HTI-4 Final Rule: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization

Fact Sheet: Overview of HTI-4

July 2025

Overview

The Assistant Secretary for Technology Policy / Office of the National Coordinator for Health Information Technology (ASTP/ONC) finalized the Health Data, Technology, and Interoperability: Electronic Prescribing, Real - Time Prescription Benefit and Electronic Prior Authorization (HTI-4) final rule July 31, 2025, which adds several new certification criteria and related standards to the ONC Health IT Certification Program (Certification Program). This fact sheet describes the policies finalized in HTI-4 including updates for electronic prescribing, real-time prescription benefit checks, and electronic prior authorization. These updates were originally proposed in the HTI-2 NPRM released in August 2024, and were finalized as part of the FY2026 CMS Hospital Inpatient Prospective Payment System (IPPS) final rule (CMS-1833-F).

Summary

- → Electronic Prescribing
- → Real-Time Prescription Benefit
- → Electronic Prior Authorization

ONC Health IT Certification Program Updates

These updates enable improvements to workflow automation, reduce the manual effort required to conduct prior authorizations, improve operational workflow, and support more timely and transparent clinical decision-making. We estimate these efficiencies will save millions of hours of clinician time annually, totaling $19 billion in labor cost savings over ten years. In turn, that time savings can be used to spend more time with patients and less time on paperwork.

Electronic Prescribing

The HTI-4 final rule updates the “electronic prescribing” certification criterion in 45 CFR 170.315(b)(3), which supports the availability of certified health IT to enable the exchange of prescription information among prescribers, pharmacies, intermediaries, and payers. The updated criterion is based on the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard version 2023011. The HTI-4 final rule aligns the “electronic prescribing” certification criterion with requirements for Medicare Part D plan sponsors.

Key Dates

- → Developers certifying a Health IT Module to the electronic prescribing criterion may use either the NCPDP SCRIPT standard version 2017071 or 2023011 during a transition period ending **December 31, 2027.**
- → After **January 1, 2028**, certified health IT developers certifying a Health IT Module to the electronic prescribing criterion may only be certified to the updated version of the criterion using NCPDP SCRIPT standard version 2023011.

Previously optional electronic prior authorization transactions are now required for the certification criterion, while additional optional transactions have been removed in order to simplify the criterion. Please see the table in the HTI-4 final rule for more details, in section XI.*B*.4.b.(3).

Real-Time Prescription Benefit

The HTI-4 final rule adopts a new "real-time prescription benefit" certification criterion in 45 CFR 170.315(b)(4) to enable access to prescription drug information that providers and their patients can use to compare the cost of a drug of a suitable alternative. The finalized certification criterion is based on the NCPDP Real-Time Prescription Benefit standard version 13. This certification criterion will be included in the Base EHR definition in 45 CFR 170.102 beginning on January 1, 2028. Any Health IT Module presented for certification to the "electronic prescribing" criterion must also be certified to the "real-time prescription benefit" criterion.

Benefits for Patients & Providers

- → Compare drug prices
- → View out-of-pocket costs
- → Access prior authorization requirements

Electronic Prior Authorization

The HTI-4 final rule adopts **three new certification criteria** to support more efficient management of electronic prior authorization tasks and reduce administrative burden for providers. These criteria are based on Fast Healthcare Interoperability Resources (FHIR®) implementation specifications developed by the HL7® Da Vinci project.

1. **Provider Prior Authorization API – Coverage Requirements Discovery**

   Enables a healthcare provider to request information from payers about coverage requirements.

2. **Provider Prior Authorization API – Documentation Templates and Rules**

   Provides a mechanism for clinicians and other EHR users to navigate and quickly assemble the information needed to support a prior authorization request according to a payer's requirements.

3. **Provider Prior Authorization API – Prior Authorization Support**

   Enables submission of prior authorization requests from health IT systems as well as checking the status of a previously submitted request.

Using health IT certified to these criteria will enable providers to interact with the Prior Authorization API requirements CMS established for impacted payers in the 2024 CMS Interoperability and Prior Authorization Final Rule. These criteria will also support healthcare providers participating in the Medicare Promoting Interoperability program and the MIPS Promoting Interoperability performance category – who will be required to report on an electronic prior authorization measure beginning in 2027.

Modular API Criteria

The HTI-4 final rule adopts two additional health IT certification criteria (and related standards) for API functionality that are referenced in the criteria for electronic prior authorization included in HTI-4.

Workflow Triggers for Decision Support Interventions — Clients
Enables clinical decision support tasks through an API, allowing decision support results to be integrated into a provider's EHR workflow.

Subscriptions — Client
Enables a user or system to be notified by a server of a particular event or data update of interest.

Adoption of Standards for Patient, Provider, and Payer APIs

The HTI-4 final rule adopts a series of implementation specifications related to the exchange of clinical and administrative data with payers as well as the sharing of formulary and provider directory information. Three of these specifications (CRD, DTR, PAS) support the criteria finalized for electronic prior authorization. The other specifications were recommended by CMS for use by payers implementing the APIs established in the Interoperability and Prior Authorization Final Rule.

- → HL7 FHIR Da Vinci—Coverage Requirements Discovery (CRD) Implementation Guide, Version 2.0.1 – STU 2
- → HL7 FHIR Da Vinci—Documentation Templates and Rules (DTR) Implementation Guide, Version 2.0.1 – STU 2
- → HL7 FHIR Da Vinci Prior Authorization Support (PAS) FHIR Implementation Guide, Version 2.0.1 – STU 2
- → HL7 FHIR CARIN Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®) Implementation Guide, Version 2.0.0 – STU 2 US
- → HL7 FHIR Da Vinci Payer Data Exchange (PDex) Implementation Guide, Version 2.1.0 – STU 2.1
- → HL7 FHIR Da Vinci Payer Data Exchange (PDex) US Drug Formulary Implementation Guide, Version 2.0.1 – STU 2
- → HL7 FHIR Da Vinci Payer Data Exchange (PDex) Plan Net Implementation Guide, Version 1.1.0 – STU 1.1 US