Medicare Part D Transition Policy

This policy tells how transition benefits apply when you are filling prescriptions at retail pharmacies and in Long-Term Care (LTC) settings. It also tells you how you can get a temporary transition supply.

This policy reflects the Centers for Medicare & Medicaid Services (CMS) transition goals for members who are eligible for a temporary transition supply. It allows for the following:

1. That you can get a temporary transition supply of non-formulary Medicare Part D drugs.
   - This includes drugs that are not on our formulary (drug list). It also includes drugs that are on the drug list but your ability to get the drug is limited. For example, you may need to get Prior Authorization (PA) or a Formulary Exception (FE) before you can get a drug. Or, Step Therapy (ST) or Quantity Limits (QL) may apply to some drugs. These are called Utilization Management (UM) requirements. You can ask for an exception to these requirements through the Coverage Determination process.

2. That you have time to do the following:
   - Work with your health care provider to switch to a formulary drug that also works for you
   - Comply with UM requirements, if needed
   - Work with your health care provider to ask for a Coverage Determination

If you or your health care provider want to ask for a Coverage Determination, you can ask us to send a form to you and/or your health care provider. These forms are available by mail, fax, and email. They are also on our website.

We will review Coverage Determination requests. If we do not approve the request, we will give you more information about your options.

This policy tells you about following:

1. Transition requirements
2. New prescriptions versus ongoing drug therapy
3. Transition time frames and temporary fills
4. Transition across contract years for current members
5. Emergency supplies for members in LTC settings
6. Treatment of re-enrolled members
7. Level of care changes
8. Transition notices

1. Transition requirements
   
   Eligible members
   
   If you are currently taking drugs that are not included in our new drug list, you may be able to get a temporary transition supply if any of the following applies:
   - You are new to the prescription drug plan at the start of 2022, following the annual co-ordinated election period
   - You are newly eligible for Medicare Part D in 2022 and are switching from other coverage in 2021
   - You switch from one Medicare Part D plan to another after the start of a contract year
   - You live in an LTC setting
   - You are affected by negative formulary changes across contract years
   - You change treatment settings because of a change in your level of care
Applicable drugs
Non-formulary drugs are as follows:
- Drugs that are not on our drug list
- Drugs that are on our drug list but your ability to get the drug is limited

PrimeWest Health’s policy includes medical review for non-formulary drug requests. It also includes, when medically appropriate, a process for switching new Part D plan members to therapeutically appropriate formulary alternatives.

You can get a temporary transition supply of non-formulary drugs to meet your needs. This gives you time to work with your health care provider to find a similar drug on the drug list or to ask for a Coverage Determination. If your Coverage Determination request is approved, you can keep getting a drug you are currently using.

You can get refills for temporary transition fills that are dispensed for less than the written amount due to a Quantity Limit. Quantity Limits may be used for safety purposes.

You may not be able to get an immediate transition fill for certain drugs at the pharmacy. These drugs need to be reviewed first to determine if they are covered.

There are 6 classes of drugs that we must approve if you have already been taking them when you join PrimeWest Health. A temporary fill will be allowed for these drugs for the first 120 days you are on our plan (for more on standard time frames for transition fills, see #3 below). These classes of drugs are the following:
- Antidepressants
- Antipsychotics
- Anticonvulsants
- Antineoplastics
- Antiretrovirals
- Immunosuppressants (for prophylaxis of organ transplant rejection)

2. New prescriptions versus ongoing drug therapy
Transition processes are applied at the pharmacy to new prescriptions when it is not clear if a prescription is new or is an ongoing prescription for a non-formulary drug.

3. Transition time frames and temporary fills
   Time frame and transition fills in outpatient settings (retail)
   If you are new to or re-enrolled in our plan, you can get up to a 31-day supply (unless the prescription is written for fewer days) any time during your first 90 days of coverage. (See Applicable drugs in #1 above for 6 specific drug classes that have a longer, 120-day supply limit.)

   Time frame and transition fills in LTC settings
   You can get up to a 31-day supply (unless the prescription is written for fewer days) of non-formulary drugs during the following times:
   - Any time during your first 90 days of coverage. You can get up to a 31-day supply, depending on how many days of the drug are filled each time (up to 31-day supply per fill).
   - If a Coverage Determination request is being reviewed after the 90-day transition period has ended, you can get a temporary emergency supply for up to 31 days.

Transition extension
The transition period may be extended on a case-by-case basis if we are still reviewing your Coverage Determination request or Appeal at the end of your minimum transition period (first 90 days of coverage).
The extension will last only until you have changed to a drug on our drug list or we have made a decision about your Coverage Determination request or Appeal.

4. **Transition across contract years for current members**
   If you have not changed to a formulary drug before the new calendar year, a temporary transition supply may be provided if the following is true:
   - Your drugs are removed from the drug list from one calendar year to the next
   - New UM requirements are added to your drugs from one calendar year to the next

   If you meet the criteria above, you can get up to a 31-day supply (unless the prescription is written for fewer days) any time during the first 90 days of the calendar year.

   The policy applies even if you enroll with a start date of either November 1 or December 1 and need a temporary transition supply.

5. **Emergency supply for current members**
   If you are in an LTC setting, you can get a 31-day supply (unless the prescription is written for fewer days) of non-formulary drugs as part of the transition process. If we are still reviewing your Coverage Determination request after the 90-day period, you may be able to get a temporary emergency supply. Your LTC pharmacy may call to see if your fill qualifies as a temporary emergency supply.

6. **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 and will be eligible for transition benefits. The transition benefits begin when you re-enroll in your original plan.

7. **Level of care changes**
   You may have changes that take you from one level of care setting to another (e.g., from an LTC setting to a hospital). During this level of care change, drugs may be prescribed that are not on our drug list. If this happens, you and your health care provider must ask for a Coverage Determination.

   To prevent a gap in care when you are discharged, you can get a full outpatient supply. This will allow therapy to continue once the limited discharge supply is gone. This outpatient supply is available before discharge from a Medicare Part A stay.

   When you are admitted to or discharged from an LTC setting, you may not be able to get the drugs you were given before. However, you can get a refill upon admission or discharge.

8. **Transition notices**
   When you or your pharmacy submit a claim for a temporary transition fill of a drug, a notice is sent to you and your provider by first class U.S. mail. The notice will be sent within 3 business days of the date your drug claim was submitted. For LTC residents given multiple fills of a Part D drug in 14-day fills or less, the written notice is sent within 3 business days of the date the first temporary transition fill is submitted.

   The notice has the following information:
   - Explains that the temporary transition supply is short-term
   - Tells you to work with your health care provider to find a new drug option that is on our drug list
   - Explains that you can ask for a Coverage Determination and tells you how
PrimeWest Senior Health Complete (HMO SNP) and Prime Health Complete (HMO SNP) are health plans that contract with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in PrimeWest Senior Health Complete (HMO SNP) and Prime Health Complete (HMO SNP) depend on contract renewal.
Attention. If you need free help interpreting this document, call the above number.

مارحلا: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

警告：如果您需要免费协助传译这份文件，请拨打上面的电话号码。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

Urruđah. Ḥuẓṣal ḥumu biṣṣar uṣhab uṣhab hoo nuf, Ḥuẓṣal al-saḥṣar uṣhab heliūnī.

Hubachiisa. Dokumentii kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenneem bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Dignin. Haddii aad u baahantahay caawimada laclag-la’aan ah ee tariimada (afeelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.
Civil Rights Notice

Discrimination is against the law. PrimeWest Health does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Auxiliary Aids and Services: PrimeWest Health provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. Contact PrimeWest Health at memberservices@primewest.org, or call Member Services at 1-800-366-2906 (toll free) or TTY 1-800-627-3529 or 711.

Language Assistance Services: PrimeWest Health provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. Contact PrimeWest Health at memberservices@primewest.org, or call Member Services at 1-800-366-2906 (toll free) or TTY 1-800-627-3529 or 711.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by PrimeWest Health. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services’ Office for Civil Rights (OCR)
You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)
Contact the **OCR** directly to file a complaint:

Director  
U.S. Department of Health and Human Services’ Office for Civil Rights  
200 Independence Avenue SW  
Room 515F  
HHH Building  
Washington, DC 20201  
Customer Response Center: Toll-free: 800-368-1019  
TDD 800-537-7697  
Email: ocrmail@hhs.gov

**Minnesota Department of Human Rights (MDHR)**

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race  
- color  
- national origin  
- religion  
- creed  
- sex  
- sexual orientation  
- marital status  
- public assistance status  
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights  
540 Fairview Avenue North  
Suite 201  
St. Paul, MN 55104  
651-539-1100 (voice)  
800-657-3704 (toll free)  
711 or 800-627-3529 (MN Relay)  
651-296-9042 (fax)  
Info.MDHR@state.mn.us (email)

**Minnesota Department of Human Services (DHS)**

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race  
- color  
- national origin  
- creed  
- religion  
- sexual orientation  
- public assistance status  
- age  
- disability (including physical or mental impairment)  
- sex (including sex stereotypes and gender identity)  
- marital status  
- political beliefs  
- medical condition  
- health status  
- receipt of health care services  
- claims experience  
- medical history  
- genetic information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.
DHS will notify you in writing of the investigation’s outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact DHS directly to file a discrimination complaint:
Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

PrimeWest Health Complaint Notice
You have the right to file a complaint with PrimeWest Health if you believe you have been discriminated against because of any of the following:

- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information
- disability (including mental or physical impairment)
- marital status
- age
- sex (including sex stereotypes and gender identity)
- sexual orientation
- national origin
- race
- color
- religion
- creed
- public assistance status
- political beliefs

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:
Rebecca Fuller
Civil Rights Coordinator
PrimeWest Health
3905 Dakota St
Alexandria, MN 56308
Toll Free: 1-866-431-0801
TTY: 1-800-627-3529 or 711
Fax: 1-320-762-8750
Email: rebecca.fuller@primewest.org

American Indian Health Statement
American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.