

Use this checklist to ensure all required, payor-relevant elements are included in reauthorization (renewal) submissions to prevent delays, denials, or treatment interruptions.

Prior authorization (PA) was developed as a tool to assess the medical necessity of treatments. In many cases, after a patient receives a PA, reauthorization (sometimes called renewal of authorization) is required after a specified period. 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 periods vary and are often short (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 REAUTHORIZATION CHECKLIST

Administrative completeness

- Correct reauthorization/renewal form obtained (payor/PBM-specific)
- All required fields completed and signed
- Signed consent from patient, if needed
- Submission within payor-required timeframe
- Reauthorization deadline tracked and met

Recent clinical evaluation

- Clinical visit within required timeframe (typically past 6-12 months)
- Updated documentation of symptoms and disease status
- Required labs, endoscopy, or pathology completed (if applicable)

Baseline vs. current status

- Baseline disease severity documented (pre-treatment)
- Current disease status documented
- Clear comparison showing improvement or stabilization

Evidence of response to therapy

- Symptom improvement
- Histologic response
- Endoscopic improvement or stabilization
- Functional or quality-of-life improvement

Continued medical necessity

- Ongoing disease activity OR risk of relapse documented
- Rationale for continuing therapy clearly stated
- Risk of discontinuation described

Therapy details (current regimen)

- Medication name
- Dose and frequency
- Duration of current therapy
- Adherence confirmed

Check for common denial reasons

- No recent clinical visit documented
- Missing baseline comparison
- No objective evidence of response
- Vague statement such as "patient stable" without detail
- Incomplete or unsigned form

UNDERSTANDING THE REAUTHORIZATION PROCESS

Information about reauthorization criteria, timing, and requirements can be found in a health plan’s drug coverage 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 or PBM 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 the 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. Avoid vague terms such as “patient stable” without supporting detail. <input type="checkbox"/> Align visit frequency with guidelines for monitoring, especially for patients on biologics.
Supporting documentation	<ul style="list-style-type: none"> <input type="checkbox"/> Provide detailed records of how the therapy has led to meaningful clinical responses. <ul style="list-style-type: none"> <input type="radio"/> Improvement or stabilization of signs and symptoms of the underlying condition; or <input type="radio"/> Improvement or stabilization of functional status; or <input type="radio"/> Disease remission or lack of disease progression <p><i>Document continued response to therapy, not just that treatment is ongoing</i></p> <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"/> 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. <input type="checkbox"/> Include risk of disease progression or relapse if therapy is discontinued (eg, fibrosis, stricture, food impaction)

TIMING IMPLICATIONS FOR REAUTHORIZATION

- Implement a system for tracking when reauthorization will be needed.
- Set a target date to gather documentation well before the reauthorization deadline.
- Denials may occur at the start of a new plan year (e.g., January 1) due to changes in:
 - Formulary status.
 - Preferred agents.
 - PBM or insurance provider.
- 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), if available, 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 appeals 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. Prepare and submit an appeal [[EoE Letter of Appeal Worksheet](#)]: Follow the health plan’s appeal process and submit supporting evidence.
4. For urgent cases, request an expedited review 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. GUIDE TO REAUTHORIZATION (Renewal of Authorization). Accessed December 30, 2025. <https://alexionaccessnavigator.com/-/media/alexionaccessnavigator/global/files/reauthorization-guide.pdf>
2. DeMarzo A. A Look into Peer to Peer. August 7, 2020. Accessed December 30, 2025. <https://www.priorauthtraining.org/a-look-into-peer-to-peer/>