2015 PacificSource Medicare Part D Transition Process for contracts H3864 & H4754:

**Essentials Rx 6 (HMO), Essentials Rx 14 (HMO), Essentials Rx 15 (HMO), Essentials Rx 16 (HMO), Essentials Rx 19 (HMO), Essentials Rx 20 (HMO), Essentials Rx 21 (HMO), Explorer Rx 4 (PPO), Explorer Rx 7 (PPO), Explorer Rx 9 (PPO), Explorer Rx 11 (PPO), MyCare Rx 22 (HMO), MyCare Rx 23 (HMO), Essentials Choice Rx 24 (HMO-POS), Essentials Choice Rx 25 (HMO-POS)**

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 a 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 CVS Caremark (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, Quantity Limit, 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, 2015, following the annual coordinated election period,
- Newly eligible enrollees to the Part D benefit,
- Enrollees changing Part D plans after January 1, 2015,
- Enrollees residing in long-term care (LTC) facilities, and newly admitted and/or in need of an emergency supply,
- LICS III member if the Patient Residence Code submitted on the claim is 03 or 09
- Current enrollees affected by negative formulary (not covered) and Prior Authorization/StepTherapy/Quantity Limit 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) of 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 or as multiple 14 day fills if required by CMS guidance) supply for all Part D eligible medications that are non-formulary (not covered) or formulary, with Step Therapy, Quantity Limit, 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. CVS Caremark 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 patient 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 will be based on approved cost-sharing tiers and consistent with cost-sharing that the plan would charge for non-formulary drugs approved under a coverage exception. The plan designated exceptions tier is used for non-formulary transition supply fills. Formulary transition supply will receive the same cost sharing that would apply for a formulary drug subject to utilization management edits provided during the transition that would apply once the utilization management criteria are met. This is done based on IT logic implemented by the PBM to assess the enrollee’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
  - Are exceeding Quantity Limits

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 our 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 (not covered), Step Therapy, Quantity Limit, 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.

- 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.

- For new and renewing member LTC & LICS III transition fills, written transition fill notifications are sent to LTC Beneficiaries within three (3) business days after adjudication of only the first temporary fill. Members will be eligible for multiple fills up to at least 31 day supply (multiple 14 day fills if required by CMS guidance) unless written for less, cumulative to at least 91 days up to 98 day supply for all Part D eligible medications that are non-formulary (not covered) or formulary, with Step Therapy, Quantity Limit, or PA requirements.

- A letter will also be sent to the prescribing physician explaining the situation.

- LICS III processing logic is allowed on a TF eligible claim for a LICS III member if the Patient Residence Code submitted on the claim is 03 (Long-term Care) or 09 (Institutions for Mental Disease and Intermediate Care Facilities for the Mentally Retarded) and the Pharmacy Service Type is not 04 (Institutional) or 05 (Long-term Care).

- Until such time as alternative transactional coding is implemented in a new version of the HIPPA standard, CVS Caremark 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 (step therapy, quantity limit)

**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 CVS Caremark Clinical Program Manager to ensure an ANOC type file is developed reflecting all changes across contract years.

- At Point Of Sale (POS), CVS Caremark’ 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, Quantity Limit, 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, Quantity Limit 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 1/1/2015 – 3/31/2015.

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

PacificSource Medicare, with the help of CVS Caremark, extends the member transition across contract years through a 180 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, Quantity Limit 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 personnel to review exceptions to the benefit design using established criteria. Criteria are approved by Pharmacy & Therapeutics (P&T) committee. Medical exceptions to the benefit design include products excluded from coverage by the pharmacy benefit (benefit exclusion) and non-formulary products. The P&T committee meets on a regular basis, but no less than quarterly and reviews procedures for coverage determination and exceptions, and, if appropriate, a process for switching new Enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

Medical Review Process - We use the following steps to review requests for medications that are non-formulary, require a prior authorization, or are subject to step therapy or quantity limits. 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, quantity limit, 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.