


Main Topic: Government Programs	Effective date: 01/01/2022
Policy Name: 2022 Medicare Part D Internal Transition Supply Policy	Review Date: 06/02/2021
Approved by: 	Revised Date: 6/2021, 5/2020

Objective:

To ensure that new or existing members to the MVP Medicare Part D program have continued access to medications that are non-formulary or are subject to utilization management tools (prior authorization, step therapy, quantity limits) during their initial enrollment period, during their stay in a long-term care facility, upon a level of care change or after a calendar year formulary change. This transition supply of medications will allow sufficient time for members to work with their provider to switch to an alternative formulary agent, to request a formulary exception, or to request a coverage determination. For a complete definition of a Coverage Determination, please refer to the CMS Prescription Drug Manual, Chapter 6, Section 30.4. This policy documents the process and procedure to effectuate a transition supply of medication. MVP Health Care delegates select transition fill activities to its Pharmacy Benefit Manager (PBM), CVS Caremark Part D Services, L.L.C. This program has been reviewed and approved by the MVP Pharmacy & Therapeutics and the Quality Improvement Committees.

Policy:

1. MVP Health Care allows a meaningful transition for the following groups of Beneficiaries whose current drug therapy may not be covered by the plan: (a.) new Beneficiaries enrolled into the plan following the annual coordinated election period; (b.) newly eligible Medicare Beneficiaries from other coverage; (c.) the transition of Beneficiaries who switch from one plan to another after the start of a contract year; (d.) current Beneficiaries affected by negative formulary changes across contract years; (e.) Beneficiaries residing in long-term

Regulation/ Requirement / Standard	Referenced in

care (LTC) facilities, including Beneficiaries being admitted to or discharged from an LTC facility.

2. MVP Health Care will submit a copy of its transition policy process as required to CMS.
3. The transition policy will apply to Non-formulary Drugs, meaning: (a.) Part D drugs that are not on the formulary; (b.) Part D drugs previously approved for coverage under an exception once the exception expires and (c.) 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 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 failing an affirmative medical necessity determination. MVP Health Care’s P&T committee will meet on a regular basis, but no less than quarterly and review procedures for coverage determination and exceptions, and, if appropriate, a process for switching new Beneficiaries to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.
4. A temporary supply of non-formulary Part D drugs will be provided in order to accommodate the immediate needs of a Beneficiary, as well as, to allow MVP Health Care and/or the Beneficiary sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons. Transition Fill (TF) processing and coding applies point-of-sale (POS) messaging to pharmacies.
5. The 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 the Beneficiary presents a prescription written for less than a month’s supply in which case the Sponsor must 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. These quantity and time plan limits may be greater based on the benefit design and will be limited by the amount prescribed. For 2022, the plan set up allows a month’s supply of 30 within the 90 day TF Window.
6. The cost-sharing tier for a temporary supply of drugs provided under the transition process will not exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible Beneficiaries.  
 For non-LIS eligible Beneficiaries:
  - a. Non-formulary Part D drugs transition supply will receive the same cost sharing that would apply for non-formulary drugs approved through a formulary exception.

Regulation/ Requirement / Standard	Referenced in

- b. Formulary transition supply will receive the same cost sharing for a formulary drug subject to utilization management edits provided during the transition that would apply if the utilization management criteria are met.
- 7. The transition process in the LTC setting will include the following attributes: (a.) 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; (b.) after the transition period has expired or the days supply is exhausted, the transition policy will provide for at least a 31-day emergency supply of non-formulary Part D drugs (unless the Beneficiary presents with a prescription written for less than the 31 days supply) while an exception or Prior Authorization determination is pending; and (c.) 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, plan set up allows a month’s supply of 31 within the 90 day TF Window for LTC and New Patient/Level of Care Change. LTC Emergency Supply allows a 31 days supply; LTC Emergency Supply is allowed per rolling 30 days.
- 8. Only the following utilization management edits will apply during transition at 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.
- 9. Transition process will allow refills for transition prescriptions dispensed for less than the written amount due to quantity limit safety edits or drug utilization edits that are based on approved product labeling.
- 10. The transition processes will be applied 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.
- 11. MVP Health Care 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 (a.) an explanation of the temporary nature of the transition supply a Beneficiary has received; (b.) instructions for working with MVP Health Care and the Beneficiary’s prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the MVP formulary; (c.) an explanation of the Beneficiary’s right to request a formulary exception; and (d.) a description of the procedures for requesting 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 3 business days after

Regulation/ Requirement / Standard	Referenced in

adjudication of the first temporary fill. MVP Health Care will use the CMS model Transition Notice via the file-and-use process. Reasonable efforts to provide notice to prescribers of affected enrollees who have received a TF will be made via mail to facilitate transitioning of Beneficiaries. CVS Caremark provides a daily extract file to MVP Health Care containing Part D TF paid transactions requiring a transition notice.

12. MVP Health Care is responsible for review of coverage determination requests. Prior authorization or exception request forms will be available upon request to both Beneficiaries and prescribing physicians via mail, fax, email, and the MVP Medicare or provider website.
13. The transition policy will be extended 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.
14. The transition policy will be available to Beneficiaries via the Medicare Prescription Drug Plan Finder link to Sponsor’s web site as well as in Beneficiary formulary and pre- and post-enrollment materials.
15. MVP Health Care will provide Beneficiaries with a process 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). MVP Health Care will allow a 30 days supply for transition extension.
16. The transition process will be effectuated for renewing beneficiaries whose drugs will be affected by negative formulary changes in the upcoming contract year. MVP Health Care’s plan set up for Renewing Beneficiary history review is at a GPI 10 level with a look back of 180 days.

Procedure:

1. The Transition Fill (TF) program is implemented by CVS Caremark according to MVP Health Care’s requested benefit design.
  - a. Transition supplies are provided at point of sale (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. Current Beneficiaries affected by negative formulary changes (including new utilization management requirements)
    - v. Beneficiaries residing in LTC facilities

Regulation/ Requirement / Standard	Referenced in

- b. Transition supply limits are defined as cumulative days supplies calculated on Generic Product Identifier (GPI) 14 and are not based on number of fills.
  - c. 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.
2. MVP Health Care will maintain a Med D TF policy and procedure and review, and if needed, revise, the document at least annually and as needed when process changes occur.
3. Non-formulary Drugs
- a. Procedures to apply the transition policy to Non-formulary Drugs are to obtain the 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.
  - b. Notwithstanding any references in this document to expiring formulary exceptions, since CMS has issued guidance stating that it does not expect Part D sponsors to include expiring formulary exceptions in their transition policies CVS Caremark Part D Services, L.L.C. will not apply its transition policy to expiring formulary exceptions unless and until CMS issues guidance requiring otherwise.
  - c. Procedures for medical review and identifying Formulary Alternatives are as follows:
    - i. Coverage determination and medical review processes for Non-formulary drug requests are documented in the MVP Health Care Pharmacy Programs Administration Policy.
    - ii. Information regarding therapeutically appropriate formulary alternatives is made available to Beneficiaries and prescribers failing an affirmative medical necessity determination.
    - iii. Beneficiaries who contact Customer Care and Pharmacies that contact the Pharmacy Help Desk are provided with information regarding available formulary alternatives when requested and/ are appropriate for Beneficiaries’ care.
4. POS transition fill processing is available and there are procedures in place for transition extensions and overrides, if needed, through the Pharmacy Help Desk and Customer Care. Transition fill POS messaging to pharmacies applies as follows:
- a. The CVS Caremark PBM adjudication system automatically processes and pays transition fill-eligible claims and transmits POS messaging that the claims are paid under transition fill rules.
  - b. 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.

Regulation/ Requirement / Standard	Referenced in

- c. 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.
  - d. 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 CVS Caremark pharmacy network department.
5. Transition Fill for New or Renewing Beneficiaries in the Non-LTC setting
- a. In a Non-LTC setting, the CVS Caremark PBM adjudication system automatically processes and pays transition fill-eligible claims and transmits POS messaging that the claims are paid under Transition Fill rules for up to a cumulative applicable month’s supply.
  - b. 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.
  - c. Transition fills are available at POS through this functionality within the first 90 days of enrollment, beginning on the enrollment effective date.
  - d. Non-LTC Level of Care Change: 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 the CVS Caremark Help Desk in order to obtain an override to submit a Level of Care transition fill request.
6. CVS Caremark will establish cost-sharing per the MVP Health Care plan design.
- a. Cost-sharing for drugs supplied as a transition fill is set by statute for low-income subsidy (LIS) Beneficiaries.
  - b. For non-LIS Beneficiaries:
    - i. Non-formulary transition supply will receive the same cost share as would apply if a non-formulary exception was applied
    - ii. Transition supply for formulary drugs with a utilization management edit will receive the same cost share as would apply if the utilization management criteria is met.
7. Long-term Care Processing
- For LTC transition fills, the CVS Caremark 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 applicable month’s 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 the applicable month’s supply of medication are allowed consistent with the

Regulation/ Requirement / Standard	Referenced in

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.

- a. LTC Transition Fill Emergency Supplies (ES)
  - i. 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 age edits secondary to Beneficiaries having exhausted or exceeded the TF new or renewing TF supply and/or being outside the TF Window.
  - ii. LTC ES is allowed, per calendar day, per Beneficiary, per drug, per pharmacy, per plan, for the cumulative days supply during a rolling month, based on benefit design.
  - iii. These quantity plan limits may be greater based on the benefit design and will be limited by the amount prescribed.
- b. LTC Level of Care Changes
  - i. 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 an applicable month’s 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.
  - ii. 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.
  - iii. 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.
  - iv. The quantity plan limits may be greater based on benefit design and will be limited by the amount prescribed.
- 8. Utilization Management Edits Not TF Eligible and TF Eligible Step Therapy and Prior Authorization processing
  - a. CVS Caremark codes the following utilization management edits on drugs such that transition fill overrides are not applied:

Regulation/ Requirement / Standard	Referenced in

- i. Drugs requiring Part A or B vs. Part D coverage determination as identified on the Delegated PBM drug database.
- ii. Drugs excluded from Part D benefit as identified on the Delegated PBM drug database.
- iii. Edits to support the determination of Part D Drug Status.
- iv. 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.

9. Cumulative Days Supply

- a. 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.
- b. 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.
- c. The TF cumulative days supply accumulates at the drug GPI 14 level by Beneficiary and across plan (or plan codes). LTC Emergency Supply and LTC Level of Care Change/New Patient benefits accumulate separately.

10. The 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 transition process will be applied to the prescription as if it is ongoing drug therapy. This is referred to as the New Beneficiary process.

11. Transition Notices

- a. A written transition notice is mailed via US First Class mail to the Beneficiary within three (3) business days after adjudication of a temporary fill.
- b. For LTC TF for oral brand solids limited to a 14 days supply, a TF notice will be sent only after the first temporary fill.
- c. The notice identifies the:
  - i. Explanation of the temporary nature of the transition supply provided to the Beneficiary
  - ii. Instructions for working with MVP Health Care 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 coverage determination.
  - iv. a description of the procedures for requesting a formulary exception

Regulation/ Requirement / Standard	Referenced in



- d. MVP Health Care will utilize 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.
  - e. CVS Caremark will provide a daily extract file to MVP Health Care containing all transition fill paid claim transactions requiring a transition notice. Prescriber names and addresses are included on the daily transition fill extract file to enable MVP Health Care to send these notices to Prescribers.
  - f. 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, or CMS model notice if provided. Reasonable efforts are made to deliver the notice to the prescriber.
12. Availability of Prior Authorization and Exception Request Forms
- a. Prior authorization and Exception Request Forms will be available upon request to the Beneficiary or prescriber via a variety of means including by e-mail, mail, fax, and the MVP Medicare or provider website. Beneficiaries may obtain forms by contacting the MVP Customer Care Center, the phone number is on the back of their ID card. Providers may also obtain forms by contacting Provider Services.
13. The transition process for new Beneficiaries is coded to apply across Contract Years for Beneficiaries with an effective enrollment date at the end of the plan year and who need access to a transition supply for a negative formulary change. These Beneficiaries are eligible for a TF for a negative formulary change from the date they enroll in the current Contract year through the TF Window which starts on January 1 of the next plan year.
14. Beneficiaries and providers will find information on the Transition Process, including the Transition Supply Policy in a variety of plan materials, including the MVP Medicare web site, plan enrollment materials (ANOC), formulary document, and the required link from the Medicare Prescription Drug Plan Finder to the MVP Medicare website. The Transition Supply policy will also be available in pre-and-post enrollment marking materials as directed by CMS.
1. Transition Extensions
15. Extensions to the transition period will be reviewed on a case-by-case basis if the exception request, prior authorization request or appeal has been received during the transition period but not yet processed or is awaiting resolution (decision) at the end of the transition period (either through the switch to an appropriate formulary drug or a decision on the exception request). The extension process can be started through the Pharmacy Help Desk, MVP Customer Care Center or Provider Services Departments.

Regulation/ Requirement / Standard	Referenced in

16. Consistent with the transition fill process provided to new Beneficiaries, CVS Caremark Part D Services, L.L.C. provides transition fills to renewing Beneficiaries during the TF Window of the Contract Year with a history of utilization of impacted drugs when those Beneficiaries have not been transitioned to a therapeutically equivalent formulary drug; or for whom formulary exceptions/prior authorizations are not processed prior to the new Contract Year. This applies at POS to all renewing Beneficiaries including those residing in LTC facilities.
- a. Renewing Beneficiary Transition Fills are available to all Beneficiaries during the TF Window who are impacted by a negative formulary change. Renewing Beneficiaries need to have a history of utilization of the drug for which coverage is being requested.
  - b. For these Beneficiaries, the CVS Caremark Part D Services, L.L.C. adjudication system automatically processes and pays transition fill-eligible claims and transmits POS messaging that these are paid under transition fill rules.
  - c. Additional transition supplies are available on a case-by-case basis through the MVP Health Care Customer or Provider Services Departments 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.
  - d. The quantity and time plan limits may be greater based on benefit design and will be limited by the amount prescribed.
17. Transition Fill Program Monitoring & Reporting within CVS Caremark
- a. Transition fill processes are monitored both across and within each program area that has responsibility for TF processes. TF program monitoring is both quantitative and qualitative.
  - b. 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; and Level of Care Change and LTC Emergency Supply TF.
  - c. Support for and Response to Audit and Other Data Requests
    - i. Audit requests for transition fill data from CMS or other appropriate entities are responded to within the time period designated in the request; or as soon as reasonably feasible, whichever is most appropriate per the requestor.
    - ii. Non-urgent requests for transition fill data are responded to within ten business days. Other response times are available on case-by-case, as needed, basis.

**IMPLEMENTATION STATEMENT**

(process implementation in conjunction with CVS Caremark Part D Services, L.L.C.)

Regulation/ Requirement / Standard	Referenced in

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 affected by negative formulary changes (including new utilization management requirements) from one Contract Year to the next
    - 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 Beneficiary’s TF eligibility start date is provided by the Sponsor and based on plan design. 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 Level of Care Change 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

Regulation/ Requirement / Standard	Referenced in

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 the formulary status of the claim. Depending on the MIC benefit design 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 edits may be bypassed for MIC drugs and claims paid outside of TF based on benefit design set-up. 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 set-up determines if it is either formulary or Non-formulary.

- i. Topical compounds are Non-formulary, so the entire claim is considered Non-formulary and TF will apply.
- ii. Non-topical compounds base the formulary status on the most expensive Part D ingredient:
  - 1. If the most expensive ingredient is a formulary drug, then all Part D ingredients in the MIC pay at contracted rates.
  - 2. 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.
  - 3. If the most expensive ingredient is not eligible for TF, the entire MIC will reject / not pay as TF.

- 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. Generic Drug Launch

Regulation/ Requirement / Standard	Referenced in

- i. Brand Drug retained as formulary when generic released: In the event of the launch of a new generic drug, the Sponsor elects whether to retain the brand on the formulary and not to add the generic to the formulary. A Beneficiary with the equivalent brand name drug in the look back history will not be eligible for a transition fill of the generic with the same formulation. The pharmacy will be messaged to dispense the brand name drug. The brand would be available without the need for a TF. 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. 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

Regulation/ Requirement / Standard	Referenced in

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**

<b>NCPDP Pharmacy Approval Message Code</b>	<b>TF Condition</b>
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

Regulation/ Requirement / Standard	Referenced in

- b. There are conditions under which it may be necessary for CVS Caremark Pharmacy Help Desk (PHD) or Customer Care (CC) to enter a manual TF override. These situations 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	
	<ul style="list-style-type: none"> <li>These quantity and time plan limits may be greater based on the benefit design and will be limited by the amount prescribed</li> <li>Non-LTC: cumulative applicable month's 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.</li> <li>LTC: cumulative applicable month's supply within first 90 days in the plan, oral brand solids 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</li> </ul>
Non-LTC Resident Level of Care Change	
<ul style="list-style-type: none"> <li>Beneficiary released from LTC facility within past 30 days</li> </ul>	<ul style="list-style-type: none"> <li>These quantity plan limits may be greater based on the benefit design and will be limited by the amount</li> </ul>

Regulation/ Requirement / Standard	Referenced in

	<p>prescribed</p> <ul style="list-style-type: none"> <li>• Non-LTC: cumulative applicable month's supply; multiple fills up to a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed.</li> <li>• TF available at POS if identified through adjudication, otherwise through manual override via Pharmacy Help Desk on case-by-case basis</li> </ul>
<b>New and Renewing TF Extension</b>	
<ul style="list-style-type: none"> <li>• New or Existing Beneficiaries</li> <li>• Outside standard TF days supply or time period parameters</li> <li>• TF parameters have been reached and Beneficiary is still pending exception/coverage determination decision</li> </ul>	<ul style="list-style-type: none"> <li>• These plan limits will be limited by the amount prescribed</li> <li>• Non-LTC: Per MVP's plan design, via manual override, additional as needed as long as exception or coverage determination decision is pending</li> <li>• LTC: per MVP's plan design, via manual override, additional as needed as long as exception or coverage determination decision pending</li> </ul>

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 applicable month's supply (or greater based on benefit design); multiple fills up to a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed.

Regulation/ Requirement / Standard	Referenced in



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 a 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 CVS Caremark 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 (LOC) Beneficiary resides in LTC Facility and is a New Patient Admission	
<ul style="list-style-type: none"> <li>Beneficiary admitted to LTC facility within past 30 days</li> </ul>	<ul style="list-style-type: none"> <li>These quantity plan limits may be greater based on the benefit design and will be limited by the amount prescribed</li> </ul>

Regulation/ Requirement / Standard	Referenced in

	<ul style="list-style-type: none"> <li>• Cumulative applicable month’s 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;</li> </ul> <p>At POS submitted with:</p> <ul style="list-style-type: none"> <li>• Submission Clarification Code 420-DK Value “18”</li> <li>• Patient Location Code identified as LTC</li> <li>• Additional fills as needed are available via manual TF overrides through the Pharmacy Help Desk</li> <li>• Multiple fills allowed to accommodate LOC changes</li> <li>• 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.</li> <li>• New and renewing Beneficiaries must have TF days supply exhausted, exceeded or the TF time period expired</li> <li>• 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.</li> <li>• If LTC LOC benefit is engaged and pays it will count towards the LTC LOC benefit. Remaining non-LTC or LTC TF benefits will still be available through the TF Window.</li> <li>• 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</li> </ul>
--	--

Regulation/ Requirement / Standard	Referenced in

	TF benefit available through the TF Window.
LTC Emergency Supply Beneficiary resides in LTC facility	
<ul style="list-style-type: none"> <li>LTC Emergency Supply (ES)</li> </ul>	<ul style="list-style-type: none"> <li>These supplies may be greater based on the benefit design and will be limited by the amount prescribed</li> <li>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.</li> </ul> <p>At POS submitted with:</p> <ul style="list-style-type: none"> <li>Submission Clarification Code 420-DK Value "7"</li> <li>Patient Location Code identified as LTC</li> <li>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.</li> <li>LTC ES is allowed per calendar day, per Beneficiary, per drug, per pharmacy, per plan a cumulative days supply during a rolling month</li> <li>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</li> <li>If LTC ES benefit is engaged and pays it will count towards the LTC ES benefit. Remaining non-LTC or LTC TF benefits will still be available through the TF Window.</li> <li>If the incoming LTC ES claim days supply exceeds the maximum LTC ES benefit, the pharmacy will be</li> </ul>

Regulation/ Requirement / Standard	Referenced in

	<p>messed to notify of the remaining non-LTC or LTC TF benefit available through the TF Window.</p>
--	---

- 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 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

Regulation/ Requirement / Standard	Referenced in

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 MVP Health Care 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, Plan-level phone numbers are provided to assist with contacting the Plan for a determination if needed. MVP reviews Part A or B vs. D determinations to determine correct coverage. 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 drugs. 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

Regulation/ Requirement / Standard	Referenced in

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, according to Sponsor benefit design, 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 Benefit 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,

Regulation/ Requirement / Standard	Referenced in

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

Regulation/ Requirement / Standard	Referenced in

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. CVS Caremark Part D Services, L.L.C. adjudication logic uses a 180-day look back period for determining new starts. The Type 2 ST-PA Drug Logic will pay the claim without TF logic, according to the plan criteria. 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

Regulation/ Requirement / Standard	Referenced in



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 at the start of Contract Year; 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 MVP Customer or Provider Care line to ensure adequate transition.
11. Transition Fill (TF) Letters are sent to Beneficiaries within three (3) 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 3 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).

Regulation/ Requirement / Standard	Referenced in

- ii. The contents of the TF Letter file are used to drive production of the appropriate Beneficiary and prescriber TF letters.
- 12. Prior Authorization and exception request forms available upon request to Beneficiaries, prescribers, pharmacies and others by a variety of means including mail, fax, email, and the MVP Medicare and Provider websites.
- 13. 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.
- 14. [Intentionally left blank to maintain consistent numbering between sections.]
- 15. 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
- 16. Transition for Current Beneficiaries
  - a. Renewing Beneficiaries need to have a history of utilization of the Non-formulary Drug(s) experiencing a year over year negative formulary change. History utilization requires the following criteria:
    - i. History look back of 180 days from current date of fill, to identify the most recent qualifying history claim
    - ii. History look back drug GPI 10 match
    - iii. History claim(s) for same drug
      - 1. Incoming claims for Beneficiaries within their renewing Beneficiary transition window will be evaluated to determine if the drug being requested has been impacted by a negative formulary change.
      - 2. Negative formulary changes are evaluated through an adjudication process that compares the current formulary edits for the drug being requested to the historical formulary edits previously implemented for the drug.
      - 3. Negative formulary change evaluation will be performed upon adjudication at POS.
    - iv. Beneficiary's clinical prior authorization(s) are not already effectuated
    - v. For instances where the Beneficiary receives a partial transition fill, the logic will ensure that the renewing Beneficiary's remaining days supply is transition fill eligible during the TF Window.
  - b. The following processes are options MVP Health Care may request CVS Caremark to implement for renewing Beneficiaries:

Regulation/ Requirement / Standard	Referenced in

- 
- i. Use the ANOC as advance notice of any formulary changes.
  - ii. Prospectively work to educate and transition current Beneficiaries on medications that will no longer be on the formulary in the new Contract Year or that will require prior authorization, step therapy or quantity limit utilization management edits in the new Contract Year.
  - iii. Encourage processing of formulary exceptions/prior authorizations prior to January 1 of a new Contract Year.
  - iv. Consistent with the transition fill process provided to new Beneficiaries, Delegated PBM provides transition fills, to renewing Beneficiaries during the first 90 days of the Contract Year with history of utilization of impacted drugs when those Beneficiaries have not been transitioned to a therapeutically equivalent formulary drug; or for whom formulary exceptions/prior authorizations are not processed prior to the new Contract Year. This applies to all renewing Beneficiaries including those residing in Long Term Care facilities.

Regulation/ Requirement / Standard	Referenced in