Frequently Asked Questions

Program Overview and Administration

1. Who is Carelon Medical Benefits Management? How will the program be administered?

Carelon is a leading specialty benefits management company with more than 25 years of experience and a growing presence in the management of radiology, cardiology, genetic testing, oncology, musculoskeletal, sleep management, surgical, and rehabilitation. Our mission is to help ensure health care services are more clinically appropriate, safer, and more affordable. We promote the most appropriate use of specialty care services through the application of widely accepted clinical guidelines delivered via an innovative platform of technologies and services. This program will be administered by Carelon.

2. What is the Cancer Care Quality Program?

The Blue Medicare Advantage Cancer Care Quality Program is a utilization management program that requires providers to request prior authorization for therapeutic and supportive medical oncology drugs. It is also a quality initiative program that enables providers to compare planned cancer treatment regimens against evidence-based, optimal cancer treatment regimens, while simultaneously ensuring prescribed regimens are aligned with Anthem medical policy or CMS Coverage Determinations (applicable for Medicare Advantage members).

3. How does the program benefit my practice and patients?

- **Actionable information:** When your practice prescribes a cancer treatment regimen for a patient and submits it to Carelon for review, the prescribed regimen is compared against evidence-based Carelon Cancer Treatment Pathways (Pathways). If the planned regimen is not aligned with a Pathway, information on available Pathway regimens may be presented for your review.
- **Synchronization with health plan medical policy:** drugs managed by Carelon are reviewed in real time against Anthem medical policy.

4. What is the relationship between Carelon and Blue Medicare Advantage?

Blue Medicare Advantage has contracted with Carelon to work directly with you to assist in promoting care that is appropriate, safe, and affordable.

5. How does Carelon work with health plans?

Carelon collaborates with health plans to help improve health care quality and manage costs for some of today's complex tests and treatments, working with physicians like you to promote patient care that's appropriate, safe, and affordable. In partnership with health plans, we are fully committed to achieving their goals – and yours – to improve health outcomes and reduce costs. Our powerful specialty benefits platform powers evidence-based clinical solutions that span the specialized clinical categories where a health plan has chosen to focus. Our robust medical necessity review process is fully compliant with regulatory and accrediting organizations, while offering a superior experience for you and the health plan's providers and members

About the Medical Oncology Program

1. When will this program begin?

Beginning September 20, 2021, Carelon's call center and Web site, Carelon ***Provider****Portal*$_{SM}$ are available for submission of order requests for medical oncology occurring on or after October 1, 2021.

2. What drugs are included in the Blue Medicare Advantage Cancer Care Quality Program?

The program applies to medical oncology and supportive care drugs. Medical oncology pertains to drugs covered under the medical benefit which require administration by a health care professional. Oncology drugs on the pharmacy benefit (e.g., oral cancer drugs) may still require authorization from Blue Medicare Advantage's pharmacy benefit manager.
Categories of drugs that may require prior authorization include:

- Chemotherapy
- Immunotherapy
- Supportive drugs

Prior authorization is not required for non-managed drugs, but the Program reviews treatment regimens as a whole, versus solely as individual drugs, and also includes some of the non-managed chemotherapy or immunotherapy drugs in the evaluation for pathway eligibility.

3. Which Blue Medicare Advantage members require prior authorization through Carelon?

Please check member benefits and eligibility to determine whether prior authorization is required. Blue Medicare Advantage requires clinicians ordering medical oncology treatments to request prior authorization for Medicare Advantage members.

Your request will be reviewed by Carelon, and they will notify you of the decision

4. Which members are not included in the Blue Medicare Advantage Cancer Care Quality Program?

The Blue Medicare Advantage Cancer Care Quality Program does not include the following members:

- Commercial HMO/POS members
- Commercial PPO/EPO plan members
- Medicaid members
- Dual eligible members (Medicare Advantage and Medicaid)
- Federal Employee Plan (FEP) members

5. Where can I find medical necessity criteria (medical policies)?

Click here to get links to medical necessity criteria or Anthem medical policy.
As always, providers should check benefits and eligibility to determine the member's benefits and any authorization requirements.

About the Carelon Clinical Review Process

1. How do I participate in the Medical Oncology Program through Carelon?

The best way to submit a review request is to use the ***Provider****Portal*.

Provider*Portal* allows you to open a new order, update an existing order, and retrieve your order summary. As an online application, ***Provider****Portal* is available 24 hours a day, 7 days a week. Your first step is to register your practice in ***Provider****Portal*- if you are not already registered. Go to www.providerportal.com to register.

If you have previously registered for other services managed by Carelon (diagnostic imaging, radiation therapy), there is no need to register again.

2. Is registration required on ***Provider****Portal*?

Each member of your staff who enters review requests will need to register. Here is how to do it:

- Step one: Go to www.providerportal.com and select "Register Now" to launch the registration wizard
- Step two: Enter user details and select user role as "ordering provider"
- Step three: Create username and password
- Step four: Enter the tax ID numbers for your providers
- Step five: Check your inbox for an email from Carelon. Click on the link to confirm email address

The ***Provider****Portal* support team will then contact the user to finalize the registration process.

3. What do I need to register?

- Your email address
- The tax ID number for the providers whose orders you will be entering
- Your phone and fax number

6. What does the ***Provider****Portal* allow me to do:

- Submit a new order request
- Update an existing order request
- Retrieve your order summary

4. Will members be able to contact Carelon?

Members should contact Blue Medicare Advantage directly if they have any questions.

5. Who can submit review requests?

Ordering providers, servicing providers, and their staff members may submit review requests. When the Ordering provider submits an order request, we encourage servicing/rendering providers to verify that prior authorization has been obtained before performing treatment for a Blue Medicare Advantage member. Providers can verify prior authorization using ***Provider****Portal*.

6. How does a physician office staff member obtain an order number from Carelon and request clinical appropriateness review?

There are two ways providers can contact Carelon to request review and obtain an order number: Online

- Get fast, convenient online service via the ***Provider****Portal* (registration required). ***Provider****Portal* is available 24 hrs./day, 7 days/week. Go to www.providerportal.com to begin.

By phone

- Call Carelon toll-free at: 1-844-767-8157
- Hours: Monday – Friday 8:00 a.m. – 5:00 p.m. CST
- If you need any help using the ***Provider****Portal*, call ***Provider****Portal* support at 1-800-252-2021.

7. What information will the ordering physician or clinician need to have ready to request prior authorization?

- Member's first and last name, date of birth, member ID number
- Line of therapy, stage of cancer, pathology
- Ordering provider's first and last name, servicing provider's name (may be a facility)
- ECOG or performance status
- Chemotherapy, immunotherapy, supportive drugs (all drugs included in the regimen)
- Biomarkers or tumor characteristics
- Tumor-specific and general worksheets can be found on the microsite here.

8. What should I enter as the date of service for the treatment?

The date of service is the actual date the treatment is likely to begin (cannot administer treatment before that date).

9. Will I be required to provide medical records or other clinical documents?

In most cases, medical records are not required. If medical records are needed to complete the review, Carelon clinical review team will notify your office.

10. Do you have to submit a new authorization request for each drug and HCPCS code?

It is preferred that regimens be submitted as a whole. However, it is not uncommon that a new drug is added to the patient's treatment plan. If a new chemotherapy or immunotherapy drug is being submitted, all drugs within that treatment plan must be submitted as a new treatment plan. If a supportive drug is being added that drug may be submitted alone and, in the additional information section, the staff may reference the previously authorized regimen's Order ID number and the type of regimen originally requested, which will help the Carelon Call Center staff to review the case more quickly.

11. Are providers able to submit order requests for supportive drugs only?

Providers may request supportive drugs through the ***Provider****Portal.* After entering the supportive drug, check the box at the bottom of the screen to acknowledge only supportive therapy is being requested at this time. The request will pend for Carelon to review the patient's past chemotherapy regimen history to determine if the supportive only drug is medically necessary and will make a determination accordingly.

12. What happens if I do not call Carelon and do not enter information through the ***Provider****Portal*?

You are encouraged to request a review of the treatment regimen prior to the start of services. Retrospective authorization requests may be initiated up to two business days after the treatment start date. Failure to contact Carelon for oncology treatment and supportive drugs covered under the Blue Medicare Advantage Cancer Care Quality Program may result in claims denials.

About Determinations

1. Once I have submitted a request, how long will it take to receive a response from Carelon?

Requests that meet medical necessity criteria:
Requests that meet criteria receive a response immediately in the ***Provider****Portal* or on the phone with the Carelon contact center.

Requests that do not meet medical necessity criteria:
When an order request cannot be approved immediately, you will have the option of discussing your case with one of our clinical experts. A peer-to-peer discussion with a Carelon medical oncologist is always offered before any adverse determination is made. No adverse determination is made until the case has been reviewed by a medical oncologist at Carelon.

It is important that when Carelon RN informs your office (always via phone), that the case pends for peer-to-peer conversation, your ordering physician calls Carelon as soon as possible to discuss it with the Carelon medical oncologist. Until we receive a phone call back from the ordering physician (or their representative Physician Assistant or Nurse Practitioner), the case will continue to pend. Non-urgent cases will pend for up to 3 business days; urgent requests will pend for up to 24 hours of receipt. At that time, if the clinical information requested is not provided and peer-to-peer didn't take place, the case will be denied. Denial letter will be sent to the member and provider.

2. How will we know when a peer-to-peer is needed?

When a case pends for review, it will go to an "In Progress" status. Carelon will call the ordering provider requesting a call-back for peer-to-peer review, should it be required.

3. Can we request an urgent authorization?

- If you have an urgent request, please contact Carelon at 1-844-767-8157
- Urgent requests will receive a response within 24 hours of receipt.

4. How are reviewed requests communicated?

Carelon will include an order ID for reviewed drugs on an Order Request Summary in the ***Provider****Portal,* whether the order request was initiated in the ***Provider****Portal* or by phone. Carelon is responsible for sending out approval and denial letters to Members and Providers.

Note: an order ID number will not be given if the request is denied.

5. How will the approval of services be communicated to providers?

Once the office staff has entered the required information into ***Provider****Portal*, an immediate decision (in many of the cases) will be rendered. When your authorization is approved, the managed drugs on the Order Request Summary will show:

- The name of the approved drug(s) and their HCPCS codes
- The dosing information
- The number of visits approved
- The total billing units approved
- A valid date range
- An Order ID number and, if applicable, a Pathway Eligible ID number
- S-Codes awarded – Health plan specific

If Carelon needs more information in order to review the case, the system will indicate that it's pending review or "In Progress". A Carelon RN will call the ordering provider's office to obtain clarification or additional clinical records.

6. How will the approval of services be communicated to the [Health Plan]?

The HCPCS code and billing units will be shared with Blue Medicare Advantage. To avoid claims denials, we urge physicians to use the ***Provider****Portal* to verify that an authorization is in place before the treatment is administered. We suggest sharing the Order Request Summary with your billing department; a copy may be printed or a PDF may be created in the ***Provider****Portal*.

7. If the treatment is not approved by Carelon, is there an option to appeal the decision?

Providers can call Carelon within 10 calendar days of a denial decision, to request a reconsideration. If a reconsideration request doesn't lead to an approval, or more than 10 calendar days passed, providers and members can submit 1st level appeals to Blue Medicare Advantage. Denial letters include appeal instructions for both providers and members.

About Carelon Cancer Treatment Pathways

1. What is a Carelon Cancer Treatment Pathway?

Carelon Cancer Treatment Pathways are developed using a rigorous review of professional consensus guidelines and published clinical data. When evaluating a regimen's clinical merits, Carelon oncologists consider:

- Clinical benefits (efficacy)
- Side effects/toxicity – particularly side effects impacting quality of life or commonly leading to hospitalizations
- Strength of consensus guidelines

Lastly, those regimens that have favorable efficacy and toxicity profiles as compared to all other chemotherapy treatments for the same diagnosis are evaluated on the basis of cost.

Standards of oncologic care evolve rapidly. To keep pace, Carelon Cancer Treatment Pathways are reviewed at least quarterly – more often when warranted by new drug approvals, new clinical data, or changes in consensus guidelines.

All Carelon Pathways and Pathway updates are vetted by a panel of practicing community and academic oncologists from the country's leading cancer care institutions before they are adopted.

2. Where can I find a copy of the Carelon Cancer Treatment Pathways?

The Pathways are posted here, where you can find information, tools, and worksheets to assist you in incorporating the program into your practice.

3. What should I consider when selecting a Pathway?

Selecting a Pathway depends upon a number of factors, including the type of cancer, the stage of disease, and the biomarkers or specific genetic profile of the patient's cancer. Within each cancer type, separate Pathways are usually available for early stage through advanced cancer, sub-types of cancer (e.g., HER2 positive), and different lines of therapy.

4. What if I am treating a patient for whom a Pathway regimen is not available?

If a Pathway regimen is not available for a particular type of cancer or line of therapy, the regimen you select will be reviewed for benefit coverage under plan medical policy. Please note that enhanced reimbursement is not available for regimens that are not Carelon Cancer Treatment Pathways.

5. Do Pathways apply to pediatric patients?

Carelon Cancer Treatment Pathways exist for cancers observed most often, but not exclusively, in adults, and can be considered for any relevant patient regardless of age. If a Pathway regimen is not available for a particular type of cancer or line of therapy for a pediatric (or adult) patient, the prescribed regimen still needs to be entered into the ***Provider****Portal* to ensure alignment with Anthem medical policy.

6. What happens if I do not select a treatment regimen that is designated as a Carelon Cancer Treatment Pathway?

The requested treatment regimen will be reviewed for alignment with Anthem medical policy. A regimen that is not a Pathway regimen may still be authorized. The claim for that regimen will be paid, but enhanced reimbursement will not be available.

7. How often are the Carelon Cancer Treatment Pathways updated?

Carelon Cancer Treatment Pathways are reviewed at least quarterly or more frequently, as needed. Updates, which include new pathways and retired pathways, are found here.

About Pharmacy Benefit Programs

1. What should I do if the drugs I am ordering require authorization/precertification through a pharmacy benefit manager (PBM)?

Some drugs used in the treatment of cancer may require prior authorization/precertification through a PBM. Include all drugs when submitting an order request to the program to determine if the regimen is on Pathway, and to learn which drugs, if any, may need to be approved. The ***Provider****Portal* will direct you, as needed, to the appropriate management channel.

About Enhanced Reimbursement

1. What is enhanced reimbursement?

Carelon Cancer Treatment Pathways support high-quality, high-value cancer treatment. By choosing designated Carelon Cancer Treatment Pathway regimens when clinically appropriate, your practice may be eligible for enhanced reimbursement*.

* BCBS in-network providers in Alabama, Arkansas, California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Michigan, Missouri, Nevada, New Hampshire, New York, North Carolina, Ohio, Virginia or Wisconsin may be eligible to receive enhanced reimbursement.

2. Am I eligible for enhanced reimbursement?

Only the ordering provider can bill S-codes to the health plan and receive the enhanced reimbursement. S-codes should be submitted via professional claims. S-codes submitted on a facility claim are not eligible at this time. If S-codes are not billed to the health plan, you will not receive the enhanced reimbursement. To see your reimbursement level, please refer to your Blue Medicare Advantage fee schedule.

The ***Provider****Portal* will display S-codes on the order summary page (we recommend saving the summary page) for ordering providers with instructions for billing S-codes to Blue Medicare Advantage; if processing an order request by phone, S-code information will be provided verbally. No letters about S-code eligibility will be sent. Closed cases will be viewable under the View My Orders tab for 90 days, and under the Check Order Status tab.

3. How will I be notified if I'm eligible for enhanced reimbursement?

If processing an order request through ***Provider****Portal*, review the order summary page for S-codes, and instructions for S-code billing. If processing an order request by phone, you will be provided S-code information verbally. A copy of the summary page can be accessed in ***Provider****Portal* whether you initiate the order request online or by phone. It is recommended that you save the summary page for your practice's records. No letters about S-code eligibility will be sent to your practice.

Simply submit your claim including the applicable S-code. If you don't bill using the S-code, you will not receive the enhanced reimbursement. To see your reimbursement level, please refer to your fee schedule.

4. What if my order summary includes more than one S-code?

The code S0353 may be issued for one-time reimbursement at the onset of treatment planning and care coordination management.

The code S0354 may be reimbursed no more than monthly while coordinating care for an established patient. S3054 is approved for a period of up to five (5) months, as specified when the code is issued. This reflects the expected duration of treatment. For a regimen of fixed duration (e.g., adjuvant therapy), enhanced reimbursement applies for the duration of all planned cycles of chemotherapy. For a treatment regimen that is indefinite (e.g., planned until disease progression), enhanced reimbursement is limited to six (6) months. If treatment continues beyond six (6) months, a new order request should be submitted to Carelon in order to continue to receive enhanced reimbursement. Most users find that the most efficient way to track approved S-code billing durations is to save a copy of the order summary available in the ***Provider****Portal* with a patient's record.

5. How often can S-codes be billed?

S0353 can only be reimbursed once per patient, at the onset of treatment, unless this treatment is changed, and a new cancer treatment Pathway is ordered.

30 days after onset of treatment, S0354 can be reimbursed for each subsequent treatment, up to the maximum number of months as specified in the order summary.* S0354 cannot be reimbursed within 30 days of being reimbursed for S0353. S0534 will be reimbursed no more than monthly (30 days). Any treatment that is extended beyond the maximum number of months on the order summary requires a new order request. S0354 reimbursement is only applicable if the patient continues to be treated with the Pathway for which the S0354 was awarded. Any changes in treatment requires a new order request to be submitted to Carelon via the ***Provider****Portal* or via the phone. It is recommended that the practice saves the approved order summary to the patient medical record. Order summaries can be found in the ***Provider****Portal*.

*S3054 is approved for a period of up to 11 months, as specified when the code is issued. This reflects the expected duration of treatment

6. How quickly will the enhanced reimbursements be paid?

Reimbursements will be paid following standard Blue Medicare Advantage claims processing time frames.

7. How will the enhanced reimbursements be paid?

It will be paid by electronic funds transfer (EFT) if the claim was submitted electronically. In rare cases, paper checks will be processed when EFT is not possible.

About the ***Provider****Portal*

1. How do I enter a request on the ***Provider****Portal*?

For step-by-step instructions for submitting a case, go to the Reference Desk in the ***Provider****Portal*

2. Why is a Duplicate Order notification displayed on my Order Request?

This notification will appear when a similar request is on file or the dates from one order to another overlap.
A Carelon RN will review these cases to verify no duplicate is being requested.

3. Why is my physician showing as Out-of-Network?

The physician is Out-of-Network and the benefits may not apply or may be paid at a lower rate. If the regimen meets Pathway criteria, the physician will not be eligible for S-codes. If you believe your provider is in-network, check with your Network Provider representative at Blue Medicare Advantage to see that your provider is entered into the system as in-network. Provider and member files are sent nightly by Blue Medicare Advantage to Carelon.

4. Why is my physician not available for selection in the ***Provider****Portal*?

Ordering Provider:

If you are unable to locate the ordering provider, please contact Carelon as the provider will need to be manually added to the case. *Note*: Ordering provider must be an individual clinician, not a facility.

Servicing Provider:

When locating a provider in the ***Provider****Portal*, you can search the following ways:

- Search for a servicing provider by facility name. *Note*: If you cannot find the facility you are looking for or the facility is showing as out of network, please search for and select the physician's last and first name as the rendering provider.
- Search by entering physician last name followed by the physician first name in the Facility Name field, OR
- Search by NPI

If your servicing provider is not available for selection, click Submit a Facility button to add a provider. These cases will transfer to Carelon for further review.

If you require additional assistance, please contact ***Provider****Portal* support at 800-252-2021.

5. What should I enter as the date of service for the treatment?

The date of service is the actual date the treatment is likely to begin (cannot administer treatment before that date).

6. What does Pathway Eligible ID on the Order Summary indicate?

Pathway Eligible ID's indicate the regimen met Pathway criteria. S-codes are available to be billed by the Ordering Provider only (not the Servicing Provider).

7. What do the deviations on my request indicate?

When entering clinical information of your request, you may encounter the following deviations. These mean that your entry does not align with the expected entry, and may affect Carelon's ability to approve it and/or meeting Pathway status.

- Custom Treatment Plan – this means the combination of therapeutic treatment drugs cannot be matched to an evidence-based regimen; therefore, all of the supportive drugs will also come up as a custom request. The dosing will be manually entered by the requesting provider. These cases will always result in "In Progress" status.

- Cycles/Dosing – changing these fields will often result in a deviation for each drug*, as the Pathways requested are selected based on these parameters as well as safety, efficacy and cost
  - Length of treatment (e.g. every 21 days)
  - Number of cycles (e.g. 1 – 4 cycles, or 1,2,3,4 cycles)
  - Days per cycles (e.g. Day 1, 8, 15)

- Frequency per day (e.g. QD)

*Most drugs are not being managed on the actual dose (e.g. mgs or Grams) but have warnings when the dose is outside the set parameters for the drug being requested. This alerts the staff to verify that the correct dose has been entered.

- Line of treatment, stage, pathology, performance status (ECOG), biomarkers – answering Unknown or Not Reported can often lead to deviations, especially when required for a particular drug (e.g. Herceptin requires a patient to be Her-2 positive). Make sure that the regimen chosen, (always listed at the top of each clinical data collection page) matches the data being entered into the case. Any mismatch will cause a deviation and may cause the case to pend for review or go to an "In Progress" status.

- Febrile Neutropenia (FN) Risk deviation - the risk of developing FN with this type of regimen is:
  - Low – 0 – 10%; no growth factor indicated. Request may require Carelon clinical review.
  - Intermediate – 10 – 20%; must have an additional risk factor to justify the use of a growth factor. Request may require Carelon clinical review.

8. What do the Case Status notifications indicate?

Case Status indicates the overall determination on the request submitted for Carelon review. In addition to case status, it's important to review drug-level notifications within each case. Refer to the question below for more information.

- In Progress – case is pending Carelon clinical review. The request will be reviewed by a Carelon RN (and Carelon MD, if necessary), to clarify/collect additional clinical information via phone call to the provider's office. Peer-to-peer may be offered to gather additional clinical information to evaluate the request against medical necessity criteria. Pathway eligibility has not been determined.

- Completed – case has been reviewed by Carelon and none of the drugs require Carelon clinical review, however they may require review by another entity, e.g., Blue Medicare Advantage or PBM. Drug-level specific messages will indicate which drugs may require review by another entity and who to contact for additional information. Pathway eligibility has been determined. S-codes have been awarded where applicable.

- Authorized – drug(s) requiring Carelon approval has/have been authorized. In addition, there may be additional drugs on the request that require review by another entity, e.g., Blue Medicare Advantage or PBM. Drug-level specific messages will indicate which drugs may require review by another entity and who to contact for additional information. Pathway eligibility has been determined. S-codes have been awarded where applicable.
- Non-Authorized – drug(s) requiring Carelon approval does/do not meet medical necessity criteria and has not been authorized. The entire case is denied. In addition, there may be additional drugs on the request that require review by another entity, e.g., Blue Medicare Advantage or PBM. Drug-level specific messages will indicate which drugs may require review by another entity and who to contact for additional information. Pathway eligibility has been determined; non-authorized cases are not eligible for Pathways. S-codes have been awarded where applicable.
- Multiple Decisions Rendered – therapeutic treatment drug(s) requiring Carelon approval has/have been authorized, but at least one supportive drug has been denied. In addition, there may be additional drugs on the request that require review by another entity, e.g., Blue Medicare Advantage or PBM. Drug-level specific messages will indicate which drugs may require review by another entity and who to contact for additional information. Pathway eligibility has been determined. S-codes have been awarded where applicable.
- Review Cancelled - the case was identified as a duplicate due to it being previously submitted.

9. What do the Drug Status notifications indicate?

Drug Status indicates drug-level determination for each drug submitted for Carelon review.

- Carelon Clinical Review Not Required – Carelon does not review this drug against Anthem medical policy; however, this drug may require review by another entity, e.g., Blue Medicare Advantage or PBM. Drug-level specific message will indicate if this drug require review by another entity and who to contact for additional information.
- Authorized vs. Non-authorized – Carelon reviewed this drug against Anthem medical policy or CMS Coverage Determinations (applicable for Medicare Advantage members only) and determined whether it meets medical necessity.
- Other Impact – Carelon does not review this drug against Anthem medical policy, and this drug requires review by another entity, e.g., Blue Medicare Advantage or PBM. Drug-level specific message will indicate who to contact for additional information.
- Refer to Health Plan – this drug may require review by Anthem. Drug-level specific messages will indicate who to contact for additional information.
- Voluntarily Cancelled – the provider's office canceled/withdrew the drug or case, following submission.
- Not Reviewed/Error Entry – the case was withdrawn (i.e. accidentally entered, duplicate case entry) prior to submission.

10. What if I can't find the diagnosis I'm searching for?

Only oncology diagnoses are managed by Carelon as part of Blue Medicare Advantage Cancer Care Quality Program and can be submitted for review. If you are unable to find the diagnosis in the system, you may call Carelon Customer Service at 1-800-252- 2021 or contact Blue Medicare Advantage.

About Clinical Trials Program

1. Does Carelon conduct prior authorization services and Pathway determination for clinical trial drugs?

The Carelon Oncology Program provides prior authorization services and Pathway determination for non-investigational drugs included in a cancer treatment regimen and executes the review of associated supportive therapy.

Carelon does not review the investigational drug(s) in a clinical trial regimen for the following reasons:

- Investigational drugs are not the financial responsibility of the health plan
- There are no clinical criteria for reviewing such requests

While the ***Provider****Portal* contains a library of current National Cancer Institute (NCI) trials that allow a provider to flag an individual's participation in a qualified trial, Carelon currently uses this information as a mechanism for reporting and analytics.

Requests should include all drugs in the regimen, including clinical trial drugs. This allows Carelon to understand all potential side effects that can occur, which may justify the use of therapeutic and supportive drugs being requested.

2. How do I indicate my patient is enrolled in a clinical trial?

After entering the treatment plan dates, the Carelon system asks the provider if the patient has been enrolled in an NCI-registered clinical trial. If the provider attests the requested treatment is part of a clinical trial, provider is asked to enter a Trial ID.

More Information

1. Where can I access additional information?

Our dedicated medical oncology provider website offers you all the tools and information you need.
To access go here.

For assistance using the ***Provider****Portal* contact us by email here or at 800- 252-2021 (Monday – Friday, 5 a.m. – 5 p.m. CT.)

2. How can I learn more about the Blue Medicare Advantage Cancer Care Quality Program?

To view a video about the Blue Medicare Advantage Cancer Care Quality Program, go here.

Carelon offers a number of resources on its website.

- Program information
- Tutorials on how to enter a request using the ***Provider****Portal*.
- Worksheets to help your office prepare the information needed to enter the request
- Frequently asked questions (FAQs)

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