

Prior Authorization: *How Targeted Reforms Can Protect Patient Access*

Prior authorization for prescription drugs has expanded well beyond its original purpose as a utilization management tool intended to promote safe, evidence-based, and cost-effective prescribing.

Historically, health insurers and pharmacy benefit managers used prior authorization selectively for high-cost therapies, medications with significant safety concerns, or treatments prone to misuse. However, what began as a targeted cost-control tool has gradually transformed into something far broader.

98%

Medicare Advantage enrollees in 2025 who were in plans that required [prior authorization for Medicare Part B](#) or physician-administered drugs.

66%

New drugs approved between 2013–2017 [were subject to prior authorization](#) under Medicare Part D.

95%

Commercial health plans [use prior authorization](#) for specialty drugs, including complex therapies for rare or chronic conditions.

And patients are paying the price. A [recent survey](#) of insured adults found that prior authorization is the “single biggest burden” when it comes to accessing tests, treatments, or medications. Almost 60% of insured adults with chronic conditions indicated their access to treatment or medication has been denied, delayed, or altered in the past two years.

A Guide to Access Barriers: Key Terms You Need to Know

Utilization management (UM)

Tools used by health insurers and pharmacy benefit managers to evaluate the medical necessity, appropriateness, and efficiency of healthcare services, procedures, and medication.

Prior authorization

A class of UM requirements in which insured patients must obtain payer approval before being able to access the healthcare service or medication.

Step therapy

A requirement applied by insurers or PBMs that mandates an insured patient to try a preferred, lower-cost medicine before a patient can access the treatment initially prescribed by their physician.

[Read more here.](#)

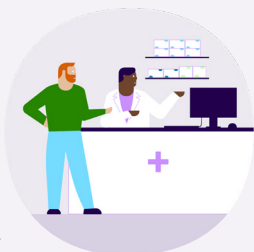
Specialty medicine

Highly complex and often requiring special handling, these therapies are not available at traditional retail pharmacies and must instead be dispensed through specialty pharmacies. [Read more here.](#)

The Patient *Prior Authorization Process*

1 THE Prescription

A physician determines a medication is medically necessary and writes a prescription, which the insurer must approve.

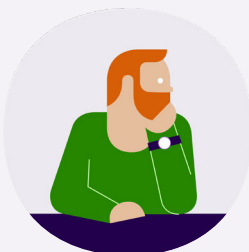


89% *of physicians*

say too many medications and services are subject to prior authorization — before the process has even begun.

2 THE Waiting Game

The patient waits while the physician's office navigates insurer-specific prior authorization rules, submits documentation, and follows up — repeatedly.



13 *hours per week on average*

that physicians and their staff spend on prior authorization requests — time taken directly away from patient care.

3 THE Disruption

For patients already stable on a treatment plan, a new or renewed prior authorization requirement can interrupt therapy mid-course with serious clinical consequences.



61% *of physicians*

report that previously stable patients have been destabilized by prior authorization-related treatment disruptions.

4 THE Harm

Delays are linked to measurable clinical harm such as disease exacerbation, hospitalizations, and in the most serious cases, permanent disability or death.



29% *of physicians*

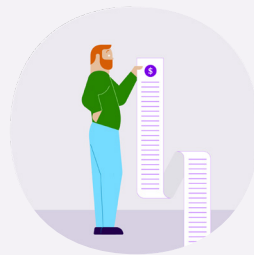
report that prior authorization has caused serious adverse events for a patient, such as hospitalizations and life-threatening situations.

34% *of insured adults*

report prior authorization has had a “major negative impact” on their mental health and emotional well-being.

5 THE Cost

Facing delays and denials, some patients pay out of pocket rather than wait — adding financial harm to clinical harm.

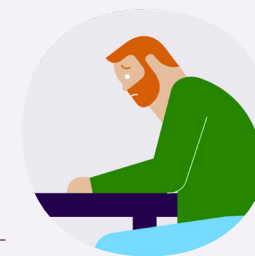


4 in 5 *physicians*

say a prior authorization delay or denial for a prescribed medication at least sometimes leads to a patient paying out of pocket.

6 THE Abandonment

Exhausted by the process or unable to absorb the financial burden, many patients sadly give up on treatment entirely.



36% *of prescriptions*

requiring prior authorization and rejected at the pharmacy will be abandoned, increasing the risk of future health problems or hospitalization.

Addressing Prior Authorization *Requires Targeted Reforms*

Policymakers recognize the burden of prior authorization on patients and recently proposed applying interoperability standards to prior authorization for prescription drugs in certain health plans that the Centers for Medicare and Medicaid Services administers or oversees. Interoperability standards define how electronic health information can be formatted and shared among healthcare providers, health insurers and pharmacy benefit managers, and patients. **For prescription drugs, the proposed interoperability standards support electronic prior authorization, require prior authorization decisions within shorter timeframes that align with federal programs, and increase transparency, including requiring denial reasons and publicly reporting on the use of prior authorization.**

While this is a start, electronic prior authorization is not a fix on its own. Adoption has been slow so far, and lowering the cost for plans to issue a prior authorization can actually increase how often it gets applied. Policymakers should consider other reforms that would lessen the clinical and administrative burdens of prior authorization on patients and healthcare providers while maintaining prior authorization as a tool for ensuring appropriate use of therapies.

Prohibit the misuse of prior authorization.

Prior authorization should not be allowed to impose requirements that go beyond a drug's FDA-approved labeling, nor should prior authorization be used to rewrite the clinical conditions under which an approved therapy may be prescribed.

Limit or remove prior authorization for stable patients.

Patients who are stable on a prescribed therapy should not face new or repeated prior authorization for small adjustments, such as dosage changes, formulary changes, or health insurer transitions.

Stop the delays in treatment for rare and autoimmune diseases.

Prior authorization can be especially harmful for patients with rare or autoimmune disease because delays in treatment may lead to irreversible disease progression, loss of function, or preventable complications. These patients frequently have limited therapeutic alternatives, so imposing prior authorization barriers on clinically appropriate therapies can disrupt disease control and undermine physician judgment.

Monitor the use of prior authorization in Medicare.

As prices under the IRA's Medicare Drug Price Negotiation Program take effect, health plans should not be allowed to use prior authorization to offset the potential patient access gains. The Centers for Medicare and Medicaid Services should monitor the use of prior authorization to assess patient access.

THE BOTTOM LINE: *Patients Can't Wait for Needless Delays*