AETNA BETTER HEALTH OF VIRGINIA (HMO SNP)

Aetna Medicare Transition of Coverage Process for Part D Drugs

The Centers for Medicare and Medicaid Services (CMS) require Part D Plan Sponsors, like Aetna Medicare, to have a transition of coverage (TOC) process.

The following applies to members who are taking Part D drugs that are not on the plan's formulary or that are subject to utilization management requirements. These members can get a transition supply of their drug in certain circumstances. This gives them the opportunity to work with their doctor to complete a successful transition and avoid disruption in their treatment.

Aetna Medicare has established a TOC process in accordance with CMS requirements. This process has different sections. It applies to new members, as well as current members who remain enrolled in their Aetna Medicare plan from one plan year to the next.

The following summary provides the key features of Aetna Medicare's TOC process. If you have questions about the process or would like more details, please call Member Services.

Right to Transition Fill

The following applies to new members who are taking a Part D drug that is either:

- Not on the Aetna Medicare formulary
- Subject to a utilization management requirement or limitation (such as step therapy, prior authorization, or a quantity limit)

You are entitled to receive a 30-day supply of the Part D drug within the first 90 days of your enrollment. (The period of time in which you are entitled to receive the transition supply is called your "transition period.")

The following applies to existing members who renew their <Aetna> Medicare coverage and are taking a Part D drug that is either:

- Removed from the formulary
- Subject to a new utilization requirement or limitation at the beginning of the new plan year

You are entitled to receive the 30-day supply during your transition period. For existing members who renew their Aetna Medicare coverage from one year to the next, your transition period is the first 90 days of the new plan year.

The 90-day transition of coverage period is also available to members throughout the plan year if a drug is removed from the formulary.

You can get multiple fills up to the 30-day supply within your transition period if your first fill is less than a 30-day supply. This applies to both new and renewing members.
In general, we will determine your right to a 30-day fill at the pharmacy when you go to fill your prescription. However, in some situations, we will need to get additional information before we can determine if you are entitled to a transition 30-day fill.

If you are a resident of a long-term care facility, you can receive a maximum single fill 31-day supply of a Part D drug during your transition period.

A copay is charged for each transition fill up to a 30-day supply through retail, mail-order, and specialty pharmacies.

You may also be eligible to receive a transition fill outside of your 90-day transition period. For example, you may be eligible to receive a temporary supply of a drug if you experience a change in your "level of care." (an instance of this would be if you returned home from a stay in the hospital with a prescription for a drug that isn't on the formulary).

There are other situations where you may be entitled to receive a temporary supply of a prescription drug. If you have questions about whether you are entitled to a temporary supply of a drug in a particular situation, please call Member Services.

After you get your refill
After you get a transition fill, you will receive a letter from Aetna Medicare telling you what to do next. These are the steps you should follow to ensure you are able to continue to get coverage for the prescription drug(s) you need:

If your drug is not on the formulary
If your drug is not on the formulary, you should either:

- Speak to your doctor about whether you should change the drug you are currently taking
- Request an exception before the transition supply ends.

Your doctor can help you determine if there's a different drug on the formulary that would be equally effective for your condition. Or, your doctor may believe it's medically necessary for you to continue taking your current medication. In that case, you will need to ask us for an exception to receive coverage for the drug.

You can make the request for a formulary exception or your doctor can make the request on your behalf. However, it may be easier to have your doctor submit the request for you. We will need the doctor to give us a written statement with the medical reasons for the formulary exception you are requesting. (We call this the "doctor's statement.") Your doctor can fax or mail the statement to us. Or your doctor can call us and follow up by faxing or mailing the signed statement.

To start the formulary exception process, you, your authorized representative, or your doctor must call, fax or write to our Precertification Unit.

If your drug is subject to a utilization management requirement
Your doctor can help you if your prescription drug is subject to quantity limits, step therapy or prior authorization. These special requirements are developed by a team of doctors and pharmacists to help our members use drugs safely and in a cost effective manner.

Prior authorization refers to a requirement that applies to certain medications. It means you or your doctor has to provide us information regarding the reason your doctor prescribed the drug. This lets us confirm that it's medically necessary. Your doctor can help you by providing clinical information needed for the prior authorization process.

You might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. This is called "step therapy." Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. This is called a "quantity limit."

If you and your doctor believe these restrictions should not apply, you or your doctor can request an exception. It may be easier for your doctor to contact our Precertification Unit and request prior authorization or removal of a restriction. You or your doctor can get in touch with us using the contact information below.

How to contact our Precertification Unit
You can contact our Precertification Unit as follows:

By Mail: Aetna Better Health of Virginia (HMO SNP)
Part D Coverage Determination
Pharmacy Department
4500 E. Cotton Center BLVD.
Phoenix, AZ 85040

By Fax: **1-844-807-8451**

By Telephone**: 1-855-463-0933**

Once we receive the physician's statement, we must notify you of our decision no later than:

- 24 hours for an expedited request
- 72 hours for a standard request

Your request will be expedited if we determine, or your doctor informs us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

What if your request is denied?
If your request is denied, you have the right to appeal. You can ask for a review of our decision. You must request this appeal within 60 calendar days from the date of our decision. If you want to file an expedited appeal, you can call or write us. If you want to file a standard appeal, you must write us.

For an Expedited Appeal, phone or fax:
Phone: **1-855-463-0933 Fax: 1-866-631-2135**

For a Standard Appeal, write or fax:
Aetna Better Health of Virginia (HMO SNP)
Attn: Appeals and Grievance Manager
7400 West Campus Road
New Albany, OH 43054

Fax: **1-866-631-2135**

Telephone: **1-855-463-0933**

If you need help requesting an exception, or would like more information about our transition policy (including alternate format or languages), please call Member Services.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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