



Medicare Part D Policy

I. General Description

Number:	Medicare-TS-04	Version:	15
Title:	Medicare Part D - Transition Supply		
Effective Date:	5/23/2014	Revision Date:	5/19/2021
		Validation Date:	5/17/2023
Prepared By:	D Vidal, Regulated Markets Services	Distribution:	External

Regulation/Requirement:	<ul style="list-style-type: none"> • 42 CFR § 423.120(b)(3) • 42 CFR § 423.154(a)(1)(i) • 42 CFR § 423.578(b) • Prescription Drug Manual, Chapter 6, Section 30.4 • Part D Transition Letter
Purpose:	This document defines Express Scripts prescription drug transition policy which is compliant with Medicare Part D transition supply requirements that are delegated to Express Scripts.
Scope:	This Policy is applicable to Express Scripts' Medicare Part D clients and its enrollees for whom Express Scripts provides pharmacy benefit management services to the extent covered under the approved contractual agreement with the Part D Plan.
Policy:	<p>Where applicable, and as required by CMS, Express Scripts provides transition- eligible Medicare enrollees a temporary supply for eligible medications when the medication meets one or more of the following conditions:</p> <ol style="list-style-type: none"> 1. Not included on the Plan's formulary; or 2. On the Plan's formulary, but are subject to utilization management rules including: Prior Authorization Required, Step Therapy or Plan-imposed Quantity Limits. <p>The process is intended to afford enrollees and their care team sufficient time to work with their health care providers to switch to a therapeutically appropriate formulary alternative or to request an exception on the grounds of medical necessity.</p>

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II. Definitions	
Centers for Medicare & Medicaid Services (CMS)	The United States federal agency which administers several federally-funded health care programs including, but not limited to, Medicare, Medicaid, and Children's Health Insurance Programs.
Current Enrollee	A beneficiary who remains enrolled in a Plan across a contract year without any gaps in coverage.
Exception	An exception request is a type of coverage determination. An enrollee, an enrollee's prescriber, or an enrollee's representative may request a tiering exception or a formulary exception. Exceptions requests are granted when a Plan sponsor determines that a requested drug is medically necessary for an enrollee.
Generic Code Number (GCN)	One of the drug data vendor's data elements that is specific to a particular drug.
Hierarchical Ingredient Code List (HICL)	One of the drug data vendor's data elements that identify the chemical ingredient of a drug.
Long Term Care (LTC)	A facility that provides long-term care including the dispensing of eligible drugs.
Maximum Daily Dose (MDD)	The maximum amount of a drug per dosing event as defined by the manufacturer and included on approved drug labeling.
New Enrollee	Beneficiaries who enroll for the first time into a Plan.
Part D Eligible Drugs	Medications determined by Medicare to count toward the true out of pocket costs for a Medicare Part D enrollee.
Pharmacy and Therapeutics Committee (P&T)	A committee comprised of participants from various clinical specialties that makes decisions affecting formulary content, including exceptions, tier value, Prior Authorizations, step therapies, quantity limitations, generic substitutions and other drug utilization activities that affect drug access.
Prior Authorization (PA)	A process through which the physician or other health care provider is required to obtain advance approval from the Plan that payment will be made for a service or item furnished to an enrollee.
Refill Too Soon (RTS)	An edit that exists indicating that a drug claim has been presented too early for the pharmacy to dispense to an enrollee.
Route of Administration (RT)	One of the drug data vendor's data elements that identify how a drug is administered (e.g., oral, injectable).
Short Cycle Fill (SCF)	Guidance and related edits pertaining to enrollees receiving certain drugs in a LTC setting. Drugs subject to short-cycle fill edits as defined by CMS must be dispensed to enrollees in limited quantities as per CMS guidance.

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III. Policy

Task 1:	Transition Requirements – CMS Attestation #1
	<p>Express Scripts offers this transition policy as a written description of the appropriate transition processes consistent with 42 CFR §423.120(b)(3) for our client’s Plan enrollees whose current drug therapies may not be included in their new Plan formulary. Express Scripts will maintain this policy and effectuate a meaningful transition as delegated for:</p> <ul style="list-style-type: none"> • New enrollees into its prescription drug plans following the annual coordinated election period; • Newly eligible Medicare enrollees from other coverage; • Enrollees who switch from one Plan to another after the start of a contract year; • Current enrollees affected by negative formulary changes across contract years; • Enrollees residing in LTC facilities; • In some cases, enrollees who change treatment settings due to a change in level of care. Enrollees who are undergoing a change in care are eligible for a temporary supply to ensure the continuity of needed medications across care settings. If the enrollee is not in their transition period during their care change, or is in the transition period but has already received their transition supply fill days maximum, the system will reject the claim and appropriate reject codes are returned to the pharmacy. Express Scripts provides additional secondary messaging (If Level of Care) and training to inform the network pharmacy of the appropriate procedure. In the circumstance where an enrollee is changing care setting and may not have access to current prescriptions, the network pharmacy may contact the Express Scripts help desk for an override to dispense a temporary transition supply. Appropriate transition notifications are generated to the enrollee and the prescriber in the required timetable. As these enrollees are vulnerable to disruption in care, Express Scripts also provides daily rejected claims data to the Plans for oversight of these enrollees experiencing a change in their care to assure the transition has been effectuated.
Task 2:	Transition Submission - CMS Attestation #2
	<p>The Plan is responsible for submitting a copy of its transition policy to CMS, ensuring that the submission is per CMS guidelines and ensuring that the policy conforms to the requirements of the Prescription Drug Manual, Chapter 6, Section 30.4.</p>
Task 3:	Transition Scope - CMS Attestation #3
	<p>The transition process is applicable to non-formulary drugs, meaning:</p> <ol style="list-style-type: none"> 1. Part D Drugs that are not on a plan’s formulary; 2. Part D Drugs that are on a plan's formulary but require PA or step therapy, or that have an approved Quantity Limit (QL) lower than the enrollee’s current dose under a plan's utilization management rules.

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	<p>For plans that manage their own coverage reviews: The plan is required to have and the plan follows its own process and procedures for medical review of non-formulary drug requests. In addition, the plan is required to have and the plan follows its process for switching new Part D enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.</p> <p>For plans where Express Scripts manages coverage review: Below is the process for review of non-formulary drug requests and process for switching enrollees to therapeutically appropriate formulary alternatives: When a coverage determination request for a non-formulary drug is received, a series of questions are posed that ask if the enrollee has tried any available formulary drugs that treat the same medical condition as the requested non-formulary drug. Formulary drugs are researched and provided if responses are not provided indicating that formulary drugs have been tried OR that they were tried but failed to appropriately treat the enrollee's condition. When a request for a non-formulary drug is received, the coverage determination process will ensure that the requested drug is being used for a Part D covered use. Information is exchanged with the requestor about formulary drugs that treat the same condition to establish whether or not the formulary alternatives available have been tried but were not effective and/or would have an adverse effect on the enrollee. When an adverse decision is made, written notice is sent to the enrollee providing the basis for the denial and includes at least two formulary alternative drug names along with the enrollee's right to request an appeal if they disagree with the decision. The enrollee's prescriber is also provided a notice of the denial with the same details.</p>
Task 4:	System Capabilities - CMS Attestation #4
	<p>Express Scripts has systems capabilities that allow the plan 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. Transition system capabilities are outlined in detail in Attachment A.</p>
Task 5:	Transition Timelines and Temporary Supplies - CMS Attestation #5
	<p>The Express Scripts transition process provides for, in the retail setting, at least a one-time, temporary supply of at least a month's supply of medication (unless the enrollee presents with a prescription written for less, in which case the plan will allow multiple fills to provide up to a total of one month's supply of medication) anytime during the first 90 days of a enrollee's enrollment in a plan, beginning on the enrollee's effective date of coverage. In some instances, greater than a one month supply will be dispensed in order to avoid having an enrollee that encounters a hard reject leaves the pharmacy without their prescribed drug.</p>

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Task 6:	Cost-Sharing Considerations - CMS Attestation #6
	<p>The plan will ensure that cost sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts for Low-Income Subsidy (LIS) eligible enrollees. For non-LIS enrollees, the plan must charge 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 42 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.</p> <p>Express Scripts will set up the benefit as specified by plan clients, including the cost share as required by law for low income enrollees.</p>
Task 7:	LTC - CMS Attestation #7
	<p>Express Scripts will ensure that in the LTC setting:</p> <ol style="list-style-type: none"> 1. The transition policy provides for a one time temporary supply of at least a month's supply of medication (unless the enrollee presents with a prescription written for less), which should be dispensed incrementally as applicable under 42 CFR § 423.154 and with multiple fills provided if needed during the first 90 days of an enrollee's enrollment in a plan, beginning on the enrollee's effective date of coverage. 2. After the transition period has expired, the transition policy provides for at least a 31-day emergency supply of non-formulary Part D drugs (unless the enrollee presents with a prescription written for less than 31 days) while an exception or PA is requested; and 3. For enrollees being admitted to or discharged from a LTC facility, early refill edits can be overridden at Point-of-Sale (POS) to allow the enrollee access to their Part D benefit, and such enrollees are allowed to access a refill upon admission or discharge. <p>Emergency Supply for LTC Enrollees outside of their Transition Period:</p> <p>An automated process is in place so that an enrollee residing in an LTC will be allowed an additional transition supply of an eligible drug once they are outside of their transition period. These automated emergency transition supply fills provide at least a 31-day supply (or in appropriate increments in the case of SCF or prepack drugs), unless the prescription is written for less than 31 days, while an exception or PA request is in process. Appropriate transition notifications will be mailed to the enrollee and prescriber.</p>

Task 8:	Edits for Transition Supplies - CMS Attestation #8
	<p>Express Scripts' transition process will automatically effectuate a transition supply for Plan enrollees, where appropriate, except where the following edits apply to the claim at the POS:</p> <ol style="list-style-type: none"> 1. Edits to determine Part A or B versus Part D and Part D versus Non D coverage; 2. Edits to prevent coverage of non- Part D drugs; 3. Edits to promote safe utilization of a Part D drug. <p>Secondary messaging is sent to the pharmacy to further inform them on the reason for the edit and additional required action on the part of the pharmacy to ensure eligible enrollee's transition supplies of needed medications are appropriately dispensed. In the case of Part A, or B versus D overlap drugs, D versus Non D, or non-Part D drugs, a coverage determination is required prior to payment. Plan oversight is required to assure prescriber's response to coverage review requests for enrollee access to needed medications.</p> <p>Step therapy and PA edits are resolved at POS.</p>
Task 9:	Quantity Limits - CMS Attestation #9
	<p>Express Scripts provides the Plan enrollee refills for transition supplies 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 enrollee will be allowed refills up to the days supply allowed in the benefit.</p>
Task 10:	New Prescriptions Versus Ongoing Drug Therapy - CMS Attestation #10
	<p>Express Scripts will apply all transition processes to a brand new prescription for a non-formulary drug at the POS if the pharmacy cannot make the distinction whether the prescription is brand-new or an ongoing prescription for a non-formulary drug. Because new and refilled prescriptions for on-going therapy for a transition eligible drug cannot always be distinguished at POS, Express Scripts' transition process assumes the drug is ongoing therapy. In addition, Express Scripts system does not limit a transition supply to one fill if the enrollee has not received their full transition supply. The process will allow for refills of a transition eligible drug at the POS to ensure enrollees receive at least a one month supply of a transition eligible drug. Express Scripts system flexibility is designed to meet the plan's model of care delegation. This flexibility allows the plan, in some cases, to provide more than the minimum required transition supply to assure the prescription is dispensed and the enrollee leaves the pharmacy with needed medications.</p>

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	<p>Clients have two system options for set up of their transition benefit:</p> <p>Reject on transition day supply</p> <ul style="list-style-type: none"> • Allow eligible transition supply fills up to the plan defined ‘transition day supply’ and then rejects a claim if no exception or PA is in place for the enrollee. <p>OR</p> <p>Reject on plan limit</p> <ul style="list-style-type: none"> • Allow fills up to the ‘plan day supply limit’ up to the point that the transition day supply is exhausted, and then reject a claim if no exception or PA is in place for the enrollee.
Task 11:	Transition Notices - CMS Attestation #11
11.1	<p>Express Scripts will send written notice consistent with CMS transition requirements. A written CMS approved notice is sent via USPS First Class Mail to the plan’s enrollee within three business days of adjudication of a temporary transition supply. The notice includes:</p> <ol style="list-style-type: none"> 1. An explanation of the temporary nature of the transition supply that the enrollee has received; 2. Instructions for working with the plan 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; 4. A description of the procedures for requesting a formulary exception, which includes expected timeframes to decision the request, and information on the right to appeal. <p>For long term care residents dispensed multiple supplies of a Part D drug in increments of 14 days or less, consistent with the requirements under 42 CFR § 423.154 (a)(1)(i), the written notice must be provided within three business days after adjudication of the first temporary fill.</p>
11.2	<p>The Plan will also ensure that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice. Where delegated, Express Scripts will send prescriber notifications with a fax notification, followed by mailing a written notification if faxing is not successful; typically the letter is sent within five business days of the adjudication date of a transition supply dispensed to their patient. The prescriber notification utilizes a separate letter for the prescribing physician notifying them of the transition supply obtained by the enrollee.</p>
11.3	<p>There are circumstances in which notifications cannot be mailed to either an enrollee or a prescriber. Those circumstances include enrollees for whom the Plan or Express Scripts does not have an approved USPS mailing address on file, or valid prescriber contact information despite Express Scripts accessing multiple national prescriber databases. In these situations, Express Scripts produces both enrollee and prescriber drop files each business day to facilitate plan action and outreach. Prescribers that may have a transient address, or situations where the transition claim has been reversed prior to the notification being generated, would not result in a transition letter being sent.</p> <p>Plan Sponsor Monitoring of daily reject reports and letter reports support the enrollee experience for this potential circumstance.</p>

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11.4	To support the plan’s model of care, Express Scripts will, where delegated, provide enrollee notification by way of weekly outbound calls notifying the enrollee that a transition supply is available.
Task 12:	Exception Request Forms - CMS Attestation #12
	Enrollees and prescribers may call Express Scripts Customer Service lines, where delegated, and request PA and/or exception request forms upon request via a variety of mechanisms including mail, fax, email. They may also download the forms from the Plan's website.
Task 13:	Transition Across Contract Years- CMS Attestation #13
	Express Scripts will extend the plan’s transition policy across contract years should an enrollee enroll in a plan with an effective enrollment date of November 1 or December 1 and need access to a transition supply. Special system handling is in place to ensure appropriate treatment of those enrollees with respect to a transition supply and the transition period that crosses a contract year. These new enrollees are allowed a minimum 90-day transition window under this ‘across Plan year’ transition process.
Task 14:	Public Notice of Transition Process - CMS Attestation #14
	The plan will make their transition policy available to enrollees via link from Medicare Prescription Drug Plan Finder to the plan’s web site and include in pre-and post-enrollment marketing materials as directed by CMS.
Task 15:	Transition Extension - CMS Attestation #15:
	Express Scripts will continue to provide necessary Part D drugs to enrollees via an extension of the transition period, on a case-by-case basis, where delegated, to the extent that the enrollee’s 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 decision on an exception request).
Task 16:	Current Enrollees- CMS Attestation #16
	<p>For current enrollees whose drugs will be affected by negative formulary changes in the upcoming year, the Plan will effectuate a meaningful transition by either:</p> <ol style="list-style-type: none"> 1. Providing a transition process at the start of the new contract year or; 2. Effectuating a transition prior to the start of the new contract year. <p>Express Scripts systems enable plans to ensure a current enrollee is provided with a 90 day cross-plan year transition window at the beginning of each contract year. During this time, a current enrollee will be provided with a transition supply of an eligible drug unless the drug was previously filled as a transition supply for the same transition eligible criteria.</p>

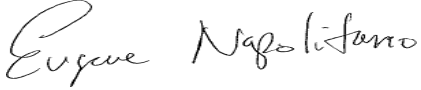
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	<p>In order to determine current enrollee transition eligibility, Express Scripts offers options to Plans:</p> <ul style="list-style-type: none"> • Express Scripts system may be set up to view the current enrollee as if they were a new enrollee. In this scenario, the current enrollee will not be limited on transition eligibility based on previous utilization <p>Or</p> <ul style="list-style-type: none"> • System looks for current enrollee’s previous utilization through a look-back window <p>If the history look back option is selected there are additional settings to select:</p> <p>Look-back window options (starting point for looking at history for utilization) and look back period:</p> <ul style="list-style-type: none"> • Begins on the last day of the previous plan year and extends through a period of plan defined days <p>Or</p> <ul style="list-style-type: none"> • Begins on the date of service and extends through a period of plan defined days. <p>Plans can choose from two drug matching criteria options:</p> <ul style="list-style-type: none"> • Based on the HICL and RT code associated with the drug on the incoming claim to any claim that paid for the enrollee that Express Scripts has history for during the lookback period for the same HICL and RT code. <p>Or</p> <ul style="list-style-type: none"> • Based on the GCN code associated with the drug on the incoming claim to any claim that paid for the enrollee that Express Scripts has history for during the lookback period for the same GCN code. <p>If the enrollee had previous utilization, they are eligible for a transition supply if the medication’s coverage status changed across the plan year.</p> <p>If the enrollee is lacking utilization within the look-back window, this will preclude a transition supply from being extended to a current enrollee during the cross plan year window, as that enrollee is not transition eligible.</p>
Task 17:	Role of the Pharmacy and Therapeutics Committee
	The Express Scripts P&T Committee performs the following functions relative to the transition supply process, if delegated by the plan:
17.1	Reviews and approves Medicare Transition Policy as outlined in this document on an annual basis.
17.2	Per CMS guidance, P&T involvement will help ensure that transition decisions appropriately address situations involving enrollees stabilized on drugs that are not on the plan’s formulary.

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17.3	Per CMS guidance, P&T involvement will help ensure that transition decisions appropriately address situations involving enrollees stabilized on drugs that are on the formulary but are subject to PA, Step Therapy, and Quantity Limits as part of a plan's utilization management requirements. This is accomplished via P&T review and approval of the appropriate policies and procedures.
Task 18:	Transition Process Oversight and Monitoring
	Express Scripts oversees and monitors the transition supply process to ensure that enrollees have access to necessary drugs as required by CMS guidance. <ul style="list-style-type: none"> Express Scripts reporting is made available to demonstrate to Plans the appropriate paid, rejected, and transition-related claims. Oversight reports are provided Plans to monitor required enrollee notifications and prescriber notifications, if delegated.

IV. Approval History

Vs.	Approver Name	Department Name	Date
15	 Eugene Napolitano – Co-Chair Government Programs Compliance	Policy Committee	5/17/2023
14	Eugene Napolitano – Co-Chair	Policy Committee	5/18/2022
13	Eugene Napolitano – Co-Chair	Policy Committee	5/19/2021
12	Eugene Napolitano – Co-Chair	Policy Committee	5/13/2020
11	Eugene Napolitano – Co-Chair	Policy Committee	5/15/2019
10	Eugene Napolitano – Co-Chair	Policy Committee	7/5/2018
9	Eugene Napolitano – Co-Chair	Policy Committee	5/16/2018
8	Ian Smith – Chair	Policy Committee	7/7/2017
7	Ian Smith - Chair	Policy Committee	6/2/2017
6	Ian Smith - Chair	Policy Committee	5/23/2017
5	Ian Smith - Chair	Policy Committee	7/6/2016
4	Ian Smith - Chair	Policy Committee	5/13/2016
3	Ian Smith – Chair	Policy Committee	4/25/2016
2	Kathryn Mihalevich - Chair	Policy Committee	5/20/2015
1	Kathryn Mihalevich - Chair	Policy Committee	5/28/2014
0	Kathryn Mihalevich - Chair	Policy Committee	5/23/2014

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V. Version History				
Vs.	Step(s)	Summary of Version(s)	Date	Approved By
15		Annual Review, no changes.	5/15/2023	Denise Vidal
14		Annual Review, no changes.	5/18/2022	Denise Vidal
13	Task 10 Task 16 Attachment A	<p>Change verbiage: specified to defined Reformatted combined lookback window options (start and period), added option to select utilization lookback period Implementation Statement #8: Replaced ‘x’ with ‘plan defined days’ #14 removed last sentence parentheses and changed to a separate sentence. # 15 removed statement about prescriber national databases Other Edits # 3 RTS Update verbiage from: The plan’s RTS logic considers both mail and retail paid claims, for the same drug, dispensed in the previous 180 days to calculate an on-hand days’ supply. The pharmacy may resubmit a claim with overrides for RTS at POSbut limits the override use to a client specified RTS refill limit for each of the following reasons within 180 days. To: The plan’s RTS logic can consider both mail and retail paid claims, for the same drug, dispensed in the previous plan defined time period to calculate an on-hand days’ supply. The pharmacy may resubmit a claim with overrides for RTS at POS but limits the override use to a client specified RTS refill limit for each of the following reasons within plan’s defined time period:</p>	5/19/2021	Julie Allen

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12	<p>Document Definitions Task 3</p> <p>Task 7</p> <p>Task 10</p> <p>Task 11.1</p> <p>Task 16 Attachment A</p>	<p>Updated ‘member’ to ‘beneficiary’, ‘patient’ to ‘enrollee’, and ‘fill’ to ‘supply/supplies’ For Pharmacy and Therapeutics Committee: Change word enrollee to participant Spelled out QL, Add description for medical review of non-formulary drug requests and process to switch to therapeutically appropriate formulary alternative failing an affirmation medical necessity determination. Add § symbol after CFR Remove option to reject emergency supply and process manually Add verbiage ‘up to the point that the transition day supply is exhausted’...; removing ‘overarching’ to match intent grid ‘plan day supply limit’ Add § symbol after CFR Add verbiage:for the same transition eligible criteria Add defined number of days in lookback period #7 - Update to remove option to reject emergency supply and process manually #8 Add verbiage: for the same transition eligible criteria # 13 Updated response message verbiage, require input of days in lookback period # 14 Removed verbiage #15 Changed order faxed, mailed, removed verbiage #17 Added Quantity Other Edits #1 Removed sample message text #7 Changed verbiage “automatically pay a’ to ‘be considered for’, Update response message verbiage</p>	5/11/2020	Julie Allen
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11	<p>Task 1</p> <p>Task 7</p> <p>Task 8</p> <p>Task 10</p> <p>Task 11</p> <p>Task 16</p> <p>Task 18</p> <p>Attachment A</p>	<p>Remove ‘CMS model’ verbiage, we use CMS approved letters</p> <p>Added ‘of medication’ to match verbiage used in task 5, removed verbiage ‘CMS model’</p> <p>Removed option 1 and 2 references to align with new system options</p> <p>Added Part D versus Non D verbiage in 2 places</p> <p>Removed option 1 and 2 references to align with new system options; replaced with ‘option titles’</p> <p>Removed ‘but not yet picked up’ verbiage</p> <p>Removed option 1 and 2 references to align with new system options</p> <p>Removed last 3 bullets as these are no longer offered</p> <p># 8 removed the verbiage ‘of the previous plan year’</p> <p>Deleted #10, program no longer offered, re-numbered 10-16</p> <p>‘Other Edits’ revised verbiage based on revised processing/CMS Guidance to allow Transition supply for plan level limits (non-safety or MME quantity limits). Corrected duplicative #7 numbering</p>	5/15/2019	J. Allen Simpson
10	<p>Attachment A</p> <p>Other Edits</p>	<p>Added Part A versus Part D Determination Required</p>	7/5/2018	L. Lowe

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9	Task 5	Replaced 30 day supply language with one month supply language from the 2019 Attestation.	5/16/2018	L. Lowe
	Task 7	Deleted extra words “to” and “needed”		
	Task 10	Replaced the LTC days supply language from the Attestation which is supported by changes to the 2019 Final Rule.		
	Task 11.3	Substituted 30 day supply with new “one month supply” language.		
	Task 16	Added clarification that Plan Sponsor’s monitor the daily reject report. Removed the reference to the matching logic which no longer includes CMS Contract ID as a qualifier.		
	Appendix A #8	Removed Contract ID reference for matching logic.		
8	Appendix A #15	Added “adjudication” to clarify the process and align with guidance.	7/7/2017	L. Lowe
	Appendix A #17	Adjusted font to match the rest of the document.		
	Other Edits #7	Beginning in 2019 opioid plan level limits that do not exceed the allowed MME quantity will transition.		
8	Task 1	Item 1, removed at the start of the Plan year.	7/7/2017	L. Lowe
	Task 7	Option #1, at least replaced up to for 31-day supply.		
	Task 11.1	New language regarding approval notice added.		
7	Task 1	Up to a 31 day supply removed.	6/2/2017	L. Lowe
	Task 3	Number 2 – Drugs previously approved removed.		
	Task 11.1	Items 1 – 4 removed and long term care language.		

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6	Policy Task 1 Task 3 Task 8 Task 11	And the State removed LTC language moved from Task 7 to Task 1. Transition to enrollees under Section III language added. Short cycle fill requirements, claim refilled too soon, and edits to prevent exceeding predetermined quantity limits removed. Appeal language added and LTC section updated.	5/23/2017	L. Lowe
5	Regulation Task 1	CFR references updated Number 2 language “at the beginning of the contract year” removed.	7/6/2016	L. Lowe
4	Task 1 Task 3 Task 7 Task 11.1 Task 16	The word beginning changed to start. Number 2 (“Drugs previously approved...”) added and new number 3 updated with QL language. Long term care setting added in item 1. Number 2 and 4 updated to match attestation. The word beginning changed to start and “will be affected by negative” added.	5/13/2016	L. Lowe
3	Task 8 Attachment A	Bullet 6 added. Opioid Medication Quantity Limits added.	4/25/2016	L. Lowe
2		Annual Review	5/20/2015	Policy Committee
1	Task 9	Added last sentence due to CMS guidance Added green highlight to specific areas for ease of update.	5/28/2014	Policy Committee
0		Orig.	5/23/2014	L. Lowe

VI. Attachments

- A) Related Policies:**
 Implementation Statement – Attachment A
 Medicare-TS-04A – Medicare Part D Transition Supply Template
- B) Retired Policies:**
 None

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Attachment A

**Express Scripts
Transition Supply – Plan Implementation Statement**

This document provides the following information:

1. A detailed explanation of the Express Scripts system processes in support of transition supply requests within our adjudication system;
2. How a network pharmacy is notified when a transition supply of medication is processed at the POS; and
3. A description of the edits and an explanation of the process network pharmacies must follow to resolve those edits at the POS during the adjudication of a transition supply.

The Express Scripts adjudication process that supports transition supply requirements operates as follows:

1. A pharmacy receives a prescription request from:
 - New enrollees into its prescription drug plans following the annual coordinated election period;
 - Newly eligible Medicare beneficiaries from other coverage;
 - Enrollees who switch from one Plan to another after the start of a contract year;
 - Current enrollees affected by negative formulary changes across contract years;
 - Enrollees residing in LTC facilities;
 - In some cases, enrollees who change treatment settings due to a change in level of care.
 - Enrollees who are undergoing a change in care are eligible for a temporary supply to ensure the continuity of needed medications across care settings. If the enrollee is not in their transition period during their care change, or is in the transition period but has already received their transition supply days supply maximum, the system will reject the claim and appropriate reject codes are returned to the pharmacy. Express Scripts provides additional secondary messaging (If Level of Care) and training to inform the network pharmacy of the appropriate procedure. In the circumstance where an enrollee is changing care setting and may not have access to current prescriptions, the network pharmacy may contact the Express Scripts help desk for an override to dispense a temporary transition fill. Appropriate transition notifications are generated to the enrollee and the prescriber in the required timetable. As these enrollees are vulnerable to disruption in care, Express Scripts also provides daily rejected claims data to the Plans for oversight of these enrollees experiencing a change in their care to assure the transition has been effectuated. The pharmacy submits the prescription request and the transition process continues if the drug is identified as non-formulary or, on the formulary but with utilization management edits applied based on the plan's approved formulary submission.
2. Express Scripts system verifies enrollment in the plan based on the eligibility set up requirements and file sent by the Plan; or, Express Scripts system verifies that the enrollee is within the transition period by reviewing the enrollee's available plan eligibility history.
3. Express Scripts system verifies that the drug submitted qualifies for a transition supply based on the reject messaging triggered. The rejects indicate one of the four transition eligible

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categories:

- Non-Formulary;
 - PA Required;
 - Step Therapy rules;
 - Quantity rules.
4. Express Scripts system determines the allowable days supply for a transition fill based on the plan's benefit set up requirements.
 5. Express Scripts system verifies that the enrollee is eligible for a transition supply of the drug based on the date of service on the claim falling within their transition eligibility period.
 6. An automated process is in place to automatically pay emergency supply claims. If an LTC enrollee is outside of a transition window and presents a transition-eligible prescription drug request, an emergency transition supply of up to 31 days will be paid.
 7. Express Scripts system determines if an current enrollee is eligible for transition across Plan years when a paid claim is found within the look back period of plan defined days for the same drug (by the Plan's choice of either HICL/RT or GCN) and where the history claim did not pay under transition logic for the same transition eligible criteria.
 8. Using the submitted days supply from the claim, the Express Scripts system will verify that the claim is within the transition days supply limit or has remaining transition day supply to be dispensed. Clients may choose from one of the options below:
 - Reject claim based on 'transition day supply'. Transition claims will be limited to the transition day supply limit established unless it is a prepackaged drug and cannot be dispensed lower than the transition day supply. Refills may be allowed on transition claims up to the point where the transition day supply obligation has been met or exceeded by the last fill.
 - Reject claim based on the Plan 'day supply limit' maximum. Transition claims may provide greater than the transition day supply limit established but not more than the Plan limits. Refills may be allowed on transition claims up to the point where the transition day supply obligation has been met or exceeded by the last fill.
 - When greater than the allowable days supply limit, the claim will hard reject and a message will be returned to the pharmacy noting the allowable day supply/quantity for a transition fill. The pharmacy is then notified to resubmit the claim within the limits presented in the message.
 9. If a previous transition supply of the same drug was already dispensed within the same transition period, Express Scripts system will verify whether a refill is allowable based on the previous days supply already dispensed.
 10. If a required full transition supply was found to have already been provided to the enrollee while in their transition period, the system will hard reject the claim and return an IF LEVEL OF CARE message to the pharmacy with instruction to contact the pharmacy help desk to determine if the enrollee is eligible for a level of care fill.
 11. Express Scripts system will calculate cost-sharing for the transition supply based on the plan's benefit requirements. For plan benefits where all enrollees are low income subsidy eligible, the copay is tiered to Brand or Generic LICs levels or, if specified, the Part D drugs are tiered to \$0 dollar cost sharing in line with the CMS LICs waiver for the plan.
 12. The process will successfully adjudicate the claim and send a message to the pharmacy with a paid response of either "PAID AS TRANSITION FILL" or "PAID AS EMERGENCY SUPPLY" depending on the type of adjudication which was completed.

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13. The required enrollee notifications are mailed within three business days of adjudication of the first fill of a transition supply. Mail notifications for refills of a transition supply are not generated.
14. The required prescriber notifications are faxed or mailed within five business days after the first fill of a transition supply. Notifications for refills of a transition supply are not generated.
15. Express Scripts' adjudication process described above is configured to automatically pay a claim for an eligible medication when an enrollee is in their transition period, or as a result of the enrollee needing an LTC emergency supply. If an enrollee is changing care setting and may not have access to current prescriptions, the network pharmacy may contact the Express Scripts help desk for an override to dispense a temporary transition supply. Express Scripts provides additional secondary messaging (If Level of Care) and training to inform the network pharmacy of the appropriate procedure to allow a level of care override.
16. If an enrollee is in need of an extension to the transition supply they can reach out to their plan in advance or at POS to request an extension. Express Scripts network pharmacies are aware of the potential need for an extension while the enrollees prescriber or plan are resolving the exception or PA needed for their medication. The network pharmacy may call the help desk to get an override for an additional transition supply in this circumstance. This final manual step enables transition eligible non-formulary, quantity, step therapy and PA edits to be resolved at POS.
17. Automated reject, paid claims and transition notification reports are posted to the plan client proprietary website location for oversight of the transition process and for discussion with their account teams on any additional care coordination or action to ensure the transition process is effectuated for their enrollees.

Other Edits:

As recognized in CMS guidance, certain edits may exist where a hard reject is returned that requires the pharmacy to take action before resubmitting the claim and achieving a paid transaction. When an edit is in place that triggers the hard reject of a transition eligible claim for a transition eligible enrollee, the pharmacy is required to take steps in order to achieve a paid transaction. The steps required by the pharmacy are included in the associated messaging returned at POS. Training and documentation on these processes is included in the Express Scripts Network Manual to support timely determinations. In addition to limited enrollee safety editing, the following hard reject messaging conditions that may be triggered during adjudication of a transition supply eligible claim are:

1. Plan Limitations Exceeded
When this message is returned, the pharmacy is required to modify the submitted quantity to be equal to or less than the amount included in the POS message. Upon resubmission with corrected information, the transition supply claim will pay and be marked as a transition supply.
2. If Level of Care Change Call Help Desk
When this message is returned, the pharmacy is required to contact the Pharmacy Help Desk. A process is in place with the Help Desk and includes a series of questions that are posed to the pharmacy. If any of the questions are answered with YES, then a level

of care change is confirmed. The Help Desk provides override codes to the pharmacy to place on the claim and the pharmacy is asked to resubmit. Upon resubmission with the override codes the claim will pay and be marked as a transition supply.

3. Refill Too Soon (RTS)

To limit inappropriate or unnecessary access to Part D drugs, an early refill edit will trigger a hard reject for a transition eligible drug during an enrollee's transition period. The plan's RTS logic can consider both mail and retail paid claims, for the same drug, dispensed in the previous plan defined time period to calculate an on-hand days' supply. The pharmacy may resubmit a claim with overrides for RTS at POS but limits the override use to a client specified RTS refill limit for each of the following reasons within plan's defined time period:

- Therapy change,
- Lost or spilled medication,
- Vacation supply.

The Plan's RTS allowance requires that an enrollee has consumed a Plan defined percentage of their drug on-hand of an ophthalmic agent as well as at least the Plan Client's defined RTS percentage of any other medication. The consumption requirement for enrollees in an LTC facility is the Plan Client's defined RTS percentage settings as delegated.

4. Med B/D Determination Required

B/D overlap drugs are excluded from transition supply processing by Medicare law as the determination must be made prior to adjudication for appropriate billing. Messaging returned to the pharmacy indicates this need for verification by sending the message: "B/D Determination Required". Training and documentation on these processes is included in the Express Scripts Network Manual to support timely determinations.

5. Part A versus Part D Determination Required

For beneficiaries who have elected the Medicare hospice benefit, drugs in the four hospice categories are excluded from the transition process, as payer determination must be made prior to adjudication for appropriate billing. Messaging returned to the pharmacy indicates this need for verification by sending the message: "Prior Authorization is Required; This product may be covered under Hospice – Medicare Part A". Additional secondary messaging includes: "Member Enrolled in Hospice; Hospice provider – request Prior Authorization. Call for review if not Hospice/Unrelated."

6. Med D/non D Determination Required

D/non-D drugs are excluded from transition supply processing by Medicare law as the determination must be made prior to adjudication for appropriate billing. Messaging returned to the pharmacy indicates this need for verification by sending the message "Med D/Non-D Determination Req".

7. Short Cycle Fill (SCF)

To comply with CMS guidance related to the LTC pharmacy requirement to dispense certain Part D drugs in small increments, various edits exist that may trigger a hard reject for an enrollee during a transition period. All SCF related hard rejects occur prior to transition supply processing and are required to be cleared by the LTC pharmacy before the claim will be considered for a transition supply. Once the SCF edits are cleared and a paid transition supply claim is adjudicated, the pharmacy receives one of the two paid claim messages of “PAID AS TRANSITION FILL” or “PAID AS EMERGENCY SUPPLY”. Subsequent transition supplies will be allowed up to the days supply set by the Plan.

8. Opioid Medication Quantity Limits

To comply with CMS requirements to limit opioid medications to appropriate quantities, there are hard edits that enforce predetermined quantity limits for opioid medications. A temporary supply of opioids with a related plan level limit will transition. Opioid quantity level limits for safety purposes, such as Morphine Milligram Equivalent (MME) quantity limits and enrollee-specific limits must be resolved before the claim will be considered for transition.