Healthfirst® Medicare Plan Transition of Coverage Process for Part D Drugs

The Centers for Medicare and Medicaid Services (CMS) require Part D Plan Sponsors, like Healthfirst®, to have a transition of coverage (TOC) process. Transition of coverage happens in two situations:

1. A member is taking a prescription drug that is not on the list of drugs that the plan will pay for. This list is called the plan's **formulary**.
2. A member is taking a drug that has restrictions on it. These restrictions are called **utilization management requirements or limitations**.

Members in these situations can get a temporary supply of their drug in some cases. This limited supply of the drug is called a "transition fill." It gives the member time to talk to their doctor about their options to help avoid any disruption in their treatment.

Healthfirst has set up a TOC process that meets CMS requirements. This process has different sections and applies both to:

- New Healthfirst Medicare Plan members
- Current Healthfirst Medicare Plan members who renew their enrollment from one plan year to the next

The summary below describes the main features of Healthfirst Medicare Plan's TOC process. If you have questions or want more details, please call Member Services at 1.888.260.1010 (TTY 1.888.542.3821), 7 days a week, 8am to 8pm.

Right to Temporary Fill (Transition Fill)

If you are a new member and you are taking a Part D drug that is not on the list of covered drugs or that is restricted, you can get a 30-day supply of that drug within the first 90 days of enrollment.

If you are a current member who renews your Healthfirst Medicare Plan coverage from one year to the next, and you are taking a Part D drug that has been taken off the list or that has new restrictions at the beginning of the new plan year, you can also get the 30-day supply if you meet certain criteria (such as a history of utilization). Your transition period will be the first 90 days of the new plan year.

The plan must provide at least this 30-day supply. It will provide at least a 30-day supply unless the prescription is written for less and does not include refills. New and renewing members can get multiple refills up to the 30-day supply within the transition period if their first fill is less than a 30-day supply.

If you are a resident of a long-term care facility, you can get a 31-day supply per fill of a Part D drug during your transition period. We will allow refills up until 31 days total. This applies unless your prescription is written for fewer days.

There is a copay for each transition refill up to a 31-day supply. This applies to retail, mail-order, and specialty pharmacies.

You may be able to get a transition fill outside of your 90-day transition period if you have special circumstances. One example of a special circumstance is a change in your "level of care," like being sent home from a hospital stay with a prescription for a drug that isn't on the formulary. There are other situations where you may be able to get a temporary supply. Please call Healthfirst Member Services if you think you may have a situation where you qualify for a temporary supply of a drug. When you call, choose the prompt for "Pharmacy."

What you need to do

When you first get the transition fill, you will also get a letter from Healthfirst that explains why your drug is not covered or is limited. The letter will tell you what you need to do to make sure you get coverage for the prescription drug you will need when the temporary supply is finished. The two basic situations are explained below:

1. **Your drug is not on the formulary**

Talk to your doctor about what to do before the temporary supply of your drug ends. Your doctor might decide that another drug on the list would work just as well for your condition. Or your doctor might think that it's medically necessary for you to keep taking your current medication. In that case, you can request an exception. If you are granted an exception, this means that the plan will cover the drug even though it is not on the formulary. Either you or your doctor can make the request.

You, your authorized representative, or your doctor must call, fax, or write to CVS Caremark (our Pharmacy Benefit Manager, or PBM). It may be easier for your doctor to submit the request for you. This is because we will need him or her to send a **"doctor's statement."** This is a *written and signed statement* giving the medical reasons for the exception. Your doctor can fax or mail us the request and statement. Your doctor can also call us first and then send the signed statement by fax or mail.

2. **Your drug needs special approvals (Utilization Management Requirement)**

Utilization Management Requirements are special approvals or restrictions on certain drugs. They are created by a team of doctors and pharmacists to help our members use drugs safely and cost-effectively. Your doctor can help you if a drug you are taking has any of the following requirements:

Prior authorization means you or your doctor must give us information about why the drug was prescribed. This information is used to double-check that it is medically necessary. Your doctor can help you by providing the information needed for prior-authorization.

Step Therapy is when you are asked to try a different drug to see if it will work for your condition before the drug you want to take will be covered for you.

A **Quantity Limit** is a limit on the amount of the drug (number of pills, etc.) the plan will cover in a set period of time.

If you and your doctor don't think these restrictions should apply to you, you can ask for an exception. The steps for asking for an exception from these restrictions are the same as for a formulary exception. You, your authorized representative, or your doctor can contact CVS Caremark. It may be easier for your doctor to request removal of a restriction or prior authorization for you. Use the contact information below.

How to request an exception

To request an exception, ask your prescribing doctor to contact CVS Caremark.

Call: 1.855.344.0930, TTY/TDD 1.866.236.1069, 7 days a week, 8am to 8pm
Fax: 1.855.633.7673
Write: CVS Caremark
Part D Services
MC 109
PO BOX 52000
Phoenix, AZ 85072-2000

Your doctor needs to submit a written statement supporting your request. It might help to bring your doctor the letter from Healthfirst or to submit the letter to his or her office. For a drug that is not on the list of covered drugs, the doctor's statement needs to say that the drug is medically necessary for treating your condition. The reason either has to be that none of the drugs we cover would be as effective or that another drug would have negative effects for you. If the exception is for a prior authorization, quantity limit, or other limit, the doctor's statement needs to explain that the prior authorization or limit would not be appropriate with your condition or would have negative effects for you.

Once we have your doctor's statement, we must notify you of our decision no later than 72 hours if it is a standard request. If it is a rush request (expedited), we will let you know in no more than 24 hours. Your request may be expedited if we decide, or your doctor tells us, that your life, health, or ability to regain maximum function may be seriously threatened by waiting for a regular request response.

What if my request is denied?

If your request is denied, you have the right to appeal. This means you can ask for the decision to be reviewed. You must request this appeal within 60 calendar days from the date of the first decision. You must file a standard request in writing. Expedited requests are accepted by telephone and in writing.

Call: 1.888.698.0577, TTY/TDD 1.866.236.1069, 7 days a week, 8am to 8pm
Fax: 1.855.633.7673

Write: CVS Caremark
Part D Services
MC 109
PO BOX 52000
Phoenix, AZ 85072-2000

If you need help requesting an exception, please call Member Services at 1.888.260.1010. TTY users should call 1.888.542.3821. We are available 7 days a week, 8am to 8pm.

Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, provider network, premium and/or copayments/coinsurance may change on January 1 of each year.

Healthfirst Medicare Plan is an HMO plan with a Medicare contract and a contract with the New York Medicaid program. Enrollment in Healthfirst Medicare Plan depends on contract renewal.

This information is available for free in other languages. Please call our Member Services number at 1.888.260.1010, TTY number 1.888.542.3821, 7 days a week, from 8am to 8pm.

Esta información está disponible en forma gratuita en otros idiomas. Por favor, comuníquese con nuestro número de Servicios a los Miembros al 1.888.260.1010, o al 1.888.867.4132 para los usuarios de TT, los 7 días de la semana, de 8:00 a.m. a 8:00 p.m.

本資訊有其他語言版本供免費索取。請致電我們的會員服務部，服務時間每週七天 **每天上午8時至下午8時**，電話號碼是1.888.260.1010， **聽力語言殘障服務專線**TTY 1.888.542.3821。

Healthfirst Medicare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-305-0408（TTY：1-888-542-3821）。