

ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	218.DC	
Subject:	Pharmacy Authorization Process	
Section:	Pharmacy	
Initial Effective Date:	10/01/2020	
Revision Effective Date(s):	07/21, 07/22, 9/22, 07/23, 07/24, 07/25, 7/26	
Review Effective Date(s):		
Responsible Parties:	Health Plan Pharmacist, P&T Committee	
Responsible Department(s):	Clinical Operations	
Regulatory References:	NCQA 2026: UM 5C:2,4,7,8; UM 7G-I; UM 11B:4, UM 11E DC Contract C.5.28.15 DC Law 25-100. Prior Authorization Reform Amendment Act of 2023.	
Approved:	AVP Clinical Operations	Senior Medical Director (Chief Medical Officer-DC)

Purpose: To define a process to ensure that Enrollees receive medically necessary medication promptly if the medication is non-formulary or formulary with a prior authorization requirement.

Scope: MedStar Family Choice, District of Columbia (DC)

Policy: MedStar Family Choice, DC follows standard processes for evaluating requests for medications requiring prior authorization in a timely fashion, consistent with the DC Contract, DC regulations, and NCQA standards.

Definitions:

Request: When an Enrollee, prescriber, or dispensing pharmacy staff asks for coverage of a specific pharmaceutical product.

- Includes concurrent and pre-service requests as defined by NCQA standards.

Urgent Request: A request for pharmaceutical services where application of the time frame for making routine or non-life-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the Enrollee or others, due to the Enrollee's psychological state, or

- In the opinion of a practitioner with knowledge of the Enrollee's medical or behavioral condition, would subject the Enrollee to adverse health consequences without the care or treatment that is the subject of the request.

Retrospective or Post-Service Request: A request for coverage of pharmaceutical services that have been received, such as if an Enrollee paid out-of-pocket for a prescription and is now seeking reimbursement.

Medical Reviewer: Medical Director or Health Plan Pharmacist

Procedure:

1. The request for medication authorization may be initiated by a prescriber, Enrollee, or dispensing pharmacy staff via telephone, fax, or on the MedStar Family Choice DC website.
 - 1.1. Requests may be submitted by telephone or fax using the corresponding submission form (see 1.2).
 - 1.1.1. Fax number: 202-243-6258
 - 1.1.2. Phone number: 855-798-4244
 - 1.2. Forms are located on the MedStar Family Choice DC pharmacy webpage. (<https://www.medstarfamilychoicedc.com/providers/pharmacy>)
 - 1.2.1. Pharmacy Prior Authorization (PA)/Non-Formulary (NF) form
 - 1.2.2. Opioid PA form for requests for any opioid medication
 - 1.2.2.1. Links to the Opioid PA form are also included on the Prior Authorization and Step Therapy table with Opioid medication listings
 - 1.3. For phone requests, preauthorization staff will take the date and time of request initiation, Enrollee's name, telephone number, prescriber's name, and details about the medication being requested.
 - 1.4. Requests must include clinical documentation to show medical necessity.
 - 1.5. After-hours pharmacy requests:
 - 1.5.1. Requests submitted outside of normal business hours (Monday through Friday, 8:00 am-5:30 pm) will be reviewed by the on-call Medical Reviewer.
 - 1.5.2. A preauthorization staff member is also on-call to receive requests, enter the data into the clinical software system, and send them to a Medical Reviewer to evaluate for a decision. The preauthorization staff will process Medical Reviewer decisions by placing any needed overrides into the PBM system and communicating the decision to the requestor, Enrollee, and/or pharmacy as appropriate.
2. Preauthorization staff enter all requests into the clinical software system and forward them to a Medical Reviewer to evaluate and render a decision. Preauthorization staff will:
 - 2.1. Categorize the reason for the request, e.g. non-formulary exception, prior authorization required, early refill or vacation request, quantity limits exceeded, etc.
 - 2.2. Document the formulary status of the requested product.

- 2.3. Collate any clinical documentation that supports the medical necessity of the request.
- 2.4. Summarize available clinical documentation.
- 2.5. Once prepared, the preauthorization staff forward the request to the Medical Reviewer for clinical evaluation.
- 2.6. If not included with the initial request, preauthorization staff may obtain additional information to support clinical evaluation of the request by the Medical Reviewer. Resources may include but are not limited to:
 - 2.6.1. Direct provider outreach;
 - 2.6.2. MedStar Family Choice's clinical software system;
 - 2.6.3. MedStar system EMR;
 - 2.6.4. LabCorp data;
 - 2.6.5. PBM prescription claims database;
 - 2.6.6. Prescription Drug Monitoring Program (PDMP) – CRISP-DC;
- 2.7. Documentation of all provider outreach attempts must be recorded in the clinical software system and include:
 - 2.7.1. Date and timestamp of outreach attempt;
 - 2.7.2. Type of outreach (e.g. fax, phone, e-mail, etc.)
 - 2.7.3. Contact details (e.g. fax, phone, e-mail address) used for outreach and the name of the recipient;
 - 2.7.4. Description of information requested.
3. The Medical Reviewer evaluates requests received in the clinical software system for medical necessity and clinical appropriateness.
 - 3.1. Medical Reviewer evaluation may include a review of medication adherence for the requested medication and/or for other medications used to manage the disease state related to the prior authorization request, as an indicator of medical necessity for the requested medication.
 - 3.2. The Medical Reviewer will also evaluate the network provider status. Prescriptions from out-of-network providers are only covered IF there is not a reasonable equivalent in-network provider of the same specialty.
 - 3.3. If additional clinical information is needed for evaluation
 - 3.3.1. The Medical Reviewer may ask preauthorization staff to procure the needed information.
 - 3.3.2. The Medical Reviewer may contact the prescribing provider for additional information.
 - 3.3.3. The Medical Reviewer may access resources as described in subsections 2.6.1-2.6.6 to identify relevant clinical information.
 - 3.4. For non-formulary medication requests, the Medical Reviewer determines medical necessity as described in pharmacy policy 205.DC Non-Formulary Medications, sections 6 and 7.
 - 3.5. The Medical Reviewer makes a decision to approve, deny, or otherwise action any request deemed to require clinical review.
 - 3.5.1. The timeline for rendering a decision is described in section 6, Table 1.
 - 3.5.2. For cases where full information is not available, the Medical Reviewer evaluates available information to make a final decision.

- 3.5.3. Requests may be redirected or voided, if deemed appropriate by the Medical Reviewer and if the original requestor agrees.
 - 3.5.4. If the Medical Reviewer successfully redirects a request to a formulary alternative that requires PA or ST, the initial request may be converted to a request for the redirected medication.
 - 3.5.4.1. Preauthorization staff may update the request when the Medical Reviewer has successfully redirected the request.
4. The default length of the approval period is the duration requested by the provider.
 - 4.1. Approval durations may have drug-specific limitations.
 - 4.1.1. Maximum 6-month approval for controlled opioid medications.
 - 4.1.2. Maximum 12-month approval for non-controlled medications and non-opioid controlled medications.
 - 4.1.3. Length of the approval period may be shorter as identified on the PA and ST table or based on clinical use for non-formulary medications.
 - 4.2. Approval periods may differ for initial versus renewal authorizations.
 - 4.3. Medical Reviewers may use their clinical judgement to render partial approvals or shorter approval duration when clinically appropriate.
 - 4.4. MedStar Family Choice DC reserves the right to discontinue an existing authorization when the new authorization would create a duplication of therapy; this may result when the prescriber has discontinued the previously authorized medication when the approval for this medication is still active.
 5. Preauthorization staff process and complete notification for all completed requests.
 - 5.1. Notification of a decision complies with the timelines as described in section 6.
 - 5.2. Approved request processing:
 - 5.2.1. Place an override in the pharmacy benefits management (PBM) claims system so the prescription will adjudicate for the approved duration.
 - 5.2.2. Notify the dispensing pharmacy to reprocess the claim.
 - 5.2.3. Communicate the approval to the requesting individual by phone or by fax.
 - 5.3. Denied request processing:
 - 5.3.1. Preauthorization staff notify the Enrollee and prescriber of the denial in writing. The denial letter includes:
 - 5.3.1.1. The specific reason(s) for the denial, in easily understandable language.
 - 5.3.1.2. A reference to the benefit provision, guideline, protocol, or other criterion upon which the denial decision is based.
 - 5.3.1.3. Formulary alternatives, if applicable.
 - 5.3.1.4. Directions to access the Formulary and/or PA & ST Table, if applicable.
 - 5.3.1.5. Procedure for initiating an appeal.
 - 5.3.1.6. Name and credentials of the Medical Reviewer.
 - 5.3.1.7. Option to discuss the denial with the Medical Reviewer, if desired.
 - 5.3.1.8. The process and timeline for initiating an appeal.
 - 5.3.1.9. Any additional information needed for the appeal.

- 5.3.1.10. A statement that upon request, Enrollees can obtain a copy of the actual benefit provision, guideline, protocol, or other criterion on which the denial decision is based.
- 5.3.1.11. Any forms required.
- 5.3.2. The appeal process is described in Member Services policies:
 - 5.3.2.1. 301.DC; Enrollee Appeals, and
 - 5.3.2.2. 307.DC; Provider Disputes.
- 5.4. Partially approved request notification follows processes described in 5.2 and 5.3.
- 6. Pharmacy requests are processed in accordance with NCQA Standards, DC Contract requirements, and DC regulations.
 - 6.1. Timelines for decision-making and notification are described in Table 1 below.
 - 6.2. Requests confirmed to be clinically urgent will be prioritized for processing, and notification of the decision will occur no more than 24 hours from the date of receipt.
 - 6.3. Requesting prescribers may speak to a Medical Reviewer at any during request processing.
 - 6.4. Enrollees may initiate a retrospective coverage request up to 180 calendar days after the date of service.
 - 6.4.1. If request approval occurs within three (3) days of the date of service, the enrollee will be instructed to return to the pharmacy for a refund.
 - 6.4.2. If request approval occurs three (3) or more days after the date of service, enrollees will be instructed to mail their pharmacy and cash register receipts as described in Appendix I.
 - 6.5. Requests that are redirected to a formulary-preferred alternative, or otherwise determined to be void/canceled will be processed within 24 hours from the date of receipt.

Table 1. Pharmacy request timelines and notification processes.

Request Type	Timeline for UM Decision Making	Timeline for Notification	Notification Method	Who Must Be Notified
All Requests other than retrospective/post-service • Enrollee Exception Requests • Non-Urgent Requests • Urgent Requests*	Within 24 hours of the receipt date of the Request for Authorization. MedStar Family Choice DC will approve, deny, or request further information. If further clinical information is not received: a decision is made	Notification of the decision within 24 hours of the receipt date. A decision is made within 24 hours of the receipt date regardless of whether clinical information is received	Notice by telephone or another telecommunication device. Electronic or written (required for denials)	Telephone or Other Telecommunication Device (required): - Requesting practitioner/provider Written (required for denials): - Requesting facility - Requesting physician or clinician - PCP - Enrollee or Enrollee's authorized representative

	within 24 hours of the date of receipt.			
Retrospective/ Post-Service Pharmacy Requests	Within 14 calendar days of the receipt date of the request.	Electronic or written within 14 calendar days of the initial receipt date of the request.	Electronic or written	- Enrollee or Enrollee's representative (verbal approval or written denial) - Treating physician or clinician or requesting provider - PCP (denial only)

*Urgent requests will be processed as expeditiously as feasible, not to exceed 24 hours from date of receipt.

Summary of Changes:	07/26 • No changes 07/25 • Updated NCQA reference to 2025 version • Added reference to DC PA Reform Amendment Act of 2023 which details PA turnaround time requirements • Policy statement: added "DC regulations" • Request definition: updated NCQA standards reference to remove the year. • Added 1.2.2.1 describing links to the Opioid PA form found in the PA/ST table • Reorganized 1.5 and subsections 1.5.1 and 1.5.2 to clarify the On-Call process for after-hours request and capture scope of work for the Medical Reviewer and preauthorization staff member who are on-call • Section 2: reorganized and updated subsections to clarify scope of work for pre-authorization staff more clearly. • Added Subsections 3.1 and 3.2 to describe additional components of the clinical evaluation • Added 3.3.3 • Subsection 3.5: Removed "final" preceding decision • Subsection 3.5.3: Added "and if the original requestor agrees" • Subsection 3.5.4.1: Reworded for clarity • Subsection 4.1.1: Added "opioid" as this limit exclusively applies to controlled opioid medications • Subsection 4.1.2: Added "and non-opioid controlled medications" • Subsection 4.1.3: Added "or based on clinical use for non-formulary medications"
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	- Added 4.4 to describe instances when a previous approval may be discontinued early to prevent therapeutic duplication with a new approval. Updated Section 6 to capture DC regulations 07/24 - P&T Committee changed from Responsible Department to Responsible Parties - Updated Approver names and titles - Updated NCQA reference to 2024 Standards - Reworded the Purpose statement for clarity and to remove references to policies that cite this policy as a reference. - Incorporated content from pharmacy policy 212.DC Prior Authorization - Reformatted procedures to improve readability and minimize redundancy. - Removed duplicative content captured in both policy 218.DC and retired policy 212.DC - Clarified the process for identifying and redirecting to formulary-preferred alternative medications. - Added section about duration of approval (section 4) - Added Appendix: Prescription Reimbursement Claim Form 07/23 - Responsible Parties changed to Health Plan Pharmacist - Health Plan Pharmacist added with Medical Director throughout Policy - Updated NCQA reference to 2023 Standards - Removed Prior Auth Medication Form. 09/22: - Updated the contact information and provided a link to the documents on the MedStar Family Choice DC Web site. - Combines all requests into Pre-Service and Post-Service. 07/22: - Updated Responsible Parties to Plan Pharmacist. - Changed Approved from Patryce Toye, MD CMO to Raymond Tu, MD Senior Medical Director (CMO).
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	• Updated NCQA Reference to 2022 Standards. • Updated tables to reflect changes to UM5C for pharmacy 24-hour response time. 07/21: • Changed Case Management to Clinical Operations in Responsible Departments. • Changed responsible parties from Dr. Patryce Toye & Dr. Danielle Gerry to Raymond Tu, MD & Seema Kazmi, PharmD. 10/20: • New policy.
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Appendix I. Prescription reimbursement claim form.



14423-STANDARD-0816

Prescription Reimbursement Claim Form

Important!



- Always allow up to 30 days from the time you receive the response to allow for mail time plus claims processing.
- Keep a copy of all documents submitted for your records.
- Do not staple receipts or attachments to this form.
- Reimbursement is not guaranteed and other contractor will review the claims subject to limitations, exclusions and provisions of the plan.

STEP 1

Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number (refer to your prescription card)

Group Number/Group Name

Last Name

First Name

MI

Address

Address 2

City

State

Zip

Country

Patient Information—Use a separate claim form for each patient

Last Name

First Name

MI

Date of Birth

Male

Female

Phone Number

Relationship to Primary Member

Member

Spouse

Child

Other

Pharmacy Information

Pharmacy Name

Address

City

State

Zip

REQUIRED: Please check appropriate box for submitting a paper claim. Claim will be returned if incomplete. (tape receipts or itemized bills on the back)

Reason I am filing this form is:

- ☐ Out of the country
☐ Pharmacy does not accept insurance
☐ Compound
☐ No insurance coverage at the time
☐ Other—provide reason below

☐ Medication purchased outside of the United States (tape receipts or itemized bills on the back)

PLEASE INDICATE:

Country:

Currency used:

Other Insurance Information

Coordination of Benefits (COB)

Are any of these medicines being taken for an on-the-job injury? ☐ YES ☐ NO

Is the medicine covered under any other group insurance? ☐ YES ☐ NO

If YES, is other coverage:

- ☐ PRIMARY ☐ SECONDARY
☐ MEDICARE PART D

If other coverage is PRIMARY, include the Explanation of Benefits (EOB) with this form.

Name of Insurance Company:

ID#:

Continued

Pharmacy Information Continued

Phone Number

Is this an on-site nursing home pharmacy?

YES

☐

NO

☐

NCPDP/NPI Required

X

Signature of Pharmacist or Representative (REQUIRED)

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

X

Signature of Plan Participant (REQUIRED)

Date

STEP 2 Submission Requirements

You **MUST** include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will **ONLY** be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Medicine NDC Number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)
- Pharmacy Name and Address or Pharmacy NABP Number

A valid Prescribing Physician's NPI (National Provider Identification) number is required, please provide:

Prescribing physician's information (all fields required):

Name:

Address:

City, state, zip:

Phone:

Additional comments:

STEP 3 Mail completed forms with receipts to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

IMPORTANT REMINDER—To avoid having to submit a paper claim form:

- Always have your card available at time of purchase.
- Always use pharmacies within your network.
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your card.