Medicare Part D Transition Period Drug Benefit Policy

This policy describes how transition benefits apply when you are filling prescriptions in retail, home infusion and Long-Term Care (LTC) pharmacy settings. It also covers how you can get a temporary transition supply.

This policy reflects the Centers for Medicare & Medicaid Services (CMS) transition goals for members who are eligible for a transition supply. It ensures the following:

1. That you can get a temporary transition supply of non-formulary Medicare Part D drugs
   - This includes drugs that are not on our plan's formulary (drug list) or drugs that are on the drug list but your ability to get the drug is limited. For example, prior authorization (PA), step therapy (ST), quantity limits (QL), or a formulary exception (FE) may be needed before a prescription can be filled. These are called Utilization Management (UM) requirements. You can request an exception to these requirements through the coverage determination process.
2. That you have enough time to do the following:
   - Work with your health care provider to switch to a new drug that also works to maintain your health
   - Comply with UM requirements, if needed
   - Work with your health care provider to request a coverage determination

If you or your health care provider want to ask for a Coverage Determination, you can ask us to send a form to you and/or your health care provider. These forms are available by mail, fax, and email. They are also available on our website.

This policy covers the following:

- Transition requirements
- New prescriptions versus ongoing drug therapy
- Transition time frames and temporary fills
- Transition across contract years for current members
- Emergency supplies for current members
- Treatment of re-enrolled members
- Level of care changes
- Transition notices

Transition requirements

Eligible members

If you are currently taking drugs that are not included in your plan's new drug list, you may be eligible for a transition supply if any of the following apply to you:

- New to the prescription drug plan at the start of a contract year
- Newly eligible at the start of a contract year
- Switching from one plan to another after the start of a contract year

- Living in an LTC setting
- Affected by negative changes to the drug list from one contract year to the next
- Change in treatment settings because of a change in your level of care

Applicable drugs
- Drugs that are not on your plan's drug list
- Drugs that are on your plan's drug list but your ability to get the drug is limited

You may be able to get a temporary supply of a non-formulary drug to meet your needs. This gives you and your plan time to work with your health care provider to find a similar drug on the drug list or to make a coverage determination request. A coverage determination request includes a medical review. If your coverage determination request is approved, you can keep getting a drug that you are currently using.

New prescriptions versus ongoing drug therapy
All transition processes are applied at the pharmacy to new prescriptions when it is not clear if a prescription is new or is an ongoing prescription for a non-formulary drug.

Transition time frames and temporary fills

Time frame and transition fills *in outpatient settings* (retail)
If you are new to or re-enrolled in our plan, you can get up to a 30-day supply (unless the prescription is written for fewer days) any time during the first 90 days of coverage.

Time frame and transition fills *in LTC settings*
You can get up to a 31-day supply (unless the prescription is written for fewer days) of non-formulary drugs during the following times:
- Any time during the first 90 days of coverage in a plan you can get up to a 31-day supply, depending on how many days of medication are filled each time (up to a 31-day supply per fill).
- After the 90-day transition period has ended, if a coverage determination request is being reviewed you can get a temporary emergency supply for up to 31 days.

If you are being admitted to or discharged from an LTC setting, an early refill will not limit access to your Part D benefit. You can get a refill upon admission or discharge.

Transition extension
The transition period may be extended on a case-by-case basis as follows:
- If a coverage determination request or appeal has not been processed by the end of the minimum transition period
- Until a transition has been made, either by switching to a drug on your drug list or a because decision is made on a coverage determination request

You can get refills for transition prescriptions that are dispensed for less than the written amount due to quantity limits. Quantity limits are used for safety purposes.

Transition across contract years for current members
If you have not changed to a formulary drug before the new calendar year, a temporary transition supply may be provided to avoid transition gaps if the following occurs:
- Your drugs are removed from the drug list from one contract year to the next

- New utilization management requirements are added to your drugs from one contract year to the next

The policy is in place even if you enroll with a start date of either November 1 or December 1 and need a transition supply. You will receive the Annual Notification of Change/Evidence of Coverage for the upcoming year. You may request a transition supply to prevent coverage gaps.

Emergency supply for current members
If you are in an LTC setting, you are eligible for a 31-day emergency supply (unless the prescription is written for less than 31 days) of non-formulary Part D drugs after the transition period has expired, while a prior authorization (including step therapy) is being processed.

Treatment of re-enrolled members
You may leave one plan, enroll in another plan, and then re-enroll in the original plan. If this happens, you will be treated as a new member to ensure that you get transition benefits. The transition benefits begin when you re-enroll in your original plan.

Level of care changes
You may have changes that take you from one level of care setting to another. During this level of care change, drugs may be prescribed that are not on your plan's drug list. If this happens, you and/or your health care provider must ask for a coverage determination.

Current enrollees who experience a Level of Care Change are eligible to receive a transition supply of a Non-Formulary Part D Drug upon admission or discharge from an applicable setting.

To prevent a gap in care when you are discharged, you can get a 31-day transition supply. This will allow therapy to continue once the limited discharge supply is gone. This outpatient supply is available before discharge from a Part A stay.

When you are admitted to or discharged from an LTC setting, you may not have access to the drugs you were previously given. However, you can get a refill upon admission or discharge.

Transition notices
When a claim is submitted for a transition supply, a notice is sent to you (by first class U.S. mail) and your provider (by mail) within three business days after the date the drug claim was submitted. For LTC residents given multiple fills of a Part D drug in 14-day fills or less, the written notice is sent within 3 business days after the date the claim is submitted for the first transition fill. The notice does the following:

- Explains that the transition fill is temporary.
- Tells you to work with your health care provider to find a new drug option that is on your plan's drug list
- Explains that you can request a coverage determination (including a formulary exception), and tells you how to make the request, your timeframes, and your appeal rights.

1-866-567-7242, TTY 1-800-627-3529 or 711

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ် ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ် လီတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ဉ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. South Country Health Alliance (South Country) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by South Country. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
South Country Health Alliance
6380 West Frontage Road, Medford, MN 55049
Toll Free: 866-567-7242 TTY: 800-627-3529 or 711 Fax: 507-444-7774
Email: grievances-appeals@mnscha.org

Auxiliary Aids and Services: South Country provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** Member Services at members@mnscha.org or call 866-567-7242, TTY 800-627-3529 or 711.

Language Assistance Services: South Country provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** Member Services at members@mnscha.org or call 866-567-7242, TTY 800-627-3529 or 711.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by South Country. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights, U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240 Chicago, IL 60601
Customer Response Center: 800-368-1019, TTY: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201, St. Paul, MN 55104
651-539-1100 (voice), 800-657-3704 (toll-free), 711 or 800-627-3529 (MN Relay), 651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.