Tips for the Payer Approval Process

Every insurance plan is different. Many plans request documentation on the questions below to make a coverage determination for the prescribed medication. This information may be requested on plan specific paperwork, including prior authorizations, appeals, and medical exceptions. Coverage determinations are individualized and based upon the patient's clinical history, relevant testing, and your independent medical evaluation of the patient.

Important Questions for Coverage Determination:

- What is the patient's diagnosis?
- What signs, symptoms, diagnostic tests, or lab results have led to confirming this diagnosis?
- What is the patient's age, height, and weight?
- Does the patient have comorbidities?
- What are the patient's clinical symptoms?
- What labs have you been monitoring for this patient?
- What therapies are currently being prescribed, if any?
- How is the patient responding to current therapies?
- Has the patient's clinical status changed?
- Which therapies have been tried and failed (include length of trial period)? Did the prior therapies fail because of lack of clinical progression or intolerance (side effects)?
- Does the patient have any contraindications to any medications?
- What is the clinical rationale for the change in the patient's treatment plan?
- What is the clinical rationale for choosing the requested therapy?

Other Considerations to Keep in Mind

- Ensure use of the correct ICD-10 code
- Be sure that all questions are addressed
- Highlight key clinical rationale in any supplemental documentation you provide
- Submit in a timely manner
- Sign and date the submission
- Provide your direct phone number for contact information
- Keep a copy of your submission

Phone: 1-855-MRM-4YOU (1-855-676-4968); Monday - Friday: 8:00 am - 8:00 pm ET