Outpatient Medications Process

Outpatient Overview

Prior authorizations (PA) for certain drug prescriptions help ensure all necessary clinical criteria are met for coverage. The process for submitting a prior authorization may differ depending on several factors.

The main consideration is the medication, which determines who will process the request. How and where the drug is administered are also key factors. Some oncology drugs and some injectables require PA before being administered at home, in a doctor's office, or an outpatient facility.

Part D Medications

Medications covered under the pharmacy benefit can be oral, injectable, infusible, or topical medications such as creams and lotions. Prescription drugs under the pharmacy benefit are subject to formulary tiers and may require authorization.

View the list of drugs and prior authorization requirements by plan.

Part B Medications

Outpatient (part B) medications are covered when Medicare coverage criteria are met. Outpatient (part B) medications, in accordance with Medicare coverage criteria, are covered when furnished "incident" to a physician service for drugs that are "not usually self-administered by the patient."

View the list of office administer part B step therapy medications.
View the list of office administered part B prior authorization therapy medications.
View the list of office administered part B medications that do not require authorization.

Please note: Requests for outpatient part B medical pharmacy drugs (J -Codes) are reviewed by the Utilization Management department.

For medications not addressed in this document, refer to the Medicare Coverage Database to search for applicable coverage policies (National Coverage Determinations, Local Coverage Determinations and Local Coverage Articles).

Part B versus D

Medicare medical insurance or part B also covers other selected medications. Some of these medications include:

- Oral anti-emetics if used within 48 hours after chemotherapy administration.
- Immunosuppressants for members who received a Medicare covered transplant.
- Immune globulins for members with primary immune deficiency when provided in the home.
- Infusion/injectable drugs that require a pump for infusion.
- Nebulized drugs for members in the home that require administration via DME.

View the list and billing determination forms for part B vs D drugs.

Where to Submit a Prior Authorization

1. Medications, processed under the pharmacy benefit, filled at retail pharmacies and self-administered specialty medications should be submitted to Navitus:

   Phone 866-610-2273

   Fax 855-668-8552

   Mail PO Box 1039
   Appleton, WI 54912-1039

   For your convenience, the standard prior authorization request form used for submitting requests for medications to be obtained by the member using their pharmacy benefit can be found here.

2. Medications, processed under the medical benefit, administered by healthcare professionals in the physician office setting should be faxed to the Utilization Department at 855-341-0720. For your convenience, the standard prior authorization request form used for submitting requests for outpatient part B medical pharmacy drugs (J -Codes) can be found here.

Where to Submit an Appeal

1. Appeals for medications, processed under the pharmacy benefit, filled at retail pharmacies and self-administered specialty medications should be submitted to CCA using the Request for Redetermination of Medicare Prescription Drug Denial form.

2. Appeals for medications, processed under the medical benefit, administered by healthcare professionals in the physician office setting, can be submitted to CCA.

   Phone 866-610-2273

   Fax 857-453-4517

   Mail Commonwealth Care Alliance
   Appeals and Grievances Department
   30 Winter Street
   Boston, MA 02108

Avoid delays

Completing and submitting the correct PA form will ensure there is sufficient information for processing your request. This will prevent delays and unnecessary denials.

Please be sure to include:

- prescriber name,
- office phone number,
- member name,
- member ID,
- requested medication/J -code,
- anticipated treatment start date,
- dosing information and frequency,
- diagnosis,
- past therapeutic failures or contraindications,
- any pertinent clinical notes,
- pathology reports,
- lab test results.

The timeframe for processing coverage determination requests is 24 hours for expedited requests and 72 hours for standard requests. To ensure efficient review of prior authorization requests, please submit complete requests.