

Radiant Services, LLC. ("Radiant")

Policy Type	Utilization Review/Management Processes	
Title	PBM-02 Formulary Exceptions and Continuity of Care Policy	
Effective Date	March 31, 2026	
Last Review Date	March 31, 2026	
Last Approval Date	March 31, 2026	
Approval Authority	<i>Accenture Legal</i>	

APPLICABILITY		
Line of Business	Funding Type	
<input checked="" type="checkbox"/> Commercial	<input checked="" type="checkbox"/> Fully Insured	<input checked="" type="checkbox"/> Contract Issuance
<input type="checkbox"/> Medicaid	<input checked="" type="checkbox"/> Self-funded (ERISA)	<input type="checkbox"/> Patient State
<input type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Self-funded (non-ERISA)	<input checked="" type="checkbox"/> Resident State

***To date, Radiant’s clients have not contracted with Radiant to conduct the peer review process or to render denial decisions of any kind (whether partial or complete, including upholding previously rendered partial or complete denials on appeal). Radiant renders only utilization review approval decisions. Radiant only renders utilization review approval decisions. If review of an appeal of an adverse benefit determination cannot be overturned based on medical necessity, the appeal is forwarded to the client’s Medical Director/Peer Reviewer for a determination.**

When performing utilization review or providing pharmacy benefit manager (“PBM”) services on behalf of a payer, Radiant will conduct utilization review and appeals services in accordance with the requirements of its payor clients and will comply with the most stringent requirements of its policies and procedures and payers’ policies and procedures.

POLICY	STATE SPECIFIC REQUIREMENTS
Purpose	<p>The purpose of this Policy is to establish procedures through which an enrollee, the enrollee’s authorized representative, or the enrollee’s prescribing provider may request coverage of a clinically appropriate prescription drug that is not included on the applicable client formulary or that is otherwise subject to coverage restrictions.</p> <p>This Policy also establishes procedures governing continuity of care and transition fills for enrollees beginning coverage under pharmacy benefit plans administered by Radiant.</p> <p>This Policy is intended to ensure compliance with applicable federal and state laws governing prescription drug benefit administration, including 45 C.F.R. §156.122(c) and applicable drug utilization review requirements.</p>

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Authority	<p>This Policy is adopted pursuant to applicable federal and state law governing prescription drug benefit administration, including:</p> <ul style="list-style-type: none"> • 45 C.F.R. §156.122(c) requiring health plans to maintain a process allowing enrollees to request access to clinically appropriate drugs not otherwise covered by the formulary; and • Applicable state drug utilization review statutes requiring managed care plans utilizing a drug formulary to maintain procedures for coverage of non-formulary drugs.
Scope	<p>This Policy applies to:</p> <ul style="list-style-type: none"> • Prescription drug benefit plans administered by Radiant that utilize a drug formulary; • Enrollees covered under such plans; • Prescribing providers authorized to prescribe prescription drugs; and • Radiant personnel responsible for utilization management, clinical review, and coverage determinations.
Definitions	<p>See Policy URA-01 Definitions. Additional definitions:</p> <p>Exception Request – A request for coverage of a prescription drug that is not included on the applicable formulary or is otherwise restricted under the benefit plan.</p> <p>Standard Exception Request – An exception request that does not involve exigent circumstances.</p> <p>Expedited Exception Request – An exception request requiring expedited review due to exigent circumstances.</p> <p>Exigent Circumstances – Circumstances in which an enrollee is suffering from a health condition that may seriously jeopardize the enrollee’s life, health, or ability to regain maximum function, or when the enrollee is undergoing a course of treatment using a non-formulary drug. [45 C.F.R. § 156.122(c)(2)(ii)]</p> <p>Transition Fill – A temporary supply of a non-formulary drug provided to maintain continuity of care while an enrollee and prescribing provider evaluate treatment alternatives or submit an exception request.</p> <p>Independent Review Organization (IRO) – An independent organization authorized to conduct external review of adverse benefit determinations.</p> <p>Specialty Drugs – Drugs designated by client health plans as specialty drugs due to clinical complexity, cost, or specific storage, dispensing, or administration requirements.</p> <p>45 C.F.R. § 156.122</p>
Delegated Clinical and Administrative Functions	<p>Radiant performs limited pharmacy benefit administration services on behalf of client health plans and plan sponsors which consists primarily of:</p> <ul style="list-style-type: none"> • Appeals of prior authorization determinations • Clinical exception reviews • Prior authorization review (if subsequently contracted to perform) <p>For the benefit plans administered under this Policy:</p> <ul style="list-style-type: none"> • Radiant does not establish prescription drug pricing, maximum allowable cost lists, or pharmacy reimbursement methodologies. • Radiant does not contract directly with pharmacies or establish pharmacy networks.

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	<ul style="list-style-type: none"> • Radiant does not adjudicate pharmacy claims or determine pharmacy reimbursement. • Radiant does not establish formularies. <p>All other pharmacy benefit functions may be performed by the applicable health plan or other delegated entities.</p> <p>Delegated functions and responsible entities shall be documented and maintained consistent with applicable regulatory requirements.</p>
Client Formulary Administration	<p>Radiant administers prescription drug benefits on behalf of client health plans, plan sponsors, and plan administrators.</p> <p>Radiant does not independently establish prescription drug formularies or clinical coverage policies. Instead:</p> <ul style="list-style-type: none"> • Formularies, coverage criteria, and utilization management requirements are established by the applicable client health plan or plan sponsor. • Radiant administers and implements those client-established formularies and clinical policies. • Exception determinations are conducted consistent with the applicable client clinical policies, benefit plan requirements, and applicable law. <p>Nothing in this Policy authorizes Radiant to independently modify or replace a client plan’s formulary.</p>
Policy	<p>I. Submission of Exception Requests Exception requests may be submitted by:</p> <ul style="list-style-type: none"> • the enrollee; • the enrollee’s authorized representative; or • the prescribing provider. <p>Requests may be submitted through one or more of the following methods:</p> <ul style="list-style-type: none"> • electronic prior authorization systems; • telephone; • fax; or • other Radiant-approved submission mechanisms. <p>Radiant may require supporting clinical documentation necessary to evaluate medical necessity and clinical appropriateness.</p> <hr/> <p>II. Standard Exception Review Upon receipt of a standard exception request, Radiant shall conduct a clinical review of the request.</p> <p>A coverage determination shall be issued within seventy-two (72) hours of receipt of the request. [45 C.F.R. § 156.122(c)(1)(ii)]</p> <p>Radiant shall notify:</p> <ul style="list-style-type: none"> • the enrollee (or authorized representative), and • the prescribing provider

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of the coverage determination.

Approval of Standard Exception

If a standard exception request is approved, coverage shall be provided for the non-formulary drug for the duration of the prescription, including authorized refills, or for such longer time as otherwise required by the benefit plan, client policies and procedures, or applicable laws and regulations. [45 C.F.R. § 156.122(c)(1)(iii)]

III. Expedited Exception Review

An expedited exception review may be requested when exigent circumstances exist.

Upon receipt of an expedited request, Radiant shall issue a coverage determination within **twenty-four (24) hours**. [45 C.F.R. § 156.122(c)(2)(ii)]

If approved, coverage shall be provided for the duration of the exigency requiring the drug therapy, or for such longer time as otherwise required by the benefit plan, client policies and procedures, or applicable laws and regulations. [45 C.F.R. § 156.122(c)(2)(iv)]

IV. External Review

If an exception request is denied following completion of the plan’s required internal appeal process, the enrollee, the enrollee’s authorized representative, or the prescribing provider may request external review by an Independent Review Organization (IRO), where required by applicable federal or state law. 45 C.F.R. § 156.122(c)(3)(i)]

The availability of external review is determined in accordance with the plan’s internal appeal structure and applicable regulatory requirements. External review procedures are governed by the plan’s Appeals and External Review Policy and applicable federal and state law.

If the external review overturns the denial, coverage shall be provided consistent with the applicable regulatory requirements.

Exhaustion of Internal Review

External review rights become available once the enrollee has exhausted the plan’s required internal appeal process, unless applicable law permits earlier access to external review. If the plan offers an additional voluntary internal appeal, the enrollee is not required to complete the voluntary appeal before requesting external review.

Expedited External Review

If an exception request involves exigent circumstances and an expedited internal appeal has been completed or waived under applicable law, the enrollee may request expedited external review in accordance with applicable federal or state requirements.

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External Review Timeframes

External review determinations of an exception request shall be issued:

- within **72 hours** for standard reviews; or
- within **24 hours** for expedited reviews.

[45 C.F.R. § 156.122(c)(3)(ii)]

Coverage Requirements

If the plan grants an external review of a standard exception request, the plan must provide coverage of the non-formulary drug for the duration of the prescription. If the plan grants an external exception review of an expedited exception request, the plan must provide coverage of the non-formulary drug for the duration of the exigency. [45 C.F.R. § 156.122(c)(3)(iii)]

V. Continuity of Care / Transition Fills

To support continuity of care for enrollees beginning coverage under a plan administered by Radiant, transition fill procedures may be implemented consistent with the client benefit design.

Transition Fills for New Enrollees

If an enrollee is currently receiving treatment with a prescription drug that is not included on the applicable formulary, Radiant may provide a temporary transition fill to allow time for the enrollee and prescribing provider to:

- transition to a formulary alternative; or
- submit an exception request.

Transition Supply

Unless otherwise required by applicable law or client policy, transition fills may include a temporary supply of the medication sufficient to allow appropriate clinical review.

Communication

Radiant shall notify the enrollee and prescribing provider regarding:

- the temporary nature of the transition fill; and
- the availability of the formulary exception process.

VI. Notification Requirements

All exception determinations shall include notification to the enrollee and prescribing provider.

Notification shall include:

- the coverage determination;
- the clinical rationale supporting the decision;
- information regarding the right to request external review; and
- instructions for submitting additional review requests.

Notifications may be delivered via written communication, secure electronic systems, or other approved methods, consistent with requirements of federal and state laws.

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	<p>VII. Integration With Clinical Governance This Policy operates as part of Radiant’s broader clinical governance framework and works in coordination with:</p> <ul style="list-style-type: none"> • Radiant’s Appeals and External Review procedures. <p>Exception request trends and utilization data may be reviewed as part of ongoing quality improvement and clinical oversight processes.</p> <hr/> <p>VIII. Electronic Prior Authorization Standards Radiant performs PBM services by accessing client systems in which the client receives prescription drug prior authorization requests onto its system. To the extent that Radiant is engaged to directly receive prior authorization requests, it shall support electronic prior authorization processes that comply with the most recent National Council for Prescription Drug Programs (NCPDP) SCRIPT standards for electronic prior authorization transactions adopted by the U.S. Department of Health and Human Services. Electronic prior authorization requests may be submitted and transmitted through approved electronic prescribing systems consistent with applicable federal and state requirements.</p> <hr/> <p>IX. Retail Pharmacy Access Radiant administers exception and utilization management processes in a manner that supports enrollee access to covered prescription drugs through in-network retail pharmacies when appropriate, unless:</p> <ul style="list-style-type: none"> • the drug requires special handling, • the drug is subject to limited distribution requirements, or • another clinically appropriate reason prevents dispensing through a retail pharmacy. <p>Pharmacy network design and access requirements are determined by the applicable client health plan.</p> <hr/> <p>X. Confidentiality Radiant shall implement measures designed to ensure confidentiality of the relationship between the enrollee and the prescribing provider and protect enrollee health information in accordance with applicable privacy and security requirements.</p> <hr/> <p>XI. Recordkeeping Radiant shall maintain documentation sufficient to demonstrate compliance with this Policy, including:</p> <ul style="list-style-type: none"> • exception request submissions, • coverage determinations, • clinical review documentation, and • external review outcomes.
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Records shall be maintained in accordance with applicable regulatory and contractual requirements.

XII. Formulary Change Notification and Transition Procedures

Because formularies are established by client health plans or plan sponsors, formulary modifications are determined by the applicable client. Radiant shall implement client-directed formulary changes consistent with applicable law and benefit plan requirements.

Notification of Formulary Changes

When required by law or client policy, Radiant shall support client plan sponsors in providing notice regarding formulary changes affecting drug coverage. Such notices may address:

- removal of drugs from the formulary,
- tier changes,
- new utilization management requirements, or
- availability of alternative therapies.

Continuity of Care

When formulary changes affect enrollees currently receiving treatment, transition procedures may be implemented to allow time for:

- therapy transition; or
- submission of a formulary exception request.

XIII. Specialty Drug Exception Procedures

Certain drugs may be designated as specialty drugs by client health plans due to clinical complexity, cost, or distribution requirements.

Radiant administers specialty drug policies in accordance with client clinical policies.

Applicability of Exceptions Process

The exception process described in this Policy applies to specialty drugs not covered under the applicable formulary or subject to utilization management restrictions.

Clinical Documentation

Exception requests involving specialty drugs may require additional clinical documentation, including treatment history, diagnosis, disease severity, laboratory results, or other relevant clinical information.

Expedited Review for Ongoing Therapy

If interruption of therapy may jeopardize the enrollee’s health, the prescribing provider may request expedited review consistent with this Policy.

XIV. Provider Non-Interference

Radiant administers prescription drug benefits on behalf of client health plans and plan sponsors and does not interfere with the independent clinical judgment of prescribing providers.

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Prescribing Authority

Nothing in this Policy restricts or interferes with a licensed provider’s authority to determine appropriate drug therapy for a patient within the provider’s legally authorized scope of practice. Prescribing providers remain responsible for determining the medical appropriateness of prescription drug therapy for their patients.

Coverage Determinations

Coverage determinations made by Radiant are administrative determinations regarding whether a prescription drug is covered under the applicable client benefit plan and do not constitute medical advice or medical practice.

Coverage determinations are based on:

- the clinical policies and formularies established by the applicable client health plan or plan sponsor;
- the terms of the applicable benefit plan; and
- applicable federal and state laws governing prescription drug benefit administration.

Clinical Review Standards

Clinical reviews conducted in connection with exception requests shall be performed by appropriately qualified health care professionals and shall be based on generally accepted standards of medical practice and available clinical evidence.

Clinical reviewers shall evaluate exception requests objectively and without regard to financial considerations unrelated to the enrollee’s clinical needs.

Generic Substitution

When a prescribing provider determines that generic substitution of a drug is medically inappropriate and indicates “Do Not Substitute,” substitution shall not occur without the provider’s approval, consistent with applicable law.

Financial Incentives

Radiant shall not implement compensation or incentive structures that encourage Radiant personnel to make exception determinations that conflict with applicable clinical standards or regulatory requirements. Any utilization management activities performed by Radiant shall be administered in accordance with applicable laws and the clinical policies established by the client health plan.

XV. Regulatory Cooperation

Radiant shall cooperate with applicable regulatory authorities and provide information reasonably requested in connection with oversight of pharmacy benefit administration activities.

Where requested by a regulatory authority, Radiant shall provide information necessary to review pharmacy benefit administration activities consistent with applicable law.

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	<p>XVI. Policy Review This Policy shall be reviewed periodically and updated as necessary to ensure continued compliance with applicable federal and state laws governing pharmacy benefit administration.</p>
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Resources & References
45 C.F.R. § 156.122(c)

Policy History		
TYPE OF REVIEW	DATE	CHANGES
Initial Draft	3/31/2026	Initial draft created by outside counsel.
QA Review	3/31/2026	QA review completed – Added citations.
Additional Review	04/02/2026	Removed “Company Confidential – For Internal Use Only.” and added “Copyright Radiant Services, LLC, 2026. All rights reserved.” to the footer.

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