Increasing Knowledge of Rare Disease Health Care Coverage

What is a Prior Authorization?

Sometimes payers (such as an insurance company, Medicaid, or Medicare) require you or your health care provider to obtain approval before a specific medical service, procedure, or medication is provided.

Insurance companies are required to follow specific guidelines when reviewing a request for medications or health care services which help to make sure everyone is treated the same. The prior authorization process can be utilized by insurance companies as a cost-control measure to ensure that the treatments and services provided to their members are necessary, appropriate, cost-effective, and fair.

Key parts of prior authorization include:

- **Approval process:** Your health care provider submits a request to the insurance company explaining why the proposed treatment or service is necessary. The insurance company then reviews this request to determine if it meets their criteria for coverage.
- **Medical necessity:** The insurance company assesses whether the requested service or medication is medically necessary based on their guidelines and policies. They may require documentation, such as medical records or test results, to support the request.
- **Coverage determination:** If the insurance company approves the prior authorization request, they agree to cover the service or medication, and it will be paid for according to the terms of your health plan. If the request is denied, you may be responsible for the full cost if you choose to move forward with the service or medication.
- **Time:** Prior authorization requests can take time to process, so it is important to plan. Urgent requests may be expedited; however, routine requests can take several days or weeks. A comprehensive list of state-specific prior authorization response timelines published by the American Medical Association (AMA), can be found here.
- **Appeals:** If a prior authorization request is denied you have the right to appeal the decision. The appeals process allows you to provide additional information or clarification to support your case. You will receive a letter with your denial. Follow the instructions carefully on how to appeal.*

**You will need to work with your health care provider to appeal.*

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