

## Policy and Procedure

<b>Policy Number:</b> HLTHSVS_ Pharm-Drug Transition			<b>Department:</b> Pharmacy
<b>Department Head:</b> Anna McGhee			<b>Applies to:</b> <input type="checkbox"/> H3727 <input type="checkbox"/> H9153 <input checked="" type="checkbox"/> Both
<b>Approval Date:</b> June 2, 2023	<b>Effective Date:</b> 1/1/2024	<b>Next Review Date:</b> June 2, 2024	<b>Page:</b> 1 of 6

### Scope:

This policy addresses a Part D drug transition fill process for CommuniCare Advantage (CCA) members and West Virginia Senior Advantage (WVSA) members. All references to the “health plan” in this policy include both CCA and WVSA. The approach outlined in this policy will be executed through the health plan’s pharmacy benefits manager.

### Purpose:

To maintain a transition process consistent with CMS guidelines for health plan members whose current drug therapies are not included in the formulary.

### Definitions:

**Non-Formulary (for the purposes of this policy):** (1) Part D drugs that are not on the health plan’s formulary, (2) drugs previously approved for coverage under an exception once the exception expires, and (3) Part D drugs that are on the health plan’s formulary but require prior authorization or step therapy, or which have an approved quantity limit lower than the member’s current dose

**Pharmacy Benefit Manager (PBM):** A third-party administrator of prescription programs for the health plan

**Prior Authorization (PA):** Plan approval in advance before the Plan will agree to cover a drug for the member

**Step Therapy (ST):** Requiring the member to try a different drug first before the Plan will agree to cover the drug that is being requested

### Policy:

Through its pharmacy benefits manager, MedImpact, the health plan’s pharmacy claims adjudication system allows pharmacies to provide a temporary supply of non-formulary Part D covered drugs in order to accommodate the immediate needs of a member. It allows sufficient time for the member to work with the prescriber on an appropriate switch to a therapeutically equivalent formulary medication or to complete an

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exception request to maintain coverage of an existing drug based on medical necessity. Medical review of non-formulary drug requests and when appropriate, the process for switching new Part D plan enrollees to a therapeutically appropriate formulary alternative failing an affirmative medical necessity determination are outlined in MedImpact's Medicare Coverage Determination Policy and Procedure and the health plan's Part D Coverage Determination Policy and Procedure. The procedure for switching to a formulary alternative is contained in the denial notification letter provided to the member as outlined in MedImpact's Medicare Coverage Determination Policy and Procedure.

The transition process promotes continuity of care and allows members to avoid interruptions in drug therapy. This process will effectuate a meaningful transition for:

- New members of our plan
- Current members affected by negative formulary changes across contract years
- Members whose exception request was not addressed within the applicable adjudication timeframe during the transition period
- Current members who are on a drug that was the result of an exception that was granted in the previous year
- Current member experiencing a level of care change
- Current members entering the long-term care (LTC) setting from other care settings
- Current members in a LTC setting requiring an emergency supply of a non-formulary drug

NOTE: This transition policy does not apply in cases in which the plan is recommending substituting generic drugs for brand name drugs as permitted under 42 CFR 423.120(b)(5)(iv).

### Regulatory Citations:

- Center for Medicare and Medicaid Services Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements, Section 30.4
- 42 CFR § 423.120(b)(3)

### Procedure:

#### Implementation

The health plan's transition policy provides a detailed explanation of how transition requests are processed within our adjudication system; how the pharmacy is notified when transition medication is processed at the point of sale; and description of edits and explanation of the process pharmacies follow to resolve transition medication edits at the point of sale.

To ensure access to a temporary supply of drugs within the first 90 days of coverage under a new plan, the member's 90 transition period begins on the first date of enrollment/coverage (i.e. member's effective date on the enrollment file) . This applies to all members including those newly enrolled into prescription drug plans

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following the annual coordinated election period, newly eligible Medicare beneficiaries from other coverage, members who switch from one plan to another after the start of a contract year, and enrollees residing in LTC facilities. The 90-day transition period applies to retail, home infusion, long term care and mail-order pharmacies as applicable to meeting the health care needs of the member.

The pharmacy claims adjudication system will be configured by MedImpact to automatically allow a one-time transition fill of at least a one month (30 day) supply in the retail setting, and a cumulative supply of at least a two month (62-day) supply in the long term care setting of a non-formulary medication. If the member presents with a prescription written for less than the transition supply allowed, then multiple fills will be allowed to provide up to the total transition supply of medication.

For a long-term care resident transition claims the pharmacy must submit the claim for up to a one-month supply of the non-formulary medication and must submit the number 3, 4, or 9 in the patient residence field. If the pharmacy does not submit a 3, 4, or 9 in the patient residence field of the claim, and the claim is for greater than a one-month supply, the claim will reject and the pharmacy will receive a message that only a one-month supply of the medication is allowed at a time for a transition fill.

The pharmacy claims adjudication system as well as step therapy (ST), prior authorization (PA), and quantity limit (QL) overrides will be configured by MedImpact to automatically allow the transition supply at the point of sale (either in one fill or multiple fills for up to the defined transition day supply) if the member is within their first 90 days of eligibility.

The transition process will be initiated when an individual first presents a prescription for a drug that is non-formulary and ongoing therapy. A 120-day look-back period will determine ongoing therapy and the pharmacy claims adjudication system will be configured to review the member's history. If the distinction between ongoing therapy and new therapy cannot be made at the point of sale, then the prescription will be treated as ongoing therapy and the member will be provided with a transition fill.

If a transition fill is provided for a protected class drug that is subject to a PA or ST on new starts only, the initial transition fill will be considered ongoing therapy and the PA or ST requirement would no longer be applicable after the first transition fill has been provided.

Through MedImpact, the health plan will make arrangements to continue to provide necessary Part D drugs to members via an extension of the transition period, on a case by case basis, to the extent that their exception request 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 decision on an exception request). This will also apply if a timely decision of an exception request has not been issued by the end of the member's transition period.

Drugs requiring ST, PA, or QL will pay at their appropriate copay tier and claims for non-formulary drugs will default to the non-preferred drug tier copay. LIS members will not pay any more than their applicable LIS level copay. Non-LIS members will pay the same cost sharing for non-formulary drugs provided during the transition period as they would for non-formulary drugs approved through a formulary exception process. Non-LIS

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members will pay the same cost share for transition fills of formulary drugs subject to utilization management edits as they would once the utilization management criteria are met.

MedImpact will maintain an adjudication system that will process transition requests, notify the pharmacy when a medication is processed at point of sale, and execute claims edits.

The pharmacy is notified when a transition medication is processed at the point of sale via pharmacy messaging placed in the claims adjudication system.

Only the following utilization management edits will be applied during transition at point of sale:

- Edits to determine Part A or B versus Part D coverage
- Edits to prevent coverage of non-Part D drugs (i.e. excluded drugs)
- Edits to promote safe utilization of a Part D drug (i.e. early refill edits)

The health plan will ensure that the pharmacies can resolve step therapy and prior authorization edits during transition at point of sale. Refills will be provided 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.

- The Customer Service Representatives will place an override in the pharmacy claims adjudication system in the Member Prior Authorization Screen to allow the claim to pay for additional refills.

For all members that require additional transitional fills outside of the first 90 days of eligibility with the plan for non-formulary medications, these additional fills will require manual intervention for the transitional claim to process. The member, the member's appointed representative, or physician must call Customer Service to have a transition override placed into the pharmacy claims adjudication system.

### Emergency Supplies

Outside of the transition period a member who resides in a long-term care setting may be provided with a 31-day emergency supply of non-formulary Part D drugs while an exception or prior authorization request is being processed.

For a member who experiences a level of care change (i.e. long-term care to hospital to long term care, hospital to home) outside of the 90-day transition period and needs a non-formulary Part D drug, the health plan will allow the member access to an emergency one-month supply transition. To the extent that a member is outside his or her 90-day transition period and is in the outpatient setting, the health plan will still provide an emergency supply of Part D covered non-formulary medications on a case by case basis, while an exception request is being processed. To the extent that a member is outside his or her 90-day transition period and is in the LTC setting, the health plan will still provide an emergency supply of Part D covered non-formulary medications while an exception request is being processed.

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- Pharmacies may submit certain Submission Clarification Codes (SCC) indicating a level of care change or the need for an emergency override. Upon submission of the appropriate SCC and identification of the LTC setting, applicable claims will adjudicate accordingly
- If a SCC is not submitted, MedImpact will send a message to pharmacies to call for a transition override for all claims rejected for non-formulary status
- Overrides will be configured at the point of sale and expire no later than 72 hours from the time it was entered
  - The Customer Service Representative will place an override in the adjudication system to allow the claim to pay without completing the non-formulary exception, prior authorization, step therapy, or quantity limit requirements

Early refill edits will not limit appropriate and necessary access to a Part D medication for members being admitted to or discharged from a long term care facility.

### Negative Formulary Changes for Current Members

A transition will be effectuated prior to the start of the new contract year for current members whose drugs will be affected by negative formulary changes in the upcoming year. The 120-day look back period will apply to determine ongoing therapy.

- The health plan will work to prospectively transition current members to a therapeutically equivalent formulary alternative and adjudicate any request received for formulary and tier exceptions to the new formulary prior to the start of the contract year
- If the health plan has not successfully transitioned affected members to a therapeutically equivalent formulary alternative or adjudicated an exception request prior to January 1, a transition supply and the required transition notice will be provided during the first 90 days of the new contract year beginning January 1.

Additionally, the transition policy will be extended across contract years should a member enroll into the Plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply.

### Transition Notices

A written notice will be sent via U.S. first class mail to each member who receives a transition fill within 3 business days of adjudication of the temporary transition fill. The health plan makes reasonable effort to notify the prescriber of affected members. The notice will include:

- An explanation of the temporary nature of the transition supply a member has received
- Instructions for working with the health plan and the member's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the health plan's formulary
- An explanation of the member's right to request a formulary exception

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- A description of the procedures for requesting a formulary exception

The health plan will make available prior authorization or exceptions request forms upon request to both members and prescribing physicians via a variety of mechanisms, including mail, fax, email, and on the health plan's website.

The health plan will make our transition policy available to members via a link from the Medicare Prescription Drug Plan Finder to the health plan's website and include it in pre-and post-enrollment marketing materials as directed by CMS.

### Other References:

- MedImpact Medicare Formulary Transition Policy and Procedure: BD-02 Medicare Formulary Transition

### Executive Approval Signature



Chief Executive Officer