# Prior Authorization Questions and Answers

[Possible In Process Q&A](#_Toc193465210)

[Possible Denied Q&A](#_Toc193465211)

[ePA Q&A](#_Toc193465212)

**Description:** Provides possible questions and answers for handling various scenarios related to PA processes, including submission, status updates, denials, and appeals.

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| Possible In Process Q&A |

Refer to the table below:

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| **#** | **Question** | **Answer** | |
| **1** | When did my doctor submit the prior authorization? | One moment while I contact the Prior Authorization department to obtain that information for you. | |
| **2** | How long will it take to get an answer for the PA? | The turnaround time can vary, depending on the information provided and the responsiveness of your physician. It will also depend on how the prior authorization was submitted. The standard turnaround time is three business days. (This is under the assumption that the information will be readily available for CCRs to see.)  Explain to the member that the turnaround time for the process is about three (3) business days from the time that the prescriber responds. They can review caremark.com for the status of the prior authorization. If they need help finding the status on the website, refer to [Caremark.com – Prior Authorization (070305)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=20ba7691-5b2a-4780-9c3a-f671151ab55c). | |
| **3** | I am on Caremark.com and my Prior Authorization has been showing "pending or in process" for multiple days. What can I do next to help expedite this process? | I can review the status and look at the forms submitted by your doctor's office .  Click the **view documents** hyperlink next to the corresponding PA submission. After reviewing the status and viewing the documents, if not enough information is provided to make a determination, call PA dept, and relay information to member.  Refer to the following scenarios: | |
| **If…** | **Then…** |
| We received all the necessary information to process the request | It can take up to three business days for your request to be processed. |
| We haven’t received all the necessary information to complete the request | We do send another request to your physician when we need additional information. Would you like me to reach out to your physician office or I can provide you with the phone number for them to call?   * If member would like you to contact the physician’s office, you can inform them we are missing information to process the member’s prior authorization request. * If member would like the phone number and Caremark handles provide the Caremark PA dept phone number 1-800-294-5979. If Caremark does not handle refer to the CIF. |
| **4** | How will I know if it has been approved? | Members will be able to see the following Prior Authorization statuses on Caremark.com:   * Initiated * Pending * Response Needed * Under Review * Not Completed * Approved * Denied * Appeal Pending * Expiration   A letter will be sent to you with additional information about your Prior Authorization. Your prescriber will also receive a fax, letting them know the status.  Inform the caller they can set up [CMP Alerts (054195)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=16d97031-aab3-4e30-b5d8-69ba322678d6) or, to assist the member with finding the status on Caremark.com, refer to [Caremark.com – Prior Authorization (070305)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=20ba7691-5b2a-4780-9c3a-f671151ab55c).  For more information on the PA Statuses in Compass, refer to [Compass – Viewing and Advising on Prior Authorization (PA) or Clinical Exception Status (056368)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=6d3aac37-46a9-4417-ac20-fa3a32337652). | |
| **5** | When my PA request was submitted, did my doctor mark it as urgent? | After clicking the View Document hyperlink for the appropriate prior authorization or appeal, you can inform the member if their request was sent as an urgent request or standard request. If view documents does not provide information, call PA dept and relay information to member. | |
| **6** | The doctor’s office says they are unable to initiate the PA request. | Determine why the doctor’s office cannot initiate the PA request.  Offer to [send an ePA request (055814)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=18bb86b7-af5b-4f25-af23-9c635e8a0aa4) on behalf of the member.  If the physician does not participate in ePA or the physician only uses fax, send the contact provider for PA task. Refer to [Compass - Support Task Types and Uses List (058147)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=6753488f-3996-45d9-88ba-257575369a98). Add the provider name, phone, and fax number in the notes of the Support Task for the PA dept.  The task MUST include the prescriber fax.  If the member would like to contact the physician on their own, you may provide them the phone number and fax number for the PA dept, only if requested by the member; do not proactively offer this option. | |
| **7** | My PA has been approved. Why has my order not shipped? | Great news! I do see your PA is approved. I will be happy to place your order today.   * If the mail order is in process being held for PA required, refer to [Compass - Manage Diverts / Conflicts (Release Order) (056291)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=d4ef5860-ef38-4ae9-afd8-a4cb0d1f12e6). * If the order has not been started place a [refill order (054262)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ad3a7263-725b-4d5d-a2ec-440f1f30d79c). * If we do not have a prescription on file, initiate a [new prescription request (054208)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a7684ce9-c2bc-4cbc-ab37-c1ffb7789706). | |
| **8** | Can a PA be transferred from one Caremark plan to another Caremark plan? | Refer to [Compass – Viewing and Advising on Prior Authorization (PA) or Clinical Exception Status (056368)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=6d3aac37-46a9-4417-ac20-fa3a32337652" \t "_blank) for information on transferring prior authorizations. | |

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| Possible Denied Q&A |

Refer to the table below:

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| **#** | **Question** | **Answer** |
| **1** | Why was my PA denied? | Review the denied PA in question and relay the denial reason to the member. Educate member on their next steps, based on the denial reason. |
| **2** | What if the Prior Authorization is denied? | If your Prior Authorization is denied for insufficient information, you may have your physician submit a new PA. If your PA was denied due to clinical reasons, you may follow the appeal process outlined within the denial letter, you may pay out of pocket for the medication, or you may contact your prescriber to discuss alternative medications covered under your plan. If you’d like, I’ll be happy to search for potentially cost-saving alternatives that do not require a Prior Authorization. |
| **3** | Someone I know has the same insurance, and the medication is covered for them, why is it not covered for me? | Prior authorizations are decided on a case-by-case basis. Approval or denial depends on the specific clinical criteria and documentation submitted by your prescriber. |
| **4** | Why is my PA being denied for step therapy when I have already taken the required alternatives? | When a prior authorization request is submitted, the approval or denial is based solely on the information provided at the time of submission. Your medication history is only considered if it is included with the required criteria form that we receive back from your physician. The fact that a medication was previously filled under your prescription benefits does not factor it into the decision-making process. |
| **5** | Why is my PA being denied for “dosage/quantity limit”. What does that mean? | Your insurance plan has guidelines on the maximum dosage or quantity of medication they will cover for a given condition within a certain time period. The prescribed dosage and/or quantity exceeds those limits. |
| **6** | Why does my denial say, “lack of medical necessity/ lack of Medical Information”? | Your insurance company requires specific clinical information to support the medical necessity of <medication name> for your condition. The information submitted by your doctor may have been incomplete or did not adequately demonstrate why this specific medication is the most appropriate treatment for you. Your physician has been notified and informed, but we have not yet received a response back. |
| **7** | Can I obtain another copy of my Prior Authorization denial letter? | Yes. One moment while I contact the Prior Authorization department to request that.    **CCR:**  Before contacting the Prior Authorization department, confirm the denied medication and the member’s mailing address to send the letter. Inform member to allow the normal 7 to 10 business days to receive the letter. |
| **8** | What are the hours of operation of the Prior Authorization department? | The hours are Monday through Friday, 8:00am to 6:00pm CST. |
| **9** | My doctor prescribed [NEW Medication], it was recently approved by the FDA, but the prior authorization was denied, why? | Insurance companies often take time to review new medications and determine their place on the formulary; it may not yet be covered by your plan.  Refer to [Advanced Control Non-Specialty and Specialty Formulary Changes with Questions and Answers (116970)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=18030a9d-2aa8-404a-8b68-007dbbcc33e1). |
| **10** | I’ve been taking [medication name] for a long time, it was previously covered. Now, the prior authorization is denied, why? | Your insurance plan may have recently updated its formulary, and <medication name> may no longer by covered. Sometimes, medications are removed from the formulary or moved to non-preferred tier due to cost, new generic availability, or changes in clinical guidelines. |
| **11** | I went to pick up my medication at a local pharmacy and received a denial. It says, “prior authorization expired.” What does that mean? | Prior authorizations for medications are often only valid for a specific period, for 6 months up to 3 years. After that, a new prior authorization is required. |
| **12** | When can my doctor renew my prior authorization? | Most medications can be renewed up to 90 days prior to expiring.  **CCR Note:** An approval is NOT guaranteed, even when previous Prior Approvals were approved. The decision to approve or deny coverage for a medication is based on information provided by the prescriber. |

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| ePA Q&A |

 When an agent initiates an ePA request through Compass, it is automatically submitted through CoverMyMeds

Refer to the table below:

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| **#** | **Question/Statement** | **Answer** |
| **1** | **Provider is calling with specific questions about CoverMyMeds.** | If user has specific questions which you are unable to answer, direct them to the CoverMyMeds Support Team.   * Live chat: Click the box at the bottom of this screen to chat at <https://www.covermymeds.com/epa/caremark/> * Phone: **1-866-452-5017** * Email: [Help@covermymeds.com](mailto:Help@covermymeds.com)   **CMM Support Hours:**   * Monday-Friday: 7 am - 10 pm CT * Saturday: 7 am - 5 pm CT   **Additional Resources:**  [Go.covermymeds.com/help](https://www.covermymeds.com/main/support-center/prescribers-pharmacist-support) |
| **2** | **What is CoverMyMeds?** | When the PA process is paper based, it requires multiple faxes and phone calls between prescribers, pharmacists, and health plans. With electronic prior authorization, prescribers, pharmacists, and health plans can receive real time responses and determinations. |
| **3** | **What is electronic** **Prior Authorization (ePA)?** | **Prior Authorization** paper-based process requires multiple faxes and phone calls between prescribers, pharmacists, and health plans. With electronic prior authorization, prescribers, pharmacists and health plans can receive real time responses and determinations. |
| **4** | **What is a KEY?** | The KEY is a 6-character code used to identify requests in CoverMyMeds. The KEY is needed to access requests started by CVS Care in CoverMyMeds.  **Reminder:** The ePA key should be provided to providers, not to other callers. |
| **5** | **What are the benefits of using CoverMyMeds for electronic prior authorization?** | * It is a free service. * Majority of requests receive a determination within 2-3 minutes. * CoverMyMeds allows you to easily renew requests. * CoverMyMeds works for all plans and all medications. * Complete PA requests initiated by pharmacies. * Initiate, submit and track PA requests in one place online. |
| **6** | **Can the prescriber initiate the ePA request using CoverMyMeds?** | Yes, the prescriber can initiate an ePA request using the CoverMyMeds system. After logging into CMM, the prescriber:   * Selects the appropriate health plan request form to initiate an ePA * Inputs key patient, drug, and plan information regarding the request * Submits the request to obtain the appropriate clinical question set |
| **7** | **Will the prescriber know the ePA submitted is for PA or Clinical Exception? Will that be included automatically based on the plan?** | It is based on the rejection messaging of the test claim that is initiated when the prescriber submits the information. |
| **8** | **If the prescriber gets PA denial and wants to appeal, can they use CoverMyMeds or will further instructions follow on how to request an Appeal?** | In the case of a denial, the prescriber should follow our existing recommended appeals process. CoverMyMeds is purely for the ePA initiation phase.  Refer to [Compass - Appeals (057981)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=2afb93f5-6068-48b7-af0f-e04000f90426). |
| **9** | **What happens when an electronic Prior Authorization (ePA) is submitted?** | When an Electronic Prior Authorization (ePA) request is submitted, the system runs a test claim. Using the resulting information, the CIF, and information on the account, the Clinical team will then request the necessary information from the Provider. |

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