

Guidance for managing stable patients responding to treatment, reauthorization requirements for continuing the same therapy, and variation in payor timelines for reauthorization

Prior authorization (PA) was developed as a tool for insurers to assess the necessity of expensive treatments. Today, it has evolved into a system requiring approval for routine medications and procedures, including long-term treatments patients rely on to manage chronic conditions.¹ In many cases, after a patient has received a PA, the patient will need reauthorization (sometimes known as a renewal of authorization) after a specified time.² The rationale for obtaining a reauthorization is to confirm that the drug continues to be medically necessary and that the patient has responded to therapy.

Initial medication authorization times vary and are often for a short amount of time (1 to 6 months). Health plans may specify different durations of coverage or approval periods. The health plan's clinical policy will dictate the duration of treatment and/or the approval period for coverage.

QUICK REFERENCE

Key documentation for reauthorization requests

Clinical data

- Pre-treatment (baseline) assessments: symptoms, labs, imaging
- Most recent provider note with documented:
 - Clinical remission
 - Endoscopic response
 - Functional improvement or disease stabilization
 - Documentation of continued response to therapy (not just continuation)

Objective measures

- Recent labs or biomarkers (e.g., C-reactive protein, fecal calprotectin)
- Endoscopic findings or imaging, if available
- Physician global assessment
- Therapeutic drug monitoring, if relevant (e.g., low levels + partial response)

Visit and monitoring requirements

- Documentation of a clinical visit or lab draw within the plan's required window (e.g., 6–12 months)
- Alignment with monitoring guidelines for biologics or immunomodulators

Administrative and timing essentials

- Date of treatment initiation and PA reauthorization timeline
- Target reauthorization submission date (avoid coverage gaps)
- Coordination with specialty pharmacy alerts and EMR tracking tools (e.g., "snooze" or tickler files)

Precise clinical language

- Use concise, guideline-supported phrases that support medical necessity:
 - "Partial response with low drug levels"
 - "Dose escalation warranted due to persistent disease activity"
 - "Stable on current therapy with documented remission"

UNDERSTANDING THE REAUTHORIZATION PROCESS

Information about reauthorization criteria, timing, and requirements can be found in a health plan's medical policy or during the PA process.

The process and specific requirements for requesting reauthorization for treatment will vary depending on the patient's health plan, pharmacy benefits, or the (medical/clinical) policy. Prior to collecting and submitting the required information, review the policy to determine what is needed to submit for renewal/reauthorization.

Policy requirements	<ul style="list-style-type: none"> <input type="checkbox"/> Review the coverage policy or PA guidelines to understand criteria, forms, clinical evidence, and deadlines required for reauthorization. <input type="checkbox"/> Ensure documentation of a clinical visit and/or labs within the payor-specified window (e.g., within the last 6–12 months), as one of the most frequent reauthorization denial reasons is failure to document a visit or labs.
Baseline and ongoing measurements	<ul style="list-style-type: none"> <input type="checkbox"/> Document baseline measurements before initiating treatment (tests, labs, symptoms). <input type="checkbox"/> Track and submit ongoing assessments showing clinical improvement compared to the baseline. <input type="checkbox"/> Include evidence of symptom relief, functional gains, or disease stabilization. <input type="checkbox"/> Align visit frequency with guidelines for monitoring, especially for patients on biologics or immunomodulators.
Supporting documentation	<ul style="list-style-type: none"> <input type="checkbox"/> Provide detailed records of how the therapy has led to meaningful clinical responses, like: <ul style="list-style-type: none"> <input type="radio"/> Improvement or stabilization of signs and symptoms of the underlying condition <input type="radio"/> Improvement or stabilization of functional status <input type="radio"/> Disease remission or lack of disease progression <input type="radio"/> Document continued response to therapy, not just that treatment is ongoing <input type="checkbox"/> Use standardized, precise clinical descriptors that directly support medical necessity for continued therapy, especially in dose-escalated or non-standard regimens: <ul style="list-style-type: none"> <input type="radio"/> Clinical remission <input type="radio"/> Endoscopic response <input type="radio"/> Partial response with low drug levels <input type="radio"/> Dose escalation warranted based on disease activity
Rationale for continuation	<ul style="list-style-type: none"> <input type="checkbox"/> Clearly justify why the patient should continue therapy, highlighting clinical progress and patient outcomes in concise, structured summaries to improve reauthorization success.

TIMING IMPLICATIONS FOR REAUTHORIZATION

Denials often occur at the start of a new plan year (e.g., Jan.) due to changes in:

- Formulary status
- Preferred agents
- PBM or insurance provider

Tips to minimize delays and time spent on reauthorizations:

- Set a target date to gather documentation well before the reauthorization deadline.
- Proactively confirm reauthorization needs and formulary coverage at the start of each calendar or plan year.
- Schedule patient visits early to complete required tests and avoid treatment delays.
- Consider the treatment start date and dosing intervals to prevent lapses in coverage between doses.
- Account for procurement times (e.g. 20+ days before refill needed) to ensure timely product delivery.
- Use EMR-based task systems (e.g., “snooze” or tickler files) to track reauthorization deadlines.
- Coordinate with specialty pharmacies, which often notify providers ahead of expirations.

HOW TO ADDRESS A REAUTHORIZATION DENIAL²

If a reauthorization request is denied, you will want to quickly understand the reason for the denial and determine the best course of action. Each health plan has specific time frames and appeal options. Review the reauthorization denial letter for specific denial reasons and contact the health plan to understand its appeal process and what is required.

1. Identify the reason: Review the denial letter to understand the specific cause.
2. Peer-to-peer review: Request a peer-to-peer discussion with a gastroenterologist to clarify clinical rationale.³
3. Prepare and submit an appeal: Follow the health plan’s appeal process and submit supporting evidence.
4. Manage delays: Request an expedited review for urgent cases to prevent treatment interruption.
5. Confirm submission: Follow up to ensure the appeal is received and processed.
6. External review option: If internal appeals are exhausted, inform the patient of their right to request an external review by independent experts.

By staying proactive and thorough, you can minimize delays and ensure your patients receive uninterrupted, necessary care.

References

1. Yehia F. Utilization controls for orphan drugs: prior authorization does not correlate with lower drug use. Johns Hopkins Sheridan Libraries. April 17, 2020. Accessed February 3, 2025. <https://jscholarship.library.jhu.edu/handle/1774.2/62594>
2. GUIDE TO REAUTHORIZATION (Renewal of Authorization). Alexion. Accessed February 3, 2025. <https://alexionaccessnavigator.com/-/media/alexionaccessnavigator/global/files/reauthorization-guide.pdf>
3. DeMarzo A. A Look into Peer to Peer. Accreditation Council for Medical Affairs. Published August 7, 2020. Accessed February 3, 2025. <https://www.priorauthtraining.org/a-look-into-peer-to-peer/>