as Medicare experts.

Find a local SHIP by calling 1-877-839-2675 or visiting shiphelp.org.

MEDICARE PRESCRIPTION PAYMENT PLAN

Medicare Prescription Payment Plan⁹

WHAT IS IT?

The Medicare Prescription Payment Plan is offered as a voluntary payment option through Medicare Part D, allowing patients to spread their OOP prescription medication costs over the calendar year, rather than paying large sums at the pharmacy all at once.

HOW DOES IT WORK?

Enrollment is voluntary and free, allowing patients to join or leave anytime during the year. Once enrolled in their Part D plan, patients' OOP cost at the pharmacy is \$0. They will receive a monthly bill covering their prescription costs, divided over the remaining months of the year.

WHO IS ELIGIBLE?

Medicare Part D enrollees

WHEN CAN PATIENTS APPLY?

- During Medicare open enrollment (October 15–December 7)
- Before the beginning of the plan year
- In any month of the plan year

HOW CAN PATIENTS APPLY?

- An election request form during enrollment
- By phone, as directed by their Part D plan
- By mail with a paper election form
- Online, as directed by their Part D plan



PATIENTS CAN CALL 1-800-MEDICARE (1-800-633-4227) for help contacting their Part D plan.

APPEALING A COVERAGE DECISION

If a patient is denied coverage for a prescription drug, they need to ask their plan to reconsider its decision by filing an appeal. The appeal process is the same for PDPs and MA-PD plans. Below are the steps needed to appeal a denial of coverage.

Appealing a Denial¹⁰

If your patients' prescription is denied at the pharmacy, the pharmacist should give the patient a notice titled **Medicare Prescription Drug Coverage and Your Rights**.

NEXT STEPS AFTER RECEIVING THE DENIAL:

- Call the patients' plan and learn the reason for denial
- Before starting the appeal process, file an exception request with the patients' plan.
- The Plan should issue a decision within 72 hours. Patients can request an expedited request within 24 hours without a physician, but the plan may not follow the expedited timeline

IF THE REQUEST IS APPROVED:

- The drug will be covered at the highest out-of-pocket copay/coinsurance for that plan benefit design

IF THE REQUEST IS DENIED:

- The plan should send a Notice of Denial of Medicare Prescription Drug Coverage
- The patient has 60 days from the date listed on this notice to begin the formal appeal process by filing an appeal with their plan

WHAT TO INCLUDE IN THE APPEAL

A Medicare appeal is also known as a redetermination request.

- Patient's name, address, and Medicare number/member number
- The name of the drug you want the plan to cover
- Reason(s) for appealing
- Any other information supporting your clinical decision to prescribe the drug, including medical records

The plan will make decisions within 7 days for standard appeals and within 72 hours for expedited appeals.

You can find more information about the exception and appeals processes at [cms.gov](https://www.cms.gov).

For more information about Medicare prescription drug coverage, visit [Medicare.gov](https://www.Medicare.gov)

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