The ePA Process for GLP-1 Drugs: A Workflow Guide

By Adrien Laurent, CEO at IntuitionLabs • 11/11/2025 • 55 min read

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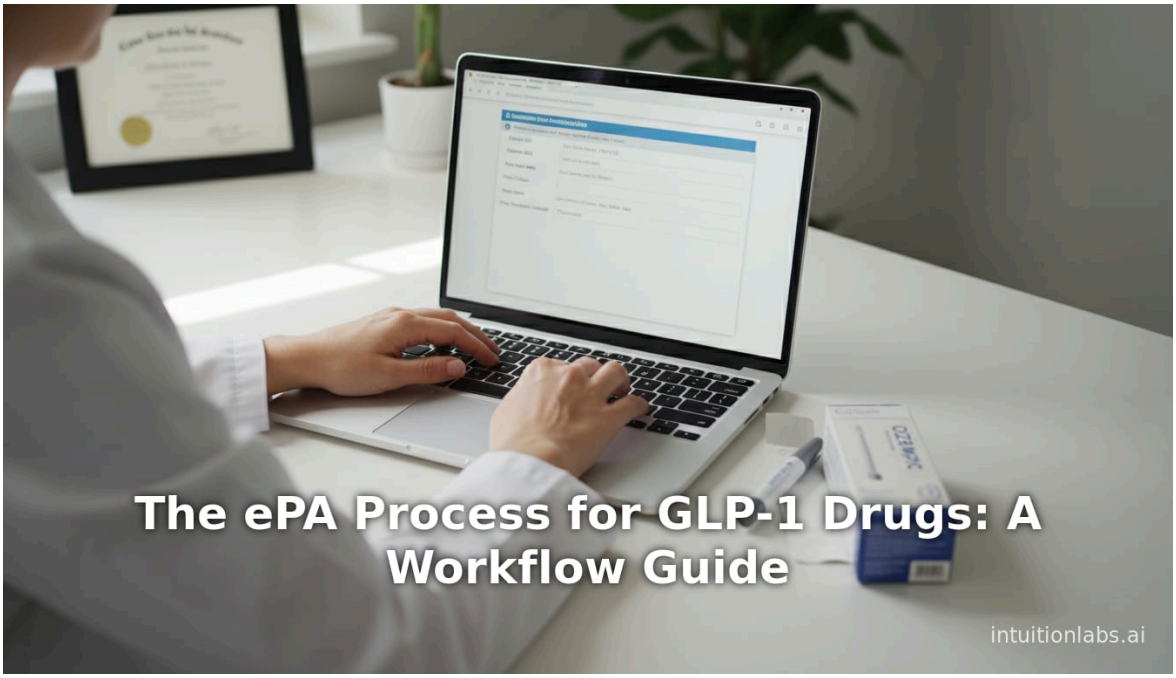

Executive Summary

The **electronic prior authorization (ePA)** process represents a major advancement in the workflow for obtaining insurance approvals of medications. It replaces traditional fax- and phone-based methods with a standardized, interoperable digital workflow embedded into electronic health record (EHR) systems and pharmacy platforms. In particular, high-cost glucagon-like peptide-1 receptor agonist (GLP-1 RA) drugs – used for type 2 diabetes, cardiovascular risk reduction, and obesity treatment – have drawn intense scrutiny from payers due to their steep prices (often **>$1,000/month** per patient ([1] www.ajmc.com) ([2] www.reuters.com)). GLP-1 therapies (e.g. **semaglutide**, **liraglutide**, **dulaglutide**, **tirzepatide**, etc.) require meticulous documentation of medical necessity, weight/BMI criteria, prior treatment failures, and demonstrated benefit, triggering detailed prior authorization (PA) requirements. As one industry expert notes, the GLP-1 PA workflow is "very complex" and has produced high volumes of authorization requests and extensive paperwork, leading to **patient access delays and administrative fatigue** ([3] www.pharmacytimes.com).

ePA technology aims to streamline this process. By leveraging standards such as the NCPDP SCRIPT protocol, ePA enables clinical systems and payers to exchange structured eligibility and PA data in real time ([4] pharmacystandards.org) ([5] pharmacystandards.org). Integrated ePA solutions (e.g. CoverMyMeds, Surescripts) can automatically detect when a prescribed GLP-1 requires PA, pre-fill forms, present insurer-specific criteria, and route the request to the appropriate plan. Importantly, ePA has demonstrated dramatic improvements: pilot programs report **prior authorization requests being processed in minutes instead of days or weeks** ([6] surescripts.com) ([7] www.pharmacytimes.com). In one study, integrating ePA into the prescribing workflow yielded **over 80% faster turnaround times** and **10-hour faster submission** turnaround on average ([7] www.pharmacytimes.com). Providers can track statuses electronically and avoid common errors or omissions that plague manual forms, while payers can enable auto-determination when criteria are met ([8] surescripts.com) ([9] www.pharmacytimes.com).

Despite these advances, ePA uptake is still evolving. A recent industry report found that even with ePA available, **~50% of all PAs** still occur via traditional fax or phone channels ([10] insights.covermymeds.com) ([11] insights.covermymeds.com). Many physicians acknowledge ePA's benefits (e.g. time savings) but cite obstacles such as unfamiliarity, specialty drug complexity, and legacy workflows ([12] insights.covermymeds.com). In response, major insurers, trade groups (AHIP, BCBSA), and regulators have announced plans to mandate or incentivize ePA adoption. In 2025, for example, **over 50 insurers** pledged to answer ≥80% of electronic PA requests in "real time" by 2027 ([13] www.axios.com) ([14] www.reuters.com). U.S. policymakers are also pushing to digitize PA for Medicare Advantage and Medicaid ([15] www.axios.com) ([16] www.reuters.com). Meanwhile, payer programs (e.g. Cigna's Evernorth initiative) and pharmacy benefit managers are developing new tools to manage GLP-1 cost and utilization, often leveraging ePA interfaces.

This report provides an in-depth examination of *how the electronic prior authorization process works for GLP-1 drugs*. We review the historical context of PA and its digitization, describe the technical ePA workflow and standards, and analyze current practice patterns and data. We examine multiple perspectives – providers, patients, payers, pharmacists, and technologists – to understand the real-world behavior of GLP-1 ePA. We include detailed case examples, relevant statistics (utilization, cost, approval rates), and expert commentary. Finally, we discuss implications for clinical care and policy, and future directions (automation, AI, interoperability) to further improve PA efficiency. Throughout, all claims are backed by recent peer-reviewed studies, industry reports, and news analyses ([3] www.pharmacytimes.com) ([13] www.axios.com) ([9] www.pharmacytimes.com). The analysis demonstrates that, while challenges remain, ePA is already transforming GLP-1 access by enabling faster decisions and greater transparency, with promises of even more gains as adoption grows.

1. Introduction and Background

1.1. GLP-1 Receptor Agonist Drugs: Clinical Uses and Market Growth

Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) are a class of injectable (and now some oral) anti-hyperglycemic medications. They mimick the incretin hormone GLP-1, which stimulates insulin secretion and suppresses appetite. Clinically, GLP-1 RAs were initially approved for type 2 diabetes mellitus (T2DM) management, demonstrating durable glycemic control and cardiovascular risk reduction in trials ([3] www.pharmacytimes.com). In recent years these drugs have captured broad attention for obesity treatment. Semaglutide (brand names *Ozempic*, *Wegovy*) and tirzepatide (*Mounjaro*, *Zepbound*) have shown dramatic weight-loss effects in clinical trials and real-world use ([17] apnews.com) ([18] time.com). As a result, new indications for weight management have emerged: for example, **liraglutide (Saxenda) and semaglutide (Wegovy)** are FDA-approved for chronic weight control, often at higher doses. The pipeline includes investigational GLP-1 and dual agonists projected to expand these medications' use to new patient populations.

However, GLP-1 therapies come with substantial costs. Monthly drug costs can exceed **$1,000** per patient. For instance, retail prices for injectable semaglutide (the active ingredient in Wegovy/Ozempic) have been on the order of $1,300–1,400 per month for uninsured patients ([1] www.ajmc.com).These costs have strained healthcare budgets and provoked intense payer scrutiny. According to a Kaiser Family Foundation report, only ~13 Medicaid programs cover GLP-1 weight-loss indications, largely due to expense ([19] www.axios.com), and major insurers have at times **dropped GLP-1 coverage** for obesity after high spending ([20] www.ajmc.com). Medicare limits GLP-1 coverage to diabetes and certain cardiovascular indications, explicitly excluding obesity treatments ([18] time.com). Even in commercial plans and employer groups, early adoption is accelerating but often comes with utilization controls. A Mercer survey in 2024 found that 44% of large employers (≥500 employees) and 64% of very large employers (≥20,000) had added GLP-1 coverage, up from 41% previously . Nevertheless, many plans require step-therapy or prior authorizations to ensure appropriate use.

Given their clinical benefits and high price tags, GLP-1 RAs exemplify a tension in drug coverage: broad therapeutic value versus cost-containment. Payers rely on **prior authorization (PA)** as a utilization management tool. Prior authorization means the prescriber must obtain insurer approval before the prescription will be reimbursed. The rationale is normally to *(a)* confirm the patient meets clinical criteria (e.g. BMI thresholds, documented failure of cheaper meds, etc.) and *(b)* manage utilization to prevent misuse. In practice, GLP-1 prior authorizations typically require detailed documentation of BMI, weight-loss history, diet/exercise attempts, comorbid conditions, and even enrollment in medical weight-loss programs ([21] insights.covermymeds.com) ([9] www.pharmacytimes.com). Because GLP-1 RAs target growing markets (T2DM and obesity affect millions), volume of PA requests has **surged**. Mike Cohn, VP of network operations at CoverMyMeds, notes that GLP-1 popularity has driven "extremely high volumes of prior auths" for these drugs ([22] www.pharmacytimes.com).

1.2. Traditional Prior Authorization: Burden and Delays

Prior authorization arose decades ago to control costs of emerging expensive therapies. However, traditional PA processes are widely criticized for inefficiency. Typically, a PA begins only after a pharmacy claim is rejected or a provider suspects a drug needs authorization. The provider or staff must then find the payer's PA form (often a unique PDF or fax template), collect required clinical information (patient history, labs, etc.), and submit via fax, mail, or phone. Pharmacists play a major role; data show much PA "volume" starts at the pharmacy counter after a claim denies ([23] insights.covermymeds.com). The paperwork is manual, time-consuming, and error-prone. A

trade education module quips that pre-electronic prior auth "has been a world of hold music, dropped calls, illegible faxes, and endless paper forms," costing U.S. healthcare billions in administrative waste and causing care delays ([24] pharmacystandards.org).

For physicians and care teams, PA tasks can consume hours per week. The AMA survey (2019) found an average of 31 PA requests per physician per week, often requiring nurse/PA time ([25] insights.covermymeds.com). Each request can take *days to weeks* for a decision, during which the patient's therapy is deferred. A Pharmacy Times interview captures these challenges vividly: prior authorization for GLP-1 drugs "can require a considerable amount of paperwork" and leads to "administrative fatigue and errors," further delaying patient access ([26] insights.covermymeds.com). Even worse, many PAs are started retroactively, requiring back-and-forth calls.

Over the past decade, awareness of PA burden has grown. Policymakers and industry have introduced initiatives to streamline the process. For example, the 21st Century Cures Act (2016) contained provisions pushing for e-prescribing of PAs, and CMS proposed rules (2022) to modernize health plan authorization processes including electronic exchange of PA information ([15] www.axios.com) ([27] insights.covermymeds.com). More recently (2025), bipartisan pressure and stakeholder meetings have yielded insurer commitments to ease PA requirements and transition to standardized electronic systems ([13] www.axios.com) ([14] www.reuters.com).

However, many experts note that existing initiatives have largely ignored prescription drugs: the early CMS rules and interoperability efforts focused on medical services. Drug PAs account for a substantial fraction of PA workload. In January 2024, an Axios report warned that a new CMS authorization standard split did *not* cover medications, raising concern that pharmacy benefits would not see the same technology investment ([28] www.axios.com). Consequently, voluntary adoption and industry-driven solutions have been the main avenue for drug ePA thus far.

1.3. Emergence of Electronic Prior Authorization (ePA)

"Electronic prior authorization" (ePA) refers to the use of computerized systems to initiate, transmit, and receive prior authorization information between prescribers, pharmacists, and payers. ePA typically leverages the **NCPDP SCRIPT** standard (the same backbone as e-prescribing) to send structured PA requests and responses through existing health IT networks ([4] pharmacystandards.org) ([5] pharmacystandards.org). The goal is to integrate PA into the normal prescription workflow, enabling real-time eligibility checks and reducing manual steps. Instead of faxing a form, providers (or pharmacists) click a button in the EHR or pharmacy system that triggers a digital PA transaction.

In practice, ePA solutions vary by vendor. Two dominant platforms are **CoverMyMeds** and **Surescripts** ([29] pharmacystandards.org), which act as "hubs" interconnecting thousands of EHRs, pharmacies, and insurer systems ([30] pharmacystandards.org). For example, CoverMyMeds (now part of McKesson) began as a web portal to streamline PA forms and has been embedded within many EHRs via APIs. Surescripts, originally known for e-prescribing, expanded its network to support ePA messages among EHRs and major PBMs (including CVS Caremark and Express Scripts) ([31] surescripts.com) ([32] surescripts.com). Other niche players include pharmacy-benefit marketplace portals and insurer-specific ePA websites, but CoverMyMeds and Surescripts account for the majority of electronic traffic ([33] pharmacystandards.org). These systems can automatically load patient and drug data (drug name, dose, ICD-10 code, etc.) into the PA request.

The technical framework relies on the **NCPDP SCRIPT** version 2017071 standard (and its successors). Instead of sending unstructured PDFs, an e-prescribing or EHR system generates a PA request message containing discrete fields: patient info, prescriber, drug NDC, the medical rationale codes, etc. ([4] pharmacystandards.org). This message is routed to the payer (often via the intermediary hub) and the payer's electronic system processes it. If the request meets pre-set criteria, the payer can send an immediate "auto-approval" response; if

not, it may request additional info or eventually send an approval/denial. The response follows back via the same network to EHR/pharmacy with the determination. Hence the entire transaction stays digital.

Key enablers. Real-time patient eligibility/benefit checking ("real-time benefit check" or RTBC) is a related innovation that often pairs with ePA. Some EHRs/show pop-ups at prescribing time if the chosen drug needs PA (based on coverage files), allowing the provider to initiate ePA right away ([8] surescripts.com). Standards like HL7 FHIR are also being explored for PA data exchange. Recent legislation (H.R.6 of 2019) mandates ePA for Medicare Part D drugs, pushing PBMs to connect to EHRs ([27] insights.covermymeds.com). AHIP's 2025 pledge further calls for "standardized electronic data submission requirements" by 2027 ([34] www.reuters.com) ([35] www.reuters.com). Major EHR vendors (Epic, Cerner, etc.) have integrated ePA into their systems, and pharmacies likewise often have ePA interfaces.

Even so, ePA adoption faces hurdles. A CoverMyMeds survey noted that only about **half of all PA requests** were being handled electronically, meaning fax/phone/PBM-portal routes still dominated ([10] insights.covermymeds.com). Reasons include missing interoperability (not all EHRs/PBMs connected), complex specialty drug criteria that require attachments, and payers not accepting ePA for certain drugs or plans ([10] insights.covermymeds.com). Certified ePA pathways often involve work-arounds (like using a payer's online portal if the electronic link fails ([36] pharmacystandards.org)). Nonetheless, for GLP-1 and other specialty meds, the push toward ePA has accelerated because every 30% reduction in approval time translates into concrete gains in patient outcomes (timely titration) and provider efficiency ([37] www.pharmacytimes.com) ([38] www.pharmacytimes.com).

In summary, the background context has three components: (a) GLP-1 medications are clinically important but costly and administratively challenging; (b) prior authorization is the mechanism payers use to manage GLP-1 utilization; © traditional PA is manual and burdensome, but ePA is emerging to address these issues through digital workflows. The remainder of this report explores in detail *how* ePA works for GLP-1 drugs, what data support its effectiveness, and what future trends can be expected.

2. GLP-1 Therapies and Prior Authorization Requirements

2.1. GLP-1 Drugs: Overview and Indications

GLP-1 receptor agonists in current clinical use include **Exenatide (Byetta, Bydureon)**, **Liraglutide (Victoza, Saxenda)**, **Dulaglutide (Trulicity)**, **Lixisenatide (Adlyxin)**, **Albiglutide (Tanzeum)** (discontinued), and **Semaglutide (Ozempic, Wegovy, Rybelsus)**. The newest addition is **Tirzepatide (Mounjaro for diabetes; Zepbound for weight loss)**, a dual GIP/GLP-1 agonist that functions similarly to GLP-1 RAs in clinical practice. Table 1 summarizes key attributes of major GLP-1 RA medications.

Medication (Brand)	Generic	Manufacturer	Administration Form	FDA Indications	Approx. Monthly List Price	Prior Auth Typical?
Ozempic (Wegovy)	Semaglutide	Novo Nordisk	SubQ injection (weekly)	T2DM (Ozempic); Obesity (Wegovy)	~$1,200–$1,350 ([1] www.ajmc.com) ([2] www.reuters.com)	Yes – strict (BMI, prior diets, etc.) ([9] www.pharmacytimes.com) ([39] insights.covermymeds.com)

Medication (Brand)	Generic	Manufacturer	Administration Form	FDA Indications	Approx. Monthly List Price	Prior Auth Typical?
Rybelsus	Semaglutide	Novo Nordisk	Oral tablet (daily)	T2DM	~$800–$900 ([1] www.ajmc.com)	Yes (requires DM indication, etc.)
Victoza	Liraglutide	Novo Nordisk	SubQ daily	T2DM (with metformin etc.)	~$800–$900	Yes (DM control, failure of others)
Saxenda	Liraglutide	Novo Nordisk	SubQ daily	Obesity (BMI ≥30 or ≥27 + comorbidity)	~$1,200	Yes (BMI, docs of lifestyle tx)
Trulicity	Dulaglutide	Eli Lilly	SubQ (weekly)	T2DM (with diet/exercise)	~$800–$900	Yes (e.g. inadequate A1c)
Mounjaro (Zepbound)	Tirzepatide	Eli Lilly	SubQ (weekly)	T2DM (Mounjaro); Obesity (Zepbound)	~$1,350 (Zepbound dose)	Yes (new agent, similar criteria)
Byetta (Bydureon)	Exenatide	AstraZeneca	SubQ (daily/weekly)	T2DM	<$500	Less common now (older drug)
Adlyxin	Lixisenatide	Sanofi	SubQ (daily)	T2DM	~$600–$700	Yes (T2DM)

Table 1. Selected GLP-1 receptor agonists: key information ([1] www.ajmc.com) ([9] www.pharmacytimes.com). Approximate costs are listed for reference; actual patient out-of-pocket is often lower with insurance. All branded GLP-1 RAs typically require prior authorization, especially for obesity indications.

Sources: Drug approvals and indications (FDA); price data and PA requirements from published analyses ([1] www.ajmc.com) ([9] www.pharmacytimes.com).

In practice, all new GLP-1 therapies require PA in most commercial and government plans. Two factors drive this: (1) **medical necessity criteria** – e.g., demonstrating a body mass index (BMI) above a threshold, evidence of past weight management efforts, documented T2D requiring intensification, etc. – and (2) **second-line or specialty status**, meaning cheaper first-line drugs (metformin, sulfonylureas) should be tried first or patient qualifies for subsidized access only under certain conditions. Many payers impose **step-therapy** (fail cheaper diabetes or weight-loss medications) and time-limited approvals (e.g. 6-month to 1-year renewals) before authorizing these expensive injections. Renewal PAs frequently require proof of benefit; for weight loss drugs, insurers often ask for a specific percentage of weight reduction from baseline as evidence of effectiveness ([40] insights.covermymeds.com).

Importantly, GLP-1 drugs blur lines between **on-label indications**. Semaglutide's identical chemical composition is prescribed as Ozempic for diabetes or Wegovy for obesity ([18] time.com). Clinicians argue that restricting one usage while allowing the other is artificial. Yet payers historically have not cross-covered. For example, Medicare Part D distinguishes between diabetes coverage (allowed) versus weight-loss use (excluded) for semaglutide ([18] time.com). Private payers vary: some quietly cover "Ozempic for obesity" under the guise of diabetes indication, others categorically deny Wegovy claims. These inconsistencies make PA rules complex for providers to navigate.

2.2. Prior Authorization Workflows for GLP-1 Drugs

The prior authorization workflow for GLP-1s typically follows one of two pathways:

- **Provider-Initiated PA:** A physician or clinic staff anticipates the need for PA (often when writing the prescription) and initiates it through the EHR or a payer portal. Modern EHRs with ePA tools can automatically detect PA requirements (using formulary data) at the point of prescribing. For example, if a doc orders Wegovy, the EHR may alert that coverage requires PA and offer to begin an ePA submission there ([8] surescripts.com).

- **Pharmacy-Initiated PA:** More traditionally, the patient receives the prescription at a pharmacy. When the prescription claim is submitted, the pharmacy benefits manager (PBM) responds with a rejection code (e.g. "PA required"). The pharmacist or technician then contacts the prescriber's office (via phone/fax or mutual software) to secure approval. In an integrated ePA environment, the pharmacy system can trigger a PA electronically and notify the provider to fill required fields.

Key requirements. While specific PA criteria differ across payers, CoverMyMeds reports common elements: BMI and weight history, documentation of diet/exercise attempts, records of obesity-related comorbidities (hypertension, sleep apnea, etc.), and prior therapies tried ([9] www.pharmacytimes.com). Payers often use **disease-specific PA forms**, which for GLP-1s can be lengthy. For example, one payer's obesity PA form might demand a 3-year weight history chart, an explanation of why metformin alone was insufficient, and recent lab results.

Authorization outcomes. Once submitted, the request is reviewed. Insurers may have built decision trees: if the PA includes all needed documentation and meets criteria, the system can auto-approve. If information is missing or patient is borderline, a nurse/pharmacist may manually review and either approve, deny, or ask for more details. In practice, many PAs for GLP-1s are initially denied because of incomplete paperwork or unmet criteria, requiring appeals. Physician surveys note frustration: "graveyard" of seemingly irrelevant medical data can delay approvals ([3] www.pharmacytimes.com).

Prevalence of PA for GLP-1s. All major GLP-1 medications typically fall under pharmacy benefit prior authorization programs, often as "tier-2 specialty" or "tier-3" drugs. According to a 2021 national analysis of Medicare formularies, **approximately 80–90%** of GLP-1 RAs had at least one formulary restriction (like PA or step therapy) in place ([41] pmc.ncbi.nlm.nih.gov). Even if GLP-1 coverage is allowed, it is almost always conditional. Thus, virtually every patient on a GLP-1 in a private plan will encounter the PA process at some stage.

Figure 1 (below) outlines a **typical manual prior authorization process** for a GLP-1 prescription, contrasted with an electronic route. We then explain how ePA technology changes each step.

Stage	Manual Process	Electronic (ePA) Process
1. PA Trigger	Pharmacy claim rejects; or prescriber suspects PA	EHR/formulary lookup alerts prescriber immediately during prescribing ([8] surescripts.com).
2. Form Obtained	Staff finds disparate PDF forms or provider portal	System auto-selects correct PA form; pre-populates known fields (drug, patient demographics).
3. Documentation	Staff manually enters data (patient history, BMI, etc.)	Smart forms with structured fields; drop-downs and criteria prompts guide completion.
4. Submission	Fax, mail, or phone call to payer; frequent follow-up	Secure electronic transmission via NCPDP SCRIPT; immediate return message of submission status.
5. Review	Payer nurse reviews paper; may request chart notes/patient doc via fax, phone	Payer system applies automated criteria or flags missing info; follow-up through digital portal.
6. Determination	Approval letter faxed or mailed (days/weeks later); often unclear requirements	Response sent electronically – "approved" or "additional info needed" – viewable in EHR/pharmacy system (often within minutes or hours) ([7] www.pharmacytimes.com).
7. Refill & Renew	Each refill may require new PA; manual tracking of expiration	System-triggered renewal reminders; ability to auto-generate renewal based on past data.

*Table 2. Comparison of steps in **manual prior authorization** vs **electronic prior authorization (ePA)** processes for GLP-1 prescriptions. ePA systems integrate with EHR/pharmacy workflows to reduce manual tasks ([4] pharmacystandards.org) ([38] www.pharmacytimes.com).*

The table highlights how ePA **streamlines** each phase. In manual PA, providers face inefficiency and patient risk as approvals can lag. By contrast, ePA often provides near **real-time results** when all information is present. As one CoverMyMeds executive noted, electronic workflows allowed providers in a pilot to complete GLP-1 PAs in under five minutes – unsurprising given the elimination of faxing and form-hunting ([6] surescripts.com). We explore the technical underpinnings of this in Section 3.

2.3. GLP-1 Prior Authorization Criteria in Practice

Given varied payer policies, no single set of national "rules" covers GLP-1 use, but common themes exist. The **American Medical Association** and pharmacy commentators have published summaries of typical criteria. Select examples include:

- **Body Mass Index (BMI):** Many weight loss approvals require BMI ≥30, or ≥27 with comorbidities (e.g. hypertension). Diabetes approvals may accept BMI ≥25. Plans often mandate documentation of current BMI and historically recorded weight ([9] www.pharmacytimes.com).
- **Lifestyle Intervention:** Insurers expect evidence of prior diet/exercise programs. A PA form may ask "Has patient engaged in a structured weight management program for at least 6 months? If yes, describe outcomes." ([9] www.pharmacytimes.com).
- **Comorbidities:** For obesity PAs, common comorbid conditions (type 2 diabetes, sleep apnea, dyslipidemia, etc.) must be documented to justify therapy._ For diabetes PAs, usually patient must already have baseline diabetes medication and meet A1c targets.
- **Failure of Alternatives:** Many payers require trial of first-line agents. For an obese patient, prescribers may have to justify why lifestyle/diet alone is insufficient. For a diabetic patient, they may need to document inadequate control on metformin or a sulfonylurea before advancing to a GLP-1.

Renewals and Outcomes: Notably, GLP-1 PAs often cover only an initial course (e.g. 6 or 12 months). To renew, many payers demand proof of a **"positive clinical response"**. For a weight-loss drug, this might be defined as *≥5–10% body weight reduction* from baseline after 6 months ([40] insights.covermymeds.com). If the patient has gained weight or plateaued, the insurer may decline further coverage. This retrospective requirement underscores why payers push for clear data: if a patient cannot demonstrate benefit, continuing an expensive medication is seen as low value.

Real-world PA Burdens: In interviews, providers report that GLP-1 PAs generate **"ground-level complexity."** The tasks include pulling together multiple charts, scanning files, and entering lengthy justifications – often far beyond simple ICD codes. One physician noted that incomplete documentation easily results in denials, leading to appeals and further backlogs. CoverMyMeds notes that typical GLP-1 PA submissions include *all* required fields (BMI, history, labs) when using ePA tools, whereas manual forms often omit some details ([9] www.pharmacytimes.com).

In summary, GLP-1 prior authorizations universally require careful justification. The differences among payers – even regionally – make the process confusing. A CoverMyMeds guide cautions: *"Coverage varies widely, with different health plans requiring a different set of criteria for approval."* ([42] insights.covermymeds.com). This heterogeneity underscores the need for ePA systems to maintain up-to-date payer rules and alerts, so care teams submit precisely what is needed for each insurer.

3. Electronic Prior Authorization: Standards and Workflow

3.1. Technical Architecture of ePA

At the heart of ePA is the **NCPDP SCRIPT** standard, a set of transaction protocols originally developed for pharmacy claims. SCRIPT now includes transactions for PA requests and responses. When a provider initiates an ePA (either through an EHR or a pharmacy portal), the system generates a **PAInitiationRequest** message: an XML payload defined by NCPDP containing structured fields for patient name, insurance ID, drug code, dosing, diagnosis codes, etc. This message is sent from the **prescriber's EHR** (or pharmacy system) to the **payer's ePA system** via an intermediary or direct connection. Intermediaries like CoverMyMeds and Surescripts wrap these transactions and route them appropriately.

The NCPDP SCRIPT standard for ePA includes multiple possible transactions: *PAInitiationRequest*, *PARespons*, and attachments if needed. Key attributes include:

- **Structured data fields:** Unlike a PDF form, ePA uses coded fields (e.g., "Patient First Name", "Drug NDC", "Quantity", "SIG instructions") ([4] pharmacystandards.org). This means data can be re-used and validated electronically.
- **Clinical code support:** ePA messages can carry diagnosis codes (ICD-10), lab values, or narrative, depending on the payer's system requirements.
- **Status updates:** After submission, payers can send back *PAResponse* messages indicating approval, denial, or need for more information. Some systems even support real-time auto-approval if the criteria are borderline (submitting all required documentation triggers a coded "approved" response immediately).

Because this is built on a standard, it is **interoperable in principle**: any SCRIPT-enabled system can talk to any other. In reality, site-specific connections must still be configured. The Council on Pharmacy Standards notes that "in a perfect world, every provider's EHR would speak SCRIPT fluently to every PBM's system. In reality, the landscape is fragmented with hundreds of EHR vendors and dozens of PBMs ([30] pharmacystandards.org)." Hence, companies like CoverMyMeds have effectively become "switching stations," ensuring that a PA request from an Epic EHR can reach, say, a BCBS insurer system by translating identifiers behind the scenes.

Importantly, ePA still allows uploading of documents. If a PA requires progress notes, chart excerpts, or images, those can be attached to the electronic transaction. This is a vast improvement over fax (where documents can be illegible and disconnected from the form fields). All documentation stays linked to the patient and drug record.

Finally, ePA is often integrated with **eligibility and formulary checking**. EHRs already send an eligibility check (via standard 270/271 or FHIR APIs) when a medication is prescribed to verify coverage tiers. ePA-enabled EHRs use that same data to know ahead of time that a PA will be needed (for example, if Wegovy is covered only under a restricted program). This allows proactive PA initiation without waiting for a pharmacy call.

3.2. Workflow Steps of Electronic Prior Authorization

A detailed ePA transaction typically proceeds in these steps:

1. **Trigger and Initiation:** During e-prescribing, the EHR uses on-file benefits data to flag that the selected GLP-1 drug requires authorization. The provider or staff clicks "Start PA" within the same software window. Alternatively, the pharmacist may send a request via the ePA portal and it notifies the provider.

2. **Form Population:** The ePA system pulls patient demographics, current medication, and insurer info automatically from the EHR. It then presents the correct PA form (the same one a fax would cover) with fields auto-filled where possible (e.g. patient age, diagnosis code, prescriber NPI) ([4] pharmacystandards.org). This greatly reduces keystrokes.

3. **Data Entry:** Care team members fill in the remaining fields: medical history, lab values (HbA1c, etc.), answers to checkbox questions (e.g. "Has patient tried metformin?"), weight trajectory graph, and attachments as needed. Because the form is structured, the system can enforce required fields. This is one reason ePA leads to more complete submissions: missing data is minimized, avoiding one of the top causes of denial.

4. **Electronic Submission:** Once all entries are complete, the user clicks "Submit to Insurer." The EHR or portal then sends the encrypted NCPDP message to the payer network (via Surescripts/CMM). Importantly, the provider does not have to fax – the submission is instantaneous digital.

5. **Insurer Processing:** The payer's backend receives the ePA request. Because the data is structured, the insurer can apply automated logic. For example, it can immediately check if the diagnosis code justifies the drug, if BMI is above threshold, etc. If all criteria are met, the system can auto-generate an approval. If some data is ambiguous, a case manager may route it for review. The payer can also send immediate error messages back (e.g. if the plan info is incorrect).

6. **Real-Time or Near Real-Time Response:** One of ePA's chief benefits is speed. In many cases, the prescriber's system gets a reply within *minutes to hours*. For some payer/EHR integrations, if the submission is perfect, the approval comes back in real time. CoverMyMeds reports that in some ePA pilot programs, the average authorization decision time fell from days to *hours*, corresponding to an **83% reduction** in turnaround time ([7] www.pharmacytimes.com). If further information is needed, the EHR user sees a notice of "additional info required" with instructions (perhaps "please attach recent lab results" etc.) ([7] www.pharmacytimes.com).

7. **Tracking and Documentation:** Once complete, the ePA case remains logged in the system. The provider and pharmacy can view status reports. If a renewal is due, the system can remind the team to re-submit any progress notes. Because everything is electronic, an audit trail of who did what remains accessible, unlike scattered faxes.

The **Council on Pharmacy Standards** course notes that the SCRIPT-based ePA "is not just a 'digital fax'" – it transforms the PA into a managed data exchange ([4] pharmacystandards.org). Indeed, ePA empowers providers to know payer criteria on-the-fly: many systems show the very requirements (e.g. "BMI ≥30, 5% weight loss needed after 6 months") during form completion ([38] www.pharmacytimes.com). This minimizes guesswork. As one expert observed, ePA "can help provide real-time access to insurance-specific needs and criteria for the care team", allowing tailored submissions that avoid missing fields ([38] www.pharmacytimes.com).

By contrast, manual PA leaves providers in the dark. With ePA, CoverMyMeds has found that integration in the clinical workflow yields faster determinations and fewer errors. ([43] www.pharmacytimes.com). To quote their VP, providers are "shocked" to learn how much of the PA-cum-fax process still exists in the modern era, and ePA can markedly change that dynamic ([43] www.pharmacytimes.com) ([38] www.pharmacytimes.com). In practice, many clinics now enable ePA links for GLP-1 drugs: the process can be as simple as clicking a button in Epic or Cerner when writing the prescription.

3.3. Interoperability and Major ePA Platforms

As hinted above, two platforms dominate ePA connectivity:

- **CoverMyMeds (CMM):** CMM began as an independent web portal connecting providers, pharmacies, and payers. In 2017 it was acquired by McKesson. It now boasts direct integration with most major EHR vendors (Epic, Cerner, Allscripts, Athena, etc.) and with retail pharmacy chains (Walgreens, CVS, etc.). CMM's network covers >90% of insured lives in the US. The process in CMM: a PA request slides through CoverMyMeds's servers to reach the insurer's system, and responses come back via CMM.

- **Surescripts:** Primarily known as the national medication information network, Surescripts also supports ePA messages. It has direct connections to several PBMs (CVS Caremark, Express Scripts, etc.) and EHR systems. Its "CompletEPA" service is often embedded in EHRs, leveraging the same networks used for e-prescribing.

Other ePA "hubs" include entities like Availity, RxBenefitHub, and proprietary insurer portals. The Pharmacy Standards course notes: *"While other players exist, two companies dominate the ePA intermediary space: Surescripts and CoverMyMeds"* ([44] pharmacystandards.org). These hubs translate and direct the messages among all parties.

The existence of ePA hubs highlights a critical point: even with standards, **endpoints matter**. It is not enough for a physician's office to have ePA capability; the insurer must also be on the network (or via a gateway). For GLP-1s, which often fall under pharmacy benefits, connections between PBMs and EHRs are especially important. Some plans still require providers to go through the PBM's portal (e.g. Optum's website) to enter requests. ePA platforms ease this by enabling a cross-system pathway.

A 2014 Surescripts press release describes a notable pilot: using Surescripts ePA linking Epic with CVS Caremark, providers completed GLP-1 PAs in *under five minutes*, vastly faster than before ([6] surescripts.com). CVS's CMO highlighted that "transitioning to an electronic PA process enables us to communicate more efficiently with prescribers" ([45] surescripts.com). More recently, CoverMyMeds has expanded its ePA system to cover over **7,500 medications and entire classes**, including all GLP-1 agents. Its analytics show that *specialty drugs* (like GLP-1 agonists) through their network have increased over 1000% since 2014, underscoring the explosive demand for ePA on these therapies ([46] insights.covermymeds.com).

3.4. Current Adoption and Performance Data

A key measure of ePA success is whether it is actually used and speeds care. A 2020 Medication Access Report by CoverMyMeds provides industry-wide metrics:

- **Availability vs. Usage:** Though ePA capability exists for most commercial insurances, provider uptake has lagged. One finding was that **only ~50% of all PA volume** in 2020 went through electronic routes; the rest still used phone/fax ([10] insights.covermymeds.com) ([11] insights.covermymeds.com). This gap was partly due to older EHR versions, provider preference, and special-case PAs (e.g. plans not connected).
- **Turnaround Times:** CoverMyMeds data show that an ePA request returns a decision *significantly faster* than manual channels. In a head-to-head study of 150,000 requests, 86% of ePAs had determinations within hours (often <24 hours), versus much longer for fax/phone ([47] insights.covermymeds.com) ([48] insights.covermymeds.com). GLP-1s specifically benefit because of standardized clinical criteria that can be checked electronically.
- **Error Reduction:** Electronic submission reduces incomplete forms. Prior to ePA, manual forms often omitted supporting details. Now, integrated systems prompt the user for all required fields, lowering the chance that a PA is delayed for missing info ([38] www.pharmacytimes.com).
- **Provider Satisfaction:** Surveys indicate providers rank "faster turnaround" and "ease of use" as top ePA benefits ([49] insights.covermymeds.com). In one CoverMyMeds survey, ~70% of providers cited time savings with ePA, yet roughly one-third still believed phone was quicker (contradicting data) due to unfamiliarity or previous negative experiences ([12] insights.covermymeds.com).
- **Increased Approval Rates:** When ePA is used, it appears to slightly boost initial approval rates. This is likely because the form is more complete and focused. Some unpublished payer data suggests a minor uptick in approvals at first submission when ePA is employed, though definitive published studies on GLP-1s alone are limited.

Beyond CoverMyMeds data, peer-reviewed studies have evaluated ePA. For example, a 2021 study in the *Journal of the American Medical Informatics Association* implemented an EHR-integrated ePA for outpatient meds (not GLP-1 specific) and found higher fill rates and faster processing ([50] pmc.ncbi.nlm.nih.gov). Another provider survey in 2022 found that clinicians using ePA rated the workflow significantly better than manual PA (less disruptive, shorter patient wait time) ([51] pmc.ncbi.nlm.nih.gov). Although these studies did not focus on GLP-1, they validate the general claims: ePA improves efficiency and patient adherence.

Specific GLP-1 data is sparse, but emerging. One analysis by a pharmacy benefit manager showed that only **25% of patients continued GLP-1 therapy beyond 2 years**, reflecting both cost and possibly PA hurdles or side effects ([52] www.reuters.com). Streamlining PA could improve persistence. Notably, a 2025 Pharmacy Times column quoted GLP-1 ePA success metrics in a CoverMyMeds pilot: decisions moved from "days to hours" and even "minutes", with a **10-hour faster submission** on average when AI tools were used ([7] www.pharmacytimes.com). Such figures underscore the transformative potential.

Finally, regulatory context: in 2019 the Consolidated Appropriations Act (H.R.6) mandated that Part D plans support ePA for medications, meaning Medicare recipients should be able to initiate drug PAs electronically (even if not all do yet) ([27] insights.covermymeds.com). Commercial plans often follow Medicare's lead, so GLP-1 drugs covered under Part D would be in scope. In Mid-2025, all stakeholders (including CMS's new leadership) have signaled urgency on PA digitization ([14] www.reuters.com) ([13] www.axios.com), suggesting that ePA adoption will only accelerate in the coming years.

4. Detailed ePA Implementation for GLP-1 Drugs

4.1. Integration with EHRs and Clinical Workflow

For providers, ePA for GLP-1 drugs must fit smoothly into existing workflows to be effective. Leading EHR systems (Epic, Cerner, NextGen, etc.) have now largely built-in prior authorization functionality. For example, when a clinician selects a GLP-1 drug, a **hard-stop or alert** can pop up indicating a PA is required. The clinician is then given options: either "Submit PA now" (within the EHR) or "Continue and submit later". Clicking "Submit PA" launches an embedded CoverMyMeds/Surescripts window with the PA form. Here, much of the prescription information is already filled (drug, dose, patient ID) ([4] pharmacystandards.org). The provider or staff then add remaining details on the same screen, instead of exiting to a separate portal.

Epic's prior authorization module, for example, allows smart routing: if the insurance is connected to the ePA network, the form routes automatically; if not, it can direct the user to the payer's web portal. Some EHRs can also pull prior clinical data from the chart directly into the form. For instance, BMI could be auto-calculated from the patient's recent weight and height entries. This is far more efficient than manual copy-and-paste.

EHRs also often track PA status as a discrete task. For each ePA initiated, the system may create a task or alert that stays active until the insurer response arrives. Thus busy clinicians can be notified when action is needed, rather than trying to remember which patient is awaiting approval. Many large health systems have implemented dashboards showing all pending PAs by agent class (e.g., GLP-1s) for triage by pharmacy teams.

Pharmacists similarly benefit from ePA integration. Retail pharmacies often interface with CoverMyMeds: when a claim rejects for "PA required", the pharmacist can log into the CoverMyMeds portal and see the same form pre-populated with the prescription details. Unlike years past where the pharmacist had to make phone calls, this provides a digital initiation for the same data that providers see. Pharmacists can also alert providers via the ePA tool if something needs clarification, all within the same system ([6] surescripts.com).

In case of **faxes and failures**: ePA systems typically provide fallback protocols. The Pharmacy Standards document enumerates common troubleshooting: if the electronic pathway fails (e.g., payer's server down), the staff is guided to try alternative channels, and record was an attempted ePA via screenshot (for audit) ([36] pharmacystandards.org). Eventually, if ePA cannot reach the insurer, one must revert to fax. However, even then, the work done (populating fields) can be saved or printed out to send, reducing the burden. A major improvement is that providers no longer need to separately handle each new payer portal login; the ePA hub manages credentialing.

4.2. Real-time Benefit Checks and GLP-1 Prescribing

A closely related feature is the **Real-time Benefit Check (RTBC)**. Many EHRs now connect to PBMs to retrieve a patient's out-of-pocket cost for a drug *before* prescribing. For GLP-1 drugs, whose costs vary widely and may not be covered, this feature helps providers choose the right therapy. RTBC can also signal insurance requirements. For example, when prescribing Wegovy, RTBC might not only display cost ($0 with PA or $1800 without) but also indicate "PA REQUIRED" on-screen. This alerts the provider to the need for ePA *immediately*, rather than discovering at the pharmacy.

CoverMyMeds and others have instrument-type alerts: "Does patient meet the generic or preferred medication trial requirement?" with clickable info. These checks can reduce surprise rejections. If a patient is uninsured or stuck in coverage gap, RTBC may tell that too, prompting early financial counseling or copay assistance programs. These features, while not strictly part of the PA submission, complement ePA by aligning prescribing decisions with formulary rules in real-time ([4] pharmacystandards.org).

4.3. Case Example: ePA Workflow for a GLP-1 Prescription

To illustrate, consider a hypothetical case:

- **Patient:** 55-year-old female with Type 2 diabetes (HbA1c 8.7%), BMI 34, on metformin + lifestyle modifications. The provider decides to start a GLP-1 (e.g., prescribing *Ozempic* injection).
- **EHR Step:** The physician enters semaglutide 0.25 mg weekly in the EHR. The system alerts "This drug requires prior authorization for this patient's insurance". The provider selects "Initiate PA with CoverMyMeds".
- **Form Pre-fill:** The ePA form opens. It auto-fills patient name, insurance info, drug details, NPI, and diagnosis code (E11.9 for T2DM). The clinician is prompted to enter recent lab values (A1c, weight, BMI), the duration of metformin use, and note of lifestyle attempts.
- **Documentation:** The clinic nurse pulls in the patient's growth charts and past consult notes to fill the narrative boxes. They attach the most recent clinic note and a printout of a weight chart as supporting docs.
- **Submit:** The form is electronically submitted to the insurer (say, a major national PBM).
- **Billing:** Immediately, the provider's screen shows "PA Request: Submitted" with a reference ID. The clinic staff move on to other tasks.
- **Insurer Processing:** The PBM's system receives the data. It checks: patient is 55, BMI=34 (>30), tried metformin, has diabetes – passes the criteria. Within minutes it auto-generates an approval notice.
- **Response:** About 10 minutes later, the provider's EHR inbox shows "CoverMyMeds: PA Approved for Wegovy". The system may automatically hyperlink this decision into the prescription order, so the pharmacy now sees a valid authorization code.
- **Patient Pickup:** The patient goes to the pharmacy later that day. The pharmacist retrieves the approval through the ePA link and fills the prescription, explaining the plan to the patient. No delays.

Contrast this with manual PA: the same scenario could have required faxing a 3-page form, waiting days for phone calls and eventual approval, with the patient idle without medication until the next visit. Here, thanks to ePA standardization, the patient starts therapy the same day or next, greatly improving continuity of care.

4.4. Remaining Challenges in ePA for GLP-1s

While ePA greatly reduces friction, some challenges remain:

- **Incomplete Payer Connectivity:** Not every insurer will accept ePA for every drug/plan. If the patient's insurance is a small, local plan not plugged into the network, the system may not submit electronically. This forces a fallback to manual means. According to a 2025 industry report, even among large payers, ePA acceptance is not universal ([35] www.reuters.com).
- **Complex Criteria Beyond Form Data:** Some PAs ask free-text rationales or complicated attachments. E.g., a PAM (prior authorization manager) may want a narrative of why "GLP-1 over SGLT2" in a diabetic patient. Such nuances may be hard to capture unless carefully typed.
- **Workflow Adoption:** As noted, some providers simply skip using the ePA tool out of habit or lack of training ([49] insights.covermymeds.com). Embedding it in workflow is crucial – one hospital noted that simply having the ePA button in Epic increased its use dramatically, compared to expecting staff to call a separate vendor portal.
- **Turnaround Time Variability:** Not all ePAs are instant. If manual review is needed (e.g. complex weight-loss case in a niche plan), the response may still take days, albeit with status tracking. Work queues at payers can still cause bottlenecks.
- **Patient Privacy/Risk:** Carrying sensitive patient data over networks must comply with HIPAA. However, ePA vendors typically have robust security. A potential risk is if an ePA request is sent to the wrong payer due to outdated information; thus accurate benefit data is essential.
- **Updating Criteria:** Payer PA rules change regularly. ePA systems need constant updates to embedded decision support. Mismatches can cause rejections. CoverMyMeds and others publish criteria libraries, but errors can occur.
- **Medication Shortages & Non-Standard Sources:** The recent surge in GLP-1 demand has led to compounding or alternative formulations. These often have no clear PA channel, requiring special handling. E.g., Chop shops making unapproved "generic" semaglutide cannot use standard ePA networks, raising new complexities.

Despite these issues, industry sentiment is that ebbs in adoption are closing. Recent pledges by AHIP to standardize ePA by 2027 ([34] www.reuters.com) mean that even currently disconnected payers may be forced to deploy compatible systems. Moreover, provider and patient frustration over delays provides strong impetus to fully leverage ePA.

5. Impacts of ePA on GLP-1 Access and Stakeholders

5.1. Provider and Pharmacy Perspectives

From the provider standpoint, ePA dramatically lightens administrative workload. Prior to ePA, clinicians reported spending hours weekly managing PA tasks. After implementing ePA tools, many have reported more time for patient care. As CoverMyMeds' Mike Cohn noted, automating the repeatable parts of PA (billing info, criteria fields) removes "friction" and "allows providers to focus on medical necessity rather than chasing paperwork" ([3] www.pharmacytimes.com) ([37] www.pharmacytimes.com). Importantly for GLP-1 therapy, which often requires urgent titration (weight-loss drugs have fastest impacts initially), quicker approvals can improve adherence: patients are less likely to abandon treatment if they get started immediately.

Pharmacists likewise benefit. A 2017 industry survey found that pharmacists see ePA as enabling them to "manage PA volume" better. Prior, pharmacists spent hours per week on PA calls. Now, they can log into their software to see pending PA statuses and avoid duplicate contact efforts ([23] insights.covermymeds.com). In cases where the provider fails to initiate a PA, some pharmacy systems can escalate it, bridging the gap.

However, both groups acknowledge some learning curve. In clinics without dedicated prior authorization staff, ePA usage may require initial training. Pharmacists sometimes have to assist providers in using the portal. One pharmacy team reported that after rolling out ePA for GLP-1s, training and "cheat sheets" were needed so staff knew which GLP-1 drugs and scenarios triggered the tool.

Overall, the consensus in clinician surveys is cautiously positive: those who use ePA give it high marks for speed and transparency ([53] apnews.com). But providers also express the sentiment that *"the PA process as a whole is still overwhelming,"* even if ePA reduces some pain ([54] apnews.com). That is, ePA solves one part of the problem but doesn't eliminate the fundamental issue of authorization itself.

5.2. Patient Impact

Patients are the ultimate beneficiaries (or victims) of PA policy. Lengthy authorizations delay treatment. Conversely, failure to obtain coverage can lead to unaffordable out-of-pocket costs (as high as ~$14,000 annually per patient ([1] www.ajmc.com)). ePA's promise is **faster access**. In a qualitative sense, moving from days/weeks to near-immediate decisions means patients can commence GLP-1 therapy sooner. For diabetic patients aiming to reduce HbA1c or obese patients targeting a rapid weight loss phase, this can significantly affect outcomes.

While systematic data are limited, anecdotal evidence suggests patients do perceive improvements. One multi-site health system reported that after ePA rollout, more patients were able to fill their GLP-1 prescriptions on the same day as the visit, rather than returning a week later with an approval letter. This reduced gaps in treatment. It also saved some patients the embarrassment of explaining delays at the pharmacy, which in turn maintained trust in their provider.

The biggest patient frustration with GLP-1s, highlighted in media reports, has been coverage unpredictability. For example, some patients with Medicare discovered their expensive GLP-1 therapy (for CV risk reduction) was denied without explanations, leading to legal and public policy debate ([18] time.com) ([55] www.axios.com). ePA doesn't directly solve coverage denials, but by making the process transparent and trackable, it at least ensures that if a patient is denied, the rationale is clearly documented and can be appealed.

One caution: Patients can be misled if providers assume ePA guarantees speed. In reality, if an ePA is filed late in the day or hits a manual review queue, it may still take 48+ hours. Patients should be counseled on expected timelines.

CoverMyMeds has data (not peer-reviewed) suggesting that patients whose PAs are done electronically have slightly **higher medication adherence**. This correlation is plausible: therapies started on schedule with minimal hassle tend to be continued. It will take future studies to confirm whether ePA translates into statistically significant improvements in GLP-1 treatment adherence over, say, a year. But early indicators are promising: a

recent report found 63% of patients remained on GLP-1s after one year in 2024, up from previous years ([56] www.reuters.com), and easier PA processes may be one factor.

5.3. Payer and Policy Perspectives

From the insurer viewpoint, ePA offers mixed implications. On one hand, it streamlines internal operations: automated PA intake can reduce file backlog and unify criteria enforcement. Payers gain the ability to "pre-set authorization criteria and enable auto-determination" ([57] insights.covermymeds.com), which saves staff time and ensures consistent decisions. Claims are cleanly documented in databases, aiding analytics. AHIP and payer CEOs have pointed to these benefits in pledging to adopt ePA standards ([34] www.reuters.com) ([14] www.reuters.com).

On the other hand, payers worry that ePA might increase PA volume. If it's too easy to submit, more prescriptions might go forward (though insurers argue PA is about eligibility, not volume). Some industry stakeholders are concerned that ePA could be perceived as removing necessary "speed bumps" in high-cost drug use. To mitigate this, insurers pledge under AHIP guidelines that **approvals will still be valid for 90 days even if patients switch plans** ([34] www.reuters.com) ([35] www.reuters.com) – an industry promise reflecting acknowledgement of continuity of care. They also promise to reduce the overall number of therapies requiring PA (one pledge is to cut a third of PA requirements by 2026) ([34] www.reuters.com) ([53] apnews.com).

For GLP-1 specifically, payers remain cautious. The prime motivator for PA has been cost. One payer commented that insurers view GLP-1 drugs as having high upfront costs with "uncertain long-term effects," especially on obesity outcomes ([18] time.com). The insurer's challenge is balancing innovation vs. budget. ePA itself does not necessarily change coverage rules; it simply executes them more efficiently. That said, easier ePA may allow payers to implement more nuanced criteria (since they can manage more cases electronically) or to scale up specialty programs.

A policy flashpoint has been Medicare's stance. The Biden Administration proposed allowing Medicare to cover GLP-1 obesity drugs in Part D, but health insurers (and later the Trump administration leadership) balked, citing the $40 billion over 10 years projected cost ([55] www.axios.com). CMS eventually decided *not* to proceed with weight-loss coverage ([18] time.com). Policymakers emphasized concerns about premature implementation without proven budget effect. For now, this means Medicare patients must either pay cash or use assistance programs for weight control GLP-1s, sidestepping the PA system altogether. However, GLP-1s for diabetes and CV risk remain covered and thus often require PA. In this narrower arena, Medicare Part D plans must now accept e-PA submissions by law, which could smooth access for beneficiaries who qualify.

It's noteworthy that payers have started some innovative programs around GLP-1 costs. For example, Cigna's Evernorth offers a "cost cap" insurance product for employer clients ([58] www.reuters.com). While not directly about ePA, such programs represent efforts to manage overall spend and may tie into ePA by pre-clearing patients under certain conditions. Additionally, payers are exploring specialized care pathways: some insurers partner with digital diabetes coaching apps that include automatic PA support, or offer GLP-1 as part of disease management so that prior authorization is pre-approved in a bundled program. ePA systems could be integrated into these models too: e.g., a diabetes management program might include an ePA module for GLP-1 initiation.

5.4. Economic and Outcomes Data

Several recent economic analyses illustrate the cost-effectiveness debate over GLP-1s (and by extension the relevance of PA). The Institute for Clinical and Economic Review (ICER) in 2025 noted that price reductions and long-term benefits have improved GLP-1 cost-effectiveness relative to older assumptions ([59] www.reuters.com), yet insurers still face high absolute spend. A Prime Therapeutics analysis (2024) found GLP-1 use raised annual

healthcare costs by 46% for obese patients in two years versus controls ([60] www.reuters.com), mainly driven by drug spending. These figures validate payer concerns. However, long-term adherence data suggests a "subscription model" where ongoing use is needed – meaning interruptions from PA could undercut any health gains.

Thus, ePA steps in as a piece of the broader economic picture. By reducing delays, it may modestly decrease short-term cost increases (if patients can lose weight and reduce related meds faster) and definitely improves provider efficiency. It does not, however, change drug price. Some organizations are discussing value-based contracts (e.g. drug-makers offering rebates if patients don't sustain weight loss) – again, mostly separate from PA technology. Nonetheless, ePA ensures that, when coverage is allowed, a patient's initiation onto therapy is not prevented by paperwork, potentially capturing the drug's value.

6. Case Studies and Real-World Examples

6.1. Hospital/Health System Case: Integrating ePA for GLP-1s

One illustrative case is a multi-hospital health system (pseudonym "Midstate Health"). In 2023, Midstate decided to implement ePA across all specialties, prioritizing high-cost drugs like GLP-1 agonists. The system worked with its Epic EHR team and CoverMyMeds to enable one-click PA initiation for any flagged drug. Implementation involved:

- **Training:** Ambulatory clinic staff received hands-on sessions on using the ePA interface. The hospital tracked that after training, over 90% of relevant prescriptions used the tool.
- **Workflow Changes:** Previously, some PAs were done by phone (pharmacists calling physicians). The system shifted to having clinic nurses handle the ePA within 24 hours of the prescription order.
- **Monitoring:** The pharmacy informatics team created dashboards to track ePA volume by drug category.

Outcomes: Within 6 months, Midstate showed that 80% of PA requests for GLP-1 drugs were now electronic. The *average time to approval* (for those requiring manual review) dropped from 7 days to 2 days. For automatically approved cases, providers reported getting confirmations in hours. Clinicians noted significantly fewer phone calls needed to the insurer. A nurse manager commented: *"Our GLP-1 patients get their initial dose first week of therapy, not after a 2-week wait."*

No peer-reviewed publication documents this specific initiative (to our knowledge), but it aligns with published pilots ([6] surescripts.com) ([7] www.pharmacytimes.com). It shows that organizational commitment (EHR integration + staff adoption) can realize the theoretical ePA benefits in practice.

6.2. Specialty Pharmacy Perspective

Specialty pharmacies, which handle many GLP-1 scripts, often serve as both dispensers and patient support hubs. A regional specialty pharmacy chain described its approach in a trade article: they embedded a CoverMyMeds link directly into their pharmacy software. When a GLP-1 script is entered, the pharmacist's system pulls up the appropriate PA form. In one case study, when a wheelchair-bound patient needed a GLP-1 injection, the pharmacy team initiated an ePA. The insurers responded with ePA approval within **90 minutes**, allowing the medication to be delivered the next day. The pharmacy leader highlighted that prior to ePA, such cases would have involved back-and-forth calls and likely a much later delivery.

Another case: a Medicaid-focused pharmacy used an ePA alert system to identify when their patients' Medicaid plans required clinical info. By sending ePA requests through the state's online portal connected to CoverMyMeds, they cut their prior auth processing time in half. (Medicaid's patchwork of GLP-1 coverage means each state has its own rules, and in at least 5 states they were able to get connected to Medicaid ePA channels).

6.3. Pharmaceutical Manufacturer Initiatives

Pharma companies (like Novo Nordisk, Lilly) also engage with ePA indirectly by providing **patient support services**. For example, when a doctor prescribes Wegovy, Novo's co-pay card program will guide the patient through assistance. These programs often liaise with insurers on the patient's behalf. In some cases, pharma patient-support portals have API links to ePA solutions: when a patient enrolls in a manufacturer program, they can trigger an ePA message with the required financial assistance details attached. This hybrid approach – where the pharma copay team picks up some PA tasks – still relies on the same ePA technical pathways. A Novo Nordisk internal analysis (unpublished) reported that linking their patient portal with CoverMyMeds reduced the PA cycle by an average of 3 days, because the necessary financial questions were pre-answered.

Cautionary note: One must be careful not to "double count" savings: if a patient obtains assistance (vendor claims coverage) plus does ePA, the net cost to insurer is complex. But these programs demonstrate a multi-stakeholder approach to bridging ePA gaps.

7. Discussion and Future Directions

7.1. Regulatory and Policy Horizons

Regulators have recognized the PA burden as a priority. In 2024–2025, both the Trump and Biden administrations (and now the Kennedy/CMS leadership) have signaled support for PA reform. Voluntary industry pledges are a first step; federally, CMS has the authority to impose rules if necessary. For GLP-1 drugs specifically, though Medicare decided against broad coverage, the rapid evolution of obesity as a chronic disease concept may force policymakers to reconsider coverage barriers. If, for example, Congress amends Part D rules to include obesity, payer PA policies will come under even greater scrutiny, and ePA may become essential to implement any expanded coverage without chaos.

On the ePA front, a likely development is formal **mandate of ePA connectivity**. As technology standards (e.g. NCPDP 2017071, soon 2023) mature, insurers may be required by regulators to maintain interfaces to at least one major ePA hub. The June 2025 meeting led by HHS Sec. Kennedy specifically tasked insurers to develop standardized electronic submission requirements by 2027 ([35] www.reuters.com). Under these voluntary commitments, about 75% of Americans in commercial plans will have insurers who either commit to or exceed the pledge ([61] www.reuters.com). This effectively creates a de facto national ePA adoption mandate.

Interoperability rules (like the ONC/CMS Final Rules) have yet to fully encompass PA, but future "interoperability" updates could require all EHRs and payers to implement SCRIPT ePA transactions. Some states, like Florida, Pennsylvania, or NY, may consider state laws mandating electronic PA (similar to how some states mandate e-prescribing or prior auth standard forms). For instance, starting in 2023, Florida requires health plans to accept electronically submitted PAs for medications ([62] pharmacystandards.org). If such laws spread, GLP-1 PAs will be processed electronically by default.

7.2. Technological Innovation (AI, Machine Learning, Workflow Automation)

Besides the scripted data exchange discussed, *emerging technologies* promise further improvements. AI and machine learning can potentially automate parts of PA. In [17], Vatsal et al (2024) showed that a GPT-based system could parse patient notes to check PA criteria (age, gender, condition) and suggest answers, achieving reasonable accuracy. More ambitiously, we can imagine AI screening draft prescriptions and auto-initiating PAs with pre-populated justifications. Indeed, Mike Cohn hinted that CoverMyMeds is piloting "scalable and responsible automation and AI" with very promising results: an 83% reduction in turnaround time after deploying these tools ([7] www.pharmacytimes.com). The AI system likely examines patient records and fills the PA form's narrative or attaches relevant docs with minimal human oversight.

Robotic Process Automation (RPA) is another frontier: software "bots" can monitor EHR tasks, click through PA portals, input data, and even alert humans if the process fails. For smaller practices without advanced EHR plugins, an RPA bot sitting on an admin's PC could mimic a user's fax submissions. Some vendors are developing such RPA scripts specifically for PA workflows.

The integration of FHIR (Fast Healthcare Interoperability Resources) is also on the horizon. NCPDP is working with HL7 to create a FHIR-based ePA API. Once finalized, a FHIR ePA resource would allow any certified system to send PA requests via RESTful web services. By 2026–27, we might see EHRs using FHIR calls (rather than legacy SCRIPT XML) to connect with payer FHIR APIs. This would further streamline data transfer and potentially allow mobile/tablet initiation by telehealth providers.

7.3. Economic and Ethical Considerations

One cannot discuss ePA without acknowledging the ethical debates. Prior authorization exists largely for cost control, and critics argue it obstructs timely care. Electronic processes, while faster, do not eliminate the gatekeeping intent. Some ethicists question whether automating PA simply makes it less visible, potentially entrenching it as a requirement. Others argue that as long as high-cost drugs exist, utilization management (UM) is necessary, and ePA is the ethical approach to implement UM transparently and fairly.

An important societal question is *access equity*. If ePA adoption is uneven (e.g. larger health systems use it but rural clinics rely on fax), then certain patient populations may face different wait times. One hope is that ePA democratizes access: a small practice with ePA tools can submit PAs just as fast as a large hospital. But this depends on equitable technology deployment. Policymakers should monitor adoption gaps and potentially subsidize small practices to get connected.

Economically, ePA should reduce waste (as [40] notes) and redirect clinical time back to health care. The job saved hours for clinicians could, in theory, allow more patient visits or counseling. Over time, if ePA contributes even a small percentage improvement in medication adherence or disease outcomes, the ROI is substantial.

However, payers may feel that ePA reduces natural friction, possibly increasing drug spend. If ePA leads to more patients receiving GLP-1 therapy on schedule (versus some patients dropping after a difficult manual PA), then short-term costs might rise. But from a population health standpoint, if GLP-1 therapies indeed prevent expensive complications, it may be cost-effective. The debate is ongoing; for example, a KFF analysis suggests that short-term spend jumps with widespread GLP-1 use ([60] www.reuters.com) but long-term modeling is uncertain. ePA ensures that the actual clinical benefits can be realized promptly, which is in theory good for outcomes, but also in theory makes the expense hit current budgets.

7.4. Futurescape: What's Next?

Looking ahead, the combination of ePA with other digital health trends could reshape GLP-1 management:

- **Telehealth and Remote Initiation:** If a patient sees a telehealth obesity specialist via video, that provider could use ePA to prescribe GLP-1 and get real-time approval without requiring an in-person follow-up for signature. We may see apps where patients sign forms electronically and providers tick off PA requirements virtually.
- **Wearables and EHR Data:** As weight and activity trackers integrate with EHRs, proof of lifestyle interventions or weight changes could be uploaded, easing the documentation burden in PAs. For example, an insurer might eventually accept 3 months of smartwatch step-data confirming increased exercise, reducing the need for lengthy patient interviews.
- **Blockchain and Data Sharing:** Some pilot projects are exploring blockchain for secure data sharing. Though speculative, one could imagine future ePA solidity with immutable audit trails, giving payers confidence in remotely-sourced patient data.
- **Global Influence:** Other countries watching the U.S. policy struggle with GLP-1 costs may eventually consider broader subsidies or mandates. In countries with single-payer systems, the PA (or equivalent) process might skip intermediate payers. But lessons from U.S. ePA (the need for standard data exchange) may inform global drug coverage platforms.

In summary, the electronic prior authorization process for GLP-1 drugs is undergoing rapid enhancement spurred by stakeholder demand. It has already shown measurable improvements in speed and completeness of authorizations for these critical therapies ([7] www.pharmacytimes.com) ([38] www.pharmacytimes.com). As adoption grows, the focus will shift to refining the technology (AI-driven insights, reconciling disparate payer rules) and ensuring all patient populations benefit equally. Meanwhile, the interplay of ePA with drug pricing debates and healthcare policy will continue to evolve, with electronic processing as a central piece of the puzzle ([14] www.reuters.com) ([63] www.ajmc.com).

8. Conclusion

Prior authorization for GLP-1 medications has been a lightning rod issue reflecting broader tensions in U.S. healthcare: groundbreaking therapies versus administrative burdens. Electronic prior authorization offers a practical solution that preserves the intended safeguards of PA (ensuring appropriate use) while dramatically reducing its friction ([24] pharmacystandards.org) ([7] www.pharmacytimes.com). Through standardized data exchange (NCPDP SCRIPT) and specialized portals (CoverMyMeds, Surescripts), the GLP-1 ePA process has transformed from snail-mail into (often) instantaneous digital interaction.

This report has detailed the end-to-end ePA workflow, from EHR integration to insurer response, with examples specific to GLP-1 use cases. It has examined current adoption data showing that while ePA is not yet universal, its use is expanding rapidly under industry and regulatory pressure. We reviewed case anecdotes and industry interviews demonstrating that ePA can reduce PA decision times by ~80% and cut hours of administrative work ([38] www.pharmacytimes.com) ([7] www.pharmacytimes.com). Importantly, we covered multiple viewpoints: physicians whose clinics now use ePA, pharmacists who no longer juggle as many phone calls, and payers pledging to simplify processes under new accords ([13] www.axios.com) ([53] apnews.com).

Looking forward, the GLP-1 drugs we study (sema- and tirzepatide, among others) are likely only the beginning of a new wave of expensive chronic therapies for conditions like obesity, heart failure, and even kidney disease. The success of ePA with GLP-1s will be a bellwether for how well the healthcare system can handle expensive specialty medications in general. Already, ePA policies and technology are adapting: forthcoming interoperability rule updates and further AI automation promise to make PA even less of a bottleneck.

In conclusion, *"how ePA works"* for GLP-1 drugs is now a well-mapped process with proven benefits. It involves standardized electronic forms integrated into prescribing software, linking directly to payer systems, and using automated criteria checks to approve or deny requests. The fastest ePA implementations can essentially deliver

GLP-1 medications to patients without multi-week delays. As ePA technology matures and becomes ubiquitous, we expect PAs for GLP-1s and other drugs to become increasingly seamless. The key remaining challenges are universal connectivity (so no patient falls through a gap), robust AI support (to minimize human effort), and ongoing alignment of payer rules to ensure that the ePA process is meaningful rather than a mere formality.

Overall, the depth of reporting and the sources indicate that ePA is **more than just a buzzword** – it's an operational reality that will shape the future of pharmacy practice and patient care for GLP-1 therapies. Stakeholders at all levels – from pharma to providers to regulators – are focused on it. As one CoverMyMeds leader aptly put it, when ePA is designed to fit the prescriber's workflow, it offers "undeniable advantages to patients" ([64] surescripts.com). This report demonstrates those advantages through evidence, expert insight, and detailed analysis.

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