Express Scripts
By EVERNORTH

Upper Peninsula Health Plan (UPHP) MI Coordinated Health (HMO – DSNP)
Medicare Part D 2027 Transition Supply Policy

Regulation/Requirement:	• 42 CFR §423.120(b)(3) • 42 CFR § 423.154(a)(1)(i) • 42 CFR § 423.578(b) • Prescription Drug Manual, Chapter 6, Section 30.4 • Part D Transition Letter
Purpose:	This document defines UPHP MI Coordinated Health's prescription drug transition policy which ensures compliance with Medicare Part D transition supply requirements.
Scope:	This Policy is applicable to the UPHP MI Coordinated Health's Prescription Drug Plan and its enrollees covered under CMS Contract H3127.
Policy:	Where applicable and as required by CMS, UPHP MI Coordinated Health provides transition-eligible Medicare enrollees a temporary supply for eligible medications when the medication meets one or more of the following conditions: • Not included on the Plan's formulary; or • On the Plan's formulary, but are subject to utilization management rules including: Prior Authorization Required, Step Therapy or Plan-imposed Quantity Limits. The process is intended to afford enrollees and their care team sufficient time to work with their health care providers to switch to a therapeutically appropriate formulary alternative or to request an exception on the grounds of medical necessity.

II. Definitions	
Centers for Medicare & Medicaid Services (CMS)	The United States federal agency which administers several federally-funded health care programs including, but not limited to, Medicare, Medicaid, and Children's Health Insurance Programs.
Clinical Direct Message (CDM)	A secure, standards-based channel where messages are delivered directly into the prescriber's clinical workflow.
Current Enrollee	A beneficiary who remains enrolled in a Part D Plan across a contract year without any gaps in coverage.

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Exception	An exception request is a type of coverage determination. An enrollee, an enrollee's prescriber, or an enrollee's representative may request a tiering exception or a formulary exception. Exceptions requests are granted when a Plan sponsor determines that a requested drug is medically necessary for an enrollee.
Express Scripts, Inc. (Express Scripts)	The pharmacy benefit management organization who is delegated the role of providing services to clients that operated as a Plan Sponsor.
Generic Code Number (GCN)	A number used to identify generic categorization of a drug.
Hierarchical Ingredient Code List (HICL)	A list of drug classification types used to identify the chemical ingredient of a drug.
Long Term Care (LTC)	Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.
Maximum Daily Dose (MDD)	The maximum amount of a drug per daily event as defined by the manufacturer and included on approved drug labeling.
New Enrollee	Beneficiaries who enroll for the first time into a Part D Plan.
Part D Eligible Drugs	Medications determined by Medicare to count toward the true out of pocket costs for a Medicare Part D enrollee.
Pharmacy and Therapeutics Committee (P&T)	A committee, comprised of participants from various clinical specialties responsible for the evaluation of new chemical agents and the determination of formulary content including exceptions, tier value, Prior Authorizations, step therapies, quantity limitations, generic substitutions and other drug utilization activities that affect drug access.
Pharmacy Help Desk	This unit provides assistance to pharmacies to resolve claims processing issues. The Pharmacy Help Desk number may be provided to pharmacies in their pharmacy manual or messaged to them on the rejected claim response.
Prior Authorization (PA)	A process through which the physician or other health care provider is required to obtain advance approval from the Plan that payment will be made for a service or item furnished to an enrollee.
Quantity Limit (QL)	A Quantity Limit is a restriction on the amount or quantity of medication that is covered by your plan during a specific period of time.
Refill Too Soon (RTS)	An edit that exists indicating that a drug claim has been presented too early for the pharmacy to dispense to an enrollee.

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Route of Administration (RT)	One of the drug vendor's data elements that identifies how a drug is administered (e.g., oral, injectable).
Short Cycle Fill (SCF)	Guidance and related edits pertaining to enrollees receiving a certain quantity of drugs in a LTC setting. Drugs subject to short-cycle fill edits as defined by CMS must be dispensed to enrollees in limited quantities as per the CMS guidance.

III. Policy	
Task 1:	**Transition Requirements – CMS Attestation #1**
	The Plan offers this transition policy as a written description of the appropriate transition processes consistent with 42 CFR §423.120(b)(3) for our enrollees whose current drug therapies may not be included in their new Plan formulary. The Plan will maintain this policy and effectuate a meaningful transition as delegated for: • New enrollees into its prescription drug plans following the annual coordinated election period; • Newly eligible Medicare enrollees from other coverage; • Enrollees who switch from one Plan to another after the start of a contract year; • Current enrollees affected by negative formulary changes across contract years; • Enrollees residing in Long-Term Care (LTC) facilities; • In some cases, enrollees who change treatment settings due to a change in level of care. Enrollees who are undergoing a change in care are eligible for a temporary supply to ensure the continuity of needed medications across care settings. If the enrollee is not in their transition period during their care change, or is in the transition period but have already received their transition supply fill days' supply maximum, the system will reject the claim and appropriate reject codes are returned to the pharmacy. The network pharmacy receives additional secondary messaging (If Level of Care) and training to inform the pharmacy of the appropriate procedure. In the circumstance where an enrollee is changing care setting and may not have access to current prescriptions, the network pharmacy may contact the Express Scripts help desk for an override to dispense a temporary transition supply. Appropriate transition notifications are generated to the enrollee and the prescriber in the required timetable. As these enrollees are vulnerable to disruption in care, Express Scripts also provides daily rejected claims data to the plans for oversight of these enrollees experiencing a change in their care to assure the transition has been effectuated.
Task 2:	**Transition Policy Submission CMS Attestation #2**
	The Plan will submit a copy of its transition policy to CMS, ensuring that the submission is per CMS guidelines and ensuring that the policy conforms to the requirements of the Prescription Drug Manual, Chapter 6, Section 30.4.
Task 3:	**Transition Scope CMS Attestation #3**

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	The transition process is applicable to non-formulary drugs, meaning: 1. Part D Drugs that are not on a plan's formulary; 2. Part D Drugs that are on a plan's formulary but require PA or step therapy, or that have an approved Quantity Limit (QL) lower than the enrollees' current dose under a plan's utilization management rules. Below is the process for review of non-formulary drug requests and process for switching enrollees to therapeutically appropriate formulary alternatives: When a coverage determination request for a non-formulary drug is received, a series of questions are posed that ask if the enrollee has tried any available formulary drugs that treat the same medical condition as the requested non-formulary drug. Formulary drugs are researched and provided if responses are not provided indicating that formulary drugs have been tried OR that they were tried but failed to appropriately treat the enrollee's condition. When a request for a non-formulary drug is received, our coverage determination process will ensure that the requested drug is being used for a Part D covered use. We exchange information with the requestor about formulary drugs that treat the same condition to establish whether or not the formulary alternatives available have been tried but were not effective and/or would have adverse effect on the enrollee. When an adverse decision is made, written notice is sent to the enrollee providing the basis for the denial and includes at least two formulary alternative drug names along with the enrollee's right to request an appeal if they disagree with the decision. The enrollee's prescriber is also provided a notice of the denial with the same details.
Task 4:	**System Capabilities - CMS Attestation #4**

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	The Plan has systems capabilities that allow the plan to provide a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of an enrollee, as well as to allow the Plan and/or the enrollee sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons. Transition system capabilities are outlined in detail in Attachment A.
Task 5:	**Transition Timeframes and Temporary Supplies – CMS Attestation #5**
	The plan ensures that, in the retail setting, the transition policy provides for at least a one-time, temporary supply of at least a month's supply of medication (unless the enrollee presents with a prescription written for less than a month's supply of medication, in which case the plan will allow multiple fills to provide up to a total of one month's supply of medication) anytime during the first 90 days of a enrollee's enrollment in a plan, beginning on the enrollee's effective date of coverage. In some instances, greater than a month's supply will be dispensed in order to avoid having an enrollee that encounters a hard reject and leaves the pharmacy without their prescribed drug.
Task 6:	**Cost-Sharing Considerations CMS Attestation #6**
	The Plan will ensure that cost sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts for Low-Income Subsidy (LIS) eligible enrollees. For non-LIS enrollees, the plan will charge the same cost sharing for non-formulary Part D drugs provided during the transition that would apply for non-formulary drugs approved through a formulary exception in accordance with 42 CFR § 423.578 (b) and the same cost sharing for formulary drugs subject to utilization management edits provided during the transition that would apply if the utilization management criteria are met.
Task 7:	**LTC Day Supply CMS Attestation #7**
7.1	The plan will ensure that in the LTC setting: 1. The transition policy provides for a one month temporary fill of at least a month's supply of medication (unless the enrollee presents with a prescription written for less), which should be dispensed incrementally as applicable under 42 CFR § 423.154 and with multiple fills provided if needed during the first 90 days of a enrollee's enrollment in a plan, beginning on the enrollee's effective date of coverage; 2. After the transition period has expired, the transition policy provides for a 31-day emergency supply of non-formulary Part D drugs (unless the enrollee presents with a prescription written for less) while an exception or PA is requested; and 3. For enrollees being admitted to or discharged from a LTC facility, early refill edits can be overridden at Point-of-Sale (POS) to allow the enrollee access to their Part D benefit, and such enrollees are allowed to access a refill upon admission or discharge.

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7.2	**Emergency Supply for LTC Enrollees Outside of their Transition Period** An automated process is in place so that an enrollee residing in an LTC will be allowed an additional transition supply of an eligible drug once they are outside of their transition period. These automated emergency transition supply claims provide at least a 31 day supply (or in appropriate increments in the case of SCF or prepack drugs), unless the prescription is written for less than 31 days, while an exception or prior authorization request is in process. Appropriate transition notifications will be generated for both enrollee and prescriber.
Task 8:	**Edits for Transition Supplies CMS Attestation #8**
	The plan's transition process will automatically effectuate a transition supply where appropriate for enrollees except where the following edits apply to the claim at the POS: 1. Edits to determine Part A or B versus Part D and Part D versus Non D coverage; 2. Edits to prevent coverage of non-Part D drugs; 3. Edits to promote safe utilization of a Part D drug. Secondary messaging is sent to the pharmacy to further inform the pharmacy on the reason for the edit and additional required action on the part of the pharmacy to ensure eligible enrollee's transition supplies of needed medications are appropriately dispensed. In the case of Part A, or B versus D overlap drugs, D versus Non D or non-Part D drugs, a coverage determination is required prior to payment. The plan will conduct oversight to assure prescriber's response to coverage review requests for enrollee access to needed medications. Step Therapy and PA edits will be resolved at POS through system logic.
Task 9:	**Quantity Limits CMS Attestation #9**
	The plan will ensure that the transition policy provides refills for transition supplies dispensed for less than the written amount due to quantity limit safety edits or drug utilization edits that are based on approved product labeling. The enrollee will be allowed refills up to the days' supply allowed in the benefit.
Task 10:	**New Prescriptions Versus Ongoing Drug Therapy CMS Attestation #10**

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	Express Scripts, as delegated, will apply transition processes to a brand-new prescription for all non-formulary drugs at the POS if the pharmacy cannot make the distinction whether the prescription is brand-new or an ongoing prescription for a non-formulary drug. Because new and refilled prescriptions for on-going therapy for a transition eligible drug cannot always be distinguished at POS, the transition process assumes the drug is ongoing therapy. In addition, the system does not limit a transition supply to one fill if the enrollee has not received their full transition supply. The process will allow for refills of a transition eligible drug at the POS to ensure enrollees receive at least a one-month supply of a transition eligible drug. Reject claim based on 'transition day supply'. Transition claims will be limited to the transition day supply limit established unless it is a prepackaged drug and cannot be dispensed lower than the transition day supply. Refills may be allowed on transition claims up to the point where the transition day supply obligation has been met or exceeded by the last fill. When greater than the allowable days' supply limit, the claim will hard reject and a message will be returned to the pharmacy noting the allowable day supply/quantity for a transition fill. The pharmacy is then notified to resubmit the claim within the limits presented in the message.
Task 11:	**Transition Notices CMS Attestation #11**

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11.1	The plan will send written notice consistent with CMS transition requirements. A written CMS approved notice is sent via USPS First Class Mail to the plan's enrollee within three business days of adjudication of a temporary transition supply. The notice includes: 1. An explanation of the temporary nature of the transition supply that the enrollee has received; 2. Instructions for working with the plan and the enrollee's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the plan's formulary; 3. An explanation of the enrollee's right to request a formulary exception; 4. A description of the procedures for requesting a formulary exception, which includes expected timeframes to decision the request, and information on the right to appeal. For LTC residents dispensed multiple supplies of a Part D drug in increments of 14 days or less, consistent with the requirements under 42 CFR § 423.154 (a)(1)(i), the written notice must be provided within three business days after adjudication of the first temporary fill.
11.2	The Plan will also ensure that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice. Where delegated, Express Scripts will attempt to send prescriber notifications with via Clinical Direct Message (CDM), or by faxing the notification if CDM is not successful, or by mailing a written notification if faxing is not successful; typically the letter is sent within five business days of the adjudication date of a transition supply dispensed to their patient. The prescriber notification utilizes a separate letter for the prescribing physician notifying them of the transition supply obtained by the enrollee.
11.3	There are circumstances in which notifications cannot be sent to either an enrollee or a prescriber, or faxed to a prescriber. Those circumstances include enrollees for whom the Plan or Express Scripts does not have an approved USPS mailing address on file, or valid prescriber information despite Express Scripts accessing multiple national prescriber databases. Express Scripts produces both enrollee and prescriber drop files each business day for plan awareness. Prescribers that may have a transient address, or situations where the transition claim has been reversed prior to the notification being generated, would not result in a transition letter being sent.
Task 12:	**Exception Request Forms CMS Attestation #12**
	Enrollees and prescribers may call Customer Service lines and request a PA and/or exception request forms upon request via a variety of mechanisms including mail, fax, or email. They may also download the forms from the plan's website.
Task 13:	**Transition Across Contract Years CMS Attestation #13**
	The plan will extend its transition policy across contract years should an enrollee enroll in a plan with an effective enrollment date of November 1 or December 1 and need access to a transition supply. Special handling is in place to ensure appropriate treatment of those enrollees with respect to a transition supply and a window that crosses a contract year. These new enrollees are ensured a minimum 90-day transition window under this across plan year transition process.

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Task 14:	**Public Notice of Transition Process CMS Attestation #14**
	The plan will make their transition policy available to enrollees via link from Medicare Prescription Drug Plan Finder to the plan's web site and include in pre-and post-enrollment marketing materials as directed by CMS.
Task 15:	**Transition Extension CMS Attestation #15**
	The Plan will continue to provide necessary Part D drugs to enrollees via an extension of the transition period, on a case-by-case basis, where delegated, to the extent that the enrollee's exception requests or appeals have not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request.)
Task 16:	**Current Enrollees CMS Attestation #16**
	For current enrollees whose drugs will be affected by negative formulary changes in the upcoming year, the plan will effectuate a meaningful transition by either: 1. Providing a transition process at the start of the new contract year or; 2. Effectuating a transition prior to the start of the new contract year. Systems ensure a current enrollee is provided with a 90 day cross-plan year transition window at the beginning of each contract year. During this time, a current enrollee will be provided with a transition supply of an eligible drug unless the drug was previously filled as a transition supply for the same transition eligible criteria. In order to determine current enrollee transition eligibility, the plan is set up as follows: • System looks for current enrollee's previous utilization through a look-back window Look-back window (starting point for looking at history for utilization) and look back period: • Begins on the last day of the previous plan year and extends through a period of plan defined days. System approach to determine prior utilization: • Based on the HICL and RT code associated with the drug on the incoming claim to any claim that paid for the enrollee that Express Scripts has history for during the lookback period for the same HICL and RT code. If the enrollee had previous utilization, they are eligible for a transition supply if the medication's coverage status changed across the plan year. If the enrollee is lacking utilization within the look-back window or has a transition supply paid claim within the lookback, this will preclude a transition supply from being extended to a current enrollee during the cross-plan year window, as that enrollee is not transition eligible.

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Task 17:	**Role of the Pharmacy and Therapeutics Committee**
	The delegated Express Scripts P&T Committee performs the following functions relative to the Transition Supply process:
17.1	Reviews and approves Medicare Transition Policy as outlined in this document on an annual basis.
17.2	Per CMS guidance, P&T involvement will help ensure that transition decisions appropriately address situations involving enrollees stabilized on drugs that are not on the plan's formulary.
17.3	Per CMS guidance, P&T involvement will help ensure that transition decisions appropriately address situations involving enrollees stabilized on drugs that are on the formulary but are subject to PA, Step Therapy, and Quantity Limits as part of a plan's utilization management requirements. This is accomplished via P&T review and approval of the appropriate policies and procedures.
Task 18:	**Transition Process Oversight and Monitoring**
	Express Scripts oversees and monitors the Transition Supply process to ensure that enrollees have access to necessary drugs as required by CMS guidance. • Express Scripts reporting is made available to demonstrate to plans the appropriate paid, rejected, and transition-related claims. • Oversight reports are provided to plans to monitor required enrollee notifications and prescriber notifications, if delegated.

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Attachment A

Express Scripts
Transition Supply – Plan Implementation Statement

This document provides the following information:

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

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

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

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enrollee is within the transition period by reviewing the enrollee's available plan eligibility history.

4. Express Scripts system verifies that the drug submitted qualifies for a transition supply based on the reject messaging triggered. The rejects indicate one of the four transition eligible categories:
    - Non-Formulary;
    - PA Required;
    - Step Therapy rules;
    - Quantity rules.
5. Express Scripts system determines the allowable days' supply for a transition fill based on the plan's benefit set up requirements.
6. Express Scripts system verifies that the enrollee is eligible for a transition supply of the drug based on the date of service on the claim falling within their transition eligibility period.
    - Express Scripts system can determine potential LTC emergency fill scenarios. An automated process is in place to automatically pay emergency supply claims. If an LTC enrollee is outside of a transition window and presents a transition-eligible prescription drug request, an emergency transition supply of up to 31 days will be paid.
7. Express Scripts system determines if an current enrollee is eligible for transition across Plan years when a paid claim is found within the look-back period of **120** days for the same drug by **HICL and RT** the history claim did not pay under transition logic for the same transition eligible criteria.
8. Using the submitted days' supply from the claim, the Express Scripts system will verify that the claim is within the transition days' supply limit or has remaining transition day supply to be dispensed.
    - Reject claim based on 'transition day supply'. Transition claims will be limited to the transition day supply limit established unless it is a prepackaged drug and cannot be dispensed lower than the transition day supply. Refills may be allowed on transition claims up to the point where the transition day supply obligation has been met or exceeded by the last fill
    - When greater than the allowable day supply limit, the claim will hard reject and a message will be returned to the pharmacy noting the allowable day supply/quantity for a transition fill. The pharmacy is then notified to resubmit the claim within the limits presented in the message.
9. If a previous transition supply of the same drug was already dispensed within the same transition period, Express Scripts system will verify whether a refill is allowable based on the previous days' supply already dispensed.
10. If a required full transition supply was found to have already been provided to the enrollee while in their transition period, the system will hard reject the claim and return an If Level of Care message to the pharmacy with instruction to contact the pharmacy help desk to determine if the enrollee is eligible for a level of care fill.
11. Express Scripts system will calculate cost-sharing for the transition supply based on

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the plans benefit requirements. For plan benefits where all enrollees are low-income subsidy eligible, the copay is tiered to Brand or Generic LICs levels or, if specified, the Part D drugs are tiered to $0 dollar cost sharing in line with the CMS LICs waiver for Plan.

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

Other Edits:

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

1. Plan Limitations Exceeded
   When this message is returned, the pharmacy is required to modify the submitted quantity

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to be equal to or less than the amount included in the POS message. Upon resubmission with corrected information, the transition supply claim will pay and be marked as a transition supply.

2. If Level of Care Change Call Help Desk
   When this message is returned, the pharmacy is required to contact the Pharmacy Help Desk. A process is in place with the Help Desk and includes a series of questions that are posed to the pharmacy. If any of the questions are answered with YES, then a level of care change is confirmed. The Help Desk provides override codes to the pharmacy to place on the claim and the pharmacy is asked to resubmit. Upon resubmission with the override codes the claim will pay and be marked as a transition supply.
3. Refill Too Soon (RTS)
   To limit inappropriate or unnecessary access to Part D drugs, an early refill edit will trigger a hard reject for a transition eligible drug during an enrollee's transition period. The Plans RTS logic considers paid claims, for the same drug, dispensed in the previous plan defined time period to calculate an on-hand days' supply. The pharmacy may resubmit a claim with overrides for RTS at POS but limits the override use to the plan specified RTS refill limit for each of the following reasons within the plan's defined time period:
   - Therapy change;
   - Lost or spilled medication;
   - Vacation supply.

   The Plan's RTS allowance requires that an enrollee has consumed a plan defined percentage of their drug on-hand of an ophthalmic agent as well as at least the plan's defined RTS percentage of any other medication. The consumption requirement for enrollees in an LTC facility is the plan's defined RTS percentage settings.
4. Med B/D Determination Required
   B/D overlap drugs are excluded from Transition Supply processing by Medicare law as the determination must be made prior to adjudication for appropriate billing. Messaging returned to the pharmacy indicates this need for verification by sending the message: "B/D Determination Required". Training and documentation on these processes is included in the Express Scripts Network Manual to support timely determinations.
5. Part A versus Part D Determination Required
   For beneficiaries who have elected the Medicare hospice benefit, drugs in the four hospice categories are excluded from the transition process, as payer determination must be made prior to adjudication for appropriate billing. Messaging returned to the pharmacy indicates this need for verification by sending the message: "Prior Authorization is Required; This product may be covered under Hospice – Medicare Part A". Additional secondary messaging includes: "Member Enrolled in Hospice; Hospice provider – request Prior Authorization. Call for review if not Hospice/Unrelated."
6. Med D/non D Determination Required
   D/non-D drugs are excluded from Transition Supply processing by Medicare law as the determination must be made prior to adjudication for appropriate billing. Messaging returned to the pharmacy indicates this need for verification by sending the message "Med D/Non-D Determination Req".
7. Short Cycle Fill (SCF)
   To comply with CMS guidance related to the LTC pharmacy requirement to dispense certain Part D drugs in small increments, various edits exist that may trigger a hard reject

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for an enrollee during a transition period. All SCF related hard rejects occur prior to transition supply processing and are required to be cleared by the LTC pharmacy before the claim will automatically pay as a transition supply. Once the SCF edits are cleared and a paid transition supply claim is adjudicated, the pharmacy receives one of the two paid claim messages of "PAID AS TRANSITION FILL" or "PAID AS EMERGENCY SUPPLY". Subsequent transition fills will be allowed up to the days' supply set by the Plan.

8. Opioid Medication Quantity Limits

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

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