

Common CoverMyMeds® Denial Codes and Reasons for Oncology Medication Prior Authorization Denials

The primary goal of enforcing prior authorizations for oncology medications in healthcare is to ensure that drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. This process aims to improve patient outcomes by promoting appropriate use and minimizing harm, while also managing prescription drug costs.

At Sun Pharma, we collaborate with prior authorization expedited electronic partners, such as CMM, to expedite the prior authorization process to help your patients receive their therapy as prescribed.

Below is a detailed document outlining common **CoverMyMeds (CMM) denial codes** typically encountered during the **prior authorization (PA)** process for **oncology medications**, including **explanations and examples** to help provider offices understand and address these issues effectively.

CoverMyMeds (CMM) streamlines the prior authorization process for providers, but payers may still deny oncology medication requests for a variety of clinical and administrative reasons. This document outlines the most frequently encountered denial codes, the rationale behind them, and example scenarios to assist healthcare offices in proactively addressing and resolving these issues.

1. Denial Code: CMM-001 – Insufficient Clinical Information

Description:

The submitted prior authorization is **missing required clinical documentation**, such as diagnosis, treatment history, lab values, or imaging results.

Common in Oncology When:

The request lacks documentation showing prior treatments, biomarker testing (e.g., HER2 status in breast cancer, EGFR mutation in NSCLC), or disease staging.

Example:

A provider submits a PA for pembrolizumab (Keytruda®) for a patient with non-small cell lung cancer (NSCLC), but omits PD-L1 expression test results. **The payer denies the request citing insufficient documentation.**

2. Denial Code: CMM-002 – Step Therapy Not Completed Information

Description:

The payer requires that a **formulary-preferred or less expensive therapy be tried and failed** before approving the requested medication.

Common in Oncology When:

The patient has not yet tried the payer's preferred chemotherapy or immunotherapy agents.

Example:

A request for abiraterone (Zytiga®) is submitted for metastatic prostate cancer. The insurer requires that enzalutamide (Xtandi®), their preferred first-line agent, be tried first. The request is **denied due to lack of documented step therapy failure.**

3. Denial Code: CMM-003 – Non-Formulary Medication

Description:

The requested drug is **not on the payer's formulary** and **does not meet the criteria for medical necessity override**.

Common in Oncology When:

The medication is newer, off-label, or not listed in the payer's approved oncology treatment regimens.

Example:

A PA is submitted for trastuzumab deruxtecan (Enhertu®) for HER2-low breast cancer, but the health plan has not yet added this indication to their formulary. The request is **denied as non-formulary**.

4. Denial Code: CMM-004 – Duplicate Therapy

Description:

The requested drug **duplicates therapy** the patient is already receiving **or is contraindicated** for co-administration.

Common in Oncology When:

Two similar mechanism-of-action drugs are requested together, or a drug is requested that overlaps with an active therapy.

Example:

A provider requests both bevacizumab (Avastin®) and ramucirumab (Cyramza®) for a colorectal cancer patient. The **payer flags this as duplicative** VEGF-targeting therapy **and denies the request**.

5. Denial Code: CMM-005 – Off-Label Use Not Supported

Description:

The request is for an **indication not FDA-approved or not supported** by major compendia (e.g., NCCN Category 1 or 2A recommendations).

Common in Oncology When:

Providers request a medication for a tumor type or line of therapy not yet formally supported by evidence.

Example:

A provider submits a PA for using lenvatinib (Lenvima®) in combination with everolimus in pancreatic cancer. The **payer denies it due to insufficient support in NCCN or FDA labeling for this use**.

6. Denial Code: CMM-006 – Incomplete Member Eligibility

Description:

The **patient's insurance information is incorrect** or they are no longer eligible for benefits under the health plan.

Common in Oncology When:

Coverage has lapsed, the wrong payer was selected, or patient demographic data is outdated.

Example:

The office submits a PA for an oral chemotherapy drug, but the **payer denies** it because the member's **coverage ended** the previous month due to a job change.

7. Denial Code: CMM-007 – Provider Not in Network

Description:

The prescribing **physician or treatment center is out-of-network** and not authorized to prescribe under the patient's benefits plan.

Common in Oncology When:

Specialist care or second opinions are sought outside the insurance network.

Example:

A community oncology practice requests a PA for a medication covered only when prescribed by a network-designated academic cancer center. The request is **denied due to the provider's out-of-network status**.

8. Denial Code: CMM-008 – Prior Authorization Expired

Description:

The previously approved **PA authorization period has lapsed** and a new PA is required for continued treatment.

Common in Oncology When:

Maintenance therapy is ongoing, but the office did not submit a renewal PA on time.

Example:

A patient receiving maintenance rituximab is **denied** the next cycle because the original 6-month **PA period has expired and no renewal was submitted**.

9. Denial Code: CMM-009 – Dose or Regimen Exceeds

Description:

The requested **dose or treatment schedule falls outside payer-defined clinical guidelines** or FDA label.

Common in Oncology When:

The office adjusts a dose based on clinical judgment, but it doesn't align with the insurer's coverage policy.

Example:

A provider requests nivolumab (Opdivo®) to be administered weekly instead of every 2 or 4 weeks. **The payer denies due to off-schedule dosing***.

10. Denial Code: CMM-010 – Pharmacy Benefit vs. Medical Benefit

Description:

The request is **submitted under the wrong benefit** (pharmacy vs. medical), leading to automatic denial.

Common in Oncology When:

Oral medications are submitted under medical benefit or infusions under pharmacy benefit.

Example:

Capecitabine (Xeloda®), an oral chemotherapy, is submitted under the medical benefit. The payer **denies and instructs the office to resubmit under the pharmacy benefit**.

Things to consider with the Prior Authorization Process in your offices

Understanding these common denial codes can help oncology practices streamline the PA process and reduce delays in patient care. Recommended best practices include:

- **Proactively gather required documentation**, including test results and treatment history.
- **Confirm formulary status and step therapy requirements** before submission.
- **Verify benefit type and patient eligibility** at time of submission.
- **Utilize CoverMyMeds' real-time tools**, or similar available tools at your office, and payer-specific forms to avoid administrative denials.