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Health Choice

Policy

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DEFINITONS

1. **Annual Notice of Change (ANOC)**: The CMS required document that must be sent to all current Beneficiaries annually in accordance with CMS directions, and that describes changes to existing benefits that are expected for upcoming new Contract Year.
2. **Applicable Month's Supply**: CMS required transition supply, as a minimum (unless prescriptions are written for fewer days); the supply is determined as the number of days submitted for the Plan Benefit Package (PBP)'s applicable month's supply submitted to CMS for the relevant plan year. CMS approval determines the approved month's supply for Beneficiaries in both the non-LTC and LTC settings. Multiple fills up to a total approved month's supply are allowed to accommodate fills for amounts less than prescribed.
3. **Beneficiary**: An individual enrolled in a Delegated PBM Sponsor's Medicare Part D Plan, also known as an Enrollee or Member.
4. **Biosimilars:** A biological product submitted to the FDA for approval via the biological abbreviated pathway created by Affordable Care Act. These products must demonstrate that they are highly similar to the reference (originator) products; i.e.: there are no clinically meaningful differences between the biological product and the reference product in terms

of safety, purity, and potency. Biosimilars have allowable differences because they are made of living organisms.

5. **CMS:** U.S. Centers for Medicare and Medicaid Services.
6. **Contract Year:** The period for which a particular plan benefit package applies. Also known as the "plan year." In the case of the transition period for current Beneficiaries across contract years in non-calendar plans, the term "contract year" refers to the calendar year for which the new formulary is effective.
7. **Delegated PBM Delegated PBM:** Sponsor's pharmacy benefit manager.
8. **Drug Utilization Review (DUR):** An analysis of drug usage prescribing intended to ensure clinically appropriate drug therapy and quality of patient care; can be conducted concurrently (between the time the prescription is written, and therapy begins), retrospectively (after medication is dispensed), and prospectively (before drugs are prescribed to influence future usage patterns).
9. **Food and Drug Administration (FDA):** A federal agency of the U.S. Department of Health and Human Services. This agency is responsible for monitoring of trading and safety standards in the food and drug industries.
10. **Generic Product Identifier (GPI):** A 14-character hierarchical classification system created by Medi-Span. It identifies drugs available with a prescription in the United States to a manufacturer and pill level.
11. **Interchangeable Biological:** An interchangeable biological product is biosimilar to an FDA-approved reference product and meets additional standards for interchangeability. An interchangeable biological product may be substituted for the reference product by a pharmacist without the intervention of the health care provider who prescribed the reference product.
12. **Long-term Care** (**LTC):** Long-term care refers to facilities or institutions, such as nursing homes and skilled nursing facilities that provide healthcare to people who are unable to manage independently in the community. This care may represent custodial or chronic care management or short-term rehabilitative services.
13. **Low Income Subsidy (LIS):** Subsidized premiums, deductibles, and/or copayments for which Eligible beneficiaries may be qualified. Also referred to as Extra Help.
14. **Medicare Part D (Part D):** Medicare Prescription drug benefit under Part D of the Social Security Act.
15. **MME:** Morphine Milligram Equivalent
16. **Multi-Ingredient Compound (MIC):** referring to the logic for the determination of reimbursement and coverage of a claim that consists of multiple ingredients which are manually assembled and dispensed by a pharmacy.
17. **National Council of Prescription Drug Programs (NCPDP):** An American National Standards Institute (ANSI) accredited group that maintains several standard formats for use by the retail pharmacy industry, some of which have been adopted as Health Insurance Portability and Accountability Act (HIPAA) standards.
18. **National Drug Code (NDC):** The National Drug Code is a unique, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act.

19. **Non-formulary Drugs**: This means: (a.) Part D drugs that are not on a Sponsor's formulary; (b.) Part D drugs previously approved for coverage under an exception once the exception expires and (c.) Part D drugs that are on a Sponsor's formulary but require prior authorization, step therapy, or approved quantity limits lower than the Beneficiary's current dose, under a Sponsor's utilization management rules.
20. **Non-Long-Term Care:** Describes Retail, Mail and Home Infusion facilities.
21. **P&T Committee:** Pharmacy and Therapeutics committee, which is a committee that, among other things, evaluates available evidence regarding the relative safety, efficacy, and effectiveness of prescription drugs within a class of prescription drugs and reviews recommendations for the development of formularies. The committee meets at least quarterly.
22. **PAMC:** Prior Authorization/Medical Certification Code. This is a field on the standardized pharmacy adjudication layout for entry of an authorization code provided by the processor.
23. **Patient Location Code (PLC):** RxClaim adjudication legacy system value that crosswalks from the Pharmacy Service Type and Patient Residence Code.
24. **Patient Residence (PR):** Pharmacies collect and record the patient residence at point of sale on the claim.
25. **PCD:** Protected Class Drug.
26. **Pharmacy Service Type (PST):** The type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy, or when benefits are based upon the type of service performed.
27. **Point of Sale (POS):** A capability of retail pharmacies to electronically access plan design and eligibility information to process and transmit drug claims data at the time of purchase.
28. **Print Fulfillment:** Delegated PBM business unit(s) that are responsible for the print fulfillment of some Beneficiary notifications including transition fill notifications to Beneficiaries and prescribers.
29. **Prior Authorization (PA):** An evaluation of the drug's prescribed use against a predetermined set of criteria to determine whether the drug/drug class will be covered by the beneficiary's insurance plan.
30. **RxClaim:** Delegated PBM information technology system that serves to process and adjudicate Part D claims; otherwise known as the "system," "platform," or "system platform."
31. **Sponsor:** A Part D Sponsor that contracts with Delegated PBM for pharmacy benefit management services including implementation of its transition process. Also known as the Plan or Plan Sponsor or Client. Sponsor is BCBSAZ Health Choice Pathway.
32. **Submission Clarification Code (SCC):** NCPDP data element indicating that the pharmacist is clarifying the claim submission.
33. **TF Window:** The Beneficiary Transition Fill window is the Sponsor specified number of days (minimum of 90 days) during which Beneficiary transition benefits apply.
34. **Transition Fill - Medicare (TF):** A temporary supply of a Part D covered drug per CMS Part D requirements.

POLICY

1. Delegated PBM implements and maintains an appropriate transition process, as approved by CMS and consistent with CMS rules and guidance. The Delegated PBM process 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 following the annual coordinated election period; (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 Year; (e.) Beneficiaries residing in long-term care (LTC) facilities, including Beneficiaries being admitted to or discharged from an LTC facility.
2. The Sponsor is responsible for submitting a copy of its transition policy process to CMS.
3. The transition policy will apply to Non-formulary Drugs, meaning: (a.) Part D drugs that are not on a Sponsor's formulary; (b.) Part D drugs previously approved for coverage under an exception once the exception expires and (c.) Part D drugs that are on a Sponsor's formulary but require prior authorization or step therapy or approved quantity limits lower than the Beneficiary's current dose under a Sponsor's 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 Sponsor Beneficiaries to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination. Delegated PBM will handle Biosimilars as non-interchangeable brand/generic products for its programs and processes involving transition fill and will apply the appropriate cost share according to CMS guidance. For Sponsors delegating formulary management to Delegated PBM, Delegated PBM P&T committee reviews 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. For 2026, Sponsor is delegating formulary management to Delegated PBM.
4. Delegated PBM will have systems capabilities that allow Delegated PBM to provide a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of a Beneficiary, as well as, to allow the Sponsor 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. Delegated PBM transition process will apply in the non-LTC setting such that the transition policy provides for a one-time temporary fill of at least the applicable month's supply of medication (unless the Beneficiary presents a prescription written for less than a month's supply in which case the Sponsor must allow multiple fills to provide up to a total of the applicable month's supply of medication) anytime during the first 90 days of a Beneficiary's enrollment in a plan, beginning on the Beneficiary's effective date of coverage. These quantity and time plan limits may be greater based on the Sponsor's benefit design and will be limited by the amount prescribed. For 2026, the Sponsor's plan

set up allows a month's supply of at least 30 days (or applicable month's supply based on the plan bid) within the 90 day TF Window.

6. Delegated PBM will apply the Sponsor's cost-sharing tier for a temporary supply of drugs provided under its transition process such that it 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 non-formulary drugs approved through a formulary exception.
    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 were met.
7. Delegated PBM transition process in the LTC setting will include the following attributes: (a.) the transition policy will provide for a one time temporary fill of at least an applicable month's supply (unless the Beneficiary presents with a prescription written for less) consistent with the applicable dispensing increment in the LTC setting with multiple fills allowed to provide up to a total of a month's supply of medication 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 supply) while an exception or Prior Authorization determination is pending; and (c.) for Beneficiaries being admitted to or discharged from an 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. For 2026, the Sponsor's plan set up allows a month's supply of 31 within the 90 day TF Window for LTC and New Patient/Level of Care Change. LTC Emergency Supply allows a 31 days supply; LTC Emergency Supply is allowed per rolling 30 days.
8. Delegated PBM will only apply the following utilization management edits 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. Delegated PBM 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. Delegated PBM will apply its transition processes 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. For 2026, Sponsor is using Delegated PBM to fulfill transition notices. Delegated PBM will send written notice consistent with CMS transition requirements to Beneficiary within three (3) business days after adjudication of a temporary transition fill. The notice will include (a.) an explanation of the temporary nature of the transition supply a 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 Sponsor'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 LTC 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. Delegated PBM will use the Transition Notice provided by the Sponsor. Delegated PBM will use reasonable efforts to provide notice of TF to prescribers to facilitate transitioning of Beneficiaries. For Sponsors not using Delegated PBM to fulfill transition notices, a daily extract file is provided to the Sponsor containing Part D TF paid transactions requiring a transition notice. For 2026, Sponsor is using Delegated PBM to fulfill transition notices.

12. For 2026, Sponsor is responsible for coverage determinations. Sponsor will make available prior authorization or exception request forms upon request to both Beneficiaries and prescribing physicians via mail, fax, email, and with the Sponsor via their plan web sites.
13. Delegated PBM will extend its transition policy 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. Sponsors are responsible for making general transition process information 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.
15. Delegated PBM will provide a process for Beneficiaries 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). For 2021, Sponsor will allow a 30 days supply for transition extension.
16. Delegated PBM will implement the transition process for renewing beneficiaries whose drugs will be affected by negative formulary changes in the upcoming Contract Year. Delegated PBM will offer Sponsors transition processes for encouraging a transition prior to the beginning of the Contract Year. The Sponsor plan set up for Renewing Beneficiary history review is at a GPI 10 level with a look back of 180 days.
17. Delegated PBM will maintain the ability to support routine and CMS-required reporting, as well as the ability to respond to ad hoc requests for: (a.) denied claim reports; and (b.) paid TF claim reports for new and renewing Beneficiaries. It will also maintain the ability to support test TF claim processing in response to ad hoc requests and will regularly review and audit TF program data and system operations to monitor adherence with Part D Transition Fill requirements.

PROCEDURES

1. The Sponsor's TF program is implemented by Delegated PBM according to the Sponsor's requested benefit design.
    a. Transition supplies are provided at POS to eligible Beneficiaries which are coded as the following:
        i. New Beneficiaries in the plan following the annual coordinated election period
        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)
        v. Beneficiaries residing in LTC facilities
    b. Transition supply limits are defined as cumulative days supplies calculated on Generic Product Identifier (GPI) 14 and are not 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. Delegated PBM will maintain a Med D TF policy and procedure and review, and if needed, revise, the document at least annually and as needed when processing changes occur.
3. Non-formulary Drugs
    a. Procedures to apply the transition policy to Non-formulary Drugs are to obtain the Sponsor's 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. CMS issued guidance stating that it does not expect Part D sponsors to include expiring formulary exceptions in their transition policies. Therefore, delegated PBM will not apply its transition policy to expiring formulary exceptions unless and until CMS issues guidance requiring otherwise.
    c. Procedures for medical review and identifying Formulary Alternatives are as follows:
        i. The Sponsor Coverage Determination and medical review processes and procedures ensure Beneficiaries have access to processes for medical review of Non-formulary drug requests.
        ii. Information regarding therapeutically appropriate formulary alternatives is made available to Beneficiaries and prescribers failing an affirmative medical necessity determination.
        iii. Beneficiaries who contact Customer Care and Pharmacies that contact the Pharmacy Help Desk are provided with information regarding available formulary alternatives when requested and/ are appropriate for Beneficiaries' care.
        iv. In some cases, the review of the procedures for coverage determinations and exceptions may result in the need for a process for transitioning a Beneficiary to a therapeutically appropriate formulary alternative.
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 Delegated 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 and through the Pharmacy Help Desk for Beneficiaries who are new to plan.
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 pharmacy network department.

5. Transition Fill for New or Renewing Beneficiaries in the Non-LTC setting
   a. In a Non-LTC setting, Delegated 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 applicable month's supply.
   b. 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.
   c. Transition fills are available at POS through this functionality within the first 90 days of enrollment, beginning on the enrollment effective date.
   d. The new and renewing Beneficiaries in a Non-LTC setting may have greater quantity and time plan limits based on the benefit design and will be limited by the amount prescribed.
   e. 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 Delegated PBM Pharmacy Help Desk in order to obtain an override to submit a Level of Care transition fill request.
6. Delegated PBM will establish the cost-sharing per the Sponsor's plan design.
   a. Cost-sharing for drugs supplied 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 share as would apply if a non-formulary exception was applied
      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 a cumulative applicable month's supply,

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. Multiple fills to provide up to a total of the applicable month's supply of medication are allowed consistent with the applicable dispensing increment in the LTC setting. These quantity and time plan limits may be greater based on the benefit design. 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 either the new or renewing TF supply has been exhausted, exceeded or the TF 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 cumulative 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 of 21-36. These drug claims would otherwise reject for being Non-formulary or formulary with prior authorization, step therapy, quantity limit, or age edits secondary to Beneficiaries having exhausted or exceeded the TF new or renewing TF 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, based on benefit design.
    iii. These quantity plan limits may be greater based on the benefit design and will be limited by the amount prescribed.
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, Refill Too Soon rejects and certain DUR service rejects for new admissions. Level of Care Transition Fills are allowed up to an applicable month's 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. Level of Care Transition Fills are allowed per calendar day, per Beneficiary, per drug, per pharmacy, per plan for a cumulative days supply within the LTC LOC benefit.
    iii. For all Beneficiaries who experience a Level of Care Change, if a dose change results in an "early refill", Refill Too Soon rejects and certain DUR service rejects, the pharmacy may call the Pharmacy Help Desk to obtain an override.
    iv. The quantity plan limits may be greater based on benefit design and will be limited by the amount prescribed.

8. Utilization Management Edits Not TF Eligible and TF Eligible Step Therapy and Prior Authorization processing
    a. Delegated PBM 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 Delegated PBM drug database.

ii. Drugs excluded from Part D benefit as identified on the Delegated PBM drug database.
iii. Edits to support the determination of Part D Drug Status.
iv. DUR safety edits such as therapeutic duplication, cumulative acetaminophen, morphine milligram equivalent (MME), drug interaction, and age alerts are set up to reject.

TF eligible Step therapy, Prior Authorization and non-safety quantity limit 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 an applicable month's supply.
   b. For DUR edits that are based on an FDA maximum recommended daily dose, Transition Fill claims which are dispensed at less than the prescribed amount due to this edit are allowed refills during the TF Window.
   c. Delegated PBM TF cumulative days supply accumulates at the drug GPI 14 level and unique edit type by Beneficiary and across plan (or plan codes). Transition fill will consider each unique Non-Formulary or Utilization Management Edit types and allow TF for each unique transition fill eligible edit type encountered on an individual GPI 14. LTC Emergency Supply and LTC Level of Care Change/New Patient benefits accumulate separately.
   d. These quantity plan limits may be greater based on the benefit design and will be limited by the amount prescribed.
10. The Delegated PBM 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 the POS, the Delegated PBM 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. For Sponsors using Delegated PBM to fulfill transition notices, a written transition notice is sent to the Beneficiary within three (3) business days after adjudication of a temporary 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* temporary 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 Delegated PBM 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. For 2026, the Sponsor is using the Delegated PBM to fulfill transition notices. Transition notices to prescribers are provided by the Delegated PBM 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. The Sponsor ensures prior authorization and exception request forms are available upon request by Beneficiary or prescriber via variety of means including by e-mail, mail, fax, and via the plan website.
13. The Delegated PBM transition process for new Beneficiaries is coded to apply across Contract Years for Beneficiaries with an effective enrollment date at the end of the plan year and who need access to a transition supply for a negative formulary change. These Beneficiaries are eligible for a TF for a negative formulary change from the date they enroll in the current Contract year through the TF Window which starts on January 1 of the next plan year.
14. [Intentionally left blank to maintain consistent numbering between sections.]
15. Transition Extensions
    On a case-by-case basis, the Plan will provide an extension of the transition period to accommodate Beneficiaries who continue to await resolution of a pending prior authorization or exception request. The extensions are available through the plan Member Services and Pharmacy department and per plan design.
16. Consistent with the transition fill process provided to new Beneficiaries, Delegated PBM provides transition fills to renewing Beneficiaries during the TF Window of the Contract Year with a 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. Renewing Beneficiaries need to have a history of utilization of the drug for which coverage is being requested.
    b. For these Beneficiaries, the Delegated PBM 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 Pharmacy Help Desk 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 benefit design and will be limited by the amount prescribed.
17. Transition Fill Program Monitoring & Reporting
    a. Transition fill processes are monitored both across and within each program area that has responsibility for TF processes. TF program monitoring is both quantitative and qualitative.
    b. Transition claim adjudication data are used to produce standard paid TF Claim and rejected claim reports for quantitative program monitoring. Program performance monitoring includes reporting and monitoring of all TF types: new and renewing Beneficiary TF; and Level of Care Change and LTC Emergency Supply TF.

c. Support for and Response to Audit and Other Data Requests
    i. Audit requests for transition fill data from CMS or other appropriate entities are responded to within the time period designated in the request; or as soon as reasonably feasible, whichever is most appropriate per the requestor.
    ii. Non-urgent requests for transition fill data are responded to within ten business days. Other response times are available on case-by-case, as needed, basis.

This policy will be reviewed on an annual basis.