Jefferson Health Plans

Jefferson Health Plans Medicare Advantage Part D Transition Policy

Jefferson Health Plans wants to make sure that all new and current members have a smooth and safe transition to the new contract year and their Medicare Part D prescription benefit. We maintain a transition supply process consistent with CMS rules and guidance.

The transition supply process allows for a meaningful transition for the following groups of members whose current drug therapy may not be covered by Jefferson Health Plans:

- New members enrolled into the plan following annual enrollment;
- Newly eligible Medicare members from other coverage;
- The transition of members who switch from one plan to another after the start of a benefit year;
- Current members affected by negative formulary changes (including new utilization management requirements) across benefit years;
- Members residing in long-term care (LTC) facilities, including members being admitted to or discharged from an LTC facility.

This policy applies to eligible Part D drugs that are not on the Jefferson Health Plans formulary and Part D drugs that are on the formulary, but are subject to certain restrictions or utilization management, such as prior authorization, step therapy, or quantity limitations.

If you are currently taking a medication that requires a formulary exception or prior authorization, we realize that you may need time to work with your doctor to consider formulary alternatives or request authorization for coverage. Working with your health care provider is your best way of getting the most value from your Medicare Part D prescription benefit. You'll avoid expensive prescription costs by considering available formulary options that have been proven to be equally effective and safe.

- **New members** can receive a temporary supply (up to a 30-day supply) for Part D medications that are either non-formulary or subject to utilization management requirements or limitations (e.g., prior authorization, step therapy, or quantity limits) during the first 90 days of your eligibility. After your first 30-day supply, we will not pay for these drugs even if you have been a member of our plan for less than 90 days.
- **Current members** may receive a temporary supply (up to a 30-day supply) of a Part D medication you were taking that has either been removed from the formulary or has new utilization management requirements or limitations in the new contract year during the first 90 days of the new contract year. After your first 30-day supply, we will not pay for these drugs unless approved through the non-formulary exception process or through prior authorization.
- **New and current members** can get multiple fills up to a 30-day supply within your transition period if your first prescription is for less than a 30-day supply.
- For **members in long-term care facilities**, you can fill a temporary supply (up to a 31-day supply) for Part D medications that are either non-formulary or subject to utilization management requirements or limitations during the first 90 days of your eligibility (unless the prescription is written by the prescriber for less than 31 days).

After you receive your transition fill of medication, we will send you a written notice explaining why you received a transition supply of medication. This notice will also describe next steps you can take to ensure continued coverage of your medication, including how to request a formulary exception or how to speak with your doctor to determine if switching to a formulary alternative is appropriate for you.

If you are a member and have a change in treatment setting due to a change in the level of care you require, you can ask us to make a formulary exception. Examples of level of care changes might include:

- Discharge from a hospital to home;
- Ending your skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and you now need to use your Part D plan;
- Changing from hospice status and reverting to standard Medicare Part A and B coverage;
- Ending a long-term care stay and returning to the community;
- Discharges from chronic psychiatric hospitals with highly individualized drug regimens.

For these unplanned transitions, you can ask us to make a formulary exception or appeal for continued coverage of your drug. In addition, we will review requests for continuation of therapy on a case-by-case basis for members that have had a change in their level of care and are stabilized on drug regimens that, if altered, are known to have risks.

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 (the first 90 days of coverage). The extension is then provided only until you have switched to an alternative drug on the plan's drug list or a decision on the coverage determination request or appeal is made.

Jefferson Health Plans will ensure that cost sharing for a temporary supply of drugs provided under our transition supply process will never exceed the statutory maximum copayment amounts for low-income subsidy (LIS) eligible members. For non-LIS members, we 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 § 423.578(b) and the same cost sharing for formulary drugs subject to utilization management edits provided during the transition period that would apply once the utilization management criteria are met.

Additional information about the drugs we cover, prior authorization, and the formulary exceptions and appeal processes, is available at www.JeffersonHealthPlans.com/medicare/prescription-drugs or by calling Member Relations at 1-866-901-8000 (TTY 1-877-454-8477). From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov.