**Possible In Process Q&A:**

**When did my doctor submit the prior authorization?**

One moment while I contact the Prior Authorization department to obtain that information for you.

**How long will it take to get an answer for the PA?**

The turnaround time can vary. Depending on the information provided and 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 the reps 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 caremark.com for the status of the prior authorization. If they need help finding the status on the website refer to Content ID : TSRC-PROD-070305 Caremark.com – Prior Authorization.

**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 look at the forms submitted by your doctor's office (click the view documents hyperlink next to the corresponding PA submission) If view documents doesn’t provide any information call PA dept and relay information to member.

-We received all the necessary information to process your request and it can take up to three business days for your request to be processed.

* It looks like 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 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.

**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 also be sent to you with additional information about your Prior Authorization. Your prescriber will also receive a fax letting them know the status.  [Caremark.com – Prior Authorization (070305)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=20ba7691-5b2a-4780-9c3a-f671151ab55c)

**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 doesn’t provide information call PA dept and relay information to member.

**The doctor’s office says they are unable to initiate the PA request.**

Determine why the doctor’s office cannot initiate the PA request.

1. Offer to send an Epa request on behalf of the member. Refer [Compass - Initiating an ePA Request (055814)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=18bb86b7-af5b-4f25-af23-9c635e8a0aa4)
2. If the physician does not participate in Epa or the physician only uses fax the CCR should send the contact provider for PA task. Refer to (TSRC-PROD-058147 Compass - Support Task Types and Uses List). And/or provide the fax number for the PA dept.

 Please note the task MUST include the prescriber fax.

1. 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 request by the member, do not proactively offer this option.

**My PA has been approved. Why has my order not shipped?**

Great news, I do see you 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: Content ID : TSRC-PROD-056291 Compass - Manage Diverts / Conflicts (Release Order) (hyper link to Manage Divert Issues Support Task)
* If the order has not been started place a refill order. Content ID : TSRC-PROD-054262 Compass - Mail Rx Refill/Renewal (Order Placement)
* If we do not have a prescription on file initiate a new prescription request refer to: Content ID : TSRC-PROD-054208 Compass - Obtaining a New Prescription (Rx) for the Member (New Rx Request)

**Possible Denied Q&A:**

**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.

**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 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.

**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 documentations submitted by your prescriber.

**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.

**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.

**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 you 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 has been informed but we have not yet received a response back.

**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 Content ID : CMS-PRD1-116970 Advanced Control Non-Specialty and Specialty Formulary Changes with Questions and Answers ( hyperlink directly to New to Market/Pending Review)

**Ive 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.

**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.