surescripts
How Healthcare Gets Connected™

Surescripts CompletEPA® Quick Reference Guide

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01 CompletEPA Workflow

Workflow

CompletEPA is an automated, real-time electronic prior authorization solution fully integrated within your current e-prescribing workflow. The product streamlines the prior authorization process and improves the efficiency of patient care, without having to leave your EHR application.

1 Provider initiates CompletEPA® request to pharmacy benefit manager (PBM)

The prior authorization process can be started before a medication is prescribed and sent to the pharmacy, or provided retrospectively after the pharmacy has advised the provider or care team that a prior authorization is needed.

Ambulatory Setting

Provider starts a prior authorization request, provides guidance to the patient regarding the prior authorization process and sets appropriate expectations for prior authorization completion.

Acute Setting

In the process of discharging a patient from the acute care setting (ED, in-patient, etc.), the care team member processing the discharge might be notified that a prior authorization is needed for a medication being prescribed.

The care team member should start the Prior authorization request before the patient is discharged and provide guidance to the patient regarding Prior authorization completion timing. Generally, the prior authorization can be completed within a few minutes, but may take longer with some medication/patient/health plan combinations.

2 PBM responds to CompletEPA® request

The PBM will review the request and return one of three responses:

- Completed - Prior authorization not needed for medication/patient/health plan combination
- Completed - Prior authorization not allowed, medication not covered
- Question Set Returned - Prior authorization allowed, please complete attached question set

3 Provider completes CompletEPA® question set provided by PBM

The provider or clinic workflow ensures that the prior authorization question set is completed and returned to the PBM by the due date indicated.

4 PBM-completes question set

The PBM will approve or deny the prior authorization based on the responses to the question set. If the PBM denies the prior authorization, there may be an option to appeal the denial.

If you need additional assistance or have any questions, please email activation@surescripts.com.

02 CompletEPA Best Practices

Using CompletEPA Within Your e-Prescribing Workflow:

- Formulary data available in the industry today is not patient specific, but health plan specific. This means that mediations may be flagged as needing additional clinical information (obtained via question set) in order for the pharmacy benefit manager to approve the dispensing of the medication because there are dispensing limitations of some kind for certain situations.

- You should always complete an eligibility check within your software prior to writing a prescription for the patient, typically no more than three days prior to the patient encounter.

- Patients often do not understand the difference between medical benefits and pharmacy benefits. Providing patient education either at the point of admission or while rooming the patient will help ensure that the clinic can successfully complete a prior authorization using the correct coverage for the patient.

- In an instance where multiple coverages are returned in the eligibility response message from Surescripts, the provider should also confirm which coverage the patient will present to the pharmacy.

- If a prescription is required during a patient visit, initiate the e-prescribing workflow within your EHR application. During this process you may be notified by the formulary that a prior authorization is required. You should also initiate a prior authorization when you want to prescribe outside the limits of one of the following formulary lists for the target medication:
  - Step Therapy
  - Gender Limit
  - Quantity Limit
  - Age Limit
  - Diagnosis Requirements/Off-Brand Use
  - Cost of Medication (Generally newer specialty medications)

- If the prior authorization cannot be completed before the patient is discharged from the hospital, please advise the patient upon discharge that the specific medication may not be ready at his or her pharmacy for up to one business day while the prior authorization is being completed. **Setting the appropriate expectations with the patient or his or her caregiver during the discharge process will reduce pharmacy calls to the hospital and patient inquiries after the patient has been discharged and sent home or transferred to the next care setting**.

- Establish department workflows to ensure that prior authorizations are monitored and completed in a timely manner. It is recommended that a prior authorization be completed before the patient is discharged from the inpatient care setting.

- During the patient encounter (either in person at the point of care or via other means), advise the patient that a prior authorization may be required by their insurance. This will set appropriate expectations for prescription availability once the patient goes to his or her pharmacy of choice. **It will also help reduce pharmacy calls to the clinic and patient inquiries after the patient has been discharged and sent home or transferred to the next care setting.**

- Complete prior authorization's within the timeframe communicated by the PBM in the question set. Ensure that the workflow established within your practice or clinic is designed to accommodate this recommendation.

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- While a PBM may be connected to Surescripts for CompletEPA, there may be health plans supported by that PBM that do not participate in electronic prior authorization. For health plans that do not participate, Surescripts CompletEPA provides connectivity to both third-party processors (i.e. Agadia, MedHok, etc.) as well as a repository of prior authorization forms through our connection to Physician Desk Reference (PDR) to allow for nearly 100% coverage.

- PBMs will generally return a question set within a few seconds of submitting the request. There are factors that could delay the response, but never more than a few minutes on average.
    - Possible delays could be due to the fact that:
        - The PBM was not able to successfully match the patient within the database to the information received in the request.
        - The medication/patient/health plan combination requires manual review before a prior authorization can be allowed.
- If the patient's PBM does not approve the prior authorization and an appeal is required, please reach out to the patient as soon as possible to advise him or her of the delay and, if possible, provide an expected date and time for the appeal to be completed.

- Pharmaceutical companies often provide a variety of co-pay or complete coverage discount cards for high cost or newer specialty medications. These do not replace the need for a prior authorization with the patient's insurer. **The prior authorization should be completed as it would be normally**. The patient should present the pharmaceutical discount card to the pharmacy to modify the cost of the drug. This will ensure the patient's medication remains covered if the prescription needs to be refilled and the discount or co-pay card has expired.

- There are various reasons why the patient may be providing different insurance coverage information to the pharmacy that may not have been known during the e-prescribing process, which may result in a retroactive prior authorization being requested by the pharmacy.

NOTE: Discount cards, co-pay assistance and other forms of pharmaceutical medication support are not included in the formulary data available within the industry today.

- In-clinic dispensed medications may be covered by the medical benefit for a patient rather than the pharmacy benefit. If dispensing items like a flu shot, you will need to confirm which benefit is being billed for the medication. Medical benefit prior authorizations are **not** covered by CompletEPA today.

- In instances where an incomplete electronic prior authorization is returned and "closed" by the PBM, there will generally be a <PANote> included providing additional instructions. It is recommended that the additional actions indicated by the PBM are completed before the medication is released to the pharmacy to help avoid duplicate work streams from occurring.

- When completing a NEWRX and REFRES, it is recommended that you include both the quantity and the days' supply. This will help reduce the number of questions sets you receive for drugs that have quantity dispense limits.

NOTE: A PBM will assume a "30-day supply" is intended to be dispensed unless otherwise indicated in the NEWRX or REFRES.

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Reason Codes

Prior authorization reason codes are used by PBMs/payers to indicate the primary reason for closing a prior authorization communication in regards to a specific request as part of a health care services review. They are typically not displayed to the user, but leveraged by the software application as a way to identify why a PBM/payer has closed or completed a message exchange.

Reason Code	Sample Text	Provider Next Steps
CC	PA not required for patient/ medication.	Proceed with prescribing the medication.
CD	Cannot find matching patient. Check patient eligibility.	Review the patient's eligibility status and confirm patient has pharmacy benefits with the PBM you are trying to send the prior authorization to.
CE	Patient not eligible; does not have coverage with the provider.	Review the patient's eligibility status and confirm patient has pharmacy benefits with the PBM you are trying to send the prior authorization to.
CF	PA duplicate/approved.	Proceed with prescribing the medication.
CG	PA duplicate/in process.	Wait for the PBM to respond to the existing prior authorization and then proceed with prescribing the medication once you receive the approval/denial.
CO*	The receiver is not the PA processor for this patient.	Call the number provided by the PBM in the <PANote> field.
CP*	The receiver is not the PA processor for this patient and medication combination.	Call the number provided by the PBM.
BX	ePA not supported. Submit via other methods.	Call the number provided by the PBM. This reason code will be utilized less and less as more health plans are activated for electronic prior authorization within the PBMs.
BY	Other	Review the note provided by the PBM and follow the provided instructions.

* Please note that Surescripts provides a solution that allows you to reach third-party prior authorization processors if the PBM does not process prior authorizations for that health plan.

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Task Types

Surescripts CompletEPA Accelerator Users only

A Task Type is used to indicate an action a provider or care team must take to process, complete, or close an electronic prior authorization (ePA) request.

Task	Description
Prior Auth Approved	Allows the user to acknowledge that the Pharmacy Benefit Manager (PBM)/insurer has approved his or her prior authorization or prior authorization appeal. Approvals may be appealed (if supported electronically).
Prior Auth Cancelled	Allows the user to acknowledge that the PBM/insurer has approved his or her request to cancel an in-progress prior authorization.
Cancel Request Denied	Allows the user to acknowledge that the PBM/insurer has denied his or her request to cancel an in-progress prior authorization. The optional accompanying <PANote> may indicate the specific reason for the denial.
Prior Auth Closed	Allows the user to acknowledge that the PBM/insurer has sent back a closed response for a prior authorization or prior authorization appeal. The reason code and optional <PANote> returned will indicate the reason the prior authorization was closed. Closed responses cannot be appealed and a new prior authorization must be started if the process is to be attempted again.
Prior Auth Deferred	Allows the user to acknowledge that the PBM/insurer has deferred the determination of a prior authorization. The PBM/insurer should include text describing the appropriate next steps for the provider and patient, and should indicate the next step they will take.
Prior Auth Denied	Allows the user to acknowledge that the PBM/insurer has denied his or her prior authorization or prior authorization appeal. The optional <PANote> may indicate why the prior authorization was denied and may provide appeal information. Denials may also be appealed electronically (if supported).
Prior Auth Error	Allows the user to acknowledge that an error condition was received. The prior authorization process will need to be restarted. For details on individual error codes and conditions, see the Surescripts CompletEPA Implementation Guide.
Prior Auth Not Needed	Call the number provided by the PBM. This reason code will be utilized less and less as more health plans are activated for prior authorization within the PBMs. Allows the user to acknowledge that a prior authorization is not needed for the patient and/or medication requested in the prior authorization.
Complete Prior Auth Criteria	Allows the user to provide more information to the PBM/insurer in regards to the requested prior authorization. Typically will come in the form of a question set that has been determined appropriate for the patient/medication.
Complete Prior Auth Criteria with PDR	Allows the user to utilize PDR, an online prior authorization form provider, to complete prior authorization criteria electronically for PBMs/insurers that are not connected to Surescripts for CompletEPA.

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Accelerator Workflow Process Statuses

Surescripts CompletEPA Accelerator Users only

These process statuses display on the Workflow Processes list and represent the current state of a CompletEPA message.

Status	Description
In Progress	The electronic prior authorization case is currently in progress and is awaiting action from either the prescriber or the PBM/insurer. The case may be "completed" and responded to by the PBM/insurer, but the task is in progress until it is acknowledged by a user in the CompletEPA Accelerator to complete the message workflow.
Complete	The CompletEPA message case has been completed and requires no further action on the part of the prescriber or the PBM/insurer. This may have been the result of an approved/denied CompletEPA message or closed status returned by the PBM/insurer.
Cancelled	An approved "cancelled" response was received from the PBM/insurer. The CompletEPA message was cancelled.
Errored	An error condition was met that resulted in the CompletEPA message case erroring out. The message must be restarted by the initiator.

Accelerator Workflow Processes Task Statuses

Surescripts CompletEPA Accelerator Users only

These statuses relate to the specific actions that have occurred on a task. They can be viewed by selecting a CompletEPA message from the workflow processes list and looking at the process history.

Status	Description
Distributed	The listed item was sent to the listed recipient.
Accepted	The listed item was accepted by the listed recipient. The user took action or began to take action on the task.
Complete	The listed item was marked as completed by the CompletEPA Accelerator. This indicates the listed item is no longer outstanding.
Released	The listed item/task was locked, and the lock was released by the user who accepted it. It was not completed. "Complete PA form" tasks will lock upon being accepted when the user selects the "start" button.
Cancelled	The listed item ended with a successful cancellation.