

KNOW YOUR BENEFITS



What Is Prior Authorization?



If you've ever been told that a medication, test or procedure needs "prior authorization," you're not alone. It's a common part of using health insurance, but it can still be inconvenient to many people. In fact, a 2026 KFF poll found that 1 in 3 insured adults say prior authorizations are a "major burden" for getting health care. An additional 4 in 10 adults say that prior authorization is a "minor burden," meaning about 7 in 10 adults find the process taxing.

While prior authorization can feel like an extra hurdle, understanding how it works can help you avoid surprises and get the care you need with less stress. This article explains prior authorization, including why and when the process is needed.

What Is Prior Authorization?

Prior authorization may also be referred to as preauthorization, precertification or prior approval. Prior authorization is a process where your doctor must get approval from your health insurance before your plan will cover certain medications, treatments or services. It acts as a green light confirming that the care you're about to receive is something your insurance plan considers appropriate and eligible for coverage.

"Step therapy" is another term you may hear when seeking health care. Step therapy is a type of prior authorization in which an insurance company has you try less expensive prescription options before "stepping up" to costlier drugs. Basically, the health plan won't cover the more expensive drug until the lower-cost medication has failed to treat the condition.

Here's a simple breakdown of what usually happens during the prior authorization process:

1. Your doctor recommends care that may need approval.
2. Your doctor's office submits paperwork to your insurance plan.
3. The insurer reviews the request, checking it against their clinical guidelines.
4. You and your doctor receive a decision that's an approval, a denial or a request for more information.

The process may involve different steps, depending on whether the doctor, the lab or a third-party service handles the request. Regardless, the goal is the same: confirming that the plan will cover the care. If the care you need is urgent, most states' laws require the insurance company to respond within 1 to 3 days; however, if the care isn't urgent, the company may take up to a few weeks.

While the prior authorization process helps control costs and reduce unnecessary care, it can also delay care if information is missing or the insurance company needs more details.

When Is Prior Authorization Needed?

You might need prior authorization for:

- Prescription drugs, especially newer, higher-risk or more expensive medications
- Imaging tests like MRI or CT scans
- Planned surgeries or hospital stays

- Specialty treatments or durable medical equipment

Emergency care generally does not require prior authorization, but follow-up treatment sometimes does.

Your benefits documents or your insurer's drug or procedure list can tell you which services need approval.

Who Handles the Prior Authorization Process?

In most cases, your health care provider is responsible for submitting the prior authorization request. They'll explain to your insurance company why you need the treatment and may need to provide medical records or document what other treatments you've already tried.

If you see a provider who is outside your plan's network, you may need to help with the request yourself by contacting your insurance carrier.

What if a Prior Authorization Is Denied?

A denial doesn't necessarily mean you can't get the care. You still have options. As such, you and your health care provider can pursue the following actions:

- Submit more information if something was missing.
- Appeal the decision and explain why the treatment is necessary.
- Explore alternatives that are covered by the plan, such as meeting step therapy requirements.

Appeals are common, and many approvals happen once more detailed medical documentation is provided.

Why Is Prior Authorization Required?

Prior authorization isn't meant to be a barrier to health care. Insurance companies require prior authorization to help ensure that:

- **The treatment is medically necessary**, meaning it's the right care for your condition based on medical guidelines and evidence. This review helps ensure that a medication, test or procedure is known to be effective for your situation. Health plans rely on clinical experts, including doctors and pharmacists, to evaluate requests and compare them to current medical research and guidelines.
- **Safer or more effective options have been considered**, especially for medications or procedures with higher risks, stronger side effects or complex alternatives. Prior authorization allows insurers to confirm that the standard, recommended or lower-cost options were explored first. In addition, insurers may require prior authorization to confirm that these treatments are safe and appropriate for you, especially when there are known risks or contraindications. This extra step helps protect patients from potential harm.
- **Costs stay manageable**, both for you and for the health plan, by checking whether a lower cost but equally effective alternative is available. Health care costs vary widely, even between medications or procedures that achieve the same result. Prior authorization helps prevent unnecessary spending by encouraging the use of treatments that are both effective and cost-efficient. For example, if a generic medication is available and works just as well as a brand-name drug, the insurer may require prior authorization to steer care toward the more affordable option. This helps keep overall plan costs and, ultimately, premiums more stable.
- **Care fits your health plan's coverage rules**, to avoid situations where a service isn't covered and leaves you responsible for a large, unexpected bill. Every health plan has its own list of covered treatments, preferred medications and participating providers. Prior authorization helps verify that the care your doctor orders aligns with your plan's benefits, network rules and coverage requirements.

Conclusion

Prior authorization can feel like an extra layer in your health care journey, but it's designed to make sure the care you receive is safe, effective and covered under your plan. The more you know about the prior authorization process, the more empowered you'll be when navigating your benefits.

If you're unsure whether something needs prior authorization, you can check your health plan documents or call your insurance company. Talk to your health care provider if you have any general questions about prior authorization.