U.S. Pain Foundation supports legislation that would standardize prior authorization protocols and streamline patient access to vital medications and treatments. Prior authorization, a check run by some insurance companies or third party payers before they will agree to cover certain prescribed medications or medical procedures, is a cumbersome process that restricts a patient’s access to timely and vital care. It is estimated that current prior authorization practices cost the US healthcare system between $23 and $31 billion annually.\(^1\)

There are a number of reasons that insurance providers require prior authorization, including age, medical necessity, the availability of a generic alternative, or checking for drug interactions. A failed authorization can result in a requested service being denied, or an insurance company requiring the patient to go through a separate process known as "step therapy" or "fail first". Step therapy dictates that a patient must first see unsuccessful results from a medication or service preferred by the insurance provider, typically considered either more cost effective or safer, before the insurance company will cover a different service.

After a physician orders a medical service for a patient, the physician's staff will contact the patient's insurer to determine if they require a prior authorization check to be run. If so, a manual process is initiated. The process to obtain prior authorization varies from insurer to insurer, but typically involves the completion and faxing of a prior authorization form. At this point, the medical service may be approved, rejected, or additional information may be requested. If a service is rejected, the physician may file an appeal based on the provider's medical review process. In some cases, an insurer may take up to 30 days to approve a request.

A 2009 report from the Medical Board of Georgia showed that as many as 800 medical services require prior authorizations.\(^9\) According to Medical Economics, physicians have expressed frustration with the current prior authorization process.
with regards to time spent interacting with insurance providers and the costs incurred based on that time.\textsuperscript{[3]} A 2009 study published in *Health Affairs* reported that primary care physicians spent 1.1 hours per week fulfilling prior authorizations, nursing staff spent 13.1 hours per week, and clerical staff spent 5.6 hours.\textsuperscript{[2]} A study in the *Journal of the American Board of Family Medicine* found that the annual cost per physician to conduct prior authorizations was between $2,161 and $3,430.\textsuperscript{[1]} It is estimated that current prior authorization practices cost the US healthcare system between $23 and $31 billion annually.\textsuperscript{[1]}