

2012 Medicare Part D Transition Process for contracts H3864 & H4754:

Essentials Rx 6, Essentials Rx 14, Essentials Rx 15, Essentials Rx 16, Premier Rx 7, Explorer Rx 1, Explorer Rx 2, and Explorer Rx 4

Through this document PacificSource Medicare is documenting how it will maintain an appropriate transition process consistent with 42 CFR 423.120(b)(3). PacificSource Medicare will make this transition policy available to enrollees via link from the Medicare Prescription Drug Plan Finder to our web site (medicare.pacificsource.com) and include in pre- and post-enrollment marketing materials as directed by CMS.

PacificSource Medicare, with the help of Express Scripts (the plan designated Pharmacy Benefit Manager) will support the CMS required transition process for enrollees' prescribed Part D drugs that are non-formulary (not covered) or formulary drugs with Step Therapy or Prior Authorization ("PA") requirements by offering an integrated solution at a retail, home delivery, home infusion, safety net or ITU pharmacy. These transition policies apply to beneficiaries who are:

- New enrollees to the plan January 1, 2012 following the annual coordinated election period,
- Newly eligible enrollees to the Part D benefit,
- Enrollees changing Part D plans after January 1, 2012,
- Enrollees residing in long-term care (LTC) facilities,
- Current enrollees affected by negative formulary (not covered) and Prior Authorization/Step Therapy changes from one contract year to the next.

Within the first 90 days of a beneficiary's enrollment in the plan and beginning on the beneficiary's effective date of coverage, PacificSource Medicare will allow enrollees a one-time temporary fill (multiple fills for LTC) for at least a 30-day fill (31 days for LTC). However, if the prescription is for less than a 30 day supply (or 31 days for LTC) the member will be eligible for multiple fills up to at least a 30 day (or 31 day's for LTC) supply for all Part D eligible medications that are non-formulary (not covered) or formulary, with Step Therapy or PA requirements unless grandfathered by the Plan.

If, after the temporary fill is provided, a transition is not made either through a switch to an appropriate formulary drug, or decision of an exception request, continuation of drug coverage may be managed through a PA override. Express Scripts systems capabilities will provide eligible beneficiaries 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. PacificSource Medicare's process for providing an extension of the transition period, an emergency fill for LTC members, or a level of care change is outlined later in this document.

There may be cost sharing for a temporary supply of drugs provided under this transition process. Cost-sharing for a temporary supply of drugs will never exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible enrollees. For non-LIS eligible enrollees, cost-sharing for a temporary supply of drugs is based on cost-sharing tiers, and this cost sharing will be consistent with cost-sharing that the plan would charge for non-formulary drugs approved under a coverage exception. This is done based on IT logic to assess the member's status and apply the appropriate cost sharing.

The Transition Process requirements will be applicable to:

- Part D medications that are non-formulary (not covered)
- Part D medications that are formulary but:
 - Are requiring a Prior Authorization
 - Are a part of a Step Therapy program

IT logic and rules will be implemented during the adjudication process to enable the temporary fill. These processes will only allow Medicare Part D eligible drugs to adjudicate. This will be determined based on a Part D eligible flag within the system. If the claim does not meet the transition fill criteria, the claim will reject appropriately and will not include messaging regarding the transition fill.

PacificSource Medicare makes available prior authorization or exception request forms upon request to both enrollees and prescribing physicians via a variety of mechanisms, including mail, fax, email and on the website (medicare.pacificsource.com).

For new enrollees, the system will work in the following manner:

- A brand-new prescription for a non-formulary drug will not be treated any differently than an ongoing prescription for a non-formulary drug when a distinction cannot be made at the point of sale. All prescriptions submitted during the Transition period by new enrollees in a Part D Plan are treated the same regardless of the submission of a new prescription from the member, because previous claim information cannot always be retrieved. When a claim for a Non-Formulary (non covered), Step Therapy, or Prior Authorization required Part D eligible drug is submitted at the pharmacy, IT logic will validate that the member is in the Transition period and allow the medication to adjudicate without any hard edit.
- If the medication is Non Formulary (non covered) and has a QLL, the member will receive multiple fills up to the days supply permitted by their Plan (at least 30 days retail and 31 days for LTC). IT logic will validate that the member is in the Transition period and allow the medication to adjudicate without any hard edit. When the medication also has a QLL, the claim will reject for QLL for safety reasons. Messaging on the rejected claim will instruct the pharmacy to lower the quantity and resubmit the claim using a code for a quantity level limit. This code will enable a unique

notification to be sent to the member advising them of the QLL. PacificSource Medicare, with the help of Express Scripts, will ensure that the transition logic provides refills for transition prescriptions dispensed for less than the written amount due to quantity limits for safety purposes or drug utilization edits that are based on approved product labeling.

- Once a Transition claim adjudicates it will trigger the appropriate transition letter to be mailed within three business days from processing date. The member letter will follow the CMS Model including (1) an explanation of the temporary nature of the transition supply an enrollee has received; (2) instructions for working with the plans sponsor and the enrollee's prescriber 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 (4) a description of the procedures for requesting a formulary exception. PacificSource Medicare has submitted the Transition member notification to CMS as a template material for a 10 day review in HPMS per Medicare Part D Chapter 3 Marketing guidance.
- A letter will also be sent to the prescribing physician explaining the situation.
- Until such time as alternative transactional coding is implemented in a new version of the HIPPA standard, Express Scripts has implemented the following messaging at the time a claim is paid:
 - Paid under transition fill. PA required
 - Paid under transition fill. Non-formulary
 - Paid under transition fill. Other reject

For Current Enrollees moving across contract years the Transition process will work in the following manner:

- PacificSource Medicare's approach for current enrollees transitioning across Contract years is to provide a transition process similar to the new enrollee process.
- PacificSource Medicare works with the Express Scripts Clinical Program Manager to ensure an ANOC type file is developed reflecting all changes across contract years.
- At POS, Express Scripts' systems will assess member utilization in the previous year and compare claims history to a negative formulary change file to indicate negative formulary (not covered), Prior Authorization and Step Therapy changes from one contract year to the next. The member will be eligible for Transitions for Part D drugs which were utilized by the member in the previous plan year and have a negative formulary (not covered) impact or are newly subject to Prior Authorization or Step Therapy for a member from one plan year to the next.

- IT logic will validate that the member is in the Transition period and allow the medication to adjudicate at POS and trigger the appropriate transition letter, which will be mailed within three business days of processing.
- A corresponding letter will also be sent to the prescribing physician explaining that the member is in the transition period.
- Current Enrollee Transition period covers the period from 1/1/2012 – 3/31/2012

For new members who become eligible for Transition at the end of the Plan Year

PacificSource Medicare, with the help of Express Scripts, extends the member transition across contract years through a 90 day look back. During the first 90 days of eligibility in the plan, the member is processed as eligible for the *new* enrollee Transition process. This approach supports the transition requirement 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.

Transition Extension

PacificSource Medicare supports the CMS requirement to continue to provide necessary Part D drugs to enrollees via an extension of the transition period, on a case-by-case basis, to the extent that their exception requests or appeals have not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a favorable decision on an exception request). Such requests are handled by the PacificSource Medicare Pharmacy Services Helpdesk, which is trained to support this requirement.

Level of Care Change Transitions

When a beneficiary has a level of care change (e.g. admitted to LTC facility) they may need additional supplies of their medications. When this occurs, the pharmacy can call PacificSource Medicare to obtain an override for the situation or for early refill edits. Early refill edits will not be used to limit appropriate and necessary access to Part D benefits for enrollees being admitted or discharged from a Long Term Care facility. This is managed by the PacificSource Medicare Pharmacy Services Helpdesk who can issue overrides directly to the pharmacy.

Emergency Access to Non-formulary Drugs

PacificSource Medicare will cover an emergency supply of non-formulary (or formulary drugs with Step Therapy or PA requirements) Part D drugs for LTC facility patients when the enrollee is outside their 90 day transition period while an exception is being processed. In these instances a 31 day supply or the total amount of the prescription, whichever is less, will be dispensed. This is managed by the PacificSource Medicare Pharmacy Services Helpdesk who can issue overrides directly to the pharmacy.

Medical Exception

The PacificSource Medicare exceptions and appeals process takes into account special circumstances to ensure that beneficiaries have access to non-formulary (or formulary drugs with Step Therapy or PA requirements) medications. An example of this situation would include when beneficiaries are discharged from a hospital. The exceptions and appeals process is described below with a description of the P&T committee involvement in the process.

The PacificSource Medicare clinical override administration process enables Pharmacy Services Helpdesk personnell to review exceptions to the benefit design using established criteria. Criteria are developed by Express Scripts clinicians and approved by Pharmacy & Therapeutics committee. Medical exceptions to the benefit design include products excluded from coverage by the pharmacy benefit (benefit exclusion) and non-formulary products.

Medical Review Process - We use the following steps to review requests for medications that are non-formulary or require a prior authorization or are subject to step therapy. If, at the end of this process, a member is rejected, they are advised on the appeal process and may work with their provider to determine the appropriate formulary alternative. This notification advises the member of the contact information and process for appealing a decision.

1. A prescription claim requiring a non-formulary drug is rejected at the point of service. The pharmacist calls the PacificSource Medicare Pharmacy Services Helpdesk to request prior authorization, step therapy or formulary exception. Pharmacy callers are automatically connected to a pharmacy services helpdesk specialist.
 - In all situations, a licensed clinical pharmacist or medical doctor will review requests for which screening criteria suggest that clinical criteria are not met.
2. If the dispensing pharmacist has medical information needed to properly review the request, the review can be completed with the pharmacist's call. If the pharmacist does not have needed information, the pharmacist can choose to notify the prescribing physician or the Pharmacy Services Helpdesk will initiate a request for clinical documentation directly from the prescriber. The prescriber can call the Pharmacy Services Helpdesk using a toll-free number dedicated to pharmacists or physicians. The prescriber can also mail or fax a letter of request.
3. PacificSource Medicare issues standard coverage determinations within 72 hours of receiving supporting documentation from the provider, member or member's appointed representative. PacificSource Medicare processes urgent or expedited requests within 24 hours.

4. Responses are communicated in the most expedient manner, usually a phone call or fax to the physician and the dispensing pharmacist. All members subject to a coverage determination receive a first-class letter informing them of the decision.
5. If the request meets criteria, the Pharmacy Services Helpdesk personnel enter an override into the claims adjudication system. The pharmacist can resubmit the claim, and the system will process it.
6. If a member is rejected, they are advised of the appeal process. Plan contact information is provided for additional assistance in effectuating a transition.

PacificSource Medicare (with the support of Express Scripts) Member and Physician Notification process for Transition fills

The system will generate a member and physician notification within 3 days of processing the claim in the following manner:

