**What is a PA or Exception:**

A Prior Authorization (PA) or Exception is an approval process that benefit plans require for certain medications before they can be covered. A Prior Authorization (PA) or Exception makes sure that a member is getting the right medication for their condition. It may also help keep costs down, so they don’t overpay.

**How is a PA works & Why is a PA required:**

Requirements depends on the benefit plan. Here are common reasons a Prior Authorization (PA) or Exception may be needed:

There may be a lower cost option that’s just as effective.

The medication has potential for misuse or abuse.

The medication is for certain conditions or diagnoses. The requestor will not be able to request an Appeal prior to PA or Exception being completed and denied.

**If the member is inquiring about why a medication needs a PA.**

I understand your concern. It will not be considered for coverage under your prescription plan until your prescriber provides additional clinical information to our Prior Authorization department. Once received, the information is reviewed by the Prior Authorization department. If criteria are met (approved), the authorization is applied to the system to allow coverage. The approval or denial is provided to your doctor’s office, and a letter of approval or denial will be mailed to you.

**If the member has questions about paying for a claim before the PA is approved.**

1. **If the member wishes to use a coupon or another form of prescription assistance:** You may have the medication filled at the retail pharmacy by paying with coupon/prescription assistance before your prior authorization is approved. Please note if you pay with coupon/prescription assistance and then the prior authorization is approved the claim will not be eligible for reimbursement.
2. **If the member wishes to pay cash out of pocket:** You may have the medication filled at the retail pharmacy by paying cash out of pocket before your prior authorization is approved. If your prior authorization is approved, it will be back dated 30 days. If you paid cash out of pocket during the 30-day back period, before the prior authorization was approved you can submit a claim for reimbursement.

**Educate the member on how the PA will be approved and the status on Caremark.com.**

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 also be sent to you with additional information about your Prior Authorization. Your prescriber will also receive a fax.   To help the member find the status on line follow this WI: [Caremark.com – Prior Authorization (070305)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=20ba7691-5b2a-4780-9c3a-f671151ab55c)

If less than two business days since the request was sent to the prescriber: Explain that the turnaround time is three (3) business days from the time that the prescriber responds. They can follow up with their prescriber for the status of the request.

**Note:** Not all clients participate in Caremark.com, refer to the CIF.

**If the member is inquiring about why a PA may need renewed.**

Prior Approval renewal is required to reevaluate the current indication for use, lab values, and disease progression. We try to balance the need for clinical re-evaluation of the medication with the least amount of disruption to the member and prescriber.

Most medications can be renewed up to 90 days prior to expiring please work with your prescriber’s office on when it would be appropriate to request the renewal prior to the expiration date on the Approval Letter.

In unique situations some prior authorizations may be cancelled prior to the expiration date due to plan changes.

Representative: 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.

**If the member needs education about why a PA was 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 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.