Nascentia Health Plus
Policy and Procedure
Formulary Transition

I. Title
Formulary Transition

II. Section
MA-PD

III. Purpose
To provide an appropriate transition process for members prescribed Part D drugs that are not covered on the plan's Part D formulary.

IV. Policy

Implementation Statement: Nascentia Health Plus maintains within this transition policy a detailed explanation of how Nascentia Health Plus will process transition requests within the adjudication system; how the pharmacy is notified when transition medication is processed at the point of sale; description of edits and explanation of the process pharmacies follow to resolve transition medication edits at the point of sale.

Nascentia Health Plus implements and maintains an appropriate transition process, as approved by CMS and consistent with CMS rules and guidance (42 CFR §423.120(b)(3)). This process allows a meaningful transition for the following groups of Nascentia Health Plus Members whose current drug therapy may not be included on the Nascentia Health Plus Part D formulary:

(a.) new members entering the Plan at the start of a contract year and/or following the annual coordinated election period;
(b.) newly eligible Medicare Beneficiaries from other coverage;
(c.) the transition of members who switch from one plan to another after the start of a contract year;
(d.) current members affected by negative formulary changes across contract years;
(e.) members residing in long-term care (LTC) facilities

Nascentia Health Plus submits a copy of its transition policy process to CMS.

This transition policy applies to Non-formulary Drugs, meaning:

a) Part D drugs that are not on Nascentia Health Plus's formulary, and
b) Part D Drugs that are on Nascentia Health Plus's formulary but require prior authorization or step therapy, or that have an approved QL lower than the beneficiary's current dose, under a plan's utilization management rules

The transition process allows for medical review of Non-formulary Drug requests, and

when appropriate, a process for switching new Nascentia Health Plus Members to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

Nascentia Health Plus delegates formulary management to a contracted PBM whose P&T committee reviews procedures for coverage determination and exceptions, and, if appropriate, a process for switching new Members to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

Nascentia Health Plus's delegated PBM Formulary Transition Policy and Formulary Transition SOP (GP-01) is attached below and included as part of this policy which further provides a detailed explanation of meeting each requirement.

Nascentia Health Plus will ensure its PBM has systems capabilities that allow it to provide a temporary supply of non-formulary Part D drugs to accommodate the immediate needs of a Member, as well as, to allow Nascentia Health Plus and/or the Member sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.

Nascentia Health Plus will ensure that the PBM Transition Fill (TF) processing and coding applies point-of-sale (POS) messaging to pharmacies and provides for at least a one-time, temporary 30-day fill, with multiple fills up to a cumulative 30-day supply allowed to accommodate fills for amounts less than prescribed, anytime during the first 90 days of a Member's enrollment in a plan, beginning on the Member's effective date of coverage.

Nascentia Health Plus will ensure that the cost-sharing tier for a temporary supply of drugs provided under this transition process will not exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible Members.

For non-LIS eligible Members:

(a) Non-formulary Part D drugs transition supply will receive the same cost sharing that would apply for non-formulary drugs approved through a formulary exception in accordance with §423.578(b).

(b) Formulary transition supply will receive the same cost sharing for a formulary drug subject to utilization management edits provided during the transition that would apply if the utilization management criteria are met.

Nascentia Health Plus will ensure that in the long-term care setting:

(a) the transition policy will provide for at least a 30 day fill consistent with the applicable dispensing increment in the long-term care setting (unless the member presents with a prescription written for less), with refills provided if needed during the first 90 days of a member's enrollment in a plan, beginning on the member's effective date of coverage;

(b) after the transition period has expired or the days supply is exhausted, the transition policy will provide for at least a 31-day emergency supply of non-formulary Part D drugs (unless the member presents with a prescription written for less than the 31 days) while an exception or prior authorization determination is pending; and
(c) for Members being admitted to or discharged from a LTC facility, early refill edits will not be used to limit appropriate and necessary access to their Part D benefit, and such Members will be allowed to access a refill upon admission or discharge.

Nascentia Health Plus will only apply the following utilization management edits during transition at point of sale (POS):
(a) edits to determine Part A or B versus Part D coverage,
(b) edits to prevent coverage of non-Part D drugs, and
(c) edits to promote safe utilization of a Part D drug.
Step therapy and prior authorization edits will be coded to be resolved at POS.

Nascentia Health Plus will allow refills for transition prescriptions dispensed for less than the written amount due to quantity limit safety edits or drug utilization edits that are based on approved product labeling.

Nascentia Health Plus will apply its transition processes to a brand-new prescription for a Non-formulary Drug if a distinction cannot be made between a brand-new prescription for a Non-formulary Drug and an ongoing prescription for a Non-formulary Drug at POS.

Nascentia Health Plus will send written notices consistent with CMS transition requirements as outlined herein.

Nascentia Health Plus ensures that prior authorization or exceptions request forms are made available upon request to both Members and prescribing physicians via mail, fax, email, and are available on plan web sites.

Nascentia Health Plus will extend its transition policy across Contract Year should a Member enroll in a plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply.

Nascentia Health Plus will make general transition process information available to Members via the Medicare Prescription Drug Plan Finder link to its web site as well as in pre- and post-enrollment materials.

Nascentia Health Plus will provide a process for Members to receive necessary Part D drugs via an extension of the transition period, on a case-by-case basis, to the extent that their exception requests or appeals have not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request).

Nascentia Health Plus will implement the transition process for renewing Members whose drugs will be affected by negative formulary changes in the upcoming Contract Year. Nascentia Health Plus will offer its transition processes at the start of the new contract year and prior to the beginning of the Contract Year for effectuating a transition prior to the start of the new Contract Year.

Nascentia Health Plus will ensure that the PBM will maintain the ability to support routine and CMS-required reporting, as well as the ability to respond to ad hoc requests for:

(a) denied claim reports; and
(b) paid TF claim reports for new and renewing Members. It will also maintain the ability to support test TF claim processing in response to ad hoc requests and will regularly review and audit TF program data and system operations to monitor adherence with Part D Transition Fill requirements.

V. Audience

All Nascentia Health employees, students and volunteers.

VI. Relevant Legislation/Guidance

42 CFR §423.120(b)(3)
Chapter 6 of the Medicare Prescription Drug Benefit Manual

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Policy

GP-01 Formulary Transition

Key Points

- **This Policy applies to Elixir and activities managed by Government Programs, Benefit Design Administration, and Formulary departments.**
- **This document outlines how Elixir implements a formulary transition procedure for Commercial Plan Sponsors according to Plan Sponsor's choice between a "hard or immediate conversion", or "grandfathering".**
- **For Medicare Part D Plan Sponsors (including Medicare-Medicaid Plan (FIDA) Sponsors) this policy outlines how Elixir implements a formulary transition procedure in accordance with the Plan Sponsor's transition policy and Medicare guidance.**

1. Commercial Plan Sponsors.

   1.1. Implement an approved formulary transition procedure for each new Plan Sponsor in accordance with agreements made between the Plan and Elixir, to ensure a smooth transition for members to the new Plan Sponsor-sponsored plan.

2. Medicare Part D Plan Sponsors (including Medicare-Medicaid Plan (FIDA) Sponsors).

   2.1. In accordance with the Center for Medicare and Medicaid Services Prescription Drug Benefit Manual Chapter 6, Section 30.4 and 42 CFR 423.120(b)(3), a transition process will be maintained for enrollees whose current drug therapies may not be included in their new Part D plan's formulary, and will effectuate a meaningful transition for:

   2.1.1. New enrollees into prescription drug plans at the start of a contract year and/or following the annual coordinated election period;

   2.1.2. Newly eligible Medicare beneficiaries from other coverage;

   2.1.3. Enrollees who switch from one plan to another after the start of a contract year; 2.1.4. Current enrollees affected by negative formulary changes across contract years; 2.1.5. Enrollees residing in long-term care (LTC) facilities;

   2.1.6. Enrollees who request an exception but there is a failure to issue a timely decision on the request by the end of the transition period;

   2.1.7. Enrollees who remain in the same plan for the new plan year and are on a drug that was the result of an exception that was granted in the previous plan year;

   2.1.8. Current enrollee experiencing a level of care change;

   2.1.9. Current enrollees entering the LTC setting from other care settings; and

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2.1.10. Current enrollees in a LTC setting requiring an emergency supply of a non-formulary drug.

2.2. In addition to Section 2 above, for Medicare-Medicaid (FIDA) Plan Sponsors unless otherwise directed, a formulary transition procedure will be implemented within the first ninety (90) days of coverage and will provide:

2.2.1. In outpatient settings, at least a one time, temporary fill of at least a month's supply of medication when the Participant requests a refill of a non-formulary drug (including drugs that are on the FIDA Plan's formulary but require Prior Authorization or step therapy under the FIDA Plan's Utilization Management rules) that otherwise meets the definition of a Part D drug during the first ninety (90) days following Enrollment in the FIDA Plan; and

2.2.2. At least a one-time temporary fill of at least a month's supply of medication when a Participant requests a refill of a non-Part D drug that is covered by Medicaid.

2.3. Transition process requirements will be applicable to non-formulary drugs, meaning both:

2.3.1. Part D drugs that are not on the applicable Plan Sponsor formulary, and Part D drugs that are on the applicable Plan Sponsor formulary but require prior authorization or step therapy, or that have an approved quantity limit (QL) lower than the beneficiaries' current dose, under the applicable Plan Sponsor's utilization management rules. Medical review of non-formulary drug requests and when appropriate, the process for switching new Part D plan enrollees to a therapeutically appropriate formulary alternative failing an affirmative medical necessity determination are outlined in the Medicare Coverage Determination Policy and Procedure for Plan Sponsors that delegate Coverage Determinations to the Organization. The procedure for switching to a formulary alternative is contained in the denial notification letter provided to the member as outlined in the Medicare Coverage Determination Policy and Procedure for Plan Sponsors that delegate Coverage Determinations to the Organization.

2.4. The pharmacy claims adjudication system will have systems capabilities that allow pharmacies to provide a temporary supply of non-formulary Part D covered drugs (including Part D covered drugs that are on the applicable Plan Sponsor formulary but require prior authorization or step therapy under Plan Sponsor's utilization management rules) in order to accommodate the immediate needs of an enrollee, as well as to allow the Plan Sponsor and/or the enrollee sufficient time to work with the prescriber on an appropriate switch to a therapeutically equivalent formulary medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.

Resources

- Center for Medicare and Medicaid Services Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements, Section 30.4
- 42 CFR § 423.120(b)(3)

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Key Points

- **This Policy applies to Elixir and activities managed by Government Programs, Benefit Design Administration, and Formulary departments.**
- **This document outlines how Elixir implements a formulary transition procedure for Commercial Plan Sponsors according to Plan Sponsor's choice between a "hard or immediate conversion", or "grandfathering".**
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1. Commercial Plan Sponsors.

   1.1. Implement an approved formulary transition procedure for each new Plan Sponsor in accordance with agreements made between the Plan and Elixir, to ensure a smooth transition for members to the new Plan Sponsor-sponsored plan.

2. Medicare Part D Plan Sponsors (including Medicare-Medicaid Plan (FIDA) Sponsors).

   2.1. In accordance with the Center for Medicare and Medicaid Services Prescription Drug Benefit Manual Chapter 6, Section 30.4 and 42 CFR 423.120(b)(3), a transition process will be maintained for enrollees whose current drug therapies may not be included in their new Part D plan's formulary, and will effectuate a meaningful transition for:

   2.1.1. New enrollees into prescription drug plans at the start of a contract year and/or following the annual coordinated election period;

   2.1.2. Newly eligible Medicare beneficiaries from other coverage;

   2.1.3. Enrollees who switch from one plan to another after the start of a

   contract year; 2.1.4. Current enrollees affected by negative formulary

   changes across contract years; 2.1.5. Enrollees residing in long-term care

   (LTC) facilities;

   2.1.6. Enrollees who request an exception but there is a failure to issue a timely decision on the request by the end of the transition period;

   2.1.7. Enrollees who remain in the same plan for the new plan year and are on a drug that was the result of an exception that was granted in the previous plan year;

   2.1.8. Current enrollee experiencing a level of care change;

   2.1.9. Current enrollees entering the LTC setting from other care settings; and

2.1.10. Current enrollees in a LTC setting requiring an emergency supply of a non- formulary drug.

2.2. In addition to Section 2 above, for Medicare-Medicaid (FIDA) Plan Sponsors unless otherwise directed, a formulary transition procedure will be implemented within the first ninety (90) days of coverage and will provide:

2.2.1. In outpatient settings, at least a one time, temporary fill of at least a month's supply of medication when the Participant requests a refill of a non-formulary drug (including drugs that are on the FIDA Plan's formulary but require Prior Authorization or step therapy under the FIDA Plan's Utilization Management rules) that otherwise meets the definition of a Part D drug during the first ninety (90) days following Enrollment in the FIDA Plan; and

2.2.2. At least a one-time temporary fill of at least a month's supply of medication when a Participant requests a refill of a non-Part D drug that is covered by Medicaid.

2.3. Transition process requirements will be applicable to non-formulary drugs, meaning both:

2.3.1. Part D drugs that are not on the applicable Plan Sponsor formulary, and Part D drugs that are
on the applicable Plan Sponsor formulary but require prior authorization or step therapy, or that have an approved quantity limit (QL) lower than the beneficiaries' current dose, under the applicable Plan Sponsor's utilization management rules. Medical review of non-formulary drug requests and when appropriate, the process for switching new Part D plan enrollees to a therapeutically appropriate formulary alternative failing an affirmative medical necessity determination are outlined in the Medicare Coverage Determination Policy and Procedure for Plan Sponsors that delegate Coverage Determinations to the Organization. The procedure for switching to a formulary alternative is contained in the denial notification letter provided to the member as outlined in the Medicare Coverage Determination Policy and Procedure for Plan Sponsors that delegate Coverage Determinations to the Organization.

2.4. The pharmacy claims adjudication system will have systems capabilities that allow pharmacies to provide a temporary supply of non-formulary Part D covered drugs (including Part D covered drugs that are on the applicable Plan Sponsor formulary but require prior authorization or step therapy under Plan Sponsor's utilization management rules) in order to accommodate the immediate needs of an enrollee, as well as to allow the Plan Sponsor and/or the enrollee sufficient time to work with the prescriber on an appropriate switch to a therapeutically equivalent formulary medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.

Resources

- Center for Medicare and Medicaid Services Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements, Section 30.4
- 42 CFR § 423.120(b)(3)

GP-SOP-T Formulary Transition

Key Points

- **This Standard Operating Procedure applies to Elixir ("The Organization") and activities managed by the Government Programs, Benefit Design Administration, and Formulary departments.**
- **The scope of this document outlines the process for formulary transition**

1. General Transition Process.
   1.1. If delegated by the Plan Sponsor, The Organization will ensure that enrollees who have used a transition benefit are provided with the appropriate assistance and information necessary to enable them to better understand the purpose of the transition process. Steps that would be considered to ensure a meaningful transition include:
      1.1.1. Analyzing claims data to determine which enrollees received a transition supply;
      1.1.2. If delegated by the Plan Sponsor, contacting those identified enrollees, via transition letters, to ensure they have the necessary information to enable them to switch to a formulary product or as an alternative to pursue necessary prior authorizations or formulary exception requests;
      1.1.3. Utilization of pharmacy/member customer service center to assist affected enrollee's with questions regarding the Plan Sponsor's transition process.
2. New Prescriptions vs. Ongoing Drug Therapy.
   2.1. The Organization will ensure that all transition processes will apply to a brand-new prescription for a non-formulary Part D drug if it cannot make the distinction between a brand new prescription for a Part D non-formulary drug and an ongoing prescription for a Part D non-formulary drug at point of sale. In other words, a brand-new prescription for a non-formulary drug will not be treated any differently than an ongoing prescription for a non-formulary drug when a distinction cannot be made at the point of sale.
   2.2. Pursuant to the Plan Sponsor's transition policy, The Organization will provide for an appropriate transition process for certain enrollees who are prescribed Part D drugs that are non-formulary in order to promote continuity of care and avoid interruptions in drug therapy while a switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons can be effectuated.
   2.3. The Organization will ensure that if applicable to the benefit, all transition processes apply to requests of a refill of a non-Part D drug that is covered by Medicaid.

3. New Enrollee Transition.

3.1. Outpatient (Retail) Setting

3.1.1. Pursuant to the Plan Sponsor's transition policy, The Organization will ensure that in the retail setting, The Organization will provide at least a one time, temporary fill of at least a month's supply of medication (unless the enrollee presents a prescription written for less than a month's supply, in which case The Organization will allow multiple fills to provide up to a total of a month's supply of medication) anytime within the first 90 days of the beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage with the Plan Sponsor. If applicable to the benefit, at least a 90-day supply of a non-Part D drug that is covered by Medicaid will be provided. If the smallest available package size exceeds the Plan Sponsor's one month supply, a transition supply for an appropriate days supply exceeding one month will be provided.

3.1.2. To the extent that an enrollee is outside his or her 90-day transition period, The Organization will still provide an emergency supply of Part D covered non-formulary medications (including Part D covered drugs that are on a Plan Sponsor's formulary that would otherwise require prior authorization or step therapy under Plan Sponsor's utilization management rules). This will occur on a case-by-case basis, when it has been identified that the enrollee's exception request or appeal has not been completed by the end of the transition period.

3.1.3. To the extent that the Plan Sponsor's transition policy differs from the above policy, The Organization will implement the Plan Sponsor's policy differences.

3.2. Long Term Care (LTC) Setting

3.2.1. In the LTC setting, The Organization will ensure:

3.2.1.1. The transition policy provides for a one time temporary fill of at least a month's supply (unless the enrollee presents a prescription written for less), which should be dispensed incrementally as applicable under 42 CFR §423.154 and with multiple fills provided if needed during the first 90 days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage;

3.2.1.2. After the transition period has expired, the transition policy provides for an up to one month emergency supply of Part D covered non-formulary medications, including Part D covered drugs that are on a Plan Sponsor's formulary that would otherwise require prior authorization or step therapy under a Plan Sponsor's utilization management rules (unless the enrollee presents with a prescription written for less than the Sponsor's one month supply), while an exception or prior authorization is requested or when it has been identified that the enrollee's exception request or appeal has not been completed by the end of the transition period; and

3.2.1.3. For enrollees being admitted to or discharged from a LTC facility, early refill edits will not be used to limit appropriate and necessary access to their Part D benefit, and such enrollees are allowed to access a refill upon admission or discharge. If the smallest available package size exceeds the month's

supply, a transition supply for an

appropriate days supply will be provided.

3.2.2. In the LTC setting, beneficiaries will be permitted to have a full outpatient supply available under Part D to continue therapy once their limited Part A supply is exhausted.

3.3. Transition Extension

3.3.1. The Organization may need to make arrangements to continue to provide necessary Part D drugs to an enrollee via an extension of the transition period, on a case-by-case basis, to the extent that his or her exception request or appeal has not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request).

3.3.2. To the extent that the Plan Sponsor's transition policy differs from the above policy, The Organization will implement the Plan Sponsor's policy differences.

4. Negative Formulary Changes for Current Enrollees.

4.1. Current Plan Sponsor enrollees receive their ANOC by September 30 of a given year. Plan Sponsors will select at least one of the following two options for effectuating an appropriate and meaningful transition for current enrollees whose drugs will be affected by negative formulary changes in the upcoming year or remain on the formulary but to which new prior authorization or step therapy restrictions are applied, or that have an approved Quantity Limit (QL) lower than the beneficiary's current dose. For the purposes of transition requirements, non-formulary Part D drugs are defined as: (1) Part D drugs that are not on a sponsor's formulary, and (2) Part D drugs that are on a sponsor's formulary but require prior authorization or step therapy, or that have an approved quantity limit lower than the beneficiary's current dose, under a plan's utilization management requirements. If the plan's quantity limit is equal to an FDA maximum dose limit, doses greater than this limit may not be allowed as part of a transition supply.

4.1.1. Provide a transition process for current enrollees consistent with the transition process required for new enrollees at the start of the new contract year. In order to prevent coverage gaps, The Organization will provide a transition supply of the requested Part D covered non- formulary prescription drug or the formulary prescription drug that is subject to new prior authorization or step therapy requirements beginning January 1 when the member has had a prescription for the medication filled within a minimum of the past 108 days (number of days to be decided by Plan Sponsor) from the date of the attempted fill. If delegated by Plan Sponsor, The Organization will provide enrollees with the required transition notice that they must either switch to a drug on the applicable Plan Sponsor formulary or get an exception (Coverage Determination) to continue taking the non-formulary medication; OR

4.1.2. Effectuate a transition for current enrollees prior to the start of the new contract year. In effectuating this transition, the Plan Sponsor will aggressively work to (1) prospectively transition current enrollees to a therapeutically equivalent formulary alternative; and (2) adjudicate any requests received for formulary and tier exceptions to the new formulary prior to the start of the contract year. If the Plan Sponsor approves such an exception request, the Plan Sponsor shall authorize

The Organization to authorize payment prior to January 1 of the new contract year.

4.1.2.1. If, however, the Plan Sponsor has not successfully transitioned affected enrollees to a therapeutically equivalent formulary alternative or adjudicated an exception request prior to January 1, The Organization, at the direction of the Plan Sponsor, will provide a transition supply beginning January 1 and the required transition notice and until such time as a meaningful transition has been effectuated. If a sponsor approves an exception request, the Plan Sponsor shall authorize The Organization to authorize payment prior to January 1 of the new contract year.

4.2. Additionally, The Organization will extend the transition policy across contract years should a beneficiary enroll into a Plan Sponsor's Plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply. It is the Plan Sponsor's responsibility to send enrollees with a November 1 or December 1 effective enrollment date and ANOC as soon as practical after the effective enrollment date to serve as advance notice of any formulary or benefit changes in the following contract year.

4.3. To the extent that the Plan Sponsor's transition policy differs from the above policy, The Organization will implement the Plan Sponsor's policy differences.

5. Transition Fills for Coverage Exceptions.

5.1. Enrollees who remain in the same plan they initially enrolled in for the new plan year and are on a drug as a result of a granted exception in the previous plan year may continue to receive that exception into the new plan year. Should the Plan Sponsor choose not to honor the exception beyond the end of the plan year, it will notify the enrollee in writing at least 60 days before the end of the current plan year and will do either of the following:

5.1.1. Offer to process a prospective exception request for the next plan year.

5.1.2. Provide the enrollee with a temporary supply of the requested prescription drug at the beginning of the plan year and then provide the enrollee with notice that they must either switch to a therapeutically appropriate drug on the formulary or get an exception to continue taking the requested drug.

5.2. The Organization will make arrangements to continue to provide necessary Part D drugs to enrollees via an extension of the transition period, on a case by case basis, to the extent that their exception request or appeals have not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request). This will also apply if the Plan Sponsor has failed to issue a timely decision of an exception request by the end of the member's transition period.

5.3. The Plan Sponsor is responsible for making available prior authorization or exceptions request forms upon request to both enrollees and prescribing physicians via a variety of mechanisms, including mail, fax, email, and on plan websites.

5.4. To the extent that the Plan Sponsor's transition policy differs from the above policy, The Organization will implement the Plan Sponsor's policy differences.

6. Level of Care Changes / Emergency Fills.

   6.1. For enrollees who are outside their transition period, and experience a level of care change in which an enrollee is changing from one treatment setting to another (example: LTC to hospital to LTC, hospitals to home, home to LTC), upon admission or discharge from a treatment setting or LTC, The Organization will allow the enrollee access to a refill equal to the Plan Sponsor's one- month supply for formulary medications and an emergency one month supply transition fill for non-formulary medications (including Part D drugs that are on Plan Sponsor's formulary but require prior authorization or step therapy).

   6.2. This policy does not apply for short-term leaves of absences (i.e. holidays or vacations) from LTC or hospital facilities.

   6.3. To the extent that an enrollee is outside his or her 90-day transition period, and is in the outpatient setting, The Organization will still provide an emergency supply of non-formulary medications (including Part D drugs that are on a Plan Sponsor's formulary that would otherwise require prior authorization or step therapy under Plan Sponsor's utilization management rules), on a case by case basis, while an exception request is being processed. To the extent that an enrollee is outside his or her 90-day transition period, and is in the LTC setting, The Organization will still provide an emergency supply of Part D covered non-formulary medications (including Part D covered drugs that are on a Plan Sponsor's formulary that would otherwise require prior authorization or step therapy under Plan Sponsor's utilization management rules), while an exception request is being processed.

   6.4. To the extent that the Plan Sponsor's transition policy differs from the above policy, The Organization will implement the Plan Sponsor's policy differences.

7. Edits for Transition Fills.

   7.1. The Organization will only apply the following utilization management edits during transition at point of sale:

      1) Edits to determine Part A or B versus Part D coverage

      2) Edits to prevent coverage of non-Part D drugs (i.e. excluded drugs, drugs that are being used for non-medically accepted indications such as Transmucosal Fentanyl)

      3) Edits to promote safe utilization of a Part D drug (i.e. quantity limits based on FDA maximum recommended daily dose; early refill edits)

      4) Edits to determine Hospice vs. Part D coverage

   7.2. The Organization will ensure that pharmacies can resolve step therapy and prior authorization edits during transition at point of sale

   7.3. The Organization will provide refills for transition prescriptions dispensed for less than the written amount due to quantity limit safety edits or drug utilization edits that are based on approved product labeling.

8. Cost Sharing Considerations.

8.1. The Plan Sponsor may charge cost sharing for a temporary supply of drugs provided under its transition process. Cost sharing for transition supplies for low-income subsidy (LIS) eligible enrollees will never exceed the statutory maximum copayment amounts. For non-LIS enrollees, a sponsor must charge the same cost sharing for non-formulary Part D drugs provided during the transition that would apply for non-formulary drugs approved through a formulary exception in accordance with 42 CFR § 423.578(b) and the same cost sharing for formulary drugs subject to utilization management edits provided during the transition that would apply if the utilization management criteria are met.

9. Transition Notices.

9.1. The Plan Sponsor is responsible for making their transition policy available to enrollees via a link from the Medicare Prescription Drug Plan Finder to their Plan Sponsor website and including it in pre-and post-enrollment marketing materials as directed by CMS.

9.2. If so delegated by the Plan Sponsor, The Organization will send written notice consistent with the CMS transition requirements.

9.2.1. Written notice will be sent via U.S. first class mail to enrollee within three business days of adjudication of a temporary transition fill. The notice must include:

9.2.1.1. An explanation of the temporary nature of the transition supply an enrollee has received;

9.2.1.2. Instructions for working with the Plan Sponsor and the enrollee's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the plan's formulary;

9.2.1.3. An explanation of the enrollee's right to request a formulary exception; and

9.2.1.4. A description of the procedures for requesting a formulary exception. For long-term care residents dispensed multiple supplies of a Part D drug in increments of 14-days- or-less, consistent with the requirements under 42 CFR 423.154,(a)(1)(i), the written notice must be provided within 3 business days after adjudication of the first temporary fill. For enrollees residing in LTC facilities, the Plan Sponsors may elect to send the beneficiary transition notice to the LTC pharmacy serving the beneficiary's LTC facility. The Organization will ensure that reasonable efforts are made to notify the LTC facility and the LTC pharmacy must ensure delivery of the notice to the beneficiary within 3 business days of adjudication of the fill.

9.3. The Plan Sponsor will provide The Organization the CMS model Transition Notice via the file-and- use process or submit a non-model Transition Notice to CMS for marketing review subject to a 45- day review. The Organization will ensure that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice.

10. Identification of Issues Regarding Adherence to Transition Policy.

10.1. The Organization will perform transition fill configuration testing, transition letter generation testing, and pharmacy notification prior to the new plan year. The Organization will perform monitoring of the transition fill process and transition letter generation process throughout the

current plan year.

10.2. In the event an issue is discovered during the plan year related to adherence to the transition policy, the Organization will immediately notify the Plan Sponsor.

10.3. It is the Plan Sponsor's responsibility to submit copies of its transition policy, and The Organization's transition policy if applicable, to CMS upon CMS' request unless CMS requests The Organization's transition policy directly from The Organization.

11. Implementation Statement.

11.1. The Organization will maintain in its transition policy a detailed explanation of how Part D Sponsors process transition requests within the adjudication system; how the pharmacy is notified when transition medication is processed at the point of sale; description of edits and explanation of the process pharmacies follow to resolve transition medication edits at the point of sale.

12. Procedure.

12.1. Commercial Plan Sponsors

12.1.1. When The Organization's formulary is implemented in a new Plan Sponsor-sponsored plan, the Plan Sponsor has two options regarding formulary transition for its plan members: A "hard conversion" or "grandfathering." A hard conversion is when the Elixir formulary becomes effective from the first day the new plan is effective. Grandfathering allows the most frequently used drugs to be processed at a lower copay level for a period of three to six months, or per Plan Sponsor specification. This allows the member time to discuss with their physician an alternative therapeutic equivalent in the new formulary, or to request prior authorization for medical necessity reasons.

12.1.2. Regardless of the Plan Sponsor's decision, The Organization will send letters to members two months prior, and again at one month prior to the effective date of the new plan, which informs the member of the hard conversion to the new formulary, or, in the alternative, the three-month grandfathering phase. If the grandfathering option was selected, reminder letters notifying members of their options are sent to members 30 days prior the end of the three to six month grandfather phase.

12.2. Medicare Part D (including Medicare-Medicaid/MMP) Plan Sponsors

12.2.1. The Organization shall obtain the Medicare Part D Plan Sponsor's transition policy on an annual basis, or more frequently as needed. Based on the transition period, minimum and maximum day supply specified in the Plan Sponsor's policy, the benefit will be configured accordingly.

12.2.2. For all new members to the plan who require transitional fills for non-formulary medication(s), or medications requiring a step therapy or prior authorization (or quantity limits if directed by the Plan Sponsor), the transitional fill will process automatically per the specifications of the Plan Sponsor's transition policy.

12.2.3. For all members that require additional transitional fills outside of the first 90 days of eligibility with the plan for non-formulary medications, or medications requiring prior authorization, or step therapy (or quantity limits if directed by

the Plan Sponsor), these

additional fills will require manual intervention for the transitional claim to process. The member, the member's appointed representative, or physician must call Customer Service to have a transition override placed into the pharmacy claims adjudication system (See Medicare Part D Transition Workflow and LTC Transition Workflow).

12.2.4. Existing members who require a transition across plan years will receive an automated transitional fill for up to a one month's supply using a feature that performs a minimum 120- day look-back in claims history based on drugs identified by the Plan Sponsor as being eligible for transition across plan years. The pharmacy claims adjudication system will be configured to review the member's history for the identified drugs per the Plan Sponsor's direction.

12.2.5. The following is a detailed explanation of how The Organization will process transition requests within the adjudication system, how the pharmacy is notified when transition medication is processed at point of sale, and a description of the edits and explanations of the process pharmacies will follow to resolve transition edits at point of sale.

12.2.5.1. The pharmacy claims adjudication system will be configured by The Organization to apply the following edits to occur during transition at point of sale (1) Edits to help determine Part A or B versus Part D coverage and Hospice vs. Part D coverage (2) Edits to prevent coverage of non-part D drugs (i.e. excluded drugs) (3) Edits to promote safe utilization of a Part D drug (i.e. quantity limits based on FDA maximum recommended daily dose, early refill edits)

12.2.5.1.1. The member's effective date on the enrollment file will be utilized to determine if they are within their first 90 days of initial enrollment with the Plan Sponsor.

12.2.5.1.2. Drugs will pay at their appropriate copay Tier. LIS members will not pay any more than their applicable LIS level copay. Non-LIS members will pay the same cost sharing for non-formulary drugs provided during the transition period as they would for non-formulary drugs approved through a formulary exception process. Non-LIS members will pay the same cost share for transition fills of formulary drugs subject to utilization management edits as they would once the utilization management criteria are met.

12.2.5.1.3. Refills will be authorized for transition prescriptions dispensed for less than the written amount due to quantity limits for safety purposes or drug utilization edits that are based on approved product labeling.

12.2.5.1.3.1. The Organization's Customer Service Representatives will place an override in the pharmacy claims adjudication system in the Member Prior Authorization (MPA) screen to allow the claim to pay for additional refills.

12.2.5.1.3.1.1. The MPA will be set up to allow the remainder of refills to process by completing the date range on tab 1 of the MPA screen. The date range should be configured for the remaining day supply based on how many days the

allowable fill is for.

12.2.5.1.3.1.2. The MPA will be set up as a “Trans-D<insert tier of drug>” on tab 2

(Action tab) in the “Mark Script As” field of the MPA screen to indicate this transition override.

12.2.5.2. For (1) new enrollees into prescription drug plans following the annual coordinated election period, (2) newly eligible Medicare beneficiaries from other coverage, (3) enrollees who switch from one plan to another after the start of a contract year. (See Appendix A - Plan Adjudication Configuration by Plan Sponsor Benefit Design):

12.2.5.2.1. The pharmacy claims adjudication system will be configured to automatically allow at least a month’s supply (either in one fill or multiple fills for up to a one month supply) of a non-formulary medication if the member is within the first 90 days of their eligibility with the Plan Sponsor unless the Plan Sponsor’s transition policy states something different. In the event the Plan Sponsor’s transition policy has different parameters, the Plan Sponsor’s transition policy differences will be implemented.

12.2.5.2.1.1. The member’s effective date on the enrollment file will be utilized to determine if they are within their first 90 days of initial enrollment with the Plan Sponsor.

12.2.5.2.1.2. The claim will default to the non-preferred drug tier copay. LIS members will not pay any more than their applicable LIS level copay. Non-LIS members will pay the same cost sharing for non-formulary drugs provided during the transition period as they would for non-formulary drugs approved through a formulary exception process.

12.2.5.2.1.3. 84-90 day supply claims will not be allowed

12.2.5.2.2. Prior Authorization (PA) and Step Therapy (ST) overrides (or quantity limit overrides if directed by the Plan Sponsor) will be configured to automatically allow at least a month’s supply (either in one fill or multiple fills for up to a one month supply)

12.2.5.2.2.1. The member’s effective date on the enrollment file will be utilized to determine if they are within their first 90 days of initial enrollment with the Plan Sponsor.

12.2.5.2.2.2. Drugs requiring ST or PA (or quantity limits if directed by the Plan Sponsor) will pay at their appropriate copay Tier. LIS members will not pay any more than their applicable LIS level copay. Non-LIS members will pay the same cost share for transition fills of formulary drugs subject to utilization management edits as they would once the utilization management criteria are met.

12.2.5.2.2.3. 84-90 day supply claims will not be allowed

12.2.5.2.3. Unbreakable/Smallest package size drugs will be configured to automatically allow a claim that is dispensed as the smallest package size available and whose day supply calculation based on

prescribed directions exceed the day

supply limitation set by the Plan.

12.2.5.2.3.1. The member's effective date on the enrollment file will be utilized to determine if they are within their first 90 days of initial enrollment with the Plan Sponsor.

12.2.5.2.3.2. Drugs will pay at the appropriate copay Tier. LIS members will not pay any more than their applicable LIS level copay.

12.2.5.2.3.3. If the Plan allows for 30 day and 90 day supplies, claims processed with a day supply of 31-83 will pay during transition.

12.2.5.3. For New Enrollees that are LTC residents (See Appendix A-Plan Adjudication Configuration by Plan Sponsor Benefit Design)

12.2.5.3.1. The pharmacy claims adjudication system will be configured to allow a one- time temporary fill of at least a month's supply, dispensed incrementally as applicable under 42 CFR §423.154 and with multiple fills provided if needed, of a non-formulary medication, or a medication that requires prior authorization or step therapy (or quantity limits if directed by the Plan Sponsor) to process automatically when submitted by a LTC pharmacy within the Organization's pharmacy network if the member is within the first 90 days of their eligibility with the Plan Sponsor unless the Plan Sponsor's transition policy states something different. Transition fills of at least a month's supply, dispensed incrementally
as applicable under 42 CFR §423.154 and with multiple fills provided if needed, will be allowed for the member during the entire 90 days of their initial eligibility with the Plan Sponsor via the following (in the event the Plan Sponsor's transition policy has different parameters, the Plan Sponsor's transition policy differences will be implemented).

12.2.5.3.1.1. The member's effective date on the enrollment file will be utilized to determine if they are within their first 90 days of initial enrollment with the Plan Sponsor.

12.2.5.3.1.2. The pharmacy must submit the claim for up to a one month supply of medication and must submit the number 3,4 or 9 in the patient residence field of the claim for the claim for non-formulary medications (including those medications with ST/PA edits) to automatically process.

12.2.5.3.1.3. If the pharmacy does not submit a 3, 4 or 9 in the patient residence field of the claim, and the claim is for greater than a one month supply, the claim will reject and the pharmacy will receive a message that only a one month supply of the medication is allowed for a transitional fill.

12.2.5.3.1.4. For Non-LIS members, the paid claim will default to the non-preferred drug tier copay for non-formulary medications and drugs requiring ST or PA (or quantity limits if directed by the Plan Sponsor) will pay at their appropriate copay Tier. LIS members will not pay any more than their applicable LIS level

copay.

12.2.5.3.1.5. 84-90 day supply claims will not be allowed.

12.2.5.4. If the member is within the first 90 days of their initial eligibility with the Plan Sponsor and The Organization cannot determine if a prescription is a new prescription, they will be instructed to follow the processes set forth in items 12.2.5.1, 12.2.5.2 and 12.2.5.3 above.

12.2.5.5. Level of Care Changes / Emergency Supplies

12.2.5.5.1. If a current member experiences a level of care change, is a hospice patient who is receiving a Part D drug that is not eligible for hospice coverage, enters the LTC setting from another care setting, or is in LTC and requires an emergency fill of a non-formulary drug, including those medications on the formulary subject to PA or ST(or quantity limits if directed by the Plan Sponsor), or requires an extension of their transition period for any other reason (i.e. the member is either outside of their transition period or previously has received the transition fill)

12.2.5.5.1.1. Pharmacies may submit certain Submission Clarification Codes (SCC) indicating a level of care change or the need for an emergency override. Upon submission of the appropriate SCC and identification of the LTC setting, applicable claims will adjudicate accordingly.

12.2.5.5.1.2. If a SCC is not submitted, the Organization will message to pharmacies to call for a transition override for all claims rejected for non-formulary status or requiring a PA or ST (or quantity limits if directed by the Plan Sponsor).

12.2.5.5.1.3. When a member/pharmacy calls the Organization, these inquiries will be handled and approved on a case-by-case basis by the Organization's Clinical Pharmacy staff.

12.2.5.5.1.4. Once the Clinical staff approves a transition fill for one of these circumstances (Non-Formulary Exception (NFE), ST or PA override (or quantity limits if directed by the Plan Sponsor)

12.2.5.5.1.4.1. The member's effective date on the enrollment file will be utilized to verify that they fall outside of their first 90 days of initial enrollment with the Plan Sponsor

12.2.5.5.1.4.2. NFE, PA and ST overrides (or quantity limit overrides if directed by the Plan Sponsor) will be configured at point of sale

12.2.5.5.1.4.2.1. The Organization's Customer Service Representative will place an override in the adjudication system to allow the claim to pay without completing the PA or ST requirements (or quantity limit requirements if directed by the Plan Sponsor)

12.2.5.5.1.4.2.2. The member prior auth screen in the adjudication system will be set up as a "Trans D <insert tier of

drug>” on tab 2 (Action

tab) in the “Mark Script As” field of the prior authorization screen to indicate that this a NFE/ST/PA transition override (or quantity limit override if directed by the Plan Sponsor).

12.2.5.5.1.4.2.3. The override will be set up to expire no later than 72 hours from the time it was entered.

12.2.5.5.1.4.2.4. The override will only allow a one month supply of the medication (as defined by Plan Sponsor’s one month supply).

12.2.5.5.1.4.2.5. Drugs requiring ST or PA (or quantity limits if directed by the Plan Sponsor) will pay at their appropriate copay Tier for Non LIS members. LIS members will not pay any more than their applicable LIS level copay.

12.2.5.5.1.4.2.6. The Organization’s Customer Service Representative will then initiate the coverage determination process.

12.2.5.5.1.4.3. Non-Formulary claims will be configured to be overridden at point of sale

12.2.5.5.1.4.3.1. The Organization’s Customer Service Representative will place an override in the system to allow the claim to pay for the non- formulary drug.

12.2.5.5.1.4.3.2. The member prior auth screen in the adjudication system will be set up as a “Trans D <insert tier of non-preferred drug>” on tab 2 (Action tab) in the “Mark Script As” field of the prior authorization screen to indicate that this is a NFE/ST/PA transition override (or quantity limit transition override if directed by the Plan Sponsor).

12.2.5.5.1.4.3.3. The override will be set up to expire no later than 72 hours from the time it was entered.

12.2.5.5.1.4.3.4. The override will only allow a one month supply of the medication (as defined by Plan Sponsor).

12.2.5.5.1.4.3.5. For Non LIS members, the claim will default to the non- preferred drug tier copay. LIS members will not pay any more than their applicable LIS level copay.

12.2.5.5.1.4.3.6. The Organization’s Customer Service Representative will then initiate the coverage determination process.

12.2.5.5.1.4.4. All manual override claims will be reviewed on a daily basis by a Clinical Coordinator to ensure the override was configured properly and the member was charged the

appropriate copay.

12.2.5.5.1.4.4.1. Any overrides identified as being incorrect will be provided to an Elixir Help Desk Supervisor for correction and adjudication

within 24 hours of receipt of notice.

12.2.5.5.1.4.5. In the event the Plan Sponsor's transition policy has different parameters, the Plan Sponsor's transition policy differences will be implemented.

12.2.5.6. Transition Across Plan Years

12.2.5.6.1. For drugs that are removed from the formulary from plan year to plan year, or drugs that remain on the formulary but are subject to new prior authorization or step therapy requirements in the upcoming plan year, The Organization will do the following (See Transition Across Plan Years for Negative Formulary Changes for Current Members Pharmacy claims adjudication Detail-Appendix A). In the event the Plan Sponsor's transition policy has different parameters, the Plan Sponsor's transition policy differences will be implemented. Plan Sponsors may choose to allow a transition fill for drugs that remain on the formulary from plan year to plan year but are subject to new or more restrictive Quantity Limits. Plan Sponsors are responsible for effectuation of a transition prior to the beginning of the contract year.

12.2.5.6.1.1. Allow members who have been on one of these impacted drugs, and who are outside of the Plan Sponsor's initial 90-day eligibility timeframe, to receive up to an accumulated one month supply (as defined by Plan Sponsor's one month supply). The pharmacy claims adjudication platform shall be configured by the Organization to allow this to occur without point of sale intervention.

12.2.5.6.1.2. To determine if a member is eligible for one of these transition fills, the Organization shall look back a minimum of 120 days (unless number of days determined by the Plan Sponsor differs) from the date of service back in the enrollee's paid claim history for a paid claim. (Since this has to do with Formulary changes from one year to the next, we assume the member was with the Sponsor the previous benefit year. Thus the historical look back is a minimum of 120 days prior to the start of the plan year and not the member's start date.)

12.2.5.6.1.3. If a paid claim is present within the look back timeframe, the transition fill will automatically process.

12.2.5.6.1.3.1. For drugs that are non-formulary in the new Plan Year, the claim will default to the non-preferred brand drug tier copay for Non-LIS members. LIS members will not pay any more than their applicable LIS level copay.

12.2.5.6.1.3.2. Drugs requiring ST or PA will pay at their appropriate copay Tier for Non-LIS members. LIS members will not pay any more than their applicable LIS level copay.

12.2.5.6.1.3.3. 84-90 day supply claims will not be allowed.

12.2.5.7. Transition Fills for Coverage Exceptions

12.2.5.7.1. The Organization will allow a transition fill for enrollees who request an exception but the Plan Sponsor has failed to issue a timely decision on the request by the end of the transition period by performing the following;

12.2.5.7.1.1. The member's effective date on the enrollment file will be utilized to verify that they fall outside of their first 90 days of initial enrollment with the Plan Sponsor.

12.2.5.7.1.2. The enrollee's claims history will be reviewed to determine that a previous transition fill has been issued.

12.2.5.7.1.3. The Organization's clinical staff will be contacted to verify that a Coverage Determination request is in process.

12.2.5.7.1.4. PA and ST overrides (or quantity limit overrides if directed by the Plan Sponsor) will be configured at point of sale

12.2.5.7.1.4.1. The Organization's Customer Service Representative will place an override in the system to allow the claim to pay without completing the PA or ST requirements.

12.2.5.7.1.4.2. The member prior auth screen in the adjudication system will be set up as a "Trans D <insert tier of drug>" on tab 2 (Action tab) in the "Mark Script As" field of the prior authorization screen to indicate that this a ST/PA transition override (or quantity limit transition override if directed by the Plan Sponsor).

12.2.5.7.1.4.3. The override will be set up to expire no later than 72 hours from the time it was entered. The override will only allow a one month supply of the medication (as defined by Plan Sponsor's one month supply).

12.2.5.7.1.4.4. Drugs requiring ST or PA (or quantity limits if directed by the Plan Sponsor) will pay at their appropriate copay Tier for Non-LIS members. LIS members will not pay any more than their applicable LIS level copay.

12.2.5.7.1.5. Non-Formulary claims will be configured to be overridden at point of sale 12.2.5.7.1.5.1. The Organization's Customer Service Representative will place an override in the system to allow the claim to pay for the non-formulary drug.

12.2.5.7.1.5.2. The PA will be set up as a "Trans D <insert tier of non-preferred drug>" on tab 2 (Action tab) in the "Mark Script As" field of the prior authorization screen to indicate that this a non-formulary transition override.

12.2.5.7.1.5.3. The override will be set up to expire no later than 72 hours from the

time it was entered.

12.2.5.7.1.5.4. The override will only allow a one month supply of the medication, as defined by the Plan Sponsor's one month supply.

12.2.5.7.1.5.5. The claim will default to the non-preferred drug tier copay for Non- LIS members. LIS members will not pay any more than their applicable LIS level copay.

12.2.5.7.1.6. All manual override claims will be reviewed on a daily basis by a Clinical Coordinator to ensure the override was configured properly and the member was charged the appropriate copay.

12.2.5.7.1.6.1.1. Any overrides identified as being incorrect will be provided to an Elixir Help Desk Supervisor for correction and adjudication within 24 hours of receipt of notice.

12.2.5.7.2. The Organization will honor exceptions that were approved in the previous plan year in the new plan year upon direction from the Plan Sponsor.

12.2.5.7.2.1. During the last quarter of the current plan year, all approved coverage determinations will be reviewed for continuance into the new plan year by the Plan Sponsor.

12.2.5.7.2.2. If it is determined by the Plan Sponsor that the coverage determination will be extended into the new plan year, The Organization's staff shall update the term date on the member prior authorization screen in the pharmacy claims adjudication system.

12.2.5.7.2.3. In the event that the Plan Sponsor should choose to no longer honor exceptions approved during the previous plan year in the new plan year, the Organization will provide the enrollee with a temporary supply of the requested prescription drug at the beginning of the new plan year as it does for new enrollees. The enrollee will not be sent a 60 day notice letter prior to the end of the year as all enrollees who receive an approved coverage determination or redetermination receive an approval letter that clearly identifies the date the coverage will end.

12.2.5.8. Transition Notification

12.2.5.8.1. If delegated, The Organization will mail Transition letters on behalf of the Medicare Part D Plan Sponsor consistent with the CMS transition requirements (See Medicare Part D Transition Letter Work Flow).

12.2.5.8.1.1. Enrollees will be notified of a prescription fill that was subject to the transition process via the model transition letter provided by the Plan Sponsor to the Organization.

12.2.5.8.1.2. An automated Crystal report will be ran Monday through Friday each week to generate an enrollee specific transition letter and

will be sent to the print vendor. Report logic will pull transition claims based on the

adjudication date.

12.2.5.8.1.2.1. Letters will be mailed on a daily basis

12.2.5.8.1.2.2. Copies of the transition letters will be available online in a searchable database located at: https://envisionrx.convergenceweb.com/Login/tabid/2879//Default.a spx?returnurl=%2default.aspx

12.2.5.8.1.2.3. Upon request, monthly reports from The Organization can be provided to Plan Sponsor summarizing transition letters mailed for the previous month.

12.2.5.8.1.3. Unless directed to do so by the Plan Sponsor, LTC pharmacies will not be notified of prescription fills that are subject to the transition process.

12.2.5.8.1.4. The Organization shall message to pharmacies the correct phone number to call to obtain a transition override.

12.2.5.8.1.5. The prescribing physician will receive a copy of the member's transition letter marked " PRESCRIBER COPY"

12.2.5.8.1.5.1. A member of The Organization's fulfillment department will run a Crystal report on a daily basis Monday through Friday each week to generate an enrollee specific transition letter.

12.2.5.8.1.5.2. Report logic will pull transition claims based on the adjudication date

12.2.5.8.1.5.3. Letters will be mailed on a daily basis.

12.2.5.8.1.5.4. Copies of the transition letters will be kept by The Organization for Plan Sponsor and will be available upon request.

12.2.5.8.1.5.5. Upon request, monthly reports from The Organization can be provided to Plan Sponsor summarizing transition letters mailed for prescribing providers for the previous month.

12.2.5.9. Identification of Issues Regarding Adherence to Transition Policy

12.2.5.9.1. PBM shall offer to provide testing of the transition fill configuration to Plan Sponsor prior to the beginning of the new plan year.

12.2.5.9.2. PBM shall offer to provide testing of the transition letter generation process to Plan Sponsor prior to the beginning of the new plan year. Refer to Policy and Procedure GP-01 for more detail.

12.2.5.9.3. On a monthly basis, PBM shall offer to provide Plan Sponsor results of ongoing transition process monitoring regarding transition fill configuration and transition letter generation.

12.2.5.9.4. In the event an issue is identified, the Account Manager for the Plan Sponsor will notify the Plan Sponsor within 3 business days of discovery of the issue.

12.2.5.10. Implementation Statement

12.2.5.10.1. The Organization will maintain a detailed explanation related to transition configuration in the adjudication system in Appendix A

12.2.5.10.2. The Organization will maintain a detailed explanation related to how pharmacies are notified when a transition fill is processed at point of sale in Appendix A

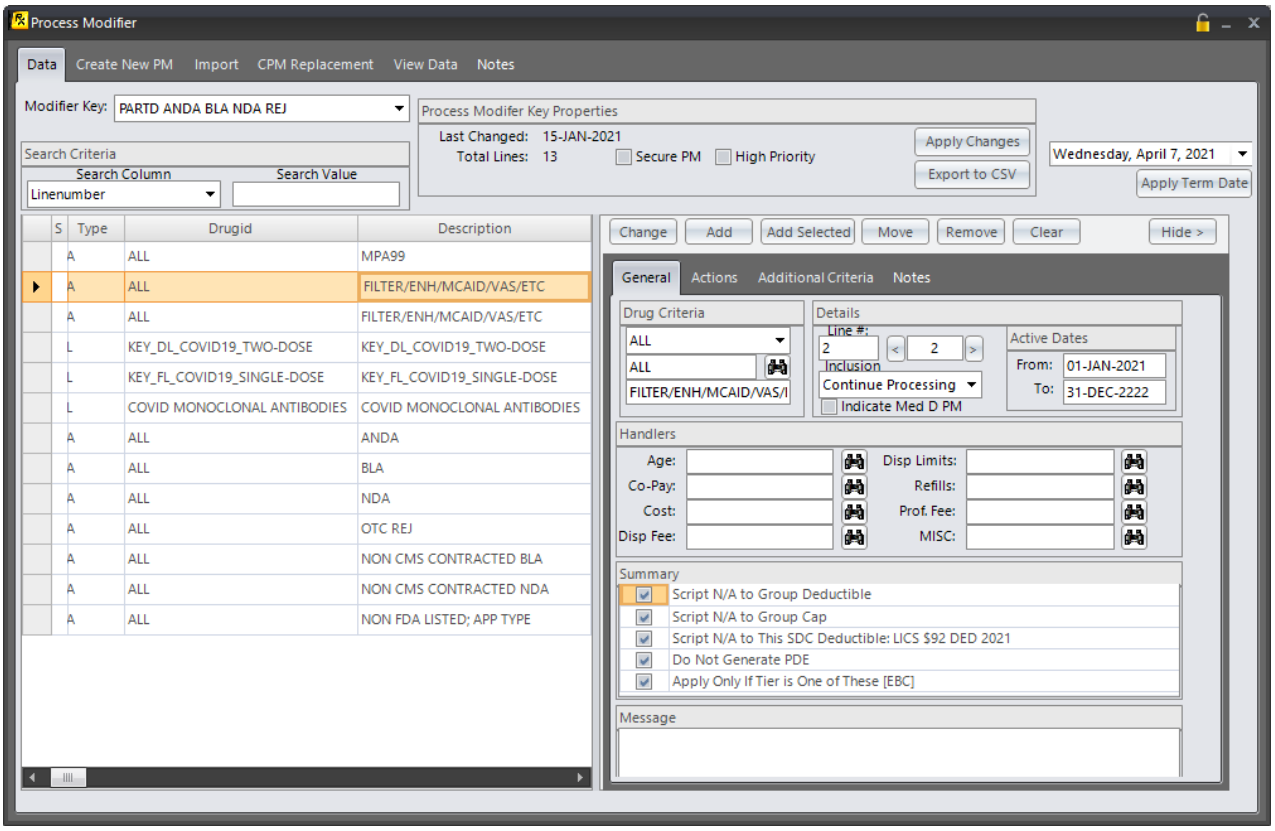
12.2.5.10.3. The Organization will maintain a detailed explanation of the process pharmacies follow to resolve transition medication edits at point of sale in Appendix A and in sections 12.2.5, 12.2.2.5.5 and 12.2.5.7 above.

Resources

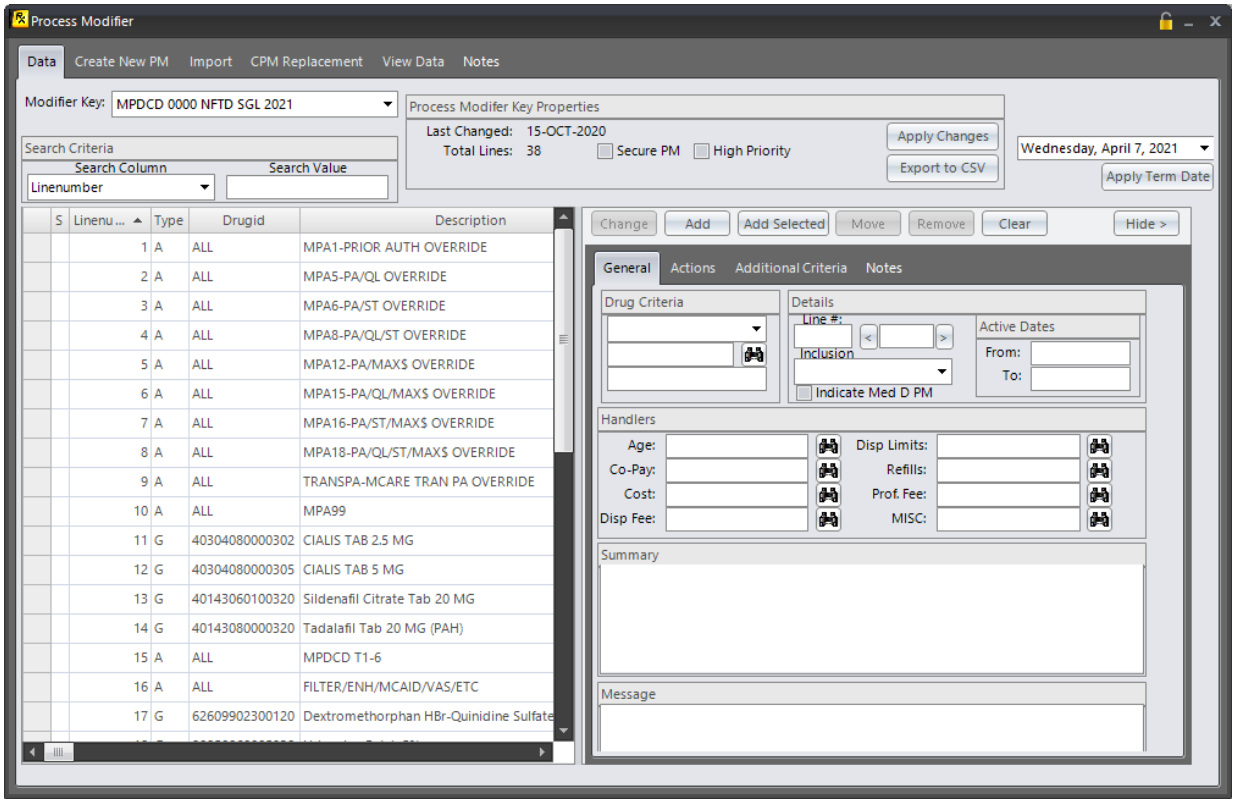
- Center for Medicare and Medicaid Services Prescription Drug Benefit Manual Chapter 13 – Premium and Cost-Sharing Subsidies for Low-Income Individuals, Section 70.3.1
- Center for Medicare and Medicaid Services Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements, Section 30.4
- 42 CFR §423.154
- 42 CFR § 423.578(b)

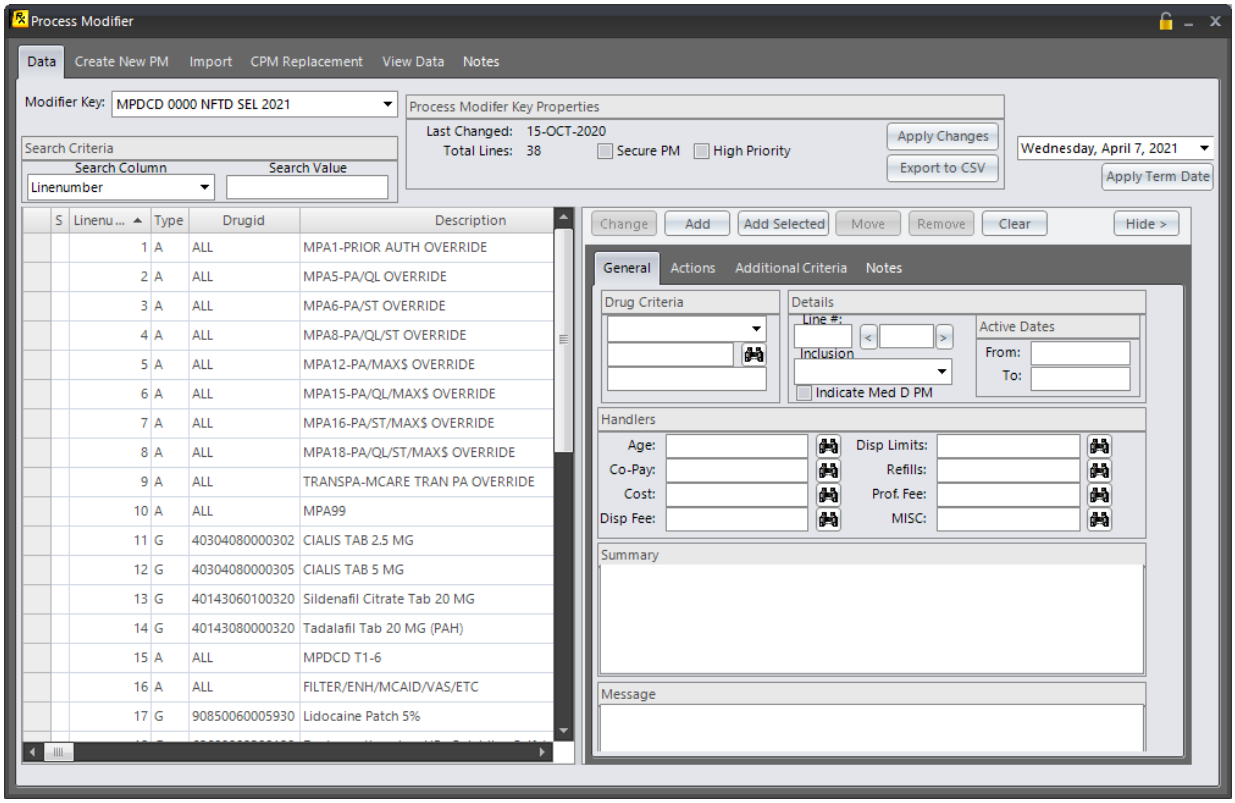
Appendix A-Plan Adjudication Configuration by Plan Sponsor Benefit Design: Adjudication Configuration for Clients with benefit design without lookback on Step Therapy Medications for a one time temporary fill of at least a month's supply (unless the enrollee presents with a prescription written for less than a month's supply) of automated transition fills for non-formulary, step therapy and prior authorization medications.

Non-Formulary Transitional Configuration:



- Non-Part D Drugs (i.e. Medicaid covered drugs) are assigned a tier of "C" or other non-numerical tier to ensure appropriate transition logic is applied to these drugs which could differ from Part D eligible drugs.


Process Modifier
Data
Create New PM
Import
CPM Replacement
View Data
Notes
Modifier Key:
MPDCD 0000 NFTD SGL 2021
Process Modifer Key Properties
Last Changed: 15-OCT-2020
Total Lines: 38
Secure PM
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Search Value
Linenumber
S
Linenu ...
Type
Drugid
Description
1 A ALL MPA1-PRIOR AUTH OVERRIDE
2 A ALL MPA5-PA/QL OVERRIDE
3 A ALL MPA6-PA/ST OVERRIDE
4 A ALL MPA8-PA/QL/ST OVERRIDE
5 A ALL MPA12-PA/MAX$ OVERRIDE
6 A ALL MPA15-PA/QL/MAX$ OVERRIDE
7 A ALL MPA16-PA/ST/MAX$ OVERRIDE
8 A ALL MPA18-PA/QL/ST/MAX$ OVERRIDE
9 A ALL TRANSPA-MCARE TRAN PA OVERRIDE
10 A ALL MPA99
11 G 40304080000302 CIALIS TAB 2.5 MG
12 G 40304080000305 CIALIS TAB 5 MG
13 G 40143060100320 Sildenafil Citrate Tab 20 MG
14 G 40143080000320 Tadalafil Tab 20 MG (PAH)
15 A ALL MPDCD T1-6
16 A ALL FILTER/ENH/MCAID/VAS/ETC
17 G 62609902300120 Dextromethorphan HBr-Quinidine Sulfate
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
Details
Line #:
Inclusion
Indicate Med D PM
Active Dates
From:
To:
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Message



- The Rx is then sent through a series of Formulary List filters to remove drugs from non-formulary transition consideration such as Medicaid, Enhanced, BVD, and actual formulary drugs. If it hits, then the claim is satisfied and it moves on to the next level of processing.
- If it is not part of one of the Formulary filters then the Rx is sent through a series of All Drugs lines setting transition tiers and day supply limitations.
    - The first 2 for exceptions based on level of care changes.
    - Then Smallest package size transition.
    - Then LTC, Assisted Living, and intermediate care.
    - The last line is set up to account for non-LTC.
- Transition lines are set up to indicate a specific tier (Set Tier to this → T), where the letter T is equal to the appropriate tier copayment/co-insurance for a non-formulary transitional drug.
- Each All Drugs line is set up to also account for the Rx Date in comparison to the member's Start date: *Apply Only If Match during GF days after Mem Start [90].*
- Based on the service code submitted and the relation in dates, the Rx will hit the appropriate line and the related actions/handlers will be applied.
- The duplication of all drug lines allows us to account for the following:
    - Day supply variations (Note: For MMPs, a 90 DS dispensing limit will be applied for

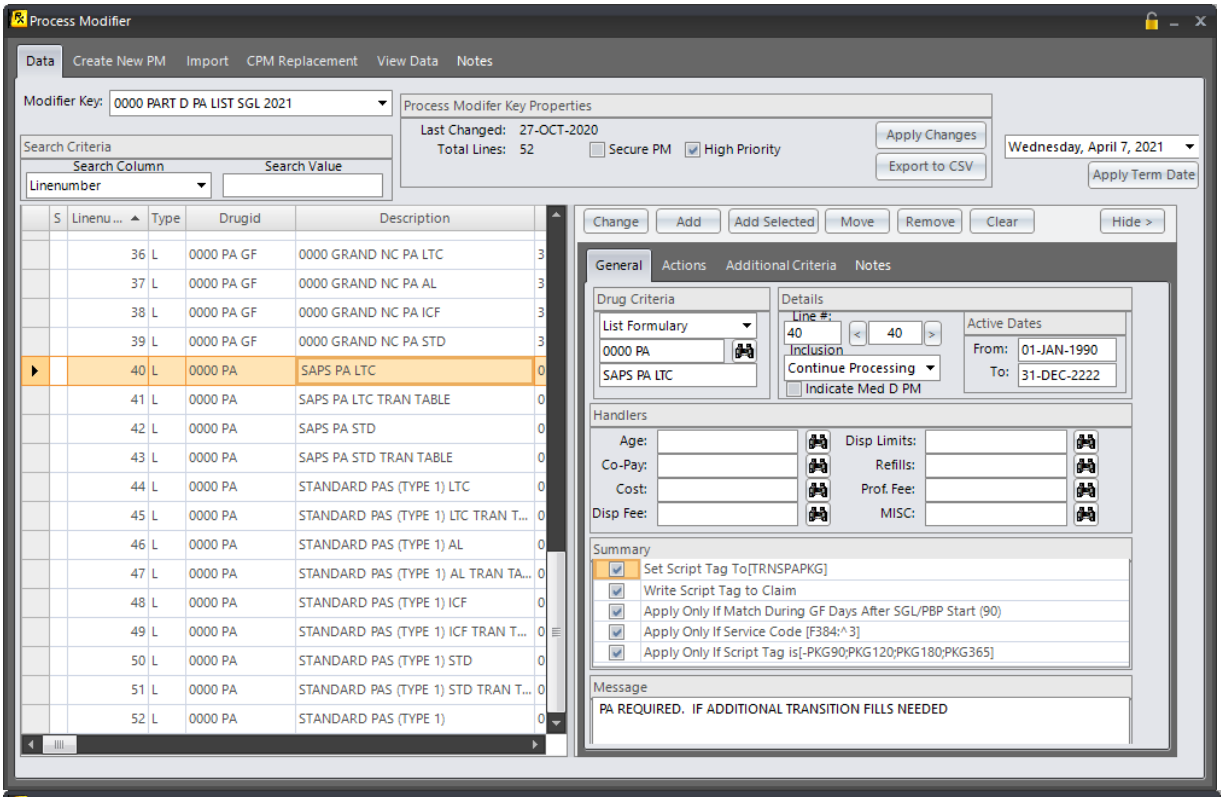
Medicaid-covered drugs which are indicated by a tier “C”).

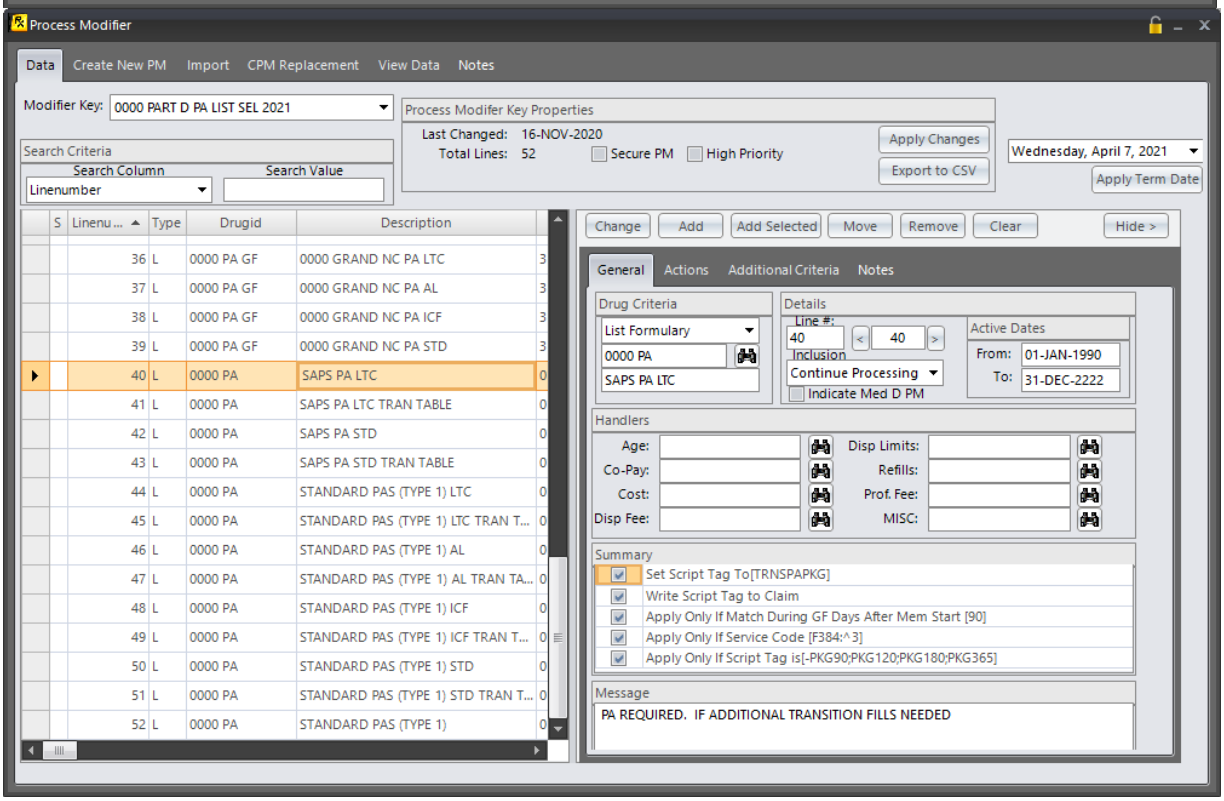
- If the RX is not part of one of the Formulary filters and the Rx Date is not within the first 90 days of members Start Date, the claim will pass through subsequent CPM’s and reject with NCPDP reject code MR, as well as with additional messaging that states “NON-FORMULARY DRUG. TRANSITIONAL PERIOD OVER. USE FORMULARY PRODUCT. Call ###-###-#### or log on to https://elixir.promptpa.com to initiate exception request.” This additional messaging is located on the XXXX20 NONFORM REJ common process modifier.

Prior Authorization and Step Therapy Transitional & Transitional LTC Accommodations

- The Prior Authorizations (PA) filters are created on the Plan Year 20## Prior Authorization List Process Modifier that looks at the member’s start date.
- If the system does not find a GPI match within 90 days of the start date of the member, then the claim hits the filter line and allows the Rx to go thru without requiring a PA.
- For medications that require a type 2 PA or ST, and are protected class drugs, the system will look for a GPI match within a minimum of 108 days of the start date of the member.
- For Transitional PA and Step Therapy (ST) non-LTC Claims, the member is allowed up to an accumulated one month supply within their first 90 days. This is done with a MISC Handler (handler name = ***TRANSD3 SEL PA/TRANSD3 SGL PA***) that is attached to all transitional PA/ST non-LTC claims. This handler allows the member up to a max of the Plan Sponsor’s one month supply within a non-LTC setting regardless of the number of prescriptions processed.
    - Each fill however is limited to a one month supply.
- For Transitional PA and Step Therapy LTC Claims, the member is allowed up to an accumulated one month supply within their first 90 days. This is done with a MISC Handler (handler name = ***TRANSD331 SEL PA/TRANSD331 SGL PA***) that is attached to all transitional PA/ST LTC claims.
- If the smallest available package size exceeds a one month supply), a transition fill for an appropriate day supply that exceeds these limits will be provided. Once outside of the member’s initial 90 days, the filter lines will no longer apply and the system will resume with the normal Prior Authorization/Step Therapy functionality if a prior authorization was not already obtained. (see section titled “CMS Notice of Appeal Rights” for additional information regarding Prior Authorization/Step Therapy functionality outside of members initial 90 days)
- If the member’s start date is different than 01/01/20XX, the 90 days can refresh from the new start date:
- If today the member start date is 4.1.2010, the filters will be active for the script(s) thru 6.30.2010.
- Each PA and ST criteria will need 5 lines.

Line 1 of PA logic:


Process Modifier
Data
Create New PM
Import
CPM Replacement
View Data
Notes
Modifier Key: 0000 PART D PA LIST SGL 2021
Process Modifer Key Properties
Last Changed: 27-OCT-2020
Total Lines: 52
Secure PM
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Search Value
Linenumber
S
Linenu...
Type
Drugid
Description
36 L 0000 PA GF 0000 GRAND NC PA LTC
37 L 0000 PA GF 0000 GRAND NC PA AL
38 L 0000 PA GF 0000 GRAND NC PA ICF
39 L 0000 PA GF 0000 GRAND NC PA STD
40 L 0000 PA SAPS PA LTC
41 L 0000 PA SAPS PA LTC TRAN TABLE
42 L 0000 PA SAPS PA STD
43 L 0000 PA SAPS PA STD TRAN TABLE
44 L 0000 PA STANDARD PAS (TYPE 1) LTC
45 L 0000 PA STANDARD PAS (TYPE 1) LTC TRAN T...
46 L 0000 PA STANDARD PAS (TYPE 1) AL
47 L 0000 PA STANDARD PAS (TYPE 1) AL TRAN TA...
48 L 0000 PA STANDARD PAS (TYPE 1) ICF
49 L 0000 PA STANDARD PAS (TYPE 1) ICF TRAN T...
50 L 0000 PA STANDARD PAS (TYPE 1) STD
51 L 0000 PA STANDARD PAS (TYPE 1) STD TRAN T...
52 L 0000 PA STANDARD PAS (TYPE 1)
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
List Formulary
0000 PA
SAPS PA LTC
Details
Line #:
40
40
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 01-JAN-1990
To: 31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Set Script Tag To[TRNSPAPKG]
Write Script Tag to Claim
Apply Only If Match During GF Days After SGL/PBP Start (90)
Apply Only If Service Code [F384:^3]
Apply Only If Script Tag is[-PKG90;PKG120;PKG180;PKG365]
Message
PA REQUIRED. IF ADDITIONAL TRANSITION FILLS NEEDED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Import
CPM Replacement
View Data
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Process Modifer Key Properties
Last Changed: 16-NOV-2020
Total Lines: 52
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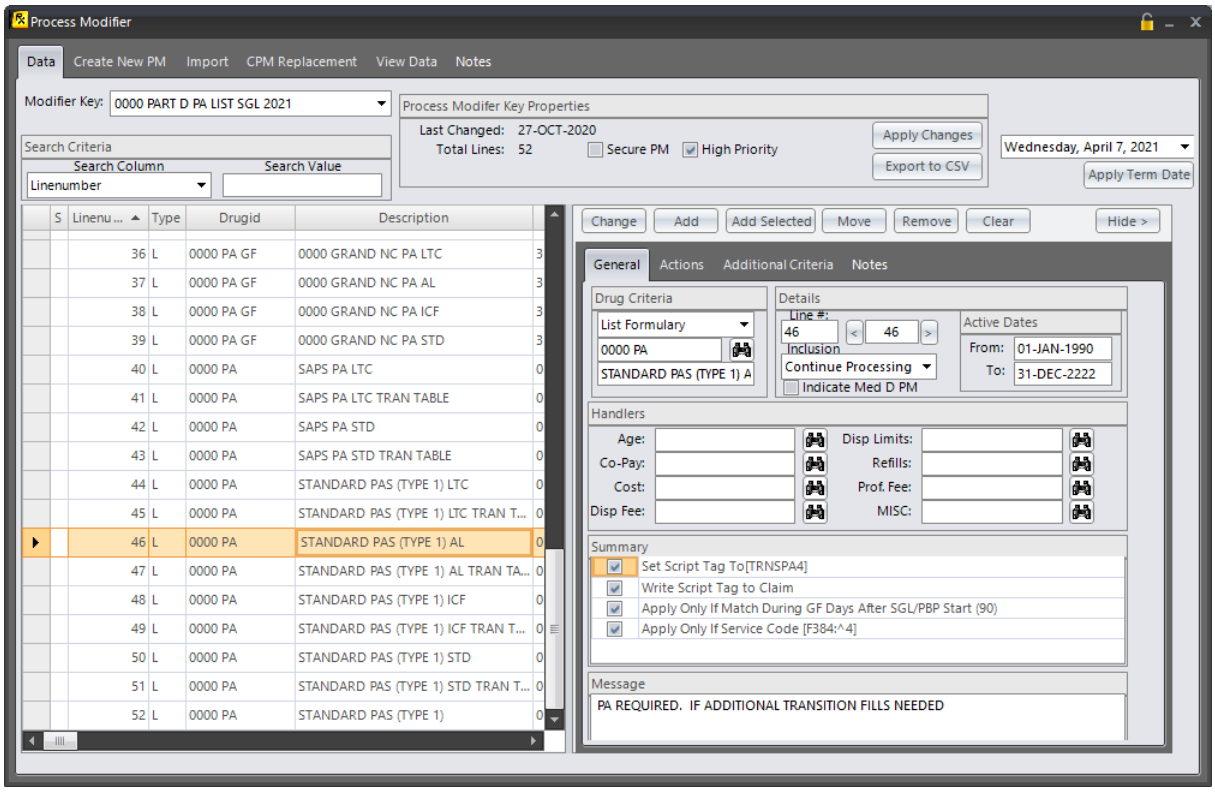
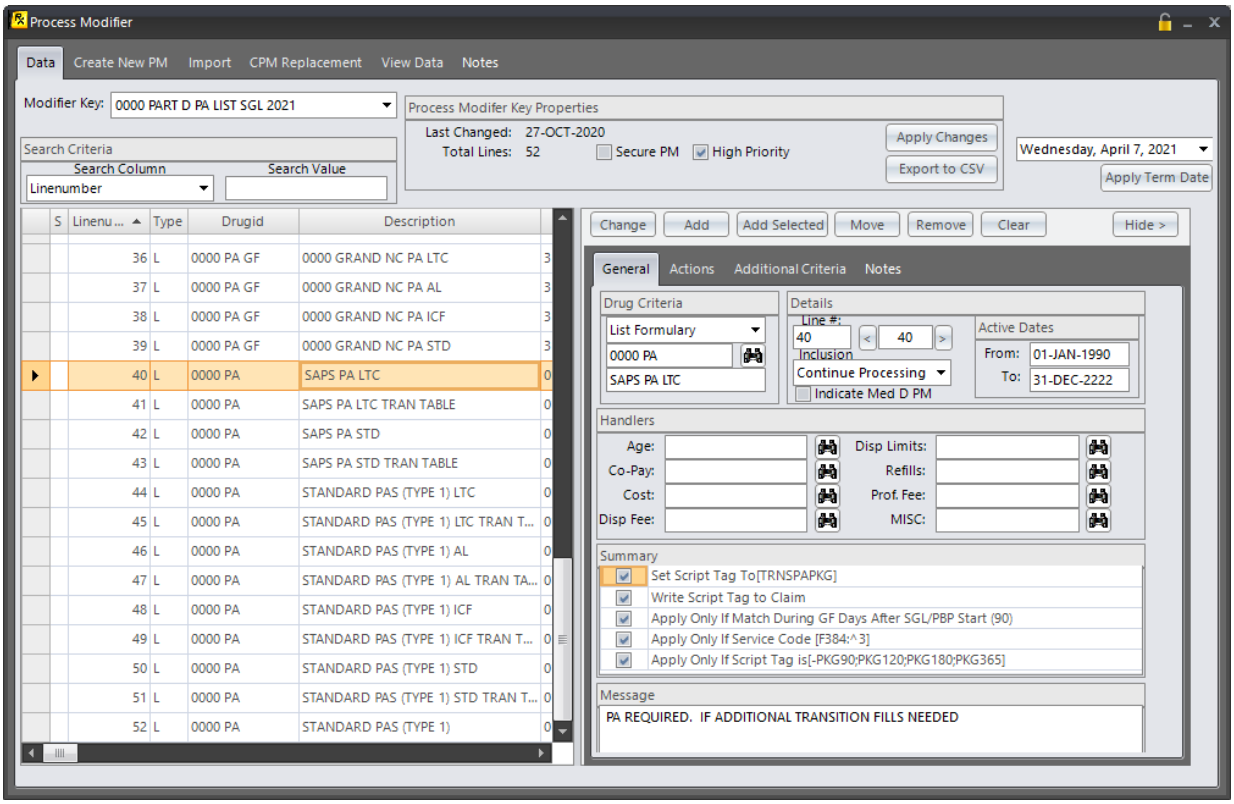
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Search Value
Linenumber
S
Linenu...
Type
Drugid
Description
36 L 0000 PA GF 0000 GRAND NC PA LTC
37 L 0000 PA GF 0000 GRAND NC PA AL
38 L 0000 PA GF 0000 GRAND NC PA ICF
39 L 0000 PA GF 0000 GRAND NC PA STD
40 L 0000 PA SAPS PA LTC
41 L 0000 PA SAPS PA LTC TRAN TABLE
42 L 0000 PA SAPS PA STD
43 L 0000 PA SAPS PA STD TRAN TABLE
44 L 0000 PA STANDARD PAS (TYPE 1) LTC
45 L 0000 PA STANDARD PAS (TYPE 1) LTC TRAN T...
46 L 0000 PA STANDARD PAS (TYPE 1) AL
47 L 0000 PA STANDARD PAS (TYPE 1) AL TRAN TA...
48 L 0000 PA STANDARD PAS (TYPE 1) ICF
49 L 0000 PA STANDARD PAS (TYPE 1) ICF TRAN T...
50 L 0000 PA STANDARD PAS (TYPE 1) STD
51 L 0000 PA STANDARD PAS (TYPE 1) STD TRAN T...
52 L 0000 PA STANDARD PAS (TYPE 1)
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
List Formulary
0000 PA
SAPS PA LTC
Details
Line #:
40
40
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 01-JAN-1990
To: 31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Set Script Tag To[TRNSPAPKG]
Write Script Tag to Claim
Apply Only If Match During GF Days After Mem Start [90]
Apply Only If Service Code [F384:^3]
Apply Only If Script Tag is[-PKG90;PKG120;PKG180;PKG365]
Message
PA REQUIRED. IF ADDITIONAL TRANSITION FILLS NEEDED

- The first line accounts for a LTC service code of 3 (*Apply Only if Service Code [F384:^3]*) and the fact that the member is within the first 90 days of their start date (*Apply Only if Match During GF days after Mem Start [90]*).
    - The MISC Hander **MUST** start with **TRANSD,**

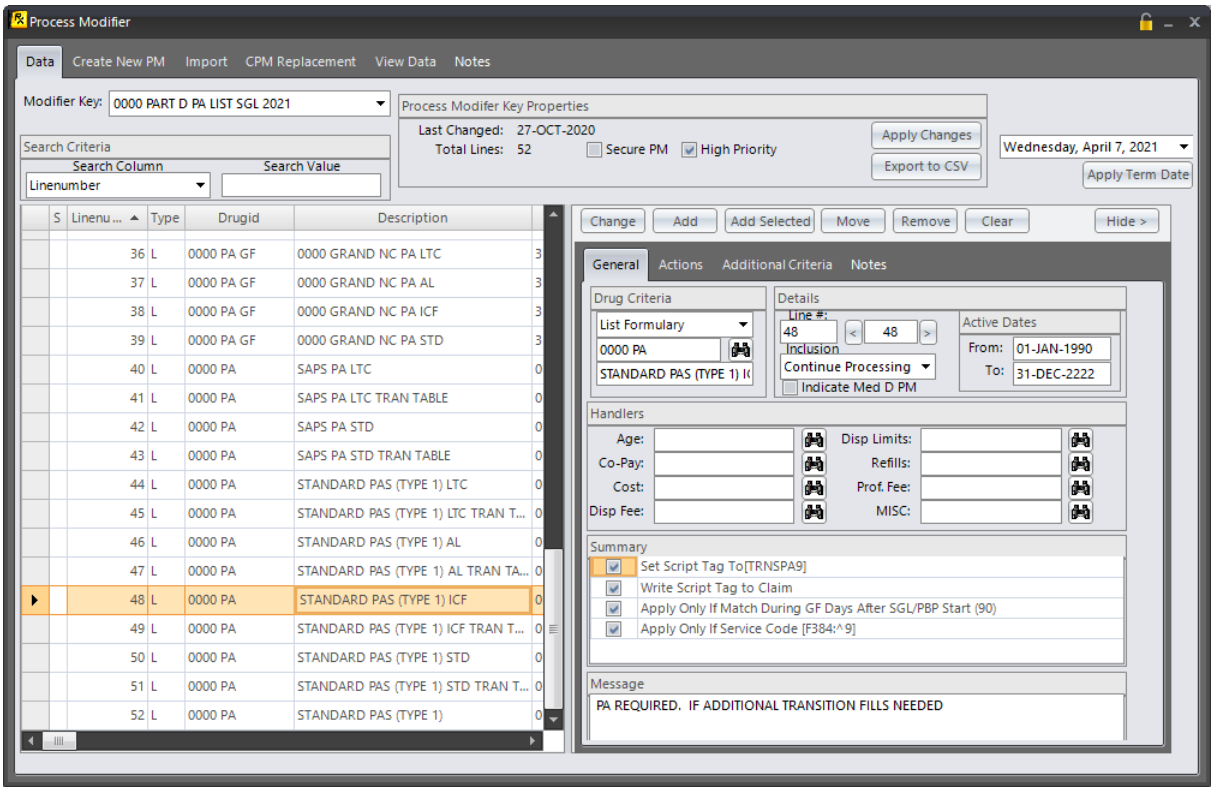
Line 2 of PA logic:

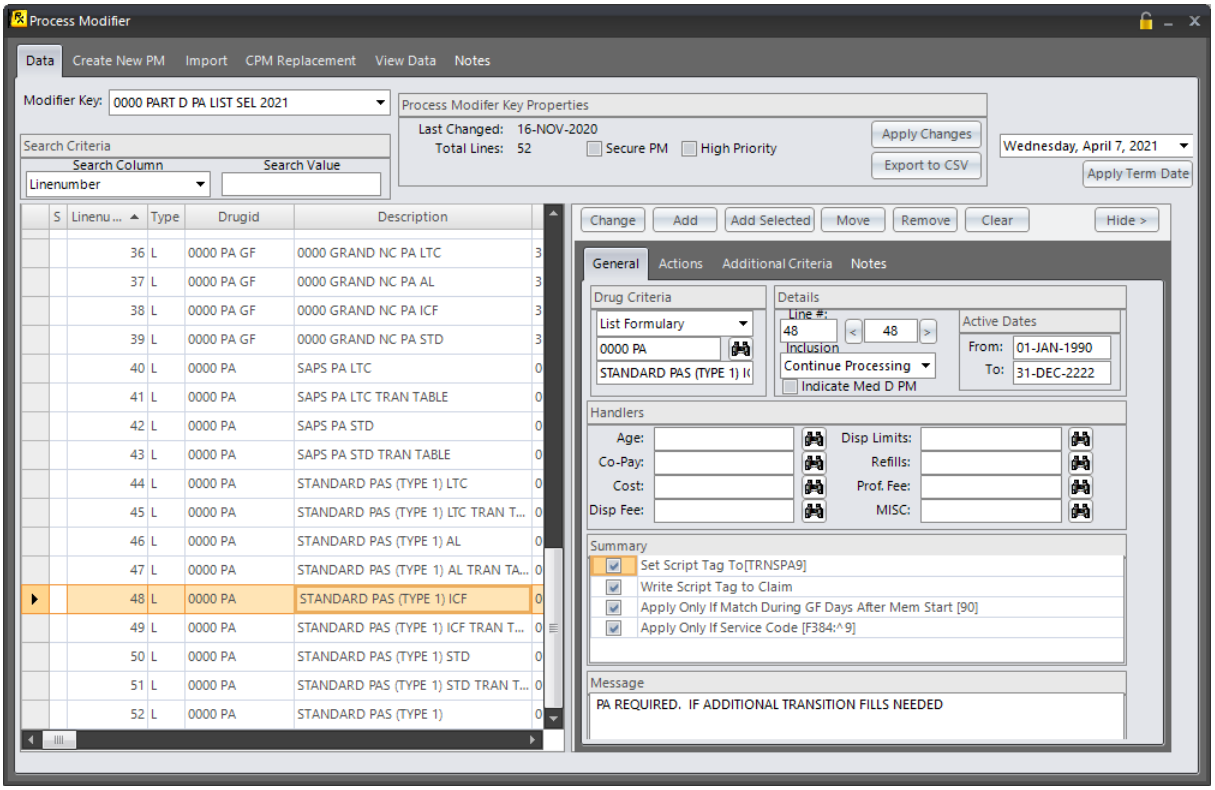




- The second line accounts for a LTC service code of 4 (Apply Only if Service Code [F384:^4]) and the fact that the member is within the first 90 days of their start date (Apply Only if Match During GF days after Mem Start [90]).
    - The MISC Hander MUST start with TRANSD.

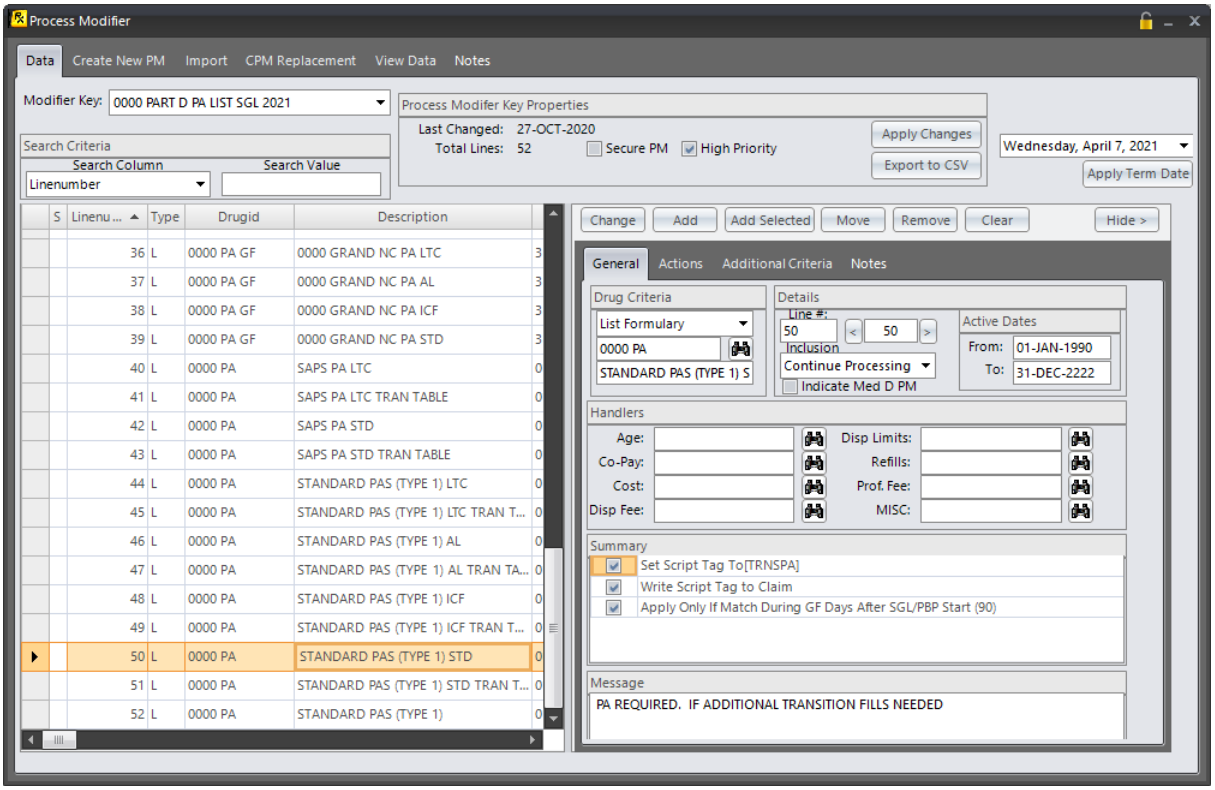
Line 3 of PA logic:





- The third line accounts for a LTC service code of 9 (Apply Only if Service Code [F384:^9]) and the fact that the member is within the first 90 days of their start date (Apply Only If Match during GF days after Mem Start [90]).
    - The MISC Hander MUST start with TRANSD.

Line 4 of PA logic:


Process Modifier
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Import
CPM Replacement
View Data
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Modifier Key: 0000 PART D PA LIST SGL 2021
Process Modifer Key Properties
Last Changed: 27-OCT-2020
Total Lines: 52
Secure PM
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Search Value
Linenumber
S
Linenu...
Type
Drugid
Description
36 L 0000 PA GF 0000 GRAND NC PA LTC
37 L 0000 PA GF 0000 GRAND NC PA AL
38 L 0000 PA GF 0000 GRAND NC PA ICF
39 L 0000 PA GF 0000 GRAND NC PA STD
40 L 0000 PA SAPS PA LTC
41 L 0000 PA SAPS PA LTC TRAN TABLE
42 L 0000 PA SAPS PA STD
43 L 0000 PA SAPS PA STD TRAN TABLE
44 L 0000 PA STANDARD PAS (TYPE 1) LTC
45 L 0000 PA STANDARD PAS (TYPE 1) LTC TRAN T...
46 L 0000 PA STANDARD PAS (TYPE 1) AL
47 L 0000 PA STANDARD PAS (TYPE 1) AL TRAN TA...
48 L 0000 PA STANDARD PAS (TYPE 1) ICF
49 L 0000 PA STANDARD PAS (TYPE 1) ICF TRAN T...
50 L 0000 PA STANDARD PAS (TYPE 1) STD
51 L 0000 PA STANDARD PAS (TYPE 1) STD TRAN T...
52 L 0000 PA STANDARD PAS (TYPE 1)
Change
Add
Add Selected
Move
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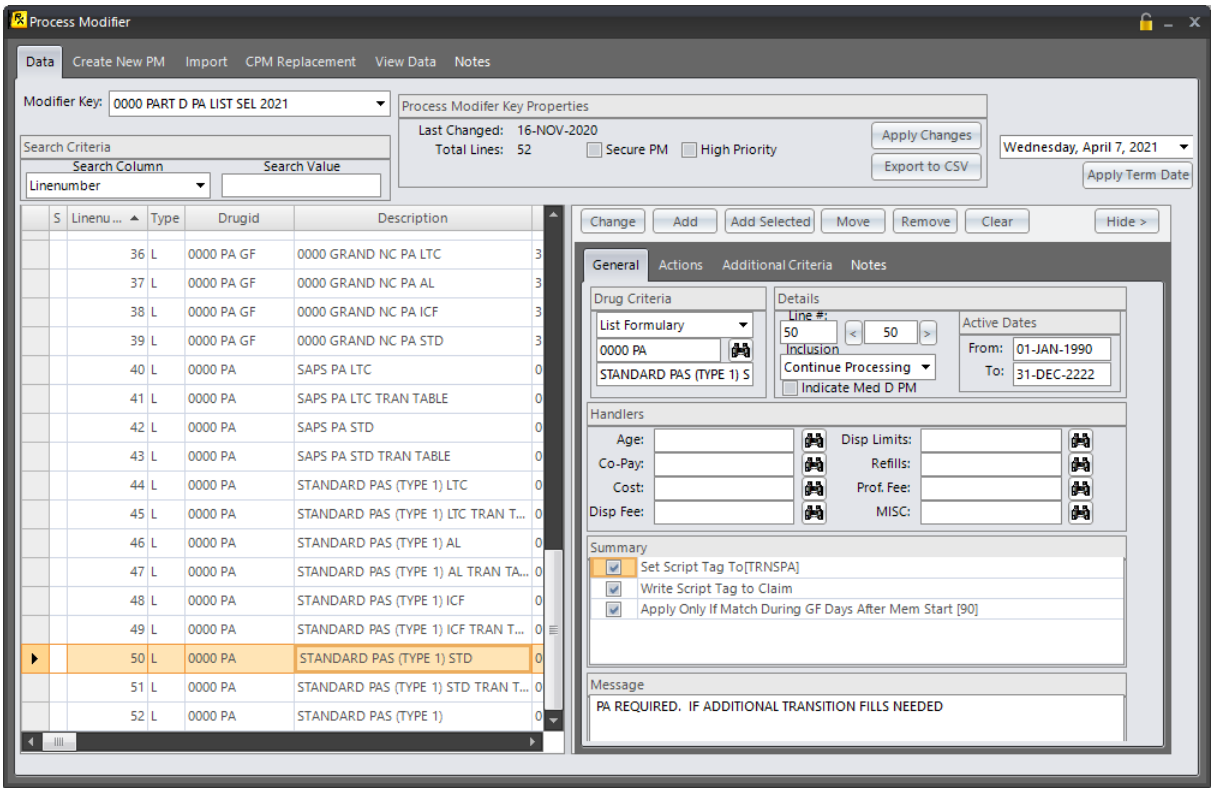
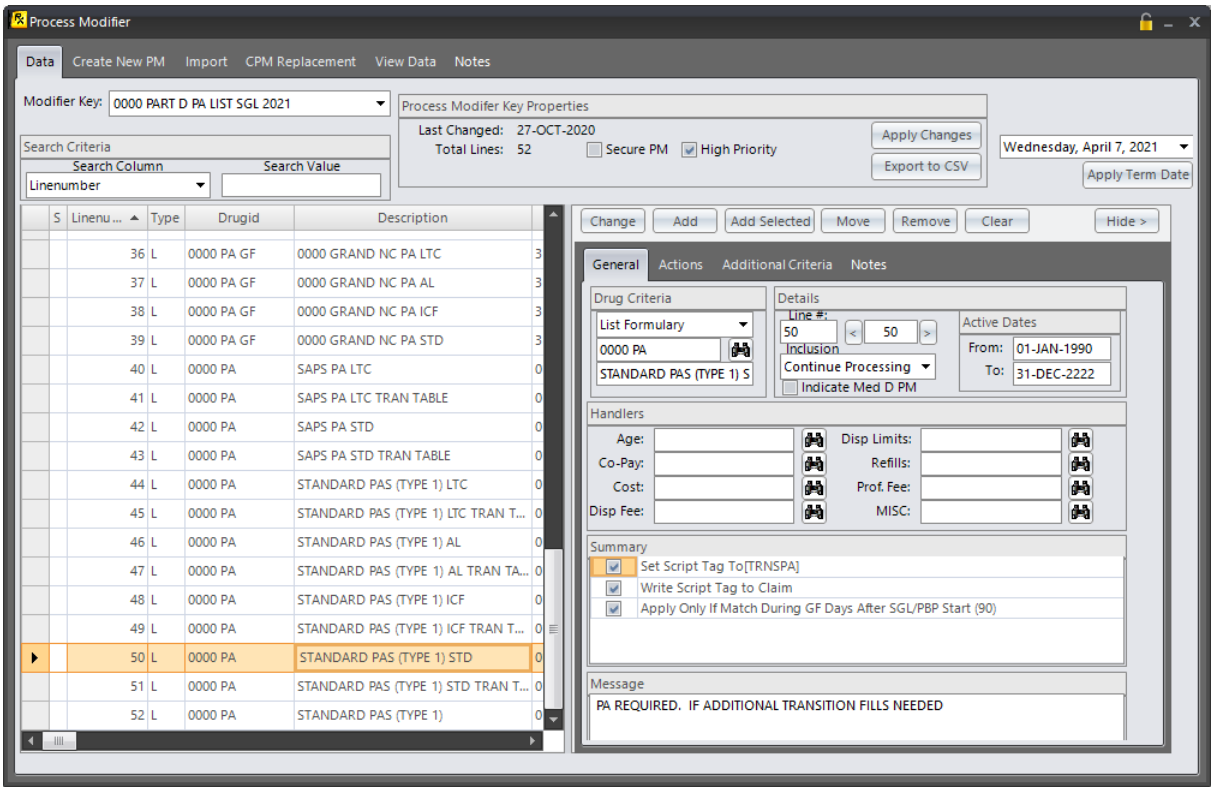
Actions
Additional Criteria
Notes
Drug Criteria
List Formulary
0000 PA
STANDARD PAS (TYPE 1) S
Details
Line #:
50
50
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 01-JAN-1990
To: 31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Set Script Tag To[TRNSPA]
Write Script Tag to Claim
Apply Only If Match During GF Days After SGL/PBP Start (90)
Message
PA REQUIRED. IF ADDITIONAL TRANSITION FILLS NEEDED



- The fourth line accounts for non - LTC claims that are within the first 90 days of the member's start date (*Apply Only if Match During GF days after Mem Start [90]*).
    - The MISC Hander **MUST** start with **TRANSD**.

Line 5 of PA logic:



- The fifth line accounts for all claims (regardless of LTC status) that are outside of the first 90 days of the member's start date.
    - This line provides back a reject 75 with the configured PA messaging.
    - See section titled "CMS Notice of Appeal Rights" for additional information regarding Prior Authorization/Step Therapy functionality outside of members initial 90 days.

Smallest Available Package Size (SAPS)

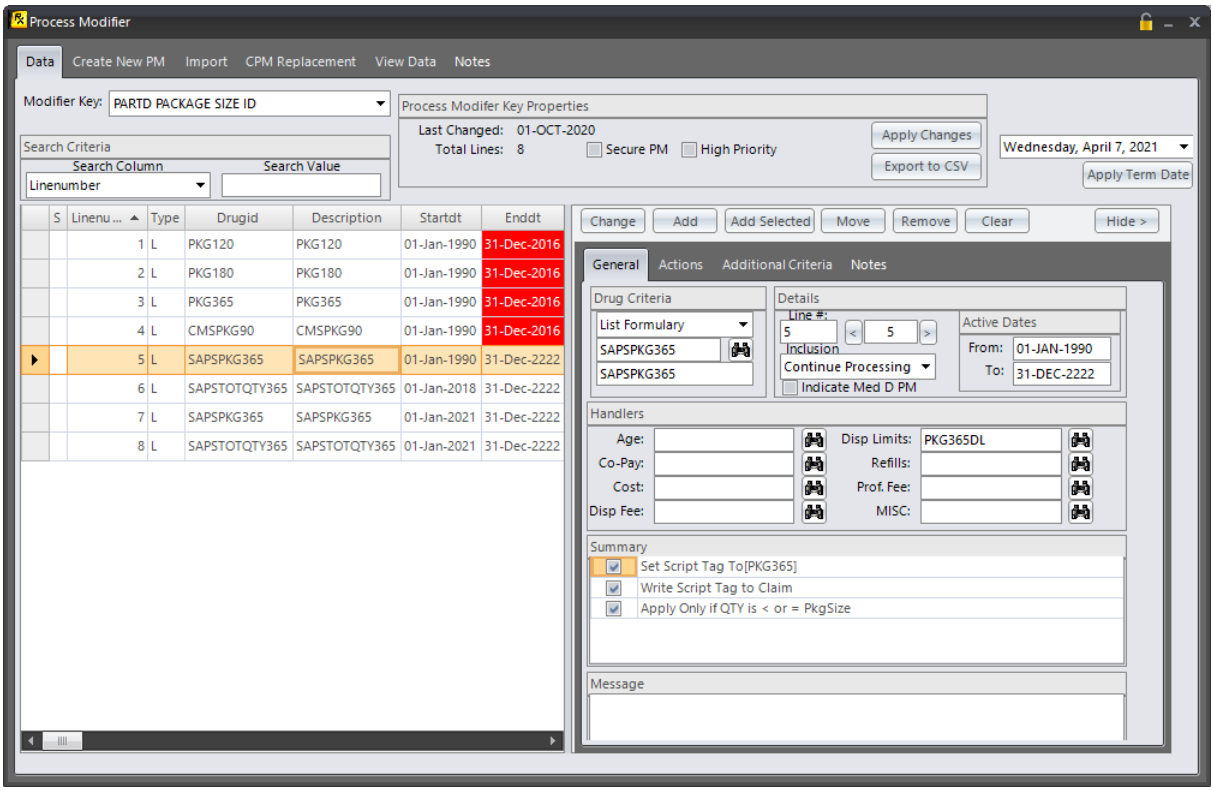
- Unbreakable/Smallest package size drug logic is configured to automatically allow a claim that is dispensed as the smallest package size available and whose day supply calculation based on prescribed directions exceed the day supply limitation set by the Plan.
- Formulary lists are used to identify drugs whose smallest available package size is commonly dispensed for a certain days supply:
    - SAPSPKG365 - SAPS where the total package quantity is commonly less than or equal to the package size
    - SAPSTOTQTY365 - SAPS where the quantity submitted is commonly less than or equal to the total package quantity

- The member's effective date on the enrollment file will be utilized to determine if they are within

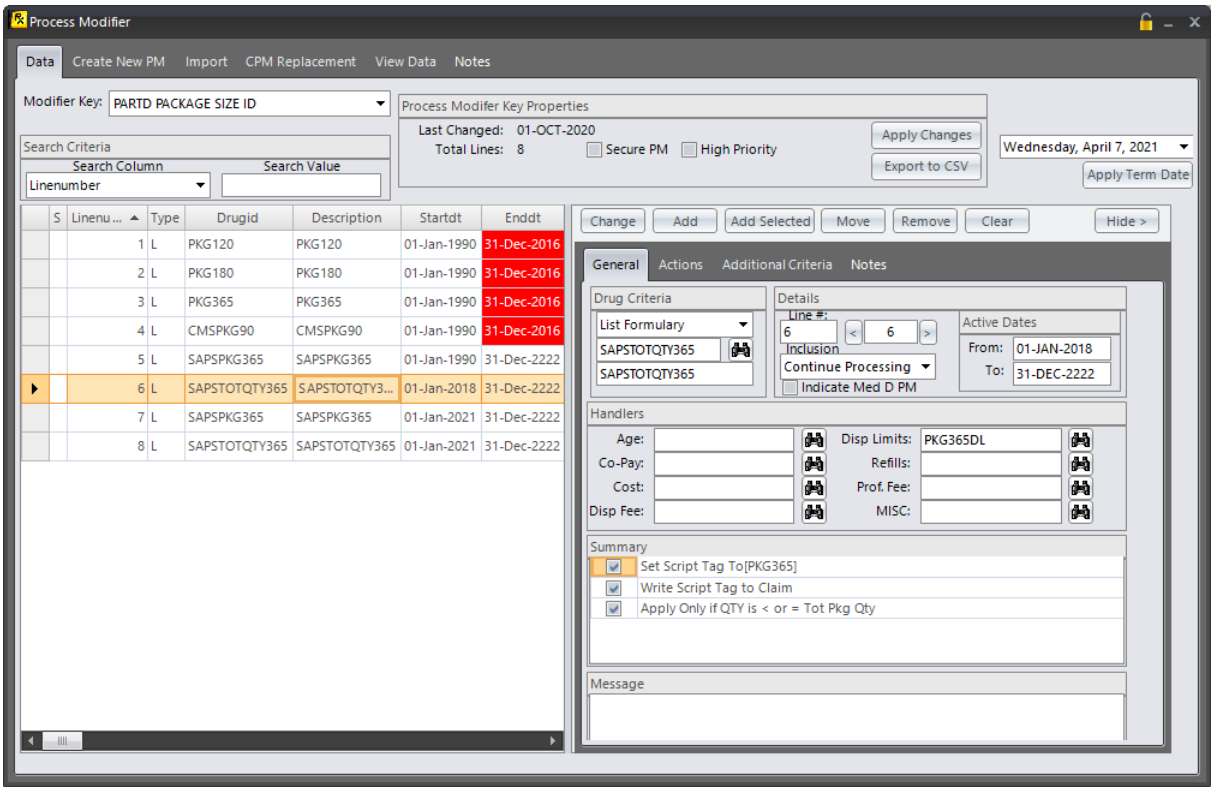
their first 90 days of initial enrollment with the Plan Sponsor and qualify for a transition fill.

- If the claim picks up a transitional script tag, it will be filtered through the plan and bypass other UM edits (NF, PA, ST, and QL) to allow the claim to pay. These fills will count as their own transition fill and will be assigned a unique Misc. Handler (***TRANSD3PKGxx***).
- UM edits are not overridden for SAPS outside of the transition period.
- SAPS claims will process up to 365 days. The 30 day transition limitation will be met if the SAPS transition claim pays for 30-365 day supply,
- Drugs that require a B vs D determination will reject to allow Payer determination to occur before granting a member the SAPS Dispensing Limit and transition logic.

Line 1:



Line 2:



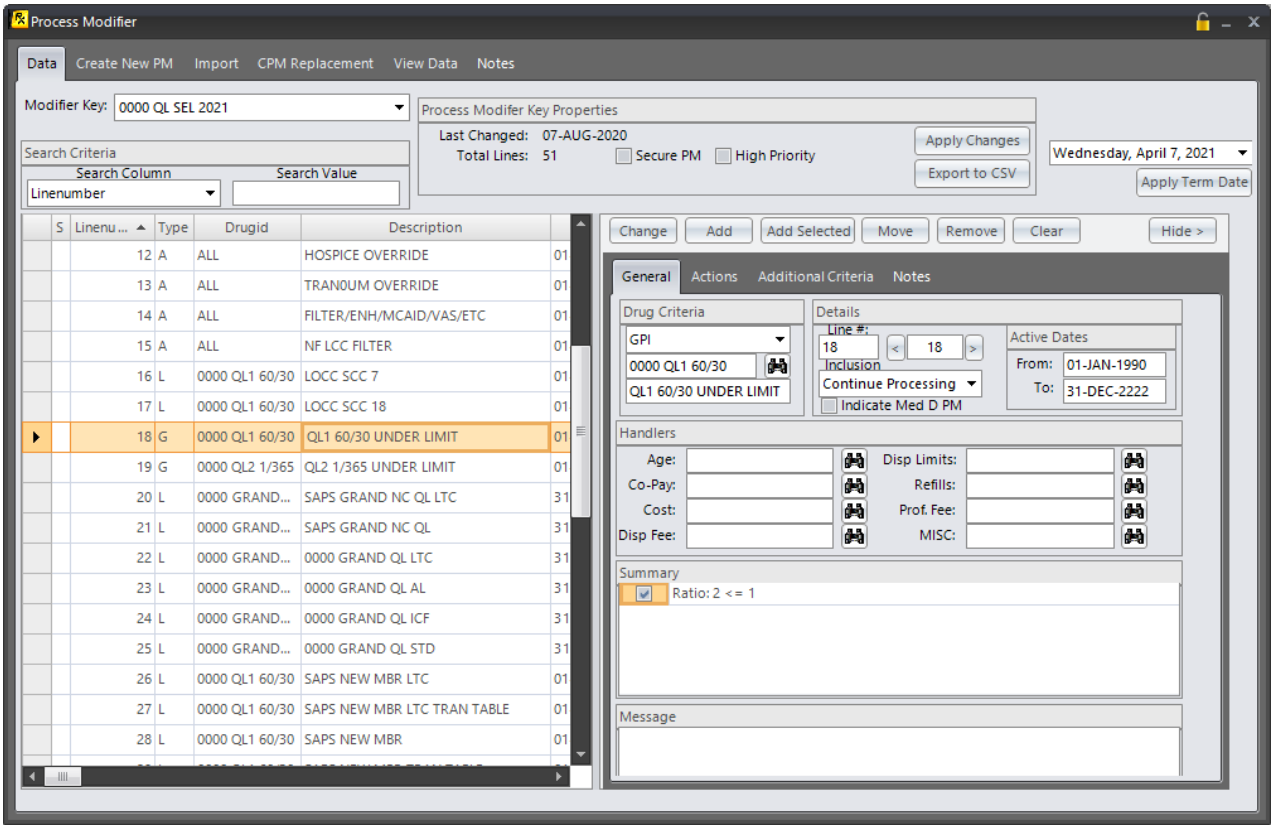
Quantity Limit (QL) Transitional Fills

- Quantity limit filters are created on the Plan Year 20## QL Process Modifier (0000 QL SEL 2020/ 0000 QL SGL 2020) that looks at the member's start date.
- If the system does not find a GPI match within 90 days of the start date of the member, or the claim is equal to or less than the filed QL the claim hits the appropriate filter line and allows the Rx to go thru without enforcing the filed QL.
- For Transitional QL non-LTC Claims, the member is allowed up to an accumulated one month's supply within their first 90 days. This is done with a MISC Handler (handler name = ***TRANSD3 SEL QL/ TRANSD3 SGL QL***) that is attached to all transitional QL non-LTC claims. This handler allows the member up to a max of the Plan Sponsor's one month supply within a non-LTC setting regardless of the number of prescriptions processed.
- Once outside of the member's initial 90 days, the filter lines will no longer apply and the system will resume enforcing the filed QLs (see section titled "CMS Notice of Appeal Rights" for additional information regarding QL functionality outside of members initial 90 days)
- If the member's start date is different than 01/01/20XX, the 90 days can refresh from the new start date
- If today the member start date is 4.1.2010, the filters will be active for the script(s) thru

6.30.2010.

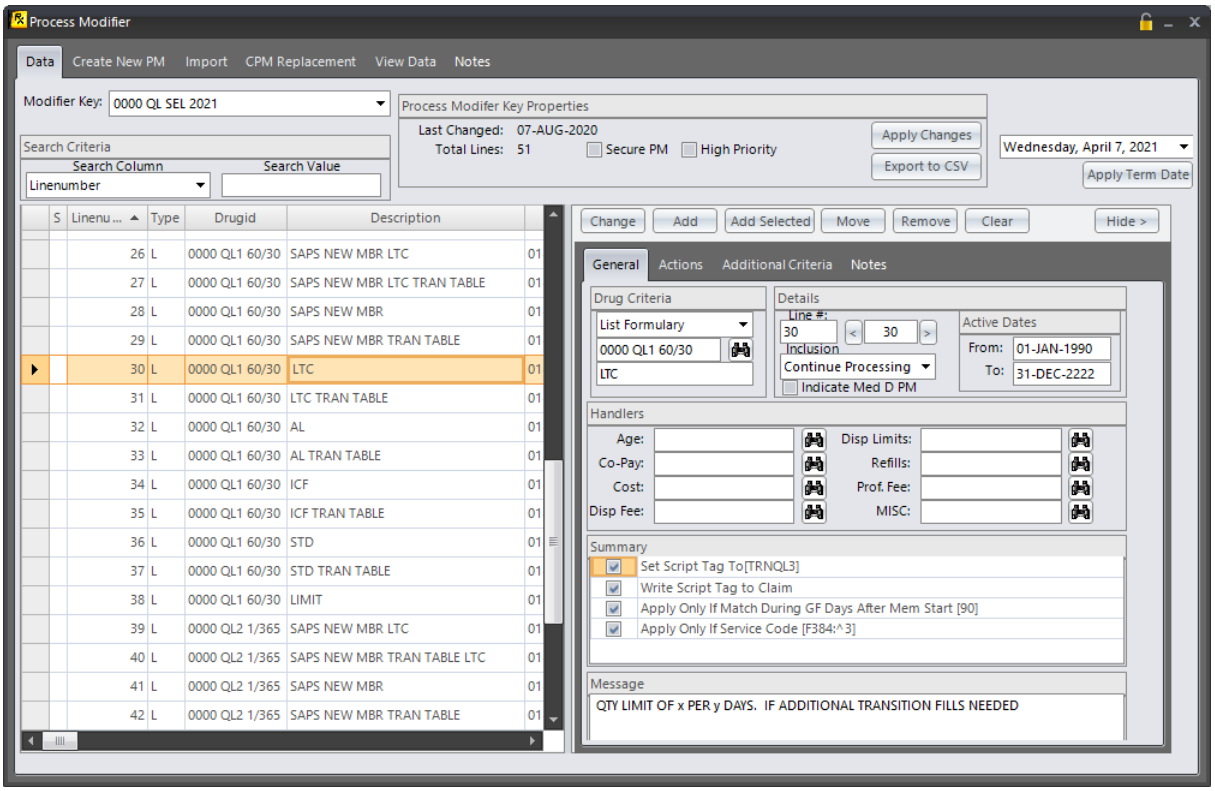
- Each QL criteria will need 6 lines.

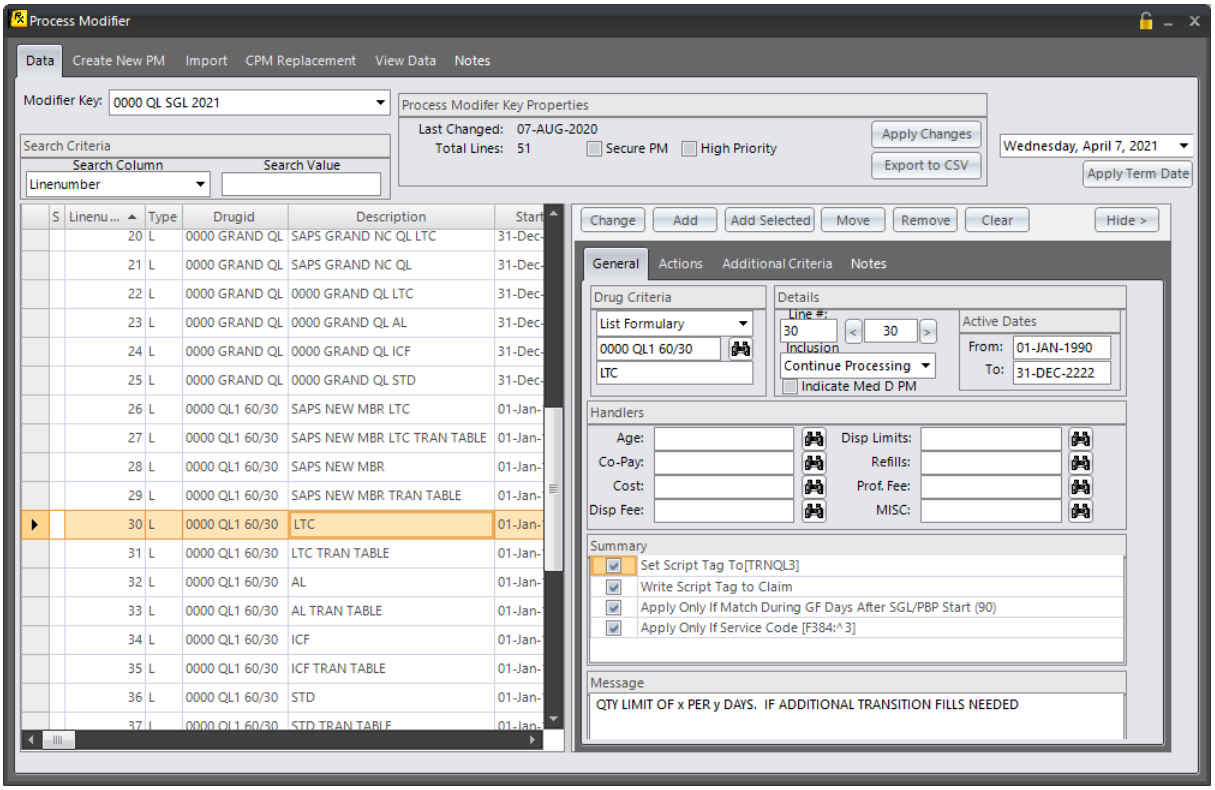
Line 1 of the QL logic:



- The first line accounts for claims submitted with a quantity/day supply that is equal to or less than the filed QL and will allow the Rx to go through without enforcing the filed QL or transition rules.

Line 2 of the QL logic:

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Import
CPM Replacement
View Data
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Process Modifer Key Properties
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Total Lines: 51
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Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Search Value
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Type
Drugid
Description
Start
20 L 0000 GRAND QL SAPS GRAND NC QL LTC 31-Dec-
21 L 0000 GRAND QL SAPS GRAND NC QL 31-Dec-
22 L 0000 GRAND QL 0000 GRAND QL LTC 31-Dec-
23 L 0000 GRAND QL 0000 GRAND QL AL 31-Dec-
24 L 0000 GRAND QL 0000 GRAND QL ICF 31-Dec-
25 L 0000 GRAND QL 0000 GRAND QL STD 31-Dec-
26 L 0000 QL1 60/30 SAPS NEW MBR LTC 01-Jan-
27 L 0000 QL1 60/30 SAPS NEW MBR LTC TRAN TABLE 01-Jan-
28 L 0000 QL1 60/30 SAPS NEW MBR 01-Jan-
29 L 0000 QL1 60/30 SAPS NEW MBR TRAN TABLE 01-Jan-
30 L 0000 QL1 60/30 LTC 01-Jan-
31 L 0000 QL1 60/30 LTC TRAN TABLE 01-Jan-
32 L 0000 QL1 60/30 AL 01-Jan-
33 L 0000 QL1 60/30 AL TRAN TABLE 01-Jan-
34 L 0000 QL1 60/30 ICF 01-Jan-
35 L 0000 QL1 60/30 ICF TRAN TABLE 01-Jan-
36 L 0000 QL1 60/30 STD 01-Jan-
37 L 0000 QL1 60/30 STD TRAN TABLE 01-Jan-
Change
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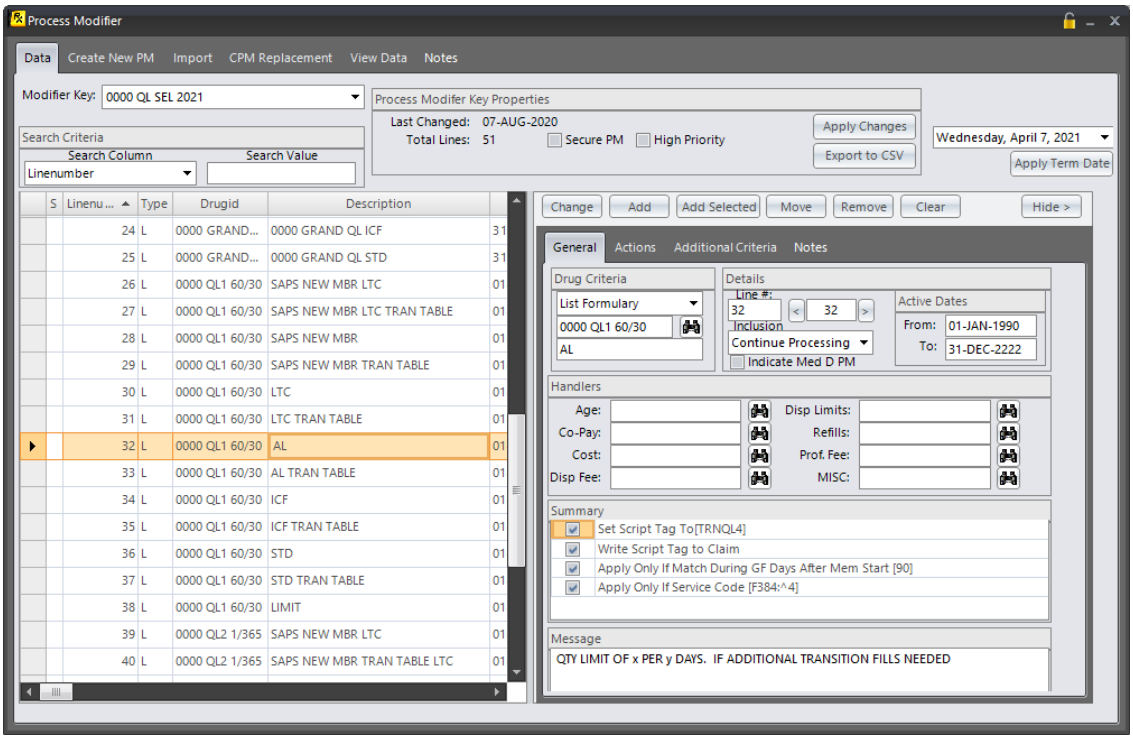
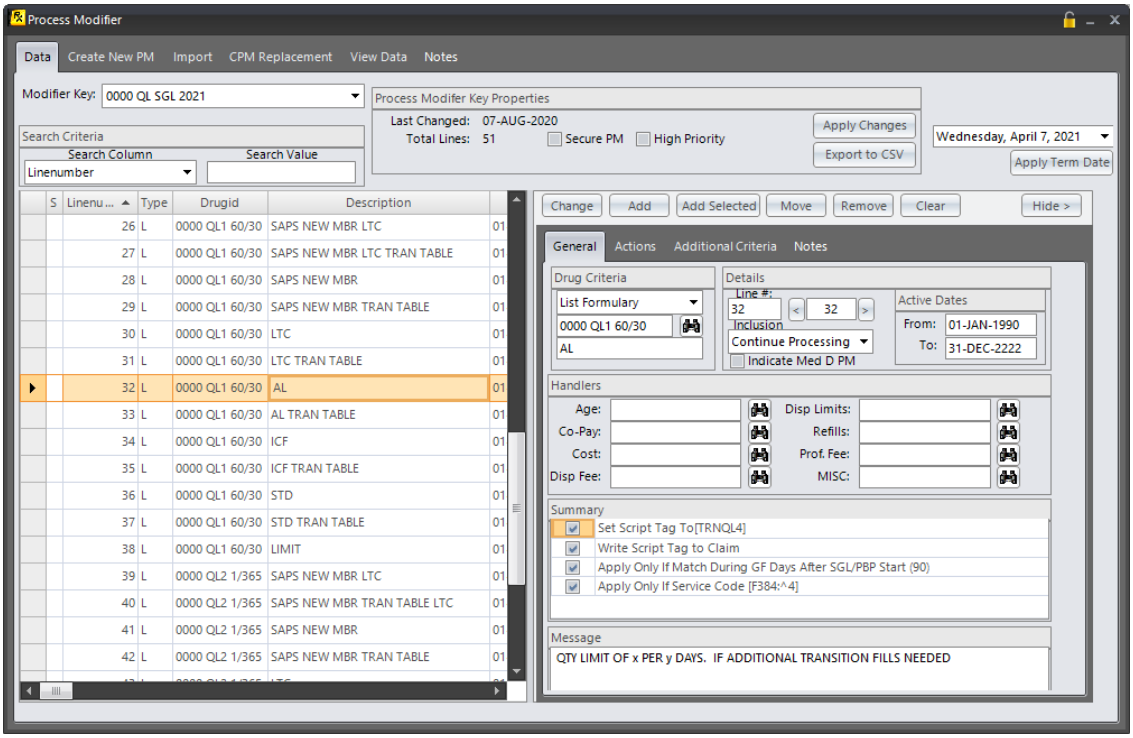
Additional Criteria
Notes
Drug Criteria
List Formulary
0000 QL1 60/30
LTC
Details
Line #:
30
30
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 01-JAN-1990
To: 31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Set Script Tag To[TRNQL3]
Write Script Tag to Claim
Apply Only If Match During GF Days After SGL/PBP Start (90)
Apply Only If Service Code [F384:^3]
Message
QTY LIMIT OF x PER y DAYS. IF ADDITIONAL TRANSITION FILLS NEEDED

- The second line accounts for a LTC service code of 3 (Apply Only if Service Code [F384:^3]) and the fact that the member is within the first 90 days of their start date.

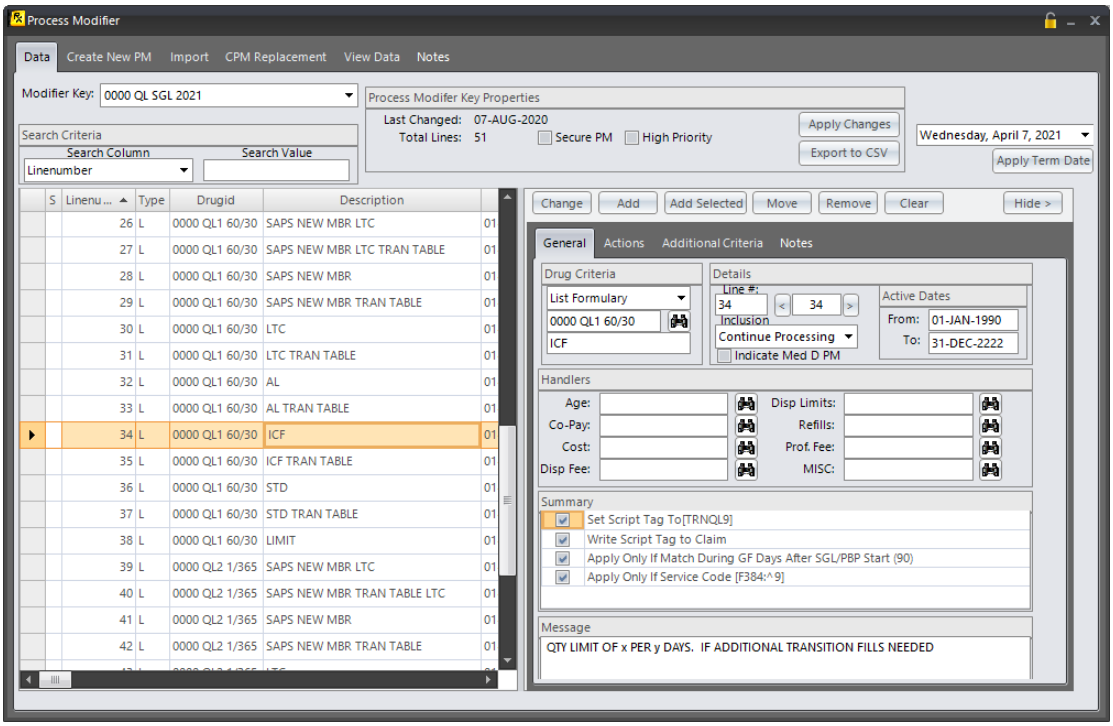
Line 3 of the QL logic:

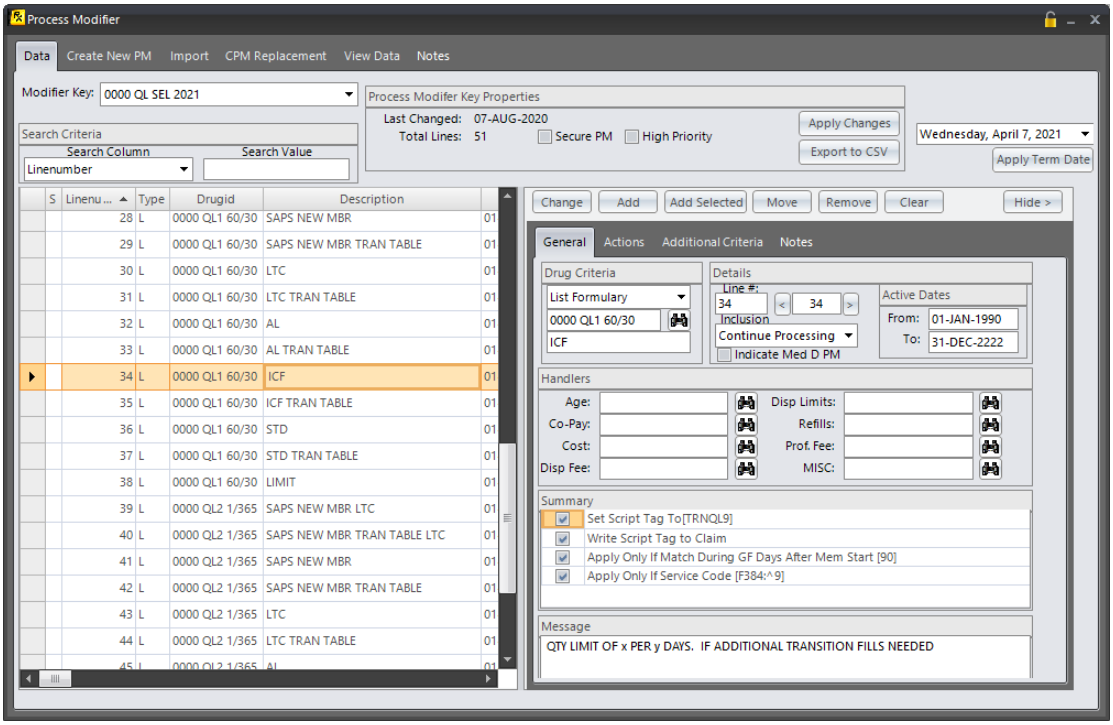



Process Modifier
Data
Create New PM
Import
CPM Replacement
View Data
Notes
Modifier Key: 0000 QL SGL 2021
Process Modifer Key Properties
Last Changed: 07-AUG-2020
Total Lines: 51
Secure PM
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Linenumber
Search Value
S
Linenu...
Type
Drugid
Description
26 L 0000 QL1 60/30 SAPS NEW MBR LTC
27 L 0000 QL1 60/30 SAPS NEW MBR LTC TRAN TABLE
28 L 0000 QL1 60/30 SAPS NEW MBR
29 L 0000 QL1 60/30 SAPS NEW MBR TRAN TABLE
30 L 0000 QL1 60/30 LTC
31 L 0000 QL1 60/30 LTC TRAN TABLE
32 L 0000 QL1 60/30 AL
33 L 0000 QL1 60/30 AL TRAN TABLE
34 L 0000 QL1 60/30 ICF
35 L 0000 QL1 60/30 ICF TRAN TABLE
36 L 0000 QL1 60/30 STD
37 L 0000 QL1 60/30 STD TRAN TABLE
38 L 0000 QL1 60/30 LIMIT
39 L 0000 QL2 1/365 SAPS NEW MBR LTC
40 L 0000 QL2 1/365 SAPS NEW MBR TRAN TABLE LTC
41 L 0000 QL2 1/365 SAPS NEW MBR
42 L 0000 QL2 1/365 SAPS NEW MBR TRAN TABLE
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
List Formulary
0000 QL1 60/30
AL
Details
Line #:
32
32
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 01-JAN-1990
To: 31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Set Script Tag To[TRNQL4]
Write Script Tag to Claim
Apply Only If Match During GF Days After SGL/PBP Start (90)
Apply Only If Service Code [F384:^4]
Message
QTY LIMIT OF x PER y DAYS. IF ADDITIONAL TRANSITION FILLS NEEDED

- The third line accounts for a LTC service code of 4 (*Apply Only if Service Code [F384:^4]*) and the fact that the member is within the first 90 days of their start date.

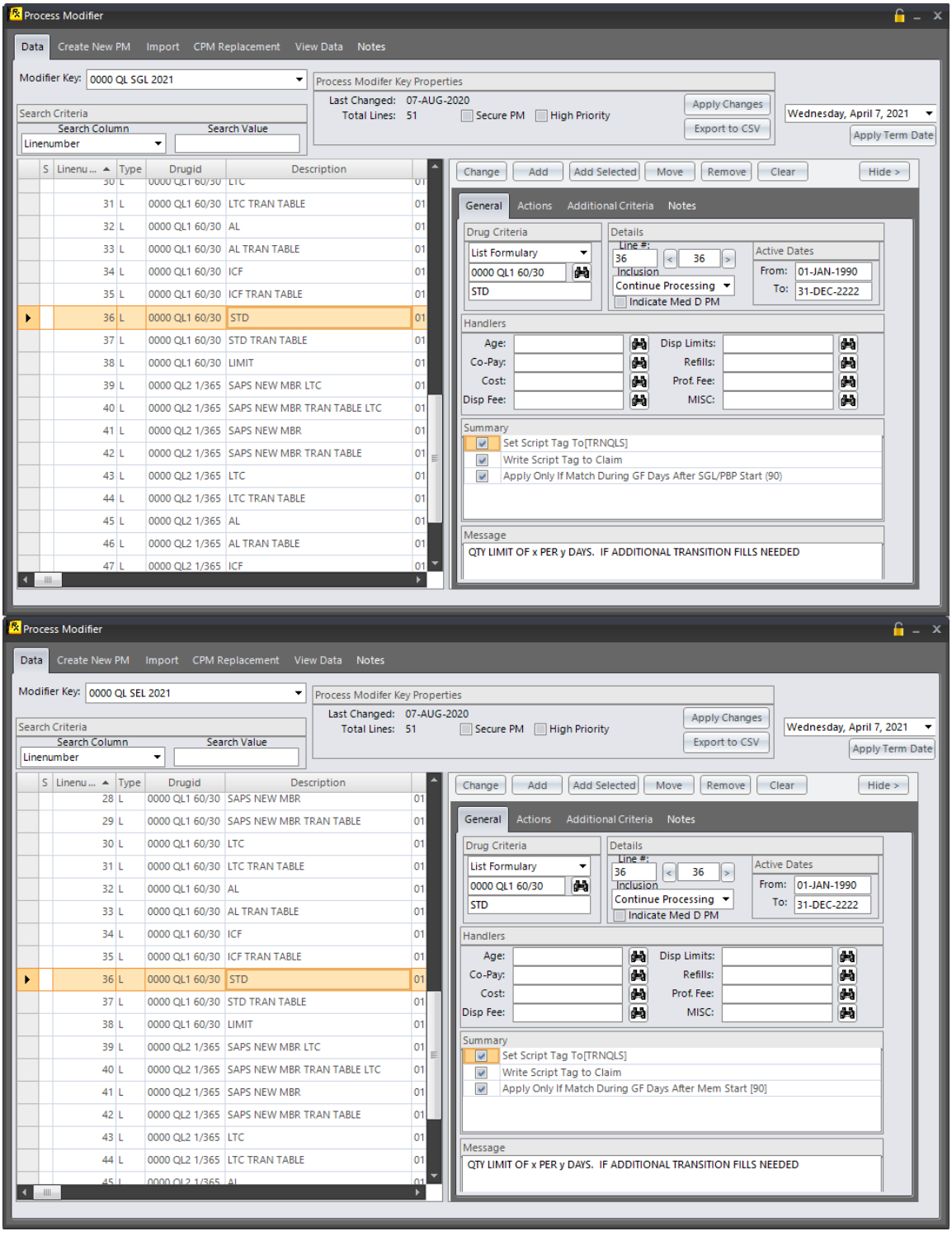
Line 4 of the QL logic:





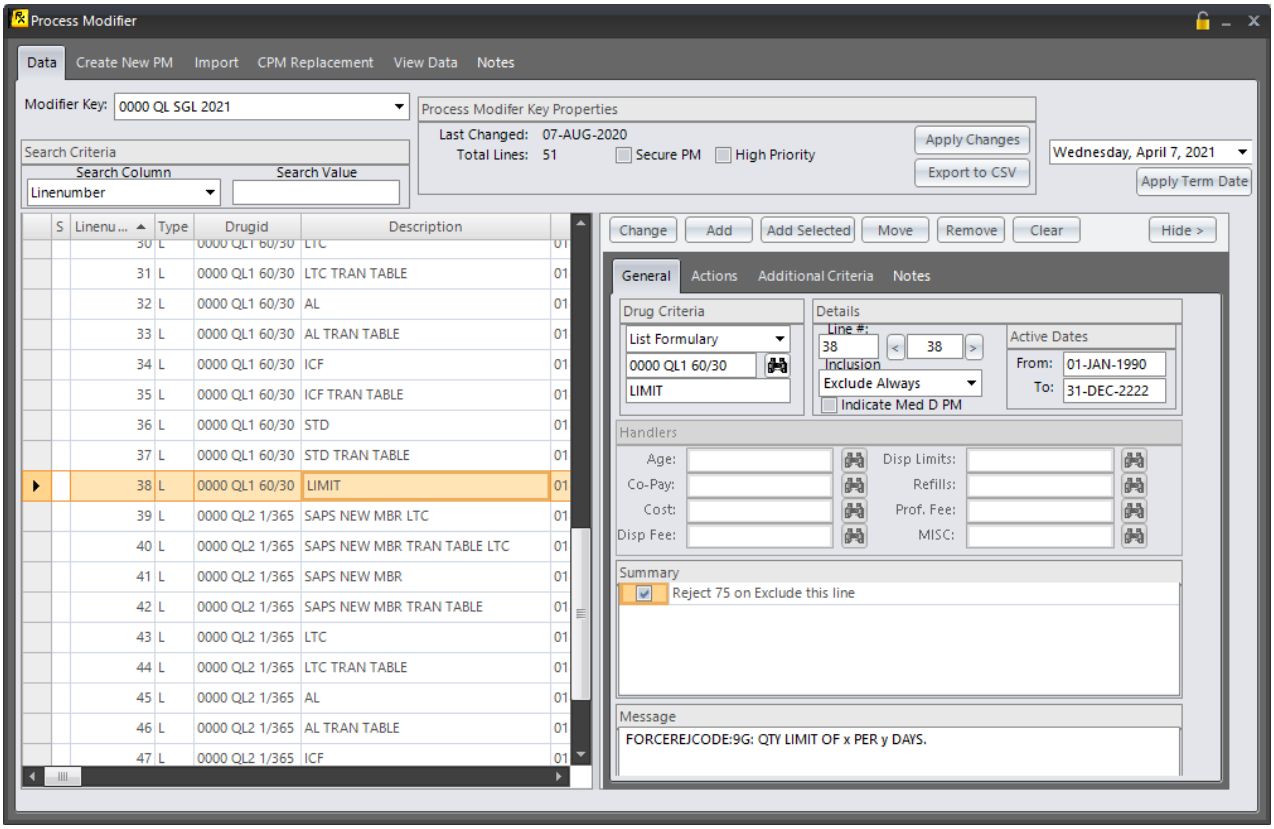
- The fourth line accounts for a LTC service code of 9 (*Apply Only if Service Code [F384:^9]*) and the fact that the member is within the first 90 days of their start date.

Line 5 of the QL logic:



- The fifth line accounts for non-LTC claims that are within the first 90 days of the member's start date.

Line 6 of the QL logic:



- The sixth line accounts for all claims (regardless of LTC status) that are outside of the first 90 days of the member's start date.
    - This line provides back a reject 9G with the configured PA messaging, if the claim is above the filed quantity limit.
    - See section titled "CMS Notice of Appeal Rights" for additional information regarding QL functionality outside of members initial 90 days).

Please Note:

- Any MISC Handler created for transitional purposes MUST have a naming convention that starts with **TRANSD3**. This handler will NOT drive Copays.
- The pharmacy is notified when transition medication is processed at the point of sale via pharmacy messaging placed in the claims adjudication system.
    - For Paid Claims
        - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2016 and forward for drugs subject to prior authorization will be: **PA REQUIRED, OR FOR ADDITIONAL LTC/TRANSITIONAL OVERRIDES CALL**

          ###-###-####
        - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2016 and forward for drugs subject to step therapy will be: **MUST HAVE TRIED**

          & FAILED DRUG BEFORE DRUG . CALL ###-###-#### FOR ADDITIONAL LTC FILLS
        - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2016 and forward for drugs that are non-formulary will be: **TRANSITIONAL FILLS/DRUGS ONLY ALLOWED ## DAY SUPPLY.CALL ###-###-#### FOR ADDITIONAL TRANSITION or LTC TRANSITIONAL FILLS/DRUGS ONLY ALLOWED ONE MONTH SUPPLY. CALL ###-###-#### FOR ADDITIONAL TRANSITION FILLS.**
    - For Rejected Claims
        - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2016 and forward for drugs subject to prior authorization will be: **PA REQUIRED. Call ###-###-#### or log on to https://elixir.promptpa.com to initiate exception request.**
        - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2016 and forward for drugs subject to step therapy will be: **MUST HAVE TRIED**

          & FAILED__BEFORE___. Call ###-###-#### or log on to https://elixir.promptpa.com to initiate exception request.
        - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2016 and forward for drugs that are non-formulary will be: **NON-FORMULARY DRUG. TRANSITIONAL PERIOD OVER. USE FORMULARY PRODUCT. Call**

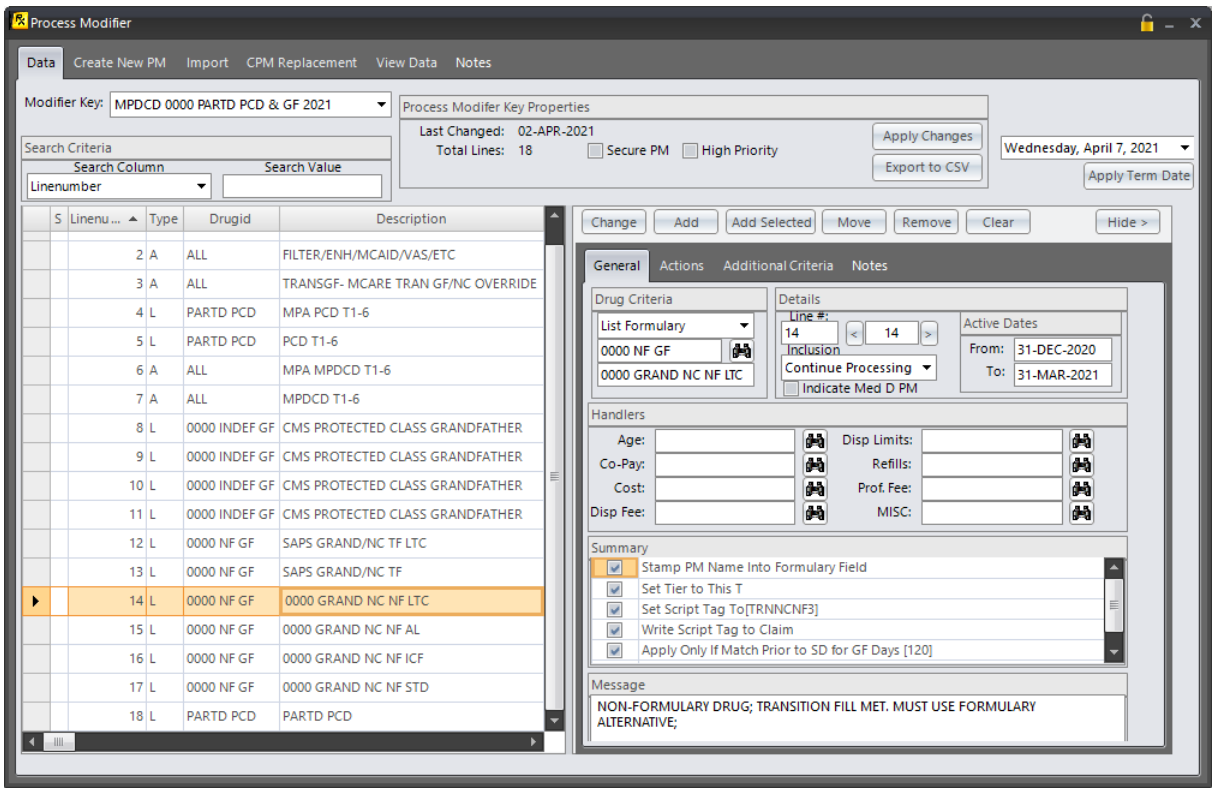
###-###-#### or log on to https://elixir.promptpa.com to initiate exception request.

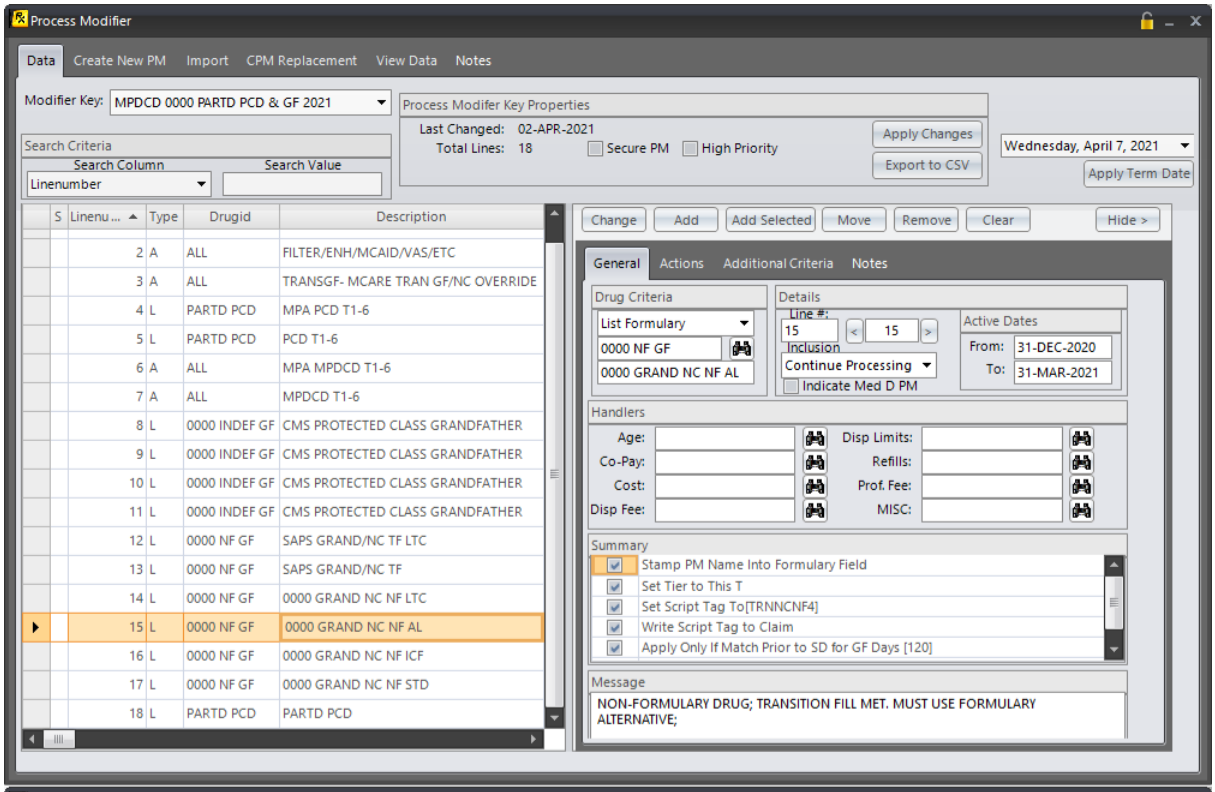
TRANSITION ACROSS PLAN YEARS FOR NEGATIVE FORMULARY CHANGES FOR CURRENT MEMBERS PHARMACY CLAIMS ADJUDICATION DETAIL

- For any drugs that become non-formulary from one plan year to the next or require a new step therapy or prior authorization within the new plan year, programming for grandfathering will be configured to allow existing members who had these drugs in their history to get up to an accumulated one month's supply transitional fill within the first 90 days of the benefit year.
- A formulary list is created and named 0000 NF GF for the drugs that have become non-formulary or have a new prior authorization or step therapy for the new-year. A formulary list should be created for each type of negative change. These formulary lists become filters within the MPDCD 0000 PARTD PCD & GF XXYY process modifier. The filters built within, allow the drugs to be treated as formulary for a transitional fill for any existing member with this drug in their history prior to the new-year.
- The tier assigned for non-formulary medications is defined by the plan and is indicated on this Common Process Modifier for non-formulary transitional fills along with the accumulated one month's supply only dispensing limits.
- The Grandfathering list is attached to a Common Process Modifier with specified rules to allow up to an accumulated one month's supply fill and indicates messaging that this is a transitional fill for the transitional period for these members.
- If the system finds a match for a drug on the Grandfathered List within the window or days going back in history (look-back period is a minimum of 108 days or as defined by the Plan Sponsor) of the new benefit year or the GF start Date go back in history, then the claim hits the transitional GF PM (filter line) and allows the Rx to go thru.
- The drug will have been be flagged as the plan's designated tier on the grandfather formulary list. This will allow the drug to continue processing within the Gross Covered Drug Cost (PPP) and TrOOP amount (PTR) Process Modifiers on the plan and attribute to the PPP (see #2) and PTR (see #3) values for this fill and include it as a PART D covered drug.
- When a transitional fill is adjudicated, a transitional letter is generated via a crystal report. This is accomplished by selecting a "Stamp PM Name into Formulary Field" checkbox edit. All claims that are "flagged" by this edit are pulled for transitional letters (see Stamp PM Name into Formulary Field shown below) (#1 D)
- Script tags are used to identify the type of transition fill (e.g. Prior Authorization, Step Therapy, Quantity Limit, Non-Formulary Part D drug) as well as LTC or non-LTC. These script tags are included on the crystal report and used to identify the appropriate transition letter language.
- Once outside of the member's initial 90 days, the filter line will no longer apply and the system will resume with the rejection for NON-formulary Drug not covered (rej MR). – also see section titled "CMS Notice of Appeal Rights" for additional information)

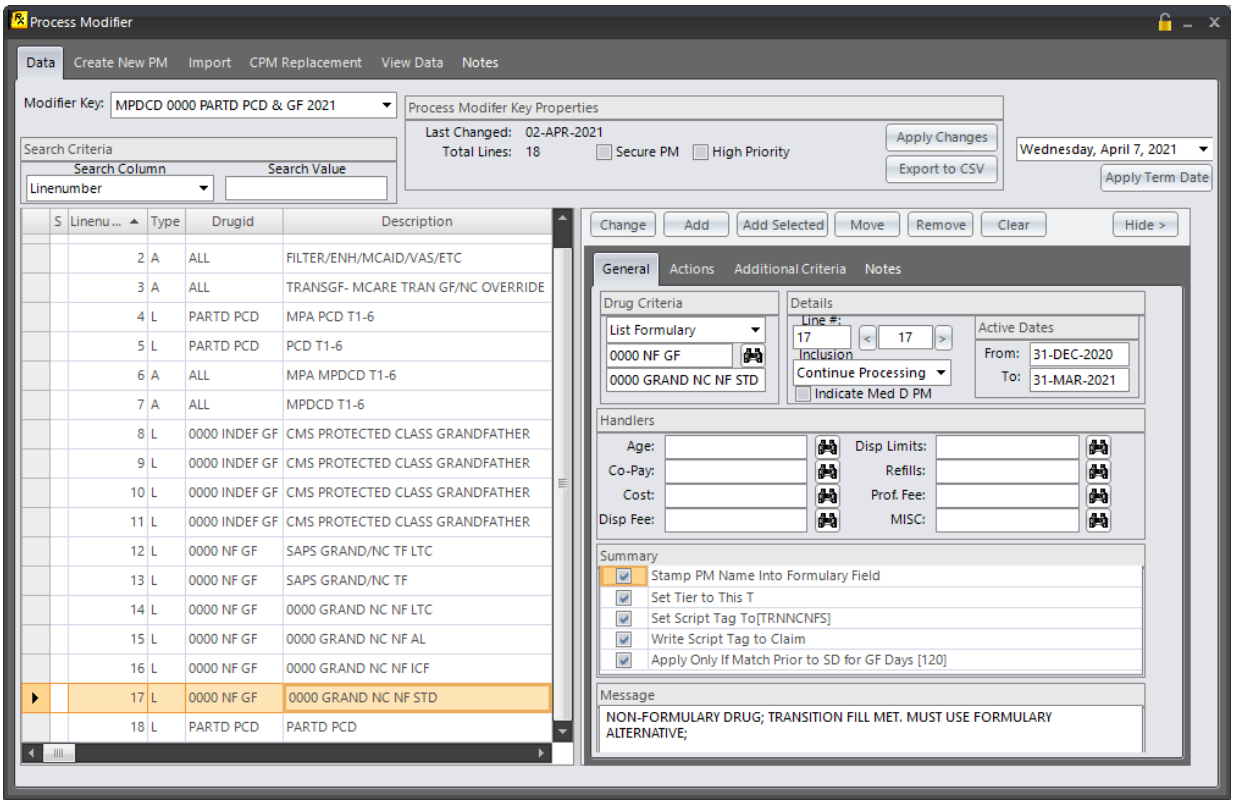
- Remember, if the member's history does not go back the allotted window, they are not eligible for this grandfathering fill.
    - The start date is 1.1.20**, for this rule to look back in history.
    - This will only allow a 1 time fill within the first 90 days of the benefit year and terms as of 3/31/20**
- In the LTC setting, additional transition fills outside of the accumulated one month's supply automated fill at this time will require the pharmacy to call Customer Service to request additional manual overrides.
- The logic in the system and looks like this:

#1-Process Modifiers showing Grandfather lists (negative changes – current members):

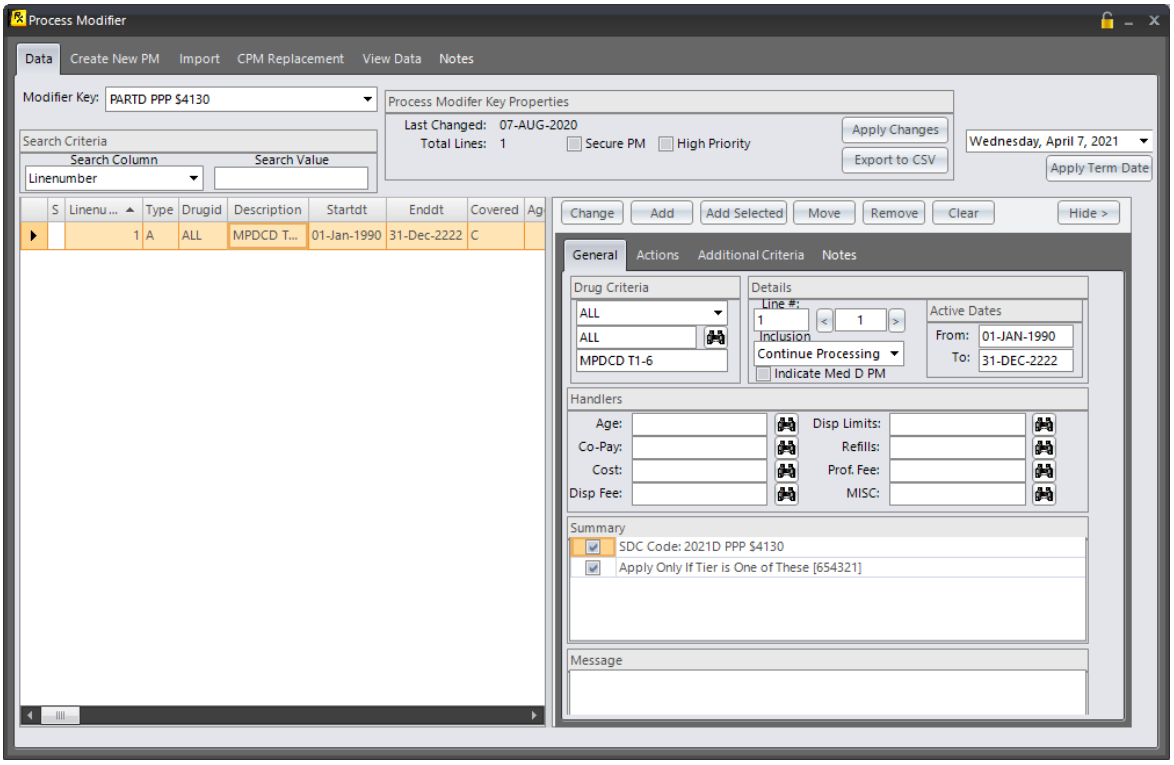




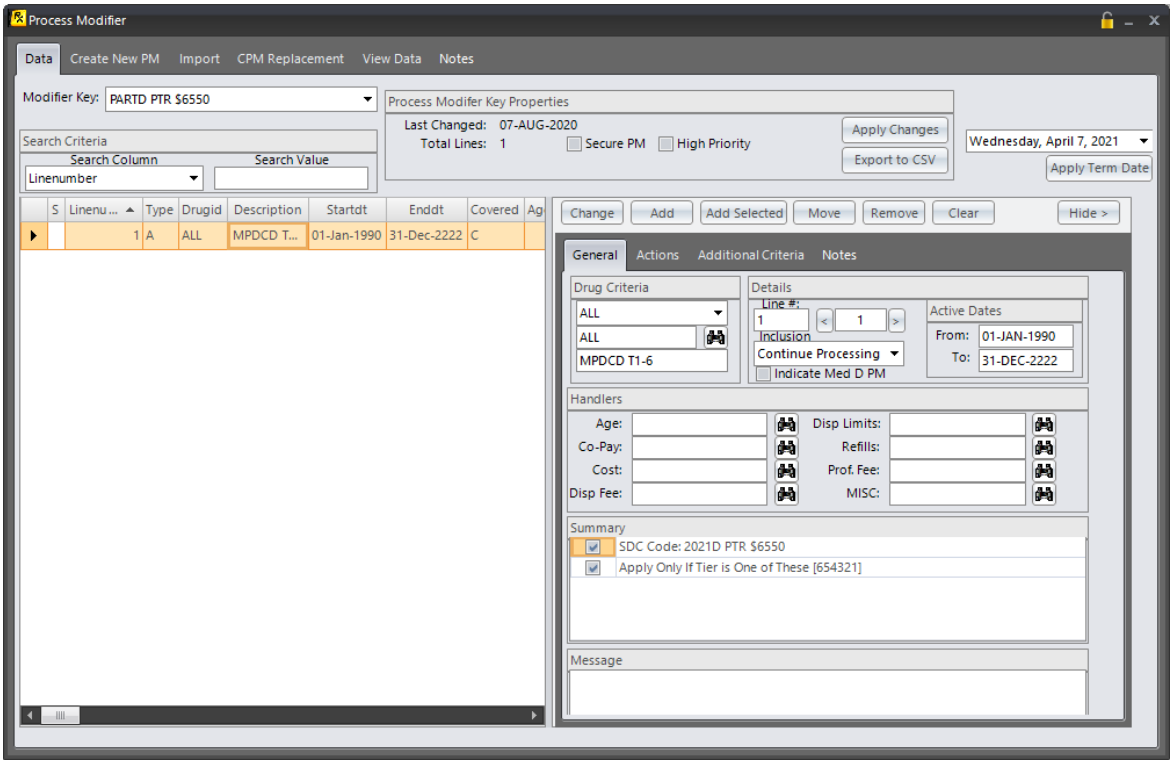
Process Modifier
Data
Create New PM
Import
CPM Replacement
View Data
Notes
Modifier Key:
MPDCD 0000 PARTD PCD & GF 2021
Process Modifer Key Properties
Last Changed: 02-APR-2021
Total Lines: 18
Secure PM
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Search Value
Linenumber
S
Linenu...
Type
Drugid
Description
2 A ALL FILTER/ENH/MCAID/VAS/ETC
3 A ALL TRANSGF- MCARE TRAN GF/NC OVERRIDE
4 L PARTD PCD MPA PCD T1-6
5 L PARTD PCD PCD T1-6
6 A ALL MPA MPDCD T1-6
7 A ALL MPDCD T1-6
8 L 0000 INDEF GF CMS PROTECTED CLASS GRANDFATHER
9 L 0000 INDEF GF CMS PROTECTED CLASS GRANDFATHER
10 L 0000 INDEF GF CMS PROTECTED CLASS GRANDFATHER
11 L 0000 INDEF GF CMS PROTECTED CLASS GRANDFATHER
12 L 0000 NF GF SAPS GRAND/NC TF LTC
13 L 0000 NF GF SAPS GRAND/NC TF
14 L 0000 NF GF 0000 GRAND NC NF LTC
15 L 0000 NF GF 0000 GRAND NC NF AL
16 L 0000 NF GF 0000 GRAND NC NF ICF
17 L 0000 NF GF 0000 GRAND NC NF STD
18 L PARTD PCD PARTD PCD
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
List Formulary
0000 NF GF
0000 GRAND NC NF AL
Details
Line #:
15
15
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 31-DEC-2020
To: 31-MAR-2021
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Stamp PM Name Into Formulary Field
Set Tier to This T
Set Script Tag To[TRNNCNF4]
Write Script Tag to Claim
Apply Only If Match Prior to SD for GF Days [120]
Message
NON-FORMULARY DRUG; TRANSITION FILL MET. MUST USE FORMULARY ALTERNATIVE;



#2 PPP Process Modifier (cap):


Process Modifier
Data
Create New PM
Import
CPM Replacement
View Data
Notes
Modifier Key:
PARTD PPP $4130
Process Modifer Key Properties
Last Changed: 07-AUG-2020
Total Lines: 1
Secure PM
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Linenumber
Search Value
S
Linenu...
Type
Drugid
Description
Startdt
Enddt
Covered
1
A
ALL
MPDCD T...
01-Jan-1990
31-Dec-2222
C
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
ALL
ALL
MPDCD T1-6
Details
Line #:
1
1
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From:
01-JAN-1990
To:
31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
SDC Code: 2021D PPP $4130
Apply Only If Tier is One of These [654321]
Message

#3 PTR Process Modifier (TrOOP):



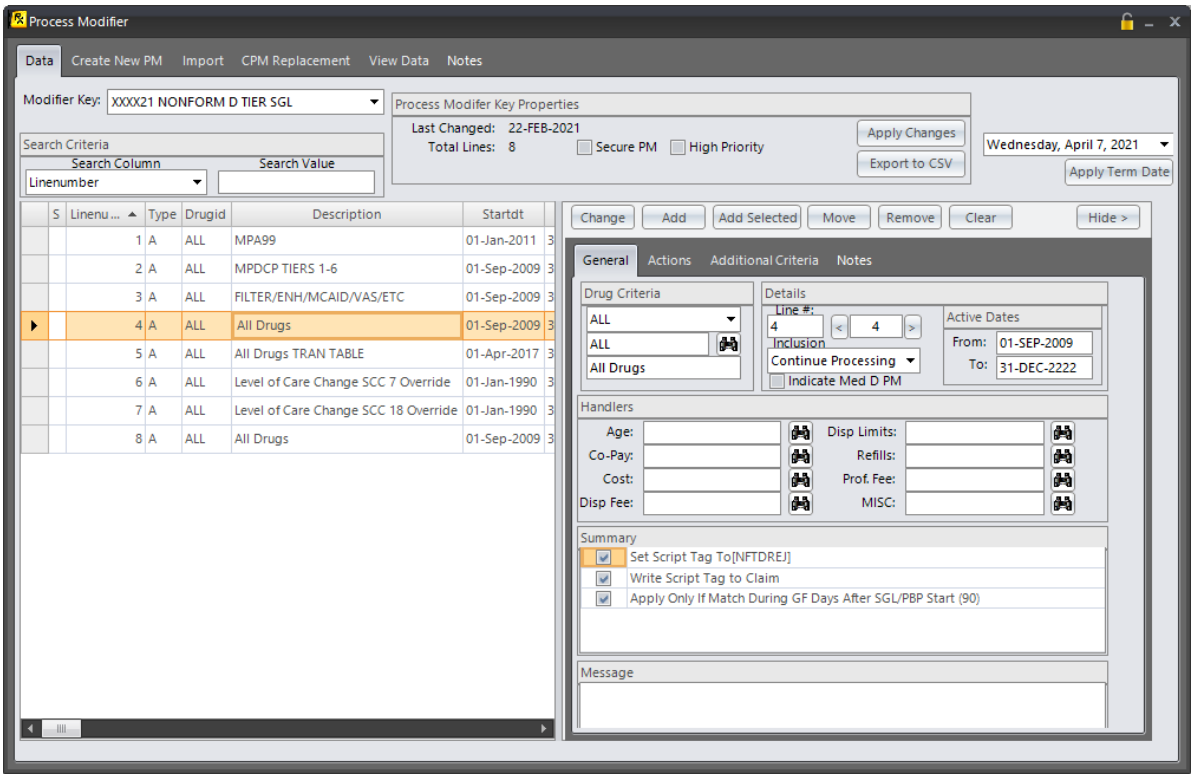
- In order to obtain additional transition refills for emergency situations or for additional LTC transitional fills that fall outside of the transition or grandfathering period, pharmacies may submit applicable Submission Clarification Codes or call the toll-free 1-800 phone number listed in the messaging and state that additional transitional refills are required.
    - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2016 forward will be: GRANDFATHER FILL MET MUST USE FORMULARY ALTERNATIVE CALL ###.###.####
- In the event the request is for a new member in the LTC setting, the additional transitional overrides will be authorized for the remaining portion of the 90 days left in the member's transition period. The Customer Service Representative will then enter an override in the pharmacy claims adjudication system to allow the members to receive their additional transition fills to occur as described in the procedures section.

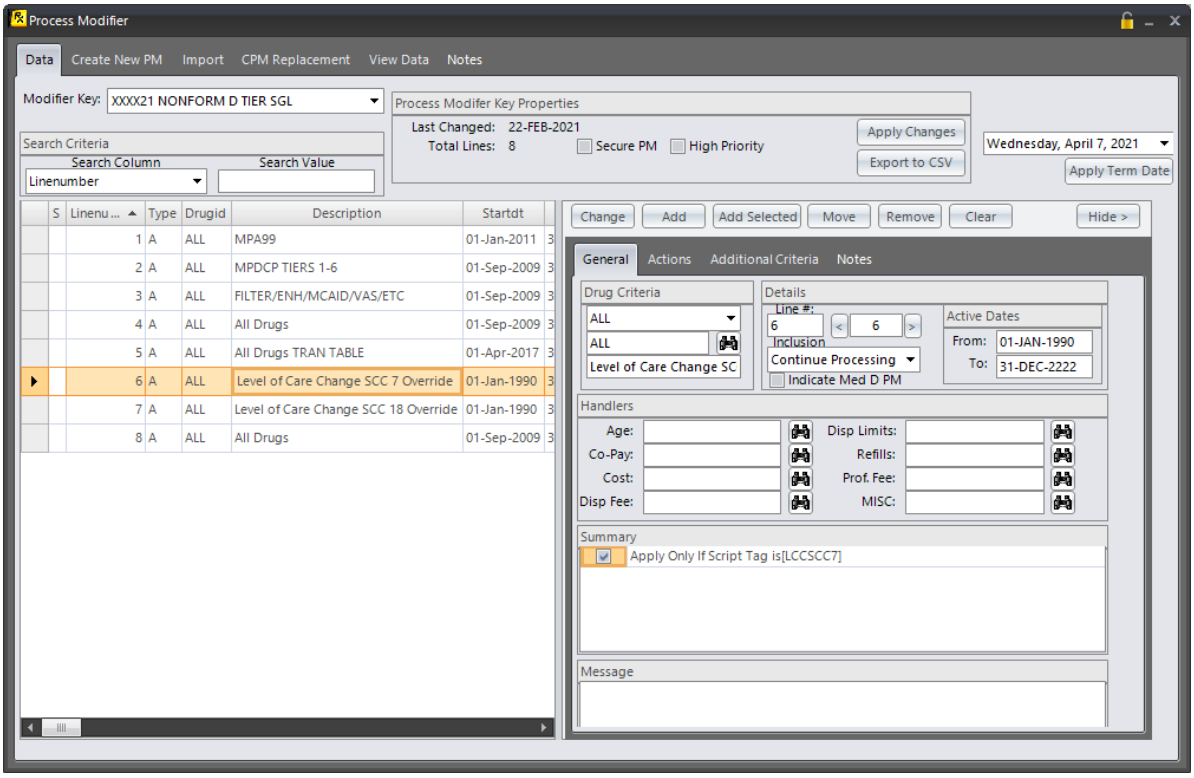
CMS Notice of Appeal Rights:

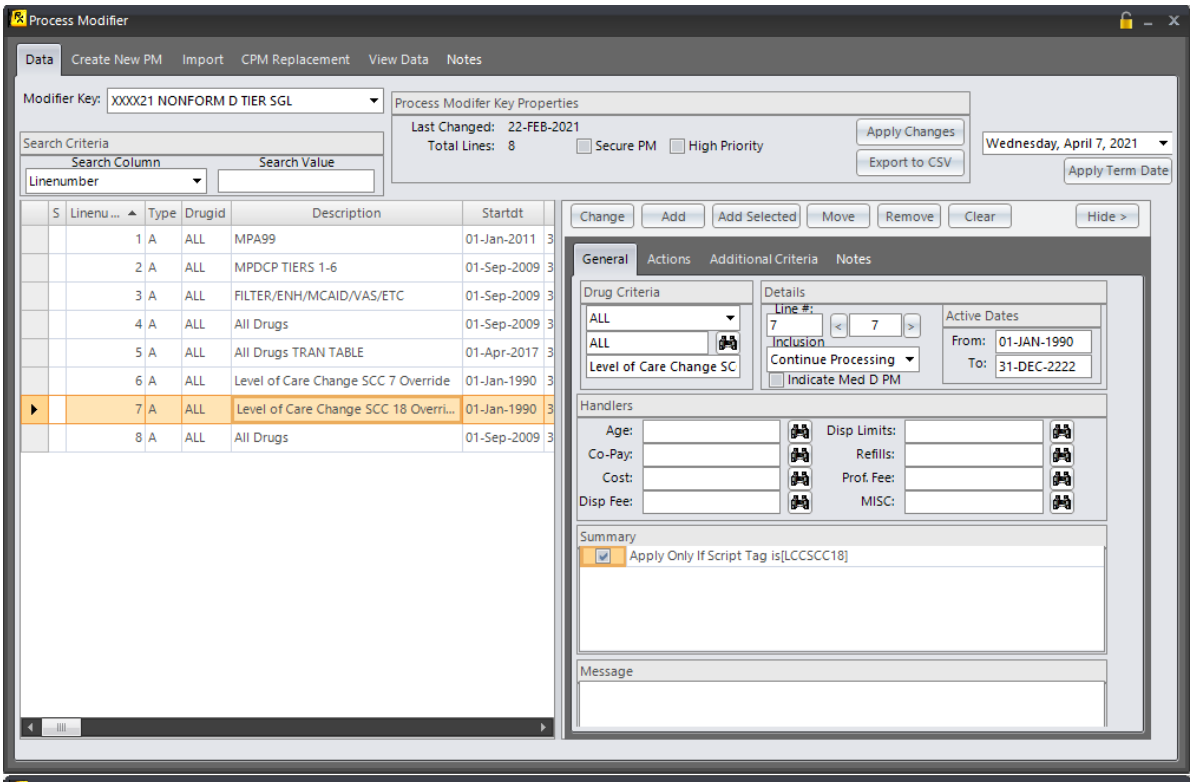
If a member fills a non-formulary drug and is no longer in their transition period, has exhausted their allowable transition fills or grandfathered supply, the claim is flagged via use of a script tag and sent through a series of filters. The filters allow for proper identification of these claims and ensure the return of a reject code "569" and message "Provide Beneficiary with CMS Notice of Appeal Rights".

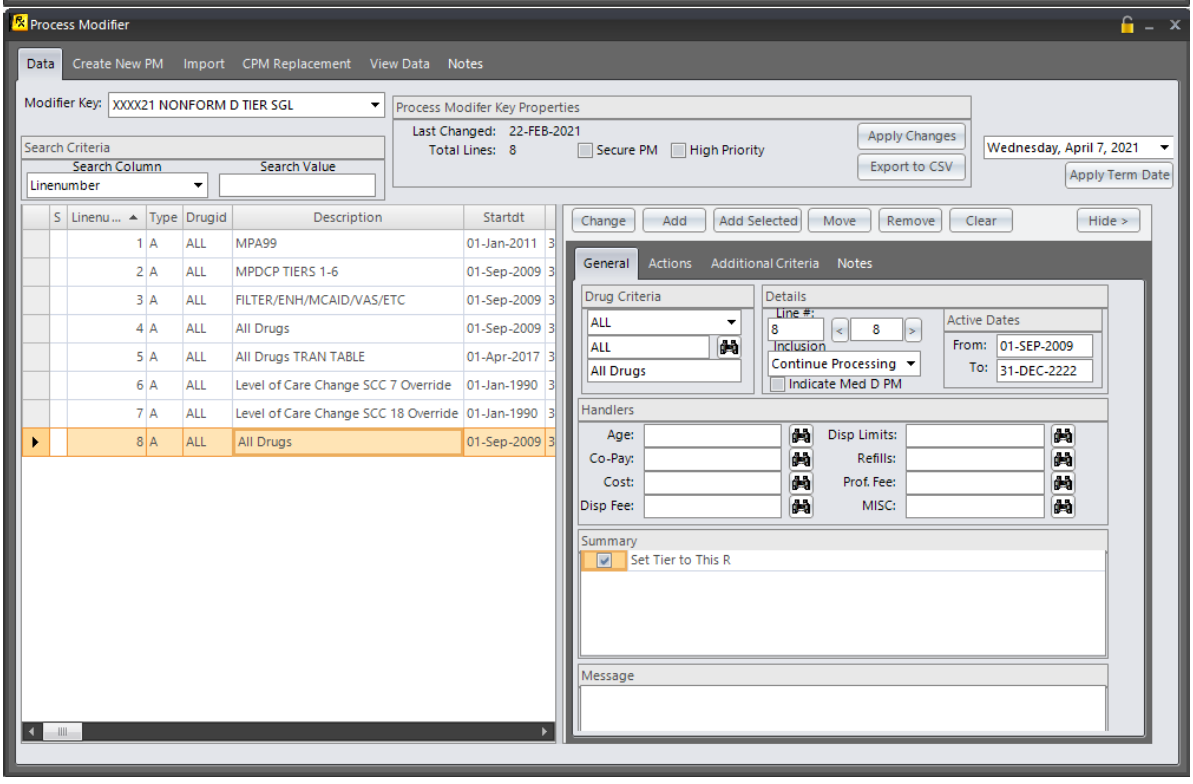
- All drugs will filter through the process modifier 0000 NONFORM D TIER SGL/SEL (see example #1)
    - First, the claim is sent through a series of formulary filters If it hits, then the claim is satisfied and it moves on to the next level of processing outside of the process modifier XXXX20 NONFORM D TIER SGL/ XXXX20 NONFORM D TIER SEL
    - If it is not part of one of the Formulary filters then the Rx is sent through a series of All Drugs lines.
    - Each All Drugs line is set up to account for the Rx Date in comparison to the member's Start date: *Apply Only If Match during GF days after Mem Start [90]*. If this criteria is satisfied, the claim is flagged with a script tag of *[NFTDREJ] or [R]*, which identifies the claim as a non-formulary drug being filled when the member is no longer in their transition period
- The claim then filters through the process modifier MED D 569 APPLY (see example #2)
    - First, the claim is sent through a series of formulary filters If it hits, then the claim is satisfied and it moves on to the next level of processing outside of the process modifier MED D 569 APPLY
    - If it is not part of one of the Formulary filters then the Rx is sent through a series of All Drugs lines.
    - Each All Drugs line is set up to apply only if the claim was flagged with a script tag of *[NFTDREJ] or [R]*, which identifies the claim as a non-formulary drug being filled when the member is no longer in their transition period
    - If the All Drugs line is applicable, the message "Provide Beneficiary with CMS Notice of Appeal Rights" will be returned to the pharmacy on the adjudicated claim.
- A reject code "569" and message "Provide Beneficiary with CMS Notice of Appeal Rights" is returned in the following instances:
    - Along with reject codes 70, 75, 9G, MR, 608, A3, A4, 828 and 7X
    - Any denied claims/drugs subject to a transition requirement

Example #1:

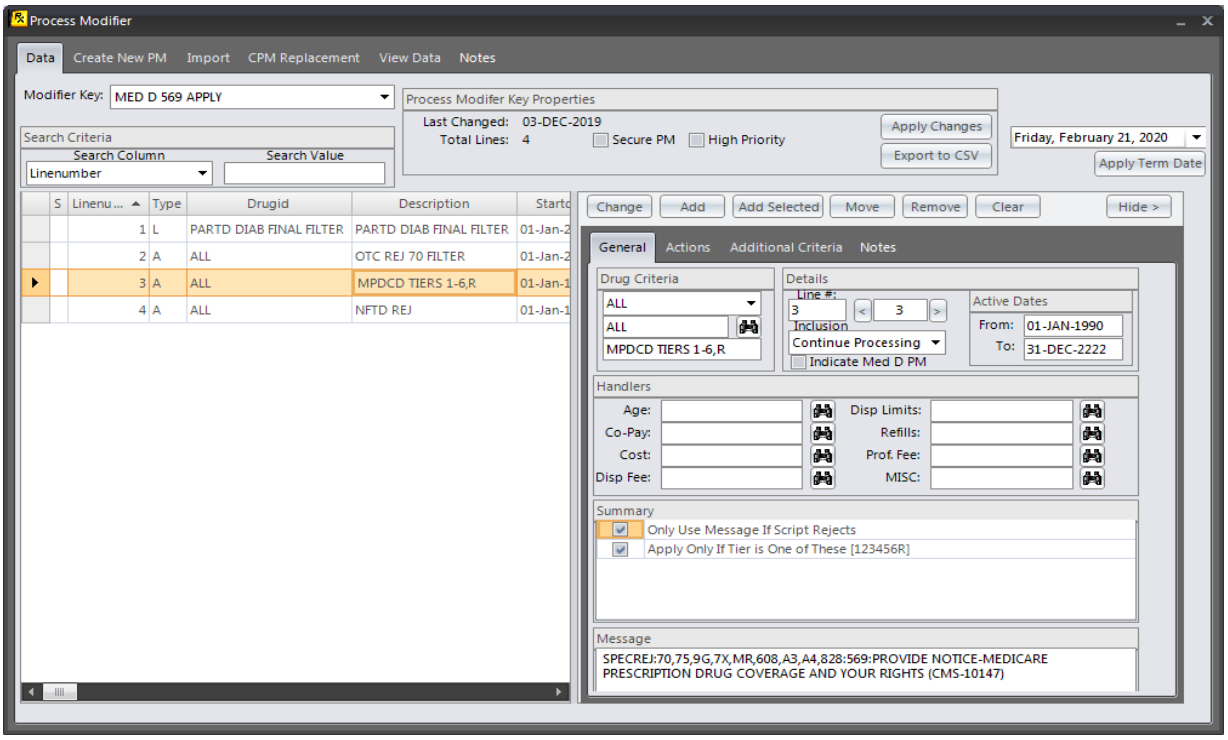

Process Modifier
Data
Create New PM
Import
CPM Replacement
View Data
Notes
Modifier Key:
XXXX21 NONFORM D TIER SGL
Process Modifer Key Properties
Last Changed: 22-FEB-2021
Total Lines: 8
Secure PM
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Search Value
Linenumber
S
Linenu...
Type
Drugid
Description
Startdt
1 A ALL MPA99 01-Jan-2011
2 A ALL MPDCP TIERS 1-6 01-Sep-2009
3 A ALL FILTER/ENH/MCAID/VAS/ETC 01-Sep-2009
4 A ALL All Drugs 01-Sep-2009
5 A ALL All Drugs TRAN TABLE 01-Apr-2017
6 A ALL Level of Care Change SCC 7 Override 01-Jan-1990
7 A ALL Level of Care Change SCC 18 Override 01-Jan-1990
8 A ALL All Drugs 01-Sep-2009
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
ALL
ALL
All Drugs
Details
Line #:
4
4
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 01-SEP-2009
To: 31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Set Script Tag To[NFTDREJ]
Write Script Tag to Claim
Apply Only If Match During GF Days After SGL/PBP Start (90)
Message

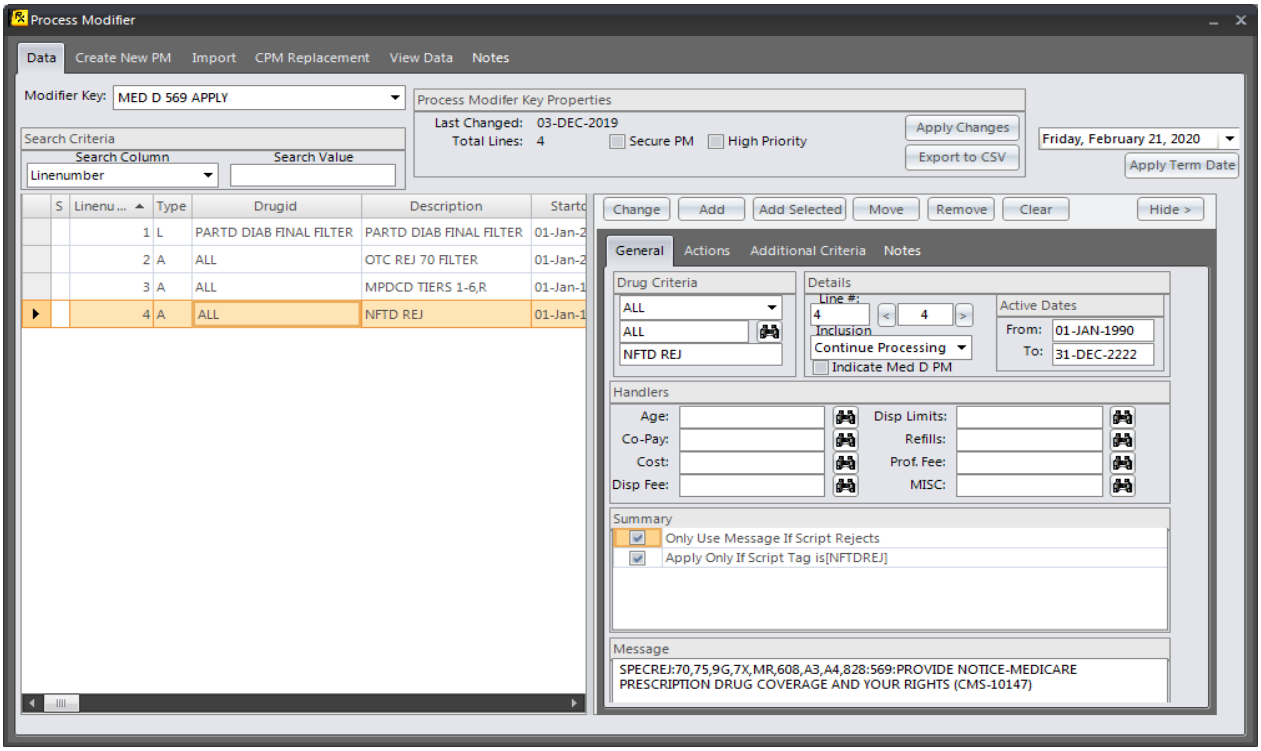

Process Modifier
Data
Create New PM
Import
CPM Replacement
View Data
Notes
Modifier Key:
XXXX21 NONFORM D TIER SGL
Process Modifer Key Properties
Last Changed: 22-FEB-2021
Total Lines: 8
Secure PM
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Search Value
Linenumber
S
Linenu...
Type
Drugid
Description
Startdt
1 A ALL MPA99 01-Jan-2011
2 A ALL MPDCP TIERS 1-6 01-Sep-2009
3 A ALL FILTER/ENH/MCAID/VAS/ETC 01-Sep-2009
4 A ALL All Drugs 01-Sep-2009
5 A ALL All Drugs TRAN TABLE 01-Apr-2017
6 A ALL Level of Care Change SCC 7 Override 01-Jan-1990
7 A ALL Level of Care Change SCC 18 Override 01-Jan-1990
8 A ALL All Drugs 01-Sep-2009
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
ALL
ALL
Level of Care Change SC
Details
Line #:
6
6
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 01-JAN-1990
To: 31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Apply Only If Script Tag is[LCCSCC7]
Message


Process Modifier
Data
Create New PM
Import
CPM Replacement
View Data
Notes
Modifier Key: XXXX21 NONFORM D TIER SGL
Process Modifer Key Properties
Last Changed: 22-FEB-2021
Total Lines: 8
Secure PM
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Search Value
Linenumber
S
Linenu...
Type
Drugid
Description
Startdt
1 A ALL MPA99 01-Jan-2011
2 A ALL MPDCP TIERS 1-6 01-Sep-2009
3 A ALL FILTER/ENH/MCAID/VAS/ETC 01-Sep-2009
4 A ALL All Drugs 01-Sep-2009
5 A ALL All Drugs TRAN TABLE 01-Apr-2017
6 A ALL Level of Care Change SCC 7 Override 01-Jan-1990
7 A ALL Level of Care Change SCC 18 Overri... 01-Jan-1990
8 A ALL All Drugs 01-Sep-2009
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
ALL
ALL
Level of Care Change SC
Details
Line #:
7
7
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 01-JAN-1990
To: 31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Apply Only If Script Tag is[LCCSCC18]
Message


Process Modifier
Data
Create New PM
Import
CPM Replacement
View Data
Notes
Modifier Key: XXXX21 NONFORM D TIER SGL
Process Modifer Key Properties
Last Changed: 22-FEB-2021
Total Lines: 8
Secure PM
High Priority
Apply Changes
Export to CSV
Wednesday, April 7, 2021
Apply Term Date
Search Criteria
Search Column
Search Value
Linenumber
S
Linenu...
Type
Drugid
Description
Startdt
1 A ALL MPA99 01-Jan-2011
2 A ALL MPDCP TIERS 1-6 01-Sep-2009
3 A ALL FILTER/ENH/MCAID/VAS/ETC 01-Sep-2009
4 A ALL All Drugs 01-Sep-2009
5 A ALL All Drugs TRAN TABLE 01-Apr-2017
6 A ALL Level of Care Change SCC 7 Override 01-Jan-1990
7 A ALL Level of Care Change SCC 18 Override 01-Jan-1990
8 A ALL All Drugs 01-Sep-2009
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
ALL
ALL
All Drugs
Details
Line #:
8
8
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 01-SEP-2009
To: 31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Set Tier to This R
Message

Example #2:


Process Modifier
Data
Create New PM
Import
CPM Replacement
View Data
Notes
Modifier Key: MED D 569 APPLY
Process Modifer Key Properties
Last Changed: 03-DEC-2019
Total Lines: 4
Secure PM
High Priority
Apply Changes
Export to CSV
Friday, February 21, 2020
Apply Term Date
Search Criteria
Search Column
Linenumber
Search Value
S
Linenu...
Type
Drugid
Description
Startc
1 L PARTD DIAB FINAL FILTER PARTD DIAB FINAL FILTER 01-Jan-2
2 A ALL OTC REJ 70 FILTER 01-Jan-2
3 A ALL MPDCD TIERS 1-6,R 01-Jan-1
4 A ALL NFTD REJ 01-Jan-1
Change
Add
Add Selected
Move
Remove
Clear
Hide >
General
Actions
Additional Criteria
Notes
Drug Criteria
ALL
ALL
MPDCD TIERS 1-6,R
Details
Line #:
3
3
Inclusion
Continue Processing
Indicate Med D PM
Active Dates
From: 01-JAN-1990
To: 31-DEC-2222
Handlers
Age:
Co-Pay:
Cost:
Disp Fee:
Disp Limits:
Refills:
Prof. Fee:
MISC:
Summary
Only Use Message If Script Rejects
Apply Only If Tier is One of These [123456R]
Message
SPECREJ:70,75,9G,7X,MR,608,A3,A4,828:569:PROVIDE NOTICE-MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS (CMS-10147)



Medicare Part D Transition Override Workflow:

Plan Sponsor Services obtains transition policy from the Plan Sponsor. Transition fills for non-formulary medications and medications subject to quantity limits, prior authorization and step therapy will automatically process in the pharmacy claims adjudication system. In circumstances where the transition will not automatically process, such as in the LTC setting when an additional Step Therapy, Prior Authorization, or non-formulary medication Long Term Care override is needed, the pharmacy, physician, or member will need to contact the Elixir Customer Service Help Desk. If a member is outside of their first 90 days of eligibility with the Plan, please see the LTC/Level of Care Change transition workflow located on page 55 of this policy and procedure.

Non Formulary/Step Therapy/Prior Authorization Transition Override (applicable to all members within the first 90 days of their eligibility with the Plan).

Customer Service Representative pulls up the Member PA screen and clicks on the Treat as Include Box.

On Tab 2 the box under "Mark Script As:" must be filled out. The transition level is dependent on the tier on which the drug falls for Prior Auth and Step Therapy meds. Non Formulary meds should default to the same tier that applies for the automated overrides

Examples:

Trans D 1 [Tier 1 drug on Client's formulary]

Trans D 2 [Tier 2 drug on Client's formulary]

Trans D 3 [Tier 3 drug on Client's formulary]

Trans D____[select appropriate tier where transition drugs fall for Client)

On Tab 4 under the reason code for the PA, please select the appropriate Transition Code:

Trans PA

Trans ST

Trans NFE

Do NOT select Other.

LTC/Level of Care Changes Transition Override (applicable to all members within the first 90 days of their eligibility with the Plan).

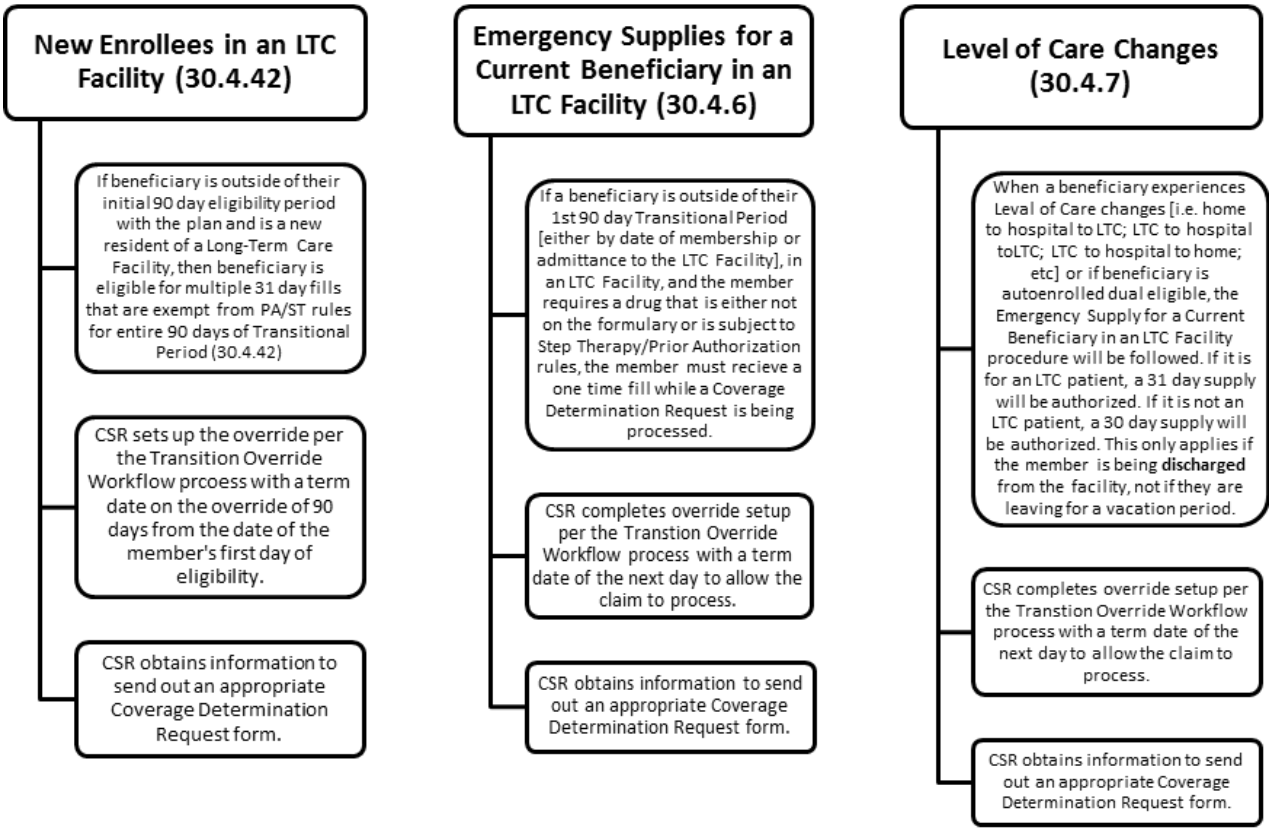
Customer Service Representative pulls up the Member PA screen and clicks on the Treat as Include Box.

On Tab 2 the box under "Mark Script As:" must be filled out. The transition level is dependent on the tier on which the drug falls for formulary medications that are Refill too Soon. If it is a Non-Formulary medication the Trans D option that corresponds to the plan's Non Preferred Brand Tier must be selected [example: Sponsor would be Trans D 4]

On Tab 4 under the reason code for the PA, select TransLTCXXX when the member falls outside of their original 90 day transition period. If the member is still in their 90 day transition period, Trans PA or Trans ST should be selected.

LTC/Level of Care Change Transition Workflow

Chapter 6 Section 30.4 is the basis for this workflow regarding the LTC Transition workflow process. Since we have no way to automate the LTC Transition process, the LTC Pharmacy will need to call the Pharmacy Help Desk to initiate the LTC Transition process.



Medicare Part D Transition Letter Workflow Process