

Medicare: Transition Policy MMP

Virginia Premier Medicare Medicaid Program Transition Policy

Virginia Premier CompleteCare will maintain an appropriate transition process consistent with 42 CFR §423.120(b)(3) that includes a written description of how, for enrollees whose current drug therapies may not be included in their new MMP's formulary, it will effectuate a meaningful transition.

To ensure a smooth transition process for Virginia Premier CompleteCare enrollees and address the needs of individuals who are joining Virginia Premier CompleteCare program from other Medicare Part D plan/MMP providers, Virginia Premier CompleteCare has established a transition process to address these needs. Virginia Premier CompleteCare has established transition guidelines to specifically address:

- (1) New enrollees into prescription drug plans at the beginning of a contract year;
- (2) The transition of newly eligible Medicare beneficiaries from other coverage at the beginning of a contract year;
- (3) The transition of individuals who switch from one plan to another after the beginning of a contract year;
- (4) Enrollees residing in long-term care (LTC) facilities; and
- (5) In some cases, current enrollees affected by formulary changes from one contract year to the next.

Virginia Premier CompleteCare's transition policy applies to:

- (a) Part D medications that are not on Virginia Premier CompleteCare's formulary.
- (b) Part D medications that are on Virginia Premier CompleteCare's formulary but may require prior authorization or step therapy under Virginia Premier CompleteCare's established utilization management rules.
- (c) Non-Medicare Part D Rx/OTC medications that are not on Virginia Premier CompleteCare's ADD (Additional Demonstration Drugs) list.

Virginia Premier's PBM vendor, Envision has created a Pharmacy and Therapeutics (P&T) committee comprised of both pharmacists and physicians from many fields (e.g. Internal Medicine, Psychiatry, etc.). The P&T committee reviews and provides recommendations regarding non-formulary medication requests. Also, the P&T committee establishes protocols for

suggestions to both Medicare Part D enrollees and their physicians on the use of therapeutically equivalent formulary alternatives failing an affirmative medical necessity determination.

Envision's Clinical Pharmacist and/or Medical Director review Formulary Exception requests. Approval or denial of requests will be based on the Plan's criteria which are based on the evidence based guidelines, documentation found in CMS recognized compendia such as DrugDex.

Procedures for Requesting an Exception or Changing Prescriptions

How do members request an exception?

The first step in requesting an exception is for the member to ask his/her prescribing doctor to contact Virginia Premier CompleteCare. The doctor must submit a statement supporting the member's request. The doctor's statement must indicate that the requested drug is medically necessary for treating your condition because none of the drugs we cover would be as effective as the requested drug or would have adverse effects for you. If the exception involves a prior authorization, quantity limit or other limit we have placed on that drug, the doctor's statement must indicate that the prior authorization or limit would not be appropriate given your condition or would have adverse effects for you. Once the physician's statement is submitted, we must notify the member of our decision no later than 24 hours, if the request has been expedited or no later than 72 hours, if the request is a standard request. The request will be expedited if we determine or the member's doctor informs us that the member's life, health or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

What if the request is denied?

If the member's drug is not covered on our formulary or is covered on our formulary but we have placed a prior authorization, step therapy or quantity limit on it, the member can ask us if we cover another drug used to treat your medical condition. If we cover another drug for the member's condition, we encourage the member to ask his/her doctor if these drugs that we cover are an option for the member.

If the request is denied, the member also has the right to appeal by asking for a review of the prior decision. The member must request this appeal within 60 calendar days from the date of our first decision. If the member needs assistance in requesting an exception or appeal, help in switching to an alternative drug or for more information about our transition policy, the member can call the customer service number on the back of his/her ID card. Prior authorization forms can be mailed, faxed, or emailed.

Transition Policy

Virginia Premier CompleteCare's transition policy addresses those situations in which members may or may not be aware of the medications that are on Virginia Premier CompleteCare's formulary, unsure what is covered by Virginia Premier CompleteCare's formulary, or unfamiliar with Virginia Premier CompleteCare's formulary exception process. Virginia Premier

CompleteCare's transition policy meets the immediate needs of our valued members and allows the member sufficient time to work with his or her prescribing physician to switch to a therapeutically equivalent formulary medication or complete the formulary exception process.

Virginia Premier CompleteCare will ensure that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible enrollees. For non-LIS eligible enrollees, the Organization will charge cost-sharing for a temporary supply of drugs provided under the Plan Sponsor's transition process is based on one of the Plan Sponsor's approved drug cost-sharing tiers (if the Sponsor has a tiered benefit design), and this cost-sharing is consistent with cost-sharing the Plan Sponsor would charge for non-formulary drugs approved under a coverage exception. Also, the Plan will charge the same cost sharing for formulary drugs subject to UM edits provided during transition that would apply once UM criteria are met for non low-income subsidy eligible enrollees

Virginia Premier CompleteCare will only apply the following utilization management edits during transition at point-of-sale: edits to determine Part B versus Part D coverage, edits to prevent coverage of non-Part D drugs, and edits to promote safe utilization of a Part D drug. Step therapy and prior authorization edits must be resolved at point-of-sale.

Virginia Premier CompleteCare will ensure that the transition policy provides refills 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.

Virginia Premier CompleteCare will ensure that it will apply all transition processes to a brand-new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.

Virginia Premier CompleteCare will extend its transition policy across contract years 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.

Ambulatory (Community) Members-Part D Drugs

During the member's first 90 days of enrollment with Virginia Premier CompleteCare, the member can obtain up to a 30-day temporary supply of a non-formulary medication (including Part D drugs that require a prior authorization or step therapy).

Long-Term Care (LTC) Members-Part D Drugs

During the member's first 90 days of enrollment with Virginia Premier CompleteCare, the member can obtain up to a 90-day transition supply. Virginia Premier CompleteCare will honor multiple fills of non-formulary Part D medications (including Part D medication that are on Virginia Premier CompleteCare's formulary but require prior authorization or step therapy under Virginia Premier CompleteCare's utilization management rules) as appropriate during the entire length of the 98-day transition period.

If an LTC enrollee is outside his or her 98-day transition period, Virginia Premier CompleteCare will provide an emergency supply of non-formulary medication (including Part D medications that are on Virginia Premier CompleteCare's formulary but require prior authorization or step therapy under Virginia Premier CompleteCare's utilization management rules). This emergency supply will be for at least 31 days of medication, unless the prescription is written for less than 31 days. The emergency supply is to ensure that members receive their medications while an exception has been requested through Virginia Premier CompleteCare.

There are times when an enrollee may experience an unplanned level of care change (e.g.; discharged or admitted to an LTC facility, discharged or admitted to hospitals, nursing facility skill level changes, etc.). In these instances, Virginia Premier CompleteCare will provide an emergency supply of non-formulary medication (including Part D medications that are on Virginia Premier CompleteCare's formulary but require prior authorization or step therapy under Virginia Premier CompleteCare's utilization management rules). This emergency supply will be for at least 31 days of medication, unless the prescription is written for less than 31 days. The emergency supply is to ensure that members receive their medications while an exception has been requested through Virginia Premier CompleteCare.

Members in All Setting Type-Non-Medicare Part D Rx/OTC Drugs (ADD-Additional Demonstration Drugs)

During the member's first 180 days of enrollment with Virginia Premier CompleteCare, the member can obtain up to a 180-day temporary supply (6 x 30-day fills) of a non-formulary ADD medication (excluding ADD drugs that require a prior authorization-due to FDA safety edits).

Negative Formulary Changes

Virginia Premier CompleteCare understands that some members who continue as Virginia Premier CompleteCare members from one year to the next may be impacted by negative formulary changes that occur to Virginia Premier CompleteCare's formulary. Even though members are sent an Annual Notice of Change (ANOC), Virginia Premier CompleteCare realizes that not all members may be aware that some medications that are considered formulary in one year may be considered non-formulary in the following year. To help alleviate some of this confusion, Virginia Premier CompleteCare allows a transitional fill, for a maximum of 30 days of medication, of all medications that are impacted by negative formulary changes from one

year to the next as long as the member had history of the medication at the end of the prior year. If the prescription is written by the prescriber for less than a 30-days supply, the prescribed days supply defines the minimum quantity authorized as the transition fill. Long term care members will receive multiple fills during the first 90 days for the new plan year. ADD drugs will be set to transition for the first 180 days with multiple fills of 6 times 30-day fills.

Transition Fill Requests Due to Other Reasons and Extension of Transitional Fills

Virginia Premier CompleteCare continues to provide necessary Part D and ADD drugs to members via an extension of the transition period, on a case-by-case basis, to the extent that their 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).

Transition Notices

All members who receive a temporary supply, as well as the prescribing physician, of a non-formulary Part D medication will receive a written notice via US mail regarding their transition fill and the transition process. This notification will be sent within 3 business days of the temporary fill. The notice will include:

- (1) An explanation of the transition supply that the member received.
- (2) Instructions for working with Virginia Premier CompleteCare for the member and prescriber to identify appropriate therapeutic formulary alternatives.
- (3) An explanation of the member's right to request a formulary exception.
- (4) A description of the formulary exception process.

Formulary exception requests will be available to members, their prescribing physicians (or other providers), and their representatives via fax, mail, and phone.

Implementation Statement

Virginia Premier CompleteCare uses EnvisionRxOptions as its PBM. Envisions implementation statement is located in Exhibit-A under the policy section, page 15, item K. The procedure for the implementation statement is listed on page 18 under section J. Pages 10-56 contain the detail for how requests will be processed in the adjudication system, how the pharmacy will be notified when a transition medication is processed at point of sale and also what processes pharmacies must follow to resolve edits at point of sale. The Organization will maintain in its transition

policy a detailed explanation of how MMP 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.

Virginia Premier CompleteCare will submit a copy of its transition process policy. Virginia Premier CompleteCare will make 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 web sites. Virginia Premier CompleteCare will make their transition policy available to enrollees via a link to the sponsor web site and include the policy in pre-and post-enrollment marketing materials as directed by CMS.

Virginia Premier CompleteCare has delegated to its PBM EnvisionRxOptions follows the following qualifications regarding a transition process for enrollees outlined in the table below:

Qualification	Location in Exhibit-A
Virginia Premier CompleteCare will maintain an appropriate transition process consistent with 42 CFR §423.120(b)(3) that includes a written description of how, for enrollees whose current drug therapies may not be included in their new Part D plan's formulary, it will effectuate a meaningful transition for: (1) new enrollees into prescription drug plans at the beginning of a contract year; (2) the transition of newly eligible Medicare beneficiaries from other coverage at the beginning of a contract year; (3) the transition of individuals who switch from one plan to another after the beginning of a contract year; (4) enrollees residing in long-term care (LTC) facilities; and (5) in some cases, current enrollees affected by formulary changes from one contract year to the next.	Policy Section, Page 7-10
Virginia Premier CompleteCare will ensure that its transition policy will apply to non- formulary drugs, meaning both (1) Part D drugs that are not on a plan's formulary; and (2) Part D Drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules. Sponsor will ensure that its policy addresses procedures for medical review of non-formulary drug requests, and when appropriate, a process for switching new Part D plan enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.	Policy Section, Page 8, 2nd full paragraph on page Procedure: Pages 17 thru 21
Virginia Premier CompleteCare will have systems capabilities that allow them to provide a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of an enrollee, as well as to allow the plan and/or the enrollee 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.	Policy Section, Pages 18-20

Virginia Premier CompleteCare will ensure that in the retail setting, the transition policy provides for at least a one-time, temporary 30-day fill (unless the enrollee presents with a prescription written for less than 30 days in which case the Part D sponsor must allow multiple fills to provide up to a total of 30 days of medication.) anytime during the first 90 days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage.	Policy Section, Page 20-22
Virginia Premier CompleteCare will ensure that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible enrollees. For non-LIS eligible enrollees, the Organization will charge cost-sharing for a temporary supply of drugs provided under the Plan Sponsor's transition process is based on one of the Plan Sponsor's approved drug cost-sharing tiers (if the Sponsor has a tiered benefit design), and this cost-sharing is consistent with cost-sharing the Plan Sponsor would charge for non-formulary drugs approved under a coverage exception.	Policy Section, Page 14-15, Pages 16-22.
Virginia Premier CompleteCare will ensure that in the long-term care setting: (1) the transition policy provides for a 91 to 98 day fill consistent with the dispensing increment (unless the enrollee presents with a prescription written for less), with refills 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; (2) after the transition period has expired, the transition policy provides for a 31-day emergency supply of non-formulary Part D drugs (unless the enrollee presents with a prescription written for less than 31 days) while an exception or prior authorization is requested; and (3) for enrollees being admitted to or discharged from a LTC facility, early refill edits are not 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.	Policy Section, Item C2, page 10 Procedure: Pages 17-19
Virginia Premier CompleteCare will only apply the following utilization management edits during transition at point-of-sale: edits to determine Part B versus Part D coverage, edits to prevent coverage of non-Part D drugs, and edits to promote safe utilization of a drug. Step therapy and prior authorization edits must be resolved at point-of-sale Part D drugs.	Policy Section, Item G, pages 13-14 Procedure page 21-22 Section A(I), A(II)
Virginia Premier CompleteCare will ensure that the transition policy provides refills 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.	Policy Section, Item G, page 13 Procedure: Pages 16-17
Virginia Premier CompleteCare will ensure that it will apply all	Policy Section, Item B,

transition processes to a brand-new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescriptions for a non- formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.	page 9 Procedure: Page 18
Virginia Premier CompleteCare will send written notice via U.S. first class mail to enrollee within three business days of adjudication of a temporary fill. The notice must include (1) an explanation of the temporary nature of the transition supply an enrollee has received; (2) instructions for working with the plan sponsor and the enrollee's prescriber to identify appropriate therapeutic alternatives that are on the plan's formulary; (3) an explanation of the enrollee's right to request a formulary exception; and (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 43.154, the written notice must be provided within 3 business days after adjudication of the first temporary fill. Sponsor will use 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. Sponsor will ensure that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice.	Policy Section, Item I, page 14 Procedure: Pages 22-23
Virginia Premier CompleteCare will extend its transition policy across contract years should a beneficiary enroll in a plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply.	Policy Section, Item D, page 12, 2nd paragraph Procedure: Pages 17-18
Virginia Premier CompleteCare 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 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).	Policy Section, Item C3, page 10-11 Procedure: page 21
For current enrollees whose drugs are no longer on the Sponsor's formulary, or remain on the formulary but to which new prior utilization or step therapy restrictions are applied, Sponsor will effectuate a meaningful transition by either: (1) providing a transition process consistent with the transition process required for new enrollees beginning in the new contract year; or (2) effectuating a transition prior to the beginning of the new contract year.	Policy Section, Item D, page 11 paragraphs 1,2&3 Procedure: page 20-21

EXHIBIT A

Envision Pharmaceutical Services, Inc. Rx Options, Inc.

Formulary Transition Policy (**URAC GUIDELINE**-DrUM 6),
MEDICARE GUIDELINE 42 CFR §423.120(b)(3) PDBM Chapter 6, Section 30.4, Transition
LAST REVIEW DATE: 05/30/2014

I. POLICY

For purposes of this Policy and Procedure, The Organization refers to the Envision RxOptions Pharmacy Benefit Management (PBM) Company.

For Commercial Plan Sponsors:

Implement a formulary transition procedure for each new Plan Sponsor according to Plan Sponsor's choice between a "hard or immediate conversion" or "grandfathering" to ensure a smooth transition for Plan Sponsor's members to the new Plan Sponsor-sponsored plan.

For Medicare Part D Plan/MMP Sponsors:

Implement a formulary transition procedure in accordance with the Plan Sponsor's transition policy, Medicare, and State guidance. In accordance with 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 (1) the transition of new enrollees into prescription drug plans at the beginning of a contract year; (2) the transition of newly eligible Medicare enrollees from other coverage at the beginning of a contract year; (3) the transition of individuals who switch from one Part D plan to another after the beginning of a contract year; (4) enrollees residing in Long Term Care (LTC) facilities; (5) in some cases, current enrollees affected by negative formulary changes from one contract year to the next; (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; (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; (8) current enrollee experiencing a level of care change; (9) current enrollees entering the LTC setting from other care settings; and (10) current enrollees in a LTC setting requiring an emergency supply of a non-formulary drug.

Transition process requirements will be applicable to non-formulary drugs, meaning both: (1) Part D covered drugs that are not on the applicable Plan Sponsor formulary, and (2) 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. (3) Non-Medicare Part D Rx/OTC medications that are not on Virginia Premier CompleteCare's ADD (Additional Demonstration Drugs) list. Plan Sponsors may choose to allow transition fills for drugs on their formulary that have quantity limits. 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 Coverage Determination Policy and Procedure MED-GA-001 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 that is provided to the member as outlined in the Coverage Determination Policy and Procedure MED-GA-001 for Plan Sponsors that delegate Coverage Determinations to the Organization.

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.

A. General Transition Process

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:

- Analyzing claims data to determine which enrollees received a transition supply.
- 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 exceptions requests.
- Utilization of pharmacy/member customer service center to assist affected enrollee's with questions regarding the Plan Sponsor's transition process.

B. New Prescriptions vs. Ongoing Drug Therapy

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.

C. New Enrollee Transition Policy

C.1 Out-Patient (Retail) Setting

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 30 day fill (unless the enrollee presents a prescription written for less than 30 days, in which case The Organization will allow multiple fills to provide up to a total of 30 days 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.

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.

To the extent that the Plan Sponsor's transition policy differs from the above policy, the Plan Sponsor's policy differences will be implemented by The Organization.

C.2 Long Term Care

In the LTC setting, The Organization will ensure (1) the transition policy provides for a 91 to 98 day fill consistent with the dispensing increment (unless the enrollee presents a prescription written for less), with refills 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; (2) after the transition period has expired, the transition policy provides for a 31-day 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 31 days), 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) 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.

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.

C.3 Members in All Setting Type-Non-Medicare Part D Rx/OTC Drugs (ADD-Additional Demonstration Drugs)

During the member's first 180 days of enrollment with Sponsor's plan, the member can obtain up to a 180-day temporary supply (6 x 30-day fills) of a non-formulary ADD medication (excluding ADD drugs that require a prior authorization-due to FDA safety edits).

C.4 Transition Extension

The Organization will 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 a time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request).

To the extent that the Plan Sponsor's transition policy differs from the above policy, the Plan Sponsor's policy differences will be implemented by The Organization.

D. Negative Formulary Changes for Current Enrollees

Current Plan Sponsor enrollees receive their ANOC by September 30th of a given year. Plan Sponsors will select one of the following two options for effectuating an appropriate and meaningful transition for current enrollees whose drugs are no longer on the Plan Sponsor's formulary or remain on the formulary but to which new prior authorization or step therapy restrictions are applied:

- 1) Provide a transition process for current enrollees consistent with the transition process required for new enrollees beginning in the new contract year. In order to prevent coverage gaps, The Organization will provide a temporary 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 when the member has had a prescription for the medication filled within the past XXX 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 a 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

- 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) complete requests for formulary and tiering 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. If, however, the Plan Sponsor has not successfully transitioned affected enrollees to a therapeutically equivalent formulary alternative or processed an exception request by January 1, The Organization, at the direction of the Plan Sponsor, will provide a transition supply beginning January 1 and until such time as a meaningful transition has been effectuated.

Additionally, The Organization will apply 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 an 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.

To the extent that the Plan Sponsor's transition policy differs from the above policy, the Plan Sponsor's policy differences will be implemented by The Organization

E. Transition Fills for Coverage Exceptions

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:

- 1) Offer to process a prospective exception request for the next plan year
- 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.

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 a 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.

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.

To the extent that the Plan Sponsor's transition policy differs from the above policy, the Plan Sponsor's policy differences will be implemented by The Organization.

F. Level of Care Changes / Emergency Fills

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 30/31 day refill (30 days in the retail setting and 31 days in the LTC setting) for formulary medications and an emergency 30/31 day refill (30 days in the retail setting and 31 days in the LTC setting) transition fill for non-formulary medications (including Part D drugs that are on Plan Sponsor's formulary but require prior authorization or step therapy).

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

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 30 day 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 31 day 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.

To the extent that the Plan Sponsor's transition policy differs from the above policy, the Plan Sponsor's policy differences will be implemented by The Organization.

G. Edits for Transition Fills

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

- Edits to determine Part B vs. Part D coverage;
- Edits to prevent coverage of non-Part D drugs (i.e., excluded drugs); and
- Edits to promote safe utilization of a Part D drug (e.g., quantity limits based on FDA maximum recommended daily dose; early refill edits).

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

The Organization will provide refills 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.

H. Cost Sharing Considerations

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 eligible enrollees, The Organization will charge cost-sharing for a temporary supply of drugs provided under the Plan Sponsor's transition process is based on one of the Plan Sponsor's approved drug cost-sharing tiers (if the Sponsor has a tiered benefit design), and this cost-sharing is consistent with cost-sharing the Plan Sponsor would charge for non-formulary drugs approved under a coverage exception.

I. Transition Notices

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.

If so delegated by the Plan Sponsor, The Organization will send written notice via U.S. first class mail to enrollee within three business days of adjudication of a temporary fill. The notice must include (1) an explanation of the temporary nature of the transition supply an enrollee has received; (2) instructions for working with the Plan Sponsor and the enrollee's prescriber to identify appropriate therapeutic alternatives that are on the plan's formulary; (3) an explanation of the enrollee's right to request a formulary exception; and (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 43.154, the written notice must be provided within 3 business days after adjudication of the first temporary fill. 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.

J. Identification of Issues Regarding Adherence to Transition Policy

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. 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.

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.

K. Implementation Statement

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.

II. PROCEDURE

For Commercial Plan Sponsors:

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 Envision RxOptions 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.

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.

For Medicare Part D Plan Sponsors:

Overview

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.

- 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.
- 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).
- Existing members who require a transition across plan years will receive an automated transitional fill for up to a 30 day supply using a feature that performs a 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.

Detail

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.

- A. The pharmacy claims adjudication system will be configured by The Organization to allow certain edits to occur on transition fills.

- I. Edits to help determine Part B vs. Part D coverage;
 - a. Transition overrides will be configured to automatically process in the adjudication system to allow a 30 day fill (either one 30 day fill or multiple fills for up to a 30 day supply)
 - b. 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.
 - c. Drugs will pay at their appropriate copay Tier. LIS members will not pay any more than their applicable LIS level copay.
 - d. 84-90 day supply claims will not be allowed
 - II. Edits to prevent coverage of non-part D drugs (i.e., excluded drugs);
 - III. and Edits to promote safe utilization of a Part D drug (e.g., quantity limits based on FDA maximum recommended daily dose; early refill edits)
 - a. 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.
 - b. Drugs will pay at their appropriate copay Tier. LIS members will not pay any more than their applicable LIS level copay.
 - c. 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.
1. The Organization's Customer Service Representative will place an override in the pharmacy claims adjudication system in the MPA screen to allow the claim to pay for additional refills.
- I. 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 remainder of the 30/31 day supply based upon how many days the allowable fill is for.
 - II. 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 prior authorization screen to indicate this transition override.
- B. For enrollees new to the Plan Sponsor via the annual election period (at the beginning of the contract year), the initial election period (including the transition of newly eligible Medicare beneficiaries from other coverage at the beginning of the contract year), or enrollees who switch from one Part D plan to the Plan Sponsor after the beginning of the contract year (See Appendix A-Plan Adjudication Configuration by Plan Sponsor Benefit Design):
- I. The pharmacy claims adjudication system will be configured to automatically allow one 30 day fill (either one 30 day fill or multiple fills for up to a 30 day 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.
 - a. 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
 - b. The claim will default to the non-preferred drug tier copay. LIS members will not pay any more than their applicable LIS level copay
 - c. 84-90 day supply claims will not be allowed

- II. PA and ST overrides (or quantity limit overrides if directed by the Plan Sponsor) will be configured to automatically allow a 30 day fill (either one 30 day fill or multiple fills for up to a 30 day supply)
 - a. 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
 - b. 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
 - c. 84-90 day supply claims will not be allowed
- C. For New Enrollees that are LTC residents (See Appendix A-Plan Adjudication Configuration by Plan Sponsor Benefit Design)
 - I. The pharmacy claims adjudication system will be configured to allow a 91 to 98 day fill consistent with dispensing increment 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 (so long as the Plan Sponsor's benefit design does not have a XXX day look back on their Step Therapy Criteria) 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 for up to a 91-98 day supply consistent with the dispensing limit increment 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):
 - a. 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.
 - b. The pharmacy must submit the claim for up to a 31 day 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.
 - c. If the pharmacy does not submit a 3, 4 or 9 in the patient location field of the claim, and the claim is for a 31 day supply, the claim will reject and the pharmacy will receive a message that only a 30 day supply of the medication is allowed for a transitional fill.
 - d. The paid claim will default to the non-preferred drug tier copay for non-formulary medications. 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.
 - e. 84-90 day supply claims will not be allowed.
- D. 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 A, B & C above.

E. Level of Care Changes / Emergency Supplies
E. Level of Care Changes/ Emergency Supplies

- I. If a current member experiences a level of care change, 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),
 - a. 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).
 - b. 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.
 - c. Once the Clinical staff approves a transition fill for one of these circumstances (NFE, ST or PA override (or quantity limits if directed by the Plan Sponsor),
 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
 2. PA and ST overrides (or quantity limit overrides if directed by the Plan Sponsor) will be configured at Point of Sale
 - I. 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).
 - II. 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 override if directed by the Plan Sponsor).
 - III. The override will be set up to expire no later than 72 hours from the time it was entered.
 - IV. The override will only allow a 30/31 day supply of the medication (30 days for the outpatient setting and 31 days for the LTC setting).
 - V. 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.
 - VI. The Organization's Customer Service Representative will then initiate the coverage determination process.
 3. Non-Formulary claims will be configured to be overridden at Point of Sale
 - I. The Organization's Customer Service Representative will place an override in the system to allow the claim to pay for the non-formulary drug.

- II. 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 ST/PA transition override (or quantity limit transition override if directed by the Plan Sponsor).
- III. The override will be set up to expire no later than 72 hours from the time it was entered.
- IV. The override will only allow a 30 day supply of the medication or 31 day supply if the member is in an LTC setting.
- V. The claim will default to the non-preferred drug tier copay. LIS members will not pay any more than their applicable LIS level copay.
- VI. The Organization’s Customer Service Representative will then initiate the coverage determination process.
- 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.
 - I. Any overrides identified as being incorrect will be provided to an Envision Help Desk Supervisor for correction and adjudication within 24 hours of receipt of notice.

F. In the event the Plan Sponsor’s transition policy has different parameters, the Plan Sponsor’s transition policy differences will be implemented. Transition Across Plan Years

- I. 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 a 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 a transition prior to the beginning of the contract year.

- 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 30 day supply (or 31 days if in the LTC setting). The pharmacy claims adjudication platform shall be configured by the Organization to allow this to occur without Point of Sale intervention.

2. To determine if a member is eligible for one of these transition fills, the Organization shall look a XXX days (number of days determined by the Plan Sponsor) 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 XXX days prior to the start of the plan year and not the member's start date.)
3. If a paid claim is present within the look back timeframe, the transition fill will automatically process.
 - I. For drugs that are non-formulary in the new Plan Year, the claim will default to the non-preferred brand drug tier copay. LIS members will not pay any more than their applicable LIS level copay.
 - II. Drugs requiring ST or PA will pay at their appropriate copay Tier. LIS members will not pay any more than their applicable LIS level copay.
 - III. 84-90 day supply claims will not be allowed.

G. Transition Fills for Coverage Exceptions

- I. 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:
 - a. 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.
 - b. The enrollee's claims history will be reviewed to determine that a previous transition fill has been issued.
 - c. The Organization's clinical staff will be contacted to verify that a Coverage Determination decision is in the process of being effectuated.
 - d. PA and ST overrides (or quantity limit overrides if directed by the Plan Sponsor) will be configured at Point of Sale
 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.
 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).

3. The override will be set up to expire no later than 72 hours from the time it was entered.
 4. The override will only allow a 30/31 day supply of the medication (30 days in the retail setting and 31 days in the LTC setting).
 5. 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.
- e. Non-Formulary claims will be configured to be overridden at Point of Sale
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.
 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 is a non-formulary transition override.
 3. The override will be set up to expire no later than 72 hours from the time it was entered.
 4. The override will only allow a 30 day supply of the medication or 31 day supply if the member is in an LTC setting.
 5. The claim will default to the non-preferred drug tier copay. LIS members will not pay any more than their applicable LIS level copay.
- f. 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.
1. Any overrides identified as being incorrect will be provided to an Envision Help Desk Supervisor for correction and adjudication within 24 hours of receipt of notice.
- II. The Organization will honor exceptions that were approved in the previous plan year in the new plan year upon direction from the Plan Sponsor.
- a. 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.
 - b. 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.
 - c. 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 Plan Sponsor will notify the enrollee in writing at least 60 days prior to the end of the current plan year that the exception will terminate at the end of the plan year and The Organization will:
 1. 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.

H. Transition Notification

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

I. Enrollees will be notified of a prescription fill that was subject to the transition process via the model transition letter provided by the Client to The Organization.

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.
 - i. Report logic will pull transition claims based on the adjudication date
2. Letters will be mailed on a daily basis.
3. Copies of the transition letter will be kept by The Organization for Plan Sponsor and will be available upon request.
4. Monthly reports from The Organization will be provided to Plan Sponsor summarizing transition letters mailed for the previous month.

II. LTC pharmacies will not be notified of prescription fills that are subject the transition process.

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

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

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.
 - I. Report logic will pull transition claims based on the adjudication date
2. Letters will be mailed on a daily basis.
3. Copies of the transition letters will be kept by The Organization for Plan Sponsor and will be available upon request.
4. Monthly reports from The Organization will be provided to Plan Sponsor summarizing transition letters for prescribing providers mailed for the previous month.

I. identification of Issues Regarding Adherence to Transition Policy

- II. PBM shall offer to provide testing of the transition fill configuration to Plan Sponsor prior to the beginning of the new plan year.
- III. 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 P&P MED-CS-002 for more detail.
- IV. 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.
- V. 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.

J. Implementation Statement

- I. The Organization will maintain a detailed explanation related to transition configuration in the adjudication system in Appendix A
- II. 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
- III. 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 A III, E, and G above

Appendix A-Plan Adjudication Configuration by Plan Sponsor Benefit Design

Adjudication Configuration for Clients with benefit design without look back on Step Therapy Medications and up to a 98 day supply of automated LTC transition fills and up to a 30 day supply of automated non LTC transition fills for non-formulary, step therapy and prior authorization medications

Non-Formulary Transitional Dependency:

The Transitional Dependency will be set up using Rule # 1: #Scripts filled (Level = 999)

Dependency Table

Dependency ID: 0000 PART D NFTD

Load Time: 25-APR-2013 16:23:37

☐ View ☒ Edit

☒ Secure Dependency

Step Therapy	Starter Dose	CoPay	Fill Rules						
Lin	Drug ID	Description	Profile Match on	Period Type	x	Rules	True PM	Lvl	Toler
1	A	ALL	ALL	14 digit GPI	2X Days	90	1: #Scripts filled	MPDCD 0000 NFTD	99: 100

Type: A:ALL Drug ID: ALL Profile Match on: 14 digit GPI MONY: Desc: ALL Same NABP: ☐

Level: 999 Rules: 1: #Scripts filled Period Type: 2X Days Not Before:

Process Modifier: MPDCD 0000 NFTD LVL99 True Color: 2: Yellow Period: 90

Historical Script Tag Match: No Historical Claims where Qty <= RXOTC:

☐ Only count profile claims with same IN/OUT network status

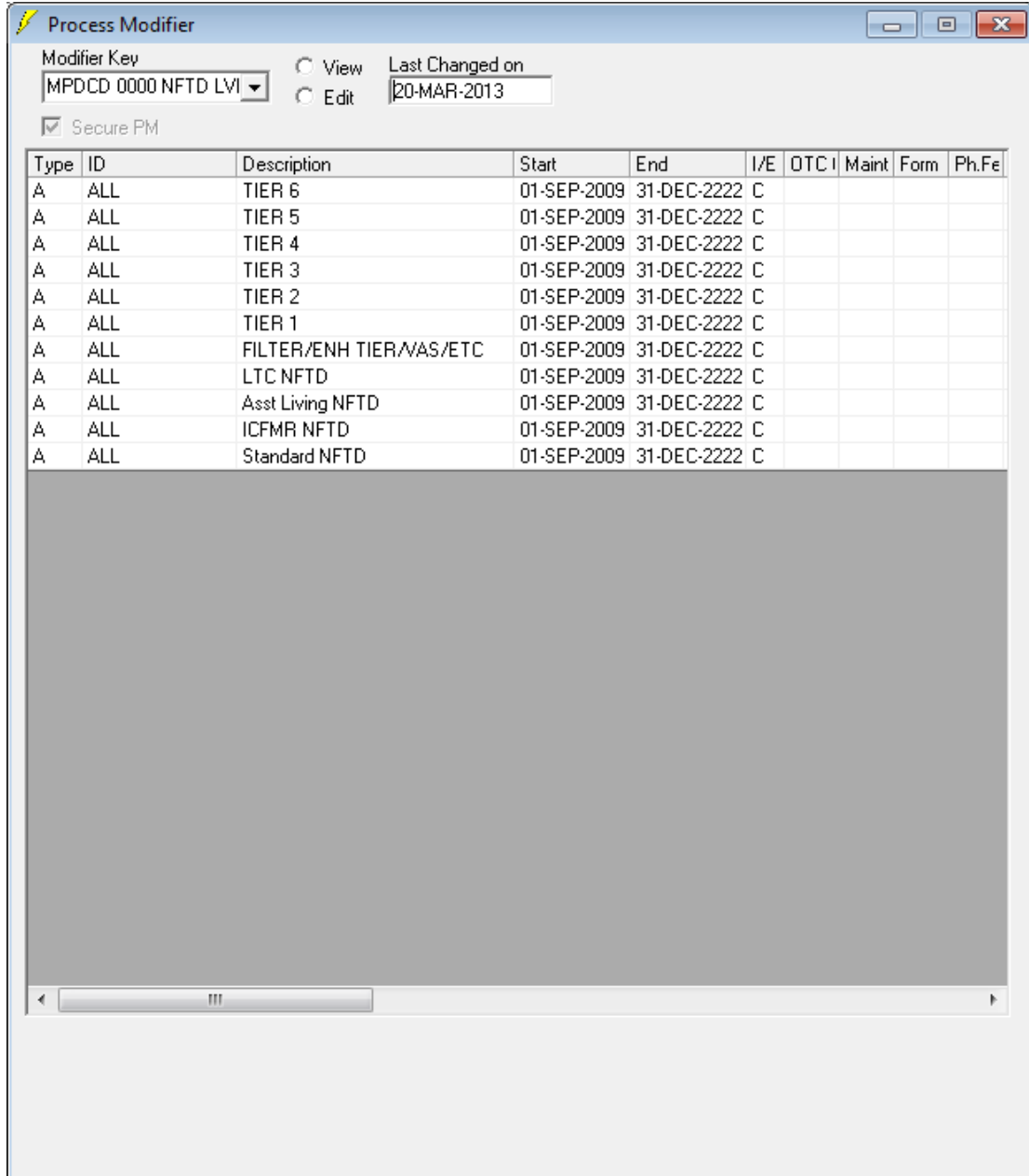
Start Date: End Date:

Insert into line#: 1

Buttons: Clear, Change, Remove, Add

The set up works as follows:

- All drugs will come into the dependency because of the Type: A:ALL
- The system will then look back in the member's history 90 days for a match on 14 digit GPI.



The screenshot shows a window titled "Process Modifier" with a toolbar containing "View" and "Edit" buttons. Below the toolbar, there is a "Modifier Key" dropdown menu set to "MPDCD 0000 NFTD LVI" and a "Last Changed on" text box containing "20-MAR-2013". A checkbox labeled "Secure PM" is checked. The main area of the window contains a table with the following data:

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.Fe
A	ALL	TIER 6	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 5	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 4	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 3	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 2	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 1	01-SEP-2009	31-DEC-2222	C				
A	ALL	FILTER/ENH TIER/VAS/ETC	01-SEP-2009	31-DEC-2222	C				
A	ALL	LTC NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	Asst Living NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	ICFMR NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	Standard NFTD	01-SEP-2009	31-DEC-2222	C				

Below the table is a large gray rectangular area, and at the bottom is a horizontal scrollbar.

- The Rx is then sent through a series of Formulary List filters. If it hits, then the claim is satisfied and it moves on to the next level of processing outside of the Dependency.
- If it is not part of one of the Formulary filters then the Rx is sent through a series of All Drugs lines.
 - The first, second and third All Drugs lines (LTC NFTD, Asst Living NFTD, ICFMR NFTD) are set up to account for LTC service codes
 - The fourth All Drugs line is set up to account for non-LTC.
- Each All Drugs line is 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:
 - Apply 31 DS dispensing limits for LTC claims where non-LTC claims will remain limited to 30 DS.
- 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 all subsequent CPM's and reject for "NON-FORMULARY DRUG. TRANSITIONAL PERIOD OVER. USE FORMULARY PRODUCT." via your NONFORM REJ CPM

Process Modifier

Modifier Key
 MPDCD 0000 NFTD LVI

☐ View Last Changed on
 20-MAR-2013

☐ Edit

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
A	ALL	TIER 2	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 1	01-SEP-2009	31-DEC-2222	C				
A	ALL	FILTER/ENH TIER/VAS/ETC	01-SEP-2009	31-DEC-2222	C				
A	ALL	LTC NFTD	01-SEP-2009	31-DEC-2222	C				

Line Maintenance

Create New PM

Drug Listing

Drug Criteria
 ALL
 ALL
 LTC NFTD

Line # 8
 Copy Change
 Remove Clear

Active Dates
 From 01-SEP-2009
 To 31-DEC-2222

☐ Indicate Med D PM

Inclusion
 Continue Processing

Handlers

Actions Add'l Criteria Actions 2

Handlers
 Age
 Co-Pay
 Cost
 Disp Fee
 Disp Limits 31DS 9999/9999/99
 Refills
 Prof. Fee
 MISC TRANSD3LTC98

Action/Criteria Summary
☒ Stamp PM Name into Formulary Field
☒ Apply Only If Match during GF days after Mem Start [90]
☒ Apply Only if Service Code [F384: ^3]
☒ Set Tier to this ----> T

Message
 LTC TRANSITIONAL FILLS ONLY ALLOWED UP TO 31 DAY SUPPLY. CALL ###-###-#### FOR ADDITIONAL LTC FILLS

Process Modifier

Modifier Key
 MPDCD 0000 NFTD LVI

☐ View
☐ Edit

Last Changed on
 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
A	ALL	FILTER/ENH TIER/VAS/ETC	01-SEP-2009	31-DEC-2222	C				
A	ALL	LTC NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	Asst Living NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	ICFMR NFTD	01-SEP-2009	31-DEC-2222	C				

Line Maintenance

Create New PM

Drug Listing

Drug Criteria
 ALL
 ALL
 Asst Living NFTD

Line # 9
 Copy Change
 Remove Clear

Active Dates
 From 01-SEP-2009
 To 31-DEC-2222

☐ Indicate Med D PM

Inclusion
 Continue Processing

Handlers

Actions

Add'l Criteria

Actions 2

Handlers
 Age
 Co-Pay
 Cost
 Disp Fee
 Disp Limits 31DS 9999/9999/99
 Refills
 Prof. Fee
 MISC TRANSD331

Action/Criteria Summary
☒ Stamp PM Name into Formulary Field
☒ Apply Only If Match during GF days after Mem Start [90]
☒ Apply Only if Service Code [F384:~4]
☒ Set Tier to this ----> T

Message
 LTC TRANSITIONAL FILLS ONLY ALLOWED UP TO 31 DAY SUPPLY. CALL ###-###-#### FOR ADDITIONAL LTC FILLS

Process Modifier

Modifier Key
 MPDCD 0000 NFTD LVI

☐ View
☐ Edit

Last Changed on
 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph
A	ALL	LTC NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	Asst Living NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	ICFMR NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	Standard NFTD	01-SEP-2009	31-DEC-2222	C				

Line Maintenance

Create New PM

Drug Listing

Drug Criteria
 ALL
 ALL
 ICFMR NFTD

Line # 10
 Copy Change
 Remove Clear

Active Dates
 From 01-SEP-2009
 To 31-DEC-2222

☐ Indicate Med D PM

Inclusion
 Continue Processing

Handlers

Actions

Add'l Criteria

Actions 2

Handlers
 Age
 Co-Pay
 Cost
 Disp Fee
 Disp Limits 31DS 9999/9999/99
 Refills
 Prof. Fee
 MISC TRANSD331

Action/Criteria Summary
☒ Stamp PM Name into Formulary Field
☒ Apply Only If Match during GF days after Mem Start [90]
☒ Apply Only if Service Code [F384:~9]
☒ Set Tier to this ----> T

Message
 LTC TRANSITIONAL FILLS ONLY ALLOWED UP TO 31 DAY SUPPLY. CALL ###-###-#### FOR ADDITIONAL LTC FILLS

Process Modifier

Modifier Key
 MPDCD 0000 NFTD LVI

☐ View
☐ Edit

Last Changed on
 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
A	ALL	LTC NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	Asst Living NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	ICFMR NFTD	01-SEP-2009	31-DEC-2222	C				
A	ALL	Standard NFTD	01-SEP-2009	31-DEC-2222	C				

Line Maintenance

Create New PM

Drug Listing

Drug Criteria
 ALL
 ALL
 Standard NFTD

Line # 11
 Copy Change
 Remove Clear

Active Dates
 From 01-SEP-2009
 To 31-DEC-2222
 Inclusion
 Continue Processing

☐ Indicate Med D PM

Handlers

Actions

Add'l Criteria

Actions 2

Handlers
 Age
 Co-Pay
 Cost
 Disp Fee
 Disp Limits 30DS 9999/9999/99
 Refills
 Prof. Fee
 MISC TRANSD3

Action/Criteria Summary
☒ Stamp PM Name into Formulary Field
☒ Apply Only If Match during GF days after Mem Start [90]
☒ Set Tier to this ----> T

Message
 LTC TRANSITIONAL FILLS ONLY ALLOWED UP TO 31 DAY SUPPLY. CALL ###-###-#### FOR ADDITIONAL LTC FILLS

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 Transitional PA and Step Therapy (ST) non-LTC Claims, the member is allowed up to an accumulated 30 Day Supply within their first 90 days. This is done with a MISC Handler (handler name = **TRANS3**) that is attached to all transitional PA/ST non-LTC claims. This handler allows the member up to a max of 30DS within a non-LTC setting regardless of the number of prescriptions processed.
 - Each fill however is limited to a 30 Day Supply.
- For Transitional PA and Step Therapy LTC Claims, the member is allowed up to an accumulated 98 Day Supply within their first 90 days. This is done with a MISC Handler (handler name = **TRANS3LTC**) that is attached to all transitional PA/ST LTC claims. This handler allows the member up to a max of 98 DS within an LTC setting regardless of the number of prescriptions processed.
 - Each fill however is limited to a 31 Day Supply.
- 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.
- Quick Review:
 - Non-LTC members up to an accumulated 30 Day Supply (regardless of # of Rxs) within their first 90 days for any transitional ST or PA drug
 - The Transitional Fill is limited to 30 Days or less per fill
 - LTC members up to an accumulated 98 Day Supply (regardless of # of Rxs) within their first 90 days for any transitional ST or PA drug
 - Any given LTC Transitional Fill is limited to 31 Days or less per fill.
- Each PA and ST criteria will need 5 lines.

Line 1:

The screenshot displays the 'Process Modifier' window. At the top, the 'Modifier Key' is set to '0000 PART D PA LIST'. Below this, there are radio buttons for 'View' and 'Edit', and a 'Last Changed on' date of '20-MAR-2013'. A checkbox for 'Secure PM' is checked.

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
L	0000 PART D PA	Standard PAs	01-JUL-2008	31-DEC-2222	C				
L	0000 PART D PA	Standard PAs	01-JUL-2008	31-DEC-2222	C				
L	0000 PART D PA	Standard PAs	01-JUL-2008	31-DEC-2222	C				
L	0000 PART D PA	Standard PAs	01-JUL-2008	31-DEC-2222	C				

Below the table, there are three main sections: 'Line Maintenance', 'Create New PM', and 'Drug Listing'.

Line Maintenance: Includes a 'Drug Criteria' section with a 'List Formulary' dropdown set to '0000 PART D PA' and a 'Standard PAs' button. There are also 'Copy', 'Change', 'Remove', and 'Clear' buttons, and an 'Indicate Med D PM' checkbox.

Create New PM: Includes a 'Line #' field set to '6', and 'Copy', 'Change', 'Remove', and 'Clear' buttons.

Drug Listing: Includes an 'Active Dates' section with 'From' (01-JUL-2008) and 'To' (31-DEC-2222) fields, and an 'Inclusion' dropdown set to 'Continue Processing'.

At the bottom, there are four tabs: 'Handlers', 'Actions', 'Add'l Criteria', and 'Actions 2'. The 'Handlers' tab is active, showing a list of handlers with input fields and icons:

- Age
- Co-Pay
- Cost
- Disp Fee
- Disp Limits: 31DS 9999/9999/99
- Refills
- Prof. Fee
- MISC: TRANSD3LTC98

To the right of the handlers is an 'Action/Criteria Summary' section with two checked items:

- ✓ Apply Only If Match during GF days after Mem Start [90]
- ✓ Apply Only if Service Code [F384:~3]

At the bottom of the 'Handlers' tab is a 'Message' field with the text: 'PA REQUIRED, OR FOR ADDITIONAL LTC/TRANSITIONAL OVERRIDES CALL ###-###-####'.

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 Handler on this line limits the LTC Rx to a maximum of 98 Day Supply Rxs within the first 90 days of the members start date.
- The MISC Handler **MUST** start with **TRANSD3LTC**, this allows for reports to be run that initiate and produce Transitional Letters.
- This line also limits each LTC Rx to a maximum of 31 Days.

Line 2:

The screenshot displays the 'Process Modifier' window. At the top, the 'Modifier Key' is set to '0000 PART D PA LIST'. Below this, the 'Secure PM' checkbox is checked. A table lists four lines, all with ID '0000 PART D PA' and Description 'Standard PAs', spanning from 01-JUL-2008 to 31-DEC-2222. The second line is highlighted. The 'Line Maintenance' section shows 'Drug Criteria' with 'List Formulary' set to '0000 PART D PA' and 'Standard PAs'. The 'Line #' is 7. 'Active Dates' are from 01-JUL-2008 to 31-DEC-2222. The 'Inclusion' dropdown is set to 'Continue Processing'. The 'Handlers' section includes fields for Age, Co-Pay, Cost, Disp Fee, Disp Limits (31DS 9999/9999/99), Refills, Prof. Fee, and MISC (TRANSD331). The 'Action/Criteria Summary' shows two checked criteria: 'Apply Only If Match during GF days after Mem Start [90]' and 'Apply Only if Service Code [F384:~4]'. A message box at the bottom states: 'PA REQUIRED, OR FOR ADDITIONAL LTC/TRANSITIONAL OVERRIDES CALL ###-###-####'.

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 Handler on this line limits the LTC Rx to an accumulated 31 DS within the first 90 days of the members start date.
- The MISC Handler **MUST** start with **TRANSD331**, this allows for reports to be run that initiate and produce Transitional Letters.
- This line also limits each Rx to a maximum of 31 Days.

Line 3:

The screenshot displays the 'Process Modifier' application window. At the top, the 'Modifier Key' is set to '0000 PART D PA LIST \', and the 'Last Changed on' date is '20-MAR-2013'. The 'Secure PM' checkbox is checked. Below this is a table with columns: Type, ID, Description, Start, End, I/E, OTC, Maint, Form, and Ph. The table contains four rows, all with 'L' as the Type and '0000 PART D PA' as the ID. The third row is highlighted in blue. Below the table are three tabs: 'Line Maintenance', 'Create New PM', and 'Drug Listing'. The 'Line Maintenance' tab is active, showing 'Drug Criteria' with a dropdown set to 'List Formulary' and a text box containing '0000 PART D PA' and 'Standard PAs'. To the right, 'Line #' is set to '8', and 'Active Dates' are 'From 01-JUL-2008' to 'To 31-DEC-2222'. Below these are buttons for 'Copy', 'Change', 'Remove', and 'Clear', along with an 'Indicate Med D PM' checkbox. The 'Drug Listing' tab shows 'Inclusion' set to 'Continue Processing'. Below the tabs are three more tabs: 'Handlers', 'Actions', and 'Add'l Criteria'. The 'Handlers' tab is active, showing a list of handlers with input fields and icons: Age, Co-Pay, Cost, Disp Fee, Disp Limits (set to '31DS 9999/9999/99'), Refills, Prof. Fee, and MISC (set to 'TRANSD331'). To the right of the handlers is an 'Action/Criteria Summary' section with two checked items: 'Apply Only If Match during GF days after Mem Start [90]' and 'Apply Only if Service Code [F384:~9]'. At the bottom is a 'Message' box with a yellow background containing the text: 'PA REQUIRED, OR FOR ADDITIONAL LTC/TRANSITIONAL OVERRIDES CALL ###-###-####'.

- 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 Handler on this line limits the LTC Rx to an accumulated 31 DS within the first 90 days of the members start date.
 - The MISC Handler **MUST** start with **TRANSD331**, this allows for reports to be run that initiate and produce Transitional Letters.
 - This line also limits each Rx to a maximum of 31 Days.

Line 4:

Process Modifier

Modifier Key: 0000 PART D PA LIST \ View Last Changed on: 20-MAR-2013
☐ Edit

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
L	0000 PART D PA	Standard PAs	01-JUL-2008	31-DEC-2222	C				
L	0000 PART D PA	Standard PAs	01-JUL-2008	31-DEC-2222	C				
L	0000 PART D PA	Standard PAs	01-JUL-2008	31-DEC-2222	E				
L	0000 PART BD PA	Standard BvD PAs	01-JUL-2008	31-DEC-2222	E				

Line Maintenance

Drug Criteria: List Formulary, 0000 PART D PA, Standard PAs

Line #: 9

Copy Change Remove Clear

☐ Indicate Med D PM

Active Dates: From 01-JUL-2008 To 31-DEC-2222

Inclusion: Continue Processing

Handlers

Age Co-Pay Cost Disp Fee Disp Limits 30DS 9999/9999/99 Refills Prof. Fee MISC TRANSD3

Action/Criteria Summary

☒ Apply Only If Match during GF days after Mem Start [90]

Message

PA REQUIRED, OR FOR ADDITIONAL LTC/TRANSITIONAL OVERRIDES CALL ###-###-####

- 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 Handler on this line limits the Rx to a maximum of an accumulated 30 DS within the first 90 days of the members start date.
 - The MISC Handler **MUST** start with **TRANS D3**, this allows for reports to be run that initiate and produce Transitional Letters.
 - This line also limits each Rx to a maximum of 30 Days.

Line 5:

Process Modifier

Modifier Key: 0000 PART D PA LIST \ View Last Changed on: 20-MAR-2013
☐ Edit

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
L	0000 PART D PA	Standard PAs	01-JUL-2008	31-DEC-2222	C				
L	0000 PART D PA	Standard PAs	01-JUL-2008	31-DEC-2222	C				
L	0000 PART D PA	Standard PAs	01-JUL-2008	31-DEC-2222	E				
L	0000 PART BD PA	Standard BvD PAs	01-JUL-2008	31-DEC-2222	E				

Line Maintenance

Drug Criteria: List Formulary, 0000 PART D PA, Standard PAs

Line #: 10

Copy Change Remove Clear

☐ Indicate Med D PM

Drug Listing

Active Dates: From 01-JUL-2008 To 31-DEC-2222

Inclusion: Exclude Always

Handlers

Actions Add'l Criteria Actions 2

Action/Criteria Summary

☒ Reject 75 on Exclude this line

Message

PA REQUIRED, OR FOR ADDITIONAL LTC/TRANSITIONAL OVERRIDES CALL ###-###-####

- 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)

Quantity Limit (QL) Transitional Fills & Transitional LTC Accommodations

- Quantity limit filters are created on the Plan Year 20## QL Process Modifier (0000 CCYY QL V2) 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 30 Day Supply within their first 90 days. This is done with a MISC Handler (handler name = **QTYTRAND3**) that is attached to all transitional QL non-LTC claims. This handler allows the member up to a max of 30DS within a non-LTC setting regardless of the number of prescriptions processed.
 - Each fill however is limited to a 30 Day Supply.
- For QL LTC Claims, the member is allowed up to an accumulated 98 Day Supply within their first 90 days. This is done with a MISC Handler (handler name = **QTYTRAND3LTC**) that is attached to all transitional QL LTC claims. This handler allows the member up to a max of 98DS within an LTC setting regardless of the number of prescriptions processed.
 - Each fill however is limited to a 31 Day Supply.
- 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:

The screenshot displays the 'Process Modifier' application window. At the top, the 'Modifier Key' is set to '0000 CCYY QL V2'. Below this, there are radio buttons for 'View' and 'Edit', and a 'Last Changed on' date of '20-MAR-2013'. A checkbox for 'Secure PM' is checked. A table lists four entries, all with ID '50250065007220' and description 'Ondansetron Orally Disintegrating', spanning from '01-JAN-1990' to '31-DEC-2222'. The first entry is highlighted in blue. Below the table, the 'Line Maintenance' section includes a 'Drug Criteria' dropdown set to 'GPI', a text field with '50250065007220', and a button with a person icon. To the right, 'Line #' is '1', with 'Copy', 'Change', 'Remove', and 'Clear' buttons. Below these is an unchecked checkbox for 'Indicate Med D PM'. Further right, 'Active Dates' are 'From 01-JAN-1990' to 'To 31-DEC-2222', and an 'Inclusion' dropdown is set to 'Continue Processing'. The 'Handlers' section at the bottom left lists 'Age', 'Co-Pay', 'Cost', 'Disp Fee', 'Disp Limits', 'Refills', 'Prof. Fee', and 'MISC', each with a text field and a person icon. To the right is an 'Action/Criteria Summary' box with a checked checkbox and the text 'Ratio: 2<=1'. At the very bottom is a 'Message' text area.

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				

Line Maintenance

Drug Criteria: GPI
50250065007220
Ondansetron Orally Disintegrating

Line #: 1
Copy Change
Remove Clear
☐ Indicate Med D PM

Active Dates: From 01-JAN-1990 To 31-DEC-2222
Inclusion: Continue Processing

Handlers

Age Co-Pay Cost Disp Fee Disp Limits Refills Prof. Fee MISC

Action/Criteria Summary: ☒ Ratio: 2<=1

Message

- 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:

Process Modifier

Modifier Key: 0000 CCYY QL V2 ☐ View ☐ Edit Last Changed on: 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				

Line Maintenance

Drug Criteria: GPI 50250065007220 ☐ Indicate Med D PM

Line #: 2

Active Dates: From 01-JAN-1990 To 31-DEC-2222

Inclusion: Continue Processing

Handlers

Age

Co-Pay

Cost

Disp Fee

Disp Limits

Refills

Prof. Fee

MISC: QTYTRAND3LTC98

Action/Criteria Summary

☒ Apply Only If Match during GF days after Mem Start [90]

☒ Apply Only if Service Code [F384:~3]

Message

LTC/TRANSITIONAL FILL - QTY LIMIT OF 60 PER 30 DAYS. CALL ###-###-#### FOR OVERRIDE INFORMATION.

- 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 (*Apply Only if Match During GF days after Mem Start [90]*).
 - The MISC Handler on this line limits the LTC Rx to a maximum of 98 Day Supply Rxs within the first 90 days of the members start date.
 - The MISC Handler **MUST** start with **QTYTRAND3LTC**, this allows for reports to be run that initiate and produce Transitional Letters.
 - This line also limits each LTC Rx to a maximum of 31 Days.

Line :3

Process Modifier

Modifier Key: 0000 CCYY QL V2 ☐ View ☐ Edit Last Changed on: 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				

Line Maintenance

Drug Criteria: GPI 50250065007220 ☐ Indicate Med D PM

Line #: 3

Active Dates: From 01-JAN-1990 To 31-DEC-2222

Inclusion: Continue Processing

Handlers

Age

Co-Pay

Cost

Disp Fee

Disp Limits

Refills

Prof. Fee

MISC: QTYTRAND331

Action/Criteria Summary

☒ Apply Only If Match during GF days after Mem Start [90]

☒ Apply Only if Service Code [F384:~4]

Message

LTC/TRANSITIONAL FILL - QTY LIMIT OF 60 PER 30 DAYS. CALL ###-###-#### FOR OVERRIDE INFORMATION.

- 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 (*Apply Only if Match During GF days after Mem Start [90]*).
 - The MISC Handler on this line limits the LTC Rx to an accumulated 31 DS within the first 90 days of the members start date.
 - The MISC Handler **MUST** start with **QTYTRAND331** , this allows for reports to be run that initiate and produce Transitional Letters.
 - This line also limits each Rx to a maximum of 31 Days.

Line :4

Process Modifier

Modifier Key: 0000 CCYY QL V2 ☐ View ☐ Edit Last Changed on: 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				

Line Maintenance

Drug Criteria: GPI 50250065007220 Ondansetron Orally Disintegrating

Line #: 4

Copy Change Remove Clear

☐ Indicate Med D PM

Active Dates: From 01-JAN-1990 To 31-DEC-2222

Inclusion: Continue Processing

Handlers

Age Co-Pay Cost Disp Fee Disp Limits Refills Prof. Fee MISC QTYTRAND331

Action/Criteria Summary

☒ Apply Only If Match during GF days after Mem Start [90]
☒ Apply Only if Service Code [F384: ^9]

Message

LTC/TRANSITIONAL FILL - QTY LIMIT OF 60 PER 30 DAYS. CALL ###-###-#### FOR OVERRIDE INFORMATION.

- 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 (*Apply Only if Match During GF days after Mem Start [90]*).
 - The MISC Handler on this line limits the LTC Rx to an accumulated 31 DS within the first 90 days of the members start date.
 - The MISC Handler **MUST** start with **QTYTRAND331**, this allows for reports to be run that initiate and produce Transitional Letters.
 - This line also limits each Rx to a maximum of 31 Days.

Line 5:

Process Modifier

Modifier Key: 0000 CCYY QL V2 ☐ View ☐ Edit Last Changed on: 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				

Line Maintenance

Drug Criteria: GPI 50250065007220  Ondansetron Orally Disintegrating

Line #: 5

☐ Indicate Med D PM

Active Dates: From 01-JAN-1990 To 31-DEC-2222

Inclusion: Continue Processing

Handlers

Age  Co-Pay  Cost  Disp Fee  Disp Limits  Refills  Prof. Fee  MISC: QTYTRAND30 

Action/Criteria Summary

☒ Apply Only If Match during GF days after Mem Start [90]

Message

LTC/TRANSITIONAL FILL - QTY LIMIT OF 60 PER 30 DAYS. CALL ###-###-#### FOR OVERRIDE INFORMATION.

- The fifth 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 Handler on this line limits the Rx to a maximum of an accumulated 30 DS within the first 90 days of the members start date.
 - The MISC Handler **MUST** starts with **QTYTRAND30**, this allows for reports to be run that initiate and produce Transitional Letters.
 - This line also limits each Rx to a maximum of 30 Days.

Line 6:

Process Modifier

Modifier Key: 0000 CCYY QL V2 ☐ View ☐ Edit Last Changed on: 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				
G	50250065007220	Ondansetron Orally Disintegrating	01-JAN-1990	31-DEC-2222	C				

Line Maintenance

Drug Criteria: GPI 50250065007220 ☐ Indicate Med D PM

Active Dates: From 01-JAN-1990 To 31-DEC-2222 Inclusion: Continue Processing

Handlers

Age ☐ Indicate Med D PM

Co-Pay ☐ Indicate Med D PM

Cost ☐ Indicate Med D PM

Disp Fee ☐ Indicate Med D PM

Disp Limits ☐ Indicate Med D PM

Refills ☐ Indicate Med D PM

Prof. Fee ☐ Indicate Med D PM

MISC: ER 60 PER 30 DAYS ☐ Indicate Med D PM

Action/Criteria Summary

Message: QTY LIMIT OF 60 PER 30 DAYS. CALL ###-###-#### FOR OVERRIDE INFORMATION.

- 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 **TRANS D3**. 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 2012 and forward for drugs subject to prior authorization will be: **Prior Auth Required. PA REQ FOR PART B VS D DETERMINATION. CALL ###-###-#### OR FOR ADDITIONAL LTC/TRANSITIONAL OVERRIDES CALL ###-###-#### or PA REQUIRED, OR FOR ADDITIONAL LTC/TRANSITIONAL OVERRIDES CALL ###-###-####**
 - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2012 and forward for drugs subject to step therapy will be: **Must Have Tried and Failed _____ before _____ . Call ###-###-#### for additional LTC fills**
 - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2012 and forward for drugs that are non-formulary will be: **LTC TRANSITIONAL DRUGS ONLY ALLOWED 31 DAY SUPPLY. CALL ###-###-#### FOR ADDITIONAL LTC FILLS**
 - For Rejected Claims
 - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2012 and forward for drugs subject to prior authorization will be: **Prior Auth Required. PA REQ FOR PART B VS D DETERMINATION. CALL ###-###-#### OR FOR ADDITIONAL LTC/TRANSITIONAL OVERRIDES CALL ###-###-#### or PA REQUIRED, OR FOR ADDITIONAL LTC/TRANSITIONAL OVERRIDES CALL ###-###-####**
 - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2012 and forward for drugs subject to step therapy will be: **Must Have Tried and Failed _____ before _____ . Call ###-###-#### for additional LTC fills**
 - Actual pharmacy Messaging placed in the pharmacy claims adjudication system for 2012 and forward for drugs that are non-formulary will be: **NON-FORMULARY DRUG. TRANSITIONAL PERIOD OVER. USE FORMULARY PRODUCT.**

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 30 day supply (or 98 day if for LTC) transitional fill within the first 90 days of the benefit year.
- A formulary list is created and named GRANDFATHER LIST 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 GRANDFATHER V2 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 30 day (or 98 days for LTC claims) only dispensing limits.
- The Grandfathering list is attached to a Common Process Modifier with specified rules to allow up to an accumulated 30 day (or up to a 98 day supply for LTC) 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 (Plan Sponsor defines look- back period) 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 PARTD 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)
- 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 70). – 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 98 day 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 Modifier showing Grandfather lists

Process Modifier

Modifier Key
 MPDCD 0000 PARTD G

☐ View
☐ Edit

Last Changed on
 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
L	0000 GRAND	PART D STANDARD GRANDFA	31-DEC-2012	31-DEC-2222	C				
L	0000 GRAND	PART D STANDARD GRANDFA	31-DEC-2012	31-DEC-2222	C				
L	0000 GRAND	PART D STANDARD GRANDFA	31-DEC-2012	31-DEC-2222	C				
L	0000 GRAND B	0000 GRAND B DRUGS	31-DEC-2012	31-DEC-2222	C				

Line Maintenance

Create New PM

Drug Listing

Drug Criteria
 List Formulary
 0000 GRAND
 PART D STANDARD GRAND

Line # 7
 Copy Change
 Remove Clear
☐ Indicate Med D PM

Active Dates
 From 31-DEC-2012
 To 31-DEC-2222
Inclusion
 Continue Processing

Handlers

Actions

Add'l Criteria

Actions 2

Handlers
 Age
 Co-Pay
 Cost
 Disp Fee
 Disp Limits 31DS 9999/9999/99
 Refills
 Prof. Fee
 MISC TRANSD3LTC98

Action/Criteria Summary
☒ Apply Only If Match prior to SD for GF days [12010]
☒ Stamp PM Name into Formulary Field
☒ Apply Only if Service Code [F384:~3]
☒ Set Tier to this ----> G

Message
 UP TO 98DS GRANDFATHER FILL MET MUST USE FORMULARY ALTERNATIVE CALL
 ####.####.####

Process Modifier

Modifier Key
 MPDCD 0000 PARTD G

☐ View
☐ Edit

Last Changed on
 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
L	0000 GRAND	PART D STANDARD GRANDFA	31-DEC-2012	31-DEC-2222	C				
L	0000 GRAND	PART D STANDARD GRANDFA	31-DEC-2012	31-DEC-2222	C				
L	0000 GRAND	PART D STANDARD GRANDFA	31-DEC-2012	31-DEC-2222	C				
L	0000 GRAND B	0000 GRAND B DRUGS	31-DEC-2012	31-DEC-2222	C				

Line Maintenance

Create New PM

Drug Listing

Drug Criteria
 List Formulary
 0000 GRAND
 PART D STANDARD GRAND

Line # 8
 Copy Change
 Remove Clear
☐ Indicate Med D PM

Active Dates
 From 31-DEC-2012
 To 31-DEC-2222
 Inclusion
 Continue Processing

Handlers

Actions

Add'l Criteria

Actions 2

Handlers
 Age
 Co-Pay
 Cost
 Disp Fee
 Disp Limits 31DS 9999/9999/95
 Refills
 Prof. Fee
 MISC TRANSD331

Action/Criteria Summary
☒ Apply Only If Match prior to SD for GF days [12010]
☒ Stamp PM Name into Formulary Field
☒ Apply Only if Service Code [F384: ^4]
☒ Set Tier to this ----> G

UP TO 98DS GRANDFATHER FILL MET MUST USE FORMULARY ALTERNATIVE CALL
 ###-###-####

Process Modifier

Modifier Key
 MPDCD 0000 PARTD G

☐ View
☐ Edit

Last Changed on
 20-MAR-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
L	0000 GRAND	PART D STANDARD GRANDFA	31-DEC-2012	31-DEC-2222	C				
L	0000 GRAND	PART D STANDARD GRANDFA	31-DEC-2012	31-DEC-2222	C				
L	0000 GRAND	PART D STANDARD GRANDFA	31-DEC-2012	31-DEC-2222	C				
L	0000 GRAND B	0000 GRAND B DRUGS	31-DEC-2012	31-DEC-2222	C				

Line Maintenance

Create New PM

Drug Listing

Drug Criteria
 List Formulary
 0000 GRAND
 PART D STANDARD GRAND

Line # 9
 Copy Change
 Remove Clear
☐ Indicate Med D PM

Active Dates
 From 31-DEC-2012
 To 31-DEC-2222
 Inclusion
 Continue Processing

Handlers

Actions

Add'l Criteria

Actions 2

Handlers
 Age
 Co-Pay
 Cost
 Disp Fee
 Disp Limits 30DS 9999/9999/99
 Refills
 Prof. Fee
 MISC TRANSD3

Action/Criteria Summary
☒ Apply Only If Match prior to SD for GF days [12010]
☒ Stamp PM Name into Formulary Field
☒ Set Tier to this ----> G

UP TO 30DS GRANDFATHER FILL MET MUST USE FORMULARY ALTERNATIVE CALL
 ###-###-####

#2 PPP Process Modifier

Process Modifier

Modifier Key: 0000 PART D PPP \$297 ☐ View ☐ Edit Last Changed on: 07-AUG-2012

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph
A	ALL	TIER 6	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 5	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 4	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 3	01-SEP-2009	31-DEC-2222	C				

Line Maintenance | Create New PM | Drug Listing

Drug Criteria: ALL (dropdown), ALL (text), TIER 6 (highlighted)

Line #: 1

Copy Change Remove Clear

☐ Indicate Med D PM

Active Dates: From 01-SEP-2009 To 31-DEC-2222

Inclusion: Continue Processing (dropdown)

Handlers | Actions | Add'l Criteria | Actions 2

Handlers:

Age [] [icon]
Co-Pay [] [icon]
Cost [] [icon]
Disp Fee [] [icon]
Disp Limits [] [icon]
Refills [] [icon]
Prof. Fee [] [icon]
MISC [] [icon]

Action/Criteria Summary:

- ☒ SDC Code: 2013D PPP \$2970
- ☒ Apply Only if Tier is one of these ---> [6]

Message:

[Yellow text area]

#3 PTR Process Modifier

Process Modifier

Modifier Key: 0000 PART D PTR \$475 | View | Last Changed on: 07-AUG-2012 | Edit

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph
A	ALL	TIER 6	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 5	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 4	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 3	01-SEP-2009	31-DEC-2222	C				

Line Maintenance | Create New PM | Drug Listing

Drug Criteria: ALL | ALL | TIER 6

Line #: 1 | Copy | Change | Remove | Clear

☐ Indicate Med D PM

Active Dates: From 01-SEP-2009 To 31-DEC-2222

Inclusion: Continue Processing

Handlers | Actions | Add'l Criteria | Actions 2

Handlers: Age, Co-Pay, Cost, Disp Fee, Disp Limits, Refills, Prof. Fee, MISC

Action/Criteria Summary:

- ☒ SDC Code: 2013D PTR \$4750
- ☒ Apply Only if Tier is one of these --> [6]

Message:

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 must 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 2013 forward will be: UP TO 30 DS 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 V2 (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 0000 NONFORM D TIER V2.
 - 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 0000 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 0000 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 and 7X
 - Any denied claims/drugs subject to a transition requirement
 -

Example #1

Process Modifier

Modifier Key: 0000 NONFORM D TIEF View Edit Last Changed on: 31-DEC-2011

☐ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
A	ALL	TIER 1	01-SEP-2009	31-DEC-2222	C				
L	0000 TIER	FILTER/ENH TIER/VAS/ETC	01-SEP-2009	31-DEC-2222	C				
A	ALL	All Drugs	01-SEP-2009	31-DEC-2222	C				
A	ALL	All Drugs	01-SEP-2009	31-DEC-2222	C				

Line Maintenance **Create New PM** **Drug Listing**

Drug Criteria: ALL, ALL, All Drugs

Line #: 8 Copy Change Remove Clear

☐ Indicate Med D PM

Active Dates: From 01-SEP-2009 To 31-DEC-2222

Inclusion: Continue Processing

Handlers **Actions** **Add'l Criteria** **Actions 2**

Handlers: Age, Co-Pay, Cost, Disp Fee, Disp Limits, Refills, Prof. Fee, MISC

Action/Criteria Summary:

- ☒ Set Script Tag To ---->[NFTDREJ]
- ☒ Apply Only If Match during GF days after Mem Start [90]
- ☒ Write Script Tag to Claim

Message

Process Modifier

Modifier Key
 0000 NONFORM D TIEF

☐ View
 ☐ Edit

Last Changed on
 31-DEC-2011

☐ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
A	ALL	TIER 1	01-SEP-2009	31-DEC-2222	C				
L	0000 TIER	FILTER/ENH TIER/VAS/ETC	01-SEP-2009	31-DEC-2222	C				
A	ALL	All Drugs	01-SEP-2009	31-DEC-2222	C				
A	ALL	All Drugs	01-SEP-2009	31-DEC-2222	C				

Line Maintenance

Create New PM

Drug Listing

Drug Criteria
 ALL
 ALL
 All Drugs

Line # 9
 Copy Change
 Remove Clear

Active Dates
 From 01-SEP-2009
 To 31-DEC-2222

☐ Indicate Med D PM

Inclusion
 Continue Processing

Handlers

Actions

Add'l Criteria

Actions 2

Handlers
 Age
 Co-Pay
 Cost
 Disp Fee
 Disp Limits
 Refills
 Prof. Fee
 MISC

Action/Criteria Summary
☒ Set Tier to this ----> R

Message

Example #2

Process Modifier

Modifier Key
 0000 MED D 569 APPL^

☐ View
 ☐ Edit

Last Changed on
 25-FEB-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
A	ALL	TIER 2	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 1	01-SEP-2009	31-DEC-2222	C				
A	ALL	All Drugs	01-SEP-2009	31-DEC-2222	C				
A	ALL	All Drugs	01-SEP-2009	31-DEC-2222	C				

Line Maintenance

Create New PM

Drug Listing

Drug Criteria
 ALL
 ALL
 All Drugs

Line # 8
 Copy Change
 Remove Clear

Active Dates
 From 01-SEP-2009
 To 31-DEC-2222

☐ Indicate Med D PM

Inclusion
 Continue Processing

Handlers

Actions

Add'l Criteria

Actions 2

Handlers
 Age
 Co-Pay
 Cost
 Disp Fee
 Disp Limits
 Refills
 Prof. Fee
 MISC

Action/Criteria Summary
☒ Apply Only if Script Tag is ---->[=NFTDREJ]
☒ Only Use Message If Script Rejects

Message
 SPECREJ:70,75,9G,7X:569:Provide Notice-Medicare Prescription Drug Coverage and Your Rights

Process Modifier

Modifier Key
 0000 MED D 569 APPL

☐ View
 ☐ Edit

Last Changed on
 25-FEB-2013

☒ Secure PM

Type	ID	Description	Start	End	I/E	OTC	Maint	Form	Ph.
A	ALL	TIER 2	01-SEP-2009	31-DEC-2222	C				
A	ALL	TIER 1	01-SEP-2009	31-DEC-2222	C				
A	ALL	All Drugs	01-SEP-2009	31-DEC-2222	C				
A	ALL	All Drugs	01-SEP-2009	31-DEC-2222	C				

Line Maintenance

Create New PM

Drug Listing

Drug Criteria
 ALL
 ALL
 All Drugs

Line # 9
 Copy Change
 Remove Clear

Active Dates
 From 01-SEP-2009
 To 31-DEC-2222
 Inclusion
 Continue Processing

☐ Indicate Med D PM

Handlers

Actions

Add'l Criteria

Actions 2

Handlers
 Age
 Co-Pay
 Cost
 Disp Fee
 Disp Limits
 Refills
 Prof. Fee
 MISC

Action/Criteria Summary
☒ Apply Only if Tier is one of these --> [R]
☒ Only Use Message If Script Rejects

Message
 SPECREJ:70,75,9G,7X:569:Provide Notice-Medicare Prescription Drug Coverage and Your Rights

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 as long as the configuration does not have a look back period for Step Therapy Medications. 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 Envision 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 54 of this policy and procedure.

Medicare Part D Transition Override Workflow, Cont'd

