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Exhibit(s): N/A		
Document Type: Policy and Procedure		

PURPOSE

To define the steps necessary for processing Prior Authorization (PA) requests for review received by the Prior Authorization Department.

SCOPE

This policy and procedure defines the process for Prior Authorization requests for review received by the CVS Caremark® Prior Authorization Department.

POLICY

1. CVS Caremark Prior Authorization (PA) program provides a reliable process for clients in order to ensure appropriate drug usage, while considering Plan Member safety, within the limits of a specific plan benefit.
2. All Review requests for prior authorization will be processed accurately and in a timely manner in compliance with state and federal regulations.
3. CVS Caremark Prior Authorization department will be available Monday through Friday, between the hours of 8am-6pm. Selected holidays may be excluded.
4. Determinations are based solely on the clinical information available to the prescriber or CVS Caremark at the time of the Review
5. All CVS Caremark Prior Authorization Representatives are required to identify themselves by first name, title and the organization name when initiating or returning calls.
6. Employees who conduct clinical prospective reviews are licensed pharmacists or pharmacy technicians who are licensed and in good standing, if required, by the state in which they work. Pharmacy technicians are supervised by licensed health care professionals.
7. Non-clinical Denials are completed by a PA Representative with supervision of a licensed health care professional.
8. Clinical Denials are rendered by a pharmacist or board certified physician reviewer who is licensed and in good standing in any state.
9. When conducting a Review, CVS Caremark accepts clinical information that is applicable to the Review, collects only the information necessary to certify the prescription and requires only the part of a Plan Member's medical record that is necessary to determine appropriateness of the prescription.
10. Accreditation standards, federal/state laws and regulations may require deviation from some policies and procedures for some clients. More stringent state requirements may supersede the requirements of this policy.

11. Prescribers must be offered an opportunity to discuss an adverse determination (Prior Authorization) with a pharmacist or physician reviewer.
12. The Language Assistance for Customer Care (Document ID: CALL-0064) will be utilized for all Plan Members contacting the Prior Authorization department who require language assistance or TDD/TYY services.
13. Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage; CVS Caremark does not reward practitioners or other individuals conducting UM for issuing Denials of coverage; and financial incentives for UM decision makers are not designed to encourage decisions that result in underutilization.
14. For all determinations that were approved or denied incorrectly, the Senior PA Representative will review the new information, and if necessary, create an Adverse Determination letter for member notification.
15. CVS Caremark has established an Inter-Rater Reliability process for monitoring the consistent application of clinical guidelines across PA decisions. (Document ID: PAR-0010)

GENERAL PROCEDURES

1. Inbound and outbound documentation will be date and time-stamped for proper documentation.
2. The CVS Caremark Prior Authorization department conducts Prior Authorization Reviews within a structured environment. This may include:
    a. Regulations – state and federal
    b. Predetermined objective clinical criteria
    c. Client-specific formularies
    d. Client-specific business/utilization management goals defined by contract agreements.
3. The provider is able to submit a Prior Authorization request online, by phone, fax, or in writing.
    a. Fax requests can be sent into the standard Commercial PA toll free fax number.
        i. The standard criteria forms are available online at www.Caremark.com or can be requested via the toll-free automated phone system.
    b. Phone requests can be initiated by the doctor's office calling the PA department toll free.
        i. CVS Caremark will have a pharmacist or physician available 24 hours a day for timely authorization of Medically Necessary services.
        ii. Plan Members can also initiate a PA request by calling Customer Care.
            1) Customer Care will verify the requested medication requires a PA
            2) Customer Care will submit an RM Task to the PA team to fax the PA Criteria to the provider's office.
            3) The PA will be processed once the criteria have been received back from the provider's office.
    c. Online requests are submitted using the ePA system.
        i. ePA allows a provider to access the Prior Authorization process through an online or e-prescribing tool.

ii. The system follows the proposed National Council of Prescription Drug Programs ePA transaction set to allow for the communications of the Prior Authorization request and response process.
iii. The provider will access and answer the criteria questions electronically. The algorithms for PA evaluation and the documentation within our prior authorization systems do not change with ePA.

d. Written requests can be mailed to the following address:
CVS Caremark Prior Authorization Dept
1300 E. Campbell Road
Richardson, TX 75081

4. The standard CVS Caremark Prior Authorization process will include:
a. Reviewing the Plan Member's PA history for:
i. Pending PA requests.
ii. Duplicate PA requests that have been previously approved or denied.
1) The PA team will follow the standard duplicate process to determine if a new PA or an appeal will be required
b. Reviewing the claim rejection or performing a test claim to ensure a prior authorization is required.
i. Claim rejections must include a Generic Product Identifier (GPI) number, Reject Code, and phone number in order for the PA team to work a prior authorization.
c. Selecting the clinical criteria by utilizing the GPI, reject code, and phone number within the pharmacy reject.
i. If the claim rejection does not include a GPI, reject message, or phone number, the PA team will validate with the CAS admin team and the appropriate account management team to verify that a PA should be worked and which criteria should be used and will request to have the missing information added to the claim rejection.
d. Opening and processing a PA in the clinical PA system by applying predetermined client approved objective criteria.
e. Collecting eligibility data, Plan Member demographics, and all pertinent clinical information.
f. Issuing decisions regarding the Review request:
i. Approval
ii. Denial
g. Entering overrides into the adjudication system as required. This includes performing a test claim to ensure the claim will pay at the pharmacy.
h. Informing Plan Members and providers in writing of the results of the Review.
i. Notifications are automatically generated and sent from the clinical PA system when a determination is made.
ii. The standard notification method is to send a fax to the provider's office and to mail a letter to the Plan Member.
1) If approved, the Plan Member and provider will be notified of the Review determination in accordance with applicable regulations.
2) If a denial is rendered, the Plan Member and provider are provided with the below information in accordance with applicable regulations:

a) PA Representatives will be accessible to respond to utilization management inquiries. Upon request, CVS Caremark will provide utilization management criteria (clinical rationale).

i. Sending a written notification to the retail or mail pharmacy regarding the results of the Review.
    i. This notification will be generated only if a retail or mail pharmacy claim has been processed prior to the PA request being received, and if the drug requires a Prior Authorization,
    ii. The PA Representative will attach the mail or retail claim to the PA request, if available in the PA system at the time the PA is created, to generate the notification
        1) A fax notification is sent to the retail pharmacy regarding the PA outcome.
        2) An e-mail notification is sent to the mail pharmacy regarding the PA outcome.

5. PA Approvals:
    a. Decision to approve a PA request will be made by a technician, pharmacist, or health care professional.
6. PA Denial or Adverse Action:
    a. Decision to deny a PA request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a pharmacist or physician.
7. For all determinations that were approved or denied incorrectly, the Senior PA representative will review the new information in accordance to the client specifications and federal and state regulations, and if necessary, create an Adverse Determination letter for member notification.
    a. If it is determined that the initial outcome will be overturned the Senior PA representative will:

        i. Contact the provider's office regarding the overturned PA outcome.
        ii. The member will be provided a written notification of the new PA outcome.
        iii. Make any appropriate updates to the overrides
        iv. Document all actions in CAS.

TIMEFRAMES FOR PA DETERMINATIONS

1. The PA Department will make a determination and give written notice to the provider and Plan Member regarding the determination as fast as the Plan Member's condition requires and following the standard timeframes:
    a. Standard PA requests:
        i. Urgent Pre-Service Reviews will be completed within 72 hours from receipt of request, however, CVS Caremark standard is to generally complete the review within 24 hours from receipt of request.

1) If insufficient clinical information is received, CVS Caremark will request the missing information within 24 hours of receipt of request and allow at least 48 hours for provider to submit.
2) CVS Caremark will make a determination within the earlier of 48 hours of receipt of necessary information or the end of the period afforded to provide the specified information.

ii. Non-urgent Pre-Service Reviews will be completed within 15 days from receipt of request, however, CVS Caremark standard is to generally complete the review within 72 hours from receipt of request.
1) If insufficient clinical information is received, CVS Caremark will request the missing information and allow a reasonable amount of time for provider to submit.
2) CVS Caremark will make a determination when completed information is provided or at the end of the period afforded to provide the specified information not to exceed 15 days from receipt of request.

iii. Post-Service Reviews will be completed within 30 calendar days from receipt of request.

NOTICES

1. The PA Department shall ensure that all written materials provided to Plan Members are:
   a. Produced in a manner, format, and language that may be easily understood by persons with limited English proficiency;
   b. Translated into prevalent languages as required by law.
   c. Made available in a format that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
   d. Such Plan Member information must be written in a manner, format and language that is easily understood.
2. Notice of Adverse Action or Denial**:** Notice of action will be sent to the requesting provider and Plan Member within the timeframes as determined by law. The PA Team must notify the requesting provider and the Plan Member in writing of any decision by the PA department to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. This notice must include:
   a. The Adverse Action the PA Team has taken or intends to take;
   b. The reason(s) for the adverse action;
   c. A reference to the benefit provision, guideline, protocol or other similar criterion on which the Denial is based;
   d. A statement that the Plan Member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the Denial was based, free of charge, upon request;
   e. The Plan Member's right to file an internal appeal or to designate an appeal representative to file an internal appeal on behalf of the Plan Member;
   f. The procedures for a Plan Member to exercise his/her right to file an internal appeal;

g. The circumstances under which expedited resolution of an internal appeal is available and how to request it.

DEFINITIONS (All defined words in this document should be displayed with initial capitals, except for acronyms.)

1. **Clinical Denial**: A denial that a prescription, service, or course of treatment has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, appropriateness, or effectiveness.
2. **Complaint**: A provider's or Plan Member's expression of dissatisfaction with any aspect of the PA process. A "Complaint" may also be referred to as a "grievance,"
3. **CVS Caremark®:** Caremark Rx, L.L.C. and each of its pharmacy benefit management subsidiaries and affiliates, including Caremark, L.L.C.
4. **CVS Health®**: CVS Health Corporation and each of its subsidiaries and affiliates.
5. **Duplicate PA**: A request for the same drug and strength
6. **Employee:** Any full-time, part-time, temporary, or casual employee of CVS Health, including, but not limited to, interns and externs employed by CVS Health
7. **Generic Product Identifier (GPI)**: A 14-character hierarchical classification system that identifies drugs from their primary therapeutic use down to the unique interchangeable product regardless of manufacturer or package size.
8. **Medically Necessary**: Health care services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.
9. **Non-clinical Denial**: A request that is based solely on the terms of the Plan, including the Plan Design Document (PDD), the preferred drug lists, formulary or other plan benefits selected by the Plan Sponsor, and does not involve a determination that the requested drug is experimental or investigational or not medically necessary.
10. **Pharmacy Technician**: Employees who are nationally certified and/or state registered pharmacy technicians.
11. **Plan Member (Member)**: A person whose prescription drug benefit is administered by CVS Caremark.
12. **Post-Service Review (Retrospective Review)**: Claim for which the member has received the medication and is requesting reimbursement.
13. **Pre-Service Review (Prospective Review)**: Drug management conducted by the organization prior to a prescription, service or course of treatment.
14. **Prior Authorization (PA) Representative**: Takes incoming calls from providers and Plan Members providing professional phone assistance and conducting initial Reviews.
15. **Reject Code**: Standardized rejected claim types established through NCPDP and generally utilized by all Pharmacy and Medical claim processors
16. **Review (Prior Authorization or PA)**: An evaluation of a drug request against a predetermined set of objective criteria before processing for payment under a drug benefit administered by CVS Caremark®.
17. **Urgent Review (Prior Authorization or PA)**: A request for services in which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life of health of the Plan Member based on a prudent layperson's judgment or

in the opinion of a provider with knowledge of the Plan Member's medical condition, would subject the Plan Member to server pain that cannot be adequately managed without the treatment this is the subject of the request.

EXHIBITS/APPENDICES

N/A