

Physician Drug Cost Survey 2026

Here, in physicians' own numbers: what they see, what it costs them, and what would make it easier to act on.

Patient cost calls

QUESTION 1
WEEKLY VOLUME

84%

of practices field five or more calls a week about high-cost prescriptions

Silent nonadherence

QUESTION 7
N = 104

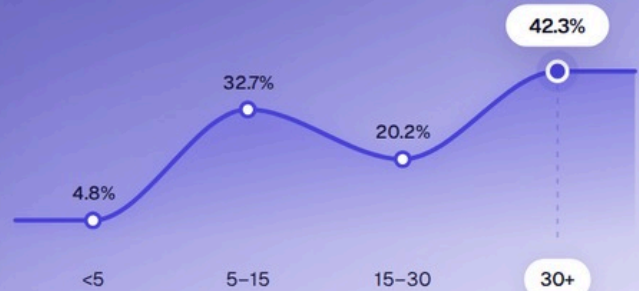
96%

have had a patient stop a medication over cost without telling them

42%

Q13

of practices manage more than 30 prior authorization requests a week



ABOUT THIS SURVEY

RazorMetrics surveyed 104 U.S. physicians in 2026 to understand how prescription drug cost pressure shows up in daily practice from patient conversations to prior authorization to the workflows physicians use to manage it all. This report follows the 2026 State of Drug Access Survey, which found that insured consumers routinely face surprise costs, confusion, and delayed care at the pharmacy counter. Here, in physicians' own numbers: what they see, what it costs them, and what would make it easier to act on.

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This report moves from the pressure physicians describe, through the full survey data, to the patterns that explain the behavior and what they mean for the organizations managing drug spend.

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READING THIS REPORT

Five questions receive a full page of their own. Every other question appears with its complete answer set, the percentage for each option, and a one-line analysis.

Why This Matters Now

The 2026 State of Drug Access Survey documented what members experience when prescription affordability fails: surprise costs, confusion, delayed care, and medication rationing. This companion white paper examines the other side of that same system: how physicians experience the cost pressure that reaches them after a prescription has already been written, and how it shapes prescribing behavior, trust in payer outreach, and administrative burden.

Physicians are already responsible for managing the invisible burden of drug affordability, and it hits them on multiple fronts at once. They field the calls, absorb the pharmacy callbacks, and manage the fallout when a patient cannot afford what was prescribed.

84%

of practices field five or more patient calls a week about high-cost prescriptions

2 out of 3

of practices spend 5 or more hours every week resolving medication cost issues after a prescription has already been written

96%

of physicians say a patient has stopped taking a medication because of cost without telling them first.

Once a cost problem reaches the physician, resolving it takes real time: finding a lower-cost alternative, checking formulary status, and clearing prior authorization or step therapy requirements before treatment can start.

This survey asked prescribers to describe the prescribing inefficiencies and how they respond to a system that pushes cost resolution downstream without giving them the tools to resolve cost constraints quickly.

The Pattern is Durable

Cost conversations are frequent, prior authorization consumes a measurable share of the practice week, and physicians already possess broad willingness to switch patients to lower-cost options.

Silent nonadherence

Nearly all physicians reported a patient has quietly stopped a medication over cost: 96% say it has happened one or more times, and only 1% say it has never happened. The pattern holds even among physicians who report high confidence in their patient's full medication list. The gap is a disclosure problem, not a documentation problem. Patients who stop a medication over cost tend not to say so.

Administrative friction

Administrative friction is substantial. 42% of physicians manage more than 30 prior authorization requests a week, and 72% spend five or more hours a week on prior authorization approvals alone. The highest-volume group carries the sharpest burden, with 68% spending more than 10 hours a week on approvals.

Willingness to switch

Physicians consistently report wanting a better system. 95% say they are comfortable switching a patient to a lower-cost, clinically appropriate alternative, and 87% will extend that fix across their broader patient panel. The data shows affordability performs best when recommendations arrive through the prescriber's existing workflow for review and approval, without adding another interruption to manage.

Outreach without action

Outreach volume does not translate into outreach action. Forty-four percent of prescribers who review PBM and payer outreach do not change anything. What physicians say would help is consistent: fewer workflow interruptions and direct patient benefit data so they can see how much a different medication will save their patient.

95%

of physicians are comfortable switching a patient to a lower-cost, clinically appropriate alternative.

Physicians are willing to act on high drug costs, but finding the lowest-cost option for each patient takes an exorbitant amount of time. What they need is an optimized workflow that automatically surfaces the lowest-cost option, rather than the current system that requires them to find the alternative themselves.

Survey Findings and Analysis

28

survey questions

8

topic areas

104

U.S. physicians

5

full-page findings

FULL-PAGE FINDING 7, 8, 16, 18, and 28

01

p. 6

Formulary and Cost Awareness

Q1–Q4 · 4 QUESTIONS

1 2 3 4

02

p. 6

Patient Conversations

Q5–Q7 · 3 QUESTIONS

5 6 7

03

p. 8

Recommending Alternatives

Q8–Q9 · 2 QUESTIONS

8 9

04

p. 9

PBM and Payer Outreach

Q10–Q12 · 3 QUESTIONS

10 11 12

05

p. 10

Workflow Friction

Q13–Q18 · 6 QUESTIONS

13 14 15 16 17 18

06

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Biosimilars

Q19–Q21 · 3 QUESTIONS

19 20 21

07

p. 14

Polypharmacy and Deprescribing

Q22–Q27 · 6 QUESTIONS

22 23 24 25 26 27

08

p. 15

AI and Technology

Q28 · 1 QUESTION

28

Formulary and Cost Awareness

Cost friction shows up long before a physician and patient ever discuss it directly. This section looks at how often that friction reaches the physician's desk, and how well existing tools keep pace with it.

Q1

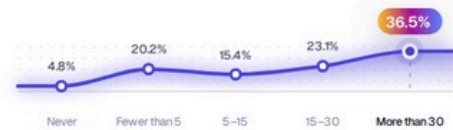
How many times a week does your office get a patient call about a high-cost prescription?



High-cost calls are a weekly occurrence for nearly every practice.

Q2

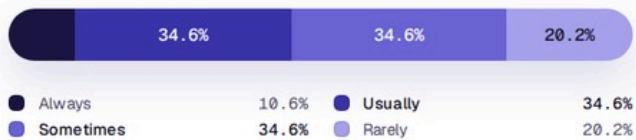
How often does your patient's payer reach out to you about a formulary change per year?



Formulary changes reach most physicians frequently — control over the outcome is a separate question.

Q3

How often do you check formulary status before writing a prescription?



Fewer than half of physicians consistently check formulary status, largely because the step sits outside their normal workflow.

Q4

How often does a patient's actual cost at the pharmacy surprise you?



Cost surprises reach the prescriber on a routine basis.

TOPIC 02 / 08

Patient Conversations

When a prescription turns out to be unaffordable, the physician becomes the default point of resolution, whether or not the visit was scheduled for that conversation. This section examines how physicians respond in the moment, and how much of the underlying problem never reaches them at all.

Q5

When a patient says they can't afford a prescribed medication, what is your most common response?



The default response is a fast, physician-executed fix.

Q6

How much time per week do you estimate you or your staff spend resolving medication cost issues after a prescription is written?

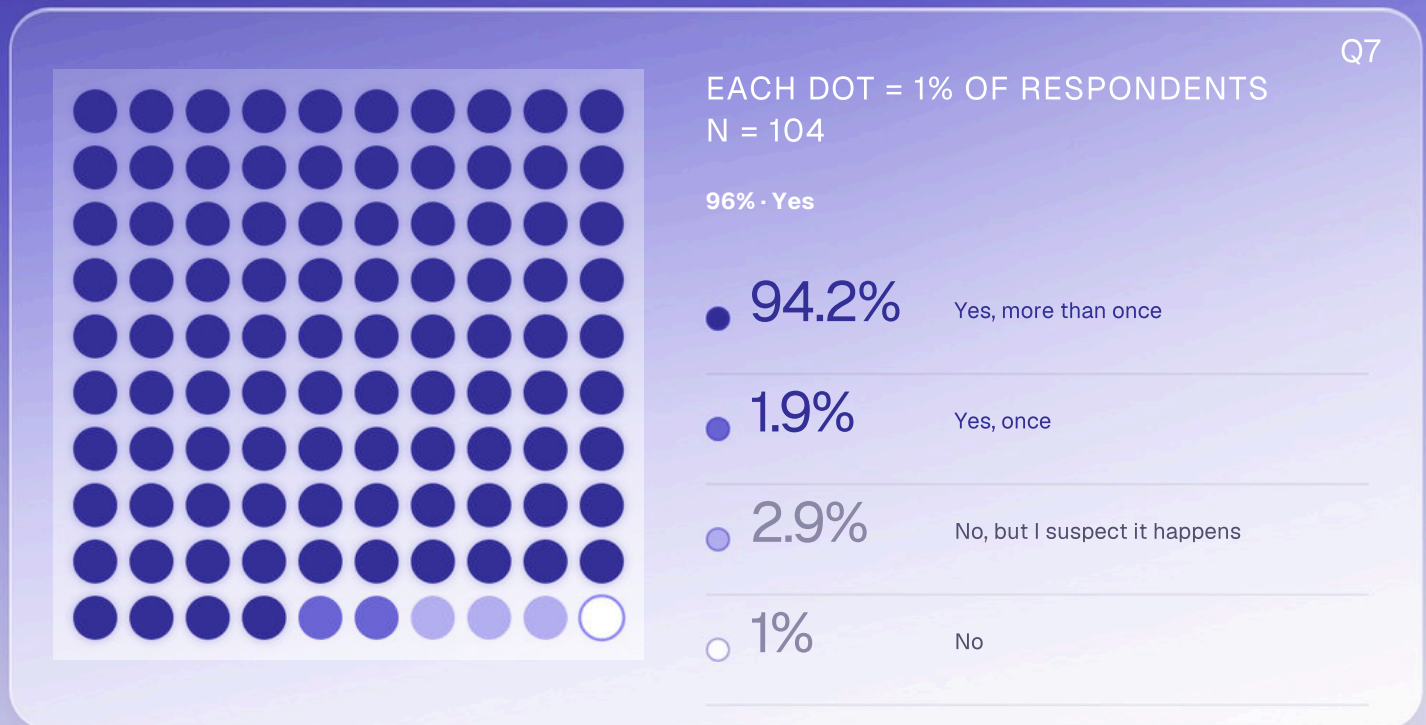


This time is a direct cost of decisions surfacing after a prescription has already been written — work a proactive process would prevent.

Have you ever had a patient stop taking a medication because of cost without telling you first?

96%

have had a patient stop a medication because of cost without telling them first



Silent nonadherence is close to universal, and it is invisible until the physician happens to ask.

5.8%

are very confident their patients take all medications as prescribed Q24

22.1%

are very confident they have a patient's full medication list Q15

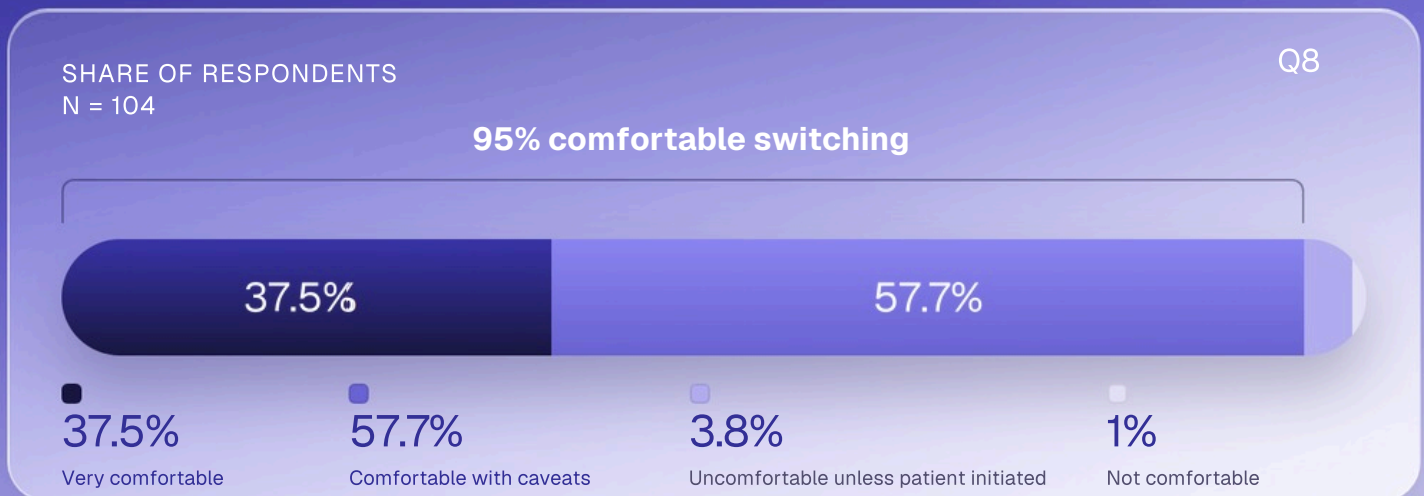
91.3%

of the most confident still report a patient quietly stopped over cost PATTERN 2

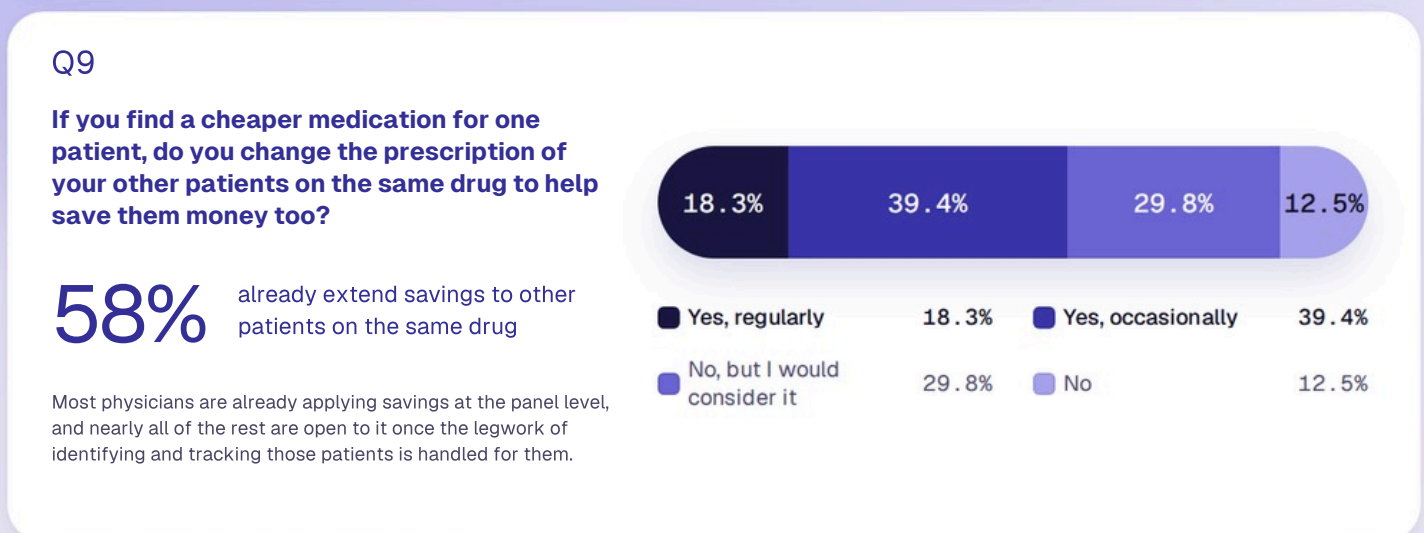
Recommending Alternatives

Physicians control which drug gets prescribed, which makes their comfort with switching, and their willingness to extend that decision across a full patient panel, the real ceiling on how much any cost intervention can scale.

How comfortable are you changing a patient's prescription to a lower-cost alternative?



Comfort with switching is nearly universal among prescribers, well beyond what assumptions about physician resistance would predict.



PBM and Payer Outreach

This section tests whether outreach from Plans and PBMs is converting into action, or simply adding to the noise physicians have to filter on top of everything else in their day.

Q10

How often do you receive outreach from PBMs or plan sponsors about high-cost drugs?

71% hear from PBMs or plan sponsors at least occasionally

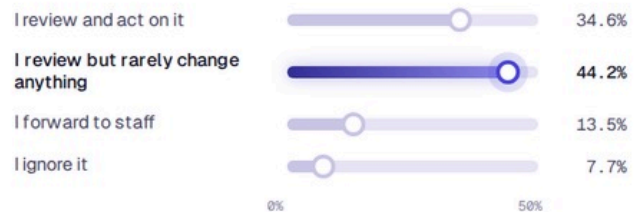


Most physicians are already being reached on a regular basis. The open question is whether that reach converts into action.

Q11

How do you typically respond to that outreach?

44% review outreach but rarely change anything



Passive review is the single most common response to payer outreach, more common than acting on it.

Q12

SELECT ALL THAT APPLY

What would make prescriber outreach more useful to you?

49% want fewer interruptions to their workflow

Physicians want outreach that fits inside their normal workflows instead of interrupting it.



Workflow Friction

Administrative burden is often described anecdotally. This section puts numbers behind how much of the physician's week prior authorization and its adjacent processes actually consume, and how confident physicians are in the information they're working from.

Q13

How many prior authorization requests does your practice manage per week on average?

42% manage more than 30 prior authorization requests a week



Prior authorization volume is heavy for a substantial share of practices, concentrated at the high end.

Q14

What percentage of your prior authorization requests are eventually approved?

48% say 50-75% of their requests are eventually approved



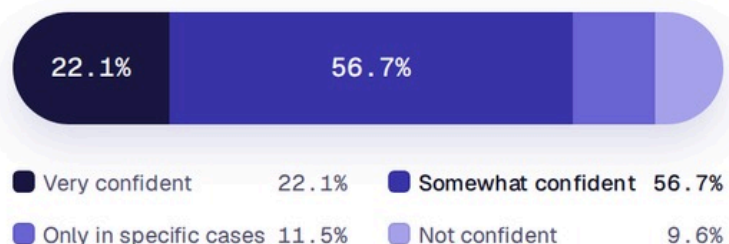
Most requests are eventually approved, but only after consuming unbillable clinic time — a cost with little clinical payoff.

Q15

How confident are you that you have your patient's full medication list?

57% are only somewhat confident they have the full list

Most physicians land at only somewhat confident, a meaningful gap given how often patients make cost-driven changes without mentioning them.



How much time per week does your practice spend on prior authorization approvals?

72% spend five or more hours a week on prior authorization approvals



Nearly three in four practices spend half a workday or more on PA approvals alone.

Q17

How much time per week does your practice spend on step therapy compliance?

53% spend three or more hours a week on step therapy



Step therapy adds a second, parallel time cost on top of prior authorization.

Do you use an RTBT (real-time benefit tool) before writing a prescription?

41% have never used a real-time benefit tool before writing a prescription



The tool built to solve this problem in real time is the one physicians use least. When asked “What do you think about RTBTs?” prescribers described it in their own words.

PRESCRIBER RESPONSES TO RTBTS

64% DISTRUST OR HAVE NEVER USED ONE

29.8% Negative / critical
inaccurate, unreliable, time-consuming, poorly integrated, useless

34.6% Unfamiliar / never used
don't know what it is, never heard of it, no experience

27.9% Positive

7.7% Neutral or unclear

Nearly two-thirds of physicians surveyed either distrust RTBTs or have never encountered one.

Biosimilars

Biosimilars represent one of the clearest cost opportunities in the drug supply chain, but only if physicians are confident enough to prescribe them and trust that a payer won't override the decision on its own.

Q19

How confident are you in prescribing biosimilars?

44% are somewhat confident prescribing biosimilars



Confidence clusters in the middle — most physicians are somewhat comfortable prescribing biosimilars.

Q20

What is your biggest barrier to prescribing biosimilars more often?

34% cite lack of clinical familiarity



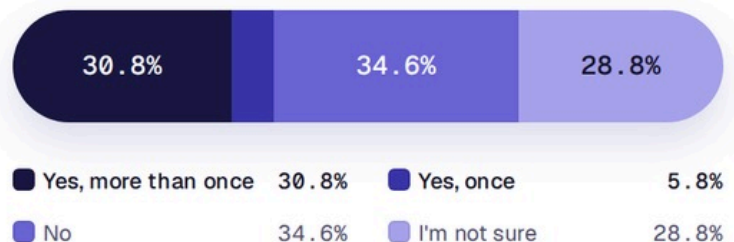
Familiarity is the leading barrier physicians name — ahead of patient hesitation.

Q21

Has a payer ever substituted a biosimilar for a branded medication without your approval?

37% have had a biosimilar substituted without their approval

A substantial share of physicians have had a biosimilar substituted without their sign-off, which cuts directly against the physician-directed model they say they prefer.



Polypharmacy and Deprescribing

As patients accumulate medications, the case for deprescribing becomes clinical as much as financial. This section examines how often physicians raise it, what stops them, and how well they can actually see what a patient is taking.

Q22

How often do you initiate a deprescribing conversation with patients on five or more medications?



Most physicians already raise deprescribing proactively, ahead of a clinical event.

Q23

What is the biggest barrier to deprescribing?



Coordination, resistance, and time are cited at nearly identical rates. No single barrier dominates, so a single fix can't address all three.

Q24

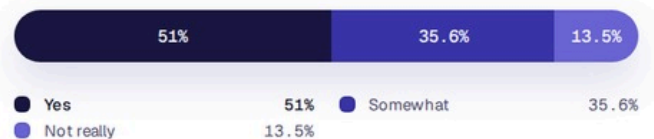
How confident are you that your patients are actually taking all medications as prescribed?



Most physicians assume at least some nonadherence by default, consistent with how often patients stop medications without saying so.

Q25

Are EHR pop-ups annoying and distracting?



A slim majority find EHR pop-ups outright distracting, and nearly all of the remainder find them at least somewhat so, a real constraint on any alert-based intervention.

Q26

How do you track your patient's full medication list?



Physicians default to asking the patient instead of relying on the EHR — reintroducing the same disclosure gap seen elsewhere in this survey.

Q27

What most often prompts you to initiate a deprescribing conversation?

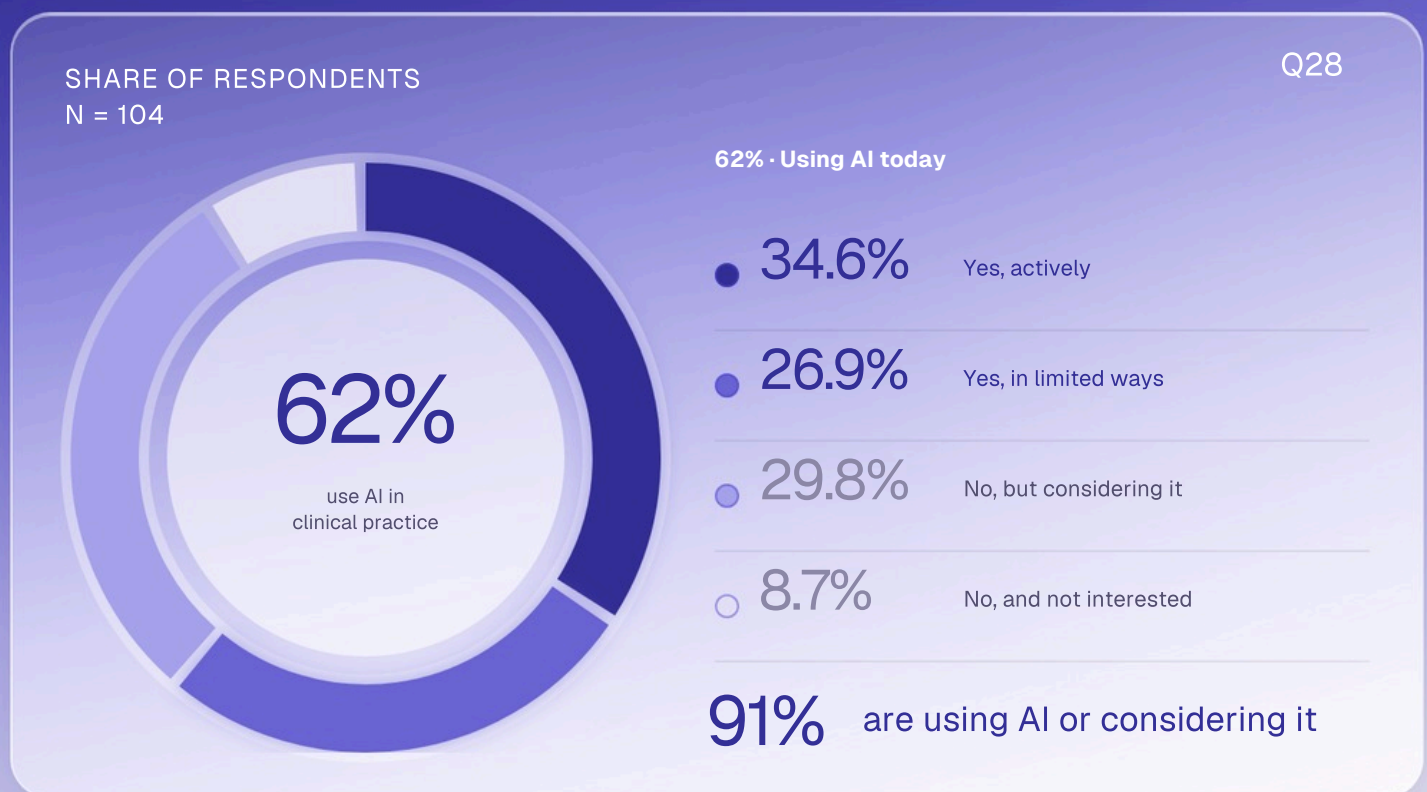


Routine review prompts deprescribing almost as often as a patient complaint does, which suggests the behavior is already closer to proactive than reactive.

AI and Technology

AI is entering clinical practice unevenly. This closing section gauges where adoption currently stands among the same prescribers who are absorbing the cost and administrative burden documented throughout this survey.

Are you currently using any AI tools in your clinical practice?



A majority are already using AI in some form, and nearly all of the remainder are open to it.

**NEXT
SECTION**

Cross-Insights: Patterns That Explain Behavior



Cross-Insights: Patterns That Explain Behavior

The cross-insight analysis pairs responses across questions to surface behavioral patterns that don't appear in isolation. These relationships show how administrative volume, outreach fatigue, and workflow friction interact to shape whether physicians act on a cost signal or let it pass.

THE THROUGH-LINE

Physician behavior around drug cost improves when the lower-cost option is surfaced inside the tools physicians already use, rather than left for the physician to locate on their own in the middle of a visit.

PATTERN 01

p. 17

Cost Burden Compounds Across Administrative Fronts

No single question in this survey captures the full weight of drug cost burden on a physician's week.

4 administrative fronts arriving at once

PATTERN 02

p. 18

Silent Nonadherence Persists Regardless of Medication List Confidence

Physicians who feel confident they have a patient's complete medication list are just as likely to have been blindsided by cost-driven nonadherence as physicians who do not.

91.3% of very confident physicians still report it

PATTERN 03

p. 19

Comfort Switching Predicts Willingness to Apply Savings Panel-Wide

Physicians who are more comfortable switching an individual patient to a lower-cost alternative are also more likely to extend that same fix across their broader patient panel.

61.5% of very comfortable switchers extend savings

PATTERN 04

p. 20

Coordination Gaps Suppress Deprescribing More Than Time Pressure

Physicians who name fragmented care coordination as their biggest barrier to deprescribing are less likely to act than physicians who name time pressure as theirs.

27.6% initiate regularly vs. 39.3% citing time

Cost Burden Compounds Across Administrative Fronts

No single question in this survey captures the full weight of drug cost burden on a physician's week. Taken together, four separate questions show burden arriving from every direction at once: the phone, the chart, the PA queue, and the step therapy queue.

IMPLICATION



A fix that only addresses prior authorization will leave three other burden points untouched. The strongest interventions reduce burden across all four fronts at once, not just the loudest one.

CROSS-QUESTION EVIDENCE 4 FRONTS

THE PHONE

Q1 · P. 6

84%

of practices field five or more patient calls a week about high-cost prescriptions, and more than a third field 15 or more.

THE CHART

Q6 · P. 6

66%

of physicians spend five or more hours a week resolving medication cost issues generally, after a prescription has already been written.

THE PA QUEUE

Q16 · P. 11

72%

of physicians spend five or more hours a week on prior authorization approvals alone.

THE STEP THERAPY QUEUE

Q17 · P. 11

53%

of physicians spend three or more hours a week on step therapy compliance, on top of prior authorization.

4

FRONTS
AT
ONCE

SOURCES Q1 · CALLS

Q6 · COST RESOLUTION

Q16 · PRIOR AUTHORIZATION

Q17 · STEP THERAPY

N = 104 · SELF-REPORTED

Silent Nonadherence Persists Regardless of Medication List Confidence

Physicians who feel confident they have a patient's complete medication list are just as likely to have been blindsided by cost-driven nonadherence as physicians who do not.

IMPLICATION



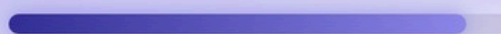
The gap is a disclosure problem: patients who stop a medication over cost tend not to say so, no matter how thorough the physician's own recordkeeping is.

CROSS-QUESTION EVIDENCE

Q15 × Q7

Very confident

in having the full medication list



91.3%

Somewhat confident



94.9%

Not confident



100%

Confidence in the medication list does not protect against cost-driven nonadherence. Every confidence group reports it at roughly the same rate.

Comfort Switching Predicts Willingness to Apply Savings Panel-Wide

Physicians who are more comfortable switching an individual patient to a lower-cost alternative are also more likely to extend that same fix across their broader patient panel.

IMPLICATION



Comfort with switching is the gating factor for population-level savings. A workflow that removes friction from the first switch is likely to unlock the second, third, and fourth switch on the same drug automatically.

CROSS-QUESTION EVIDENCE

Q8 × Q9

Very comfortable switching

already extend savings to other patients regularly or occasionally



61.5%

Uncomfortable unless patient initiated

do so regularly



0%

Uncomfortable unless patient initiated

say they do not extend savings at all



25%

The first switch is the gate. Physicians who clear it comfortably are the ones who carry savings across the rest of the panel.

Coordination Gaps Suppress Deprescribing More Than Time Pressure

Physicians who name fragmented care coordination as their biggest barrier to deprescribing are less likely to act than physicians who name time pressure as theirs, even though both groups report the barrier at similar rates. Given subgroup sizes in this sample, this pattern should be read as directional rather than statistically definitive.

IMPLICATION



Deprescribing support that only saves the physician time will miss the group most stalled today. What that group needs is visibility into what other prescribers have already ordered, not a faster workflow for a conversation they are already prepared to have.

CROSS-QUESTION EVIDENCE

Q23 × Q22

Cite time constraints

still initiate deprescribing conversations regularly,
the highest rate of any barrier group



39.3%

Cite lack of coordination

initiate regularly



27.6%

Cite lack of coordination

do so only rarely



13.8%

Time pressure slows deprescribing less than fragmented coordination does.

Implications for Health Plans, PBMs, and Employers

Physician-reported data points to a consistent conclusion: timing and delivery, not physician willingness, are the bottleneck in drug cost management.

01

Routine cost friction already consumes hours of physician time every week.

02

Physicians are already willing to switch patients to lower-cost, clinically appropriate alternatives at a near-universal rate. The absence of a workflow that surfaces the option automatically is what limits scale.

03

Deprescribing stalls most where care is fragmented across prescribers, not where time is short. Communication of full medication lists across the different prescribers is the unlock for that population.

04

Administrative time burdens concentrate sharply among high-volume practices, and the cost is significant to clinics. Targeted communication with medication cost and approval information will free up time for patient care and be greatly appreciated by prescribers.

05

Strategies that reduce cognitive load and deliver patient-specific data inside the clinical encounter improve both cost and adherence outcomes.

06

Strategies that operate through the physician relationship, rather than around it, are more likely to earn the trust that drives sustained behavior change.

A Framework for Physician-Directed Affordability

Effective affordability programs operate through physicians, integrate into existing workflows, act across the full patient panel rather than one prescription at a time, and reduce administrative load rather than adding to it.

01

Deliver the lower-cost, clinically appropriate option directly to the physician for approval, rather than requiring the patient to discover a cost problem on their own at the pharmacy counter.

02

Identify confirmed savings opportunities across the physician's full panel after physician approval, since most physicians are already willing to extend a fix once they find it for one patient.

03

Replace generic PBM messaging with patient-specific benefit data delivered inside the EHR, matching what physicians consistently say would make outreach useful.

04

Give physicians visibility into what other prescribers have already ordered for a shared patient, directly addressing the coordination gap that stalls deprescribing.

05

Reduce administrative burden for pre-validated switches, returning unbillable clinic hours to patient care instead of paperwork.

06

Measure success by physician time recovered and prescriptions changed.

Methods and Limitations

104

physicians completed
the survey

Jun–Aug

fielded in 2026

\$75

honorarium per
completed response

Wave 1

fielded annually
going forward

Fielding

This survey fielded from June through August 2026 to a national list of licensed prescribers. Participation was voluntary and incentivized with a \$75 honorarium per completed response. 104 physicians completed the survey.

How to read the sample

Because participation was opt-in and incentivized, this sample should be read as a targeted snapshot of engaged prescribers rather than a random or representative sample of U.S. physicians. Findings are directional and useful for identifying patterns in physician-reported behavior, not for population-level estimates. Specialty and practice-size skew are noted in the About You section of the underlying data and should be considered when applying these findings.

Self-reported data and subgroup analysis

All findings reflect self-reported experience rather than verified claims, EHR, or prior authorization system data. Cross-question subgroup analysis, such as the barrier-group comparisons in the Cross-Insights section, splits an already modest sample (n=104) into smaller groups and should be read directionally rather than as statistically definitive. This is the first wave of this survey; RazorMetrics intends to field it annually to build a longitudinal view of physician-reported cost burden.

Why RazorMetrics Is Built for This Moment

The findings in this report point to a consistent gap between how the pharmacy system asks physicians to manage cost and how much time they have to do it. Cost decisions surface too late, coordination is fragmented across prescribers, and the system's cost-cutting tactics create intense friction for the physicians expected to carry them out.

RazorMetrics was designed to address these prescriber concerns. Our physician-directed pharmacy optimization model identifies lower-cost, clinically appropriate alternatives and delivers them inside the prescriber's existing workflow for review. Medication changes occur only with physician approval, and confirmed savings extend across a physician's full patient panel automatically.

Fewer interruptions

Recommendations arrive inside the existing workflow rather than as another alert to manage.

Patient-specific data

Physicians see what a different medication will actually save their patient.

Handled upstream

Cost decisions are resolved automatically and clinically.

By operating inside clinical workflows, RazorMetrics reduces the administrative burden this survey documents while giving physicians exactly what they say they want: fewer interruptions, patient-specific data, and cost decisions handled automatically, clinically, and upstream.

About RazorMetrics

RazorMetrics creates pharmacy cost containment solutions that reduce drug costs by engaging physicians directly. Its proprietary technology identifies cost-saving opportunities through medication switching, deprescribing, and deduplication, adapting to each client's plan, preferences, and formulary. RazorMetrics plugs into the prescriber's existing workflow, improving healthcare decisions while reducing medication costs for members and plan sponsors. Based in Austin, Texas, RazorMetrics supports self-funded employers, health plans, PBMs, and organizations seeking clarity, efficiency, and more value from their pharmacy benefit.



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