Prior Authorization Framework and Accreditation (PAFA)

Program Guide

PAFA PRIOR AUTHORIZATION FRAMEWORK & ACCREDITATION PROGRAM

An Overview of PAFA

The Prior Authorization Framework and Accreditation (PAFA) program is a non-profit organization that has developed a framework for efficiencies in prior/special authorization administration processes and practices, and an accreditation process to recognize payers[1] who adopt PA efficiencies. The PAFA program has been developed in response to research findings noted in the source list below that identify ongoing challenges within PA administration processes and practices in Canada and elsewhere.

The goal of the PAFA Program is to recognize Canadian public and private payers who have adopted PA claims administration efficiencies and/or have implemented electronic prior authorization (ePA).

A working group of benefits and private healthcare professionals with expertise in prior authorization (Appendix 1) developed the PAFA Program, with input from a larger group of stakeholders with a knowledge of PA. The Program incorporates solutions that have been recommended or implemented in Canada and the U.S., with reference to prior authorization processes elsewhere in the world (Appendix 2).

Sources that were referenced in the development of the PAFA Program include:

- The 2020 Report on Private Payer Prior Authorization in Canada: Simplify Prior Authorization by Connex Health and the Pangaea Group
- One-on-one meetings with PA stakeholders between 2021-2024, plus consultations to explore the marketplace for an ePA solution, the critical role of electronic medical record systems (EMRs) in PA, the development of the Simplify Prior Authorization (SPA) website resource, and preparation for articles, blogs and podcasts
- Prior authorization principles, recommended practices, and legislation in the U.S. and elsewhere (Appendix 2).

1. Payers in this context include both public and private payers. Private payers include insurers, pharmacy benefit managers (PBM), or other third parties that make reimbursement decisions for drugs that require prior authorization.

Program Goal and Objectives

The primary goal of the PAFA Program is to engage payers to make positive changes in their PA claims processes and practices through a membership and accreditation program, thereby improving the PA experience for patients and other PA stakeholders. To achieve this goal, the PAFA Program is committed to recognizing Canadian public and private payers who have adopted efficiencies in their PA claims administration practices and processes.

The practices and processes that create efficiencies will improve the patient experience, the experiences of other PA stakeholders, reduce administration, the time for claims processing, and improve the overall PA process.

Private payers can differentiate themselves from their competitors, while also benefiting from the administration efficiencies in the PAFA Framework.

The PAFA Program is an important tool for other stakeholders who are part of the PA process or are impacted by the process. There are many stakeholders in this group including patients, caregivers, physicians (prescribers), patient groups, patient support, patient navigators, pharmacy, ePA solution providers, as well as benefit advisors and plan sponsors. Many of these stakeholders work within the PA claims environment, often with both public and private payers.

PA stakeholders want to work with payers that have a patient centric process that is well communicated, consistent across payers, and efficient, transparent and fair. Stakeholders can use PAFA to explore the marketplace for those payers who have a patient centric process and have been recognized through PAFA accreditation.

Management, Funding and Oversight

The PAFA Program is a membership funded and managed non-profit organization, with oversight from PAFA's Directors and the Framework and Accreditation Advisory Board (FAAB). Members and associate members can apply to join FAAB. Associate members can also apply to join the Accreditation Panel. Other external expertise, including patient groups or representatives, may be invited to join FAAB and the Accreditation Panel.

Denise Balch is the Executive Director of the PAFA Program and chairs the Board of Directors and both the FAAB and the Accreditation Panel (Appendix 3). Section 4 includes details of membership and associate membership.

The Framework and Accreditation Advisory Board (FAAB) monitors PA practices and maintains oversight of the Framework and Accreditation Program. The nine members[2] of the FAAB Advisory Board, including the Executive Director, work together to ensure that the Framework and Accreditation adheres to the four foundational values to ensure payer accreditation is within reach. The values are fair, current, relevant and achievable.

The Accreditation Panel (AP) evaluates applications for accreditation from payers and is made up of five representatives from associate member organizations, and external expertise as noted above, including the Executive Director.

2. Member organizations include associate member organizations.

Accreditation and Membership

Four Guiding Principles form the basis for membership and associate membership. A Framework for PA and three accreditation opportunities are included in the PAFA Program. Payer members can apply to be accredited. This means they will be recognized for incorporating administration efficiencies into their processes and practices that benefit non-payer stakeholders, and/or for implementing electronic prior authorization that will deliver additional time savings for claims completion, submission, and response to PA claims. Members that achieve both accreditations will receive a Gold accreditation to identify their achievement.

Memberships are available to payers, and associate memberships are available to other stakeholders (non-payers), including those without direct involvement in prior authorization. To be eligible for membership, payers must demonstrate their organization's written agreement to the PAFA Program Guiding Principles. Non-payers should be familiar with and support the PAFA Program Guiding Principles.

Membership applications can be found on the PAFA website. A sample membership commitment can be found in Appendix 4.

There are several benefits to membership and associate membership, including the use of PAFA branding, recognition on the PAFA website, accreditation (members only), and contributions to the management of the PAFA Program. Details are found in Section 4.

Details of the PAFA Program are included in this Guide and are divided into the following sections:

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About this Guide

This Guide provides a comprehensive overview of the PAFA program, including the structure and management of the Framework and Accreditation processes. It is a reference, evaluation and recognition tool for PA claims administration processes and practices in Canada for both public and private payers. Other stakeholders[3] can also use the Guide to learn about opportunities for payers to improve PA in Canada and to compare a payer's practices and process against this research-based Framework (Section 3).

Payers can apply for accreditation to determine if they meet the requirements for one or both accreditations in this Guide (Section 4).

The PA framework contained in this Program Guide will result in timelier access to prescribed medications and eligible diagnostics for patients, and introduce objective metrics to evaluate improvements. The administrative burden of current PA practices can only be improved if payers adopt progressive approaches to PA that will benefit all stakeholders in the process.

3. Stakeholders in this context includes advisors and consultants, drug access navigators (DANs), healthcare professionals and their associations, patients and their caregivers, patient groups, patient support programs (PSPs), patient access navigators, pharmaceutical manufacturers, prescribers and pharmacy.

1. Background

The 2020 Report on Private Payer Prior Authorization in Canada examined private payer policies and processes with a view to answering the question 'Is it possible to create change at an industry level?'. The recommendations called for addressing the challenges through a multi-stakeholder collaboration to:

- Create a patient centric PA process – that better serves the needs of patients
- Create consensus on some standardization between private payers to enable administrative efficiencies, expedite claims processing and reduce the administrative burden on all stakeholders
- Develop standards for annual reporting, accreditation and recognition of private payers who achieve and maintain best practices, cost/benefit metrics and stakeholder evaluations
- Identify industry best practice benchmarks for PA
- Provide a central web portal managed by an independent agency dedicated to simplifying PA while serving the best interests of patients and their need for information on navigating the PA process.

After the 2020 report, the Simplify Prior Authorization (SPA) initiative was created to address the report's recommendations. Since the release of the report the SPA initiative has worked collaboratively with industry stakeholders to be a catalyst for change. The result has been an extensive industry education and advocacy campaign on the need to improve prior authorization through administration efficiencies and ePA. The PAFA Program responds to the final outstanding recommendation in the 2020 Report.

‘Private payers in Canada recognize the need to move to digitization of a number of insurance processes that remain paper-based, including ePA,’ according to a May 2023 statement from Joan Weir, vice-president, group benefits, Canadian Life and Health Insurance Association (Appendix 2).

Details of the advocacy campaign, educational information, and resources can be found on the Simplify Prior Authorization website, expanded and relaunched in January 2023.

Since 2020 additional one-on-one interviews with PA stakeholders were conducted and additional research was sourced by the SPA initiative (Appendix 2). This resulted in further insights into best practices and process improvements, many of which were used in developing the PAFA Program and this Guide. The challenges today remain very similar to those in the original 2020 report and include:

1. The lack of easy access to information on the PA process for patients and other stakeholders
2. The heavy administrative burden on patients, medical practitioners and patient navigators
3. The challenge of assessing patient eligibility prior to claims submission
4. Inconsistent policies for
    a. Maintaining medication approvals on change of carrier, and
    b. Honouring medication approvals during temporary suspension of drug use due to changes in a patient’s medical condition
5. The physical and mental health impact of PA on patients, particularly those who experience extended wait times for approvals to access sometimes life-changing therapies
6. The financial burden of PA management and administration on payers.

Developing a Framework and Accreditation Program

The PAFA Program establishes a framework and a recognition and accreditation program for payers that addresses many stakeholders’ concerns. It also responds to the recommendations in the original 2020 Report on Prior Authorization in Canada that called for the development of standards for annual reporting, accreditation and recognition of private payers who achieve and maintain best practices as well as cost/benefit metrics, and stakeholder evaluations.

The PAFA Program was created in collaboration with a multi-stakeholder working group (Appendix 1) with experience and/or exposure to PA brought together through the SPA initiative. Their mandate was to develop guiding principles and a framework based on their expertise and with reference to PA research, including the 2020 Report on Prior Authorization in Canada. The group included representatives from drug access navigation, group benefit advisors, patient groups, patient support, pharmacy and pharmaceutical manufacturers. Payers were also invited to participate.

The goal of the PAFA Program is to recognize Canadian public and private payers who have adopted PA claims administration efficiencies and have implemented ePA.

- Payers are recognized by PAFA for their achievements and gain a competitive advantage by improving their administration processes and practices and upgrading their systems to accept electronic prior authorization (ePA).
- PA stakeholders, particularly advisors, can use the PA program as a reference tool to evaluate payers against the PAFA Program’s administration efficiencies and ePA Framework. Stakeholders can easily identify payers who are PAFA accredited, and encourage payers to seek PAFA accreditation if they are not PAFA accredited.

The PAFA Framework was developed based on four fundamental values to ensure payer accreditation is within reach: fair, current, relevant and achievable.

In March 2024, twenty-eight diverse stakeholders with experience or exposure to PA reviewed the PAFA Program Guide draft and provided their input. This group included representation from group benefit advisors, drug access navigation, patient groups, patient support, payers, pharmacy and pharmaceutical manufacturers.

In July 2024, the original working group members and eight of the twenty-eight reviewers were invited to make a final review. The final eight reviewers were selected based on their status as key opinion leaders and their expertise in PA processes, patient support and navigation, ePA, and as payers. Contributors to the Guide can be found in Appendix 1.

The Guiding Principles, Framework and Accreditation

After the four fundamental values were identified, the Guiding Principles for the PAFA Program, the Framework, and three accreditation categories were identified.

The four Guiding Principles include communication, transparency and fairness, consistency and efficiency, details of which are found in Section 2. These were developed with input from the PAFA working group and with reference to the U.S. Prior Authorization and Utilization Management Reform Principles (2017) and the U.S. Consensus Statement on Improving the Prior Authorization Process (2018) (Appendix 2).

The PAFA Framework and Accreditation is divided into two distinct areas:

Administration Efficiencies (AE) and **electronic Prior Authorization (ePA).** The objective in developing the Framework was to identify areas where prior authorization processes and practices could be more patient centric and consistent across payers, and more efficient, equitable, modern, and transparent, without compromising proprietary aspects of the process such as each payer's criteria for reimbursement. A summary is provided here, and details are found under Industry Framework, Section 3.

A. Administration Efficiencies

The idea of improving the administration of PA claims is not unique to this initiative. Public payers of specialty drugs in both British Columbia and Ontario have introduced improvements in their special authorization (PA) processes, including ePA. The U.S. has also been working towards changes to PA practices and ePA implementation through advocacy by healthcare associations, and state and federal legislation (Appendix 2).

Implementing a baseline for administration processes, including communication, for public and private payers in Canada will clarify the PA process for stakeholders, making PA easier to navigate and therefore mitigate some of the administrative burden. It will also create the foundation for a common process for patients who require temporary changes in medication or when their coverage moves between payers.

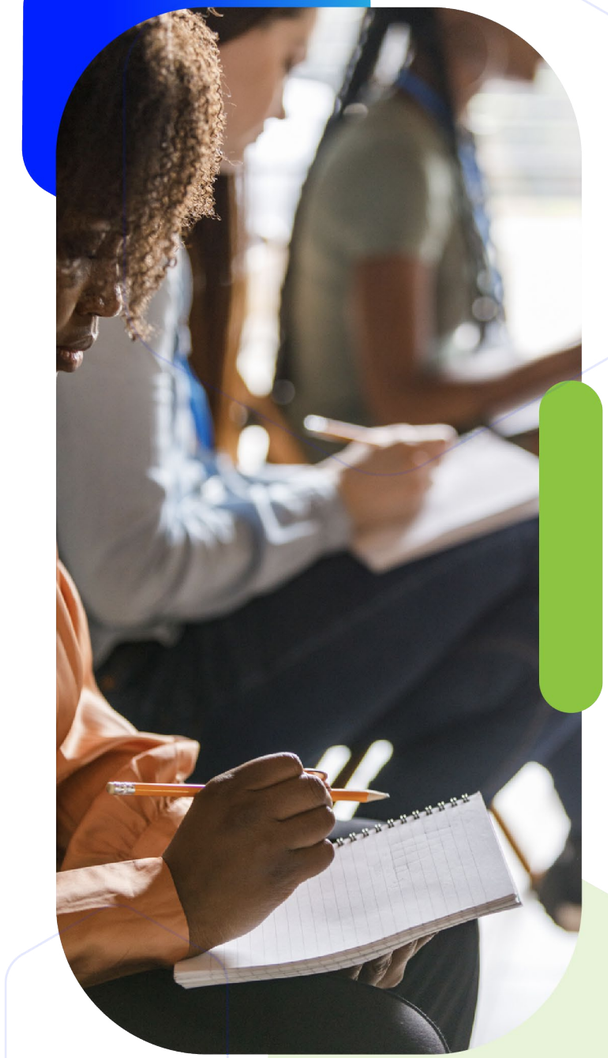
B. Electronic Prior Authorization

Further efficiencies can be created through the adoption of electronic PA (ePA). In this context, ePA is defined as a process by which prior authorization forms can be completed online through a PA claims application, and relevant patient medical records can be attached via physician's electronic medical records (EMR). The completed information is then transmitted electronically to a payer via an application programming interface (API). This eliminates the need for hard copies, mail and faxes.

A move to ePA can reduce the administrative burden of PA for all stakeholders, decrease claims processing time, and deliver easy access to demonstrable patient outcome metrics through the collection and reporting of aggregate data analytics, something patient support programs have been striving to achieve. One Canadian ePA solutions provider, has already successfully demonstrated a 70% reduction in the time to claims completion through an electronic process.

Once payers in Canada allow the submission of claims through an API, which means they can receive PA claims electronically, the security of the transmission of sensitive health information will be assured, the time delays of the mailing process will be eliminated, and greater efficiencies will result.

Provincial public drug plans in Ontario and British Columbia (BC) have already adopted electronic prior authorization applications to improve the efficiencies of their exceptional access programs (EAPs). A list of relevant data on the impact of the Ontario and BC ePA process are found in Appendix 2.



2. Guiding Principles

The Guiding Principles were developed by a working group of individuals with knowledge and experience in prior authorization. In developing the Guiding Principles the working group took into consideration the U.S. Reform Principles developed in 2017 and Consensus Statement developed in 2018 (Appendix 2). While the Canadian and U.S. private payer markets differ, both countries are similar in their heavy reliance on private payers to underwrite and adjudicate prescription drug and prior authorization claims, and experience many of the same challenges.

The U.S. 2017 Reform Principles for prior authorization were developed by a consortium of associations, primarily representing physicians, hospitals, and pharmacists. The principles address clinical validity based on 'accurate and up-to-date clinical criteria' and allow for appeals of denials, the importance of continuity of care, transparency and fairness, timely access and administration efficiency, including ePA, and allowance for alternatives and exemptions from PA requirements.

The 2018 Consensus Statement on Improving the Prior Authorization Process was developed by a group consisting of hospitals, physicians, pharmacists, medical groups, and health plans. This group identified goals that included 'promoting safe, timely and affordable access to evidence-based care' including 'enhancing efficiency and reducing administrative burdens', while also identifying five areas of opportunities for improvement in PA program and processes for meaningful reform.

The PAFA Guiding Principles create a foundation for improving PA. Each element of the Framework can be measured against these Principles. If an element of the Framework doesn't fit within one or more of the Guiding Principles, then it should not be part of the Framework.

Four Guiding Principles

1. **Communication** — Make PA information and communications patient centric i.e. use plain language that is easy for plan members and patients to understand, and that meets accessibility standards. Information on plan coverage and a list of PA medications should be easily accessible online to all stakeholders, including details of any non-proprietary aspects of PA and the claims process.

2. **Transparency and Fairness** — Build transparency into all aspects of PA that are not proprietary to improve stakeholder understanding of the flow of the PA process, including denials and appeals, and to ensure that patients and their healthcare team have access to and receive timely information on the status of their claim.

3. **Consistency** — Develop evidence-based, informed and consistent guidelines, practices, and decision making that promotes equitable, fair and reliable access to deliver positive patient outcomes.

4. **Efficiency** — Strive for continuous improvement, including the review and improvement of processes, practices, and resources to deliver an efficient and timely patient focused process, with a commitment to adopt new technologies, including ePA, to improve the patient and PA stakeholder experience.

Public and private payers who practice these Guiding Principles will be contributing to a more patient centric and consistent PA process. This is the future of PA.

Stakeholders with an interest in PA, including public and private payers, can become payer members or associate members of PAFA. Any member or associate member can apply for participation as an Advisory Board member to contribute to the future development of these Guiding Principles and the Framework. Details of membership, associate membership, and member benefits are provided under Membership and Accreditation (Section 4).

3. Industry Framework and Accreditation

The Benefits

PAFA is an industry framework and accreditation program that has benefits for all stakeholders and will also recognize payers who adopt the Framework. Patients will benefit from improvements in the PA process, as will payers and other PA stakeholders, including physicians.

Payers should be interested in the competitive advantages of PAFA accreditation. Accredited payers will be able to promote their accreditation to existing and prospective clients and advisors, confident they are following the most up to date PA processes and practices. Plus, they will receive recognition from PAFA. They will also benefit from:

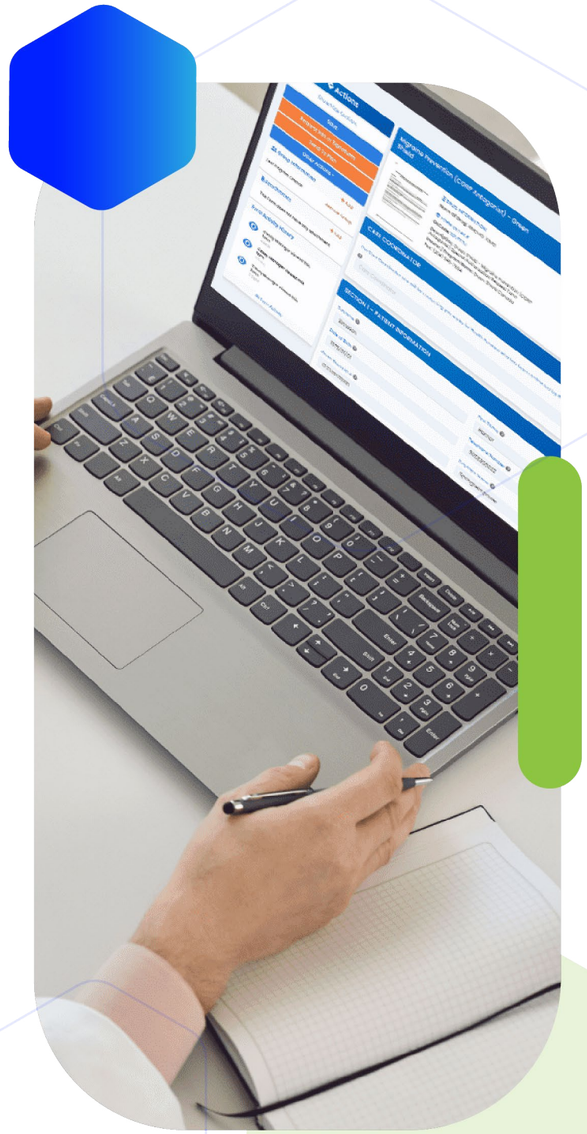
- **Time savings:** Fewer phone calls and emails from patients, plan members, patient support, pharmacists and physicians because plan coverage details, the PA claims and appeals process, and PA claims forms are clear and available online. Once a payer adopts ePA, claims processing will move more quickly, reducing administration needs and expenses.
- **Reduce duplication/errors with ePA:** A move to ePA claims administration, which includes accepting claim forms and supporting documentation electronically, will reduce duplicate/missing faxed claim forms, eliminate mail time, calls to check on receipt of claims, and follow up for missing information.
- **Automated ePA adjudication:** When payers eventually move to automated ePA, at least for some medications or diagnostics with very clear eligibility criteria, the administrative burden will reduce even further because adjudication will take place electronically.

Patients benefit because they will receive access to their medication quickly with a lower administrative burden:

- Their coverage and the PA claims process will be easier to access and understand online.
- They will be able to hand over most of the process to their physician or patient support program (if they wish).
- Their wait time will be shorter to access their medication.

Physicians and other PA Stakeholders benefit because their administrative burden for each claim will be lower:

- They will have easier access to patient coverage and PA claims process information
- They will be able to access claim forms more easily and when ePA is introduced, they can complete and submit claim forms online to each payer, including relevant medical records from EMRs
- They will be able to make inquiries and communicate directly with each payer on behalf of their patient.



The PAFA Framework and Accreditation is divided into two distinct areas: **Administration Efficiencies (AE)** and **electronic Prior Authorization (ePA).**

Framework and Accreditation Requirements

Payers who are PAFA members can apply for one or both accreditations in each application. Accreditation is not sequential and can be taken in any order. Once payers receive both the **Administration Efficiencies** and **electronic Prior Authorization (ePA)** accreditations they will receive their **Gold Accreditation**. Details of the member and associate member process and benefits are in Section 4 - How to Apply: Membership and Accreditation.

Level 1: Administration Efficiencies

The goal of the **Administration Efficiencies (AE)** accreditation is to create efficiencies and a better understanding of payer PA administration practices and processes for all stakeholders, including patients and their caregivers. The AE accreditation includes recommended administration and customer service standards for PA, including the review and approval processes, the categorization of PA medications, communications, and internal reporting.

The Framework was developed based on research conducted between 2020-2024 including the 2020 Report on Prior Authorization in Canada, one-on-one discussions with PA stakeholders, and activities in the U.S. (Appendix 2). Research revealed that stakeholders were concerned about payer PA policies, practices, and processes, and their impact on patients and their caregivers, physicians, patient support programs and patient navigators. They also expressed concerns about the overall administration burden on stakeholders, including payers. As a result, the Framework has been developed to address the following:

1. Responsibilities for the review and identification of a PA medication
2. Considerations made in the review and identification of a PA medication
3. How plan members and other non-payer stakeholders identify which medications require prior authorization and whether a patient may be eligible for a PA medication
4. How plan members and other stakeholders access information regarding the claims process
5. The ability of patients or their caregivers to authorize their healthcare professional, patient support program or patient navigator to submit the claim on their behalf and access information regarding the status of a claim that has already been submitted for reimbursement
6. The process for submission of additional information related to a PA claim to payers
7. Reasonable timelines to expect payer requests for additional information, approvals or denials
8. How to appeal a claim that has been denied
9. Policies for the continuation of approval for a medication during a temporary change in medication resulting from a change in condition, or on change of carrier.

The Administration Efficiencies Framework includes two parts that must be satisfied to receive accreditation: **Practices and Processes** (Table 1), and **Timelines** (Table 2).

A. Practices and Processes - Requirements

The administration of PA claims includes important stages in PA. Table 1, summarizes the practices and processes required to receive the Administration Efficiencies accreditation. Evidence to support a payer's attestation that they meet these requirements must be provided as part of their accreditation application.

Table 1

Administration Practices and Processes
PA advisory committee: This committee is required to exist to review and identify medications and diagnostics that will be subject to PA, establish reimbursement criteria, and make any necessary changes to reimbursement criteria over time, including changes to PA designation. It should consist of a cross functional team that includes PA claims adjudicators as well as clinical expertise e.g. pharmacist or physician, with the latitude to consult external clinical or patient expertise as required.
Criteria for reimbursement: The PAFA Program acknowledges that the criterion for reimbursement is proprietary to each payer, and that it is commonplace for payers to consider a combination of factors when creating the reimbursement criteria for a medication or diagnostic tool i.e. a combination of the indication, the criteria for other medications in the same therapeutic area, clinical practice guidelines, and the manufacturers submission dossier. Criteria that is established based heavily on one resource or reference are discouraged, such as the Canadian Drug Agency (CDA), or on price alone. CDA can have limited relevance to the impact on private markets, or single source product listing agreements.
Information about PA: Ability for plan members, patients, or their caregivers to access general information online and in an accessible format about PA that meets current Web Content Accessibility Guidelines and PDF UA requirements of the Accessible Canada Act 2019. Clear explanation of the PA process, in plain language, including: how to confirm coverage, how to determine if a medication they have been prescribed requires PA, where to find PA claim forms, expected response times, including approval timelines, how to get help when completing a claim form, how to submit a PA claim, why a claim may be denied, the appeals process, and who to contact for inquiries or assistance.

Administration Practices and Processes
Designates: Patients or their caregiver may designate one or more healthcare professionals (HCPs), patient support program (PSP) representatives, drug access navigator (DAN), or pharmacist to communicate on their behalf and to receive communications, including approvals, denials and meet accessibility standards, appeal decisions, by phone, electronically, by fax, or by mail.
Communications including approvals, denials, and appeal decisions: Targeted and timely communications to patients and their designates. Communications should be easy to understand, using plain language, and clearly outline next steps if applicable.
Additional information: Plan member/patient or their designated HCPs, PSPs, DANs or pharmacist can submit additional information by mail, fax, or through a secure and confidential online portal or electronic prior authorization (ePA) application if ePA is available.
Temporary changes of PA medication: When changes to prescribed medications are made temporarily, i.e. for a period of under six months, because of a change or exacerbation in the patient's condition, then the temporary change in medication should not impact the ability of the patient to recommence treatment with the previously approved PA medication for the duration of the original approval or renewal with the prescribing physician's recommendation.
Renewals of PA medication: Limited information requirements on renewal when patients have been stable for 6 months or more on their PA medication regime, and the indication of the medication is for a long term, ongoing, chronic condition.
Change of carrier: The existing payer provides the necessary information to a new payer to ensure patients can continue an approved PA medication during the transition period and until the expiry of their original approval date.
Key performance indicators (KPIs): Payers applying for this accreditation must commit to recording and reporting annually to PAFA on the following (in percentages): PA claims approved, requests for additional information, declined, appealed, medication switches (temporary), medication renewals, medication interruptions, and claim response times that meet the timelines in Table 2. Payers must also administer a patient experience survey and report results to PAFA. The scope of the survey can be found in Appendix 5. A list of the required minimum patient experience survey questions will be set by PAFA. Non-identifying results will be included in the annual public PAFA report.

B. Administration Timelines - Requirements

The timelines for administration of PA claims are critical to the physical and mental wellbeing of patients. Table 2, below, summarizes the timelines required to receive the Administration Efficiencies accreditation. Evidence to support a payer's attestation that they meet these requirements must be provided as part of their accreditation application.

Table 2

Administration Timelines - Based on Stage of Claim	Expected Payer Response for Urgent Claims[4]	Expected Payer Response for Non-Urgent Claims
Acknowledgement of receipt Initial claim and any additional documentation related to claim, plus expected timeline for response based on current workflow.	Within 24 hours of initial receipt.	Within 2 business days of initial receipt.
Notice of outstanding or additional information Scan for and respond back to whoever has facilitated the claim submission with all missing/additional information that will prevent any action/decision on the claim, including signatures, personal information such as DOB, policy or certificate number, and electronic medical records or diagnostics.	Within 24 hours of initial receipt or appeal.	Within 4 business days of initial receipt or appeal.
Notice of approval or denial of claim	Within 24 hours following receipt of all necessary information.	Within 4 business days following receipt of all necessary information.

4. Urgent claims in this context are any oncology or oncology related medication or diagnostics, any request for temporary switching or adjunct therapy to an existing PA approved medication because of a temporary change in condition i.e. autoimmune flair.

Administration Timelines - Based on Stage of Claim	Expected Payer Response for Urgent Claims[4]	Expected Payer Response for Non-Urgent Claims
Notice of additional time requirements for payer review and/or external consultation	Within 24 hours following receipt of all necessary information.	Within 4 business days following receipt of all necessary information.
Claim renewal Notice of upcoming renewal of PA medication including any renewal specific claim form and details of the necessary information and documentation required, including diagnostics and imaging.	Two months	Two months
Inquiries Response to inquiries or questions about a specific PA claim, the claims process, appeals, or other details regarding PA requirements.	Within 24 hours	Within 24 hours
Patient experience surveys An online patient experience survey must be offered to all patients – those approved and declined (Appendix 5).	Within 24 hours of notification.	Within 24 hours of notification.

Level 2: Electronic Prior Authorization (ePA) Accreditation

The goal of ePA Accreditation is to reduce the administration burden of PA and improve timelines for patients to access their prescribed medication(s). The accreditation is in place to encourage payers to adopt ePA and acknowledge payers who have improved their PA process through ePA implementation.

Patients receive timelier access to their prescribed medication or diagnostics when ePA is in place because the administration burden is reduced, which saves time and money for PA stakeholders, including payers. Completing a claim form online, obtaining signatures, attaching documentation and patient records electronically, and submitting them online to payers is much quicker than a paper, mail/fax process. One Canadian ePA technology solutions provider, has demonstrated a 70%-time savings for the preparation of PA claims, which does not include savings from the elimination of the mail/fax submission process currently required by payers. There are more benefits to ePA. Aggregate patient health outcomes data can be easily gathered through an ePA solution without compromising patient confidentiality. Documenting aggregate patient health outcomes can be used to support product listing, health outcomes-based agreements, and inform future policy. Most importantly to payers, ePA does not impact the proprietary nature of their PA claims criteria.

The benefits of ePA have been well-recognized in the U.S. within several states. West Virginia and California (where legislation is still pending) will require prior authorization requests to be submitted and decisions to be communicated electronically, specifically through an electronic portal. In early 2024, the Centers for Medicare & Medicaid Services (CMS) finalized the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F). This rule calls for the improvement of the electronic exchange of health information and encourages ePA implementation among all impacted payers. (Appendix 2).

ePA - Requirements

The timelines for administration and adjudication of PA claims are critical to the physical and mental wellbeing of patients. Table 3, below, summarizes the requirements for ePA accreditation. Evidence to support a payer's attestation that they meet these requirements must be provided as part of their accreditation application.

Table 3

ePA - Requirements
PA forms: All PA forms must be available online to plan members, through their public domain, sign-in to their payer portal, or through their payer's ePA application. Healthcare practitioners, drug access navigators, patient support programs, and pharmacy must also be able to access PA forms to start the claims process on behalf of patients.

ePA - Requirements
Accessibility: All ePA solution providers and payer PA claim forms must meet current Web Content Accessibility Guidelines and PDF UA requirements of the Accessible Canada Act 2019 and should be updated to reflect any changes in the Act.
Claim form completion and submission: All PA claims must be eligible for completion electronically through an ePA provider, and for electronic submission from an ePA provider through a secure application programming interface (API) to the payer. This includes the ability to attach relevant patient electronic medical records (EMRs). The result is a complete end-to-end ePA solution.
Communication: To become ePA accredited, the payer must be able to send and receive communications regarding a claim to patients and their designates through an ePA solutions provider. This includes claim status, requests for further information, approvals, denials, and appeals, according to the timelines under Administration Efficiencies Accreditation outlined in Table 2. Communication may also be made by phone when warranted because of complexity or urgency but must be followed up with a confirmation through the ePA solution or by mail if required for record keeping purposes.
Claim status and inquiries: The payer must make claim status available to patients and their designates in the following categories regarding the status of their claim through the ePA portal after their claim i.e. received, notice of outstanding/additional information required, in review, notice of approval/denial sent, notice of additional time for review/ consultation, renewal notification sent, and inquiry under review, based on the timelines in Table 2.
Patient experience surveys: An online patient experience survey must be offered to all patients – those approved and declined - within 24 hours of notification (Appendix 5).
Key performance indicators (KPIs): Payers applying for this accreditation must commit to recording and reporting annually to PAFA on their compliance with the ePA requirements in Table 3, and on the following (in percentages): PA claims approved, requests for additional information, declined, appealed, medication switches (temporary), medication renewals, medication interruptions, and claim response times that meet the timelines in Table 2. Payers must also administer a patient experience survey and report results to PAFA. The scope of the survey can be found in Appendix 5. A list of the required minimum patient experience survey questions will be set by PAFA. Non-identifying results will be included in the annual public PAFA report.

Gold Certification

Once a payer has attained accreditation in both **Administration Efficiencies** and **ePA**, they will receive PAFA's Gold accreditation.

Future Accreditation Opportunities

As the PA adjudication landscape develops in Canada and elsewhere there will be new efficiencies and additional accreditation opportunities. The PAFA is committed to adapting to reflect new developments. Those payers who have already received their PAFA Gold accreditation will be able to secure additional recognition and accreditation when they become available.

Some examples of future opportunities include the following:

- **Selective Application of PA or Gold Carding** — In some states in the U.S., prescribers who have developed trusted relationships with payers benefit from an accelerated approval process for PA claims. The process, called Gold Carding, involves prescribers who consistently follow PA criteria in their prescribing, and whose patients are consistently approved for their PA medications. This has benefits for all stakeholders by speeding up the claims adjudication process and providing quicker access to patients for their prescribed medication or diagnostics.
- **Automated ePA Adjudication** — This recognizes payers who enable automated claims adjudication for some PA medications. This is most likely to include medications or diagnostics that are high volume and moderate cost, where the criterion for eligibility is straightforward. This also has benefits for payers by lowering administration times and therefore adjudication costs and speeding up the claims adjudication process. Patients will also receive quicker access.

4. How to Apply: Membership and Accreditation

Membership

The PAFA working group has committed considerable effort and engaged close to thirty PA stakeholders to develop a consensus for a PA framework and accreditation program in keeping with the recommendations of The 2020 Report on Private Payer Prior Authorization in Canada. The PAFA Program Guide catalogues much-needed clarity and efficiencies in prior authorization administration practices and processes, including ePA, that will improve the PA process, and provide recognition opportunities for those payers that meet the PAFA Framework.

The working group would like to thank the associations, group benefit advisors and consultants, patient groups, patient support programs, patient navigators, electronic medical record (EMR) experts, ePA solution providers, industry associations, pharmacy, and payers that have participated in the development of the PAFA Program and this Guide.

When payers become PAFA members and other stakeholders become PAFA associate members, they are demonstrating their support for the PAFA Program, its's fundamental values, and Guiding Principles.

When payers apply for accreditation, they are reinforcing the value of improvements in PA administration to improve the PA claims process for all stakeholders.

Membership and associate membership fees provide financial support to ensure that PAFA can continue to work collaboratively with all industry stakeholders to develop an efficient and effective PA process. Members (private and public payers) and associate members (all other stakeholders) are encouraged to participate in the ongoing management of the PAFA program through the Framework and Accreditation Advisory Board (FAAB).

Payer Membership

All private and public payers can apply for membership. Private payers include insurers, pharmacy benefit managers (PBM), or other third parties that make reimbursement decisions for drugs that require prior authorization. Public payers include provincial and territorial drug benefit programs.

The annual membership options and fees for public and private payers are:

- $10,000 plus HST annually for the silver level.
- $15,000 plus HST annually for the gold level. This is a requirement for organizations who apply for a seat on the Framework and Accreditation Advisory Board.

To qualify for membership, payers are required to make a written commitment to the PAFA Program's Guiding Principles. Internally, payers are required to communicate the commitment to employees responsible for prior/special authorization claims review and adjudication. Externally, payers are required to communicate the commitment to patients and other stakeholders in a prominent position on the prior/special authorization section of the applicant's website. More details can be found in Appendix 4.

Payer Member Benefits

Members will be recognized for their membership and commitment to the PAFA Guiding Principles in the following ways:

- **On the PAFA website** and in all communications and promotions.
- **Framework and Accreditation Advisory Board (FAAB):** Eligibility to apply for one of nine seats on the Advisory Board at the gold member level. The PAFA Board will meet semi annually to review and make any updates to the Guiding Principles, Framework and accreditation requirements.
- **Use of the PAFA membership logo:** Members may promote their PAFA membership status to new and existing clients, demonstrating their commitment to improving PA practices and processes, therefore providing them with a competitive advantage over those payers without PA membership.
- **Accreditation:** Members may apply for accreditation for administration efficiencies or ePA accreditation. Once accredited, PAFA members may use the PAFA accreditation logo to promote their accreditation status to new and existing clients. This will provide accredited payers with a competitive advantage over payers that are not accredited.
- **Advance notice of changes to the Guiding Principles and Framework:** Members will be invited to provide input before changes are finalized, even if they do not sit on the FAAB.
- **PAFA annual report -** Members will:
  - Have an opportunity to review and comment on the annual PA survey before distribution
  - Be invited to provide a quote/ comment on the results of the annual report
  - Receive a more detailed report that is not publicly available
  - Receive an advanced copy of the final report before public release.

Associate Membership

Any organization other than a payer may apply for associate membership. This includes associations, group benefit advisors and consultants, drug access navigators and patient groups, patient support programs, pharmacies, pharmaceutical manufacturers, and any pharmacy benefit managers or third parties that do not adjudicate PA claims. The list of eligible groups also includes physicians, plan sponsors, and any other organization or group with an interest in PA. Drug access navigator associations and patient groups qualify for associate membership at a reduced rate.

The annual membership options and fees for non-payer stakeholders are:

- $10,000 plus HST annually for the silver level.
- $15,000 plus HST annually for the gold level. This is a requirement for organizations who apply for a seat on the Framework and Accreditation Advisory Board or the Accreditation Panel.

Drug access navigator associations and patient groups receive a preferred associate membership rate of $2,500 plus HST annually. These organizations may also apply for a seat on the Advisory Board or Accreditation Panel.

Associate Member Benefits

Associate members will be recognized for their membership and commitment to the PAFA Guiding Principles in the following ways:

- **On the PAFA website:** and in all communications and promotions.
- **Framework and Accreditation Advisory Board (FAAB):** Eligibility to apply for one of nine seats on PAFA's Advisory Board at the gold associate member level. The FAAB will meet semi-annually to review and make any updates to the guiding principles and accreditation framework.
- **Accreditation Panel (AP):** Eligible to apply for one of five seats on the Accreditation Panel at the gold associate member level. The Accreditation Panel will meet quarterly to review accreditation applications.
- **Use of the PAFA associate membership logo:** demonstrating their commitment to improving PA practices and processes.
- **Advance notice of changes to the Guiding Principles and Framework:** Associate members will be invited to provide input before changes are finalized, even if they do not sit on the FAAB.
- **PAFA annual report:** Associate members will:
  - Have an opportunity to review and comment on the annual PA survey before distribution
  - Be invited to provide a quote/comment on the results of the annual report
  - Receive an advanced copy of the final report before public release.

Accreditation

Members can complete and submit their application for accreditation to the PAFA Program anytime. The accreditation application is considered complete when members have submitted their application and all supporting documentation electronically, with required e-signatures.

Applications can be found online at www.priorauthframework.ca beginning in November 2024. Applications will be reviewed anonymously by PAFA's Accreditation Panel, which meets quarterly. The first review of accreditation applications will take place in January 2025. Successful applicants for accreditation will be notified on completion of the Panel's review.

Once a member receives accreditation, their accreditation is valid for 36 months, 3 years, from the date of approval from PAFA, providing their membership remains in good standing. After 36 months, 3 years, accreditation will continue if the member submits an accreditation renewal application and maintains their membership. Members should reapply for accreditation at least four months before their accreditation expires to ensure there is no loss in accreditation status.

Application fees for new accreditation and renewal are as follows:

Accreditation Level	Application Fee*	Renewal Fee – after 36 months*
Administration Efficiencies	$15,000	$10,000
ePA Accreditation	$15,000	$10,000
Gold Accreditation (combined AE and ePA applications)	$20,000	$10,000

*plus HST

Framework and Accreditation Advisory Board (FAAB)

FAAB is responsible for the ongoing maintenance of PAFA and the Framework. The Board will meet at least twice annually to review PAFA operations and the Framework.

The Advisory Board is made up of nine voting members, including the Executive Director of PAFA. Preference will be given to representatives from member and associate member organizations who have experience in prior authorization. Advisory Board members for September 1, 2024-August 31, 2025, PAFA's first year of operation, will be chosen by the Executive Director and a nomination committee that includes the original working group members and several PAFA Guide reviewers with an expertise in prior authorization. Terms will continue for up to three years; however, the term of each participant may vary. The list of those sitting on the FAAB in the 2024-25 year will be posted in Appendix 3.

Accreditation Panel

The PAFA Program Accreditation Panel is responsible for the review and approval of accreditation applications, ensuring each applicant meets the Framework for administration efficiencies or ePA. The Panel will meet quarterly in January, April, July and October as required, depending on the number of applications.

The Accreditation Panel is made up of five voting members, including the Executive Director of PAFA. Preference will be given to representatives from associate member organizations who have experience in prior authorization. Accreditation Panel members for September 1, 2024-August 31, 2025, PAFA's first year of operation, will be chosen by the Executive Director and a nomination committee that includes the original working group members and several PAFA Guide reviewers with an expertise in prior authorization. Terms will continue for up to three years; however, the term of each participant may vary. The list of those sitting on the Accreditation Panel in the 2024-25 year will be found in Appendix 3.

Right of Audit

The Accreditation Panel may, based on a majority vote, exercise a right of audit of a payer's practices and processes to ensure they meet accreditation requirements. Payers must be prepared to provide records of policies, practices, claims processing timelines, including employee attestations when they apply for accreditation and at any time after accreditation has been granted. Additional information may be required in case of audit.

5. Reporting

Annual Report

The PAFA Program will prepare and publicly release an annual report on prior authorization in Canada and the PAFA Program. The report will provide insights into the PA landscape, including claims processing, and practices, as well as a review of the PAFA Program. PAFA members and associate members will have an opportunity to participate in the process and comment on the results as indicated under Section 3, Membership and Accreditation.

The report will include the following:

An overview of the current PA landscape in Canada: private and public, including important changes, advancements, new research and the results of the multi stakeholder industry survey

Updates and changes: To the Framework and Accreditation Program

Members and associate members: New and renewing

Accredited payers: Including new and renewal applications

PAFA management: The Board of Directors, the Framework and Accreditation Advisory Board, and Accreditation Panel participants.

Industry Survey

To develop the industry survey, PAFA will work with the FAAB, and member and associate member organizations to identify questions and target stakeholder groups from the PA landscape which may include several or all the following:

- **Drug Access Navigators:** including therapeutic areas of support, percentage urgent vs non-urgent, successful reimbursement rates
- **Patients:** experience of the PA claims process, including communication, timeliness, and results of patient experience surveys
- **Patient groups:** feedback from patients on the PA process and their capacity to effectively assist
- **Patient Support Programs:** nature of requests for additional information, claims turn around times, rates of approvals and denials
- **Payers:** number of PA claims processed, percentage urgent vs non-urgent claims and turn around times, percentages with additional information requirements, percentage of claims approved vs denied, and appeal rates
- **Pharmacy:** role in the PA claims process as specialty and a non-specialty pharmacy, and the patient experience of the PA process
- **Physicians:** administration burden, access to information, referral to PSP or DAN, use of ePA (as a percentage of total prescribing), experience with EMR integration.

The report will be publicly released and promoted across the group benefits and public payer landscape.

6. Patients and Caregivers, Prescribers, Plan Advisors and Plan Sponsors

This section provides additional resources, definitions, and terminology to assist in navigating prior authorization and evaluating payer practices and processes based on this Framework.

The Prior Authorization Framework and Accreditation (PAFA Program)

The PAFA Program recognizes payers, mostly insurers, and public payers, that follow the prior authorization (PA) claims practices and processes in the Framework. When payers follow the Framework the claims experience will improve for patients, their physicians and other stakeholders who work with patients through the claims process. In the case of electronic prior authorization (ePA), where claim forms can be completed and submitted electronically, payers who implement ePA will also create internal efficiencies and reduce the time patients wait for their medications to be approved.

There are two key elements to the PAFA Program: **Guiding Principles**, and the **Framework and Accreditation**. More on these can be found in Section 2 and Section 3.

Sources that were used to develop the PAFA Program include:

- The 2020 Report on Private Payer Prior Authorization in Canada: Simplify Prior Authorization by Connex Health and the Pangaea Group
- One-on-one meetings with PA stakeholders between 2021-2024, including the exploration of the marketplace for an electronic prior authorization (ePA) solution, the critical role of electronic medical record systems (EMRs) in PA, the development of the Simplify Prior Authorization (SPA) website resources, and preparation for articles, blogs and podcasts
- Prior authorization principles, recommended practices, and legislation in the U.S. and elsewhere (Appendix 2).

You can find which payers are PAFA Program members, and which hold one or more accreditations at www.priorauthframework.ca.

As PAFA's membership and associate membership grows and private and public members become accredited, you will find out more about prior authorization, how it works, and some of the challenges and opportunities at www.simplifypriorauth.ca.

What You Can Take Away From PAFA

Patients and Patient Groups

The PA landscape is changing. There are many more medications that now require prior/special authorization and that means that payers, mostly insurers and public drug plans, are experiencing a growing administrative burden for reviewing PA claims. This Framework encourages payers to make improvements and create efficiencies in the PA process so that patients can receive their prescribed medications and diagnostics more quickly. This also means that physicians, and others that work with patients spend less time on claims administration.

This is a new Framework and not all payers, or organizations that adjudicate PA claims on their behalf, will become accredited right away. As a patient or patient group, you can use this Framework as a guide for what you should expect from payers when a PA claim is made. You can find details of the administration efficiencies and electronic prior authorization (ePA) requirements for accreditation in Section 3.

You can also refer to the Simplify Prior Authorization site for additional information on prior authorization from an advisor perspective and find answers to additional resources as well as any terms not found in Section 7.

Advisors

As an advisor you may be familiar with the claims paid for medications that require prior authorization, usually specialty drugs, but may not be as familiar with details of the claims process.

The growth in the number of medications that require prior authorization adds administrative pressure to payers and other stakeholders because of the time-consuming paper-based claims process for prior/specialty authorization that currently exists. This may impact the time it takes for plan members to be approved by their insurer or provincial plan for their prescribed medication.

If you haven't already become involved in a PA claim on behalf of a plan member, then it is likely that you will in the future. If you have been involved, you may have noticed that practices and processes are not consistent between payers and often not transparent. These are two of the issues the PAFA Program has been designed to address.

Here are some tips on how you can make the PAFA Program work for you:

- **Starting in September 2024:** You can ask an insurer, or other private or public payer whether they are a member of PAFA. You can also ask if they are following the PAFA Framework and when or if they plan to apply for accreditation.
- **At renewal:** You can refer to www.priorauthframework.ca to determine if your client's current PA adjudicator or insurance carrier is a PAFA payer member and in 2025, you can ask if they have applied for a PAFA accreditation or have received it.
- **On plan marketing:** You can incorporate the Guiding Principles and Framework in your insurer questionnaire at renewal and during market surveys.

Remember to ask at least these two questions of insurers

- Are you a member of PAFA?
- Are you accredited with PAFA? If so, which accreditation does your company hold.

If the answer is no to membership or accreditation, then try asking some of these questions:

1. How many of the following administrative practices and processes do you follow from the PAFA Program? (Send them a copy of the Administration Efficiencies table.)
2. Is your existing PA process paper based i.e. mail/fax or have you implemented ePA?
3. If you have implemented ePA: What does that look like?
4. If you have not implemented ePA: Do you have plans to do so - when?
5. How long, on average, does an urgent claim take to be reviewed and responded to if all information you require to make the evaluation for eligibility is complete?
6. How long, on average, does a non-urgent claim take to be reviewed and responded to if all the information required to make the evaluation for eligibility is complete?

If a plan member/patient asks for assistance:

With a PA claim that is taking longer than expected there are several courses of action:

- You and the plan member/patient can contact the patient assistance program or the drug access navigator, or whoever else completed and submitted the claim form on behalf of the plan member/patient.
- You and the plan member/patient can contact the insurer directly through the prior authorization claims team. If that fails, contact your group representative.

If a PA claim has been denied here are some tips:

- The plan member should receive written notice of the reason for the denial, which they may be willing to share.
- If the reason is for missing information, then that can be provided by the prescribing physician, and the claim can be resubmitted, and the decision appealed.
- If the reason is that the medication prescribed is off formulary or off label, then the prescribing physician should be contacted for other prescribing options.
- The plan member/patient may also want to appeal the denial for other reasons, including additional medical information. The insurer will be able to provide information on how to appeal the denial.

You can also refer to the Simplify Prior Authorization site for additional information on prior authorization from an advisor perspective and find answers to additional resources as well as any terms not found in Section 7.

Plan Sponsors

As a plan sponsor you may be familiar with the claims paid for medications that require prior authorization, usually specialty drugs. You may not be as familiar with the claims process. The PA landscape is changing. There are many more medications that now require prior authorization and that means that insurers are experiencing a growing administrative burden for reviewing PA claims. This may impact the time it takes for your plan members to be approved for their prescribed medication. When that happens, it is possible that not having access to their prescribed medication may prolong their recovery and delay their return to optimal work performance or even delay their return to work.

The PAFA Framework is important because it gives payers and public payers an incentive to make improvements and create efficiencies in their practices and processes, through membership and recognition for those insurers who make changes. This is a new Framework and not all insurers will become accredited right away. You and your advisor can use this Framework as a guide at renewal and during the marketing process when you are evaluating an insurer.

If one of your plan members comes to you and they are having difficulty with a prior authorization claim, you can direct them to your advisor who can work with them and your insurer to resolve the issue. This may include contacting the prescribing physician, a patient support program or drug access navigator who helped with the initial claim, or it may mean making an appeal.

You can also refer to the Simplify Prior Authorization site for additional information on prior authorization from an advisor perspective and find answers to additional resources as well as any terms not found in Section 7.

7. Definitions/Glossary of Terms

If you, a plan member, a patient, or a client have a prescription medication that requires prior authorization, you may hear or see terms that are specific to prior authorization claims. Many of them are explained here:

Advisor - A general term applied to licensed insurance and financial advisors who may specialize in one or more of financial planning, individual, or group insurance/employee benefits. An advisor offers professional advice and guidance to their clients and are compensated on either a commission or on a fee for service basis.

Coordination of Benefits – Coordination of benefits occurs when you, your spouse or dependents are eligible to claim under more than one benefit plan. You should always submit any claims to the group plan where you are an employee, or primary plan member, first. If your group plan does not reimburse all your medication costs then you can claim the balance under another group insurance plan where you have coverage, including your spouse's plan. When both parents have plans and their children are covered under both plans as dependents, the plan of the parent with the earlier birth date in the calendar year pays first. A detailed description of all circumstances where coordination of benefits may apply can be found from the Canadian Life and Health Insurance Association (CLHIA).

Copay - A co-pay is the percentage of eligible expenses that a plan member is required to pay but it can also be referred to as 'plan member coinsurance'.

Coinsurance - Coinsurance usually refers to the percentage of eligible expenses that will be paid to a plan member when they submit a claim, but it may be used as the percentage of eligible expenses the plan is required to pay.

Deductible - The dollar amount of an eligible expense that a plan member is required to pay out-of-pocket before the co-pay/coinsurance is applied.

Dependant - A spouse or a dependent child who is attending school full-time and who relies on the primary plan member for financial support. To claim under a group plan, all eligible dependents must be enrolled in the group plan. If the dependent has coverage as an employee or under a student plan, they must claim under those plans first. For specific ages and exceptions, you should refer to your plan member portal with your insurer or ask your employer's human resources/benefits department. You can also find guidance from the Canadian Life and Health Insurance Association (CLHIA).

Drug Access Navigator (DAN) - Also known as Drug Access Facilitators or Medication Reimbursement Specialists, Drug Access Navigators (DANs) are drug access experts that come from diverse professional backgrounds including pharmacy assistants, pharmacists, nurses, and social workers. A pharmacist or social worker may do the role of the DAN even by a different title.

Electronic Prior Authorization (ePA) – A process by which prior authorization claim documentation is completed online, and the data is electronically submitted to payers (insurers, pharmacy benefit managers (PBMs), or public drug plans) via a secure application programming interface (API) according to criteria established by payers. This results in a complete end to end submissions and consumption of claims. The process is frequently facilitated by a patient advocate in the form of a drug access navigator (DAN) or patient support program (PSP) but may also be facilitated by the prescribing physician or a specialty pharmacy. EPA delivers administrative efficiencies and can reduce the time a patient waits for approval of the medication their physician has prescribed. A detailed description of ePA is available online at the Simplify Prior Authorization website.

Formulary - A list of prescription drugs, with a drug identification number, that are eligible expenses under a group health plan, also called a list of eligible drugs. This can vary between plan sponsors and between insurers.

Primary Coverage - Primary coverage or primary insurance is the insurance plan that takes on the priority of payment and is the initial source of coverage when you file a claim. In contrast, secondary coverage is often used to fill the gaps, or as a backup to primary coverage.

Group Benefits - Insurance coverage provided under one policy to a group of individuals, usually employees, but can also be members of a union, alumni, or association. Premiums are usually lower than for similar individual policies that provide similar coverage, and some coverage may be provided without the need for medical evidence. The policyholder is the group or association who designs and arranges the plan, is a signatory to the contract with the insurer, reports eligible plan members to the insurer, and is responsible for remitting premium payments.

Off Label - When a drug or therapy is prescribed for an indication, condition, other than the one for which it has received regulatory approval from Health Canada.

Other Stakeholders – Includes advisors and consultants, drug access navigators (DANS), healthcare professional and their associations, patients (including caregivers), patient groups, patient support programs (PSPs), pharmaceutical manufacturers, prescribers and pharmacy.

Patient - Includes patient and caregiver. In this context a caregiver is a person who acts on a patient's behalf during the claims process when they are appointed by the patient as a designate or because the patient is unable to act on their own behalf, and where the patient is a minor.

Patient Support Program (PSP) - A service that patients are usually referred to by their physician for assistance in the claims process for specialty drugs that require prior authorization. PSPs are typically paid by pharmaceutical companies to assist patients with claims and reimbursement for the drug(s) they have been prescribed, including exploring funding from private and public sources. PSPs may also operate a specialty pharmacy to dispense and/or administer medications.

Payer – Includes both public and private payers. Private payers include insurers, pharmacy benefit managers (PBM), or other third parties that make reimbursement decisions for drugs that require prior authorization. PBMs and other third-party reviewers like FACET and Reformulary may provide advice and assistance to insurers or third-party administrators (TPAs) on how to manage claims for prior authorization drug , and they may adjudicate some or all an insurer's or TPA's prior authorization program.

Plan Member – An individual enrolled as an insured member in a group insurance plan. The plan member may also refer to an eligible insured dependent spouse or child(ren).

Plan Sponsor - An association, company, partnership, trusteed group/union who is signatory to the contract for a group insurance plan that typically includes coverage for prescription drugs.

Pharmacy Benefits Manager (PBM) – Companies that are hired by insurers to administer real time online, claims adjudication, mostly for non-specialty prescription drugs, to community pharmacy. When a payer decides that a prescription drug is subject to the prior or special authorization claims process then the claim must be submitted for approval manually. The review and approval process may be administered by a PBM on behalf of an insurer.

Provincial Coverage - public health insurance paid by province. Within Canada, the level of coverage for prescription drugs that each province provides differs greatly. Some provinces may only cover drugs under exceptional access plans, or for those who do not have access to a private plan. Other provinces may have a more comprehensive Pharmacare plan. Find out more about your province and prior authorization.

Reimbursement – The process of payment for an eligible expense under the group insurance contract, in this case prescription drug(s), by a payer, usually an insurer, when satisfactory claims documentation and medical information has been submitted to them.

Specialty Drug - Specialty drugs are a designation group of medications that are usually high-cost (typically >$10,000), and often require special handling or administration. They are typically used in the treatment of more complex conditions including cancer, autoimmune diseases and other chronic diseases. Specialty drugs are usually subject to prior authorization under both group insurance and provincial special access programs.

Specialty Pharmacy - A pharmacy that dispenses medications used to treat rare or complex diseases that either may be subject to prior authorization or may not be routinely stocked at a community pharmacy. Medications subject to prior authorization may have short expiry dates, be required to be stored in a temperature-controlled environment or may need to be administered by a medical professional in an infusion center.

Patients who are prescribed the medications dispensed by a specialty pharmacy have usually been diagnosed with a disease that requires more complex treatment therapies. Specialty pharmacies also provide services that include PSP services, treatment assessment, patient monitoring, frequent communication with patient caregiver and healthcare provider (HCP). Infusion centres are also available at some locations.

Step Therapy - a managed care approach to prescription drugs and therapies that requires patients begin treatment for a condition with the most cost-effective drug therapy and progress to other more costly or newer therapies if medically necessary to treat their condition.

If you do not see the term you are looking for here the Simplify Prior Authorization website contains a larger glossary and other important information related to prior authorization.

8. Appendices

Appendix 1

PAFA Program Working Group Members and Guide Reviewers

A great deal of time and effort has been invested into the development of the Prior Authorization Framework and Accreditation (PAFA) Program Guide. The working group provided guidance, advice and input into the Guide. The reviewers provided their input and recommendations into the Guide, a number of whom reviewed more than one version of the draft. We would like to extend our thanks for everyone's valuable input and advice.

Working Group

Each of the members that made up the Prior Authorization Framework and Accreditation (PAFA) Program working group have a special interest or work directly in the prior authorization (PA) process. This included benefit consultants, drug access navigation, a national patient group, patient support programs, pharmaceutical manufacturers, and pharmacists. They share a common desire to contribute to the improvement in PA practices and processes.

A special mention goes to Alecia Henderson, Senior Vice President, Benefit Services, NFP, an Aon company, Gavin Mosley, Group Benefits Consultant, Mosley Group Benefits Inc., Beth Stefaniuk, Vice President, Administration, Jones DesLauriers Blevins Insurance Group, and Shanta Zurock, Director, Reimbursement, Cencora - Innomar Strategies, for their contributions.

Guide Reviewers

There were 65 organizations and individuals that were approached to participate in the review of the PAFA Program Guide. Each of these have a special interest or work directly in the PA process. Of the 65 invited, 28 individuals from 26 organizations reviewed the Guide and provided their feedback. This included representation from group benefit advisors and consultants, drug access navigators, patient groups, patient support programs, electronic medical (EMR) experts, electronic prior authorization (ePA) solution providers, industry associations, pharmacy, pharmaceutical manufacturers, and payers.

A special mention goes to the following for their contribution in reviewing the Guide:

- John Anacleto, Healthcare Consultant
- Cheryl Bielicz, Director Payer and Stakeholder Relations, Incyte Biosciences Canada
- Shelley Burnett, Executive Vice President, Product and Product Delivery, Auxita
- Michelle Capon, Director of Patient Support Programs, Patient Access, and Customer Service, Operational Excellence, GSK
- Uchenwa Genus, Vice President, Specialty Pharmacy, McKesson Biopharma and Payer Solutions
- Dr. Imtiaz Khan, Rheumatologist and Director, Ontario Rheumatology Association and Chair Private Payers
- Leanne MacFarlane, Director of Pharmacy Service, MHCSI, Sobeys National Pharmacy Group
- Ursula Mann, Principal and Chief Patient Officer (CPO), Patient Voice Partners
- Patrick Morin, Executive Vice President, Growth and Operations, Auxita
- Laurie Proulx, Managing Director of the Canadian Arthritis Patient Alliance
- Todd Stephen, Vice President, Employee Benefits and Pensions, Select Path and Chair, Benefits Alliance Advocacy Committee
- Theresa Underwood, Drug Access Facilitator, Grand River Regional Cancer Center

Appendix 2

Prior Authorization Framework and Accreditation (PAFA) Program Background Research and Relevant Documents.

United States

U.S. Prior Authorization and Utilization Management Reform Principles (2017) https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf

U.S. Consensus Statement on Improving the Prior Authorization Process (2018) https://ahiporg-production.s3.amazonaws.com/documents/Prior-Authorization-Consensus-Statement.pdf

AMA Measuring progress in improving PA (2023) https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

U.S. State Prior Authorization State Law Chart (2024) https://www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf

CMS Interoperability and Prior Authorization Final Rule CMS-0057-f (2024) https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

Canada

Ontario SADIE News (2020) https://files.ontario.ca/moh-newsletter-en-2020-12.pdf

B.C. OSCAR Provincial eForms Solution (2021) https://oscarbc.ca/wp-content/uploads/Provincial-eForms-Solution-2021-04-17.pdf

"Why It's Time to Change the Prior Authorization Process" https://www.simplifypriorauth.ca/document-repository/articles/why-its-time-the-change-the-prior-authorization-process/

Appendix 3

The Framework and Accreditation Advisory Board and Accreditation Panel

Members of Framework and Accreditation Advisory Board and the Accreditation Panel will be announced in December 2024 and this page will be updated. You can find details of who is eligible to join the Advisory Board and the Accreditation Panel in Section 4 of the PAFA Program Guide.

Appendix 4

Sample Payer Commitment to PAFA Guiding Principles

PAFA is a newly created non-profit organization that provides payers[5], both public and private, with a framework and accreditation program for prior or special authorization. Only PAFA members are eligible to apply for accreditation.

To be approved for membership, applicants must make a written commitment to PAFA's Guiding Principles. Below is a summary of the internal and patient commitment to PAFA's Guiding Principles and samples to guide you. Your company's commitments must be submitted with your payer membership application. You can upload the documents during your application process.

Membership and Commitment Requirements

1. Payer organizations applying for membership must make a written commitment on behalf of their organization to PAFA's four Guiding Principles , both internally and externally. The principles are communication, transparency and fairness, consistency, and efficiency. Details of these can be found in Section 2 of the PAFA Program Guide.

2. The written commitment must be made by a senior official with responsibility for drug reimbursement policies and practices. For the private sector, this could be the president, COO, or vice president of group claims. For the public sector, this could be the Deputy Minister of Health or another appropriate senior ministry or drug programs official.

3. Every member of the prior or special authorization team should be familiar with these guiding principles and take these into consideration in the design and development, and ongoing management of your organization's prior or special authorization claims processes and practices.

4. The applicants written commitment must be made:
    - Internally to employees responsible for prior/special authorization claims review and adjudication. A copy of the internal commitment communication must be included in this application. Include the location that employees can find a hard copy of your commitment in the workplace as a reminder/reference to employees. Please include a copy with your application.
    - Externally to patients and other stakeholders in a prominent position on the prior/special authorization section of the applicant's website. The patient commitment and the URL where it is posted on the applicant's website must be included in the membership application.

5. Payers in this context include both public and private payers. Private payers include insurers, pharmacy benefit managers (PBM), or other third parties that make reimbursement decisions for drugs that require prior authorization.

Sample Internal Commitment – on company/provincial or ministry letterhead

YOUR ORGANIZATION'S NAME Internal Commitment to Prior/Special Authorization

YOUR ORGANIZATION'S NAME is committed to prior/special authorization process for patients and healthcare stakeholders based on the four guiding principles identified by the Prior Authorization Framework and Accreditation Program (PAFA), that being communication, transparency and fairness, consistency, and efficiency found in Section 2, Guiding Principles, of the PAFA Program Guide. PAFA is a newly created non-profit organization that provides payers with a framework and accreditation program for prior/special authorization.

Every member of our prior/special authorization team should be familiar with these guiding principles and take these into consideration in the design and development of our prior/special authorization claims processes and practices.

Our Commitment to the Four Guiding Principles of Prior/Special Authorization

1. **Communication** – We are committed to making prior/special authorization (PA) information and communications patient centric i.e. we are committed to the use plain language that is easy for plan members and patients to understand, and that meets Web Content Accessibility Guidelines and PDF UA. Information on plan coverage and a list of PA medications will be easily accessible online to all stakeholders, including details of any non-proprietary aspects of PA, related to the claims and appeals process.

2. **Transparency and Fairness** – We will build transparency into all aspects of PA that are not proprietary to improve stakeholder understanding of the flow of the PA claims process. We will include transparency and fairness in denials and appeals, also ensuring that patients and their healthcare team have access to and receive timely information on the status of their claim.

3. **Consistency** – We believe in developing evidence-based, informed and consistent guidelines, practices, and decision making that promotes equitable, fair and reliable access to deliver positive patient outcomes.

4. **Efficiency** – We will strive for continuous improvement, including the review and improvement of processes, practices, and resources to deliver an efficient and timely patient focused process, with a commitment to adopt new technologies, including electronic prior authorization now or in the future, to improve the patient and PA stakeholder experience.

Signed: _____

Title: _____

Date: _____

Sample External Commitment – on company/provincial or ministry letterhead

YOUR ORGANIZATION'S NAME Commitment to Prior/Special Authorization

YOUR ORGANIZATION'S NAME is committed to prior/special authorization processes and practices for patients and healthcare stakeholders based on the four guiding principles identified by the Prior Authorization Framework and Accreditation Program found in Section 2, Guiding Principles of the PAFA Program Guide. PAFA is a non-profit organization that provides payers with a framework and accreditation program for prior authorization claims processes and practices that benefit patients and all other stakeholders in the process.

Our Commitment to Plan Members and Patients URL: https://www.xxxxxx.com/ca/org

1. **Communication** – **YOUR ORGANIZATION** is committed to making prior/special authorization (PA) information and communications patient centric i.e. we are committed to the use of plain language that is easy for plan members and patients to understand, and that meets Web Content Accessibility Guidelines and PDF UA. Information on plan coverage and a list of PA medications will be easily accessible online to all stakeholders, including details of any non-proprietary aspects of PA and the claims process.

2. **Transparency and Fairness** – We will build transparency into all aspects of PA that are not proprietary to improve stakeholder understanding of the flow of the PA process. We will include transparency and fairness in denials and appeals, also ensuring that patients and their healthcare team have access to and receive timely information on the status of their claim.

3. **Consistency** – We believe in developing evidence-based, informed and consistent guidelines, practices, and decision making that promotes equitable, fair and reliable access to deliver positive patient outcomes.

4. **Efficiency** – We will strive for continuous improvement, including the review and improvement of processes, practices, and resources to deliver an efficient and timely patient focused process, with a commitment to adopt new technologies, including electronic prior authorization, to improve the patient and PA stakeholder experience.

Signed: _____

Title: _____

Date: _____

Appendix 5

Patient Experience Survey

The Prior Authorization Advisory Board will establish a patient experience survey with questions that payer members will be required to request from every claimant who submits a claim, is prescribed a temporary switch, whose approval renews, or whose plan switches between payers.

The survey must be available to be completed online and meet accessibility requirements of the Accessible Canada Act 2019.

They must be offered to any plan member, including dependents over 18, who have submitted a claim subject to prior/special authorization. For payers who are accredited, results must be submitted annually to PAFA.

The survey will include questions related to the following:

- Whether information on the claims process is easily accessible, clear and easy to understand
- Whether communications they receive about their claim, including emails, mail, faxes and phone calls are clear and easy to understand
- Whether they received timely information on the status of their claim, including requests for additional information, approvals, denials and appeal decisions.
- If they were able to provide additional information easily
- If they believe they have been fairly treated by the payer during the claims process
- Their experience during a doctor-prescribed **temporary switch in medication**
- Their experience **switching back to their original medication** after a temporary medication switch
- Their medication renewal experience
- Whether their drug coverage continued or was interrupted after a switch to a new insurer.

PAFA is committed to developing a fair patient experience survey and looks forward to input from the Framework and Accreditation Advisory Board in developing the final patient experience survey for 2025.

If you have any questions about PAFA, this Guide, membership or accreditation, you can contact Denise Balch, Executive Director at denisebalch@priorauthframework.ca or call 905 220 4260.

PAFA PRIOR AUTHORIZATION FRAMEWORK & ACCREDITATION PROGRAM