

Influence of Prior Authorization Requirements on Provider Clinical Decision-Making

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Prior authorization (PA) of prescription medications is used by health insurers to manage access to costly and/or low-value medications to ensure safe, effective, and value-based use of medications.¹ However, meta-analyses have found that PA and other formulary restrictions can adversely influence medication adherence, clinical outcomes, and treatment satisfaction.^{2,3} Moreover, recent provider surveys have affirmed that medication PA disrupts workflow and affects provider satisfaction. For instance, an American Medical Association survey⁴ reported that providers spend a mean of 14.4 hours on PAs per week, and a significant majority of providers rated the burden of insurance company administrative challenges as “high” or “extremely high.” Almost two-thirds stated that they wait at least a day to hear from the insurance company on a PA request and slightly under one-third reported that they wait at least 3 business days. The type of medical specialty can also significantly contribute to the PA burden, as noted in the 2019 ePA National Adoption Scorecard published by CoverMyMeds. These findings have been reinforced by more in-depth qualitative studies highlighting provider burden due to extensive paperwork and inconsistent PA requirements among health plans.⁵⁻⁷

There is also growing evidence that the medication PA process can delay patient care and contribute to adverse patient outcomes.⁸⁻¹³ When surveyed, 24% of physicians noted that PA had led to a serious adverse event in at least 1 of their patients, 91% reported that PA requirements caused care delays, and 90% reported that PA delays resulted in worse patient outcomes.⁴ Furthermore, PA-related cost restrictions create delays that result in patients abandoning prescriptions.¹⁴ Given these consequences and the burden of PA, providers, pharmacists, policymakers, and other stakeholders have supported efforts to limit, standardize, and/or streamline PA processes.¹⁵⁻¹⁸

Although there is a body of evidence on the benefits and unintended consequences of PA, there is a gap in the literature on whether medication PA alters providers' clinical decision-making and use of work-arounds to avoid PA requirements. We identified 1 study in this area, which was a survey of psychiatrists.¹⁹ In that survey, a majority of providers reported at least occasionally using tactics such as diagnosis modification or falsification of previous medication

ABSTRACT

OBJECTIVES: Prior authorization (PA) aims to promote the safe and effective use of medications and to control costs. However, PA-related administrative tasks can contribute to burden on health care providers. This study examines how such tasks affect treatment decisions.

STUDY DESIGN: Cross-sectional, online survey.

METHODS: We conducted an online survey of US medical providers in 2020 based on a convenience sample of 100,000 providers. Multivariate path analysis was used to examine associations among provider practice characteristics, step therapy and other health plan requirements, perceived burdens of PA, communication issues with insurers, and prescribing behaviors (prescribing a different medication than planned, avoiding prescribing of newer medications even if evidence-based guideline recommendations are met, and modifying a diagnosis). Weighted analyses were conducted to assess nonresponse bias.

RESULTS: A total of 1173 respondents [1.2% response rate] provided 1147 usable surveys. Step therapy requirements had the largest effect on clinical decision-making. Other significant effects on clinical decision-making included perceived PA likelihood, communication issues, and health plan requirements (eg, clinical documentation). Weighted analyses showed that the study conclusions were unlikely to have been biased by nonresponse.

CONCLUSIONS: Respondents report that they may alter clinical decisions to avoid PA requirements and related burdens, even in cases in which use of the PA medication was clinically appropriate. Processes that reduce the administrative burden of PA through improved communication and transparency as well as standardized documentation may help ensure that PA more seamlessly achieves its goals of safe and effective use of medications.

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TAKEAWAY POINTS

We conducted a cross-sectional, online survey of licensed providers in the United States to evaluate attitudes toward medication prior authorization (PA) and to assess whether PA requirements are linked to clinical decisions in patient care.

- ▶ PA aims to promote appropriate use of medications while containing cost, but it places administrative burden on providers and payers.
- ▶ Providers report that they may prescribe different medications than originally planned, avoid prescribing newer medications, or modify a diagnosis to avoid PA burdens.
- ▶ Reducing administrative burden of PA through improved communication, standardization, and technology may help ensure that PA more seamlessly achieves its goals of safe and effective use of medications.

trials to meet PA requirements. Further, two-thirds reported that they occasionally refrain from prescribing a medication they would otherwise prefer due to a known or expected PA requirement. However, this prior study did not assess factors related to PA work-arounds that can be attributed to the PA requirements and processes.

To address this concern, we conducted a nationwide survey of providers to evaluate their attitudes toward medication PA and whether PA requirements are linked to clinical decision-making in patient care. By doing so, the current study provides insight into how modifications to improve and streamline the PA process could affect provider work-arounds and help ensure that the PA process achieves the intended goal of promoting safe, high-value drug therapy.

METHODS

Sampling Frame and Survey Administration

This study was part of an effort to design a digital solution for medication PA conducted under the auspices of a National Institute of Mental Health Small Business Technology Transfer grant. We developed a 58-item survey, a process informed by focus groups and stakeholder interviews. The study oversampled mental health providers because they are the current focus of the software platform. The remaining specialty types were selected based on provider likelihood of encountering PA: dermatology, gastroenterology, internal medicine, oncology, and rheumatology.²⁰ These and other nonpsychiatry specialties often encounter PA requirements for newly emerged specialty medications or particularly expensive medications.

We administered the survey in October 2020 using the Qualtrics platform. Invitation emails with a unique hyperlink were sent out to 100,000 providers with emails drawn from a curated, nationwide list of licensed providers. All participants provided consent prior to taking the survey (University of Nebraska Institutional Review Board No. 00000672).

Survey Instrument

Exogenous measures. A single item assessed challenges associated with identifying step therapy requirements prior to prescribing (“In general, how challenging is it to identify appropriate step therapy requirements prior to prescribing a medication?”), with responses

on a 5-point scale ranging from “not at all challenging” to “extremely challenging.” A single item assessed active patient load (“What is your active patient load?”), with responses on a 5-point scale ranging from “fewer than 25 patients” to “more than 200 patients.”

Nine items assessing interactions with health plans were used to create 2 subscales, one capturing health plan requirements related to PA and a second reflecting communication issues that arise between provider and health plans (see **eAppendix** [available at ajmc.com] for additional details). The health

plan requirements subscale included 5 items, each starting with “Regarding insurance companies, how often do you find them...” and ending with the following: “requiring manual PA as opposed to electronic”; “requiring PA for generic medications”; “denying PA because of missing description of adverse effects”; and “denying PA because of dosing issues or formulation issues” (separately) ($\lambda_{\text{avg}} = 0.64$). Response options ranged from 1, “very rarely or never,” to 5, “extremely often.”

The communication subscale included a unit-weighted risk index for practice characteristics based on 4 items assessing communication with health plans (see eAppendix for details). These questions each started with “How often do you find that...” and ended with the following: “it is necessary to send additional clinical documentation,” “your software says a medication is denied by insurance and you later discover it was approved,” “you are not notified of a medication approval,” and “you are not notified of a medication denial” ($\lambda_{\text{avg}} = 0.65$). The same 5-point response format was used. These subscales were moderately correlated ($r = 0.61$; $P < .001$), suggesting that the 2 scales share some variance, yet they capture different elements of transacting with health plans.

We also created a unit-weighted risk index based on 4 items assessing practice characteristics that included, for the provider personally, the number of medication PAs that they completed in a week (6-point response scale ranging from “none” to “more than 50”); how many hours per week they spent completing PAs (5-point scale ranging from “less than 5 hours” to “more than 20 hours”); length of time they waited for PA decision from health plan (7-point scale ranging from “under 1 hour” to “more than 5 business days”); and length of time, from start to finish, they typically needed to complete PAs, including chart reviews and patient research (6-point scale ranging from “0-3 hours” to “more than 2 weeks”). Higher scores on the risk index reflect more perceived burdens of PA based on practice experiences.

Endogenous measures (outcomes). Respondents were asked in what percentage of cases they prescribe a different medication than initially planned due to PA delays (5-point scale ranging from “less than 10%” to “more than 50%”). A second item assessed how often prescribers avoided prescribing newer medications due to anticipated need for PA, even if the patients meet evidence-based

TABLE 1. Mean (SD) Comparisons Among Gender, Specialty Type, and Provider Type^a

Measure	Gender		Specialty type		Provider type		
	All	Men	Women	Psychiatry	Other	MD/DO	Other
Exogenous measures							
Age in years	50.52 (12.90)	52.65* (13.78)	48.65 (11.79)	52.56* (13.78)	48.83 (11.87)	50.67 (13.40)	50.05 (11.21)
Practice size	2.30 (1.52)	2.34 (1.53)	2.32 (1.52)	2.16* (1.48)	2.42 (1.53)	2.37* (1.56)	2.06 (1.36)
Patient load	3.76 (1.44)	3.87* (1.43)	3.72 (1.42)	3.61* (1.40)	3.88 (1.45)	3.78 (1.43)	3.70 (1.45)
PA burden risk index ^b	1.32 (1.17)	1.34 (1.15)	1.32 (1.17)	0.99* (1.09)	1.59 (1.16)	1.33 (1.19)	1.29 (1.11)
PA weekly load	2.31 (1.11)	2.41* (1.18)	2.22 (1.05)	2.18* (0.97)	2.41 (1.20)	2.33 (1.13)	2.22 (1.04)
PA time weekly	1.23 (0.61)	1.26 (0.62)	1.22 (0.60)	1.15* (0.43)	1.30 (0.71)	1.25* (0.64)	1.17 (0.48)
Waiting time for PAs	4.71 (1.59)	4.61 (1.57)	4.77 (1.61)	4.46* (1.55)	4.92 (1.58)	4.70 (1.60)	4.73 (1.54)
Length of time to complete PAs	2.35 (1.68)	2.25 (1.63)	2.43 (1.73)	1.97* (1.56)	2.66 (1.72)	2.37 (1.70)	2.29 (1.62)
% of denied PAs that are then approved	3.13 (1.53)	3.10 (1.54)	3.13 (1.51)	3.20 (1.58)	3.08 (1.49)	3.17 (1.54)	3.01 (1.50)
Challenge identifying proper step therapy	2.93 (1.15)	2.99 (1.15)	2.86 (1.13)	2.88 (1.15)	2.96 (1.15)	2.99* (1.17)	2.72 (1.04)
Payer requirements	— ^c (0.90)	-0.04 (0.91)	0.04 (0.90)	-0.02 (0.92)	0.01 (0.90)	-0.01 (0.92)	0.02 (0.86)
Payer communication	— ^c (0.92)	-0.03 (0.92)	0.02 (0.92)	-0.13* (0.93)	0.10 (0.91)	-0.01 (0.95)	0.05 (0.84)
Endogenous/outcomes measures							
% cases prescribe different medication	2.92 (1.37)	2.95 (1.38)	2.92 (1.36)	2.72* (1.37)	3.08 (1.35)	2.89 (1.38)	3.01 (1.33)
Frequency avoiding newer medication	3.19 (1.14)	3.16 (1.20)	3.20 (1.09)	3.28* (1.17)	3.11 (1.11)	3.17 (1.15)	3.25 (1.10)
Frequency modified diagnosis	1.95 (0.98)	1.97 (1.03)	1.92 (0.94)	1.89* (0.96)	2.00 (1.00)	1.95 (1.00)	1.95 (0.95)

PA, prior authorization.

^aMeans comparing column on the left to the column immediately to the right with an asterisk differ significantly at *P* < .05 [ie, men vs women, psychiatry vs other, and MD/DO vs other].

^bUnit-weighted risk index with 4 measures ranging from 0 to 4.

^cNot applicable as this was a weighted (standardized to mean = 0) factor score.

guidelines, and a third item assessed how often respondents have modified a diagnosis to obtain PA (5-point response scale for both ranging from “very rarely” to “extremely often”).

Covariates. Additional information collected from respondents included gender, race, practice specialty, and practitioner type.

Statistical Analysis

We examined relations among gender, race (White vs other), practice specialty (psychiatrist vs other), and practitioner type (MD/DO vs other) using χ^2 tests of independence. We used the Student *t* test to examine mean differences for continuous measures based on gender, practice specialty, and practitioner type. A path regression model was conducted using the Mplus statistical software program (Muthén & Muthén) with maximum likelihood estimation to examine associations between exogenous variables and PA-related changes in clinical decision-making.²¹ Model fit was evaluated based on the χ^2 statistic (ratio of $\chi^2:df < 5$ equals good fit), comparative fit index²² and Tucker-Lewis index^{23,24} (numbers closer to 1.0 indicate better fit), and standardized root mean residual and the root mean error of approximation,²⁵ both of which consider values less than 0.05 to indicate good fit.²⁶

Adjusting for Nonresponse

To account for sampling bias, we used propensity weighting strategies²⁷ to make the sample distributions better conform to the known

characteristics of total sampled population.²⁰ These methods are detailed in the eAppendix.

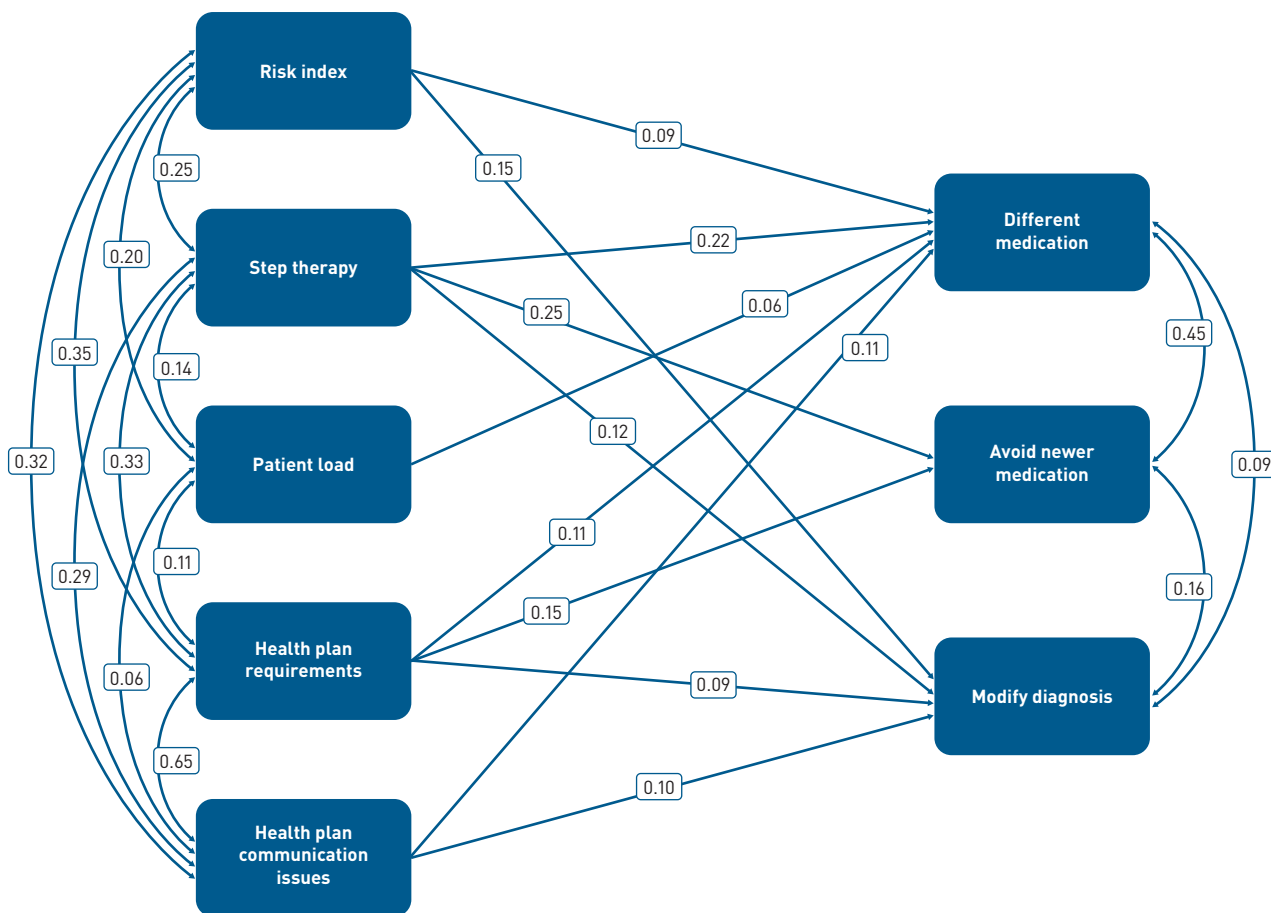
RESULTS

A total of 1173 respondents (1.2% response rate) generated 1147 usable surveys (at least 50% complete). The final sample was 49.6% female with a mean (SD) age of 50.5 (12.9) years (Table 1). A majority were MD/DO providers (76%; 69% MD and 7% DO), with smaller percentages of nurse practitioners (14%) and physician assistants (10%). A majority of the sample was White (67%), followed by Asian (18%). The largest proportion of survey respondents were in psychiatry, per the study design (44.9%), followed by internal medicine (18.0%), dermatology (13.1%), gastroenterology (8.0%), neurology (5.9%), oncology (5.8%), and rheumatology (4.4%).

Compared with respondents in other medical specialties, psychiatry respondents were older, had fewer providers in their practice, had smaller practice loads, encountered fewer medication PAs per week, spent fewer hours doing PAs, had lower waiting time for PA results, took less time to complete medication PAs, reported more communication issues with health plans, and perceived lower practice burden risk associated with PAs.

Regarding the 3 endogenous outcomes, 36% reported changing medications due to delays in medication more than 30% of the time, 26% reported modifying diagnoses to make the PA process

FIGURE. Final Path Model Predicting Provider Work-arounds*



*Boxes represent measured (observed) variables. Straight lines with single-headed arrows are path regression coefficients [standardized]. The curved double-headed arrows on the left-hand side represent associations among the exogenous measures; on the right-hand side, they represent correlations among the endogenous outcome measures net of prediction. Measures of health plan requirements and communication issues are factor composites. Model is trimmed of nonsignificant paths.

easier, and 75% reported often avoiding new medications, even if evidence-based, to avoid potential difficulties with PA. By specialty, psychiatrists reported a lower percentage of cases in which they prescribed a different medication, but a higher percentage in which they avoided prescribing newer medications, even if evidence-based, and reported fewer cases in which they would modify a diagnosis.

The Figure presents the results of the path analysis. Parameter estimates and their CIs are contained in Table 2. After removing paths between exogenous and endogenous variables that were not significant, the 2 largest effects overall were identified with the paths from step therapy to “avoid prescribing newer medication” ($\beta=0.24$; 95% CI, 0.188-0.301; $P < .001$) and from step therapy to “prescribe different medication” ($\beta=0.22$; 95% CI, 0.166-0.279; $P < .001$). The next largest effects were from health plan insurance requirements to “avoid prescribing a newer medication” ($\beta=0.15$; 95% CI, 0.074-0.221; $P < .001$) and then from the practice burden risk index to “modify

a diagnosis” ($\beta=0.14$; 95% CI, 0.086-0.204; $P < .001$). Overall, step therapy requirements and health plan insurance requirements were significantly related to all 3 endogenous outcomes. The remaining exogenous measures each had 2 significant paths to the endogenous outcomes. Although significant, the smallest effect overall was from patient load to “prescribe different medication” ($\beta=0.06$; 95% CI, 0.014-0.112; $P < .05$).

The curved double-headed arrows on the left side of the Figure represent associations among the exogenous measures; those on the right side represent correlations among the endogenous outcome measures net of prediction. For the exogenous measures, there was a moderate association between health plan requirements and communication issues ($r=0.65$; $P < .001$). Associations among the 3 outcome measures indicate that respondents linked “avoid prescribing newer medications” with “prescribe different medication” ($r=0.45$; $P < .001$). The variance accounted for in

TABLE 2. Associations Between Practice Characteristics and Perceived Burdens for PA and Provider Prescribing Behaviors^a

Measure	Structural path coefficient					
	Prescribe different medication		Avoid newer medication		Modify diagnosis	
	β	95% CI	β	95% CI	β	95% CI
Perceived practice burden risk index	0.07*	0.011-0.129	-0.04	-0.101 to 0.019	0.13***	0.069-0.190
Step therapy requirements	0.22***	0.166-0.279	0.24***	0.188-0.302	0.11***	0.054-0.173
Patient load	0.08**	0.028-0.137	0.04	-0.013 to 0.098	0.06 ^m	-0.001 to 0.112
Health plan requirements	0.11**	0.040-0.188	0.15***	0.079-0.228	0.08*	0.009-0.162
Health plan communication issues	0.11**	0.035-0.181	0.08*	0.002-0.149	0.10**	0.029-0.178

β, standardized coefficient; PA, prior authorization.

P* < .05; *P* < .01; ****P* < .001; ^m = marginal effect *P* < .06.

^aModel parameters are for fully saturated model not trimmed for nonsignificant effects. Negative signs indicate suppression in light of the positive zero-order associations among these measures. Outcome questions: "In what percentage of cases do you prescribe a different medication than initially planned due to PA delays?"; "How often do you avoid prescribing newer medications due to anticipated difficulties with PA, even if you feel patients meet evidence-based guidelines for their use?"; "How often have you modified a diagnosis to obtain a PA?"

the endogenous outcomes was $R^2 = 0.161$ for "prescribe different medication," $R^2 = 0.133$ for "avoid newer medication," and $R^2 = 0.103$ for "modify diagnosis." Additional model comparisons based on gender and provider function (MD/DO vs all others) indicated some small albeit significant differences in the model parameters. However, upon closer inspection, these differences were trivial and not clinically meaningful (results of these specific analyses are available from first author).

The comparison of psychiatrists ($n = 515$) with other specialty groups ($n = 631$) revealed a few minor differences in the magnitude of path regression coefficients. However, the absolute value of the differences in parameter estimates contrasting psychiatrists and other specialty groups was small (0.002), indicating relatively similar effects for the 2 groups. Further analyses suggest that the 2 groups can be considered randomly drawn from the same population. Detailed information on path model differences by specialty and related statistical analyses are detailed in the eAppendix.

Adjusting for Nonresponse

The results of the weighted vs unweighted analyses for the fully saturated model using the composite weight indicated some trivial differences in model parameter estimates. However, the overall mean difference (risk bias) in the regression parameters was $\Delta\beta_s = 0.0005$ and the same for the ΔSEs was 0.004. Also worth noting, the mean difference in mean estimates for model variables between unweighted and weighted data was 0.001 (SE = 0.006). Taken together, the findings from the weighted and unweighted analyses suggest that nonresponse bias had minimal effect on the final results.

DISCUSSION

To our knowledge, this study is the first to provide clarity on factors that contribute to providers' perceptions of medication PA burdens and the effect of these burdens on their prescribing behavior. Other nationwide surveys have reported that providers find PA burdensome,

both personally and administratively, and that PA affects clinical decision-making. However, the current study drilled deeper into what these burdens involve and how these burdens affect clinical decision-making.

Overall, step therapy requirements had the largest effect on prescribing behavior, being significantly associated with all 3 prescribing behavior outcomes and most strongly with prescribing a different medication and avoiding prescribing a newer medication. This finding is not unexpected given that step therapy is an ordered protocol. In its most efficient form, information exchange for step therapy is based on available medication dispensing data and is fully automated. However, at times, step therapy can require providers to complete extensive documentation of prior treatment history, including adverse effects, intolerances, or medication failures.

Health plans vary not only in their PA policies but also in the specific documentation that they require. This adds a layer of administrative burden to providers who must keep up with the different requests from different health plans. Accordingly, we distinguished step therapy from other measures because it represents a different facet of provider-payer interaction specific to demonstrating a patient's outcomes with prior treatment. Indeed, previous studies' findings have shown considerable variation with respect to how providers view step therapy, specifically whether they feel it is a viable method to ensure clinically appropriate use of medication and for managing drug costs.²⁸

Perceived practice burden and health plan communication issues were both associated with prescribing behavior and changing a diagnosis. Workplace perception of burdens was reflected in the PA volume and time spent on completing PAs or waiting from a response from health plans. The additional hours that accrue from processing PAs most likely represent what respondents view as "burdens" that have been noted in various professional surveys. Practices have tried to ease the PA burden through numerous methods, including hiring dedicated staff or outsourcing PA processes. In this study, we were able to show that these burdens are linked with changes in prescribing behavior. Interestingly, patient load, which reflects practice size,

had a very small effect on prescribing a different medication and no effect on the other 2 markers of clinical decision-making. These null findings may indicate that respondents are not hampered by the size of their practice or how many patients they see on a weekly basis as much as by the insurance-specific requirements of medication PA.

Health plan requirements, such as the need to send additional information to the health plan, and communication issues, such as discrepancies between the PA decision communicated to the provider and how it is adjudicated at the pharmacy, also significantly influenced clinical decision-making. PA requirements and communication issues reduce patient care time and therefore lead respondents to seek “work-arounds” to avoid the PA process.

This study also identified modest differences between psychiatry and other specialties. Psychiatry respondents were less inclined to prescribe a different medication or avoid a newer medication in response to patient load and health plan requirements compared with other specialty groups. However, psychiatry respondents were more likely than other specialties to avoid a newer medication when faced with health plan communication issues. This may suggest that psychiatry respondents alter their medication prescribing behavior when they feel that communication with the health plan is too demanding. This occurs despite their having smaller patient loads and completing fewer medication PAs on average. Other differences between psychiatry respondents and other specialty groups may reflect the types of drugs being prescribed and the diagnoses relevant to the different specialty types.

Study findings related to PA requirements and communication issues highlight the fundamental desirability for standardization of PA criteria across health plans and continued development and adoption of digital solutions for PA processes. By reducing PA burdens, these efforts may reduce the need for respondents to seek work-arounds, which can lead to suboptimal drug treatment and poor patient outcomes. Yet in the absence of widespread solutions to the burden of PA, various stakeholders are advocating for local and federal legislation that will limit the scope of PA and step edits. In addition to numerous PA legislative initiatives by individual states, the US House of Representatives recently passed the Improving Seniors’ Timely Access to Care Act of 2021 (HR 3173), which establishes several requirements and standards relating to PA processes under Medicare Advantage plans. This trend is likely to continue should the burden of PA on providers and patients not be addressed through standardization, digital solutions, or other means.²⁹

Limitations

This study has certain limitations. Selection bias could be present because providers who have a strong opinion or complaint about the PA process might be more likely to respond. Cross-sectional data can be used to identify association but not causation. Survey response was low, and although expected given the online approach, it contributes to the risk of nonresponse bias. Despite this low response rate, the resulting sample demographic profile matched

well to national numbers for all physicians. Although propensity weighting procedures were used to bring the sample data in line with population estimates, the pool of adjustment variables was limited. As a result, the final sample may contain moderate bias, which may affect generalizability of the findings.

We did not sample all medical specialties but focused on providers with high-volume medication PA, according to the CoverMyMeds 2019 ePA National Adoption Scorecard. Future studies may want to include additional specialties with different PA volume and experiences and widen the subject pool to include pharmacists, administrators, and support staff involved in the PA process. Finally, we did not qualify PA process burdens by payer type. Given Medicare Part D requirements for expedited processing of medication PAs, future studies may want to consider payer type and delve more deeply into how communication with health plans can be modified to reflect patient-centric concerns.

CONCLUSIONS

In this nationwide survey, respondents reported that they may alter clinical decisions to avoid PA requirements and related burdens, even in cases in which use of the PA medication was clinically appropriate. Processes that reduce the administrative burden of PA through improved communication and transparency as well as standardized documentation may help ensure that PA more seamlessly achieves its goals of safe and effective use of medications. ■

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eAppendix: Multi-item scales assessing health insurance plan requirements and communication

Regarding insurance companies, how often do you find them requiring...

	Very rarely or never (1)	Rarely (2)	Often (3)	Very often (4)	Extremely often (5)
<u>manual</u> prior authorization requests rather than allowing it to be done electronically?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
prior authorization for <u>generic</u> medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Regarding insurance companies, how often do you find them denying prior authorization requests because...

	Very rarely or never (1)	Rarely (2)	Often (3)	Very often (4)	Extremely often (5)
PA requests are missing <u>specific</u> adverse effects of past medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
of <u>dosing</u> issues (For instance, they will authorize two 10mg tablets but not a 20mg tablet)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
of <u>formulation</u> issues (For instance, they will authorize a capsule but not a tablet)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How often do you find that...

	Very rarely or never (1)	Rarely (2)	Often (3)	Very often (4)	Extremely often (5)
it is necessary to send additional clinical documentation in order to get a medication authorized?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
your software says that a medication is denied by insurance and you later discover that it was actually approved?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
you are NOT notified of a medication approval?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
you are NOT notified of a medication denial?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>