



Navigating Pre-Authorizations: Medications



Picture this: At your last cardiologist appointment, your doctor prescribed a new medication to treat your high cholesterol. The nurse tells you that they have requested pre-authorization and will let you know when they hear back from your insurance company. You thank the nurse and leave the office.

It Matters Empowerment Pathways

So... what really just happened and what does your insurance have to do with it?

A pre-authorization is a restriction placed on certain drugs that require your doctor to get the go-ahead from your benefit plan before your plan will cover the medication. Sometimes they are called pre-approvals, or prior approvals or prior authorizations, but they all mean the same thing. This practice is common in all types of insurance, and even with government sponsored coverage like Medicare, Medicaid, or Tricare.



Your insurance company will review the request sent in by your doctor's office and decide, based on their policies, if you meet their criteria for the medication. Much like you would need to be pre-approved for an auto loan or a mortgage; this process is typical with insurance companies. But why do you have to go through it?

Approved prior authorization is common for medications that have serious side effects, ones that are harmful when combined with other medications, or that are often misused. Or, if your doctor prescribes a medication when less expensive drugs might work the same, your health plan may require authorization for the more expensive medication. Your doctor may also have to provide documentation to your health plan of medications you have tried that did not work well for you or had serious side effects.



After the health plan has completed their review, you and your doctor should both receive the decision, typically in writing. This process can take up to 30 days. However, if your doctor feels that waiting that long might harm you, an urgent (called expedited) request can be submitted. At that point, you should receive a decision within 72 business hours.



A pre-authorization is a restriction placed on certain drugs that require your doctor to get the go-ahead from your benefit plan before your plan will cover a medication.

