

Prior authorizations, exceptions, and appeals

A guide to navigating access
for prescription drugs

A healthcare provider, a woman with short blonde hair wearing a white lab coat, is leaning over a desk and looking at a tablet held by a middle-aged man with glasses and a yellow t-shirt. They are both smiling and appear to be in a collaborative discussion. The background is a bright, modern clinical setting with large windows.

This resource supports
healthcare providers
in navigating government
and private health plans
to obtain coverage for
medically necessary
prescription drugs.

Table of contents

Coverage scenarios >	3
Prior authorizations (PAs) >	4
Tips for submitting PAs >	4
Exception requests >	5
Tips for submitting an exception request >	5
Exception request timelines >	6
Appeals >	7
Types of denials >	7
Tips for submitting an appeal >	8
Appeals processes >	9
Medicare >	9
Medicaid >	10
Medicare and Medicaid resources >	11
Teva Total Support™ >	12

Coverage scenarios

Many health plans require prior approval before a patient can start a prescribed treatment. Even if a health plan does not have an established coverage policy, or doesn't list a medication on its formulary, there are still pathways to help patients access their prescribed treatment. Coverage for prescription treatments may come through the pharmacy benefit or the medical benefit, and will differ based on a patient's plan, including its formulary and overall benefit design.¹

Teva Access and Reimbursement Managers (ARMs) are available for educational support on submitting PAs, exception requests, managing denials, and appeals. Ask your sales representative how to contact your ARM today.

Prescription drugs can fall into several different coverage scenarios^{1,2}:



Covered (on-formulary)

- On the plan-approved drug list, usually broken into tiers
- Tiers determine patient copays and coinsurance (lower tier = lower costs)

Some medications that are on formulary are covered with restrictions:

- **Prior authorization (PA)** requires prescribers to obtain plan approval before medication is covered
- **Step therapy** requires a patient to try and fail an alternative medication
- **Quantity limit** caps the amount of medication dispensed within a certain timeframe



Not covered (non-formulary)

- Not on plan approved drug list
- Patients and providers can **request an exception** for medications that are not covered

Teva Total Support™ helps you and your staff overcome treatment barriers that may prevent your patients from getting the medications they need.

Enroll your patient for support getting started and staying on therapy.

Prior authorizations (PAs)

PAs are a common plan requirement. To confirm medical necessity, plans require providers to obtain approval before the treatment is covered.¹

Tips for submitting a PA³⁻⁵

- ✓ **Review the patient's health plan policies and processes for PAs**
- ✓ **Consider submitting a *letter of medical necessity* to supplement the request.** The letter should include:
 - ✓ Patient information
 - ✓ Prescriber's specialty and credentials
 - ✓ Patient diagnosis and disease severity
 - ✓ Prior treatments, duration, and responses
 - ✓ Rationale for why the requested treatment is medically necessary

Medicare Part D plans generally issue PA decisions within 72 hours for standard and 24 hours for expedited reviews.

Commercial plans often follow similar timing but may vary based on state law and plan policies.

- ✓ **Include supporting documentation** such as medical records, clinical trials, and clinical guidelines to support the requested treatment
- ✓ **Keep records** of all documentation sent, calls placed, and the names, phone numbers, and titles of individuals who have been contacted at the plan
- ✓ **Take note of deadlines and expiration dates.** PAs can expire and it's not uncommon that reauthorization is required every 6-12 months
- ✓ **Submit an appeal if the PA is denied.** Denials are often overturned with a well-written appeal letter

PAs can be submitted through the CoverMyMeds portal for most Teva products.

Additionally, many Teva brands offer a letter of medical necessity template and other patient support services to support the PA process.

Exception requests

An exception request, a type of coverage determination, is a request to the health plan to pay for a medication that is not covered.⁴

Medications can be covered either under the medical benefit or the pharmacy benefit. Either coverage scenario allows use of an exception request.^{1,4}

Consider submitting an exception request when the prescribed treatment²:

- Is not on the plan formulary (**formulary exception**) or, if covered under the medical benefit, when no applicable medical policy exists
- Is on a higher or non-preferred tier and lower cost-sharing is requested (**tiering exception**)
- Is subject to prior authorization, step therapy, or quantity limits that may be inappropriate for the patient

Another appropriate situation to request a formulary exception is when a newly approved medication has not yet been added to the formulary or when a coverage policy has not yet been established.²

Tips for submitting an exception request^{4,6}

An exception request can be initiated by the patient, their caregiver/representative, or provider.

- ✓ Review the plan's process for submitting exception requests, including the use of specific forms or online platforms
- ✓ Provide the clinical rationale as to why the plan's preferred treatment is not appropriate for the patient
- ✓ If the patient is stable on the requested medication, note their response and why switching to a formulary alternative may be unsafe or less effective
- ✓ If requesting a tiering exception, provide the rationale as to why the patient should pay the lower tiered price
- ✓ Consider including a letter of medical necessity to strengthen the request and help support approval

Exception request timelines

Payers must respond promptly to exception requests. The following response timelines are as defined by the Centers for Medicare & Medicaid Services (CMS) for Part D plan sponsors and reflect general standards followed by many commercial payers.⁴



**24
hours**

**72
hours**

Expedited process:

Plans must respond within 24 hours; reserved for high-risk patients

Standard process:

Plans must respond within 72 hours

For either process, the clock starts with receipt of the provider's supporting information

If the exception request is denied, providers should submit an appeal to the plan. Denials are often overturned with a well-written appeal letter.³

An expedited exception decision may be appropriate when waiting longer could jeopardize the patient's life, health, or ability to regain maximum function.⁷

Many states have passed laws that require health plans to offer a process to request an exception to step therapy. For a state-by-state overview.

Visit steptherapy.com.

Appeals

If a PA or an exception request is denied, the next step is to file an appeal. An appeal is a formal request asking the plan to review and reconsider its decision.¹

Types of denials^{5,7,8}



Administrative

Incorrect dates

Improper coding

Missing documentation

Missed submission deadlines

Providers can amend and resubmit the request, or resolve through customer service.



Clinical

Lack of medical necessity

Not clinically appropriate for patient

An appeal may be appropriate to cite specific clinical rationale for coverage.



Coverage

Not covered or excluded from formulary

PA not submitted

Patient has not met PA criteria, including step therapy

Lapse or change in coverage

All plans are required to have a formal appeals process and to provide a written explanation of the next possible level of appeal when a request is denied.

According to a 2024 KFF analysis of CMS Medicare Advantage data, while only ~12% of denied PAs are appealed in Medicare plans, most appeals (~81%) are overturned.

Tips for submitting an appeal⁷

- ✓ **Review the plan's appeal process and deadlines for submission**
- ✓ **Address the reason(s) for the denial**
- ✓ **Consider submitting a *letter of appeal*, which should include:**
 - ✓ Patient information
 - ✓ Denial letter date and denial reason
 - ✓ Statement acknowledging the plan's coverage policy or restrictions
 - ✓ Prescriber's specialty and credentials
 - ✓ Patient diagnosis and disease severity
 - ✓ Prior treatments, duration, and responses
 - ✓ Rationale for why the requested treatment is medically necessary
 - ✓ If relevant, why the plan's preferred alternative may be less effective or poorly tolerated
- ✓ **Include documentation such as a copy of the denial letter, medical records, clinical trials/literature, and clinical guidelines to support the appeal**
- ✓ **Keep records of all documentation sent, calls placed, and the names, phone numbers, and titles of individuals who have been contacted at the plan**
- ✓ **Adhere to plan deadlines and follow up if timely response is not provided**

Many Teva brands offer letter of appeal templates and other patient services to support the appeal process.

Medicare Part D appeals process

Medicare Part D plan sponsors are required to respond to each level of benefit coverage appeal within a specified time frame and to offer both standard and expedited processes⁹:

Request for Coverage Determination	First Appeal Level	Second Appeal Level	Third Appeal Level	Fourth Appeal Level
Review of the PA or coverage exception request by the plan sponsor	Redetermination by the plan sponsor	Reconsideration by the Independent Review Entity (IRE)	Hearing by an Administrative Law Judge (ALJ)	Review by the Medicare Appeal Council
Standard: 72 hours* Expedited: 24 hours	Standard: 7 days Expedited: 72 hours	Standard: 7 days Expedited: 72 hours	Standard: 90 days Expedited: 10 days	Standard: 90 days Expedited: 10 days
After Medicare Appeal Council decision				
Judicial Review	Federal District Court	The patient's out-of-pocket expense must be ≥ \$1,960		

*Time limits shown are for benefit-related appeals. Plans are allowed up to 14 days to respond to payment-related appeals.



If denied, 60 days allowed to file next-level appeal.

For more information about Medicare Part D appeals >

Medicaid appeals processes

Federal law requires all state Medicaid programs to maintain a process that allows beneficiaries to appeal denials. It is important to check with the patient's individual plan as processes vary, but there are some similarities^{7,10}:



Beneficiaries must receive *written* notice when a service is denied. The notice must outline the reason for the denial and explain how to request an appeal.



States may choose to offer beneficiaries a local or county hearing prior to a state-level appeal. States must ensure that hearings are completed within a reasonable period, typically within *90 days* of receiving an appeal request.

If a state does not provide local hearings, it must still offer a state hearing upon request within the federally required timeframe.



Previously authorized services generally must continue without interruption until a final decision is reached, provided a request for continuation of benefits is made within 10 days of receiving the adverse decision.



If the patient is currently stable on the prescribed therapy (even from another plan or recent hospitalization), highlight stability in the appeal as evidence of medical necessity and document the risk of harm if therapy is changed or interrupted.

Medicaid plan rules vary by state. The official Medicaid website has compiled a state-by-state summary of Medicaid and Children's Health Insurance Program (CHIP) plans.

Learn more at
Medicaid.gov.



Medicare and Medicaid resources

Medicare Prescription Drug Appeals and Grievances

Learn more about coverage determinations and appeals (redeterminations)

[Visit CMS.gov >](#)

Medicare appeals forms

Coverage Determination Request Form

Model form to request a coverage determination, including an exception

Request for a Medicare Prescription Drug Redetermination

Model form to request an appeal (redetermination)

Request for Reconsideration of Prescription Drug Denial Form

Model form to request a reconsideration with the Independent Review Entity (IRE)

[Access Medicare appeals forms >](#)

State Health Insurance Assistance Program

Find your state-specific local contact for assistance navigating Medicare

[Visit Shiphelp.org >](#)

Medicaid

Use the interactive map to view information about Medicaid plans in your state

[View interactive map >](#)

teva Total Support

Teva Total Support™ helps you and your staff overcome treatment barriers that may prevent your patients from getting the medications they need. We assist through patient services like benefits investigations, navigating PAs, and nurse support so patients have help to start and stay on treatment.



Navigate your patients and their caregivers through their insurance, Medicare, or Medicaid coverage options to start and stay on treatment



Proactive support throughout the PA process, including accelerating PAs and/or appealing PA denials, to eliminate delays in starting treatment



Coordinated specialty pharmacy services to help ensure timely delivery and seamless experience for patients



Tailored services to keep patients and caregivers informed, supported, and engaged throughout their unique treatment journey through on-demand and ongoing nurse support



Teva Total Support
1-800-887-8100
M-F, 9AM to 8PM ET

Enrollment in the patient support HUB can be completed via enrollment form or by calling 1-800-887-8100, Monday-Friday, 9AM-8PM ET.

References: 1. Centers for Medicare & Medicaid Services. Medicare & You 2026. Accessed June 17, 2026. <https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>. 2. Patient Advocate Foundation. Exploring drug tiers and formulary exceptions. Accessed June 17, 2026. <https://www.patientadvocate.org/wp-content/uploads/PAF-Empowerment-Pathways-Exploring-Drug-Tiers-and-Exceptions.pdf>. 3. American Medical Association. Tips to help physicians reduce the prior authorization burden in their practice. Accessed June 17, 2026. <https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-practice-resources>. 4. Centers for Medicare & Medicaid Services. Exceptions. Accessed June 17, 2026. <https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Exceptions>. 5. National Association of Insurance Commissioners. What is prior authorization? Accessed June 17, 2026. <https://content.naic.org/article/what-prior-authorization>. 6. Medicare.gov. Drug plan rules. Accessed June 17, 2026. <https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules>. 7. Patient Advocate Foundation. A patient's guide to navigating the insurance appeals process. Accessed June 17, 2026. <https://www.patientadvocate.org/wp-content/uploads/Navigating-the-insurance-appeals-guide-pages.pdf>. 8. KFF. Medicare Advantage insurers made nearly 53 million prior authorization determinations in 2024. Published June 16, 2025. Accessed June 17, 2026. <https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024>. 9. Centers for Medicare & Medicaid Services. Medicare prescription drug (Part D) coverage determination/appeals process. Accessed June 17, 2026. <https://www.cms.gov/medicare/appeals-and-grievances/medprescriptdrugapplgriev/downloads/flowchart-medicare-part-d.pdf>. 10. Medicaid and CHIP Payment and Access Commission (MACPAC). Federal requirements and state options: Appeals. Published July 2018. Accessed June 17, 2026. <https://www.macpac.gov/wp-content/uploads/2018/07/Federal-Requirements-and-State-Options-Appeals.pdf>.