# PeopleSafe - Value Formulary Utilization Management Step Therapy, Prior Authorization, Quantity Limits, Exceptions, and Appeals for Customer Care

[Prior Authorization / Exception Requests](#_Toc134530275)

[When to Contact the Senior Team](#_Toc134530276)

[Identifying Value Formulary Targeted Drugs and Providing Alternatives or Explaining Clinical Requirements](#_Toc134530277)

[Reject Messages](#_Toc134530278)

[Related Documents](#_Toc134530279)

**Description:** Information about Prior Authorizations, exceptions, quantity limits, and appeals under Value Formulary (VF).

|  |
| --- |
| Prior Authorization / Exception Requests |

** Note:** Some clients will have a non-formulary exceptions process for medications that get a “NDC Not Covered” reject in the rejections message. You can determine this when performing a test claim for the medication. The rejection message indicates a 1-800-type phone number to call for a non-formulary exception. However, if the Test Claim for a non-formulary medication does NOT indicate a phone number to call for an exception, and the reject is for “NDC Not Covered,” advise the Prior Authorization process or appeals process (if a PA has already been denied) for the plan; but with ANY reject 70, follow PA process first. Refer to the [Prior Authorization, Exceptions, Appeals Guide (063978)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=657ddfe3-27d1-4a21-8f51-8cbd3961001c) for further information and links to specific process documents.

Value Formulary Clinical PA and Exceptions requests will be handled by a designated team within the Prior Authorization and Exceptions departments. When either group receives a fax or call from a physician regarding a targeted VF drug, the teams assess if the targeted drug is medically necessary. Basic requirements for medical necessity include (but are not limited to):

* Documented contraindication or potential drug interaction with the available alternatives.
* Intolerance or confirmed adverse event with the available alternatives.
* Inadequate treatment response with 2-3 available alternatives.

|  |  |
| --- | --- |
| **If the physician…** | **Then…** |
| Calls our PA team and agrees to prescribe an alternative and the plan member utilizes home delivery | The PA Team can offer to connect the physician with FastStart to obtain a new prescription. |
| Prefers that the plan member use the targeted drug | The PA team will begin the Clinical Prior Authorization process. |

|  |  |
| --- | --- |
| **If contacting the…** | **Then…** |
| **VF PA Team** | The designated toll-free phone number for the VF PA Team is **1-877-203-1681**.  **Note:** Do not transfer to the regular PA Team.   * If you receive a call from a physician requesting approval for a targeted VF drug, warm transfer the physician to this number. |
| **VF Exceptions Team** | The designated toll-free **fax** number for the VF Exceptions Team is **1-888-487-9257**.  **Note:** This number only applies to physicians who complete Tiering Exceptions Requests for non-formulary medications, that is, medicines that pay to a high copay/coinsurance.   * If you receive a call from a physician requesting approval for a VF drug on this high copay/coinsurance, direct the physician to the VF Homepage at: <Http://info.caremark.com/highvalueplan>. * Do not transfer the call to the VF PA Team or to the regular PA Team, as this process must be completed by fax only. |

|  |  |
| --- | --- |
| **If the Prior Authorization is...** | **Then...** |
| **Approved**  or formulary exception, for non-formulary brands on Value Formulary standard and Narrow plans | Plan member will be able to obtain the targeted drug at the plan designated copay.   * The approval will be on file for 1-3 years, depending on the standard duration period for the drug. * After this period has elapsed, the member will need to attempt to meet the clinical requirements, or have the physician initiate a renewal request for the prior authorization. |
| **Denied** | Plan member has three options:   * Try one of the listed alternatives. * Purchase the targeted drug at 100% of the cost. * Initiate the [Appeals (007339)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cd7126d2-19b7-4743-913c-8e9dd7329c08) process if allowed by the client’s plan design. |

|  |  |
| --- | --- |
| **If Tiering Exception(s)…** | **Then…** |
| **Approved** | If the Tiering Exception for Value FormularyTiered plans is approved, the plan member will be able to obtain the targeted drug at the plan’s preferred brand copay/coinsurance.  **Note:** If the plan member’s deductible has not been met, the tiering exception WILL NOT lower the cost of the drug.   * The approval will be on file for 1-3 years, depending on the standard duration period for the drug. * After this period has elapsed, the member will need to attempt to meet the clinical requirements, or have the physician initiate a renewal request for the exception. |
| **Tiering Exceptions Reimbursement (following Exception Approval)** | Members may request reimbursement for paying the Tier 3 coinsurance for the brand for which they have recently received a Tiering Exception. Perform the following steps to ensure the validity of this request:   * Access the member’s **PeopleSafe Main Screen**, click **Plan Benefit Override**. * Identify any “OD – Override all except DUR” overrides and click **View PA Status**. * Check the Status and Resolution columns to confirm an approval of a Tiering Exception. * Confirm the start date of the override for the Tiering Exception to ensure that the claim for which reimbursement is requested falls within those dates.   + Overrides are typically back-dated 1 month, and if a claim falls outside of that time frame the claim should not be reimbursed (or the client should be consulted under special circumstances). |

**Note:** If PA has been approved, unlike Medicare D, tiering exception process is still available if allowed by client.

Once you have confirmed that the Tiering Exception applies to the member’s prescription, complete as appropriate:

|  |  |
| --- | --- |
| **If it is a...** | **Then...** |
| Retail claim | Call the dispensing retail pharmacy and ask them to reprocess the claim. This should be for claims that have occurred within 2 weeks of your current activity.   * If the pharmacy can’t reprocess the claim, inquire if the pharmacy can contact their third-party billing company.   + If the pharmacy refuses or does not have a way to contact them, contact the Senior team. |
| Mail order claim and the claim is less than 90 days old, or 120 days old in New York | Submit a Reverse and Reprocess [(Copay – Mail Order Reverse and Reprocess Claim) (021894)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5d4876c1-e43f-41d8-ba45-0e4a72aee882) task. |
| Mail order claim and it is more than 90 days old, or 120 days old in **New York** | Warm Transfer to the Senior team. |

**Tiering Exception Denied:**

If the exception is not approved, the plan member has three options:

* Try one of the listed alternatives.
* Purchase the targeted drug at 100% of the cost.
* Initiate the Appeals process if allowed by the client’s plan design.

**Appeals Requests:**

All VF clients should be set up for the standard PBM appeals process. Refer to the [Appeals (007339)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cd7126d2-19b7-4743-913c-8e9dd7329c08) work instruction to assist members in understanding the process for the filing of claims and the process for Appeals.

[Top of the Document](#_top)

|  |
| --- |
| When to Contact the Senior Team |

Contact the Senior Team in the following situations:

* The tiering exception is approved and pharmacy refuses to reverse and reprocess the claim.
* The Tiering exception is approved and the pharmacy refuses to contact their Third-Party Billing Company.
* The claim is a Mail order claim and it is more than 90 days old; or more than 120 days old in **New York**.
* Member escalation.

If none of the above situations apply and you still cannot resolve the situation, refer to [When to Transfer Calls to the Senior Team (016311)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=9eef064d-c7d7-42f7-9026-1497496b4d51).

[Top of the Document](#_top)

|  |
| --- |
| Identifying Value Formulary Targeted Drugs and Providing Alternatives or Explaining Clinical Requirements |

Perform the steps below:

|  |  |
| --- | --- |
| **Step** | **Action** |
| **1** | Refer to [Value Formulary Medicines with Clinical Requirements](https://www.caremark.com/portal/asset/Value_Formulary_MCR.pdf). |
| **2** | Read the introductory paragraphs to ensure that the document is appropriate to the member’s question. |
| **3** | Press **Ctrl + F** to open the “Find” box then type in the name of the targeted drug and press **Enter**.  **Result:** The box that lists the drug name is selected. |
| **4** | Provide the information that directly ties to the drug in question.  **Note:** If there are numerous drug names, ask the member if they have a pen and paper to write them down.   * **PA**: Primary Clinical Requirements to Consider column. * **ST**, **PA**: Plan Medicines to Consider First column. * **QL**: Limit for 30-Day Prescriptions column **or** Limit for 90-Day Prescriptions column depending on whether member fills a 30-day **or** 90-day prescription. * **QL**, **PA**: Limit for 30-Day Prescriptions column **or** Limit for 90-Day Prescriptions column, depending on whether member fills a 30-day **or** 90-day prescription. |
| **5** | Advise the member to consult with their physician on these clinical requirements. The physician may need to:   * Change the member’s script to a plan medicine without clinical requirements (in the case of a drug that requires step therapy). * Request a prior authorization (for a drug with step therapy, or for a drug that requires a specific diagnosis, or for a drug that is restricted by quantity limits but is eligible for higher quantities). |
| **6** | After consulting with the member on these options, if the member still strongly prefers to use a medication that has prior authorization, step therapy with post-step prior authorization, or quantity limits with post-limit prior authorization:   * Advise the plan member to have their physician contact our Prior Authorization Team at **1-877-203-1681** to initiate a PA request or start a [Prior Authorization, Exception, Appeal (063978)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=657ddfe3-27d1-4a21-8f51-8cbd3961001c). * Inform the member that if an exception is granted for the medication, it may then be covered under their benefit plan. If not, they may be responsible for up to the full cost of the medication if they continue to use it. * Advise the member they can see the status of the PA (approved or denied) on Caremark.com. Single Sign on clients may not have this ability to view the status. |

[Top of the Document](#_top)

|  |
| --- |
| Reject Messages |

Specialty:

|  |  |
| --- | --- |
| **If it is a** **Specialty Product Managed by closed formularies (Value Formulary, Exchange, and select Managed Medicaid Templates) have rejected for...** | **Then the new Message will include...** |
| Prior Authorization (PA) required | * If Specialty NDC is **formulary**, reject for R75 – Prior Authorization Required, with additional message “PA required, please call **1-866-814-5506**”. * If Specialty NDC is **non-formulary**, reject for R70 – NDC Not covered, with message “Non-Formulary Specialty (SGM) Product”. Additionally, “non-formulary drug, contact prescriber” will also be displayed as part of standard messaging.   **Turnaround Time (TAT):** Standard TAT for Prior Authorizations and Tiering Exceptions done by fax is up to 3 business days, as well for Prior Authorizations and Tiering Exceptions done by phone. However, Prior Authorizations and Tiering Exceptions done by phone have the potential TAT of 1 business day for resolution as information for the PA/Tiering Exception is being reviewed in real time; often, in that case, a determination on coverage can be made immediately.  **Note:**  The processing time is dependent on physicans responsiveness and on the information provided. |

[Top of the Document](#_top)

|  |
| --- |
| Related Documents |

[HIPAA (Health Insurance Portability and Accountability Act) - Disclosure Reporting and Complaints (027852)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=555c2e42-bed9-4648-91b9-19dc103b0ff1)

[Customer Care Abbreviations, Definitions, and Terms Index (017428)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c1f1028b-e42c-4b4f-a4cf-cc0b42c91606)

**Parent Document:** [CALL 0049 Customer Care Internal and External Call Handling](https://policy.corp.cvscaremark.com/pnp/faces/DocRenderer?documentId=CALL-0049)

[Top of the Document](#_top)

Not To Be Reproduced or Disclosed to Others Without Prior Written Approval

**ELECTRONIC DATA = OFFICIAL VERSION – PAPER COPY – INFORMATIONAL ONLY**