eviCore healthcare and Cigna Integrated Oncology Management Program
Frequently Asked Questions

Who is eviCore healthcare?
eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides certain utilization management services for Cigna.

What is the relationship between Cigna and eviCore?
eviCore will manage prior authorization requests for services for customers with Cigna-administered benefits beginning on February 20, 2017 for dates of service February 20, 2017 and after for affected medical oncology drugs (including primary chemotherapy and supportive drugs [e.g., medical injectables and infusions]). Cigna will continue to handle all those prior authorization requests prior to February 20, 2017.

Effective July 1, 2017, eviCore will also manage prior authorization requests for oral chemotherapy drugs.

Note: Services performed without prior authorization may be denied for payment, and you may not seek reimbursement from customers in these cases.

How can I initiate a prior authorization request?
The preferred, most efficient method is to initiate a request online at www.evicore.com. You may also initiate requests via phone at 866-668-9250.

What are the hours of operation for the prior authorization department?
eviCore’s prior authorization call center is available from 7:00 a.m. to 7:00 p.m. local time, Monday through Friday. The web portal is available for access 24/7.

What Cigna plans or lines of business are covered under this agreement?
The following plans are included/excluded in this program:

<table>
<thead>
<tr>
<th>Benefit plan type</th>
<th>Included?</th>
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</thead>
<tbody>
<tr>
<td>All core PHS+, Health Matters Care Management Preferred and Health Matters Care Management Complete medical plans (e.g., managed care, OAP, LocalPlus, PPO, indemnity)</td>
<td>Yes</td>
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<tr>
<td>Individual &amp; Family Plans (IFP)</td>
<td>Yes</td>
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<tr>
<td>Shared Administration (SAR)</td>
<td>No</td>
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<td>Arizona Medicare</td>
<td>No</td>
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<td>Third party vendors (TPV)</td>
<td>No</td>
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<td>Client-specific networks (CSN)</td>
<td>No</td>
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<tr>
<td>Payer Solutions</td>
<td>No</td>
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<td>Cigna Global Health Benefit (CGHB)</td>
<td>No</td>
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What are the elements of the Integrated Oncology Management Program?
The main component of the Integrated Oncology Management Program is prior authorization for all primary chemotherapy and supportive drugs (e.g., medical injectables and infusions), beginning February 20, 2017. Oral chemotherapeutic drugs used in the treatment of cancer will be included beginning July 1, 2017. The program also includes newly approved chemotherapy services.

What procedures will require prior authorization?
For the list of affected drugs that require prior authorization, please login to the Cigna for Health Care Professionals website at (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Precertification Policies > Changes to Precertification List Effective February 2017). Note that newly approved chemotherapy agents not on this list and used for the treatment of cancer do require prior authorization.

What medical providers will be affected by this agreement?
All physicians who perform oncology related injection and infusion procedures are required to obtain a prior authorization for services prior to the service being rendered in an office or outpatient setting. Physicians and facilities who render oncology related injection and infusion procedures within the scope of this program must confirm that prior authorization has been obtained. Please note that services performed without prior authorization may be denied for payment, and you may not seek reimbursement from customers in these cases.

You will need to request prior authorization for your patients with Cigna coverage, including those who are receiving these services in the outpatient setting and whose Cigna ID card indicates that prior authorization is required for outpatient procedures.

What information will be required to obtain a prior authorization?
- Member or Patient’s Name, Date of Birth, and health plan ID Number
- Ordering Physician’s Name and NPI Number
- Ordering Physician’s Telephone and Fax Number
- Facility’s Name, Telephone and Fax Number
- Requested drug(s)

Relative diagnosis and medical history including:
- Signs and symptoms
- Results of relevant test(s)
- Relevant drugs
- Working diagnosis and stage
- Patient history including previous therapy
- Recommended Dosing and Administration Information

What is the most effective way to get authorization for urgent requests?
Urgent requests should be made by calling eviCore’s toll free number at 866-668-9250 (7:00 am – 7:00pm local time).
The provider must notify eviCore that the test is “URGENT” and demonstrate medical necessity by providing the appropriate clinical documentation. Urgent care decisions will be made when following the standard timeframe could result in seriously jeopardizing the patient’s life, health or ability to regain maximum function. Note that for in-scope services rendered in settings other than ER, observation, or urgent care, a provider may request a prior authorization on an urgent or expedited basis in cases where there is a medical need to provide the service sooner than the conventional prior authorization process would accommodate.

Will there be any site redirection for high-cost drugs?

Initially, eviCore will request that Neulasta be administered at SOS (11 - office) or (12- home) when the prescriber indicates that they wish to administer the drug at SOS 19 or 22 (OP Hospital) Effective 5/15/2017, eviCore will also request site redirection for Sandostatin, Lanreotide, Aranesp and Procrit.

eviCore will approve these drugs for 30 days of use, after that point Cigna will take over the review

What is the process to follow for urgent Prior Authorization requests if eviCore is not available?
Note that prior authorization is not required for drugs provided in an Emergency Room. Chemotherapy is rarely administered on an urgent basis, however supportive drug therapies that may meet urgent criteria can be submitted through the website and will often receive immediate approval.

If a patient is undergoing treatments that begin before February 20, 2017, but continue after February 20, 2017, will the treatment need a new authorization from eviCore?
No. Patients who are undergoing active treatments on and after February 20, 2017 that have already been approved for coverage by Cigna do not need additional prior authorization approval from eviCore. Existing medical and pharmacy authorizations will continue as previously approved.

What happens if the provider’s office does not know the treatment regimen that needs to be ordered?
The caller must be able to provide either the drug name or the HCPCS code in order to submit a request. eviCore will assist the physician’s office in identifying the appropriate code based on presented clinical information and the current HCPCS code(s) provided.

Where can I see eviCore’s medical oncology coverage criteria?
You can see eviCore’s clinical guidelines for medical oncology at:

Once I ask for a prior authorization, how long will it take to get a decision?
When a prior authorization is initiated online and the request meets clinical criteria consistent with NCCN guidelines and Cigna’s coverage policies, the service will be approved immediately, and a time stamped approval will be available for printing. If the non-urgent request does not meet clinical criteria or requires additional clinical review, a determination is typically made within two business days upon receipt of all necessary clinical information to process a medical necessity review. All decisions are made within five business days once all necessary clinical information is received.
Please note that obtaining a prior authorization approval from eviCore isn’t a guarantee that Cigna will pay for services rendered. The customer must be enrolled in the plan and eligible for benefits on the date you requested the service. Please see plan documents for details about coverage.

**How long will the Prior Authorization approval be valid?**
The length of time for which a prior authorization will be valid will vary by request ranging from approximately 8 – 12 months.

When a prior authorization number is issued for a treatment regimen, the requested start date of service will be the starting point for the period in which the course of treatment must be completed. If the course of treatment is not completed within the approved time period, or if there is a drug change in the regimen, then a new prior authorization number must be obtained.

**Is a separate authorization needed for each drug ordered?**
No. A single authorization number will cover the entire regimen for the length of treatment (up to 12 months depending on the treatment selected). The eviCore system will collect the clinical data needed and provide a list of regimens consistent with NCCN guidelines (single agent and multi-agent) which to consider. Providers may also custom build a regimen by selecting from a list of all drugs covered in the program. In either case, the entire regimen must be provided at the time the authorization is requested. If a new drug is needed at a later date a new authorization will be needed for the complete regimen to be used from that date forward.

**Who should request prior authorization in cases where a Primary Care Physician refers a patient to a specialist, who determines that the patient needs cancer treatment including a drug that requires prior authorization?**
The physician who orders the drug should request the prior authorization. In this case, it would be the specialist.

If a prior authorization number is still active and a patient comes back within the time for follow up and needs an additional infusion of the authorized drug, will a new prior authorization number be required?
No. If the infusion is needed during the timeframe in the prior authorization, the prior authorization will cover additional infusion services of the authorized drug.

**What happens if a service is rendered despite an authorization denial?**
The Integrated Oncology Management Program is a prior authorization program that includes a medical necessity determination for the requested treatment regimen. Coverage for treatment regimens that are not medically necessary may be denied as not covered. Failure to comply with any prior authorization protocol may result in an administrative claim denial.

**In the event of an adverse determination, can I request a peer to peer conversation?**
A peer-to-peer physician discussion can be conducted anytime during the determination and up to 14 calendar days after the determination to add additional information that may affect the outcome of the initial medical necessity decision. Instructions on how to initiate a peer-to-peer discussion will be listed on the denial letter.

**Are any drug modifications allowed under the Medical Oncology Prior Authorization program?**
Yes. However, any modifications to the authorized drug treatment regimen will require a new authorization through eviCore in order for the entire regimen to be covered from the date of the modification moving forward.

Is prior authorization required through eviCore when using an in-scope drug to treat a non-cancer diagnosis?
No. Only drugs used for medical oncology services require prior authorization through eviCore. Oncology-related drugs for non-cancer diagnosis may still require prior authorization through Cigna. Please contact Cigna directly in these cases.

If a denial occurs because of a coding mistake, can I resubmit the claim?
Yes. If the mistake is administrative (related to coding), then a claim can be resubmitted as long as prior authorization remains in effect (and the drug and/or procedure are medically necessary).

If the patient starts a medical oncology regimen at one facility and changes to another facility during a course of treatment, is a new prior authorization required?
Yes. If a new physician group is treating the patient, a new treatment plan will likely follow. Therefore, you must ask for a new prior authorization number.

Where should I send claims once I provide services?
Send all claims as you would normally to Cigna.

Can only the provider request prior authorization?
A representative of the provider’s staff can also request authorization, preferably someone with clinical background acting on behalf of the requesting provider.

How will the referring provider or rendering provider know that a prior authorization has been approved?
The referring provider or rendering provider will be able to verify if a prior authorization request was approved by checking the status on the eviCore website (eviCore.com) or by calling the eviCore Customer Service department.

What information about the prior authorization will be visible on the eviCore website?
The authorization status function on the website will provide the following information:
- Prior Authorization Number or Case Number
- Status of Request
- Cancer Type
- Site Name and Location
- Prior Authorization Date
- Expiration Date

How will all parties be notified if the prior authorization has been approved?
When a prior authorization is initiated online and the request meets clinical criteria consistent with NCCN guidelines and Cigna’s coverage policies, the service will be approved immediately, and a time stamped approval will be available for printing. Providers will also receive a fax confirmation of the approval.
In all other cases, providers will be notified of the prior authorization via fax. Providers can see the status of a prior authorization request anytime by using the eviCore website or by calling eviCore customer service.

Customers will be notified in writing and by phone.

**If a prior authorization is not approved, what follow-up information will the referring provider receive?**
The referring and rendering provider will receive a fax that contains the reason for denial as well as reconsideration and appeal rights and processes. Please note that after the denial has been issued, the referring provider may request a peer-to-peer discussion with an eviCore Medical Director to review the decision.

**Does eviCore follow state-mandated communication requirements related to prior authorization notification?**
Yes. In case of a state law or mandate that requires communication outside of eviCore’s standard practices, eviCore will adhere to that state requirement. This may mean, for example, sending a written letter for a denial in addition to a fax.

**What is the format of the eviCore authorization number?**
An authorization number is (1) one alpha character followed by (9) nine numeric numbers. For example: A123456789.

**If my office does not have Internet access, how can I verify that drugs/services have been authorized?**
If your office does not have Internet access, please call eviCore at 866-668-9250, available 7:00 am – 7:00pm local time.

**What are the parameters of an appeals request?**
Cigna will manage all appeals for the Integrated Oncology Management Program. Providers should refer to the denial notification for instructions on where to submit appeals.