CLL SOCIETY

PATIENT RESOURCE

CLL/SLL PATIENT TOOLKIT

Medicare

Getting the Treatment Your Doctor Prescribes

A practical guide to choosing Medicare coverage, checking drug and provider rules, handling prior authorization and step therapy, and appealing a denial

For people with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), and their care partners.

Insurance can control whether, when, and how you pay for your health care. **It should not change your treatment plan.** If a medicine is delayed, denied, or suddenly costs more than expected, contact your CLL care team before changing or stopping treatment.

This guide is educational. It does not replace medical advice, legal advice, your plan documents, or your clinician's judgment. Plan rules and deadlines change. Confirm the rules for your exact plan.

How to use this toolkit

You do not need to read this guide from start to finish. Go to the section that matches the problem in front of you.

IF YOU NEED TO...	GO TO...
Choose between Medicare Advantage and Original Medicare	**Section 2**
Choose a Part D plan	**Section 3**
Decide what to do because your plan will end or you are moving	**Section 4**
Check coverage before treatment starts	**Sections 5–7**
Respond to a delay or denial of a prescribed treatment	**Section 8**
Get help with treatment costs	**Section 9**
Prepare for the next plan year	**Section 10**
Find a phone script or tracking page	**Section 11**

Four simple steps that can help you understand and reduce coverage problems

- Use the exact plan name and contract shown on your member card. The insurance company name alone is not enough.
- Check the drug, the dose, the pharmacy, the treating clinician, the cancer center, and the infusion site (if applicable). One answer does not cover all six.
- A prescription is not the same as coverage approval. If you are waiting for a payer decision, ask whether the request is complete and when a decision is due.
- When dealing with a Medicare Advantage or Part D plan, do not rely on a phone call alone. Ask for the policy, decision, and approval dates in writing.

1 Know which part of your coverage pays

CLL treatment can cross several parts of an insurance benefit. The place where you receive a drug often affects which part pays for it.

CARE OR MEDICINE	USUALLY HANDLED THROUGH	WHAT TO CONFIRM
Oral medicines taken at home	Prescription drug benefit; for Medicare, usually Part D	Formulary, tier, prior authorization, step therapy, quantity limit, required specialty pharmacy
Infused or injected treatment in a clinic, hospital outpatient dept or physician office	Medical benefit; for Medicare, usually Part B or the Medicare Advantage plan	Provider and site network, prior authorization, coinsurance, buy-and-bill or specialty-pharmacy rules
Labs, scans, office visits	Medical benefit	Provider and facility network, referral, prior authorization, cost sharing
A regimen with both oral and infused drugs	Both drug and medical benefits	Separate approvals, timing, pharmacies, infusion site, labs, and renewal dates

2 Medicare decision:

Original Medicare or Medicare Advantage?

For someone with CLL/SLL, the most important differences are provider access, total medical cost, drug coverage, and whether you have eligibility for additional coverage (Medicaid, employer sponsored retiree benefits) or can obtain Medigap. Extra benefits can matter, but they should not decide the question before coverage for your cancer care is confirmed.

DECISION POINT	ORIGINAL MEDICARE	MEDICARE ADVANTAGE (MA)
Doctors and hospitals	Any U.S. provider that accepts Medicare. Usually no network.	A network and service area usually apply. Out-of-network non-emergency care may not be covered or may cost more.
Specialists	Usually no referral is required.	The plan may require a referral.
Prior authorization	Usually not required for Part A- or Part B-covered care, although coverage rules still apply.	Often required for services, drugs, imaging, or sites of care.

DECISION POINT	ORIGINAL MEDICARE	MEDICARE ADVANTAGE (MA)
Medical out-of-pocket exposure	No annual limit by itself. Most people add Medigap or other secondary coverage (Medicaid, retiree benefits) to pay the 20% coinsurance in Medicare Part B.	The plan has an annual limit for covered Part A and Part B services; copays and coinsurance vary but are usually lower than original Medicare.
Prescription drugs	Choose (and pay for) a separate Part D plan unless you have other creditable drug coverage.	Most MA plans offer a Part D plan. Check ***both*** the medical network and drug benefit.
Travel or care away from home	Broad access within the U.S. if the provider accepts Medicare.	Non-emergency care may be limited outside the plan's service area or network.
Extra benefits	Routine dental, vision, and hearing benefits are not included.	Plans may offer extra benefits. Check limits and participating providers.

CLL/SLL questions to answer before enrolling in an MA plan

- Are my hematologist/oncologist, cancer center, hospital, laboratory, imaging facility, and infusion site (if applicable) in network—and accepting this exact plan next year?
- Are my current medicines on the drug list? Check every strength and form. What prior authorization (PA), step therapy (ST), quantity (QL), or specialty-pharmacy rules apply?
- If my doctor recommends a new CLL treatment midyear, how would the plan review it?
- What would I pay for oncology (specialist) visits, Part B drugs, infusions, hospital care, imaging, and labs —not just the premium?
- Do I need a referral from an in-network primary care provider to continue seeing my hematologist/oncologist?
- If I leave MA for Original Medicare, do I have a federal or state right to buy Medigap without medical underwriting?

DO NOT MISS THE MEDIGAP ISSUE

Annual Medicare enrollment periods let you change Medicare coverage. They do not always give you a right to buy a Medigap policy. Outside your initial eligibility when you turn 65 and limited special enrollment periods, a Medigap insurer may be allowed to use "medical underwriting," meaning that they can review your medical history and decide to not let you enroll or to charge you more. Understand this before selecting MA over Original Medicare and when thinking about leaving MA.

3 Medicare decision:

Which Part D plan?

Start at Medicare.gov/plan-compare or call 1-800-MEDICARE. Enter every medicine you take—not only your CLL medicines—and select the pharmacies you actually use. If you are not yet on active treatment, ask your doctor about which treatments you should make sure are covered if you need them. Medicare Plan Compare can estimate total yearly cost and show basic coverage restrictions. It is the starting point, not the last word.

WHERE TO GET HELP

A State Health Insurance Assistance Program (SHIP) counselor can help you compare plans. These are trained volunteers; they do not sell insurance or have any incentive to steer you to one plan over another.

Find your State Health Insurance Assistance Program at shiphelp.org. Have your complete medication list, preferred pharmacies, doctors, treatment sites, and any plan notices handy.

Check these items for every plan you are considering

CHECK	WHAT TO LOOK FOR
Every current medicine	Is the exact drug, strength, and form on the formulary? What tier is it on?
CLL treatment rules	Prior authorization? Step therapy? Quantity limit? Required specialty pharmacy?
Other medicines	Include heart, blood pressure, infection-prevention, diabetes, and all other drugs. A plan that works for one cancer drug may be costly overall.
Pharmacies	Are your retail and specialty pharmacies in network? Are they preferred? Is mail order optional or required?
Total annual cost	Compare premium + deductible + drug cost sharing. Look at the month-by-month estimate, not only the annual total.
Coverage before the deductible	Are there any tiers that are covered before you satisfy your deductible?
Restrictions	Read the formulary and Evidence of Coverage for the drugs you take or may take. Save screenshots or PDFs showing the rules you relied on in making your decision.

How to read between the lines on coverage rules

A formulary may mark a drug "PA" (prior authorization) meaning that your clinician's office will have to give your plan information on why you need the drug they prescribe. Sometimes drugs marked with "PA" are only available if the patient first tries and fails (or has a medical reason for not trying) the plan's "preferred" drug. That is called step therapy (ST). Medicare treats step therapy as a type of prior authorization, and some plans place the fail-first requirement inside the prior authorization criteria. Some also publish a separate step-therapy criteria document.

1. Find the plan's complete formulary—not only the short drug list shown in Plan Compare. To do this, take note of the specific name of the plan. Go to the insurer's website and find the formulary listing for the plan.
2. Search the formulary for the brand name and generic name. Confirm the strength and formulation (e.g., capsule, tablet).
3. Write down every code beside the drug, such as PA, ST, or QL. Read the key that defines each code.
4. Open the plan's Prior Authorization Criteria. Find the drug and read what the plan requires for CLL/SLL.
5. Search for an open any separate Step Therapy Criteria or Requirements document—even if the formulary shows only PA.
6. Look for phrases such as "previous trial," "inadequate response," "intolerance," "contraindication," "history of use," "preferred product," or "continuation of therapy." These phrases may signal a step requirement.
7. Confirm the preferred drug, and how the step requirement is satisfied as well as exceptions that let you avoid the "fail first" requirement.
8. Save the document, web address, publication date, and a screenshot of the drug entry. Criteria can change.

Important Part D numbers

YEAR	MAXIMUM STANDARD DEDUCTIBLE	ANNUAL OUT-OF-POCKET THRESHOLD FOR COVERED PART D DRUGS
2026	**$615**	**$2,100**
2027	**$700**	**$2,400**

NOTE: A plan may have a lower deductible. Premiums do not count toward the Part D out-of-pocket threshold. The Medicare Prescription Payment Plan can spread Part D cost sharing across the remaining months of the year; it does not lower the total amount owed.

WORDS YOU CAN USE

"I am comparing plans for next year. For [drug and strength], please read the prior authorization criteria—not only the formulary code. Does approval require prior use of another drug? If so, which drug, for how long, and what exceptions apply? Is there a separate step-therapy document? Please tell me where I can find all of this in writing."

4 If your Medicare plan will end or is no longer offered

DO NOT IGNORE THE NOTICE

A plan nonrenewal does not mean you lose Medicare. It does mean you must make an active choice if you want to control your coverage and avoid preventable gaps.

What to do

- Read the Annual Notice of Change and the nonrenewal or termination notice. Keep the notice and the envelope.
- Confirm the last day of coverage and the exact Special Enrollment Period that applies.
- Compare replacement options before the old plan ends. Check providers, treatment sites, all medicines, pharmacies, and authorization rules.
- **NOTE:** There are very few opportunities to move from MA to Original Medicare with a "guaranteed issue" Medigap plan. One of these is having your plan no longer offered to you.
- If you plan to enroll in a different MA plan, tell your cancer center and provide the new plan information. Ask the office to check whether new approvals are needed for visits, infusions, laboratory tests, scans, and prescriptions.
- If returning to Original Medicare, enroll in a Part D plan unless you have other creditable drug coverage. Investigate Medigap immediately.

What happens if you do nothing?

If an MA plan is not renewed and you do not join another MA plan, Medicare generally returns you to Original Medicare. That does not automatically add a Part D plan or Medigap. A gap in either can be costly and limit your ability to get affordable coverage later.

Key timing rules

SITUATION	MEDICARE CHANGE PERIOD
Your MA or Part D contract is not renewed for the next year	You may switch from December 8 through the last day of February of the following year.
Medicare terminates the plan's contract	The period generally starts 1 month before the contract ends and lasts 2 full months after it ends.
The plan ends its contract with Medicare, or the plan and Medicare agree to end it	The period generally starts 2 months before the contract ends and lasts 1 full month after it ends.

POSSIBLE MEDIGAP PROTECTION

If your MA plan leaves Medicare, stops serving your area, or has a significant network change, you may have a federal guaranteed-issue right to certain Medigap plans if you switch to Original Medicare. The application window can begin before MA coverage ends and generally closes 63 days after it ends. State law may provide more rights. Call SHIP or your State Insurance Department to make sure you know the rules in your state or to get help.

5 Before treatment starts:

Understand your plan's rules and how to get your treatment when you need it.

CONFIRM	DETAILS TO RECORD
Treatment	Drug name, dose, schedule, intended start date, and planned duration
Benefit	Pharmacy benefit, medical benefit, or both
Approval	Authorization number, approved dose/quantity, start date, and end date
Supplier or site	Required specialty pharmacy; infusion location; whether each is in network
Patient cost	Expected amount for the first fill/visit and later fills/visits
Clinical steps	Labs, monitoring, premedication, ramp-up, and who confirms readiness
Owner	Name of the person handling each unfinished action and next follow-up date

Check coverage before treatment

WORDS YOU CAN USE

"I am calling about treatment for CLL/SLL. Under my exact plan, does [drug/service] require prior authorization, step therapy, a formulary exception, a specific pharmacy, or a specific treatment site? Please give me the policy name, submission method, and call reference number."

A prior authorization "approval" has an expiration date

When your plan approves your treatment for coverage, it may cover only a specific drug, strength, dose, quantity, pharmacy, diagnosis, or time period. A refill authorization from the prescriber is not the same as an insurance authorization. Re-authorization is usually required at least every 12 months, and often more frequently.

- Record the authorization number, effective date, and expiration date.
- Confirm the approved drug, strength, dose, quantity, and required pharmacy or treatment site.
- Ask whether the approval covers dose changes, for example, a venetoclax ramp-up pack, maintenance dosing, and the full planned treatment course.
- Put the expiration date (date when re-authorization is needed) on your calendar. Ask your doctor's office when it will start renewal; 30–45 days before expiration may be reasonable, but follow the clinic's and plan's timing.
- Recheck approval after a plan change, January 1 renewal, dose or quantity change, new pharmacy, new infusion site, or treatment interruption.
- Before the final approved refill, confirm that the renewal request was submitted, is complete, and has a decision due date.

FIXED-DURATION COMBINATION TREATMENT

The approval period should match the treatment plan. If it does not, put the date for re-authorization on your calendar and follow up with your doctor's office to ensure that the re-authorization is requested and approved without interrupting your treatment plan.

6 BTK inhibitor selection

is based on patient-specific factors and the treating clinician's judgment

BTK inhibitors act on the same pathway, but they are different medicines. The National Comprehensive Cancer Network's CLL/SLL guidelines state that covalent BTK inhibitors are not interchangeable and that selection should be made by your treating physician based on patient-specific factors and clinician judgment.

Your care team may consider prior treatment, disease features, other medical conditions, heart rhythm and bleeding risks, other medicines, side effects, dosing needs, and patient preferences. If your plan denies coverage for your prescribed treatment, an exception request should explain the reasons that apply to you.

> **WORDS YOU CAN USE**
>
> "My doctor chose this medicine after reviewing my medical history, other medicines, prior treatment, risks, and treatment needs. Please review the clinician's patient-specific exception request. Do not treat the BTK inhibitors as interchangeable."

7 Explanations:

Prior authorization, step therapy, and fixed-duration treatment

Prior authorization

The plan requires information before it will pay. Ask whether the request was received, whether it is complete, and when the plan must decide.

"Pending" does not necessarily mean active review.

Step therapy

The plan wants you to use a preferred drug first. The requirement may appear as "ST," but it may also be embedded inside prior authorization (PA) criteria. The prescriber may request an exception when the plan's "preferred" drug is not as good a fit for the patient as an alternative treatment.

How an automatic claim edit creates an immediate rejection (denial)

When the pharmacy submits a claim, the plan's computer system checks the claim against its rules and the medication history it can see. If the system does not find the required preferred-drug trial, prior authorization, quantity, or other condition for coverage, it may reject the claim immediately—before anyone reviews why your clinician selected the treatment. This looks like a denial but your clinician's office will probably treat it as a new prior authorization request and may be able to expedite a decision.

WHAT HAPPENS	WHAT THE PATIENT SHOULD DO
The pharmacy sees a rejection message	Ask for the exact reject code and the full message—not only "insurance denied it."
The message says PA is required	Ask whether the PA criteria contain a prior-drug or step requirement. Do not assume "PA" and "ST" are separate.
The system says there is no record of the required step	Tell the clinic about any earlier use, intolerance, contraindication, or use under a former plan. The current plan's claim history may be incomplete.
The preferred drug is not appropriate	Ask the prescriber to request an exception that addresses the exact step requirement and explains the patient-specific reasons. Your doctor should include the NCCN guidelines and emphasize that the BTK inhibitors are not interchangeable.
The pharmacy keeps rerunning the same claim	Confirm that the clinic is working on a coverage determination or exception. Repeatedly resubmitting an unchanged claim usually does not resolve the underlying edit.

A CLAIM REJECTION IS A SIGNAL, NOT THE CLINICAL ANSWER

An automatic edit does not establish that the preferred drug is medically appropriate. It identifies the plan rule that must be satisfied or formally waived.

Fixed-duration treatment

A planned treatment course is time-limited, but the coverage work may involve separate approvals and suppliers. Delaying one part can disrupt the sequence.

REGIMEN	COVERAGE PIECES	TIMING ISSUE
Venetoclax + obinutuzumab	Venetoclax under the drug benefit; obinutuzumab, infusion, and monitoring under the medical benefit	Venetoclax begins after obinutuzumab starts and uses a 5-week ramp-up. Oral-drug access, infusion dates, labs, and clinical readiness must align.
Acalabrutinib + venetoclax	Two oral drugs may have separate authorizations, quantity rules, pharmacies, and approval dates	Acalabrutinib starts before venetoclax; venetoclax uses a 5-week ramp-up. Both approvals must cover the planned course.

- [ ] I know who supplies each medicine.
- [ ] I have written approval dates and quantities for each drug.
- [ ] The clinic has confirmed the shipment or pickup date.
- [ ] The infusion site and services are approved, if applicable.
- [ ] The required labs and monitoring are scheduled.
- [ ] I will wait for the care team's instruction before taking the first dose.

8 If treatment is delayed or denied

First, identify what happened

WHAT YOU HEAR	WHAT IT MAY MEAN	NEXT QUESTION
"The claim was rejected."	The pharmacy could not process the claim. This is not always a formal coverage denial.	What is the exact reject code and message?
"More information is needed."	The request may be incomplete or paused.	What exact item is missing, who must send it, and when will review restart?
"The drug is not preferred."	A formulary or step-therapy rule may apply.	What exception process and criteria apply?

WHAT YOU HEAR	WHAT IT MAY MEAN	NEXT QUESTION
"Not medically necessary."	The plan says a coverage criterion was not met.	Which criterion, where is it written, and what evidence would address it?
"Use another pharmacy or site."	A network or distribution rule may apply.	Would the change delay or disrupt care, and can an exception be requested?

Then act

- Get the complete decision in writing if possible. Make note of the reject code and what you were told verbally.
- Send it to your care team the same day. Confirm that they have received the information and ask who will respond and when they expect to submit the required information.

Check a pending request

> **WORDS YOU CAN USE**
>
> "Please confirm the date the request arrived, whether it is complete, what type of review is open, the decision due date, and anything still missing. Who must take the next action?"

Medicare Part D decision clocks

REQUEST	STANDARD	EXPEDITED
Coverage determination or formulary exception	Generally 72 hours after the plan receives the request—and the prescriber's supporting statement when required	**Generally 24 hours**
First-level appeal (redetermination)	Generally 7 days	**Generally 72 hours**

Use the deadline in the plan's notice and current Medicare instructions. A fast review is not automatic; the request must qualify for expedited handling.

> **WORDS YOU CAN USE**
>
> "Please read the complete reason for the decision and the exact criteria the plan says were not met. What is the next review level, the deadline, the submission method, and the case number?"

FREE TOOLS THAT CAN HELP YOU DRAFT AN APPEAL

Some free online tools use AI to help patients write appeal letters, such as Forus and Squad Health. They can help you organize your story and respond to the plan's stated reason for denial. Share your draft with your care team before you send it. For drug exceptions, your prescriber's supporting statement usually carries the most weight. Only share the health information the tool needs.

9 Medicare Prescription Payment Plan

and financial help

What the Medicare Prescription Payment Plan does

The Medicare Prescription Payment Plan is available through every Part D plan, including Medicare Advantage plans with Part D drug coverage. It lets you pay the plan for covered Part D cost sharing in monthly bills instead of paying the pharmacy directly before you receive your treatment. Participation is voluntary and there is no enrollment fee.

IT CHANGES TIMING—NOT COST

The payment plan does not reduce drug prices, lower your annual Part D costs, change the formulary, waive prior authorization, or make a denied drug covered. The annual Part D out-of-pocket limit applies whether or not you enroll.

When it is most likely to help

MAY BE WORTHWHILE

- You expect high Part D costs early in the calendar year.
- A large first fill or early-year deductible and coinsurance would strain your monthly cash flow.
- You enroll early enough to spread the balance over many remaining months.
- You can manage a separate monthly bill from the plan in addition to the plan premium.

MAY ADD LITTLE VALUE OR BE A POOR FIT

- Your yearly drug costs are low.
- Your costs are already low and even each month.
- You enroll late in the year, leaving only a few months to pay the balance.
- You qualify for Extra Help, a Medicare Savings Program, or other assistance that may actually lower costs.

The monthly amount may change. New prescriptions and refills add costs to the balance, and there are fewer months left to spread those costs as the year continues. A person can reach the annual out-of-pocket limit and still receive payment-plan bills later in the year for costs already incurred.

How to opt in

1. Contact your Part D or MA-PD plan—not Medicare and not the pharmacy—to enroll. Use the plan website or member-services number on your card.
2. You may enroll at any time during the calendar year. If you expect high costs, enroll before the expensive fill when possible. Plans generally must process an election made during the plan year within 24 hours.
3. Note your plan's confirmation that your request was received and processed. Once active, the pharmacy should charge $0 for covered Part D cost sharing, and the plan will send a separate monthly bill.
4. Keep paying the plan premium separately. Payment-plan participation does not replace the premium.
5. Check the first pharmacy receipt and first plan bill. Confirm that the fill was included and the remaining balance is correct.
6. Participation generally renews automatically for the next year if you stay in the same plan, unless you opt out. If you change plans, contact the new plan to enroll again.

IF THE PRESCRIPTION IS URGENT

Call the plan immediately. Special retroactive-election protections may apply when waiting for enrollment could seriously jeopardize your health. The patient generally must request urgent retroactive election within 72 hours of filling their prescription. Ask the plan for its process; do not assume reimbursement is automatic.

If you miss a payment or want to leave the payment plan

A missed payment does not cancel Medicare drug coverage, but the plan can remove you from the payment program after giving you the required notice. You still owe the balance, without interest or late fees. You may leave the program at any time, but leaving does not erase the balance; new drug costs will again be paid at the pharmacy.

Other financial help

Coverage approval and financial help are separate. Track them separately so a temporary supply does not hide an unresolved denial.

TYPE OF HELP	WHAT IT DOES—AND DOES NOT DO
"Extra Help"	Helps eligible people with Part D premiums and drug costs. Eligibility rules are based on income.
Independent charitable foundation	May help with disease-related costs. Eligibility and availability change.
Manufacturer patient assistance	May provide free medicine to eligible patients. Rules differ for people with Medicare and other government coverage.
Manufacturer bridge or temporary supply	May prevent an immediate gap. It does not prove the insurer approved ongoing coverage.

10 Your annual Medicare review

Review coverage every fall even if you like your current plan. Formularies, pharmacies, networks, premiums, cost sharing, and prior authorization rules can change each year.

- [ ] Read the Annual Notice of Change.
- [ ] Look through the current Medicare & You handbook. Medicare mails it each fall, and the latest edition is always at medicare.gov/medicare-and-you.
- [ ] Ask every key clinician and facility about the exact plan for next year. A provider directory alone may be outdated.
- [ ] Enter every medicine in Medicare Plan Compare and save the comparison.
- [ ] Check each CLL medicine's formulary status and restrictions directly with the plan.
- [ ] Compare total estimated yearly cost and the timing of costs.
- [ ] Check the required (in-network) retail and specialty pharmacies.
- [ ] If considering a move from MA to Original Medicare, confirm Medigap rights and price before making the change.
- [ ] If possible, give new cards to your doctor's office before January appointments, infusions, or refills.

FREE, UNBIASED HELP

State Health Insurance Assistance Programs (SHIPs) provide free Medicare counseling. Find your local program at shiphelp.org or call 1-800-MEDICARE.

11 Coverage record and call log

INFORMATION	RECORD IT HERE
Exact plan name and contract/plan number	
Member ID; Rx BIN/PCN/group	
Plan phone number	
Clinic access contact	
Required specialty pharmacy	
Authorization number and dates	
Appeal or case number	
Next action, owner, and due date	

Call log

DATE	PERSON / ORGANIZATION	REFERENCE NUMBER	RESULT AND NEXT STEP

Sources and current-information links

Rules, plan documents, formularies, and drug labels change. Use the current version. Medicare information and 2027 amounts were checked in August 2026.

1. **Compare Original Medicare and Medicare Advantage.**
   https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage
2. **Medicare Plan Compare.**
   https://www.medicare.gov/plan-compare/
3. **Medicare Special Enrollment Periods.**
   https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
4. **Choosing a Medigap Policy.**
   https://www.medicare.gov/publications/02110-choosing-a-medigap-policy.pdf
5. **Choosing Medicare drug coverage.**
   https://www.medicare.gov/publications/11163-Compare-Medicare-Drug-Coverage.pdf
6. **Medicare drug-plan rules: prior authorization, step therapy, and quantity limits.**
   https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
7. **Medicare Prescription Payment Plan.**
   https://www.medicare.gov/prescription-payment-plan
8. **Medicare Prescription Payment Plan fact sheet.**
   https://www.medicare.gov/publications/12211-whats-the-medicare-prescription-payment-plan.pdf
9. **Medicare Part D coverage determinations.**
   https://www.cms.gov/medicare/appeals-grievances/prescription-drug/coverage-determinations
10. **CMS Part D exceptions.**
    https://www.cms.gov/medicare/appeals-grievances/prescription-drug/exceptions
11. **Medicare drug plan appeals.**
    https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans
12. **CMS 2027 Medicare Advantage and Part D Rate Announcement.**
    https://www.cms.gov/files/document/2027-announcement.pdf

13 **NCCN Guidelines Insights: CLL/SLL, Version 2.2026.**
https://pubmed.ncbi.nlm.nih.gov/41825137/

14 **VENCLEXTA prescribing information.**
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b118a40d-6b56-cee3-10f6-ded821a97018

15 **CALQUENCE prescribing information.**
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=b1409184-3267-4d8c-8f17-4e01f69828b1&type=display

16 **Medicare & You handbook.**
https://www.medicare.gov/medicare-and-you

CLL SOCIETY

Smart Patients Get Smart Care™