Pharmacy Benefit Appeal Process

CVS Caremark offers a two level appeal process for Trust members. These levels are:

- Level 1- initial benefit reconsideration appeal
- Level 2- medical necessity appeal

Initial Benefit Reconsideration (1st level)

Appeals not relating to clinical benefits (e.g., eligibility, copay issues, plan exclusions, quantity limits, etc.) are reviewed by the appeals analyst who has knowledge of the plan document. These benefit appeals are reviewed strictly against the plan design.

Appeal determinations for clinical based denials (e.g., diagnosis, prior authorization) are reviewed by the appeals pharmacist. These appeals are reviewed against the client approved criteria for the drug based on its approved FDA indication(s). These appeals are not reviewed for medical necessity. They are reviewed to be sure the criteria were applied correctly and if the information submitted with the appeal would now meet the criteria. If the appeals pharmacist denies the Level 1 clinical based appeal, the participant or physician may submit for a second level appeal to determine medical necessity.

Medical Necessity Appeals (2nd level)

Medical necessity appeals are only for prior authorization (diagnosis based) denials that were upheld in the first appeal. If the appeals pharmacist has denied a clinical appeal, the participant or physician may submit a second appeal for medical necessity.

All medical necessity appeals are sent to an external medical review organization. An independent physician will review the criteria, patient/physician documentation and available medical literature to determine if the drug is medically necessary for the participant's situation. A medical necessity review will consider criteria outside the standard FDA approved indications.

Appeal Review Time Frame

First level appeals not related to clinical benefits are reviewed within 30 days. First level clinical appeals are reviewed within 15 days. Second level medical necessity appeals are reviewed within 15 days.

Urgent appeals may only be requested for clinical based (e.g., diagnosis based, prior authorization) appeals and can only be requested by the participant's physician. Urgent appeals are reviewed within 72 hours.

Participants are notified in writing of the appeal decision. If the appeal decision is a denial, the participant is also advised of their rights for their next option in the appeals process.

Submitting an Appeal

The participant or their representative (e.g., physician) should submit their appeal in writing either by fax or mail to the CVS Caremark Appeals department. This information is provided in Prior Authorization denial letters and notifies members of their right to appeal within 60 days of notice.

Prescription Claim Appeals MC 109
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