Transition Process

1.0 Purpose

This policy and procedure outlines the MMM Healthcare process for complying with Medicare Part D transition requirements including but not limited to processes for New Enrollees prescribed non-formulary drugs, Current Enrollees affected by negative formulary changes across Contract Years, level of care changes, LTC emergency fills, and transition extension requests.

The purpose of providing a transition supply is to promote continuity of care and avoid interruptions in drug therapy while a switch to a therapeutically equivalent drug or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons can be effectuated.

2.0 Scope

In order to comply with CMS’ requirements and prevent coverage gaps, MMM/PMC provides a temporary supply of the requested prescription drug (where not medically contraindicated), which represents ongoing therapy but is non-formulary, and provides Enrollees with notice that they must either switch to a drug on MMM/PMC formulary or request an exception to continue taking the requested drug. CVS Part D Services has systems capabilities that allow Part D Services to provide a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of an Enrollee, as well as to allow the plan and/or the Enrollee sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons. MMM/PMC has procedures for medical review of non-formulary drug requests, and when appropriate, a process for switching new enrollee to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination. The coverage determination and medical review process for non-formulary requests are documented in PH-801 Coverage Determination. Also, CVS transition fill (TF) processing and coding applies point-of-sale (POS) messaging to pharmacies.

This policy and procedure applies to MMM Healthcare, LLC and PMC Medicare Choice, applicable to the following contract numbers:

- MA-PD H4003 for MMM Healthcare, LLC
- MA-PD H4004 for PMC Medicare Choice
- MA-PD H7522 for MMM Healthcare, LLC

Our transition policy applies to non-formulary drugs, meaning both (1) Part D drugs that are not on a plan's formulary, and (2) Part D Drugs that are on a plan's formulary but require prior authorization or step therapy, or that have an approved QL lower than the
beneficiary's current dose, under a plan's utilization management rules.

3.0 Policy

MMM/PMC and CVS Caremark, where delegated to manage and support the Medicare-required transition process for Enrollees who are prescribed Part D drugs that represent ongoing therapy with that drug but are non-formulary, offer an integrated transition solution at the pharmacy point of service (POS) for:

- New Enrollees into prescription drug plans following the annual coordinated election period.
- Newly eligible Medicare Enrollees from other coverage.
- Individuals within SNP programs who switch from one plan to another after the start of a Contract Year. In other words; if an Enrollee disenrolls and then re-enrolls in a plan, that Enrollee would be eligible for transition.
- Enrollees residing in long-term care (LTC) facilities, or Enrollees with level of care changes.
- Enrollees who require a transition extension.
- Current Enrollees affected by negative formulary changes across Contract Years.
- Enrollees affected by a PBM Transition, if applicable.

4.0 Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Account Team</td>
<td>The main point of contact at PBM.</td>
</tr>
<tr>
<td>Annual Notice of Change (ANOC)</td>
<td>The CMS required document that must be sent to all current Enrollees annually in accordance with CMS directions, and that describes changes to existing benefits that are expected for upcoming new Contract Year.</td>
</tr>
<tr>
<td>Benefits Team</td>
<td>CVS Department responsible for set up and maintenance of the transition process.</td>
</tr>
<tr>
<td>Current Enrollee</td>
<td>An enrollee that remains on a Part D plan across a Contract Year without any gaps in coverage.</td>
</tr>
<tr>
<td>CVS Caremark Part D Services, L.L.C. (Part D Services):</td>
<td>The Caremark subsidiary that provides certain pharmacy benefit management services to Medicare Part D plans.</td>
</tr>
<tr>
<td>DUM</td>
<td>Drug Utilization Management.</td>
</tr>
<tr>
<td>DUR</td>
<td>Drug Utilization Review that does not allow override of select DUR safety edits which are set up to reject at point of sale.</td>
</tr>
</tbody>
</table>
### Eligibility Data Element
The Ben Admin element requested to write rules based on the number of days an enrollee has been enrolled in Part D plan.

### Food and Drug Administration (FDA)
A federal agency of the U.S. Department of Health and Human Services. This agency is responsible for monitoring of trading and safety standards in the food and drug industries.

### GPI
Generic Product Indicator categorizes drug products by a hierarchical therapeutic classification scheme. The GPI defines pharmaceutically equivalent drug product that are identical in: active ingredient(s), dose form, route, strength or concentration.

### Low Income Subsidy (LIS)
Subsidized premiums, deductibles, and/or copayments for which Eligible Enrollees may be qualified. Also referred to as Extra Help.

### LTC
Long-Term Care. This care may represent custodial or chronic care management or short term rehabilitative services.

### MC-21
Delegated entity to manage the pharmacy network.

### MEDB
Flag that can be set up on the Rx Claim Prior Authorization table to specify Med B vs. D drugs.

### MIC
Multi-Ingredient Compound.

### NCPDP
National Council for Prescription Drug Programs. This is the non-profit industry standards development organization that develops prevailing Part D claim telecommunications/claims processing standards and guidance.

### New Enrollee
New enrollees into Part D plans following the annual coordinated election period, newly eligible Medicare enrollees from other coverage, or individuals who switch from one plan to another [PBP ID] after the start of the Contract Year.

### Non-Long-term Care
Describes Retail, Mail and Home Infusion facilities.

### NPI
National Provider Identifier.

### P&T Committee
Pharmacy and Therapeutics committee, which is a committee that, among other things, evaluates available evidence regarding the relative safety, efficacy, and effectiveness of prescription drugs within a class of prescription drugs and reviews.

### PAMC
Prior Authorization / Medical Certification Code.

### Part D Drug
Term referring to medications determined by Medicare to count toward the true out of pocket costs for a Part D enrollee.
### Transition Process

<table>
<thead>
<tr>
<th>Patient Location Code (PLC)</th>
<th>RxClaim adjudication legacy system value that crosswalks from the Pharmacy Service Type and Patient Residence Type Code.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBM</td>
<td>Pharmacy Benefit Manager.</td>
</tr>
<tr>
<td>PH-801</td>
<td>Coverage Determination Policy and Procedure.</td>
</tr>
<tr>
<td>Point of Sale (POS)</td>
<td>A capability of retail pharmacies to electronically access plan design and eligibility information to process and transmit drug claims data at the time of purchase.</td>
</tr>
<tr>
<td>Prior Authorization (PA)</td>
<td>An evaluation of the drug’s prescribed use against a predetermined set of criteria in order to determine whether the drug/drug class will be covered by the Enrollee’s insurance plan.</td>
</tr>
<tr>
<td>QL</td>
<td>Quantity Limit</td>
</tr>
<tr>
<td>QvT</td>
<td>Quantity over Time.</td>
</tr>
<tr>
<td>RMU</td>
<td>Reject Monitoring Unit.</td>
</tr>
<tr>
<td>RX Claim</td>
<td>CVS Caremark Part D Services, L.L.C. information technology system that serves to process and adjudicate Part D claims; otherwise known as the “system,” “platform,” or “system platform.”</td>
</tr>
<tr>
<td>SCF</td>
<td>Guidance and related edits pertaining to enrollees receiving certain drugs in a long-term care setting. Drugs subject to short-cycle fill edits were defined by CMS and must be dispensed to patients in limited quantities as per the CMS guidance.</td>
</tr>
<tr>
<td>Submission Clarification Code (SCC)</td>
<td>NCPDP data element indicating that the pharmacist is clarifying the claim submission.</td>
</tr>
<tr>
<td>SNP</td>
<td>Special Needs Plan.</td>
</tr>
<tr>
<td>ST</td>
<td>Step Therapy.</td>
</tr>
<tr>
<td>Transition Fill (TF)</td>
<td>A temporary supply of a Part D covered drug per CMS Part D requirements.</td>
</tr>
<tr>
<td>TF Window</td>
<td>The Enrollee Transition Fill window is the Sponsor specified number of days (minimum of 90 days) during which Enrollee transition benefits apply.</td>
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</table>
5.0 Responsibilities

5.1 MMM/PMC directs their CVS Account Team to assure that their Transition Policy is set up appropriately within the CVS applicable department per the benefit set up and the formulary submitted to CMS by the Plan. The maximum days’ supply set up in the client’s Part D benefits design is used as the basis for the transition supply but only if equal to or longer than the minimum transition period required by CMS.

5.2 MMM/PMC and CVS thoroughly validate all Part D benefits during a comprehensive iteration testing process which includes validation of the benefit design, formulary and CMS regulation requirements for new implementations; and all changes to benefits for existing clients, when applicable.

5.3 MMM/PMC is responsible for providing a CMS approved letter to be sent to the Enrollee and provider, as specified in this policy.

5.4 CVS obtains MMM’s approved formulary and UM edits and codes it into the adjudication system to identify TF eligible claims at point of sale so that it can be paid.

5.5 CVS implements soft edits in the claims adjudication process to enable temporary transition fills for Medicare Part D Eligible drugs. If a claim is approved under transition fill criteria, it includes messaging indicating that the claim was paid pursuant to transition fill requirements at the point of sale and a CMS approved letter is sent to the Enrollee and provider as specified in this policy.

5.6 MMM/PMC is responsible for making prior authorization, formulary exception request forms, and the plan’s transition fill policy available upon request to enrollees, authorized representatives, and prescribing physicians by mail, fax, email, and plan web sites.

5.7 MMM/PMC is responsible for submitting a copy of the transition policy to CMS and for posting it in its website.
Transition Process

POS transition supply processing is available and there are procedures in place for transition extensions and overrides, if needed, through the Pharmacy Help Desk. Transition fill POS messaging to pharmacies applies as follows:

a) CVS Part D Services’ adjudication system automatically processes and pays transition fill-eligible claims and transmits POS messaging that these are paid under transition fill rules.

b) Transition fill messaging to pharmacies is consistent with current 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”) and include: 1) “Paid under transition fill. Non-formulary”; 2) “Paid under transition fill. Prior authorization (PA) required”; and 3) “Paid under transition fill. Other Reject”, which includes step therapy, quantity limit (quantity vs. time or daily dose) or, age edit transition fill reasons. Pharmacies are not required to either submit, or resubmit, a coverage determination request, or other transition fill-specific code for transition fill-eligible claims to pay.

c) Transition fill processing applies to both new and ongoing prescriptions at POS.

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 MC-21.

e) 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, MMM/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.

6.1 Transition Process in the Retail Setting:

6.1.1 MMM/PMC provides a single fill or multiple up to a maximum of 30-day supply when an Enrollee presents at a 30 day supply pharmacy to request a refill of a non-formulary drug anytime within the first 90 days of an Enrollee’s enrollment in a plan, beginning on the Enrollee’s effective date of coverage. If the Enrollee presents with a prescription written for less than 30 days, MMM/PMC allows multiple fills to provide up to a total cumulative of 30 days of medication. If the smallest available marketed package exceeds a 30 day supply, MMM/PMC still provides a transition supply when required.

6.1.2 For Enrollees with level of care changes 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 transition fill is authorized by MMM/PMC once the pharmacy identifies that a claim reject is being reflected in their claim adjudication system, but that Enrollee was allowed to access prescribed drugs upon admission or discharge.

6.1.3 The current enrollee transition period covers the period from January 1 to March 31 of the Contract Year, except for new Medicare eligible Enrollees and SNP program eligibility changes. During this time, a current Enrollee is provided with a transition supply of an eligible drug anytime there is evidence of prior utilization of the drug within the established look back window. Prior utilization is confirmed based on the GPI10 associated with the drug on the incoming claim to any claim that paid for the Enrollee within the same CMS PBP ID for the same GPI10 within the last 365 days. Lacking prior utilization within the look-back window precludes a transition supply from being extended to a current Enrollee during their cross-plan year window.

6.2 Transition Process in the Long Term Care (LTC) Setting:
MMM/PMC provides with continued access to transition eligible drugs during their entire 90 days transition window at POS. In compliance with CMS guidance related to SCF, recurring fills of 14 day supplies (of oral brand solids) are dispensed throughout the Enrollee’s window if the drug is subject to the SCF guidance. LTC transition fills are allowed for cumulative days’ supply of at least 91 days and up to 98 days consistent with the applicable dispensing increment in the long term care setting. If the Enrollee presents with a prescription written for less than 91 days to 98 days, MMM/PMC allows multiple fills to provide up to a total cumulative of at least 91 days to a maximum of 98 days of medication during the first 90 days of an Enrollee’s enrollment is a plan. If the smallest available marketed package sizes do not align with this timeframe, MMM/PMC still provides a transition supply when required.

6.2.1 In addition, MMM/PMC covers an emergency supply of non-formulary drugs for Enrollees in long-term care facilities who are beyond their 90 day transition period to allow requests for formulary exceptions or prior authorization to be processed. In such instances, a minimum of a thirty-one (31) day supply, regardless of dispensing increments, or the prescribed amount of medication, whichever is less, is dispensed. This process is managed by MMM/PMC prior authorization advocates.

6.2.2 MMM/PMC ensures that Enrollees admitted to/or discharged from a LTC facility, receive a bypass for early refill edits, to guarantee appropriate and necessary access to their Part D benefit. Such
enrollees are allowed access to a refill upon admission or discharge.

6.2.3 Cases for Enrollees with level of care changes are also authorized by MMM, in a similar way as for retail setting.

6.3 Transition process for current Enrollees affected by negative formulary changes in the upcoming year.

MMM/PMC effectuates a meaningful transition by either:

6.3.1 Effectuating a transition prior to the start of the new Contract Year
   6.3.1.1 MMM/PMC may proactively identify the Enrollees affected by negative formulary changes and grant the authorization (grandfather) of the drug before the start of the new Contract Year, depending on the type of medication therapy, impact on safety to the Enrollee, and Enrollee demonstrated adherence to the therapy, to avoid Enrollee disruption.

6.3.2 Or, providing a transition process at the start of the new Contract Year
   6.3.2.1 Enrollees that are not grandfathered are notified of negative formulary changes and of the exception process through the printed version of the formulary and provided a transition fill at the start of the new Contract Year, if applicable.

6.3.3 MMM/PMC notifies Enrollees with an annual notice of change reflecting negative formulary changes (including step therapy and prior authorization changes) across Contract Years for purposes of determining transition fill eligibility.

6.3.4 MMM/PMC designs and executes an annual communication plan with the providers and pharmacies to educate them on the new formulary changes and what are their best alternatives for transition. The plan may include targeted communications to providers with Enrollees impacted by the changes.

6.3.5 When these Enrollees do not switch to the new formulary alternatives, visit a contracted pharmacy, and claim a drug that is no longer on the formulary across Contract Year, the Transition Process in the Retail Setting or LTC Setting section, as explained above, applies.

6.3.6 The current Enrollee transition period covers the period from January 1 to March 31 of the Contract Year, except for new Medicare eligible Enrollees and SNP program eligibility changes.

6.4 Edits during Transition:

6.4.1 CVS implements soft edits in the claims adjudication process to enable temporary transition fills for Part D drugs. Enrollee eligibility is determined based on an Eligibility Data Element. If an Enrollee is not
eligible, the claim would not meet transition fill criteria and it would be appropriately rejected. The pharmacy would receive appropriate messaging at the point of sale corresponding to the rejection. If a claim is approved under transition fill criteria, it includes messaging indicating that the claim was paid pursuant to transition fill requirements at the point of sale and a CMS approved letter is sent to the Enrollee and provider as specified in this policy.

6.4.2 Note, however, that transition refills may be rejected or dispensed for less than the prescribed amount for safety reasons including quantity level limits or drug utilization edits based on approved product labeling. In such cases, messaging instructs the pharmacy to lower the quantity and to resubmit the claim using a code for a quantity level limit. The code enables a unique notification to be sent advising the Enrollee of the quantity level limit or drug utilization edit as may be required.

6.4.3 Transition fills proceed for all step therapy and prior authorization edits at point of sale, other than the following:
   a) Edits to determine Part A or B vs. Part D coverage.
   b) Edits to prevent coverage of non-Part D medications (i.e. excluded drugs, OTC)
   c) Edits to promote safe utilization of a Part D drugs such as:
      a. an Enrollee-level opioid claim edit;
      b. quantity limits based on FDA maximum recommended daily dose such as APAP;
      c. early refill edits not a result of a dose change.
   d) Edits to support the determination of Part D drug status.

6.4.4 For new Enrollees presenting with a prescription that represents ongoing therapy with a non-formulary opioid medication or a formulary opioid medication subject to PA or ST under the new plan’s utilization management rules, a temporary supply can be provided during transition in accordance with this section, as long as the temporary transition fill does not exceed plan-level limits, cumulative opioid MED edits, or Enrollee-specific limits documented by the previous plan that the current plan also applied.

6.4.5 All edits are subject to exceptions and appeals. MMM/PMC’s prior authorization, formulary exception request forms, and the plan’s transition policy are available upon request to Enrollees, authorized representatives, and prescribing physicians by mail, fax, email, and plan web sites.

6.4.6 MMM/PMC provides 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. This is handled on a case-by-case basis via a coverage determination, according to PH-801.

6.5 Transition Timeframes:

6.5.1 MMM/PMC provides a one time, temporary maximum of 30-day fill (unless the Enrollee presents with a prescription written for less than 30 days) supply when an Enrollee presents at a pharmacy to request a refill of a non-formulary drug within the first 90 days of their coverage under the new plan.

6.5.2 MMM/PMC provides a temporary supply fill anytime during the first 90 days of enrollment in a plan.

a) For those Enrollees that enroll in the plan at any time during the Contract Year, this requirement applies beginning on the Enrollee’s first effective date of coverage, and not only to the first 90 days of the Contract Year.

6.5.3 When going through a PBM claims processing transition or exchange MMM/PMC considers all Enrollees eligible for a temporary supply fill anytime during the first 90 days of an Enrollee’s enrollment in a plan as defined above.

6.6 Transition Extensions:

6.6.1 MMM/PMC continues to provide necessary Part D drugs to an Enrollee via an extension of the transition period on a case-by-case basis, to the extent that his or her exception request or appeal has not been processed by the end of the minimum transition period. Continuation of drug coverage will be provided until either a switch to an appropriate formulary drug or a decision on an exception request is made. Procedures are in place for transition extensions and overrides at the POS, if needed, through the Pharmacy Help Desk and Member Services. 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.

6.6.2 MMM/PMC extends transition policy across Contract Years should an Enrollee enroll in the plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply. These Enrollees are eligible for a TF from the date they enroll in the current Contract Year (i.e. Nov or Dec 1) through the TF Window which starts on January 1 of the next plan year.

6.6.3 MMM/PMC gives affected Enrollees guidance regarding how to proceed after a temporary fill is provided, so that an appropriate and meaningful transition can be effectuated by the end of the transition
period. Until that transition is actually made, however, either through a switch to an appropriate formulary drug, or decision of an exception request, continuation of drug coverage will be provided, other than for drugs not covered under Medicare Part D.

6.7 Brand-new prescription distinction:
MMM/PMC applies all transition processes to a brand-new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.

MMM/PMC treats new Enrollees that were allowed an initial transition fill for protected class drugs that are subject to PA or ST on new starts only as currently taking the drug. Therefore, any protected class PA or ST requirements for new starts are no longer applicable after the first fill has been provided.

6.8 Transition Notices:

6.8.1 CVS triggers the CMS Model Transition Notice, approved via the file-and-use process or submission of a non-model Transition Notice to CMS for marketing review subject to a 45-day review, to be mailed via U.S. first class mail within three (3) business days from adjudication date to each Enrollee and long term care Enrollee who receives temporary transition fills. Transition notices to prescribers are generated and mailed when an Enrollee's transition fill notice is produced. The content of this notice is based on the content of the Enrollee transition fill notice, as approved by CMS. Reasonable efforts are made to deliver the notice to the prescriber.

6.8.2 For level of care changes, MMM/PMC sends a written notice via U.S. first class mail to each Enrollee who receives transition fills.

6.8.3 The Text of the letter to each affected Enrollee follows the model language provided by CMS and include: (1) an explanation of the temporary nature of the transition supply an enrollee has received; (2), instructions for working with the plan sponsor and the enrollee's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the plan's formulary (3) an explanation of the enrollee's right to request a formulary exception and; and (4) a description of the procedures for requesting a formulary exception.

6.8.4 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.

6.9 Cost-Sharing for Transitional Fills:
6.9.1 For non-LIS Enrollees MMM/PMC charges the same cost sharing for non-formulary Part D drugs provided during the transition that would apply for non-formulary drugs approved through a formulary exception in accordance with cfr 423.578 (b) and the same cost sharing for formulary drugs subject to utilization management edits provided during the transition that would apply if the utilization management criteria are met.

6.9.2 Although LIS does not apply for US territories (P.R.), for LIS Enrollees, the cost sharing for a temporary supply would never exceed the statutory co-payments amount for low income cost sharing eligible Enrollees.

6.10 Public Notice of Transition Process:

6.10.1 Company makes general information about their transition process available to Enrollees in a manner similar to information provided on formularies and benefit design. MMM/PMC Transition Process is available in plan pre- and post-enrollment materials.

6.10.2 Enrollees may also view MMM/PMC Transition Process via the MMM/PMC website link from the Medicare Prescription Drug Plan Finder.

6.11 Therapeutic Interchange:

The Pharmacy Director or Medical Director is available to review with the prescribing physician a request for non-formulary drugs, and when appropriate, to define a process for switching MMM/PMC Enrollees to therapeutic formulary alternatives that fail an affirmative medical necessity coverage determination per PH-801 Coverage Determination.

6.12 Reject Monitoring:

On a daily basis the Reject Monitoring Unit validates that all rejects related to non-formulary, prior authorization, step therapy, quantity limits, cost exceeds, NPI and B vs D, issued in the claims adjudication system are appropriate and correct according to the CMS approved formulary. Protected class drugs rejects and those rejects related to Enrollees in transition are as well included within the above categories. For those that are not appropriate the RMU makes the necessary efforts to override the affected drug for 30 day supply and orient the Enrollee about Coverage Determination processes.

6.13 Transition Fill Program Monitoring & reporting:
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.

CVS utilizes Transition claim adjudication data 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 Enrollee TF; and New Patient Admission and LTC Emergency Supply TF. CVS supports and responds to audits and other data requests, as follows:

a) 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.

b) 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.

Each January, CVS Caremark monitors Transition Fill letters to ensure accuracy and that the content reflects correct information. CVS Caremark also reviews claim reports to flag any rejects that are not getting filled according to the Transition Fill Policy. Transition Fill processing quality checks continue throughout the year in conjunction with routine claim reviews. Weekly and Monthly reports of transition fills and notices are shared with MMM/PMC. Should additional ad-hoc reporting be required by CMS, CVS develops such reporting.

6.14 P&T Committee Role in Transition:

MMM/PMC P&T committee addresses procedures for medical review of non-formulary drug requests and, when appropriate, a process for switching new MMM/PMC Enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination. MMM/PMC P&T committee reviews and provides recommendations regarding the procedures for medical review of non-formulary drug requests. P&T committee involvement helps ensure that transition decisions appropriately address situations involving Enrollees stabilized on drugs that are not on the MMM/PMC formulary (or that are on the formulary but require prior authorization or step therapy under utilization management requirements) and which are known to have risks associated with any changes in the prescribed regimen.
7.0 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 Enrollee 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 Enrollees in the plan following the annual coordinated election period
      ii. Newly eligible Medicare Enrollees from other coverage
      iii. Enrollees who switch from another Part D plan after the start of a Contract Year
      iv. Current Enrollees affected by negative formulary changes (including new utilization management requirements) from one Contract Year to the next
      v. Enrollees residing in LTC facilities
   b. Transition fill processing is also available via manual overrides through the Pharmacy Help Desk for the scenarios detailed later in this implementation statement.
   c. Transition fill window and eligibility check is applied to the claim. The Enrollee’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 transition fill time or cumulative days’ supply parameters based on Enrollee 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 an Enrollee 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 Enrollees who are new to plan, renewing Enrollees within first 90 days of Contract Year, and for LTC new patient admissions and emergency supplies, TF for dosage escalation is allowed, as appropriate, by manual override via the Pharmacy Help Desk.
      i. Part D Drugs only allowed for TF.
      Non-Part D drugs are excluded from TF processing. Non-Part D drugs are identified with an “N” in the “Med D” field on the CVS Caremark Part D
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Services, L.L.C. 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 CVS Caremark Part D Services, L.L.C. drug database.

f. Multi-Ingredient Compounds (MIC) processed for TF.

TF processing for Multi-Ingredient Compound (MIC) drugs is based on the most expensive ingredient submitted. Only Non-formulary will process under MIC TF rules. Step therapy protocols are bypassed for MIC drugs and these claims are paid outside of TF. QvT, daily dose, and age edits will not be bypassed for MIC drugs and claims paid outside of TF based on benefit design set-up. Since MICs 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.).

Step 1: MIC adjudication determines the type of compound; determines if 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 most-expensive Part D ingredient; determines if it is either formulary or Non-formulary.

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

ii. 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.

iv. 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. Claims for Non-formulary Drugs are eligible for TF processing.

a. In the event of the launch of a new generic drug, MMM/PMC may elect whether to retain the brand on the formulary and not to add the generic to the formulary, an Enrollee with only the equivalent brand drug in history will not be eligible for a transition fill of the generic with the same formulation, if MMM/PMC 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 an Enrollee is currently taking a brand drug, a transition fill for the brand drug with a formulary change will be provided to allow Enrollee 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. Enrollees with a claim for a drug with a quantity limit lower that the Enrollee’s current dose will be eligible for TF processing.

c. 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.

d. 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 Enrollees.

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 TF communication document that is sent annually to network pharmacies prior to the beginning of each new Contract Year.

iii. Pharmacy Help Desk (PHD): Pharmacies contacting the PHD are verbally informed of Enrollee’s TF availability, process and rights for requesting prior authorization and/or exception, and how to submit an automated TF request.

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 Prior Authorization/Medical Certification Code (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.
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

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

e. There are conditions under which it may be necessary for the PHD to enter a manual TF override. These situations include, but are not necessarily limited to:
   
i. Non-LTC Enrollee moves from one treatment setting to another, if not identified automatically through the adjudication process
   
ii. Enrollee 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
   
f. 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 Enrollee for manual TF overrides same as POS overrides.

3. TF Days’ Supply & Time Period Parameters (and LTC Days’ Supply for Statement 7)
# Transition Process

<table>
<thead>
<tr>
<th>Description</th>
<th>TF Days’ Supply</th>
</tr>
</thead>
</table>
| **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: 30 cumulative days’ supply within first 90 days in new plan  
  **•** LICS III: LICS III cumulative days’ supply as defined by the plan. Either non-LTC, LICS III or LTC parameters are applied according to the LICS level and pharmacy submitted codes.  
  **•** LTC: 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; multiple fills for a cumulative days supply of at least 91 to max 98, consistent with the dispensing increment / 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: up to a 30 days’ supply; multiple fills up to a cumulative 30 days’ supply are allowed to accommodate fills for amounts less than prescribed.  
  **•** LICS III: LICS III cumulative days’ supply as defined by the plan. Either non-LTC, LICS III or LTC parameters are applied according to the LICS level and pharmacy submitted codes.  
  **•** 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** | |

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• 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 Sponsor’s plan design, via manual override, additional as needed as long as exception or coverage determination decision is pending
• LICS III: LICS III cumulative days’ supply as defined by the plan. Either non-LTC, LICS III or LTC parameters are applied according to the LICS level and pharmacy submitted codes.
• LTC: per Sponsor’s plan design, via manual override, additional as needed as long as exception or coverage determination decision pending

a. LICS III Member benefit conversion

A LICS III Enrollee is identified by the pharmacy submitted codes along with eligibility LICS Level of III.

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 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 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.

4. The adjudication system ensures that cost-sharing applied to TF’s for low-income subsidy (LIS) Enrollees never exceeds statutory maximum co-pay amounts; and for non-LIS Enrollees, 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.
5. 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, Long-term Care 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 pharmacy network operations and MMM/PMC 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 PLC’s designating LTC.
   c. LTC Emergency Supply (ES) is allowed after the transition supply parameters are exhausted for new Enrollees and a coverage determination or exception is still pending. Transition supply parameters do not need to be exhausted for renewing Enrollees to receive LTC ES. 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 New Patient Admission/ 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.

<table>
<thead>
<tr>
<th>Description</th>
<th>TF Days’ Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC New Patient Admission/Level of Care Change</td>
<td></td>
</tr>
<tr>
<td>Beneficiary resides in LTC Facility (New Admission)</td>
<td></td>
</tr>
<tr>
<td>• Beneficiary admitted to LTC facility within past 30 days</td>
<td>• These quantity plan limits may be greater based on the benefit design and will be limited by the amount prescribed</td>
</tr>
<tr>
<td>• New Patient Admission (NP) Level of Care Change (LOC)</td>
<td>• 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</td>
</tr>
</tbody>
</table>
### Transition Process

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 NP is allowed per calendar day, per Beneficiary, per drug, per pharmacy, per plan a cumulative days supply
- New Beneficiaries must have TF days’ supply exhausted, or TF time period expired even when LTC cumulative days’ supply not yet used

### 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
Transition Process

- New Beneficiaries must have TF day supply exhausted, or TF time period expired, and while an exception or prior authorization is pending.

e. LTC New Patient Admission or Level of Care Change for Enrollees being admitted to or discharged from an LTC facility - early refill edits are not used to limit appropriate and necessary access to their Part D benefit, and such Enrollees are allowed access to a refill upon admission or discharge.

<table>
<thead>
<tr>
<th>Description</th>
<th>Edit</th>
<th>Reject Code</th>
<th>Point of Sale</th>
<th>Manual Override Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC New Patient</td>
<td>RTS/ Plan Option 15</td>
<td>79</td>
<td>Y</td>
<td>Y (if Drug Qualifies as TF, TF Override used)</td>
</tr>
<tr>
<td>LTC Emergency Supply</td>
<td>RTS/ Plan Option 15</td>
<td>79</td>
<td>N</td>
<td>Y (if Drug Qualifies as TF, TF Override used)</td>
</tr>
<tr>
<td>LTC New Patient</td>
<td>DUR – Plan Option 30</td>
<td>88</td>
<td>Y</td>
<td>Y (if Drug Qualifies as TF, TF Override used)</td>
</tr>
<tr>
<td>LTC Emergency Supply</td>
<td>DUR – Plan Option 30</td>
<td>88</td>
<td>N</td>
<td>Y (if Drug Qualifies as TF, TF Override used)</td>
</tr>
</tbody>
</table>

LTC NEW PATIENT & LTC EMERGENCY SUPPLY
REFILL TOO SOON (RTS) & DRUG UTILIZATION REVIEW (DUR) OVERRIDES

6. 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.
   b. **Refill Too Soon (RTS)**
      Automated TF system logic for new and renewing Enrollees 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.
   c. **DUR Safety Edits**
      Automated TF system logic for new and renewing Enrollees 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.
d. **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.

e. **Part A or B vs. Part D (A or B vs. D)**

Part A or B vs. D drugs (formulary drugs with a UM edit) are not provided a TF because coverage is not available for the drugs. A determination is needed to identify what coverage will be applied to 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. This allows the pharmacy or Enrollee to call Delegated PBM for clinical review to determine coverage. The identifier flag can be set up on the RxClaim Prior Authorization table to specify Med A or B vs. D drugs. Med A or B v. D claims reject as A6 (B vs. D), A5 (Not D, not B. Not covered under Part D Law) or A4 (This Product May Be Covered Under The Medicare- B Bundled Payment To An ESRD Dialysis Facility). A3 (This Product May Be Covered Under Hospice – Medicare A). Plan-level phone numbers are returned in the reject messaging for formulary drug claims rejecting for A or B vs. D determinations to enable pharmacies to follow-up. Once the determination is made, if a drug is determined to be Part D eligible, a PA is entered.

Non-formulary drugs in these categories, as a rule, will not be covered under Part A or B or Part D. Therefore, a TF is provided to allow the enrollee to leave the pharmacy with a temporary supply and work with their prescriber to identify a formulary alternative.

f. **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. Enrollees can request a Formulary Exception for these drugs. Drugs will only be approved for Enrollees who provide the diagnosis demonstrating that the drug is prescribed for a medically accepted indication. Enrollees who have a coverage determination (prior authorization or Formulary Exception) denied, will receive a denial letter indicating their drug is not a Part D eligible drug. Enrollees 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).

g. **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 Enrollee obtained a TF (“grandfathered” or Type 2 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 Enrollee 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, TF Letters are not sent to either Enrollees or prescribers. Step TF overrides reject 76/75.

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
Transition Process

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 edits 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 day’s 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
Transition Process

may be dispensed. The intent of this logic is to ensure an Enrollee 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. **Member Level / Clinical Prior Authorizations (PA)**
Member 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 Member / clinical PA already exists on the Enrollee 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 Enrollees.

h. **Processed without TF**
   i. **Protected Class Drugs (PCD) Logic**
      The PCD Logic will override the Step and PA edit and pay the claim without TF according to the plan criteria. TF processing will apply to any TF-eligible edit which the PCD logic has not overridden.

7. **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 Enrollee 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.

8. **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.**
   i) Enrollees who are new to plan include: new plan Enrollees at the start of Contract Year; newly eligible Enrollees from other coverage; and
Enrollees who switch from one plan to another after the start of a Contract Year.

ii) Transition fills are available at POS through transition processing during the TF Window.

iii) Additional transition supplies are available on a case-by-case basis through the Pharmacy Help Desk to ensure adequate transition.

iv) The quantity and time plan limits may be greater based on benefit design and will be limited by the amount prescribed.

9. For Sponsors using CVS Caremark Part D Services, L.L.C. to fulfill transition notices, TF Letters are sent to Enrollees 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 Enrollees. For long-term care 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 Enrollees and prescribers.

iii. TF Combo Tag: This tag is used to designate the specific TF letter language content for the TF notice to Enrollees 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 Enrollee and prescriber TF letters.

10. MMM/PMC transition process for new Enrollees 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
Transition Process

Years where the TF Window extends across Contract Years.

11. TF Extensions are available for New or Existing Enrollees, non-LTC or LTC, through the PHD. 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 Enrollee is still pending exception/coverage determination decision

12. Consistent with the transition fill process provided to new Enrollees, CVS Caremark Part D Services, L.L.C. provides transition fills, to renewing Enrollees during the first 90 days of the Contract Year with history of utilization of impacted drugs when those Enrollees 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 Enrollees including those residing in LTC facilities.

13. Transition Across Contract Years for Current Enrollees Renewing
   a. Enrollees need to have a history of utilization of the Non-formulary Drug(s).
      History utilization requires the following criteria:
      i. History look back from current date of fill, 365 days
      ii. History look back drug GPI 10 match level
      iii. History claim(s) for same drug:
         1. Not paid as transition fill(s).
         2. or if only a paid transition fill is in history,
            a. the history transition fill reject reason must not match the incoming claim transition fill reject reason
            b. or if the history TF reject reason does match the incoming claim TF reject reason AND the NDCs of each claim must be different.
            c. Or if the history transition fill reject reason does not match the incoming claim transition fill reject reason AND the NDC of each claim is the same AND the reason is QL, the current QL limit must be lower than the history limit.
      iv. Enrollee’s clinical authorization(s) are not already effectuated.
      v. For instances where the Enrollee receives a partial transition fill, the logic will ensure that the renewing Enrollee’s remaining days’ supply is transition fill eligible during the TF Window. New Enrollee, LTC ES and LTC NP & Enrollee PA (reason TF) paid TF claims are not included in the look back calculation to determine if the renewing Enrollee received a partial fill and has remaining days’ supply.

   b. Renewing Enrollee logic has the following hierarchy: brand generic logic, transition fill reject reason comparison, then look back calculation for remaining days’ supply.
14. 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 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 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 and Sponsor monitoring report)
      These reports track the days between paid TF claims and date TF letters provided to Enrollees. They are used to monitor adherence with requirements to send Enrollee TF letters within three (3) business days of adjudicated TF.
   e. **Paid TF Claim File** (internal and Sponsor 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 Sponsor 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.

8.0 **Regulatory References:**
8.1 Prescription Drug Benefit Manual Chapter 6 (Rev. 18, 01-15-16)
8.2 Part D Formulary Submission and Review CY2017 Training Materials
8.3 CMS 2016 Medicare Advantage & Prescription Drug Plan Spring Conference & Webcast

9.0 **Related Policies and Procedures:**
9.1 PH 801 Coverage Determinations
Transition Process

9.2 PH 406 Pharmacy and Therapeutic Committee
9.3 PH 802 Exception Process

10.0 Attachments:
N/A

11.0 Document Approvals:

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<tr>
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<th>Position</th>
<th>Name of Approver</th>
<th>Approval Signature</th>
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<td>Director of Formulary</td>
<td>Maria I. Lazaro; Pharm.D.</td>
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<td>05/23/2017</td>
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<td>AVP of Pharmacy</td>
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<td>Medical Director</td>
<td>Angel Viera; MD</td>
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<td>05/23/2017</td>
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<tr>
<td>Final Approver</td>
<td>VP of Pharmacy MMM Holdings, LLC.</td>
<td>Nury Toledo Nuñez; Pharm.D.</td>
<td>05/23/2017</td>
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12.0 Revision History:

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## Transition Process

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