

Medicare Transition POLICY AND PROCEDURES

POLICY

The Plan will maintain an appropriate transition process, consistent with 42 CFR §423.120(b)(3), Chapter 6 of the Medicare Prescription Drug Benefit Manual and any other CMS guidance, 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.

PURPOSE

To describe the Plan's transition process and how it addresses situations in which an individual first presents at a participating pharmacy with a prescription for a drug that is not on the formulary, unaware of what is covered, or unaware of the exception or prior authorization, step therapy process to provide access to Part D drugs.

DEFINITIONS

CMS: Centers for Medicare & Medicaid Services.

Emergency Fill: After the initial new-enrollee transition period and initial 90 days formulary change across contract year period, LTC facility residents who are ordered non-formulary, PA, ST drugs, must receive their medications as ordered without delay. Therefore, Part D plans must cover an emergency supply of these drugs for LTC facility residents as part of their transition process. These emergency supplies of non-formulary Part D drugs – including Part D drugs that are on a sponsor's formulary but require prior authorization or step therapy under a sponsor's utilization management rules – must be for at least 31 days of medication, unless the prescription is written by a prescriber for less than 31 days, in this case allow multiple fills up to 31 days' supply.

Enrollee: Member of a Medicare Part D plan.

Formulary: Plan's formulary lists products that have been compared and evaluated against other brand-name and generic products by the plan's Pharmacy and Therapeutics Committee (P&T Committee). Products may be listed as preferred, non-preferred, and/or excluded with respect to plan benefits. Products on the preferred drug list are chosen because they provide maximum quality and value for the plan's enrollees.

Formulary Changes Across Contract Years: Includes drugs that will become Non-Formulary (no longer covered on the formulary), or drugs that remain on the formulary but have new PA or ST restriction added from one contract year to another (negative change).

HPMS: Health Plan Management System. Web-enabled information system that serves a critical role in supporting the implementation and ongoing operations of the Medicare Advantage and Medicare Prescription Drug programs. HPMS and its software modules are used to collect and receive data.

Level-of-Care Change: When an enrollee is changing from one treatment setting to another. Examples include, but are not limited to: (1) beneficiaries who enter LTC facilities from hospitals; (2) beneficiaries who are discharged

from a hospital to a home; (3) beneficiaries who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary; (4) beneficiaries who give up hospice status to revert to standard Medicare Part A and B benefits; (5) beneficiaries who end an LTC facility stay and return to the community; and (6) beneficiaries who are discharged from psychiatric hospitals with drug regimens that are highly individualized. Within adjudication system Level-of-Care Change has been identified based on Patient Residence Code (vD.0 format) change.

LIS: Low-Income Subsidy.

LTC Facility: Long-Term Care Facility. Skilled nursing facility as defined in section 1819(a) of the Social Security Act, or a medical institution or nursing facility for which payment is made for an institutionalized individual under section 1902(q)(1)(B) of the Social Security Act.

MADD: Maximum Allowable Daily Dose.

Medicare Part D Excluded Drugs: Drugs for which payment as so prescribed and dispensed or administered to an individual is available for that individual under Part A or Part B, even though a deductible may apply, or even though the individual is eligible for coverage under Part A or Part B but has declined to enroll in Part A or Part B. Drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) or (d)(3) of the Social Security Act, except for smoking cessation agents.

Medicare Part D Plan (Part D Plan): Prescription Drug Plan (PDP), Medicare Advantage Prescription Drug Plan (MA-PD), Program of All-Inclusive Care for the Elderly (PACE) Plan offering qualified prescription drug coverage, or a Cost Plan offering qualified prescription drug coverage.

NCPDP: National Council of Prescription Drug Programs.

NCOA: National Change of Address database; the NCOA process consists of computer software purchased, leased, or developed by the Company to access the NCOA database. The U.S. Postal Service certifies the process and licenses the NCOA product to private sector companies for commercial mail list processing or internal mail list management.

Network Pharmacy: Licensed pharmacy under contract with a Part D plan to provide covered Part D drugs at negotiated prices to its Part D plan enrollees.

Non-Formulary Drug: Part D drug that is not on a Medicare Part D plan's formulary. A non-formulary drug may include a medication that was covered under the enrollee's prior plan but is not on the Medicare Part D formulary for the plan (i.e., non-covered Part D medication). The plan does not distinguish between a new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug when a distinction cannot be made at the POS for the purposes of transition.

Participating Pharmacy: Licensed pharmacy under contract with a Part D plan to provide covered Part D drugs at negotiated prices to its Part D plan enrollees.

POS: Point-of-Sale.

PA: Prior Authorization

Plan: A MedAdvantage Prescription Drug Plan (MA-PD) or a Part D Prescription Drug Plan (PDP) contracted with CMS to enroll Medicare beneficiaries.

Prior Authorization, Step Therapy Transition Codes: Two-letter codes used to specify the type of transition fill.

SNF: Skilled Nursing Facility.

SME: Subject Matter Expert.

Transition: Includes (1) transition of new enrollees into a Medicare Part D plan following the annual coordinated election period (ACEP); (2) transition of newly eligible enrollees into a Medicare Part D plan from other coverage; (3) transition of enrollees from one plan to another after the start of a plan year (i.e., after January 1); (4) movement of enrollees in or out of an LTC facility; or (5) current enrollees in a Medicare Part D plan affected by formulary changes from one plan year to the next. Copayment and cost-sharing for transition claims are processed in accordance with the enrollee's full benefit design. The plan will extend its transition process across contract years should an enrollee join the plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply.

Transition Period: The first 90 days of coverage under a Medicare Part D plan following a transition. During this time, Medicare Part D plans must provide a temporary fill of a non-formulary drug or drug on formulary with a PA, St or QL.

Transition Notice: A written notice mailed to the enrollee following receipt of a temporary fill during the transition period. The notice is in accordance with CMS guidance and contains the following information: (1) an explanation of the temporary transition supply the enrollee has received during the transition period; (2) instructions for working with the plan and the enrollee's prescriber to identify appropriate therapeutic alternatives that are on the Medicare Part D plan's formulary or exception request forms (available to enrollee via USPS mail, web site, or facsimile) for formulary drugs that need a prior authorization or step therapy; (3) an explanation of the enrollee's right to request an exception; and (4) a description of the procedure for requesting an exception. Each Medicare Part D plan is responsible for obtaining CMS approval of the transition notice, as required by CMS.

UM: Utilization Management.

PROCEDURES

A. SUBMISSION OF POLICY

1. The plan will provide a copy of this transition policy on an annual basis.
2. This policy will have been reviewed and approved by the plan's P&T Committee, business process owners, and SMEs.
3. The plan is responsible for, P&T reviews, and submission to CMS for review and approval.
4. The plan is also responsible for making the Transition Policy available to Medicare beneficiaries via link from the Medicare Prescription Drug Plan Finder and on the plan's website.
5. The plan will monitor CMS guidance for updates or revisions to current policy as needed.

B. TRANSITION SUPPLY FOR NON-FORMULARY DRUGS

The plan has system capabilities that allow 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.

1. The plan's Transition Policy will apply to non-formulary drugs, meaning both:

- a. Part D drugs that are not on the plan's formulary
 - b. Part D drugs that are on the plan's formulary but require prior authorization or step therapy under the plan's UM rules.
2. The plan's 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.

C. TRANSITION SUPPLY FOR DRUGS WITH UM CONTROLS

The plan's Transition Policy also applies to Part D drugs that are on a plan's formulary but require PA or step therapy under the plan's UM rules.

1. The plan will apply the following UM edits during transition at POS:
 - a. Edits to determine Part B versus Part D coverage
 - b. Edits to prevent coverage of non-Part D drugs
 - c. Edits to promote safe utilization of a Part D drug
 - d. Edits to determine non-covered Part D drugs vs. covered Part D drugs
2. The plan has also established medical review and coverage determination processes to evaluate the medical necessity of non-formulary drug requests and to provide authorizations or therapeutic formulary alternatives when medical necessity is not affirmed.
3. Enrollees and physicians can obtain forms to arrange for PA of non-formulary drugs through a variety of means, including mail, fax, email, and the plan's website. Although these forms are not required, they are helpful for the evaluation of the requests.

D. TRANSITION FOR NEWLY IMPLEMENTED UM CONTROLS

1. For current enrollees whose drugs are no longer on the formulary, or remain on the formulary but with new prior utilization or step therapy restrictions applied, the plan will effectuate a meaningful transition by either:
 - a. Providing a transition process consistent with the transition process required for new enrollees beginning in the new contract year, or
 - b. Effectuating a transition prior to the beginning of the new contract year

E. RETAIL SETTING - TEMPORARY FILL AMOUNT

1. The plan will ensure that in the retail setting, the Transition Policy provides for at least a one-time, temporary 30day fill, unless the enrollee presents with a prescription written for less than 30 days, in which case the plan must allow multiple fills to provide a total of 30 days of medication. The plan will also allow appropriate transition fills for drugs manufactured in "unbreakable packages."
2. This may occur anytime during the first 90 days of a beneficiary's enrollment in the plan, beginning on the enrollee's effective date of coverage
3. If applicable, the plan provides a transition fill for current enrollees within the first 90 days of the plan year under "Formulary Change Across Contract Year" transition rules.

F. COST-SHARING ON TEMPORARY FILLS

1. The plan charges cost-sharing for a temporary supply of drugs provided under its transition process, subject to the following guidelines:
 - a. Cost-sharing for transition supplies for LIS-eligible enrollees never exceeds the statutory maximum copayment amounts.
 - b. For non-LIS enrollees, charges for cost-sharing for non-formulary drugs is based on one of the plan's approved drug cost-sharing tiers, and this cost-sharing is consistent with cost-sharing that is charged for non-formulary drugs approved under a coverage exception.
 - c. For non-LIS enrollees, cost-sharing for formulary drugs with UM waived for transition supply is based on the applicable formulary tier had the UM not been waived for transition.

G. TRANSITION FOR LTC SETTING

The plan will ensure that in the LTC setting:

1. The Transition Policy provides for a 91- to a 98-day fill consistent with dispensing increment requirements, 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 consistent with dispensing requirements while an exception or PA is requested.
3. For enrollees being admitted to or discharged from an 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.
4. LTC enrollees are identified based on the patient residence code submitted on the claim. This indicator permits the total days' supply of the transition fill allowed is a total of 98 days.

H. LEVEL-OF-CARE CHANGES

The plan provides transition fills for enrollees who experience a transition characterized as a level-of-care change from one treatment setting to another.

1. Examples of level-of-care changes where a transition may apply include:
 - a. Enrollees who are discharged from a hospital to a home setting (i.e., assisted living, LTC, or private home) accompanied by a list of medications that may not always consider the formulary of the enrollee's plan due to the short-term nature of the hospital visit
 - b. Enrollees who end their SNF Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary
 - c. Enrollees who give up hospice status to revert to standard Medicare Part A and B benefits
 - d. Enrollees who end an LTC facility stay and return to the community
 - e. Enrollees who are discharged from psychiatric hospitals with drug regimens that are highly individualized
2. The plan considers these unplanned transitions and applies the transition fill process as required.
3. The plan understands that while Part A provides reimbursement for "a limited supply" to facilitate enrollee discharge, the enrollee is entitled to a full outpatient supply in order to continue therapy once this limited supply is exhausted. This is particularly true for enrollees using a mail-order pharmacy or home infusion

therapy, or for those residing in rural areas where obtaining a continuing supply of drugs may involve certain delays.

4. The plan ensures that enrollees are able to receive their outpatient Part D prescriptions in advance of discharge from a Part A stay through this transition process.

I. ONE-TIME FILLS FOR UNPLANNED TRANSITION FROM HOSPITAL, LTC, SNF, OR HOSPICE

For an enrollee leaving a hospital, SNF, or hospice setting (where prescriptions are covered under Medicare Part A or Part B), the discharge list of prescription orders may contain medications that are either non-formulary or subject to UM edits. (Please refer to the “Level-of-Care Change” definition to review additional examples of Level-of-Care changes).

1. The level-of-care change automated programming identifies if the member has a change in patient residence code based on the most recent claim.
2. If a level-of-care change is identified, the system can be configured to automatically override the following edits on Part D-covered drugs at the plan’s discretion to allow the claim to pay:
 - a. Refill-too-Soon
 - b. Duplicate prescription
 - c. Duplicate therapy
 - d. Non-formulary
 - e. Prior authorization (excluding B vs. D PAs)
 - f. Step therapy
 - g. Quantity limits
3. If the member didn’t have a change identified by a change in patient residence code, in order to ensure that the enrollee does not have a gap in therapy, the pharmacist should call the plan’s call center to notify them of the level-of-care change in order to have an authorization placed in the system allowing the claim to pay.
4. This authorization will address the above edits, resulting in a paid claim as determined by the plan.
5. These authorizations will be entered as one-time authorizations; however, if the member has subsequent level-of-care changes, additional one-time authorizations will be entered to ensure there are no gaps in therapy.
6. If the rejection is related to a clinical reason (i.e., non-formulary, PA, step therapy), the coverage determination team will also be notified to begin the coverage determination and exception process with the prescriber.
7. Enrollees are provided with appropriate written transition letter notification regarding their transition supply for any of the reasons indicated in the CMS model transition notice. This notice will include an explanation of the temporary nature of the transition supply, along with instructions for working with the plan and the enrollee’s prescriber to determine an appropriate therapeutic formulary alternative.
8. Additionally, the letter template will provide an explanation on the enrollee’s right to request a formulary exception with the procedures on how to pursue that option.
9. One transition letter is generated per claim, so if the drug has exceeded both PA and quantity limit restrictions, one letter will include both reasons.

10. If a member receives multiple transition fills of different drugs on the same day, a letter will be generated for each drug.
11. At least annually, the plan pharmacy network will be reminded of the clarification codes to submit for these situations via fax blast from the Provider Relations Department.

J. QUANTITY LIMITS, REFILL-TOO-SOON, AND SAFETY EDITS

The plan's 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.

1. The plan only applies certain drug utilization management edits during a beneficiary's transition period at POS.
2. Drug utilization management edits that are appropriate during this transition period include: edits to help determine Part B vs. Part D coverage; edits to prevent coverage of non-Part D drugs (i.e., excluded drugs); or edits to promote safe utilization of Part D drugs (i.e., MADD edits based on FDA maximum recommended doses, early refill edits); or edits to maximize appropriate dose.
3. The plan applies edits to certain non-six clinical class drugs, MADD edits, B vs. D administrative PA edits, and early refill edits during transition. Resolution of edits is made by the dispensing pharmacist at POS by either: (1) resubmitting claim with revised/corrected information, or (2) calling the Member Services Department/Pharmacy Help Desk. Edits that are placed on the formulary vary by formulary (CMS-approved) and plan benefit design.
4. Edits applied during transition are managed and resolved through POS and review activity.
5. If any non-formulary, prior authorization or step therapy edit is overridden at POS for transition purposes only, but not permanently, the plan notifies the beneficiary so that he or she can begin the exception process, if necessary. Notification occurs via U.S. first-class mail to the enrollee within three (3) business days of adjudication of a temporary fill. Notification specifics are outlined under "Transition Notification" section.
6. The plan implements additional step therapy-type PA or PA edits during transition if such edits can be resolved at the POS.
7. All non-formulary, prior authorization and step therapy edits are subject to exception request and appeal. The plan ensures that beneficiaries are made aware of any edits that result in a prescription being filled differently than originally written, as well as their right to request an exception.
8. The plan expeditiously processes such exception requests so that beneficiaries will not experience unintended interruptions in medically necessary Part D drug therapies and/or inappropriately pay additional cost-sharing associated with multiple fills of lesser quantities when the originally prescribed doses of Part D drugs are medically necessary.
 - a. All non-formulary, prior authorization and step therapy edits (not including B vs. D PAs, Part D vs. non-Part D, edits to reject non-part D drugs, quantity limits for safety reasons, and early refill edits) are overridden during the transition period to allow multiple fills up to the overall transition day(s) supply

limit. Multiple refills of a transition supply may therefore be obtained up to the maximum allowable days' supply of a transition supply.

- b. Enrollees must be allowed to refill a transition supply of a non-formulary Part D drug if the prescription is dispensed for less than the written amount due to quantity limits for safety purposes or DU edits that are based on approved product labeling.
- c. All non-formulary, prior authorization and step therapy edits will be resolved at the point-of-service adjudication. No "hard edits" are utilized in order to manage transition supplies. Since the UM edits (except B vs. D PAs) are overridden to allow the transition fill during the first 90 days of enrollment, there is no need for retail, home infusion, safety-net, or I/T/U pharmacists to enter an override. These claims will pay without any additional input from the submitting pharmacist, and the enrollee will, therefore, never leave the pharmacy without a transition supply.

K. MESSAGING

During the transition period, the plan's claims system allows a transitional fill for all products identified as transition-eligible. The plan's coding and claims processing system allows temporary supplies of non-formulary Part D drugs (including Part D drugs that are on the formulary but require PA or step therapy-type PA under UM rules). The claims processing system has an automated configuration that determines if the criteria for a transition supply is met. Claims are processed at POS and do not require additional action from the pharmacist, unless an allowable edit is in place. This accommodates the immediate needs of an enrollee, as well as allowing 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.

1. If a transition fill is effectuated, the dispensing pharmacy receives:
 - a. A free text message in the pharmacy response identifying this as a transition fill and other information related to authorization processing as needed.
 - b. NCPDP-approved message codes in the pharmacy response. The pharmacy only receives the NCPDP reject codes relative to transition and is dependent on the pharmacy's software to apply the appropriate message.
 - c. When a transition supply claim is paid through the system, pharmacies will be notified via an electronic message informing them that the fill was part of a transition supply. If the claim encounters a valid transitional reject, a message is returned to the pharmacy to indicate the reason for the rejection.
 - d. Once the transition period has ended, the system will reject those claims for which the products are non-formulary, need PA, or exceed plan limitations.

L. TRANSACTIONAL CODING IMPLEMENTATION

1. Until such time as alternative transactional coding is implemented in a new version of the HIPAA standard, the plan will promptly implement either:
 - a. Appropriate system changes to achieve the goals of any additional new messaging approved by the industry through NCPDP to address clarifying information needed to adjudicate a Part D claim, or
 - b. Alternative approaches that achieve the goals intended in the messaging guidance.

M. DETERMINING ONGOING THERAPY

The plan 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 POS.

1. Enrollees who remain in same plan and are on a drug as a result of an exception that was granted in the prior year:
 - a. The plan has the option of “honoring” exceptions that were granted in the prior year beyond the end of the plan year (i.e., plan may choose to honor an exception for as long as the enrollee remains in the plan).
 - b. If the plan is NOT going to honor an exception beyond the end of the plan year, it must notify the enrollee in writing at least 60 days before the end of the prior plan year and either:
 - i. Offer to process a prospective exception request for the current plan year, or
 - ii. Provide the enrollee with a temporary supply of the requested prescription drug at the beginning of the current plan year and provide the enrollee with notice that they must either switch to a therapeutically appropriate drug on the plan’s formulary or get an exception to continue taking the requested drug.
2. Protected Class Drugs
 - a. Enrollees who receive a transition supply of a PA or step therapy (formulary) drug in the Six Classes of Clinical Concern will automatically be grandfathered to continue taking that medication throughout benefit year.
 - b. They will not be considered “new starts” and will not need to go through the coverage determination and exception process in order to continue on their medication.
 - c. These members will not be sent a transition letter since they will continue on their therapy without interruption.

N. TRANSITION NOTIFICATION

1. Transition supplies are identified by the adjudication system based on specific indicators on the claim.
2. For new enrollee transition claims, “Formulary Change Across Contract Year” and “Level-of-Care Emergency Fill” transition claims, each claim is stamped with a transition claim indicator.
3. These indicators are used to define the type of transition and the reason for the transition, as defined in the CMS transition letter template (i.e., non-formulary, PA, step therapy, etc.).
4. If a temporary fill is provided for a non-formulary Part D drug under its transition process, an appropriate written notice regarding the transition process is mailed within three (3) business days of the temporary fill submitted by provider.
5. The plan will send written notice to both the enrollee and the prescriber via U.S. first-class mail within three (3) business days of adjudication of a temporary fill. The notice must include:
 - a. Explanation of the temporary nature of the transition supply an enrollee has received
 - b. Instructions for working with the plan and the enrollee's prescriber to identify appropriate therapeutic alternatives that are on the plan's formulary
 - c. Explanation of the enrollee's right to request a formulary exception
 - d. Description of procedures for requesting a formulary exception

3. For LTC residents dispensed multiple supplies of a Part D drug in increments of 14-days-or-less, consistent with the requirements of 42 CFR § 423.154, the written notice will be provided within three (3) business days after adjudication of the first temporary fill.
4. The plan will use the CMS model Transition Notice via the file-and-use process or submit a non-model Transition Notice to CMS subject to 45-day marketing review.

O. AVAILABILITY OF FORMS FOR PAs AND FORMULARY EXCEPTIONS

The plan will make available PA or exception request forms to both enrollees and prescribing physicians via a variety of mechanisms, including mail, fax, email, and on the plan's websites. The forms, however, are not required; they are provided for convenience.

P. EXTENSION OF TRANSITION ON CASE-BY-CASE BASIS

1. The plan 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).
2. Extensions need to be initiated by the beneficiary, beneficiary's authorized representative, prescriber, or pharmacy. Requests can be made in writing telephonically, or by email, or fax.

Q. TRANSITION ACROSS CONTRACT YEARS

1. This transition process applies to both transition-eligible drugs that are removed from the formulary from one contract year to the next, as well as formulary drugs that remain on the formulary, but to which a new PA/step therapy-type PA restriction is added from one contract year to the next. The plan 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.
 - a. The Plan has implemented a transition process for current enrollees consistent with the transition process required for new enrollees. In order to prevent coverage gaps, the plan provides a temporary supply of the requested prescription drug (where not medically contraindicated) to members with previous utilization and provides enrollees with notice that they must either switch to a drug on the sponsor's formulary or get an exception to continue taking the requested drug.
2. Combination Approach
 - a. There is a combination of both CMS options for effectuating transitions for enrollees whose drugs are no longer on the formulary, or have had a PA or step therapy added to them effective January 1 of the next contract year.
 - b. There is a transition process for current enrollees consistent with the transition process required for new enrollees; AND notification and encouragement for current enrollees to transition to a therapeutically appropriate formulary alternate and/or complete requests for formulary and tiering exceptions to the new formulary prior to the start of the new contract year (per PDBM, Chapter 6, Section 30.4.5).

- c. To ease the volume of member calls and authorization requests as of January 1, enrollees and/or their providers are encouraged to proactively seek non-formulary exceptions (and other exceptions for drugs that have had UM added) prior to the beginning of the next contract year.
 - d. The plan supports enrollee notification of formulary changes across contract years using various methods, to provide ample opportunity for members to proactively seek a non-formulary exception:
 - Annual ANOC (not sufficient notice by itself)
 - EOBs in November and/or December
 - Direct enrollee mailings (targeted)
3. When such exceptions have been approved, the enrollee will be able to continue on that medication through the end of that contract year (ensuring payment is authorized prior to January 1) and through the next contract year in accordance with the “Coverage Determinations Policy and based on the CMS-approved coverage duration defined in the PA criteria.
 4. If the enrollee, enrollee’s authorized representative, or physician has submitted a coverage determination and exception request, and the decision is still pending on the last day of the contract year, an override for a one-time temporary 30-day supply will be entered to ensure there is no coverage gap while proceeding through the exception process. Even though the one-time authorization has been entered, the coverage determination team will still turn around the exception request within the CMS-required time frames.
 5. If the enrollee, an authorized representative, or prescribing physician has not requested an exception prior to the end of the contract year, the enrollee, their authorized representative, or the prescribing physician must still request a coverage determination exception review as expeditiously as possible.
 6. If the enrollee has not successfully transitioned to a formulary alternative by January 1, the plan will provide a transition supply beginning January 1, consistent with the process for new enrollee transitions, by programming the negative formulary changes across contract years (drugs that have UM added or have become non-formulary) to allow the additional transitional fill for current beneficiaries who utilized the drug during the past at least 120 days.

R. TRANSITION REPORTING AND DOCUMENTATION

1. The plan runs the following reports and information quarterly, or more frequently.
 - a. Transition fulfillment report outlining transitions granted and notices sent
 - b. Compliance reporting for information regarding timeliness of fills and transition notice fulfillment
 - c. Data to support the Transition Monitoring Program Analysis.

S. P&T COMMITTEE / MEDICAL POLICY GROUP (MPG) RESPONSIBILITIES

1. The plan ensures that the P&T Committee/MPG review provides recommendations regarding procedures used for medical review of drugs requiring PA, step therapy, or non-formulary drug requests.
2. P&T Committee/MPG involvement ensures that transition decisions appropriately address situations involving:
 - a. Enrollees stabilized on drugs that are not on the plan’s formulary and that are known to have risks associated with any changes in the prescribed regimen

- b. Enrollees stabilized on drugs that are on the plan's formulary but require PA or step therapy-type PA under its UM requirements and that are known to have risks associated with any changes in the prescribed regimen
3. The P&T Committee reviews this transition policy at least annually to ensure that transition decisions appropriately address situations involving enrollees stabilized on drugs, both non-formulary drugs or formulary drugs, that require PA or step therapy and which may have risks associated with a change in the prescribed regimen.