Policy

GP-01 Formulary Transition

Key Points

- **This Policy applies to Elixir and activities managed by Government Programs, Benefit Design Administration, and Formulary departments.**
- **This document outlines how Elixir implements a formulary transition procedure for Commercial Plan Sponsors according to Plan Sponsor's choice between a "hard or immediate conversion", or "grandfathering".**
- **For Medicare Part D Plan Sponsors (including Medicare-Medicaid Plan (FIDA) Sponsors) this policy outlines how Elixir implements a formulary transition procedure in accordance with the Plan Sponsor's transition policy and Medicare guidance.**

1. Commercial Plan Sponsors.

   1.1. Implement an approved formulary transition procedure for each new Plan Sponsor in accordance with agreements made between the Plan and Elixir, to ensure a smooth transition for members to the new Plan Sponsor-sponsored plan.

2. Medicare Part D Plan Sponsors (including Medicare-Medicaid Plan (FIDA) Sponsors).

   2.1. In accordance with the Center for Medicare and Medicaid Services Prescription Drug Benefit Manual Chapter 6, Section 30.4 and 42 CFR 423.120(b)(3), a transition process will be maintained for enrollees whose current drug therapies may not be included in their new Part D plan's formulary, and will effectuate a meaningful transition for:

   2.1.1. New enrollees into prescription drug plans at the start of a contract year and/or following the annual coordinated election period;

   2.1.2. Newly eligible Medicare beneficiaries from other coverage;

   2.1.3. Enrollees who switch from one plan to another after the start of a contract year;

   2.1.4. Current enrollees affected by negative formulary changes across contract years;

   2.1.5. Enrollees residing in long-term care (LTC) facilities;

   2.1.6. Enrollees who request an exception but there is a failure to issue a timely decision on the request by the end of the transition period;

   2.1.7. Enrollees who remain in the same plan for the new plan year and are on a drug that was the result of an exception that was granted in the previous plan year;

   2.1.8. Current enrollee experiencing a level of care change;

   2.1.9. Current enrollees entering the LTC setting from other care settings; and

2.1.10. Current enrollees in a LTC setting requiring an emergency supply of a non- formulary drug.

2.2. In addition to Section 2 above, for Medicare-Medicaid (FIDA) Plan Sponsors unless otherwise directed, a formulary transition procedure will be implemented within the first ninety (90) days of coverage and will provide:

2.2.1. In outpatient settings, at least a one time, temporary fill of at least a month's supply of medication when the Participant requests a refill of a non-formulary drug (including drugs that are on the FIDA Plan's formulary but require Prior Authorization or step therapy under the FIDA Plan's Utilization Management rules) that otherwise meets the definition of a Part D drug during the first ninety (90) days following Enrollment in the FIDA Plan; and

2.2.2. At least a one-time temporary fill of at least a month's supply of medication when a Participant requests a refill of a non-Part D drug that is covered by Medicaid.

2.3. Transition process requirements will be applicable to non-formulary drugs, meaning both:

2.3.1. Part D drugs that are not on the applicable Plan Sponsor formulary, and Part D drugs that are on the applicable Plan Sponsor formulary but require prior authorization or step therapy, or that have an approved quantity limit (QL) lower than the beneficiaries' current dose, under the applicable Plan Sponsor's utilization management rules. Medical review of non-formulary drug requests and when appropriate, the process for switching new Part D plan enrollees to a therapeutically appropriate formulary alternative failing an affirmative medical necessity determination are outlined in the Medicare Coverage Determination Policy and Procedure for Plan Sponsors that delegate Coverage Determinations to the Organization. The procedure for switching to a formulary alternative is contained in the denial notification letter provided to the member as outlined in the Medicare Coverage Determination Policy and Procedure for Plan Sponsors that delegate Coverage Determinations to the Organization.

2.4. The pharmacy claims adjudication system will have systems capabilities that allow pharmacies to provide a temporary supply of non-formulary Part D covered drugs (including Part D covered drugs that are on the applicable Plan Sponsor formulary but require prior authorization or step therapy under Plan Sponsor's utilization management rules) in order to accommodate the immediate needs of an enrollee, as well as to allow the Plan Sponsor and/or the enrollee sufficient time to work with the prescriber on an appropriate switch to a therapeutically equivalent formulary medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.

Resources

- Center for Medicare and Medicaid Services Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements, Section 30.4
- 42 CFR § 423.120(b)(3)