Medicare Part D Transition Policy

This policy describes the transition requirements published by the Centers for Medicare and Medicaid Services (CMS) which state that all Part D sponsors must provide an appropriate transition benefit for members.

This policy covers the following:

- Eligible members
- Applicable drugs
- New prescriptions versus ongoing drug therapy
- Transition timeframes
- Transition extensions
- Transition across contract years for current members
- Emergency supply for current members
- Treatment of re-enrolled members
- Level of care changes
- Transition notices

This policy describes how transition benefits apply when you are filling prescriptions in:

- Long-Term Care (LTC) settings
- Retail pharmacies
- Extended Supply Network (ESN) (90 days at retail setting)
- Mail Order pharmacies

Eligible members

If you are currently taking drugs that are not included in your plan's new formulary (drug list) from one year to the next, you may be eligible for a transition supply if you are:

- New to the prescription drug plan at the start of 2019
- Newly eligible for Medicare Part D in 2019
- Switching from one Medicare Part D plan to another after January 1, 2019
- Affected by negative changes to the plan's drug list from 2018 to 2019
- Living in an LTC setting

Applicable drugs

The transition benefit allows members to receive a supply of eligible Part D drugs when the drugs are:

- Not on your plan's drug list
- Previously approved for coverage under an exception once the exception expires
- On your plan's drug list, but your ability to get the drug is limited
    - For example, under a Utilization Management (UM) program that requires:
        - Prior Authorization (PA)
        - Step Therapy (ST)
        - Quantity Limits (QL)

You may be eligible for a transition supply of a drug in order to meet your immediate needs. This is meant to allow enough time for you to work with your doctor to find a similar drug on the plan's drug list that will meet your medical needs or to complete a coverage determination to continue coverage of a drug you are currently taking based on medical necessity. An approved coverage determination request may allow continued coverage of a drug you are currently taking.

Certain drugs may not be eligible for a transition supply at the pharmacy; these drugs first require a review to determine if they can be covered by your Part D plan.

If you or your doctor wants to request a coverage determination, the forms are available by mail, fax, email, and on our website; you can access the forms yourself or request a form be sent to you and/or your doctor. The plan reviews coverage determination requests and will notify you once a decision is made. If the plan does not approve the request, you will be provided with additional information regarding your options.

You may qualify for refills of transition supplies that are dispensed for less than the written amount due to quantity limits, which may be used for safety purposes.

New prescriptions versus ongoing drug therapy

Transition benefits are applied at the pharmacy to new prescriptions when it is not clear if a prescription is for a drug you are taking for the first time or an ongoing prescription for a drug that is not on your plan's drug list.

Transition time frames

In outpatient settings (retail, ESN and mail order)

If you are new or re-enrolled to the plan, you may be allowed a 30-day transition supply of eligible Part D drugs (unless the prescription is written for fewer days) any time during your first 90 days of coverage.

In LTC settings

You may be allowed a 31-day transition supply (unless the prescription is written for fewer days) of eligible Part D drugs during the following times:

- Any time during the first 90 days of coverage in a plan you may get a 31-day transition supply, depending on how many days of medication are filled each time.

- After the 90-day transition period has ended, if a coverage determination request is being processed you may be able get an emergency 31-day supply

Transition extension

The transition period may be extended on a case-by-case basis if the review of a coverage determination request or an appeal has not been processed by the end of your minimum transition period (first 90 days of coverage). The extension is then provided only until you have switched to a drug on the plan's drug list or a decision on the coverage determination request or appeal is made.

Transition across contract years for current members

If you have not switched to a covered drug prior to the new calendar year, a transition supply may be provided if the following has occurred:

- Your drugs are removed from the plan's drug list from 2018 to 2019
- New UM requirements are added to your drugs from 2018 to 2019

If you are an existing member with recent history of using a drug which is not covered by your plan or you have limited ability to get the drug:

- In a retail setting you may get a 30-day transition supply (unless the prescription is written for fewer days) any time during the first 90 days of the calendar year
- In an LTC setting you may get a 31-day transition supply (depending on how many days of medication are filled each time) any time during the first 90 days of the calendar year.

This policy is in place even if you enroll with a start date of either November 1 or December 1 and need a transition supply.

Emergency supply for current members

If you are in a LTC setting, you may be allowed a 31-day emergency supply as part of the transition process, unless the prescription is written for fewer days, of a drug that is not on the drug list, or your ability to get the drug is limited. In the event that a coverage determination request is still being processed after the 90-day period, you may be able to get an emergency supply. Your LTC pharmacy can call to see if your fill qualifies as an emergency supply.

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 so you are eligible for transition benefits. The transition benefits begin when you re-enroll in your original plan.

Level of care changes

During a level of care change, drugs that are not covered by our plan may be prescribed. If this happens, you and your doctor must use our plan's Coverage Determination Request process.

To prevent a gap in care when you are discharged, you may get a full outpatient supply that will allow therapy to continue once the limited discharge supply is gone. This outpatient supply is available before discharge from a Medicare Part A-covered 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 may get a refill upon admission or discharge.

Transition notices

When you or your pharmacy submit a prescription drug claim for a transition supply, a letter is sent to you by first class U.S. mail within three business days of the date your drug claim is submitted. Efforts are made to notify doctors when a prescription they write for a member results in a transition supply. This letter is sent to explain the following information:

- That the transition supply is temporary and may not be refilled unless a coverage determination request is approved
- That you should work with your doctor to find a new drug option that is on your plan's drug list
- That you can request a coverage determination and how to make the request, timeframes for processing requests, and the appeal rights if the coverage determination is not approved

Cost considerations

You will be charged the cost share amount for a transition supply of drugs provided, as follows:

- For low income subsidy (LIS) members, you will not be charged a higher cost sharing for transition supplies than the statutory maximum copayment amounts.
- For non-LIS enrollees, you will be charged:
  - The same cost share amount for Part D drugs that are not on the drug list that you would be charged for drugs approved through a formulary exception; or
  - The same cost share amount for drugs on the drug list with UM edits that would apply if the UM criteria are met.

For questions about this policy, please call the phone number on the back of your Member ID card.

Florida Blue Preferred HMO is an HMO plan with a Medicare contract. Enrollment in Florida Blue Preferred HMO depends on contract renewal.

For assistance, current members can contact our Member Services number at 1-844-783-5189 for additional information. (TTY users should call 1-800-955-8770.) Hours are 8 a.m. - 8 p.m. local time, seven days a week.

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