CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.
CDPHP UNIVERSAL BENEFITS,® INC.
(Collectively referred to within this policy as "CDPHP®")
Medicare Advantage
Pharmacy Policy

Policy/Procedure Name: **Control Number:**

MEDICARE PART D TRANSITION MANAGEMENT **1350/20.000186**

DISCLAIMER NOTICE:

The purpose of this policy is to provide guidance for benefit and coverage determinations only. Benefit and coverage determinations are subject to the contractual limitations of an enrollee's individual benefit plan.

If there is a discrepancy between this policy and an enrollee's individual benefit plan, the benefit plan will control. It is not the intent of this policy to dictate to health care practitioners how to provide appropriate health care to their patients. Health care practitioners shall exercise their own medical judgment when deciding the most appropriate care to enrollees. The CDPHP® coverage determinations are benefit decisions only and are not to be interpreted as providing health care services.

EFFECTIVE DATE OF POLICY: 1/1/2022

DESCRIPTION:

To provide a process for both new enrollees and current beneficiaries to Capital District Physicians' Health Plan, Inc. and CDPHP Universal Benefits, Inc. (collectively referred to as CDPHP) to obtain coverage for non-formulary drugs (i.e. drugs not on the CDPHP formulary as well as Part D drugs that are on the formulary but require prior authorization, step therapy or quantity limits). The process also ensures that CDPHP meets all CMS requirements for new member transition into a CDPHP benefit plan or, for existing members who have a change in level of care or who enter a long-term care (LTC) facility.

This policy, as the overriding policy, works in conjunction with the standard transition policy and procedure used by the Delegated PBM, in order to allow CDPHP to meet CMS requirements. CDPHP follows the Transition Fill Implementation Statement as described in Delegated PBM Medicare Part D Transition Plan Document No: MEDAFF-0027 (see Sources of Information No. 2.)

An applicable month's supply is determined as the number of days submitted to CMS for the Plan Benefit Package (PBP)'s applicable month's supply for the relevant plan year (2022= 30 days Non-LTC; 31 days LTC). CMS approval determines the approved month's supply for Beneficiaries in both the LTC and non-LTC settings.

POLICY:

- Delegated PBM implements and maintains an appropriate transition process, as approved by CMS and consistent with CMS rules and guidance from Best Practice memos. The Delegated PBM process allows a meaningful transition for the following groups of beneficiaries: (1) New beneficiaries enrolled into the plan following the annual coordinated election period; (2) newly eligible Medicare beneficiaries from other coverage; (3) the transition of beneficiaries who switch from one plan to another after the start of a contract year; (4)existing beneficiaries; (5) beneficiaries residing in long-term care (LTC) facilities, including beneficiaries being admitted to or discharged from an LTC facility. In order to be consistent with best practices, CDPHP maintains the same transition process for new and existing members. All beneficiaries will be treated as newly enrolled for the purpose of meeting CMS transition requirements.
- The transition policy will apply to non-formulary drugs, meaning: (1) Part D drugs that are not on the CDPHP formulary; and (2) Part D drugs previously approved for coverage under an exception once the exception expires; and (3) Part D drugs that are on the formulary but require prior authorization or step therapy or approved quantity limits lower than the beneficiary's current dose under the CDPHP utilization management rules. The transition process allows for medical review of non-formulary drug requests, and when appropriate, a process for switching new Part D plan beneficiaries to therapeutically appropriate formulary alternatives if the drug is found to be not medically necessary. A formulary exception may be granted if CDPHP determines that the non-formulary drug is medically necessary. The physician's supporting statement must indicate that the requested drug is medically required and other formulary drugs and dosage limits may not be as effective because other covered Part D drugs on any tier of a plan's formulary would not be as effective or have not been as effective for the enrollee as the non-formulary drug, and/or would have adverse effects. CDPHP also considers the following factors in making its determination: (i) whether the requested Part D drug is therapeutically equivalent to any drugs on the formulary; (ii) the number of drugs on the formulary that are in the same class and category as the requested drug. In general, it is required that the member try at least two other formulary drugs used to treat the same condition. A pharmacist or pharmacy benefit specialist initially reviews formulary exceptions, and a medical director reviews all requests that do not meet the criteria for approval. Delegated PBM will handle Biosimilars as non-interchangeable brand/generic products for its programs and processes involving transition fill and will apply the appropriate cost share according to CMS guidance. The CDPHP Pharmacy and Therapeutics Committee meets at least 5 times a year and reviews the procedures in place for coverage determinations and exceptions, and, if appropriate, a process for switching new beneficiaries to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.
- The Delegated PBM will have the system capabilities that allow Delegated PBM to provide a temporary supply of non-formulary Part D drugs (or drugs with UM requirements or step therapy requirements) in order to accommodate the immediate needs of a beneficiary, as well as to allow CDPHP and/or the

beneficiary sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or to complete an exception request to maintain coverage of an existing drug based on medical necessity reasons. Delegated PBM Transition Fill (TF) processing and coding applies point-of-sale (POS) messaging to pharmacies.

- The Delegated PBM transition process will apply in the non-LTC setting such that the transition policy provides for a one-time, temporary fill of at least the applicable month's supply of medication unless beneficiary presents a prescription written for less than a month's supply in which case CDPHP will allow multiple fills to provide up to a total of the applicable month's supply of medication anytime during the first 90 days of a beneficiary's enrollment in a plan, beginning on the beneficiary's effective date of coverage. For 2022 CDPHP's plan setup allows a month's supply of 30 within the 90 day TF window.
- For low-income subsidy (LIS) beneficiaries, the cost-sharing for a temporary supply of drugs provided under the transition process never exceeds the statutory maximum co-payment amounts for LIS beneficiaries. For non-LIS eligible beneficiary's, CDPHP charges the appropriate cost-sharing for a temporary supply of medication provided under this transition process based on its approved medication cost-sharing tiers (generic, preferred, and specialty/non-preferred).
    1. Non-Formulary Part D drugs (brands and generics) transition supply will receive the same cost sharing that would apply for a non-formulary exception approved under the formulary exception process (Tier 4)
    2. Formulary Part-D drugs (drugs with a utilization management (UM) edit) transition supply will receive the same cost sharing that would apply if the UM edit criteria are met (ie. whatever tier the drug is assigned to)
- In the LTC setting the transition policy will provide for a one time temporary fill of at least an applicable month's supply (unless the beneficiary presents with a prescription written for less) consistent with the applicable dispensing increment in the LTC setting with multiple fills allowed to provide up to a total of a month's supply of medication if needed during the first 90 days of a beneficiary's enrollment in a plan, beginning on the beneficiary's effective date of coverage. After the transition period has expired or the benefit is exhausted, the transition policy will provide for at least a 31-day emergency supply of non-formulary Part D drugs (unless the beneficiary presents with a prescription written for less than the 31 days' supply) while an exception or prior authorization determination is pending. For beneficiaries being admitted to or discharged from an LTC facility, early refill edits will not be used to limit appropriate and necessary access to their Part D benefit, and such beneficiaries will be allowed to access a refill upon admission or discharge. For 2022, CDPHP's plan setup allows a month's supply of 31 within the 90 days TF window for LTC and New Patient/Level of Care Change. LTC Emergency Supply allows a 31 day supply; LTC Emergency Supply is allowed per rolling 30 days.
- Delegated PBM will only apply the following utilization management edits during transition at point of sale (POS): edits to determine Part A or 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 will be coded to be resolved at POS.

- Delegated PBM will allow refills for transition prescriptions dispensed for less that the written amount due to quantity limit safety edits or drug utilization edits that are based on approved product labeling.
- Delegated PBM will apply the 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.
- Delegated PBM will send written notice via U.S first class mail to beneficiary within three business days of adjudication of a temporary transition fill. The notice will include an explanation that the beneficiary has been provided a one-time temporary fill by CDPHP and to advise the beneficiary to consult with their physician to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the formulary. The notice also includes an explanation of the beneficiary's rights to request a formulary exception and a description of the procedure used to request a formulary exception. For LTC residents dispensed multiple supplies of a Part D drug in increments of 14 days or less, the written notice will be provided within three business days after adjudication of the first temporary fill. Delegated PBM will use reasonable efforts to provide notice of TF to prescribers to facilitate transitioning of beneficiaries. For 2022, CDPHP is using Delegated PBM to fulfill transition notices.
- CDPHP will make available prior authorization or exception request forms upon request to both beneficiaries and prescribing physicians via mail, fax, email, and via the plan web site at www.cdphp.com. For 2022 CDPHP is responsible for handling coverage determinations. Delegated PBM 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.
- The CDPHP Pharmacy and Therapeutics (P&T) committee meets regularly and reviews and provides recommendations regarding the procedures for medical review of non-formulary drug requests. The P&T committee involvement helps ensure that transition protocol decisions appropriately address situations involving members that are stabilized on drugs that are not on the CDPHP formulary and which are known to have risks associated with any changes in the prescribed regimen.
- CDPHP will make general transition process information available to beneficiaries via the Medicare Prescription Drug Plan Finder link to the CDPHP website as well as in beneficiary formulary and pre- and post-enrollment materials.
- Delegated PBM will provide a process for beneficiaries to receive necessary Part D drugs via an extension of the transition period, on a case-by-case basis, to the extent that their exception requests or appeals have not been processed by the end of the minimum transaction 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). For 2022, CDPHP will allow a 30 day supply for transition extension.

- Delegated PBM will implement the same transition process for renewing beneficiaries as new beneficiaries. All renewing beneficiaries will be treated as new for purposes of transition fills.

PROCEDURE: CDPHP's TF program is implemented by Delegated PBM according to CDPHP's benefit design

- Transition supplies are provided at POS to eligible beneficiaries which are coded as the following:
  i. New beneficiaries in the plan following the annual coordinated election period
  ii. Newly eligible Medicare beneficiaries from other coverage
  iii. Beneficiaries who switch from another Part D plan after the start of a Contract Year
  iv. Existing beneficiaries
  v. Beneficiaries residing in LTC facilities
- Transition supply limits are defined as cumulative days supplies calculated on Generic Product Identifier (GPI) 14 and are not based on number of fills.
- Transition-eligible claims submitted for LICS III beneficiaries are processed according to the beneficiary's LICS Level and pharmacy submitted codes to determine if the claim received will be processed as non-LTC, LICS III or LTC.
- Delegated PBM will maintain a TF policy and procedure and update at least annually and as needed when processing changes occur.
- Non-Formulary Drugs
  i. Procedures to apply the transition policy to non-formulary drugs are to obtain the CDPHP P&T committee approved formulary and UM edits and code into the adjudication system to identify the TF eligible claim at POS so that it can be paid.

  ii. Notwithstanding any references in this document to expiring formulary exceptions, since CMS has issued guidance that it does not currently expect Part D Sponsors to include expiring formulary exceptions in their transition policies. Delegated PBM will not apply its transition policy to expiring formulary exceptions unless and until CMS issues guidance requiring otherwise.

  iii. Beneficiaries who contact Pharmacy Customer Care and Pharmacies that contact the Pharmacy Help Desk are provided with information regarding available formulary alternatives when requested and/or are appropriate for a beneficiary's care.
- POS transition supply processing is available and there are procedures in place for transition extensions and overrides, if needed, through the Pharmacy Help Desk and Pharmacy Customer Care. Transition fill POS messaging to pharmacies applies as follows:

1. The delegated PBM's adjudication system automatically processes and pays transition fill-eligible claims and transmits POS messaging that the claims are paid under transition fill rules.
2. Transition fill messaging to pharmacies is consistent with current National Council of Prescription Drug Programs (NCPDP) Telecommunication claim standards (at the time of this publication, the current standard is D.0 and hereafter referred to as "Current NCPDP Telecommunication Claim Standards"). Pharmacies are not required to either submit, or resubmit, a Prior Authorization/Medical Certification Code (PAMC) or other transition fill-specific code for transition fill-eligible claims to pay.
3. Transition fill processing applies to both new and ongoing prescriptions at POS and through the Pharmacy Help Desk for beneficiaries who are new to plan.
4. Communication and educational outreach to network pharmacies is ongoing throughout the year to provide information and instructions regarding transition fill policies and claim processing. At least annually, and more often as needed, transition fill pharmacy communications are distributed through the pharmacy network department by the Delegated PBM.

TRANSITION FILL FOR NEW OR RENEWING BENEFICIARIES IN THE NON-LTC SETTING

i. In a Non-LTC setting, Delegated PBM automatically processes and pays transition fill-eligible claims for and transmits POS messaging that the claims are paid under Transition Fill rules for up to a cumulative 30 days supply.
ii. Pharmacies are not required to either submit, or resubmit, a PAMC or other transition fill-specific code for transition fill-eligible claims to adjudicate and pay.
iii. Transition fills are available at POS through this functionality within the first 90 days of enrollment, beginning on the enrollment effective date.

- Non-LTC Level of Care Change
  i. For non-LTC residents, an early refill edit will not be used to limit appropriate and necessary access to a transition fill. A transition fill may be provided automatically at POS, if the adjudication process indicates a Level of Care change from LTC to non-LTC with an early refill edit. Otherwise, the pharmacy will call Delegated PBM Pharmacy Help Desk in order to obtain an override to submit a Level of Care transition fill request.
- Cost sharing for drugs supplied as a transition fill is set by statute for low-income subsidy (LIS) beneficiaries. For non-LIS beneficiaries, a non-formulary transition supply will receive the same cost share as would apply if a non-formulary exception was applied. Transition supplies for formulary drugs with a utilization management edit will receive the same cost share as would apply if the utilization management criteria is met.

LONG TERM CARE (LTC) PROCESSING

For LTC transition fills, the Delegated PBM adjudication system automatically processes and pays transition fill-eligible LTC claims and transmits POS messaging that these are paid under Transition Fill. LTC transition fills are allowed a cumulative 31 days supply, except for oral brand solids which are limited to 14-day fills with exceptions as required by CMS guidance, unless submitted with a submission clarification code (SCC) of 21-36. SCC codes 21-36 indicate LTC dispensing of varying days' supply. Multiple fills to provide up to a total of 31 days supply of medication are allowed consistent with the applicable dispensing increment in the LTC setting. Pharmacies are not required to either submit, or resubmit a PAMC, or other transition fill-specific code for transition fill-eligible claims to adjudicate and pay.

- LTC Resident Transition Fill Emergency Supplies
    1. To accommodate emergency fills for LTC residents after either the new or renewing TF supply has been exhausted, exceeded or the TF window expired, and while an exception or prior authorization is pending, an SCC is submitted by the pharmacy on POS claims. Emergency Supply Transition Fills are allowed up to a cumulative 31 days supply except for oral brand solids which are limited to 14-day fills with exceptions as required by CMS guidance, unless submitted with an SCC of 21-36. These drug claims would otherwise reject for being non-formulary or formulary with prior authorization, step therapy, quantity limit or daily dose less than FDA maximum labeled dose, or age edits secondary to beneficiaries having exhausted or exceeded TF new or renewing TF supply and/or being outside the TF window.
    2. LTC ES is allowed per calendar day, per beneficiary, per drug, per pharmacy, per plan for the cumulative days' supply during a rolling month.

- LTC Level of Care Changes
    1. For LTC residents, an SCC is submitted by the pharmacy to allow transition fills and to override transition fill eligible rejects, Refill Too Soon rejects and certain DUR service rejects for new admissions. Level of Care Transition Fills are allowed up to a 31 days supply except for oral brand solids which are limited to 14-day fills with exceptions as required by CMS guidance, unless submitted with an SCC 21-36. These drug claims would otherwise reject for being non-formulary or formulary with utilization management edits.
    2. Level of Care Transition Fills are allowed per calendar day, per beneficiary, per drug, per pharmacy, per plan for a cumulative days' supply within the LTC LOC benefit.
    3. For all beneficiaries who experience a Level of Care Change, if a dose change results in an "early refill" Refill Too Soon rejects and certain DUR service rejects, the pharmacy may call the Pharmacy Help Desk to obtain an override.

UTILIZATION MANAGEMENT EDITS NOT TF ELIGIBLE AND TF ELIGIBLE STEP THERAPY AND PRIOR AUTHORIZATION PROCESSING

- The Delegated PBM codes the following utilization management edits on drugs such that transition fill overrides are not applied:
  1. Drugs requiring Part A or B vs. Part D coverage determination as identified on the Delegated PBM drug database.
  2. Drugs excluded from Part D benefit as identified on the Delegated PBM drug database.
  3. Edits to support the determination of Part D drug status.
  4. DUR safety edits such as therapeutic duplication, cumulative acetaminophen, morphine milligram equivalent(MME), drug interaction, and age alerts are set up to reject.
- TF eligible Step therapy, prior authorization and non-safety quantity limit edits are resolved at POS.

CUMULATIVE DAYS' SUPPLY

- Transition refills for supplies dispensed at less than amount written, or less than the days' supply available under transition rules are allowed multiple fills up to at least an applicable month's supply.
- For DUR edits that are based on an FDA maximum recommended daily dose, Transition Fill claims which are dispensed at less than the prescribed amount due to this edit are allowed refills during the TF window.
- Delegated PBM TF cumulative days' supply accumulates at the drug GPI 14 level by member and across plan. LTC Emergency Supply and LTC Level of Care Change/ New Patient benefits accumulate separately.

The Delegated PBM transition process is coded such that if the distinction cannot be made between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the POS, the Delegated PBM transition process will be applied to the prescription as if it is ongoing drug therapy. This is referred to as the New Beneficiary process.

TRANSITION NOTICES

- A written transition notice is mailed via U.S. First Class mail to the beneficiary within three business days after adjudication of a temporary fill.
- For LTC TF for oral brand solids limited to a 14-day supply, a TF notice will be sent only after the *first* temporary fill.
- The notice identifies the:
  i. Explanation of the temporary nature of the transition supply provided to the beneficiary.
  ii. Instructions for working with CDPHP and prescriber to satisfy utilization management requirements or to identify therapeutically equivalent and appropriate formulary alternatives.
  iii. An explanation of the Beneficiary's right to request a formulary exception.

iv. A description of the procedures for requesting a formulary exception.

- CDPHP in conjunction with our Delegated PBM, supports use of the current CMS "Model Part D Transition Notice" for notification to Beneficiaries of the reasons for their transition fills and recommendations for actions. Notwithstanding any reference in this policy to submitting a transition notice that uses the CMS model notice via the file and use system, since CMS has stated that this is not required, the model notice will not be submitted via the file and use process unless and until CMS requires this.
- Transition notices to prescribers are provided when a beneficiary transition fill notice is produced. The content of this notice is based on the content of the beneficiary transition fill notice. Reasonable efforts are made to deliver the notice to the prescriber.

AVAILABILITY OF PRIOR AUTHORIZATION AND EXCEPTION REQUEST FORMS

- Prior authorization and exception request forms are available upon request by beneficiary or prescriber through a variety of means including by e-mail, mail, fax, and via forms posted on the CDPHP website, www.cdphp.com.

TRANSITION EXTENSIONS

- On a case-by-case basis, the Pharmacy Customer Care unit may provide an extension of the transition period to accommodate beneficiaries who continue to await resolution of a pending prior authorization or exception request. The extensions are available through the Pharmacy Help Desk or Pharmacy Customer Care and per CDPHP plan design.

TRANSITION ACROSS CONTRACT YEARS FOR CURRENT BENEFICIARIES

- CDPHP will use the ANOC as advance notice of any formulary changes. Consistent with the transition fill process provided to new beneficiaries, CDPHP provides transition fill, to renewing beneficiaries during the TF window of the contract year. This applies at POS to all renewing beneficiaries including those residing in Long Term Care facilities.
    - Renewing Beneficiary Transition Fills are available to all beneficiaries during the TF Window
    - For these beneficiaries, the Delegated PBM adjudication system automatically processes and pays transition fill-eligible claims and transmits POS messaging that these are paid under transition fill rules.
    - Additional transition supplies are available on a case-by-case basis through the Pharmacy Help Desk to ensure adequate transition. Pharmacies are not required to either submit or resubmit a PAMC or other transition fill specific code for transition fill-eligible claims to adjudicate and pay.

TRANSITION FILL PROGRAM MONITORING

- Transition fill processes are monitored both across and within each program area that has responsibility for TF processes. TF program monitoring is both qualitative and quantitative. Transition claim adjudication data are used to produce standard paid TF claim and rejected claim reports for quantitative program monitoring. Program performance monitoring includes reporting and monitoring of all TF types: new and renewing beneficiary TF, Level of Care Change and LTC Emergency Supply TF.

- CDPHP delegates the operational functions of transition fills to its PBM. As a part of the delegation monitoring agreement between CDPHP and the Delegated PBM, CDPHP may elect to identify and monitor a sample of up to 25 transition fill letters that have been mailed to beneficiaries by Delegated PBM during the previous 12 months and request in writing that Delegated PBM produce copies of such sample of transition fill letters. The Delegated PBM will then have 45 days to provide copies of these letters to CDPHP to ensure that the proper CMS turnaround times have been met.

- In addition, CDPHP customer service representatives report to the pharmacy department any transition concerns that they receive through either phone calls or working through the coverage determination process. Through daily resolution of CMS issues (and working with the Appeals and Grievance Department), CDPHP may receive issues concerning transition. A CDPHP pharmacist works with the Delegated PBM to solve any transition concerns (including those brought to the attention of CDPHP by the Appeals and Grievance department) and resolve the member's concern within required timeframes. The pharmacist also works with the Delegated PBM for quick resolution that may include possible system changes.

PUBLIC NOTICE OF TRANSITION PROCESS AND AVAILABILTY OF PA AND EXCEPTION REQUEST FORMS

- CDPHP makes general information about the transition processes available to members in a manner similar to information provided on formularies and benefit design. Each year, the CDPHP transition process will be available in plan enrollment materials and on the CDPHP website.

- Annually, CDPHP will also submit a copy of the document so that members may also view the CDPHP transition process via the CDPHP website link from the Medicare Prescription Drug Plan Finder. CDPHP also includes transition process information in its pre- and post-enrollment materials as appropriate to members.

TRAINING

- CDPHP conducts training that includes all CDPHP pharmacy department staff and all other contact points in CDPHP who could be involved in the transition process prior to the start of the new calendar year. Refresher classes will be offered for the upcoming new calendar year. This training will include:
    i. Review of Medicare and new benefits for the upcoming year. This includes an overview of Medicare, definitions, premiums, and copay changes.
    ii. Transition policy for the new calendar year. This includes the transition policy for retail members, long term care members, level of care changes and emergency refills. It also includes what medications are covered during the transition period (non-formulary, step therapy, prior authorization, etc.) and what is not covered as a transition medication (excluded classes, Part B medications, non-maintenance drugs, etc.).
    iii. Formulary changes for the upcoming calendar year. This includes formulary enhancements, formulary deletions, and clinical edit changes.
    iv. CDPHP educates all personnel throughout the year on any changes in the transition policy that will directly impact members and providers. CDPHP associates are trained through team meetings or one-on-one discussions. New CDPHP associates are trained on the transition policy during the associate's initial training period.
    v. Training is documented with appropriate signature logs indicating date of training and materials used to train.

IMPLEMENTATION STATEMENT
The following is a summary statement for how eligible claims process under TF adjudication system rules upon point of sale (POS) and manual submission to allow the override of system edits that would otherwise result in rejected claims. The objective of these TF adjudication system rules is to ensure pharmacies are able to resolve and override TF-eligible edits at POS toward the goal of ensuring beneficiary access to medications per Part D requirements and guidance.

1) TF Adjudication System ensures that:
    a. TF-eligible claims for new and ongoing prescriptions automatically adjudicate upon submission at POS for:
        i. New beneficiaries in the plan following the annual coordinated election period
        ii. Newly eligible Medicare beneficiaries from other coverage
        iii. Beneficiaries who switch from another Part D plan after the start of a contract year
        iv. Current beneficiaries

v. Beneficiaries residing in LTC facilities

b. Transition fill processing is also available via manual overrides through the Pharmacy Help Desk.

c. TF Window and eligibility check is applied to the claim.
The TF eligibility start date is always set to January 1 of the calendar year for existing beneficiaries and as the enrollment start date for new beneficiaries. TF logic is not invoked if a claim exceeds either TF Window or cumulative days' supply parameters based on beneficiary eligibility.

d. TF processing allows for transition supplies of different drug strengths.
TF benefits (including Cumulative Days' Supply) are set up based on Drug Generic Product Identifier (GPI) 14 to allow TF processing of different strengths of a drug under TF system rules. This ensures that a beneficiary taking a drug with one strength is able to receive TF for same drug/different strength if they present with a new prescription within TF-eligible time period.

e. For beneficiaries who are new to plan, renewing beneficiaries during the TF window, and for LTC new patient admissions and emergency supplies, TF for dosage escalation is allowed, as appropriate, by manual override via the Delegated PBM Pharmacy Help Desk.

f. Med D Drugs only allowed for TF.
Non-Med D drugs are excluded from TF processing. Non-Med D drugs are identified with an "N" in the "Med D" field on the Delegated PBM drug database. This enables the system TF logic to exclude these from transition fill processing when claims for these drugs are submitted by pharmacies. Drugs that are covered under the Medicare Part D benefit and, therefore potentially eligible for TF, are identified with a "Y" on the Med D field on the Delegated PBM drug database.

g. Multi-Ingredient Compounds processed for TF.
TF processing for Multi-Ingredient Compound (MIC) drugs is based on formulary status of the claim. Depending on the MIC setup selected, the formulary status of the MIC claim can be based on the formulary status of the most expensive ingredient submitted or the formulary status of the entire claim (if all MICs are considered formulary, or all Non-formulary, or only topical MICs are considered Non-formulary and non-topical MICs are based on most expensive ingredient submitted). Non-formulary drugs will process under MIC TF rules. Step, QvT, daily dose and age are not bypassed for MIC drugs. For MICs that are Non-formulary drugs and generally covered only pursuant to an approved exception request, MIC drugs processed for TF are assigned the cost share applicable to the exception tier (i.e. the cost sharing applicable to Non-formulary drugs approved pursuant to an exception request).MIC transition supply for formulary drugs with a UM edit will receive the same cost share as would apply if the UM criteria is met.

Step 1: MIC adjudication determines the type of compound; determines if the MIC is a Part A or B or Part D drug. If the MIC is determined to be Part D eligible drug (no Part A or B ingredients and at least one Part D ingredient), then proceed to Step 2.

Step 2: Adjudication determines the formulary status of the Part D MIC claim based on benefit design; benefit setup determines if it is either formulary or Non-formulary.

i. If the plan has designated all compounds or only topical compounds as Non-formulary, then the entire claim is considered Non-formulary and TF will apply.

ii. If the plan bases the formulary status on the most expensive Part D ingredient:

a. If the most expensive ingredient is a formulary drug then all Part D ingredients in the MIC pay at contracted rates.

b. If the most expensive ingredient is Non-formulary and is eligible for TF, then all Part D ingredients in the MIC pay as a TF. The TF letter refers to this prescription as a "compound" prescription.

c. If the most expensive ingredient is not eligible for TF, the entire MIC will reject / not pay as TF.

For 2022, CDPHP will process MIC claims with topical compounds designated as Non-Formulary and non-topical MICs based on the most expensive ingredient submitted. The following edits will not be bypassed for MIC claims: Step, QvT, daily dose and age.

2) This policy and procedure is updated at least annually in advance of the CMS TF attestation window with the process changes expected for the following year. The policy is also updated as needed for additional changes.

3) Claims for non-formulary drugs are eligible for TF processing.
   a. Brand Drug retained as formulary when generic released: In the event of the launch of a new generic drug, CDPHP elects whether to retain the brand on the formulary and not to add the generic to the formulary. A beneficiary with the equivalent brand drug in the look back history will not be eligible for a transition fill of the generic with the same formulation, if CDPHP elects not to offer the TF. The pharmacy will be messaged to dispense the brand. The brand would be available without the need for a transition fill. If a beneficiary is currently taking a brand drug, a transition fill for the brand drug with a formulary change will be provided to allow beneficiary sufficient time to work with the prescriber to obtain 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.
   b. Generic drug immediate substitution: In the event of the launch of a new generic drug, CDPHP will evaluate if the generic drug will be immediately added to the formulary and the brand drug changed to a Non-formulary status that is not TF eligible.
   c. Beneficiaries with a current claim for a drug that requires a quantity limit lower than the quantity limit on the beneficiary's history dose will be eligible for TF processing.

4) Systems capabilities exist to provide transition supplies at POS. Pharmacies are not required to either submit, or resubmit a PAMC or other TF-specific codes for a TF-eligible claim to adjudicate.
   a) POS Pharmacy Provider Notification
      i. Pharmacies are notified at POS that claims have paid under TF rules, which is intended to assist pharmacies with discussing next steps with beneficiaries.
      ii. TF processing information and communications are sent to all network pharmacies. The TF processing information and communications include, though are not necessarily limited to, the Pharmacy Provider Manual and all related updates; and the Medicare Part D Information/Reminders document that is sent annually to network pharmacies prior to the beginning of each new contract year.
      iii. Delegated PBM Pharmacy Help Desk (PHD): Pharmacies contacting the PHD are verbally informed of beneficiary's TF availability, process and rights for requesting prior authorization and/or exception, and how to submit an automated TF request.
      iv. Auto-pay of TF-Eligible Claims
      When submitted claims are eligible for payment under TF rules, RxClaim adjudication system logic applies the TF PAMC 22223333444 to the claim, tags the claim as a paid TF, and returns the below messaging on paid TF claims. Pharmacies are not required to either submit, or resubmit a PAMC or other TF-specific codes for a TF-eligible claim to adjudicate. The TF-related codes and messaging returned to pharmacies on paid TF claims is compliant with Current NCPDP Telecommunication Claim Standards. In accordance with these standards, the "Paid under transition fill" messaging follows the ADDINS (additional

insurance) and Brand/Generic Savings messaging when these apply. Otherwise, the "Paid under transition fill" is returned as the first message on paid TF claims. Non-TF eligible claims are rejected and are not paid under TF rules.

"Paid under transition fill. Non-formulary."
"Paid under transition fill. PA required."
"Paid under transition fill. Other reject." (Note: This includes Step, QvT, Daily Dose and Age requirements)

In addition to the POS messaging above, and in accordance with Current NCPDP Telecommunication Claim Standards, the below approval message codes are also returned on TF paid claims.

TF APPROVAL MESSAGE CODES

NCPDP Pharmacy Approval Message Code	TF Condition
005	TF claim is paid during transition period but required a prior authorization
006	TF claim is paid during transition period and was considered Non-formulary
007	TF claim is paid during transition period due to any other circumstance
009	TF claim is paid via an emergency fill scenario but required a prior authorization
010	TF claim is paid via an emergency fill scenario and was considered Non-formulary
011	TF claim is paid via an emergency fill scenario due to any other circumstance
013	TF claim is paid via a level of care change scenario but required a prior authorization
014	TF claim is paid via a level of care change scenario and was considered Non-formulary
015	TF claim is paid via a level of care change scenario due to any other circumstance

b) There are conditions under which it may be necessary for the Delegated PBM PHD or Pharmacy Customer Care to enter a manual TF override. These include but are not necessarily limited to:
   i) Non-LTC Beneficiary moves from one treatment setting to another, if not identified automatically through the adjudication process
   ii) Beneficiary has requested an exception and the decision is pending at the time the TF period expires, or the TF cumulative days supply exhausted
   iii) TF for dosage increase is needed

c) When manually entered with the TF PAMC, these TF overrides are adjudicated and tagged via the same processes as automated POS TF's. The same "Paid under transition fill…" messaging is returned to Pharmacies on manual TF overrides as returned on automated paid TF claims. TF letters are produced and sent to beneficiary for manual TF overrides same as POS overrides.

5) TF Days' Supply & Time Period Parameters (and LTC Days' Supply for Statement 7)
a)

Description	TF Days' Supply
New & Renewing Beneficiaries	
	• These quantity and time plan limits may be greater based on the benefit design and will be limited by the amount prescribed • Non-LTC: Cumulative 30 days supply within first 90 days in the plan; multiple fills up to a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed • LTC: Cumulative 31 days supply within first 90 days' in the plan, oral brand solids which are limited to 14 days'' supply with exceptions as required by CMS guidance, unless submitted with an SCC 21-36; multiple fills for a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed/first 90 days
Non-LTC Resident Level of Care Change	
• Beneficiary released from LTC facility within past 30 days	• These quantity plan limits may be greater based on the benefit design and will be limited by the amount prescribed • Non-LTC: Cumulative 30 days supply; multiple fills up to a cumulative 30 days supply are allowed to accommodate fills for amounts less than prescribed. • TF available at POS if identified through adjudication, otherwise through manual override via Pharmacy Help Desk on case-by-case basis.

New and Renewing TF Extension	
• New or Existing Beneficiaries • Outside standard TF days' supply or time period parameters • TF parameters have been reached and beneficiary is still pending exception/coverage determination decision	• These plan limits will be limited by the amount prescribed • Non-LTC: Per the CDPHP plan design, via manual override, additional as needed as long as exception or coverage determination decision is pending. • LTC: Per the CDPHP plan design, via manual override, additional as needed as long as exception or coverage determination decision pending

b) Non-LTC Resident Level of Care Change
   i) For non-LTC residents, a transition fill may be provided automatically at POS, if the adjudication process indicates a Level of Care change from LTC to non-LTC and the claim is rejecting for Refill Too Soon (R79) or DUR (R88). Otherwise, the pharmacy may call the Delegated PBM Pharmacy Help Desk in order to obtain an override to submit a Level of Care transition fill request.
   ii) A Level of Care change from LTC to non-LTC is indicated in the adjudication process if the submitted drug matches a claim in the most recent 120 days of history on GPI 14 with a Patient Location Code indicating LTC. The non-LTC residents are allowed up to a cumulative 30 days supply (or greater based on benefit design); multiple fills up to a cumulative 30 days supply are allowed to accommodate fills for amounts less than prescribed.

6) The adjudication system ensures that cost-sharing applied to TF's for low-income subsidy (LIS) beneficiaries never exceeds statutory maximum co-pay amounts; and for non-LIS beneficiaries, cost-sharing is based on one of the plan's approved cost-sharing tiers and is consistent with that charged for non-formulary drugs approved under a coverage exception. Non-formulary transition supply will receive the same cost sharing that would apply for a non-formulary exception and transition supply for formulary drugs with a UM edit will receive the same cost share as would apply if the UM criteria is met.

7) Processing for LTC Setting
   a. Pharmacy Network and Patient Residence Type Codes
      TF parameters can vary by network level (or list of networks) through the use of network or pharmacy lists. Therefore, different TF days' supply can be accommodated for Retail, Mail, LTC and/or Home Infusion providers. The Pharmacy Service Type and Patient Residence Type codes on submitted claims are used to identify the claim as either non-LTC or LTC for purposes of reimbursement and allowed TF days' supply.
      i. The values defined as being LTC by Delegated PBM pharmacy network operations are cross-walked internally during RxClaim adjudication to the legacy system value "Patient Location Code" (PLC) 03.

   b. LTC TF cumulative days' supply limits are allowed for qualified claims submitted with PLCs designating LTC.
   c. LTC Emergency Supply (ES) is allowed after the transition supply parameters are exhausted, exceeded or expired for new and renewing Beneficiaries and a coverage determination or exception is still pending. The LTC ES transition policy provides for a cumulative 31 days' supply, except for oral brand solids which are limited to 14 days' supply with exceptions as required by CMS guidance, unless submitted with an SCC 21-36.

d. TF LTC Level of Care Change and LTC Emergency Supply are automated based upon specific POS claim submission rules. Pharmacies are instructed on how to correctly submit qualifying claims via Provider Manual updates and ongoing network communications so that these claims correctly process as TF under applicable LTC TF conditions.

LTC LEVEL OF CARE CHANGE & LTC EMERGENCY SUPPLY	
Description	**TF Days' Supply**
LTC Level of Care Change **Beneficiary resides in LTC Facility and is a New Patient Admission)**	
• Beneficiary admitted to LTC facility within past 30 days •	• These quantity plan limits may be greater based on the benefit design and will be limited by the amount prescribed • Cumulative 31 days supply, except for oral brand solids which are limited to 14-days' supply with exceptions as required by CMS guidance, unless submitted with an SCC 21-36 At POS submitted with: • Submission Clarification Code 420-DK Value "18" • Patient Location Code identified as LTC • Additional fills as needed are available via manual TF overrides through the Pharmacy Help Desk • Multiple fills allowed to accommodate LOC changes • TF LTC LOC is allowed per calendar day, per Beneficiary, per drug, per pharmacy, per plan a cumulative days' supply within the defined LTC LOC benefit. • New and renewing beneficiaries must have TF days' supply exhausted, exceeded or the TF time period expired

	• For LTC claims, where SCC 18 is applied to the primary side of a single transaction coordination of benefit claim to override Refill Too Soon (RTS) (R79, R88) that same override for RTS (R79, R88) will also apply to the secondary side of the transaction. • If LTC LOC benefit is engaged and pays it will count toward the LTC LOC benefit. Remaining non-LTC or LTC TF benefits will still be available through the TF window. • If the incoming LTC LOC claim days supply exceeds the maximum LTC LOC benefit, the pharmacy will be messaged to notify of the remaining non-LTC or LTC TF benefit available through the TF window.
LTC Emergency Supply Beneficiary resides in LTC facility	
• LTC Emergency Supply (ES)	• These supplies may be greater based on the benefit design and will be limited by the amount prescribed • Cumulative 31-days' supply, except for oral brand solids which are limited to 14-days' supply with exceptions as required by CMS guidance, unless submitted with an SCC 21-36. At POS submitted with: • Submission Clarification Code 420-DK Value "7" • Patient Location Code identified as LTC • POS automated TF LTC ES is set-up to allow one ES every rolling 30 days, limited to one ES per LTC stay. The adjudication logic looks back 30 days starting the day after the date of fill. • LTC ES is allowed per calendar day, per beneficiary, per drug, per pharmacy, per plan a cumulative days supply during a rolling month • New and renewing beneficiaries must have TF day supply exhausted, exceeded or the TF time period expired, and while an exception or prior authorization is pending • If LTC LOC benefit is engaged and pays it will count toward the LTC LOC benefit. Remaining non-LTC or LTC TF benefits will still be available through the TF window.

	• If the incoming LTC LOC claim days supply exceeds the maximum LTC LOC benefit, the pharmacy will be messaged to notify of the remaining non-LTC or LTC TF benefit available through the TF window.

e. LTC Level of Care Change for Beneficiaries 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 beneficiaries are allowed access to a refill upon admission or discharge.

LTC LEVEL OF CARE CHANGE & LTC EMERGENCY SUPPLY
REFILL TOO SOON (RTS) & DRUG UTILIZATION REVIEW (DUR) OVERRIDES

Description	Edit	Reject Code	Point of Sale	Manual Override Available
LTC Level of Care Change	RTS/ Plan Option 15	79	Y	Y (if Drug Qualifies as TF, TF Override used)
LTC Emergency Supply	RTS/ Plan Option 15	79	N	Y (if Drug Qualifies as TF, TF Override used)
LTC Level of Care Change	DUR – Plan Option 30	88	Y	Y (if Drug Qualifies as TF, TF Override used)
LTC Emergency Supply	DUR – Plan Option 30	88	N	Y (if Drug Qualifies as TF, TF Override used)

8) Transition Fill Edits

a) **Override Edits Not Applied During TF**
TF overrides are not applied at POS, or manually to drugs with dose limits based on maximum FDA labeling, A or B vs. D drugs requiring coverage determination prior to application of TF benefits, or drugs not covered by CMS under Part D program benefits, which include drugs that require a medically accepted indication.

i. **Refill Too Soon (RTS)**
Automated TF system logic for new and renewing beneficiaries does not allow override of RTS (except for LTC New Patient Admission or Level of Care Change) edits. Instead, reject 79 (RTS) is returned to pharmacies when submitted claims hit this edit.

ii. **DUR Safety Edits**
Automated TF system logic for new and renewing beneficiaries does not allow override of DUR safety edits that are set up to reject at point of sale. Instead, reject 88 (DUR) is returned to pharmacies with appropriate instructions when submitted claims hit this edit.

iii. **Part A or B Only Drugs**
Automated TF adjudication logic is not applied to Part A or B only drug claims. All Med A or B 'only' drugs are excluded from TF processes and payment under TF rules and are tagged with an "N" status in the "Med D" status field on the Delegated PBM drug database. Part A or B only drugs reject using the appropriate reject codes and applicable Current NCPDP Telecommunication Claim Standards structured reject messaging.

iv. **Part A or B vs. Part D (A or B vs. D)**
Part A or B vs. D drugs are not provided a Part D TF to determine the appropriate Part A or

Part B vs. D coverage. A determination is needed to identify the correct coverage of the drug. Part A or B vs. D drugs reject using the appropriate reject codes and applicable current NCPDP Telecommunication Claim Standards structured reject messaging. The Beneficiary, prescribing physician, or pharmacy is informed to call CDPHP for clinical review to determine the applicable coverage. In the RxClaim adjudication system, Part A or B vs. D drugs are set up with an identifier flag in the RxClaim Prior Authorization table. The identifier flag specifies that a drug is classified as a Part A or B vs. D drug.
Part A or B v. D claims reject with A3 (This Product May Be Covered under Hospice – Medicare A); A4 (This Product May Be Covered Under The Medicare-Bundled Payment to an ESRD Dialysis Facility); A5 (Not Covered under Part D Law); or A6 (This Product/Service May Be Covered under Medicare Part B. In the reject messaging of these drug claims, CDPHP phone numbers are provided to assist with contacting the Plan for a determination if needed. A determination of the correct coverage will be made by CDPHP. If a formulary drug is covered by Part D, a PA is entered into the RxClaim system to allow the claim to pay under the Beneficiary's Part D coverage if it is eligible based on standard Part D coverage. If a Non-formulary drug is covered by Part D, the claim is evaluated to determine if it is Transition Fill eligible. If the claim is TF eligible, then a TF is provided and the Beneficiary receives the appropriate TF notification.

v. **Excluded Drugs-not covered by CMS under Part D program benefits**
CMS requires some drugs be reviewed to determine the Part D drug status. These drugs will require a medically accepted indication based on the FDA approved label or the CMS approved compendia in determining if it is eligible for Part D coverage**.** Beneficiaries can request a formulary exception for these drug**s.** Drugs will only be approved for beneficiaries who provide the diagnosis demonstrating that the drug is prescribed for a medically accepted indication**.** Beneficiaries who have a coverage determination (prior authorization or formulary exception) denied, will receive a denial letter indicating their drug is not a Part D drug. Beneficiaries will have the right to appeal the decision**.** If the drug is determined to be for a medically accepted indication and so a Part D drug, but any additional utilization management criteria are not met, then the claim is reviewed for TF eligibility and a PA is entered if appropriate.
Excluded drugs may reject for the following reasons:
1. Formulary drugs will reject for prior authorization (PA) required (R75).
2. Non-formulary drugs will reject as non-formulary (R70).

b) **TF-Eligible Edits**
TF day supply and time parameters are applied to submitted claims for:

- Non-formulary drugs
- Formulary drugs with prior authorization, step therapy, QL (quantity vs. time, daily dose) or age edits. TF logic may or may not be applied in situations where there is a maximum FDA labeled dosage that should not be exceeded for safety reasons. The following is the order of processing for drugs to which edits are applied: Step Therapy; Prior Authorization; Quantity Limits (including daily dose and age).

The unique types of transition fill conditions are listed below.

i. **Non-formulary (NF)**
Drugs that are not covered on a closed formulary. NF TF overrides a reject code 70 for NDC Not Covered (Plan reject 70). National Drug Code (NDC).

ii. **Prior Authorization (PA)**

Drugs that are covered on the formulary but require prior authorization. PA TF overrides a reject code 75 for Prior Authorization.

iii. **Step Therapy**
Formulary drugs that reject for Step Therapy prerequisites may be eligible for TF. TF processing allows the Step Therapy reject to be overridden and the claim to process through Step Therapy program logic and post to history appropriately. A Step Therapy transition fill notice may be generated for this edit.
For some drugs with step therapy edits where the beneficiary obtained a TF ("grandfathered" or Type 2 ST- PA meaning submitted to CMS as step for new starts to therapy only), the TF itself satisfies the step therapy requirements for that drug. This means that the beneficiary has already met the step requirements and will be able to continue to obtain future fills of that drug without encountering a reject. In these cases, Step TF Letters are not sent to either beneficiaries or prescribers. Step TF overrides 608 reject step therapy, alternative drug therapy required based upon plan setup.

iv. **Quantity Limits (QL's)**
Quantity vs. Time (QvT) or Maximum Daily Dose (DD)
Drug quantity limits are used to establish the allowed amounts for coverage of selected drugs to specified values over a set period of time. For the purposes of TF, a quantity limit is considered a type of transition fill for drugs that require limited supply of a drug to be dispensed based on days' supply or allowed quantity across time or maximum doses per day.

1. Drugs that would otherwise reject for quantity limitations when submitted for more than the allowed quantity are eligible for transition fill processing during the transition time period. TF system logic allows the quantity limit reject to be overridden and the claim to process through TF program logic and to post to history appropriately. If a claim is not eligible for TF override and rejects for quantity limits (i.e. TF days' supply exhausted, or TF time period expired), it will continue to reject according to quantity limit parameters using Reject 76. TF overrides "quantity over time" edits that are set up to either count continuous fill history across contract years (quantity "period to date" Type D set-up), or to count fill history beginning January 1 of each contract year. QL/QvT TF overrides the reject code 76.
2. In addition to TF for QL/QvT, TF is available for DD drug edits. DD and QL/QvT edits are mutually exclusive. If both were ever to be set up together on the same plan, TF for the QL/QvT edits takes precedence over the DD TF. DD TF overrides reject 76.
3. For QvT TF and Plan Limitations, a QvT set up on drug NDC (Plan Option 10) and/or GPI (Plan Option 11) will override Plan Limitations that are set up on Plan Options 26.1 and 26.2, Preferred Formulary. Therefore, when TF is allowed for QvT reasons, the Plan Limitations on 26.1 and 26.2 are also overridden. However, cumulative TF days' supply does not override either once used/exhausted.
4. For QL changes, the system will look at the QL edit in history and compare it to the current/active QL edit. If the current QL edit is lower than the history edit, the QL edit is overridden and the claim processes through TF program logic.

v. **Age Edits**
TF is available for formulary drugs that are set up with Age Edits for safety reasons. Age Edit TF overrides a reject 76.

vi. **AG Reject**
An AG Reject is a claim reject due to a days' supply limitation. Claims submitted for more than remaining allowed TF Days' Supply return an "AG" reject code and message "Resubmit

for Remaining Day Supply of XX" with "XX" being the number of remaining allowed TF cumulative days' supply. The "AG" reject code is returned as the primary reject code, unless, per current NCPDP Telecommunication Claim Standards, this reject is required to follow either the ADDINS (additional insurance) and/or Brand/Generic Savings messaging when these apply. AG rejects are returned on both initial claims with no prior TF in history, as well as subsequent submissions when cumulative days' TF supply have not been exhausted with previous paid TF. When a pharmacy reduces the claim days' supply and resubmits, TF-eligible claims process via TF rules.

vii. **Unbreakable Pre-packaged Medication Logic**
Drugs for which the manufactured packaging cannot be split for the dispensing of a prescription may be considered an unbreakable pre-packaged medication for which the pre-packaged medication days' supply may be dispensed. The intent of this logic is to ensure a beneficiary receives their entire TF days' supply (DS) even though the DS exceeds the maximum benefit, due to the type of packaging for the drug. This logic will apply if the pre-packaged medication cumulative DS is less than the required benefit, prior to the current fill. If the pre-packaged medication cumulative DS including the current fill quantity exceeds the maximum benefit, and is less than or equal to the quantity of a single package of medication, the TF will pay. If the pre-packaged medication cumulative DS including the current fill quantity exceeds the maximum benefit, and the current fill quantity exceeds the quantity of a single package of medication, the pharmacy will be messaged to resubmit for a single package of the medication. The claim will retain the messaging and the rejects associated with the processing.

viii. **Beneficiary Level / Clinical Prior Authorizations (PA)**
Beneficiary level clinical prior authorizations will be entered to override all TF-eligible edits. Otherwise, a TF will be allowed for any TF-eligible edit for which the PA has not been entered. When a beneficiary / clinical PA already exists on the beneficiary record to override all TF-eligible edits, TF processing is not applicable. Under this condition, claims do not process as TF and TF letters are not sent to beneficiaries.

c.) Processed without TF

i. **Type 2 ST-PA Drug Logic** Type 2 ST-PA Drug edits are edits submitted to CMS as Step for new starts to therapy only. Delegated PBM adjudication logic uses a 108-day minimum look back period for determining new starts. The Type 2 ST-PA Drug Logic will pay the claim without TF logic. TF processing will apply to any TF-eligible edit which the Type 2 ST-PA Drug Logic has not overridden.

9) TF Claims History
All history for a drug during the transition time period is counted, regardless of the dispensing pharmacy/network. POS, manually entered, and beneficiary submitted (paper) claims for Retail, Mail, Long Term Care and Home Infusion networks are counted together to determine the total cumulative days' supply for a drug. TF days' supply limits are defined as cumulative supplies based on Part D days' supply requirements to ensure that refills for TF-eligible drugs are available when TF is dispensed at less than the amount written secondary to quantity limits due to safety, or edits based on approved product labeling; the system automatically "counts" prior related TF claims to allow correct TF days' supply accumulation parameters to apply.

10) If the distinction cannot be made between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the POS, the transition process is applied to a brand-new prescription for a non-formulary drug.

a) Beneficiaries who are new to plan include: new plan beneficiaries enrolled into the plan following the annual coordinated election period; newly eligible beneficiaries from other coverage; and beneficiaries who switch from one plan to another after the start of a contract year.
b) Transition fills are available at POS through transition processing during the TF Window.
c) Additional transition supplies are available on a case-by-case basis through the Pharmacy Help Desk to ensure adequate transition.
d) The quantity and time plan limits may be greater based on benefit design and will be limited by the amount prescribed.

11) TF Letters are sent to beneficiaries within three business days of adjudicated TF claim; reasonable and best efforts are also made to identify a current prescriber address/contact information and provide notice of TF to prescribers to facilitate transitioning of beneficiaries. For LTC residents dispensed multiple supplies of a Part D drug in increments of 14 days or less as required by CMS guidance, the written notice will be provided within three business days after adjudication of only the *first* temporary fill. TF Letters are generated from the TF Claim and Letter Tags which are extracted to the daily TF Letter File.
    a) TF Claim and Letter Tag Indicators Based on TF-eligible Edits
        i) TF Claim Tag: This is the adjudication system tag applied to the claim when adjudicated under TF system rules. This tag represents the reason the claim paid under TF processes and what edits were overridden by TF rather than rejecting as otherwise would happen when TF is not available. These tags can represent either a single TF reason (e.g. Non-formulary, PA, Step, or Qty Limit); or can also represent a combination of TF reasons (e.g. PA with Qty Limit; Non-formulary with Qty Limit, etc.).
        ii) TF Letter Tag: This tag is used to designate the specific TF letter language content for the TF notice to Beneficiaries and prescribers.
        iii) TF Combo Tag: This tag is used to designate the specific TF letter language content for the TF notice to Beneficiaries and prescribers for Sponsors who choose to print a paragraph for each edit that was overridden by TF.
    b) Daily TF Letter File
        i) Paid TF claims are automatically extracted to a daily TF Claim File. For every paid TF claim, there is either a corresponding record on the correlated daily TF Letter File, or the record is captured on the daily internal Exception file with the reason the record is not included on the TF Letter File (example: same day paid/reversed).
        ii) The contents of the TF Letter file are used to drive production of the appropriate beneficiary and prescriber TF letters.

12) Delegated PBM transition process for new beneficiaries is applied from the date of enrollment through the TF window. The enrollment date does not need to be the start of the contract year and the transition process may extend across contract years where the TF window extends across contract years

13) TF Extensions are available for New or Existing Beneficiaries, non-LTC or LTC, through the PHD or CC. The request is reviewed for the following and processed according to Sponsor instructions:
    a) Outside standard TF days' supply or time period parameters
    b) TF parameters have been reached and beneficiary is still pending exception/coverage determination decision

14) Transition for Current Beneficiaries

a) CDPHP will use the ANOC as advance notice of any formulary changes. Consistent with the transition fill process provided to new beneficiaries, CDPHP provides transition fill, to renewing beneficiaries during the TF window of the contract year. This applies at POS to all renewing beneficiaries including those residing in LTC facilities.
   - Renewing Beneficiary Transition Fills are available to all beneficiaries during the TF Window
   - For these beneficiaries, the PBM's adjudication system automatically processes and pays transition fill-eligible claims and transmits POS messaging that these are paid under transition fill rules.
   - Additional transition supplies are available on a case-by-case basis through the Pharmacy Help Desk to ensure adequate transition. Pharmacies are not required to either submit or resubmit a PAMC or other transition fill specific code for transition fill-eligible claims to adjudicate and pay.

15. TF program performance monitoring and reporting includes the production and ongoing review of the items below:
    a. TF Claim Extract Control and Exception Reporting (internal monitoring report)
    These reports serve as internal controls to confirm that all paid TF claim records are extracted to the daily TF extract file, which is used to produce TF letters or to the Exception file.
    b. TF Letter Print Quality Control Reviews (internal PBM monitoring)
    TF Letter Print Quality Control Reviews are used by print fulfillment to validate letter print quality and reliability of printing merge process when changes are made to the templates or process.
    c. TF Response File (internal PBM monitoring file)
    This file serves to confirm that for every valid TF record received from adjudication, there is a corresponding TF letter printed/mailed or distributed by other approved method.
    d. TF Letter Turn-Around-Time (TAT) Reports (internal PBM and CDPHP monitoring report)
    These reports track the days between paid TF claims and date TF letters provided to beneficiaries. They are used to monitor adherence with requirements to send Beneficiary TF letters within three (3) business days' of adjudicated TF.
    e. Paid TF Claim File (internal and CDPHP monitoring report)
    This file supports monitoring of the paid TFs to validate the claims should have paid under TF rules and that the correct TF tags are applied during adjudication.
    f. Rejected Claim File (internal and CDPHP monitoring file)
    Daily Rejected claim reports are produced and reviewed for monitoring of rejected claims to validate that these should not instead have paid under TF rules.
    g. TF Mock and Test Claims
    RxClaim maintains ability to process Mock TF claims on demand in support of claim testing. These allow the Pharmacy Help Desk and Customer Care Services to run claims for confirmation of associated costs, co-payments, and how "live" claims would process and pay under TF. "Paid" mock TF claims return the standard paid TF messaging as returned on POS claims.

MEDICARE ADVANTAGE: Subject to the terms and conditions noted in above application. Benefits for Medicare Part D prescription drugs are only available to Beneficiaries who have elected a CDPHP Medicare Advantage Part D plan. The CDPHP Medicare Advantage Part D plan products do not cover any prescription drugs not covered by Medicare, with the exception of additional coverage purchased with a group-enhanced rider. In addition, for those individuals enrolled in the CDPHP Medicare Advantage product who have not elected a Part D option, CDPHP only covers those prescription drugs covered by Medicare Parts A and B, not those covered by Part D.

Bruce Coplin MD FACC
Vice President, Specialty Transformation

New: 04/09
Revised: 04/10, 8/10, 11/11, 9/2012, 5/2013, 5/2014, 7/2014, 12/2014, 5/2015, 5/2016, 11/2016, 5/2017, 7/2017, 5/2018, 5/2019, 5/2020, 5/2021

Sources of Information:

1. Medicare Part D Manual Chapter 6-Part D Drugs and Formulary Requirements Section 30.4-Transition
2. Medicare Part D Transition Plan-CVS Caremark Part D Services L.L.C, Document No: MEDAFF-0027, Revised May 2021