MVP Health Care ***2017 Medicare Part D***

Internal Transition Supply Policy

For Contracts: H3305, H9615, S0586

Overview

To ensure that new or existing members to the MVP Medicare Part D program have continued access to medications that are non-formulary or are subject to utilization management tools (prior authorization, step therapy, quantity limits) during their initial enrollment period, during their stay in a long-term care facility, upon a level of care change or after a calendar year formulary change. This transition supply of medications will allow sufficient time for members to work with their provider to switch to an alternative formulary agent, to request a formulary exception, or to request a coverage determination. For a complete definition of a Coverage Determination, please refer to the CMS Prescription Drug Manual, Chapter 6, Section 30.4. This policy documents the process and procedure to effectuate a transition supply of medication. This program has been reviewed and approved by the MVP Pharmacy & Therapeutics and the Quality Improvement Committees.

POLICY

1. MVP Health Care allows a meaningful transition for the following groups of Beneficiaries whose current drug therapy may not be covered by the plan (a.) new Beneficiaries enrolled into the plan at the start of a contract year; (b newly eligible Medicare Beneficiaries from other coverage; (c.) the transition of Beneficiaries who switch from one plan to another after the start of a contract year; (d.) current Beneficiaries affected by negative formulary changes across contract years; (e.) Beneficiaries residing in long-term care (LTC) facilities, including Beneficiaries being admitted to or discharged from an LTC facility
2. MVP Health Care will submit a copy of its transition policy process as required to CMS.
3. The transition policy will apply to Non-formulary Drugs, meaning: (a.) Part D drugs that are not on the formulary; (b.) Part D drugs previously approved for coverage under an exception once the exception expires unless the exception timeframe is identified in the approval notification and (c.) Part D drugs that are on a the formulary but require prior authorization or step therapy or approved quantity limits lower than the Beneficiary's current dose under the utilization management rules. The transition process allows for medical review of Non-formulary Drug requests, and when appropriate, a process for switching new Part D Plan Beneficiaries to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination. Delegated PBM will handle Biosimilars as non-interchangeable brand products for it programs and processes involving transition fill. The P&T committee will meet on a regular basis, but no less than quarterly and review procedures for coverage determination and exceptions, and, if appropriate, a process for switching new Beneficiaries to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.
4. A temporary supply of non-formulary Part D drugs will be provided in order to accommodate the immediate needs of a Beneficiary, as well as, to allow MVP Health Care and/or the Beneficiary 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. Delegated PBM Transition Fill (TF) processing and coding applies point-of-sale (POS) messaging to pharmacies.

5. The transition process will apply in the non-LTC setting such that the transition policy provides for at least a one-time, temporary 30-day fill, with multiple fills up to a cumulative 30 days supply allowed to accommodate fills for amounts less than prescribed, anytime during the first 90 days of a Beneficiary's enrollment in a plan, beginning on the Beneficiary's effective date of coverage.
6. The cost-sharing tier for a temporary supply of drugs provided under the transition process will not exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible Beneficiaries.
   For non-LIS eligible Beneficiaries:
   a. Non-formulary Part D drugs transition supply will receive the same cost sharing that would apply for a non-formulary drugs approved through a formulary exception in accordance with §423.578(b).
   b. Formulary transition supply will receive the same cost sharing for a formulary drug subject to utilization management edits provided during the transition that would apply if the utilization management criteria are met.
7. The transition process in the long-term care setting will include the following attributes: (a.) the transition policy will provide for up to a 93 day fill consistent with the applicable dispensing increment in the long-term care setting (unless the Beneficiary presents with a prescription written for less), with refills provided if needed during the first 90 days of a Beneficiary's enrollment in a plan, beginning on the Beneficiary's effective date of coverage; (b.) after the transition period has expired or the days supply is exhausted, the transition policy will provide for at least a 31-day emergency supply of non-formulary Part D drugs (unless the Beneficiary presents with a prescription written for less than the 31 days) while an exception or prior authorization determination is pending; and (c.) for Beneficiaries being admitted to or discharged from a LTC facility, early refill edits will not be used to limit appropriate and necessary access to their Part D benefit, and such Beneficiaries will be allowed to access a refill upon admission or discharge.
8. Only the following utilization management edits will apply during transition at POS: edits to determine Part A or B versus Part D coverage, edits to prevent coverage of non-Part D drugs, and edits to promote safe utilization of a Part D drug. Step therapy and prior authorization edits will be coded to be resolved at POS.
9. Transition process will allow 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.
10. The transition processes will be applied 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 POS.

11. MVP Health Care will send written notice via U.S first class mail to Beneficiary within three business days of adjudication of a temporary transition fill. The notice will include (a.) an explanation of the temporary nature of the transition supply an Beneficiary has received; (b.) instructions for working with the Plan Sponsor and the Beneficiary's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the plan's formulary; (c.) an explanation of the Beneficiary's right to request a formulary exception; and (d.) a description of the procedures for requesting a formulary exception. For long-term care residents dispensed multiple supplies of a Part D drug in increments of 14-days-or-less, the written notice will be provided within 3 business days after adjudication of the first temporary fill. MVP Health Care will use the CMS model Transition Notice via the file-and-use process. Reasonable efforts to provide notice prescribers of affected enrollees who have received a TF will be made via mail or fax. A daily extract file from CVS Caremark is provided to MVP Health Care containing Part D TF paid transactions.
12. Prior authorization or exception request forms will be available upon request to both Beneficiaries and prescribing physicians via mail, fax, email and the MVP Medicare or provider website.
13. The transition policy will be extended across contract years 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.
14. The transition policy will be available to Beneficiaries via the Medicare Prescription Drug Plan Finder link to Sponsor's web site as well as in Beneficiary formulary and pre and post enrollment materials as directed by CMS
15. MVP Health Care provide Beneficiaries with a process to receive necessary Part D drugs 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 transaction 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).
16. The transition process will be effectuated for renewing beneficiaries whose drugs will be affected by negative formulary changes in the upcoming contract year.

Procedures

1. The Transition Fill (TF) program is implemented by CVS Caremark according to MVP Health Care's requested benefit design.
    a. Transition supplies are provided at point of sale (POS) to eligible Beneficiaries which are coded as the following:
        i. New Beneficiaries in the plan at the start of a Contract Year
        ii. Newly eligible Medicare Beneficiaries from other coverage
        iii. Beneficiaries who switch from another Part D plan after the start of a Contract Year

iv. Current Beneficiaries affected by negative formulary changes (including new utilization management requirements) across Contract Year
v. Beneficiaries residing in LTC facilities

b. Transition fill supply limits are defined as cumulative days supplies calculated on Generic Product Identifier (GPI) 14 and are note based on number of fills.
c. Transition-eligible claims submitted for LICS III Beneficiaries are processed according to the Beneficiary's LICS Level and pharmacy submitted codes to determine if the claim received will be processed as non-LTC, LICS III, or LTC.

2. MVP Health Care will maintain a Med D TF policy and procedure and review the document at least annually and as needed when process changes occur.
3.
    a. Procedures to apply the transition policy to Non-formulary Drugs are to obtain the P&T Committee approved formulary and UM edits and code into the adjudication system to identify the TF eligible claim at POS so that it can be paid.
    b. Procedures for medical review and identifying Formulary Alternatives are as follows:
        i. Coverage determination and medical review processes for Non-formulary requires are documented in the MVP Health Care Pharmacy Programs Administration Policy.
        ii. Beneficiaries who contact Customer Care are provided with information regarding available formulary alternatives when requested.
4. POS transition fill processing is available and there are procedures in place for transition extensions and overrides, if needed, through the Pharmacy Help Desk and Customer Care. Transition fill POS messaging to pharmacies applies as follows:
    a. The CVS Caremark PBM adjudication system automatically processes and pays transition fill-eligible claims and transmits POS messaging that the claims are paid under transition fill rules.
    b. Transition fill messaging to pharmacies is consistent with current National Council of Prescription Drug Programs **(**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"). 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.
    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 the CVS Caremark pharmacy network department.

5. Transition Fill for New or Renewing Beneficiaries in the Non-LTC Setting
    a. In a Non-LTC setting, The CVS Caremark PBM adjudication system automatically processes and pays transition fill-eligible claims and transmits POS messaging that the claims are paid under Transition Fill rules for up to a cumulative 30 days supply.
    b. Pharmacies are not required to either submit, or or resubmit a PAMC, or other transition fill-specific code for transition fill-eligible claims to adjudicate and pay.
    c. Transition fills are available at POS through this functionality within the first 90 days of enrollment, beginning on the enrollment effective date.
    d. Non-LTC Level of Care Change: For non-LTC residents, an early refill edit will not be used to limit appropriate and necessary access to a transition fill. 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 pharmacy will call the CVS Caremark Help Desk in order to obtain an override to submit a Level of Care transition fill request.
6. CVS Caremark will stablish cost-sharing per the MVP Health Care plan design.
    a. Cost-sharing for drugs supplies as a transition fill is set by statute for low-income subsidy (LIS) Beneficiaries.
    b. For non-LIS Beneficiaries:
        i. Non-formulary transition supply will receive the same cost sharing that would apply for a non-formulary exception
        ii. Transition supply for formulary drugs with a utilization management edit will receive the same cost share as would apply if the utilization management criteria is met.
7. Long-Term Care Processing
   For LTC transition fills, the Delegated PBM adjudication system automatically processes and pays transition fill-eligible LTC claims and transmits POS messaging that these are paid under Transition Fill. LTC transition fills are allowed multiple fills up to a 31 days supply per fill, except for oral brand solids which are limited to 14 day fills with exceptions as required by CMS guidance, unless submitted with a submission clarification code (SCC) of 21-36. SCC codes 21-36 indicate LTC dispensing of varying days supply. LTC transition fills are allowed for cumulative days supply of 93 consistent with the applicable dispensing increment in the LTC setting. Pharmacies are not required to either submit, or resubmit a PAMC, or other transition fill-specific code for transition fill-eligible claims to adjudicate and pay.
    a. LTC Transition Fill Emergency Supplies (ES)
        i. To accommodate emergency fills for LTC residents after the new or renewing TF days supply has been exhausted or the transition window expired, and while an exception or prior authorization is pending, an SCC is submitted by the pharmacy on POS claims. Emergency Supply Transition Fills are allowed up to a 31 days cumulative supply except for oral brand solids which are limited to 14 day fills with exceptions as required by CMS guidance, unless submitted with an SCC of 21-36. These drug claims would otherwise reject for being Non-formulary or

formulary with prior authorization, step therapy, quantity limit or daily dose less than FDA maximum labeled dose, or age edits secondary to Beneficiaries having exhausted TF new or renewing TF days supply and/or being outside the TF window.

ii. LTC ES is allowed, per calendar day, per Beneficiary, per drug, per pharmacy, per plan, for the cumulative days supply during a rolling month.

b. LTC Level of Care Changes
   i. For LTC residents, an SCC is submitted by the pharmacy to allow transition fills and to override transition fill eligible rejects and Refill Too Soon rejects for new admissions. Level of Care Transition Fills are allowed up to a 31 days supply except for oral brand solids which are limited to 14 day fills with exceptions as required by CMS guidance, unless submitted with an SCC 21-36. These drug claims would otherwise reject for being Non-formulary or formulary with utilization management edits.
   ii. Levels of Care Transition Fills are allowed per calendar day, per Beneficiary, per drug, per pharmacy, per plan for a cumulative days supply.
   iii. For all Beneficiaries who experience a Level of Care Change, if a dose change results in an "early refill" or Refill to Soon reject, the pharmacy may call the CVS Caremark Pharmacy Help Desk to obtain an override.
c. LICS III Beneficiaries
   i. LICS III processing logic is allowed on a TF eligible claim for a LICS III with the appropriate pharmacy submitted codes.
   ii. TF eligible LICS III claims are allowed 31 days supply per fill up to a 93 cumulative days supply.

8. Utilization management edits not TF Eligible and Step Therapy and Prior Authorization processing
   a. CVS Caremark codes the following utilization management edits on drugs such that transition fill overrides are not applied:
      i. Drugs requiring Part A or B vs. Part D coverage determination as identified on the CVS Caremark drug database.
      ii. Drugs excluded from Part D benefit as identified on the CVS Caremark Part D Services, L.L.C. drug database.
      iii. Edits to support the determination of Part D drug status.
      iv. DUR safety edits such as therapeutic duplication, drug interaction, age alerts are set up to reject instead of pay as TF.
   b. Step therapy and prior authorization edits are resolved at POS.
9. Cumulative Days Supply
   a. Transition refills for supplies dispensed at less than amount written, or less than the days supply available under transition rules are allowed multiple fills up to at least a 30 days supply at Non-LTC settings and for LTC Beneficiaries

allow at least 91 to maximum 98 cumulative days supply consistent with the dispensing increment.

b. For cDUR edits that are based on an FDA maximum recommended daily dose, Transition Fill claims which are dispensed at less that the prescribed amount due to this edit are allowed during the TF Window.
c. CVS Caremark Part D Services, L.L.C. TF cumulative days supply accumulates at the drug GPI 14 level by Beneficiary and across plan. LTC Emergency Supply and LTC New Patient benefit accumulates separately.

10. CVS Caremark Part D Services, L.L.C. transition process is coded such that 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 POS, the CVS Caremark Part D Services. L.L.C. transition process will be applied to the prescription as if it is ongoing drug therapy. This is referred to as the New Beneficiary process.

11. Transition Notices
    a. A written transition notice is mailed via US First Class mail to the Beneficiary within three business days after adjudication of a transition fill.
    b. For LTC TF for oral brand solids limited to a 14 days supply, a TF notice will be sent only after the first transition fill.
    c. The notice identifies the:
        i. Explanation of the temporary nature of the transition supply provided to the Beneficiary.
        ii. Instructions for working with MVP Health Care and prescriber to satisfy utilization management requirements or to identify therapeutically equivalent and appropriate formulary alternatives
        iii. An explanation of the Beneficiary's right to request a formulary exception
        iv. A description of the procedures for requesting a formulary exception
    d. MVP Health Care will utilize the current CMS "Model Part D Transition Notice"' submitted via the CMS marketing materials "file and use" process, for notification to Beneficiaries of the reasons for their transition fills and recommendations for actions.
    e. CVS Caremark will provide a daily extract file containing all transition fill paid claims
    f. Transition notices to prescribers are generated and mailed and/or faxed when a Beneficiary transition fill notice is produced. The content of this notice is based on the content of the Beneficiary transition fill notice, or CMS model notice if provided. Reasonable efforts are made to deliver the notice to the prescriber.
12. Availability of Prior Authorization and Exception Request Forms
    a. Prior authorization and Exception Request Forms will be available upon request to the Beneficiary or prescriber via a variety of means including by email, mail, fax, and the MVP Medicare or provider website. Beneficiaries may obtain forms by contacting the MVP Customer Care Center, phone

number is on the back of their ID card. Providers may also obtain forms by contacting Provider Services.

13. The CVS Caremark Part D Services, L.L.C. transition process for new Beneficiaries is coded to apply across Contract Years for Beneficiaries with an effective enrollment date of either November 1 or December 1 and who need access to a transition supply. These Beneficiaries 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.
14. Beneficiaries and providers will find information on the Transition Process, including the Transition Supply Policy in a variety of plan materials, including the MVP Medicare web site, plan enrollment materials (ANOC), formulary document, and the required link from the Medicare Prescription Drug Plan Finder to the MVP Medicare website. The Transition Supply policy will also be available in pre-and-post enrollment marking materials as directed by CMS.

15. Transition Extensions
    Extensions to the transition period will be reviewed on a case-by-case basis if the exception request, prior authorization request or appeal has been received duing the transition period but not yet processed or is awaiting resolution (decision) at the end of the transition period (either through the switch to an appropriate formulary drug or a decision on the exception request). The extension process can be started through the MVP Customer or Provider Services Departments.
16. Consistent with the transition fill process to new Beneficiaries, CVS Caremark Part D Services, L.L.C. provides transition fills, to renewing Beneficiaries during the first 90 days of the Contract Year with history of utilization of impacted drugs when those Beneficiaries 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 at POS to all renewing Beneficiaries including those residing in LTC facilities.
    a. Renewing Beneficiary Transition Fills are available to all Beneficiaries during the TF Window who are impacted by a negative formulary change across Contract Years. Renewing Beneficiaries need to have a history of utilization of the drug for which coverage is being requested.
    b. For these Beneficiaries, the CVS Caremark Part D Services, L.L.C. adjudication system automatically processes and pays transition fill-eligible claims and transmits POS messaging that these are paid under transition fill rules
    c. Additional transition supplies are available on a case-by-case basis through the MVP Health Care Customer or Provider Services Departments to ensure adequate transition. Pharmacies are not required to either submit, or resubmit a PAMC, or other transition fill-specific code for transition fill-eligible claims to adjudicate and pay.
    d. The quantity and time plan limits may be greater based on the benefit design and will be limited by the amount prescribed.

Implementation Statement (process implementation in conjunction with CVS Caremark Part D Services, L.L.C.)

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 Beneficiary 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 Beneficiaries in the plan at the beginning of a Contract Year
      ii. Newly eligible Medicare Beneficiaries from other coverage
      iii. Beneficiaries who switch from another Part D plan after the start of a contract year
      iv. Current Beneficiaries affected by negative formulary changes (including new utilization management requirements) from on Contract Year to the next.
      v. Beneficiaries residing in LTC facilities
   b. Transition fill processing is also available via manual overrides through the Pharmacy Help Desk.
   c. Transition fill window and eligibility check is applied to the claim.
      The Beneficiary'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 window or cumulative days supply parameters based on Beneficiary 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 a Beneficiary 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.
      i. For Beneficiaries who are new to plan, renewing Beneficiaries 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 Delegated PBM Pharmacy Help Desk.
   f. Med D Drugs only allowed for TF.
      Non-Med D drugs are excluded from TF processing. Non-Med D drugs are identified with an "N" in the "Med D" field on the Delegated PBM 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 Delegated PBM drug database.
   g. Multi-Ingredient Compounds processed for TF.
      TF processing for Multi-Ingredient Compound (MIC) drugs is based on the most expensive ingredient submitted. Only Non-formulary drugs 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 may 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 the MIC is a 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 formulary and qualifies to process under TF, all Part D ingredients in the MIC pay as TF. The TF letter refers to this prescription as a "compound" prescriptions
iii. If the most expensive ingredient is Non-formulary and is eligible for TF, then all Part D ingredients in the compound pay as a TF. The TF letter is based on the most expensive ingredient.
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.
3. Claims for Non-formulary Drugs that are eligible for TF processing
   a. In the event of the launch of a new generic drug, the Sponsor elects whether to retain the brand on the formulary and not to add the generic to the formulary. A Beneficiary with the equivalent brand name drug in the look back history will not be eligible for a transition fill of the generic with the same formulation. The brand name drug would be available without the need for a transition fill. If a Beneficiary is currently taking a brand drug, a transition fill for the brand drug with a formulary change will be provided to allow Beneficiary 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. Drugs approved for a coverage exception are eligible for TF processing whenever the exception expires during the plan year. A minimum 30 days supply will be provided.
   c. Beneficiaries with a claim for a drug with a quantity limit lower than the beneficiary's current dose will be eligible for TF processing.

4. 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.
   a. 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 Beneficiaries.
      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: Pharmacy Provider Manual and all related updates; and the Medicare Part D Information/Reminders document that is sent annually to network pharmacies prior to the beginning of each new Contract Year.
      iii. Delegated PBM Pharmacy Help Desk (PHD): Pharmacies contacting the PHD are verbally informed of Beneficiary's TF availability, process and rights for requesting prior authorization and/or exception, and how to submit an automated TF request.
      iv. 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 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.

"Paid under transition fill. Non-formulary."
"Paid under transition fill. PA required."
"Paid under transition fill. Other reject." (Note: This includes Step, QvT, Daily Dose and Age requirements)

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

NCPDP Pharmacy Approval Message Code	TF Condition

005	TF claim is paid during transition period but required a prior authorization
006	TF claim is paid during transition period and was considered Non-formulary
007	TF claim is paid during transition period due to any other circumstance
009	TF claim is paid via an emergency fill scenario but required a prior authorization
010	TF claim is paid via an emergency fill scenario and was considered Non-formulary
011	TF claim is paid via an emergency fill scenario due to any other circumstance
013	TF claim is paid via a level of care change scenario but required a prior authorization
014	TF claim is paid via a level of care change scenario and was considered Non-formulary
015	TF claim is paid via a level of care change scenario due to any other circumstance

b. There are conditions under which it may be necessary for the Delegated PBM PHD or CC to enter a manual TF override. These situations include, but are not necessarily limited to:
   i. Non-LTC Beneficiary moves from one treatment setting to another, if not identified automatically through the adjudication process
   ii. Beneficiary 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

c. 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 Beneficiary for manual TF overrides same as POS overrides.

5. TF Days Supply & Time Period Parameters (and LTC Days Supply for Statement 7)
   a.

Description	TF Days Supply
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	
• 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

b. LICS III Beneficiary benefit conversion
A LICS III beneficiary is identified by the pharmacy submitted codes along with eligibility LICS Level of III
c. 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 Delegated PBM 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.

6. The adjudication system ensures that cost-sharing applied to TF's for low-income subsidy (LIS) Beneficiaries never exceeds statutory maximum co-pay amounts; and for non-LIS Beneficiaries, 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.
7. 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 submitting pharmacy as either non-LTC or LTC for purposes of reimbursement and allowed TF days supply.
        i. The values defined as being LTC pharmacy by Delegated PBM pharmacy network operations 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 PLCs designating LTC.
    c. LTC Emergency Supply (ES) is allowed after the transition supply parameters are exhausted for new Beneficiaries and a coverage determination or exception is still pending. Transition supply parameters do nto need to be exhausted for renewing Beneficiaries 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.

LTC NEW PATIENT ADMISSION & LTC EMERGENCY SUPPLY	
Description	**TF Days Supply**
LTC New Patient Admission/Level of Care Change **Beneficiary resides in LTC Facility (New Admission)**	
• Beneficiary admitted to LTC facility within past 30 days • New Patient Admission (NP) Level of Care Change (LOC)	• These quantity plan limits may be greater based on the benefit design and will be limited by the amount prescribed • 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 "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 either a 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 depending. • LTC ES is allowed per calendar day, per Beneficiary, per drug, per pharmacy, per plan a cumulative days supply during a rolling month • New Beneficiaires 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 Beneficiaries 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 Beneficiaries are allowed access to a refill upon admission or discharge.

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

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

8. 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.
      i. **Refill Too Soon (RTS)**
      Automated TF system logic for new and renewing Beneficiaries 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 these edits.
      ii. **DUR Safety Edits**

Automated TF system logic for new and renewing Beneficiaries does not allow override of DUR safety edits that are set up at point of sale. Instead, reject 88 (DUR) is returned to pharmacies with appropriate instructions when submitted claims hit this edit

iii. **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.

iv. **Part A or B vs. Part D (A or B vs. D)**
Part A or B vs. D drugs are not provided a TF because coverage is 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 pharmacy or Beneficiary 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. Part B vs. D drugs reject using the appropriate reject codes and applicable Current NCPDP Telecommunication Claim Standards structured reject messaging. Med A or B v. D claims reject as A6 (B vs. D), A5 (Not D, not B. Not covered under Part D Law), A4 (This Product May Be Covered Under The Medicare- B Bundled Payment To An ESRD Dialysis Facility) or 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 prescribers to identify a formulary alternative.

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

b. **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 Beneficiary 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 Beneficiary 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, Step TF Letters are not sent to either Beneficiaries or prescribers. In 2Q2017, functionality is scheduled to be in production that will allow set ups for grandfather logic to apply without TF. Refer to C.ii below for additional details. 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 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 QL edits do not match, 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 days 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 may be dispensed.. The intent of this logic is to ensure a Beneficiary 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 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. **Beneficiary Level / Clinical Prior Authorizations (PA)**
Beneficiary 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 Beneficiary / clinical PA already exists on the Beneficiary 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 Beneficiaries.

c. **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, if the plan selects this logic. TF processing will apply to any TF-eligible edit which the PCD logic has not overridden.
   ii. **Grandfather Drug Logic**
   The Grandfather Drug Logic will override the Step, PA and NF edit and pay the claim without TF according to the plan criteria, if the plan selects this logic. TF processing will apply to any TF-eligible edit which the Grandfather Drug Logic has not overridden.

9. 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 Beneficiary 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.
10. 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.
    a. Beneficiaries who are new to the plan include: new plan Beneficiaries at the start of Contract Year; newly eligible Beneficiaries from other coverage; and Beneficiaries who switch from one plan to another after the start of a Contract Year.
    b. Transition fills are available at POS through transition processing during the TF Window
    c. Additional transition supplies are available on a case-by-case basis through the MVP Customer or Provider Care line to ensure adequate transition

11. Transition Fill (TF) Letters are sent to Beneficiaries within three (3) business days of adjudicated TF claim; reasonable and best efforts are also made to identify a current prescriber address and provide notice of TF to prescribers to facilitate transitioning of Beneficiaries. 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

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.).

TF Letter Tag: This tag is used to designate the specific TF letter language content for the TF notice to Beneficiaries and prescribers.

TF Combo Tag: This tag is used to designate the specific TF letter language content for the TF notice to Beneficiaries and prescribers for Sponsors who choose to print a paragraph for each edit that was overridden by TF.

Daily TF Letter File

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).

The contents of the TF Letter file are used to drive production of the appropriate Beneficiary and prescriber TF letters.

12. Prior Authorization and exception request forms available upon request to Beneficiaries, prescribers, pharmacies and others by a variety of means including mail, fax, email, and the MVP Medicare and Provider websites.
13. Delegated PBM transition process for new Beneficiaries is applied during the first 90 days of enrollment. The enrollment date does not need to be the start of the Contract Year and may extended across Contract Years for Beneficiaries with an effective enrollment date of either November 1 or December 1 and who need access to a transition supply.
14. [Intentionally left blank to maintain consistent numbering between sections.]
15. TF Extensions are available for New or Existing Beneficiaries, non-LTC or LTC, through the PHD or CC. 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 Beneficiary is still pending exception/coverage determination decision
16. Transition Across Contract Years for Current Beneficiaries

a. Renewing Beneficiaries need to have a history of utilization of the Non-formulary drugs(s). History utilization requires the following criteria:
    i. History look back of 180 day from current date of fill.
    ii. History look back drug GPI 10 match
    iii. History claim(s) for same drug not paid as transition fill(s)
        1. Or if only a paid transition fill is in history, the history transition fill reject reason must not match the incoming claim transition fill reject reason
        2. If the history TF reject reason does match the incoming claim TF reject reason and the reason is QL, the QL limits for each claim must be different.
    iv. Beneficiary's clinical prior authorization(s) are not already effectuated.
    v. For instances where the Beneficiary receives a partial transition fill, the logic will ensure that the renewing Beneficiary's remaining days supply is transition fill eligible during the TF Window. New Beneficiary, LTC ES and LTC NP & Beneficiary PA (reason TF) paid TF claims are not included in the look back calculation to determine if the renewing Beneficiary received a partial fill and has remaining days supply.
b. Renewing Beneficiary logic has the following hierarchy: brand generic logic, transition fill reject reason comparison, then look back calculation for remaining day supply.
c. The following processes are options Sponsors may request Delegated PBM to implement for renewing Beneficiaries:
    i. Use the ANOC as advance notice of any formulary changes.
    ii. Prospectively work to educate and transition current Beneficiaries on medications that will no longer be on the formulary in the new Contract Year or that will require prior authorization, step therapy or quantity limit utilization management edits in the new Contract Year.
    iii. Encourage processing of formulary exceptions/prior authorizations prior to January 1 of a new Contract Year.
    iv. Consistent with the transition fill process provided to new Beneficiaries, Delegated PBM provides transition fills, to renewing Beneficiaries during the first 90 days of the Contract Year with history of utilization of impacted drugs when those Beneficiaries 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 Beneficiaries including those residing in Long Term Care facilities.
d. For Sponsors using the Delegated PBM Pharmacy Help Desk, the Pharmacy Help Desk is instructed to provide transition supplies per Sponsor's plan design to renewing Beneficiaries who were on medications

in the prior Contract Year that are Non-formulary. For Sponsors using Delegated PBM Customer Care, on a case-by-case basis, Delegated PBM Customer Care may provide extensions per Sponsor's instructions to accommodate Beneficiaries who continue to await resolution of a pending prior authorization or exception requests.