

NAIC Prescription Drug Coverage (B) Working  
Group

# Prior Authorization in the Pharmacy Benefit

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# Level Set: Medical vs. pharmacy prior authorization

One term, two processes — different benefits, systems, and rules.

## Medical benefit PA

- **What it covers:** clinician-administered drugs, imaging, procedures
- **How it is submitted:** provider files with the plan by **portal or fax**; billed with J-codes
- **Who decides, how fast:** plan clinicians apply medical-necessity policy; takes days
- **Federal mandate:** CMS-0057-F — software integration (FHIR Prior Authorization API) by January 1, 2027
- **Volume:** 7% of medical claims require a Prior Auth

## Pharmacy benefit PA

- **What it covers:** drugs from retail or specialty pharmacy, billed via the PBM
- **How it is submitted:** at prescribing or dispensing — claim rejects, criteria return electronically or by fax
- **Who decides, how fast:** PBM staff review, automated approvals in seconds, faxed requests days
- **Federal mandate:** none — voluntary unless CMS-0062-P is finalized
- **Volume:** 4% of medical claims require a Prior Auth

**Why the distinction matters:** volume, turnaround, and denial data are not comparable across benefits, and most published PA data is medical — this deck addresses pharmacy.

# Why prior authorization is necessary — and recurs

## Patient safety

- Flags dangerous interactions, contraindications, and misuse risk before dispensing
- PBMs see every medication billed to a patient, catching risks no single prescriber can

## Affordability

- FTC: PBMs use step therapy and PA “to lower prescription drug costs and increase formulary compliance”
- NASEM: without controls such as PA, “insurance premiums would rise”
- Up to 50% savings on targeted drugs or drug categories

## Review recurs by guideline

- Phenytoin re-titrated every 7–10 days on levels; INR from weekly to every 4–12 weeks
- Leqembi: imaging abnormalities in 21%; review at the 5th, 7th, and 14th dose

**The point:** an annual cap assumes the clinical picture holds still for twelve months; guidelines set the interval in months, not years.

# How a prior authorization is decided

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Clinicians write the criteria; clinicians apply them to each patient.

- 01 Criteria are developed** Independent P&T committees of physicians and pharmacists write the criteria.
- 02 A drug is flagged for review** PA targets drugs with safety, misuse, or narrow-use concerns, or a lower-cost equivalent.
- 03 The request is reviewed** PBM clinical reviewers weigh the patient's full medication profile against the criteria.
- 04 A determination is issued** Coverage is approved or an alternative offered; appeals cover documented medical necessity.

# In practice: GLP-1s, diabetes vs. weight loss



## Semaglutide (Ozempic / Wegovy)

The same molecule is Ozempic for type 2 diabetes and Wegovy for weight management — different indications, doses, and coverage rules.

### Why the drug triggers review

- Semaglutide and tirzepatide: top two U.S. drugs by spending in 2024
- List prices of \$10,000–\$16,000 per patient per year, ongoing
- 26.5% of diagnosed diabetes patients used a GLP-1 in 2024; ~130 million could qualify for weight loss

### Why the review matters

- Weight-management net prices ran nearly 2.5x the diabetes version, although discounted in direct-to-consumer programs
- Separates an approved use from an off-label cosmetic request

# Criteria are drug-specific - one size does not fit all

Two reviews, GLP-1 and oncology: almost nothing in common.

## Semaglutide (Ozempic / Wegovy)

GLP-1 receptor agonist · sample PA form

### CLINICAL CRITERIA REVIEWED

- ☐ Type 2 diabetes with documented A1c
- ☐ BMI  $\geq 30$ , or  $\geq 27$  with comorbidity
- ☐ Metformin trial or lifestyle program
- ☐ Not for cosmetic weight loss
- ☐ Weight / A1c change for reauthorization

## Pembrolizumab (Keytruda)

Oncology biologic · sample PA form

### CLINICAL CRITERIA REVIEWED

- ☐ Tumor type, stage, ICD-10 diagnosis
- ☐ PD-L1 CPS/TPS, MSI-H or dMMR status (biomarkers)
- ☐ Line of therapy and prior regimens
- ☐ ECOG performance status (daily living scale)
- ☐ Dose and interval per FDA label / National Comprehensive Cancer Network (NCCN)

*One standard form would omit the biomarker and line-of-therapy detail oncology needs — each form is built to its drug's criteria.*

# Where the process breaks down today

The clinical review is sound; the handoff between prescriber and PBM is not.

## Still running on fax and phone

- **47% of transactions are still manual** and ePA adoption is just 53% (AHIP 2024)
- **68,000 prescribers** at 42 health systems ePA-enabled, May 2026 — up 50% in six months (Surescripts).
- Cost and time: Fax or phone: 24 minutes and \$7.50; portal: 16 minutes; **electronic: \$1.89**

## Patients wait

- **Manual review takes a median two days, delaying therapy up to 13 days**

**The friction is caused by delayed adoption:** criteria do not change on an electronic channel.

# ePA is the solution

Turnaround depends on how the request is submitted, not the drug for the form. ePA replaces fax and phone between PBMs and prescribers

## SPEED OF DECISION

< 2 hrs

for 62% of electronic PA requests

62% of ePA requests resolve in under two hours — versus none by fax or phone (CoverMyMeds).

Surescripts: four minutes electronic, two days manual.

Therapy starts up to 13 days sooner.

Automating PA could save plans and providers **\$437 million each year** (CAQH Index, 2021).

Sources: CoverMyMeds; Surescripts; 2021 CAQH Index.

# What's coming: CMS requirements

One rule is final and phasing in; a second, covering drugs, is only proposed.

## Jan 1, 2026 — in effect

CMS-0057-F sets decisions at 72 hours expedited, 7 days standard, with a reason on every denial.

## Jan 1, 2027 — compliance

Payers must run four FHIR APIs, including one for PA; X12 278 alone will not satisfy it.

## CMS-0062-P — proposed

Would extend NCPDP SCRIPT drug PA to Medicaid and CHIP; comments closed June 15, 2026.

**Excluded:** CMS-0057-F covers Medicare Advantage, Medicaid and CHIP, not standalone Part D or commercial plans, so pharmacy ePA stays voluntary.

Sources: CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), January 2024; CMS-0062-P proposed rule, comment period closed June 15, 2026.