Prescription Drug Transition Policy 2024

Doctors HealthCare Plans, Inc. wants to ensure that as a new or continuing member in our Plan, you safely transition into the 2024 plan year.

The purpose of providing a transition is to promote continuity of care and avoid interruptions in drug therapy while a switch to a therapeutically equivalent drug or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons can be achieved.

General Transition Requirements

Doctors HealthCare Plans provides a Transition Fill to certain Members who present at a network pharmacy with a prescription for a drug that is not on the Doctors HealthCare Plans drug list (i.e., is "non-formulary") or is on Doctors HealthCare Plans drug list (i.e., "formulary") but has utilization management requirements, such as prior authorization (PA), quantity limits (QL), or step therapy (ST).

You may be eligible for a Transition Fill if you are:

- A New Member enrolled into a Doctors HealthCare Plans Part D plan following Open Enrollment Period, Initial Enrollment, or Annual Election Period;
- A Newly eligible Medicare beneficiary enrolled into a Doctors HealthCare Plans Part D plan;
- A Member who switched from one plan to another following the annual coordinated election period;
- A beneficiary with an effective enrollment date of either November 1 or December 1 (You are provided a 90- day transition period extending across the following contract year);
- A Current Member affected by Negative Formulary Changes across contract years;
- A Member residing in a long-term care (LTC) facility.

Transition Fills allow you to leave the pharmacy with your current therapy and have sufficient time to work with your medical provider to switch to a therapeutically appropriate formulary alternative or to request a Coverage Determination or Formulary Exception.

One-Time Transition Supply at a Retail or Mail-Order Pharmacy beginning Jan. 1, 2024, when you have limited ability to receive your current prescription therapy:

• **Doctors HealthCare Plans will cover a one-time, 30-day supply of a Part D covered drug** unless the prescription is written for less than 30 days (in which case, Doctors HealthCare Plans will allow multiple fills to provide up to a total of 30 days of medications) **during the first 90 days of your eligibility for the current plan year, or during the first 90 days of your enrollment**. If the smallest available marketed package exceeds a 30-day supply, Doctors HealthCare Plans provides a Transition Fill for the smallest available package size. Doctors HealthCare Plans will provide refills for transition prescriptions dispensed for less than the written amount due to quantity limits for safety purposes or drug utilization edits that are based on approved product labeling.

• If you leave a Doctors HealthCare Plans plan and re-enroll during the original 90-day Transition Period, the Transition Period begins again with the new effective date of enrollment.

• After you have obtained your 30-day supply ("Transition Fill"), you'll receive a letter that explains the temporary nature of the transition medication supply. After you receive the letter, talk to your doctor and decide if you should switch to an alternative drug or request an exception or prior authorization. Doctors HealthCare Plans may not pay for refills of temporary supply drugs until an exception or prior authorization has been requested and approved.

Doctors HealthCare Plans provides a Transition Fill **except** where the following edits apply to the claim:

1. Determination of Part A or Part B vs. Part D coverage;
2. Prevent coverage of a non-Part D drug (*e.g.,* excluded drugs such as a drug that may be used for sexual dysfunction, or formulary drugs dispensed for an indication that is not medically accepted such as Transmucosal Immediate Release Fentanyl (TIRF) drugs);
3. Promote safe utilization of a Part D drug (*e.g*., a maximum daily dose as recognized by FDA supported literature has been exceeded, refill too soon);
4. Member-level opioid restrictions;
5. Hospice; and
6. End-Stage Renal Disease (ESRD)

During the member's transition period, all edits (with the exception of those outlined above) associated with non-formulary drugs are automatically overridden at the point-of-sale. Pharmacies can also contact the Pharmacy Benefit Manager's (PBM) Pharmacy Help Desk directly for immediate assistance with point-of-sale overrides. The PBM can also accommodate overrides at point-of-sale for emergency fills as described below.

Transition Supply for Residents of Long-Term Care (LTC) Facilities

For LTC residents, Doctors HealthCare Plans provides a one month temporary 31-day Transition Fill to accommodate the immediate needs of the Member (unless the member presents a prescription written for less). This coverage is offered anytime during the first 90 days of your eligibility for the current plan year or during the first 90 days of your enrollment, when your current prescription therapy is filled at a LTC pharmacy.

Emergency Supplies and Level of Care Changes for Current Members

An Emergency Supply is defined as a one-time fill of a non-formulary drug that is necessary with respect to current members in the LTC setting. If your ability to receive your drug therapy is limited – but you're past the first 90 days of membership in your plan – Doctors HealthCare Plans will cover a 31-day emergency supply unless the prescription is written for less than 31 days. In that case, Doctors HealthCare Plans will allow multiple fills to provide up to a total of 31 days of a Part D-covered drug so you can continue therapy while an exception or prior authorization is requested and processed. If the smallest available marketed package exceeds a 31-day supply, Doctors HealthCare Plans provides a Transition Fill for the smallest available package size. If you are being admitted to or discharged from a LTC facility, you will be allowed to access a refill upon admission or discharge, and early refill edits will not apply.

If you are experiencing a Level of Care change, you may access a refill upon admission or discharge to a LTC facility. If you are in need of a one-time Transition Fill, or are prescribed a Non-Formulary drug as a result of a level of care change, you can be placed in transition via a National Council for Prescription Drug Plans (NCPDP) pharmacy submission clarification code (SCC) via manual override at the point of service (POS) or Doctors Health Care Plans, Inc. can also accommodate a one-time fill in these scenarios via a manual override at point- of-sale.

A level of care change may include: Entering a long-term care facility from hospitals or other settings; Leaving a long-term care facility and returning to the community; Discharge from a hospital to a home; End a skilled nursing

facility; stay covered under Medicare Part A (including pharmacy charges), and reverting to coverage under Part D; Reverting from hospice status to standard Medicare Part A and B benefits; and Discharge from a psychiatric hospital with medication regimens that are highly individualized. If you are prescribed a drug that is not on our formulary or your ability to get your drugs is limited, you may request a one-time temporary supply to allow you time to discuss alternative treatment with your doctor or to pursue a formulary exception.

For current members whose drugs will be affected by negative formulary changes in the upcoming year, Doctors Health Care Plans, Inc. will provide a transition process at the start of the new contract year. Negative changes are changes to a formulary that result in a potential reduction in benefit to members. These changes can be associated to removing the covered Part D drug from the formulary, changing its preferred or tiered cost-sharing status, or adding utilization management. The transition across contract year process is applicable to all drugs associated to mid-year and across plan-year negative changes. This allows current members to access transition supplies at the point-of-sale when their claims history from the previous calendar year contains an approved claim for the same drug that the member is attempting to fill through transition and the drug is considered a negative change from one plan year to the next. To accomplish this, the system looks for Part D claims in the member's claim history that were approved prior to January 1 of the new plan year.

After you receive your temporary supply of a Part D drug, your medication may require medical review if it:

- Is not on Doctors HealthCare Plans drug list (i.e., is "non-formulary") or
- Is on Doctors HealthCare Plans drug list (i.e., "formulary") but has utilization management requirements, such as prior authorization (PA), quantity limits (QL), or step therapy (ST).

You may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover, or request a formulary exception, so that we will cover the drug you take. If you're stabilized on a drug not on the formulary or a drug requiring prior authorization, quantity limits, or have tried other drug alternatives, your doctor can provide Doctors HealthCare Plans with a statement of your clinical history to help with the prior authorization or exception request process.

Transition Extension

Doctors HealthCare Plans makes arrangements to continue to provide necessary drugs to you via an extension of the transition period, on a case-by-case basis, to the extent that your exception request or appeal has not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request).

Cost-sharing for Drugs Provided through the Transition Policy

If you're eligible for the low-income subsidy (LIS) in 2024, your copayment or coinsurance for a temporary supply of drugs provided during your transition period won't exceed your LIS limit. For non-LIS enrollees, the copayment or coinsurance will be based on the approved drug cost-sharing tiers for your plan and is consistent with the cost-sharing tier Doctors HealthCare Plans would charge for non-formulary drugs approved under a coverage exception and the same cost sharing for formulary drugs subject to utilization management edits provided during the transition that would apply once the utilization management criteria are met.

Protected Class Drugs

Per CMS guidance, members transitioning to a plan while taking a drug within the six Protected Classes must be granted continued coverage of therapy for the duration of treatment, up to the full duration of active enrollment in the plan. Utilization management restrictions (PA and/or Step Therapy), which may apply to new members naïve to therapy, are not applied to those members transitioning to the Medicare Part D plan on agents within these key categories. The six classes include:

1) Antidepressant;
2) Antipsychotic;
3) Anticonvulsant;
4) Antineoplastic;
5) Antiretroviral; and
6) Immunosuppressant (for prophylaxis of organ transplant rejection).

Member Notification

Doctors HealthCare Plans, Inc., will send written notice via U.S. first class mail to member within three business days of the temporary transition fill. If the member completes his or her transition supply in several fills, Doctors Health Care Plans, Inc. will send notice with the first transition fill only. The notice will include (1) an explanation of the temporary nature of the transition supply a member has received;(2) instructions for working with Doctors Health Care Plans, Inc. and the member's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the plan's formulary; (3) an explanation of the member's right to request a formulary exception; and (4) a description of the procedures for requesting a formulary exception. For long-term care residents dispensed multiple supplies of a Part D drug in increments of 14-days-or-less, consistent with the requirements under 42 CFR 423.154(a)(1)(i), the written notice will be provided within 3 business days after the first temporary fill. Transition fills for drugs in the Six Protected Classes (as described above) that are subject to utilization management edits such as PA and/or Step Therapy will not generate a Transition Notice.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee involvement ensures that transition decisions appropriately address situations involving beneficiaries stabilized on drugs that are not on formulary or that are on the formulary but require utilization management requirements, such as prior authorization (PA), quantity limits (QL), or step therapy (ST).

DISCRIMINATION IS AGAINST THE LAW

Doctors HealthCare Plans, Inc. complies with applicable civil rights laws and does not discriminate or exclude individuals on the basis of race, color, national origin, age disability, sex, sexual orientation, pregnancy, gender, gender identity, or religion.

Doctors HealthCare Plans, Inc. provides: (1) free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and, (2) free language services to individuals whose primary language is not English, such as, qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your ID Card. If you believe that Doctors HealthCare Plans, Inc., has failed to provide these services or discriminated in any way, you can file a grievance with: **Doctors HealthCare Plans, Inc.,** *Attention: Member Services Department*, 2020 Ponce de Leon Blvd., PH 1, Coral Gables, FL 33134 or call (786) 460-3427 or (833) 342-7463, TTY: 711; 7 days a week; 8AM to 8PM EST.

You can file a grievance by calling, in person, by mail, or by fax. If you need help filing a grievance, our Member Services Representatives are available to help you at the number listed above. You can also file a civil rights complaint electronically through the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or call (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 833-342-7463 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 833-342-7463 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 833-342-7463 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 833-342-7463 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 833-342-7463 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 833-342-7463 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 833-342-7463 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 833-342-7463 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 833-342-7463 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 833-342-7463 (TTY: 711).Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 833-342-7463 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 833-342-7463 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 833-342-7463 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 833-342-7463 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 833-342-7463 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 833-342-7463 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、833-342-7463 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。