

Prior Authorization (PA) Checklist for HCP Offices



This guide is intended to provide tips and information to help healthcare providers prepare prior authorization (PA) submissions on behalf of their patients. This does not substitute for a physician's medical judgment. Individual payer requirements may vary.

Pre-Submission Note: Verify whether the patient's insurance plan requires a PA, has a step therapy requirement, or has a non-preferred/non-formulary status. If so, seek out the plan's specific guidelines, including PA requirements, forms, preferred submission methods, and submission deadlines before preparing the submission.



Submitting a Prior Authorization (PA)

Step 1 – Gather Patient & Prescriber Information:

- ☐ Patient name, date of birth, and health insurance information (member ID, BIN/PCN, group number)
- ☐ Prescriber name, NPI, phone, and fax number
- ☐ Medication name, dose, diagnosis, and ICD-10-CM code(s)

Step 2 – Prepare Supporting Clinical Documentation:

The following may vary from plan to plan:

- ☐ Clinical notes and medical records, including current and prior treatment history and response to previous therapies, if relevant
- ☐ Relevant lab results, imaging, diagnostic test results, and pathology reports
- ☐ Letter of Medical Necessity (LOMN), including clinical appropriateness, medical justification for the specific therapy, published data, and clinical practice guidelines

Step 3 – Complete & Submit the PA:

- ☐ Complete the plan's required PA form and attach supporting documentation, such as clinical notes and medical records, diagnostic test results, and LOMN
- ☐ If this is for a Medicare patient, use the CMS Model Coverage Determination Request Form, if applicable. If the patient has a Medicare Advantage plan, there may be a separate plan-specific form
- ☐ Submit using the plan's preferred submission method and retain copies for recordkeeping purposes

Prior Authorization (PA) Checklist for HCP Offices (cont.)



Submitting a Prior Authorization (PA) (cont.)

Step 4 – Follow Up:

- ☐ HCP office should make sure to be available during the 24- to 72-hour time period after request submission, should the plan reach out for additional information
- ☐ Keep track of the submission date and the plan's decision time frame
- ☐ Upon PA approval, check with the plan on the length of the authorization, which may vary. Re-authorization may be required



If the PA Is Denied

Step 1 – Review the Denial:

- ☐ Read the denial letter carefully to understand whether the denial is administrative, coverage related, or clinical, such as incorrect/incomplete information, submission deadline missed, non-covered benefit, PA or precertification required, changes in coverage, diagnosis not covered in the health plan, lack of medical necessity, or not medically appropriate
- ☐ If the denial reason is not provided, request written explanation for the denial from the plan

Step 2 – Prepare the Appeal:

- ☐ Confirm the plan's appeals process, submission deadlines, and required forms, and any applicable state and federal guidelines
- ☐ Gather the commonly required documents: a copy of the denial letter, Letter of Appeal with concise rationale for the plan to reconsider the decision, LOMN for the named patient, and other potential clinical documentation

Step 3 – Submit the Appeal:

- ☐ File the appeal as soon as possible, ahead of the plan's deadline, using payer-specific appeal forms if required, via the plan's preferred appeal submission method
- ☐ Double-check submission for completeness and accuracy per plan requirements before filing

Step 4 – Follow Up on the Appeal:

- ☐ Keep track of the submission date and the plan's decision time frame. Be sure to document all discussions and correspondence with plan representatives regarding the denial
- ☐ You may consider requesting a peer-to-peer review with a clinician from the plan where you can explain the clinical need and rationale to cover the previously denied treatment

Prior Authorization (PA) Checklist for HCP Offices (cont.)



Medical Exception

- ☐ If the medication is covered with a restriction or not covered by a payer, an exceptions request may need to be filed with the patient's payer. A formulary exception letter should be completed, describing why the drug is necessary for treating the patient's condition
- ☐ Submit the exceptions letter and supporting clinical documentation using the plan's required method. Once submitted, retain copies for recordkeeping



General Tips

- Be thorough and detailed in all documentation — incomplete submissions are a leading cause of delays
- LOMN may be proactively submitted with the PA to expedite a timely coverage decision
- Keep copies of all submissions, supporting documents, and correspondence with the plan

Find support for BMS medications at [BMSPatientSupportResources.com](https://www.bmspatientresources.com)



Questions? Connect with your dedicated Access & Reimbursement Manager

