# Prior Authorization, Exceptions, Exchanges

# Glossary of Terms

**Click on the appropriate hyperlink below to jump to alphabetized category of terms and definitions.**

**Note:** Do not share definition of terms with callers

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| [**A**](#_Definitions) | [**B**](#_Available_Task_Types) | [**C**](#_Various_Work_Instructions_3) | [**D**](#_Participant_for_Spouse) | [**E**](#_Participant_for_Minor) | [**F**](#_Third_Party_Caller) | [**G**](#_Custodial_Parent_Not) | [**H**](#_Benefits_Office_Calling) | [**I**](#_Nursing_Home_Calling) | [**J**](#_J) | [**K**](#_K) | [**L**](#_L) | [**M**](#_M) | [**N**](#_N) | [**O**](#_O) | [**P**](#_P) | [**Q**](#_Q) | [**R**](#_R) | [**S**](#_S) | [**T**](#_T) | [**U**](#_U) | [**V**](#_V) | [**W**](#_W) | [**X**](#_X) | [**Y**](#_Y) | [**Z**](#_Z) | [**Numbers**](#_Numbers) |

**Quicker Search Results: Press Ctrl+F → Type in Keyword → Click Find Next**

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| A1C | Glycated hemoglobin – an A1C test will identify the patient’s average plasma glucose concentration over the past 2 to 3 months |
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| Abort PA | Type of PA close option to be used if a PA should not have been worked.  This type of closure will leave the PA viewable on the Members’ profile.  Example: incorrect criteria, duplicate PA, plan override/extension in adjudication |
| ACA (PPACA) | Patient Protection and Affordable Care Act (the ACA) under federal healthcare reform |
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| ADL | An Adverse Determination Letter is a custom apology sent to a member when a PA has been approved in error. |
| Administrative Appeals (Coverage Determination) | A coverage determination or administrative appeal is based solely on the terms of the Plan, including the preferred drug lists, formulary or other plan benefits selected by the Plan Sponsor, and does not involve a determination of medical necessity ([Coverage Determination](#CoverageDeterminations)). |
| ADR | Auto Denial Reason |
| Adverse Benefit Determination | (Except for Coverage Determinations as defined below) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. |
| Adverse Coverage Determination Letter | When an approval gets overturned to a denial per the Account Team’s request, the patient will receive a letter explaining the overturned decision, the date on which the current override will be termed, and the appeals options. |
| Adverse Event | An unexpected medical problem that happens during treatment with a drug or other therapy |
| Age Limitation | A restriction of coverage for certain drugs to a specific age |
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| Allergy | Abnormal reaction of the immune system to a medication.  Examples: hives, rash or fever. |
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| Appeals or Exceptions Request | Any request that cannot be approved through the normal PA process. Appeals generally consist of Letter of Medical Necessity, or Lab/Chart Notes, etc.  Appeals - Plan specific steps to request an appeal are provided to the member and prescriber within the denial letter. To request an appeal, there must be a Prior Authorization (PA), Exception, or Initial Benefit Review (IBR) denial on file. If there is no denial, there is nothing to Appeal.  Clinical Exception - An exception is a special case where the PBM may make an allowance outside the usual guidelines, often based on medical necessity. |
| Appeal Level | The stage in the appeals process, which may include initial, second, or external reviews, depending on the complexity of the case |
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[Top of the Document](#_top)

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| Backdating Approvals | The practice of setting the approval date back one month on overrides to allow for any paper claim processing of the medication that may have been purchased out of pocket prior to being approved through the prior authorization or appeals process |
| Barcode with PA Number | Fax document not automatically sorted by the system |
| Benefit Exclusion | A request for a drug that returns reject messaging, “drug not covered/plan exclusion/route of administration,” or other similar messaging. Working a benefit exclusion is intended for denial purposes and the generation of a letter to the member. |
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| Brand Medication | "Brand" medications are marketed under a proprietary, trademark-protected name. While under patent by the Food and Drug Administration (FDA), the brand medication is the only version of that drug available for dispensing. Once the patent on a brand medication expires other drug manufactures are free to market "generic" versions of the drug. Generally speaking, brand medications are priced higher than generic medications. |
| Brand Penalty Exception | Exception that waives the penalty assessed with receiving a brand name drug in place of the generic |
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| Business Days | Used to compute time for deadlines. A business day is Monday through Friday and typically covers the period from 8 a.m. to 5 p.m. Excludes weekends and holidays. The Commercial Appeals department’s business hours are 7 a.m. to 5:30 p.m. Arizona time. |
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[Top of the Document](#_top)

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| Calendar Days | All days in a month, including weekends and holidays |
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| Chronic Pain | Generally defined as pain that typically lasts greater than 3 months. |
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| Clinical Appeals | A reconsideration of a pre-service claim denial that requires a review of clinical information about a member’s medical condition.  Example: LOMN (letter of medical necessity), lab notes, chart notes. |
| Clinical Follow Up Queues | Consists of ePA requests that did NOT meet plan criteria and need a denial review |
| Clinical Information | Information provided by the physician or physician’s office that may include:   * Handwritten/typed notes * General Clinical information (Duration of therapy, Therapy indication, alternatives tried and failed) * Chart notes or Lab notes/values * Any or all answered criteria questions * Diagnosis in addition to the information above.   A diagnosis or ICD 10 code on its own is not considered clinical information unless a determination can be made or reviewer is able to answer additional questions. |
| Clinical Review | An assessment conducted by a pharmacist or medical professional to determine if a prior authorization request meets clinical criteria. |
| Clinically Denied | PA is denied by a Pharmacist or Medical Director due to NOT meeting clinical criteria or providing insufficient information.  Insufficient information denials are considered to be clinical denials. |
| Closed Formulary | A list and/or classes of drugs, which the coverage and administration of a drug benefit plan is either limited or restricted |
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| Combined Criteria | Combination of two Opioid criteria on to one form which limits the number of PA’s being worked in the system. Rewriting the two criteria into one form.  Example: Opioid Post limit criteria combined with Opioid ER Step |
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| Completed Criteria Date | Timestamp for when all clinical info needed for determination is received |
| Completed Timestamp | The time and date that the company received all of the necessary information to make a determination. |
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| Compound Drug | Drug created by combining two or more medications and/or another ingredient(s).  Also see [High Dollar Compound](#highdollarcomp). |
| Compound Exception | Exception to allow coverage of a compounded drug.  Refer to [CMS-PRD1-097648 Exceptions Compound Process](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8bfbd659-0569-4009-a8ad-f3b7534cc1c1) on how to process a Compound Exception request. |
| Compound Exception (for excluded ingredients) | Exception to allow a member to have coverage for a compounded products containing ingredient(s) excluded from the pharmacy benefit. |
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| Contraceptive Zero Copay Exception | Exception to allow a member to receive a contraceptive product for a zero dollar member cost share. |
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| Contraindication | A specific situation in which a drug should not be used because it may be harmful to the person.  Examples: Isotretinoin contraindicated in pregnancy due to risk of birth defects. Certain decongestants contraindicated in patients with high blood pressure. |
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| Cost Exceeds Exception | Exception to allow coverage of a medication that has exceeded the plan’s maximum dollar amount per claim |
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| CoverMyMeds (CMM) | A privately held healthcare software company that creates software to automate the prior authorization process used by some health insurance companies in the United States. |
| Coverage Determination (Administrative Appeals) | Any decision made on behalf of a plan sponsor regarding payment or benefits to which a member believes they are entitled. A coverage determination is based solely on the terms of the Plan, including the preferred drug lists, formulary or other plan benefits selected by the Plan Sponsor, and does not involve a determination of medical necessity. (See Administrative Appeal) |
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| Criteria | A defined set of questions about a drug class or a specific drug that doctor’s offices complete for the prior authorization process to determine if a medication will be approved or denied for coverage for a patient |
| Criteria Form | A form that lists drug specific clinical questions the physician must answer for the prior authorization request. |
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| Custom Client | A client that has requirements that deviate from the standard appeals process |
| Custom Criteria | Client specific written criteria. Maintenance and/or letters can differ from the standard making custom which requires updates from the Client.   * CL REQ at the top of the guidelines indicate Custom Criteria |
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[Top of the Document](#_top)

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| DAW (Dispense as Written) | A prescriber has two options when writing a prescription either to allow generic or some brand substitutions, or specify that the prescription be dispensed exactly as written (no generic or formulary substitutions allowed). Usually the preprinted prescription form will have two lines for the prescriber's signature one will indicate "substitutions allowed" and the other will indicate "dispense as written." The prescriber signs on the line indicating how the prescription is to be dispensed. |
| DAW Codes | A prescribing directive to pharmacists to dispense only the medication ordered: Prevents generic drug substitution.  0 – No DAW indicated  1 – Dispense as written by the prescriber  2 – Substitution allowed, member requested brand  3 – Substitution allowed, pharmacist requested brand  4 – Generic available, not in stock  5 – Substitution allowed, brand dispensed as generic  6 – Override  7 – Brand mandated by law  8 – Substitution allowed, no generic available in marketplace  9 – Other |
| DAW Penalty | The additional amount charged on a prescription for dispensing the brand name drug instead of the available generic equivalent/alternative. Usually calculated as the cost difference between the brand and generic drugs. |
| Days Supply | The number of days’ worth of medication a provider prescribes for. The number of days’ worth of medication allowed by the prescription benefit plan. |
| DEA | Drug Enforcement Administration |
| Dedicated Phone Number & Fax Number | * Opioid Phone number 844-449-8734 * Opioid Fax number 866-217-5644 |
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| Disallowed Quantity | A quantity or combined strength of a medication that exceeds the limits placed on the drug by the drug-specific guidelines. |
| Disease Management | The concept of reducing health care costs and improving quality of life for individuals with chronic conditions by preventing or minimizing the effects of the disease through integrated care |
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| Drug Benefit Design | The structure and schedule of the drug coverage specifications used to adjudicate prescription claims. |
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| Drug Intolerance | An inability to tolerate the adverse effects of a medication.  Examples: Metformin serious side effects of lactic acidosis or low blood sugar. Atorvastatin serious side effect of rhabdomyolosis (muscle pain/damage) or liver damage. |
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| DUR | Drug Utilization Review. Ensures patient safety and manages medication therapy by examining a patient’s physician orders and checking for drug-drug, drug-allergy, drug-food, and drug-condition interactions using patient factors such as gender, age, weight, medical history and current treatments. |
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[Top of the Document](#_top)

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| Edit | Parameters established by each plan for a drug or drug class, to require a PA to override the edit and process at the pharmacy |
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| ePA | Electronic Prior Authorization; ePA stands for electronic Prior Authorization. It is the process in which the physician submits the Prior Authorization request online. |
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| Exception | A standardized program to support client requests for making exceptions to certain aspects of a client’s plan design |
| Exception Process | A course of action that allows patients to challenge the placement of a drug on a higher-cost tier or the exclusion of a particular drug from their formulary |
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| Exclusions | A list of drugs that are not to be covered under a client's specific client plan. |
| Exhausted Rights | The member has completed or exhausted all available appeal options. The member may have additional rights under their plan. |
| Exigent Circumstances | Exigent circumstances are defined as when 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 an enrollee is undergoing a current course of treatment using a non-formulary drug. |
| Expedited/Urgent | Any inbound phone call or fax request received that is marked by the Physician and/or the physician’s office as “Urgent”, “STAT”, “ASAP”, “Expedite”, etc.… |
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| External Client | A client who does their own data entry for prior authorization |
| External Review | The federal or state appeals process that may be available to members for an independent review of their case once the internal appeals process has been exhausted, unless due to circumstances allowed by the federal or state law, the internal appeals process does not need to be exhausted |

[Top of the Document](#_top)

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| Failure | An inadequate treatment response.  Example: Giving highest dose of Gemfibrozil and triglycerides continue to rise instead of decrease. |
| FA-PA | Formulary Alternative Prior Authorization |
| FDA (Food and Drug Administration) | The federal agency that controls the development, manufacturing, marketing and distribution processes of drugs |
| FDA-Approved Indication | The basis for initiation of a treatment for a disease as approved by the Food and Drug Administration |
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| Formulary | List of approved or recommended drugs deemed to be the most effective and economical |
| Formulary Exception | Exception allows for coverage of an excluded drug from the standard CVS/Caremark formulary |
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[Top of the Document](#_top)

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| Generic Equivalent | A generic or non-brand drug that basically has the same ingredients and therapeutic effects as a name brand drug. Typically, the generic drug is less expensive. Generics cannot be manufactured and distributed until after the Brand patent has expired. |
| Generic Medication | Bioequivalent, generally lower cost version of a brand-name drug, available when patent protection expires on a brand name drug (lowest co-pay on the plan) |
| Generic Substitution | The dispensing of a drug product in place of a brand name drug which: 1) contains the same active ingredients; 2) is identical in dose, form and administrative method; 3) has the same indications, cautions and instructions; and 4) is produced under the same FDA Good Manufacturing Practices. |
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| GPI | Generic Product Identifier:   * A coding scheme used by Medi-Span to classify and identify specific drug products based on their chemical make-up, strength and form; * One number per generic covering all forms of the drug, therapeutic classification scheme for drug interaction & allergy checking and plan edits. * The GPI number is not manufacturer or package size specific. The 14-character number consists of a hierarchy of seven subsets, each providing increasingly more specific information about drug products.   12-34-56-78-90-12-34 Drug Group  12-34-56-78-90-12-34 Drug Class  12-34-56-78-90-12-34 Drug Subclass  12-34-56-78-90-12-34 Drug Name  12-34-56-78-90-12-34 Drug Name Extension  12-34-56-78-90-12-34 Dosage Form  12-34-56-78-90-12-34 Strength   * Wild cards should only be used in pairs based on the 7 subsets of a GPI number. Under normal circumstances, the last four (Dosage From and Strength) are the only ones you would want to wild card. |
| Grandfathered | A status under the ACA for plans that have not made significant changes to their plan that exempts them from having to comply with the regulations |
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| Guidelines | Lists which questions must be answered yes or no on the criteria in order for a medication to be approved and for what length of time an approval can be given Example: 12 months, 6 months |

[Top of the Document](#_top)

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| High Dollar Compound | A compound with a total submitted cost of $5000 or more.  See [Compound Drug](#compounddrug) and/or [Compound Kit](#compoundkit). |
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| HRM | High Risk Medications that reject for Members over the age of 70 years of age |
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[Top of the Document](#_top)

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| ICD-10 | International Classification of Disease Clinical Modification Coding System |
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| Independent External Review | An appeals review that is conducted by a third party that is not affiliated with the health plan or a providers' association and has no conflict of interest or stake in the outcome of the review |
| Internal Denial | A denial option for plans that are reviewed internally by an RPh |
| Initial Benefit Review (IBR) | Written notification to members of the reasons for the adverse benefit determinations of their claim and what their appeal rights are. The IBR must be sent to the member before an appeal can be submitted and processed. |
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[Top of the Document](#_top)

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[Top of the Document](#_top)

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[Top of the Document](#_top)

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| Letter of Medical Necessity (LOMN) | A letter of medical necessity may include handwritten notes from the doctor on the PA criteria form or a denial letter, a prescription pad, etc., or a formal letter on the doctor's letterhead and signed by the doctor that contains medical information justifying that the service rendered was reasonable and appropriate for the diagnosis or treatment of a medical condition or illness. The appeals pharmacist will exercise good judgment in determining if the information is sufficient for review. |
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| Life Style Medications | Medications that generally do not treat a life-threatening disease but are designed to improve the quality of life or extend the normal life span   * These may include drugs that would successfully:   + Restore or improve sexual potency   + Restore hair growth,   + Allow acute treatment to prevent conception (so-called morning-after pill)   + Reverse the effects of aging |
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[Top of the Document](#_top)

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| Management of Select Unapproved Products | Exception to allow a member to have coverage for select products excluded from the pharmacy benefit. |
| Mandatory Mail Exception | Exception to allow a member to continue to receive a maintenance medication at a retail location when the member’s plan requires the use of mail order for fills on maintenance medications |
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| Medical Director Review | Medical necessity review by a Caremark MD based on criteria and compendia |
| Medical Necessity | Medications, health care services or products are considered Medically Necessary if use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated; use of the medication, service, or product is based on recognized standards for the health care specialty involved; use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and use of medication, service or product is not solely for the convenience of the member, member’s family, or provider. |
| Medical Necessity Review | A clinical review by an independent physician to determine if the requested medication is medically necessary for the patient |
| Medically Necessary (or Medical Necessity) | Medications, health care services or products are considered Medically Necessary if use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated; use of the medication, service, or product is based on recognized standards for the health care specialty involved; use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and use of medication, service or product is not solely for the convenience of the member, member’s family, or provider. |
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| Miscellaneous Formulations Exception | Exception to allow a member to have coverage of select products excluded from the pharmacy benefit. |
| Misdirected Appeals | Appeal requests submitted to the Commercial appeals team for clients that are not contracted with CVS Caremark to process their appeals, a particular level of appeal or when the internal appeals process has been completed |
| Misdirected PA | PA requests that are sent to the wrong department or PA team |
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| MME | Opioid limitations based on CDC recommendations to restrict based on Morphine milligram equivalents (MME) which are more restrictive than the FDA (labeled) limits. |
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| Multi-Source | A prescription drug for which there are both brand and generic versions. |

[Top of the Document](#_top)

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| NABP | * National Association of Boards of Pharmacy. |
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| NDC | National Drug Code. A system that is designed to provide drugs in the United States with a specific 11-digit number that identifies the labeler, product, and trade package size. Digits 1-5 identify the manufacturer, digits 6-9 the strength/dosage, and digits 10-11 the package size. |
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| NFME | Non-Formulary Marketplace Exception ([HMF](#hmf)) - form worked for all drugs rejecting for non-formulary for Exchange clients |
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| Non-Formulary | The status of brand name drugs on the formulary which may have a multiple tier benefit design where non-formulary brand name drugs are considered the third tier co-pay (highest co-pay on the plan) |
| Non PA Drugs | A request for a medication that is not available for Prior Authorization (i.e., no PA reject, refill too soon, plan exclusion) |
| Non-Clinical Denial (Autoclose-Denied, Incorrect Form) | PA auto denies by CAS or denied for incorrect form used (MA clients). |
| Non-Clinical Exception | Member is requesting a Non-Clinical Exception  Examples:   * Tier Exception- member requesting medication is covered at a lower tier. * DAW Exception- member is requesting DAW cost share is waived. * MChoice Exception- Member is requesting to use a non-Mchoice network pharmacy and no opt-out is available on plan. |
| Non-Clinical Information | If the following pieces of information are provided on their own, the request would be considered non-clinical:   * Drug name * Drug strength * Quantity * Day supply * SIG (instructions on how to take the medication) * Diagnosis or diagnosis code   A diagnosis or ICD 10 code on its own is not considered clinical information unless a determination can be made or reviewer is able to answer additional questions. |
| Non-Preferred | The status of brand name drugs on the formulary which may have a multiple tier benefit design where non-preferred brand name drugs are considered the third tier co-pay (highest co-pay on the plan) |
| Not a PA Client | Client or Member PA request which are not processed by CVS Caremark |
| Notification of Decision | A communication sent to the member and/or provider informing them of the outcome of a prior authorization request or appeal. |
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[Top of the Document](#_top)

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| Off Label Use | The use of a drug for clinical indications other than those stated in the product labeling approved by the Food and Drug Administration (FDA).  Example: A drug that has received FDA approval for the treatment of certain types of cancer (ovarian, bladder, breast) may be used to treat another type of cancer (pancreatic) |
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| Override | An Override is used to supersede a specific plan edit. At the client’s request, we can override plan edits such as:   * Days supply * Refill Too Soon (for member vacation supply or if drugs were lost, damaged or stolen) * Route of Administration * Maximum quantity per fill * Maximum dollar amount per prescription * Maximum dose * Patient Age * Injectable restriction * QVT limits * Retail penalty * Brand penalty |

[Top of the Document](#_top)

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| P2P | Peer to Peer |
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| PA Approval Dates | The beginning and end dates of time for which a Prior Authorization is valid |
| PA Class (PAC) | A classification used in CAS to identify what type of appeal is being pended (i.e., Benefit Reconsideration, Appeals Commercial – Other) |
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| Palliative Care | A specialized medical care for people with serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness |
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| Peer Review Literature | Literature found in scientific and medical journals (e. g. *Journal of the American Medical Association*, or *New England Journal of Medicine*) that have been reviewed by experts in the field, who are not a part of the journal’s editorial staff. For PA, peer-reviewed literature should support the prescribed dosing and treatment using the drug in question. |
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| Peer-to-Peer Review | Physician-to-physician review of the request prior to a decision being made by the CVS Caremark Medical Director to potentially deny the request |
| Pending Appeal | An Appeal request that has been started and is not yet approved or denied |
| Pending Denial | PA request that requires a review by a Caremark Medical Director or an Independent Review Organization (IRO). |
| Pending MD Review - PA | Close option the pharmacist selects to send the case for physician review. |
| Pending Prior Authorization | A prior authorization request that has been started and is not yet approved or denied |
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| Physician Verbal Notification Date | Timestamp for when the Physician’s office received verbal notification of the determination. Also see [Verbal Notification Timestamp](#verbalnotification) |
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| Post Limit PA | The prior authorization process that reviews for a higher quantity limit of a covered medication when the drug has exceeded the plan limit. The request for a higher quantity is applied against a set of pre-defined clinical criteria (provided by the Plan Sponsor) to determine whether there is a need for the higher plan quantity limit. |
| Post Peer-to-Peer Review | Physician-to physician review of the request after a decision has been made by a CVS Caremark medical director |
| Post Step Therapy | Criteria worked if the patient does not meet the initial step therapy. |
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| Preferred | The status of brand name drugs on the formulary which may have a multiple tier benefit design where the preferred drugs are considered the second tier co-pay (higher than the generic, but less than the non-preferred/non-formulary co-pay on the plan) |
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| Preventive Drug List | A list of prescription drugs approved by the FDA to help prevent certain medical conditions as defined by the Internal Revenue Service (IRS) |
| Preventive Breast Cancer Zero Copay Exception | Exception to allow a member to receive Tamoxifen or Raloxifene for a zero dollar member cost share. |
| Preventive Services Zero Copay Exception (excluding Contraceptives) | Exception to allow a member to receive a preventive services product (excluding contraceptives) for a zero dollar member cost share |
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| Prior Authorization or Pre-Authorization | CVS Caremark’s Pre-service review of a member’s initial request for a particular medication. CVS Caremark will apply a set of pre-defined medical criteria (provided by the Plan Sponsor) to determine whether there is need for the requested medication  A prior authorization is a beneficial process where your doctor seeks approval from your prescription benefit manager (PBM) before prescribing certain medications. This helps ensure that you receive the most effective and appropriate treatment, tailored to your specific needs. This is typically required for medications that may have alternatives or could be prone to misuse. It may also help keep costs down, so you don’t overpay. |
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[Top of the Document](#_top)

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| Quantity Limit | A specific quantity of medication allowed within a certain time period |
| Quantity vs. Time (QVT) | QVT is a “look back” rejection, basically it’s a fancy early refill rejection. It looks back over that specified amount of time and calculates how much the member has received plus what they want now against the limit they are allowed and then rejects for plan limits or allows a partial fill based on the limits.    It also can be viewed as a “too early to refill” rejection, depending on when the member is trying to obtain their medication, as this sets limits on how often the medication can be refilled as well as how much |
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[Top of the Document](#_top)

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| Reject 76 | Plan Limitations Exceeded (Maximum Dollar Exceeded/Claim $ amount exceeded) |
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| Request Received Date | For prior authorizations cases, this is the date and time when clinical information is first received. For Initial Benefit Review cases, this is the date and time when the request is first received. |
| Request Timestamp | The time and date that the company received a request with any clinical information. Also see [Completed Timestamp](#completedtimestamp). |
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| Resolution Date | Timestamp for when the case is resolved and/or closed out |
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[Top of the Document](#_top)

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| SGM / SPC | Specialty PA |
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| Specialty Guideline Management (SGM) | Supports the safe, clinically appropriate and cost-effective use of specialty medications |
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| Step Therapy | This is the practice of utilizing the most cost-efficient way to treat a member via protocol that calls for using one therapy before proceeding to something more expensive or difficult to use. For example, this is the practice of initially treating a member with a lower cost, similarly effective antibiotic before trying a more expensive, yet no more effective one. |
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| Successful Attempt | Outbound call to MDO for answering a criteria question in which the PA Rep was able to:  1)     speak to a representative at the MDO, or leave a voicemail message  AND  2)     specify information needed to complete the PA request  AND  3)     leave the PA team contact phone number of 1-855-240-0535. |
| Supporting Documentation | Medical records, clinical notes, or other relevant information submitted to support a prior authorization request or appeal. |
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[Top of the Document](#_top)

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| TAT | [Turnaround Time](#TAT) |
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| Tiering Exception | Exception to lower the co-pay from a non-preferred co-pay to a preferred co-pay |
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| Turnaround Time (TAT) | The amount of time allotted to complete the request based on contractual agreement |

[Top of the Document](#_top)

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| Urgent Request | An urgent situation is one in which the member’s health may be in serious jeopardy or, in the opinion of a physician; the member may experience pain that cannot be adequately controlled while waiting for a decision on a PA. If the member or physician believes the situation is urgent as defined by law, the member or physician may request an expedited Prior Authorization.   |  |  |  |  | | --- | --- | --- | --- | | **Accelerate** | **ASAP** | **Do this today** | **Expedite** | | **Fast** | **Hurry** | **Immediate** | **Now** | | **Rush** | **Suicidal** | **Severe pain** | **STAT** | | **Terminally Ill** | **Urgent** | **Exigent Circumstances** |  | |
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[Top of the Document](#_top)

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[Top of the Document](#_top)

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| Women’s Contraceptive  Zero Copay Exception | Exception to allow a member to receive a contraceptive product for a zero dollar member cost share |
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[Top of the Document](#_top)

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[Top of the Document](#_top)

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[Top of the Document](#_top)

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[Top of the Document](#_top)

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[Top of the Document](#_top)

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