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Department: Health Services	**Number: UM D-001**
Title: UM D-001 Part D Transition	
Original Effective Date: 01/01/12	**Latest Revision Date: 7/24/14**
Current Revision: 05/1/14 ☐ New Policy ☐ Renumbered Only ☐ Revised ☐ Retired ☒ Annual Review	Previous Policy # Med-Management 45 ☐ No longer applicable ☐ Replaced by Policy #_____
Interdepartmental: ☒ Yes ☐ No	
Affected Departments: ☐ All Associates ☐ All Departments ☒ Listed - Envision, Health Services, Customer Service, Grievance & Appeal	
LOB: ☐ **Part C** ☒ **Part D** **All** ☐	
References: 30.4 of Chapter 6 of the Prescription Drug Benefit Manual; 42 CFR §423.120(b)(3)	
Approvals: Policy Review Date: 9/29/15	
Approved By: Signature, Title & Date	
_____ **Michael Tarrell, CEO**	9/30/15 **Date**
_____ **Janet Green, CCO**	9/30/2015 **Date**

Purpose

Ultimate Health Plans (UHP) contracts with a pharmacy benefit management company (PBM) to provide an appropriate transition process for new members prescribed Part D drugs that are on or not on UHP's formulary. The transition policy will follow all CMS guidelines.

Definitions

PBM - EnvisionRxOptions (Envision) is UHP's Pharmacy Benefit Management (PBM) Company

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

Transition Period - The ninety (90) day period following the initial effective date of enrollment in the Plan Sponsor's Part D plan.

Transition Process - A Part D plan's process, policy, and procedures that meet CMS standards regarding temporary coverage of certain drugs during the transition period of a beneficiary's Part D coverage.

Transition Supply - A temporary supply of non-formulary Part D drugs provided to a member for a specified Transition Period of time. Transition Supply also includes covered formulary Part D drugs that are subject to prior authorization or step therapy under UHP's utilization management rules.

Policy

UHP maintains in its transition policy a detailed explanation of how the PBM processes 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. (See Attachment A: PBM Adjudication Configuration by UHP Benefit Design.)

Ultimate Health Plans must provide for an appropriate transition process consistent with 42 CFR §423.120(b)(3) that includes a written description of how a transition process will be maintained for members whose current drug therapies may not be included in their new Part D drug formulary, and it will effectuate a meaningful transition for:

1. New members enrolled in a prescription drug plan 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 start of the contract year,
4. Members residing in long-term care (LTC) facilities, and
5. In some cases, current members affected by formulary changes from one contract year to the next.

Transition process requirements are applicable to non-formulary drugs, meaning both: (1) Part D drugs that are not on UHP's formulary, and (2) Part D drugs that are on UHP's formulary but require prior authorization or step therapy under UHP's utilization rules, since a formulary drug whose access is restricted via utilization management requirements is essentially equivalent to a non-formulary Part D drug to the extent that the relevant utilization management requirements are not met for a particular member.

UHP transition policy addresses procedures for medical review of non-formulary drug requests, and when appropriate, a process for switching new Part D plan members to therapeutically appropriate formulary alternatives failing an affirmative medical necessary determination.

UHP's transitioning process 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 by UHP or UHP's exception process for providing access to Part D drugs that are not-covered. The PBM has systems capabilities that allow them to provide a one time, temporary supply of non-formulary Part D drugs (including Part D drugs that are on UHP's formulary but require prior authorization or step therapy under the UHP's utilization management rules) in order to accommodate the immediate needs of the member, as well as, to allow the PBM and/or member sufficient time to work out with the prescriber 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.

UHP will make transition policy available to members via link from Medicare Prescription Drug Plan Finder to UHPs web site and include in pre-and post –enrollment marketing materials as directed by CMS.

Procedure

1. Ultimate Health Plans Utilization Management Department is responsible for implementation and on-going monitoring of the transition process.

2. In coordination with the contracted PBM, Ultimate Health Plans Utilization Management Department ensures the provision of Part D drugs in accordance with the following transition process, member types and timeframes:

   ❑ New Prescriptions verses Ongoing Drug Therapy

   CMS realizes it is difficult to distinguish between new prescriptions for non-formulary Part D drugs and refills for ongoing drug therapy involving non-formulary Part D drugs. Ultimate Health Plans attempts to follow up with prescribing physicians and pharmacies to ascertain the status of a prescription presented during the transition period, if the PBM is unable to make this distinction at the point-of-sale; it is required to apply all transition process standards to a new prescription for a non-formulary Part D drug. 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.

   ❑ Transition Timeframes and Temporary Fills

   UHP ensures that in the retail setting, the member receives at least a one-time, temporary 30-day fill (unless the member presents with a prescription written for less than 30 days in which case the PBM will allow multiple fills to provide up to a total of 30 days of medication.), anytime during the first 90 days of a member's enrollment in a plan, beginning on the member's effective date of coverage.

   The PBM has system capabilities to allow the Member to be provided, within the first 90 days of coverage, a temporary 30-day fill (unless the member presents with a prescription written for less than 30 days) in order to accommodate the immediate needs of a member, as well as, to allow Ultimate Health Plan and/or the member sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity when he/she presents at a Ultimate Health Plans network pharmacy for a refill of a non-formulary drug that the beneficiary was

prescribed prior to enrollment. This 90-day time frame applies to *retail*, *home infusion*, *long-term care* and *mail-order* pharmacies.

UHP is responsible for providing a temporary supply anytime during the first 90 days of a member's enrollment into the Plan. Since Members join the Plan at any time during the year, this requirement will apply beginning with the member's first effective date of coverage, and not only to the first 90 days of the contract year. This 90 day timeframe assists those members transitioning from other prescription drug coverage who obtained extended (e.g., 90-day) supplies of maintenance drugs prior to the last effective date of their previous coverage. Note: This requirement includes Part D drugs that are on Ultimate Health Plans formulary but require prior authorization or step therapy.

- ❑ Timeframe and Transition Fills in Outpatient Setting

In the outpatient setting, the one time, temporary supply of non-formulary Part D drugs-including Part D drugs that are on UHP's formulary but require prior authorization or step therapy under UHP's utilization management rules – must be for at least 30 days of medication, unless the prescription is written by a prescriber for less than 30 days. Note: Outside the long-term care setting, such a temporary fill may be a one-time fill only.

- ❑ Timeframe and Transition Fills in the Long Term Care (LTC) Setting

UHP will ensure that in the long-term care setting:

a. The transition policy provides for a 91-98 day fill consistent with the dispensing increment (unless the member presents with a prescription for less), with refills provided if needed during the first 90 days of a member's enrollment in a plan, beginning on the member's effective date of coverage.

b. After the transition period has expired, the transition process provides for a 31-day emergency supply of non-formulary Part D drugs (unless the member presents with a prescription written for less than 31 days) while an exception or prior authorization is requested; and

c. For members being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to their Part

benefit, and such members are allowed to access a refill upon admission or discharge.

The PBM, in addition to sending members residing in LTC facilities a model transition notice via file-and-use process) via U.S. mail within 3 business days of the transition fill, may elect to send the member transition notice to the LTC pharmacy servicing the member's LTC facility. The LTC pharmacy must then ensure delivery of the notice to the member within 3 business days of the fill.

The PBM electing this option must:

a. Document the LTC pharmacies' willingness to be delegated transition notice responsibilities; and

b. Maintain a fully functional electronic communication process with the LTC pharmacy once a transaction fill has occurred (within 3 business days).

c. The LTC pharmacy maintains a process that demonstrates notice has been provided to the member (or his/her representative) within the 3-day period.

❑ Transition Extension

UHP makes arrangements to continue to provide necessary drugs to a member via an extension of the transition period, on a case-by-case basis, to the extent that his/her exception request or appeal has not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request).

UHP gives affected members clear guidance regarding how to proceed after a temporary fill is provided, so that an appropriate and meaningful transition can be effectuated by the end of the transition period. Until that transition is actually made regarding an exception request, continuation of drug coverage is necessary, other than for drugs not covered under Part D.

❑ Transition Across Contract Years

After members receive their ANOC on September 30th of a given year, the PBM selects one of the following options to effectuate an appropriate and meaningful transition for members whose drugs are no longer on the formulary. These transition requirements apply to both drugs that are removed (negative formulary change) from UHP's formulary from one contract year to the next, as well as to formulary drugs that remain on the formulary but to which a new prior utilization or step therapy restriction is added from one contract year to the next:

For current members whose drugs are no longer on the formulary, or remain on the formulary but to which new prior utilization or step therapy restrictions are applied,

UHP will effectuate a meaningful transition by either 1) providing a transition process consistent with the transition process required for new members beginning in the new contract year; or 2) effectuating a transition prior to the beginning of the new contract year.

- Provide a transition process for current members consistent with the transition process required for new members. In order to prevent coverage gaps, UHP is expected to provide a temporary supply of the requested prescription drug (where not medically contraindicated) and provide members with notice that they must either switch to a drug on UHP's formulary or get an exception to continue taking the requested drug: or

- Effectuate a transition for current members prior to the start of the new contract year. Under this option Ultimate Health Plans works aggressively to 1) prospectively transition current members 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 new contract year. If Ultimate Health Plans approves such an exception request pursuant to Chapter 18, Ultimate Health Plans will authorize payment prior to January 1 of the new contract year.

If UHP can identify objective information demonstrating a meaningful transition has occurred (such as processing of an exception request and/or evidence of a new prescription claim for a formulary alternative processed in the month of December) UHP does not have to provide access to a transition supply in the New Year for the member.

However, lacking such evidence, UHP is expected to provide a transition supply in the new contract year and provide the corresponding transition notice.

UHP extends their transition policies across contract years should the member enroll into the Plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply. UHP also send members with a November 1 or December 1 effective enrollment date an ANOC as soon as practicable after the effective date of enrollment. The ANOC serves as advance notice of any formulary or benefit changes in the following contract year.

- ❑ Emergency Supply for Current Members

Current members in a LTC setting requiring an emergency supply of non-formulary drugs: If a member of a Ultimate Health Plans MAPD plan is in a LTC setting and is outside his or her 90 day transition period, Ultimate Health Plans must provide an emergency supply of non-formulary Part D drugs, including Part D drug that are on the Ultimate Health Plans formulary that require prior authorization or step therapy while an exception is being processed. Part D drugs must be provided for at least 31 days unless the prescription is written for less than 31 days.

- ❑ Level of Care Changes

If a current Ultimate Health Plans MA-PD plan member experiences a level of care change outside their transition period (i.e., changing from one treatment setting to another), Ultimate Health Plans allows transition drugs and supplies to be provided to the member. Under this situation, members and providers must avail themselves to Ultimate Health Plans exceptions and appeals processes. UHP makes coverage determinations and redeterminations as expeditiously as the member's health condition requires.

Effective transition of care at time of discharge to home is a major concern in LTC. Ensuring appropriate medication reconciliation in the community is a safety issue, and requires pre-discharge planning. Optimally prescriptions would be written and transmitted to the member's family in the week before discharge, to assure that the medications are obtained in advance of community discharge, to prevent a gap in care. The billing date may appear to overlap the skilled nursing home stay, but the

medications, which are dispensed be either the LTC or retail pharmacy, are to be used in the home setting. While Part A does provide for "a limited supply" to facilitate the members discharge, members are permitted to have a full outpatient supply available to continue therapy once this limited supply is exhausted. This is particularly true of members using mail-order pharmacy, home infusion therapy, or residing in rural areas where obtaining a continuing supply of drugs may involve certain delays.

When a member is admitted or discharged from a LTC facility, he/she will not have access to the remainder of the previously dispensed prescription and, therefore the PBM must allow the member to access a refill upon admission or discharge. An early refill edit cannot be used to limit appropriate and necessary access to the members Part D benefit. UHP's PBM incorporates processes in the transition process that allows for transition supplies to be provided to current members with level of care changes.

- ❑ Edits for Transition Fills

UHP ensures that new members are able to leave a pharmacy with a temporary supply of non-formulary Part D drugs without necessary delays. UHP only applies utilization management edits that are appropriate during a member's transition period including the following:

- Edits to help 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). Step therapy and prior authorization edits must be resolved at point-of-sale.

UHP's PBM may implement step therapy or prior authorization edits during transition, if such edits are resolved at the point of sale. However, during transition, the PBM would need to allow pharmacies to override this edit if the prescriber will not authorize the change at point of sale. If the dose optimization edit (or any other step therapy/prior authorization edit) is overridden at the point of sale for transition purposes only, but not permanently, the member is notified so that he/she can begin the exception process, if necessary.

UHP 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 during a member's transition period.

To the extend the prescription is dispensed for less than written amount due to a plan edit, the PBM must provide refills for that transition supply (at least a 30-day supply in an outpatient setting and a 31-day supply with multiple refills in a LTC setting).

UHP will ensure that it will apply all transition processes to a brand-new prescription for a non-formulary drug if it cannot make it 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.

Irrespective of transition, all these edits are subject to exceptions and appeals. The PBM expeditiously processes such exception requests so that members will not experience unintended interruptions in medically necessary Part D drug therapies and/or will not inappropriately pay additional cost-sharing associated with multiple fills of lesser quantities when the original prescribed dose of Part D drugs were medically necessary.

UHP's PBM does not retain the authority to deny access to quantities or doses during transition (i.e., where clearly articulated safety limits established by the FDA or based upon the same peer reviewed medical literature or well-established clinical practice guidelines used by the P&T committee in formulary management have been exceeded). Prior to implementing such denial, the PBM should ensure and track that both: (1) an initial transition supply has been provided up to the maximum limit, and (2) the PBM has assisted the member or physician in filing an exception or that an exception has been processed.

- ❑ Cost-sharing Considerations

UHP may charge cost-sharing for a temporary supply of drugs provided under its transition process. UHP ensures 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 members.

For non-LIS enrollees, a sponsor must charge the same cost sharing for non-formulary Part D drugs provided during the transition that would apply for non-formulary drugs approved through a formulary exception in accordance with § 423.578(b) and the same cost sharing for formulary drugs subject to utilization management edits provided during the transition that would apply once the utilization management criteria are met.

3. **Transition Notices**

The PBM sends a written notice, via U.S. First Class mail, to each member who receives a transition fill. In addition, this notice is sent to each effected member within 3 business days of the temporary fill. This provides the affected member sufficient time (especially in light of CMS's 30-day transition fill policy in the outpatient setting) to work with his/her prescriber to switch to a therapeutically equivalent drug that is on UHP's formulary or to process an exception request.

UHP utilizes the CMS Model Transition Notice approved by CMS. The notice includes, at a minimum:

- ❑ That the transition supply provided is temporary and may not be refilled unless a formulary exception is approved;
- ❑ That the member should work with the PBM as well as his/her health care provider to identify appropriate therapeutic alternatives that are on UHP's formulary and that will likely reduce his/her costs;
- ❑ That the member has the right to request a formulary exception, the timeframe for processing the exception, and the member's right to request an appeal if UHP issues an unfavorable decision; and
- ❑ UHP's procedures for requesting a formulary exception

For long-term care residents dispense multiple supplies of a Part D drug in increments of 14-days- or-less, consistent with the requirements under 43.154, the written notice mill be provided within 3 business days after adjudication of the first temporary fill.

4. The PBM will make every effort to notify prescribers of affected members who receive a transition notice.

5. UHP makes prior authorization or exception request forms available upon request to both members and prescribing physicians and via a variety of mechanisms—including by mail, fax, email and on UHP's Web site.

6. The Compliance Officer is responsible for submitting a copy of the Transition Process Policy via HPMS and for ensuring that any changes in the requirements and/or expectations of CMS regarding the transition process (as evidenced by HPMS memos or changes to Chapter 6 of the Prescription Drug Benefit Manual) are routed to the Health Services Administrator and that said changes are incorporated into the transition policy.

7. UHP makes its Transition Policy available to members via UHP's website and it is included in pre-and post-enrollment marketing materials as directed by CMS.

8. The PBM's P&T Committee reviews and provides recommendations regarding the procedures for medical review of non-formulary drug requests. P&T Committee involvement helps to ensure that transition decisions are appropriately addressing situations involving members stabilized on drugs that are not on UHP's formulary (or that are on the formulary but require prior authorization or step therapy under UHP's utilization management requirements) and which are known to have risks associated with any changes in the prescribed regimen.

Attachment A: PBM Adjudication Configuration by UHP Benefit Design

The following is a detailed explanation of how The PBM processes 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 is configured by The PBM 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 UHP.

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

d. Claims for an 84-90 day supply will not be allowed

II. Edits to prevent coverage of non-part D drugs (i.e., excluded drugs); and

III. 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 UHP.

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 PBM's Customer Service Representative places 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 UHP 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 UHP after the beginning of the contract year.

I. The pharmacy claims adjudication system is 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 UHP.

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 UHP

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. Claims for an 84-90 day supply will not be allowed

II. Prior Authorization and Step Therapy (PA and ST) overrides (or quantity limit overrides as directed by UHP) 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 UHP

b. Drugs requiring ST or PA (or quantity limits as directed by UHP) will pay at their appropriate copay Tier. LIS members will not pay any more than their applicable LIS level copay

c. Claims for an 84-90 day supply will not be allowed

III. Unbreakable/Smallest package size drugs will be configured to automatically allow a claim that is dispensed as the smallest package size available and whose day supply calculation based on prescribed directions exceed the day supply limitation set by the Plan.

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

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

C. For New Enrollees that are LTC residents.

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I. The pharmacy claims adjudication system will be configured to allow a 91 to 98 day fill consistent with dispensing increment the of a non-formulary medication, or a medication that requires prior authorization or step therapy (or quantity limits as directed by UHP) to process automatically when submitted by a LTC pharmacy within the PBM's pharmacy network if the member is within the first 90 days of their eligibility with UHP unless UHP'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 UHP via the following:

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 UHP.

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 as directed by UHP) will pay at their appropriate copay Tier LIS members will not pay any more than their applicable LIS level copay.

e. Claims for an 84-90 day supply will not be allowed.

D. If the member is within the first 90 days of their initial eligibility with UHP and the PBM 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

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 Prior Authorizations (PA) or Step Therapy (ST) (or quantity limits as directed by UHP), 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 PBM 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 as directed by UHP).

b. When a member/pharmacy calls the PBM, these inquiries will be handled and approved on a case by case basis by the PBM'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 as directed by UHP),

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 UHP

2. PA and ST overrides (or quantity limit overrides as directed by UHP) will be configured at Point of Sale

i. The PBM'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 as directed by UHP).

ii. The member prior authorization 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 as directed by UHP).

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 as directed by UHP) will pay at their appropriate copay Tier. LIS members will not pay any more than their applicable LIS level copay.

vi. The PBM'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 PBM'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 authorization 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 as directed by UHP).
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 PBM'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. 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 PBM will do the following:

1. Allow members who have been on one of these impacted drugs, and who are outside of UHP'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 will be configured by the PBM 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 PBM will look a 90 days 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, it is assumed that the member was with UHP the previous benefit year. Thus the historical look back is 90 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. Claims for an 84-90 day supply will not be allowed.

G. Transition Fills for Coverage Exceptions

The PBM will allow a transition fill for enrollees, who request an exception on a case by case basis. (The PBM 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:)

I.

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 UHP.

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

c. The PBM'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 as directed by UHP) will be configured at Point of Sale

1. The PBM'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 authorization 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 as directed by UHP).
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 as directed by UHP) 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 PBM'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 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 PBM will honor exceptions that were approved in the previous plan year in the new plan year upon direction from UHP.

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 UHP.

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

c. In the event that UHP should choose to no longer honor exceptions approved during the previous plan year in the new plan year, UHP 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 PBM 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 PBM mails Transition letters on behalf of UHP.

I. Enrollees are notified of a prescription fill that was subject to the transition process via the model transition letter provided by UHP to the PBM.

1. A member of the PBM'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 PBM for UHP and will be available upon request.

4. Monthly reports from the PBM will be provided to UHP 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 PBM will 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

I. PBM shall offer to provide testing of the transition fill configuration to Plan Sponsor prior to the beginning of the new plan year.
II. 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.
III. 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.
IV. 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

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ULTIMATE HEALTH PLANS
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