CVS Caremark Prior Authorizations and Appeals Program Prior Authorization (PA) Program

If a prescription requires a PA, there are multiple ways to start the PA process. A PA may be initiated by phone call, fax, electronic request or in writing to CVS Caremark by a member's prescribing physician or his/her representative. A member may initiate a PA by calling the Customer Care number on the back of their pharmacy benefits card. A pharmacist may initiate a PA by calling the PA department, who will reach out to the prescribing physician to obtain the necessary information, or they will be instructed to have the member's physician or designated representative contact CVS Caremark directly. The PA request is evaluated using client-approved criteria. A decision will be made solely on the clinical information available at the time of the review. PAs are processed within the following timeframes:

- **Urgent requests** from the member's physician are processed within 2 business days from receipt of the request.
- **Non-urgent requests** are processed within 72 hours from receipt of the request. If the PA is approved, CVS Caremark will enter an override and approval notifications are generated and faxed to the physician and mailed to the member.

If the PA does not meet the criteria requirements as required by the plan, the appropriate clinical reviewer will deny the PA request. Denial letters are generated and faxed to the physician and mailed to the member. Denial letters include directions on how to appeal the denial.

Appeals Program

Once a member or member's representative is notified that a claim is wholly or partially denied (an adverse determination), he or she has the right to appeal. Appeal requests must be received within 180 days of receipt of the adverse determination letter.

Once an appeal is received, the appeal and all supporting documentation are reviewed and completed, including a notification to the member and physician, within the following timelines:

- Urgent Pre-Service Appeal: 72 hours
- Non-Urgent Pre-Service Appeal:
- For plans with two levels of appeal: 15 days for each level of appeal
- Post-Service Appeal: 30 days

Once the first-level appeal is received, it will be reviewed with the supporting information provided and decisioned within the timeframes listed above. The member and the physician will be notified of the decision and if the denial is upheld, they will be provided information on how to request a second-level

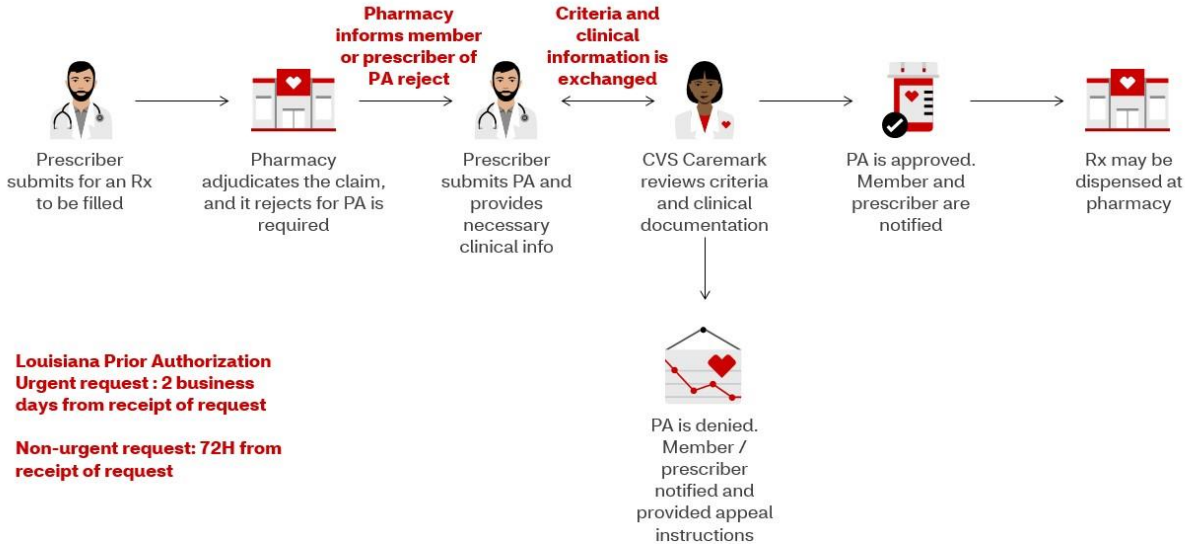
appeal. The request for a second-level appeal must be received within 180 days of receipt of the adverse determination letter.

Once a second-level appeal is received, it will be reviewed with the supporting information provided and reviewed for medical necessity with an appropriately qualified reviewer. The member and the physician will be notified of the decision and if the denial is upheld, they will be provided information on how to request an external review by an independent reviewer.

Contact Us

For information about a specific Prior Authorization or Appeals claim, please call the Customer Care phone number found on the back of your prescription benefits card.

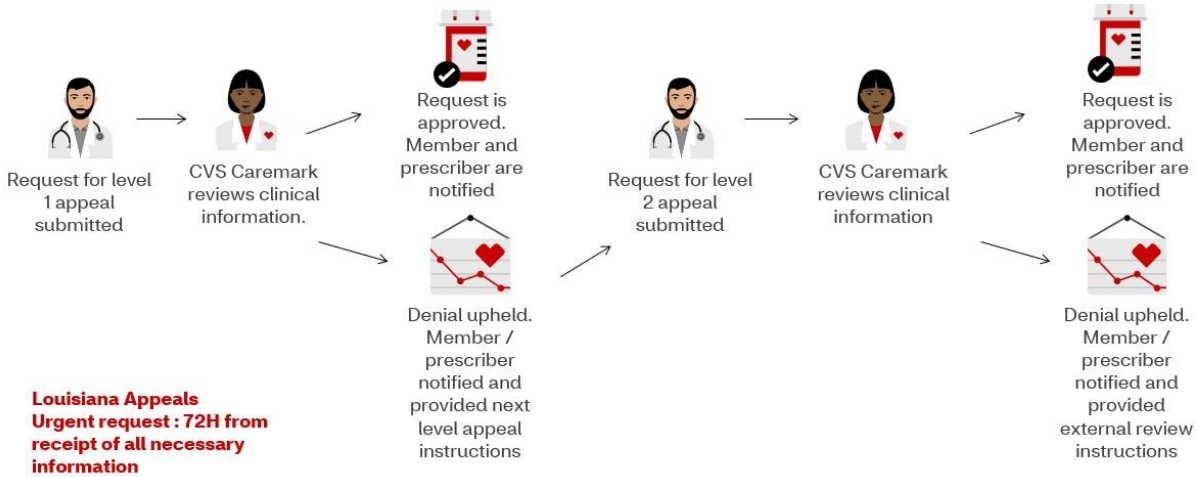
Process Flow – Prior Authorization



Louisiana Prior Authorization
Urgent request : 2 business days from receipt of request

Non-urgent request: 72H from receipt of request

Process Flow – Appeals (2 Levels of Internal Appeal)



Louisiana Appeals
Urgent request : 72H from receipt of all necessary information
Non-urgent request: 15 days for each level from receipt of request