STATE OF DELAWARE PRESCRIPTION PLAN
Coverage Review Process

The Coverage Review Process is designed to keep up with changes in the prescription marketplace to ensure plan participants are receiving prescription medications that result in appropriate, cost-effective care.

If you are taking any drugs that are subject to coverage review, CVS Caremark will need to review additional information from your doctor before a decision can be made on coverage under the prescription plan. Medications listed as not covered on the State of Delaware Prescription Drug Plan Level Exclusion are not eligible for review.

The coverage review is the ***Initial Determination*** based on plan rules and FDA-approved prescribing and safety information, clinical guidelines, and ACA guides (Affordable Care Act).

The coverage review process may be necessary:

- When the medication is not on the formulary or covered under your plan, or
- When certain medications are used to treat multiple conditions, or
- When the dosage for medications being prescribed **exceeds** the FDA (and formulary) limits.

How the Coverage Review Process Works:

You, your doctor, or the pharmacist can initiate a coverage review by calling CVS Caremark , toll-free at 1-833-458-0835.

In order to begin the coverage review process, please have available your prescribing doctor's name and fax number. CVS Caremark is open 24/7.

- If you use CVS Caremark Home Delivery (mail order), CVS Caremark will call your doctor to start the coverage review prior authorization process for you.
- The coverage review prior authorization process may take up to 15 days however it is often completed within 72 hours upon receipt of all the necessary information from your prescribing doctor.
- If the request is urgent, the request will be completed within 72 hours upon receipt of all the necessary information from your prescribing doctor.
- Upon completion of the coverage review, CVS Caremark will send you and your prescribing doctor a letter confirming whether the prior authorization was approved or denied.
    - If the prior authorization is approved, an approval timeframe is given for each medication depending on the medication. An approval letter will be mailed to you. This letter will reference the date the prior authorization is approved and the date the prior authorization will expire. Once that approval expires, you will need to initiate the coverage review process again.
    - If the prior authorization is denied, you and your prescribing doctor will receive a letter explaining the details of the denial and information with your rights to submit a First-Level Standard Appeal.

Information regarding the non-Medicare Prescription Plan Appeals Process is located online at de.gov/statewidebenefits.