Here's what we can do to minimize the daily hassle of prior authorizations

Disruptive and expensive—what could be worse for your and your patients' morale?

Insistence on prior authorization (PA) when prescribing certain pharmaceuticals has grown considerably over the past 5 years. Most requests for PA are issued by pharmacy benefit management (PBM) companies that have been contracted by an insurer. A PA can be triggered when a physician orders:

- a brand-name medication
- a medication not on the formulary of the PBM
- a quantity above an arbitrary ceiling
- a medication that has multiple indications (that is, the PBM won't pay for indication *X* but will pay for indication *Y*).

What are the problems caused by PAs? I outline a number of them, and their potential consequences, in this "Commentary." What can we do, in our practices, to lessen the disruption they cause and the time and money they cost us (***Box***)?

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'Prior authorization'—a misleading, disingenuous term

The physician's prescription *is* legal authorization for the patient to receive the medicine. It would be more accurate if PBMs labeled what they do "prior approval for reimbursement."

PBMs exist to manipulate and coordinate the demand for medication generated, on one hand, by patients and their physician and, on the other, by the cost of supplying

Disclosure
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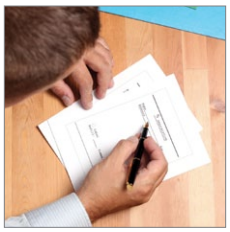

Prior authorization

Clinical Point

A PA is meant to boost profits at the PBM—*not* to pay for the best fit between the needs of the patient and available medications

Box

Can the daily hassle of prior authorizations be softened?

Put off by online methods? Physicians are often encouraged to complete PAs on the PBM's Web site. Never having tried that, I can't say that responding online does, or does not, save time. Even if this does save time, however, be wary about privacy issues! Would patients want to be at risk of having hackers find out why they are taking an antipsychotic, leaving them vulnerable to embarrassment, blackmail, or other threats?

If you choose to decline the offer to complete PAs online, what can be done to minimize the burden on you?

Enlightening and coaching the patient. I find it helpful to print a page of suggestions to give to my patients, to serve as guidance if they encounter the need for a PA when they go to the pharmacy. To begin, my list of suggestions explains what a PA is; recommends that, if the pharmacist says a PA is needed, the patient should ask the pharmacist for the PBM's telephone number; and urges the patient to call as soon as possible.

After patients identify themselves to the PBM, I explain that they should ask the PBM to send its specific relevant questionnaire to my office by fax. Most of the time, the representative of the PBM complies; occasionally one does not. In that case, I advise, patients should call the PBM again in 10 minutes, and (usually) speak to a different person—who might be cooperative.

I make it clear to the patient that, once I receive the questionnaire, I will fill it out as soon as I can and send it back to the PBM. Answering some of the PBM's complicated questions can be challenging—but that challenge is good for the gray matter!

Enlisting the patient's help is designed not only to save me time but to bring patients into the process, so that they can observe, first-hand, what hurdles have to be overcome to get access to the pharmaceutical benefits that they are paying for. Furthermore, working with patients to resolve the delay caused by the PBM creates a connection between us. It helps them see me as an ally—not as the party causing the delay.

Organized appeals. Over the intermediate or long term, there are ways that you, individually and through your professional organizations, can push for structural changes in the system architecture of PAs. We should, for example, be persistent in asking PBMs and insurers to employ software that allows them to forward questionnaires to your office swiftly, from the time first contact is made at the pharmacy. That step alone would:

- save enormous time and money, I believe, thus eliminating the need to deal with the most time-consuming hurdle of all: the dreaded initial call
- prevent miscommunication between the pharmacy and the physician's office
- promote quick action to ensure there is no gap in the patient's use of prescribed medication.

It also might be helpful if professional associations, including the American Psychiatric Association, established a joint task force to explore other possible methods by which patients can be better protected from having their medication suddenly defunded by the PA process.

a portion of that demand. The cost of a medication to the PBM is controlled by:

- negotiating rebates with drug manufacturers
- advantageous contracting with pharmacies
- denying payment, when feasible, using the PA system.

The goal of the PA is to boost the profits of the PBM—*not* to pay for the best fit between the needs of the patient and the medications available, as determined by the treating physician.

The games begin!

The PA process usually begins when the patient goes to the pharmacy, prescription in hand, and gives it to the pharmacist, who enters it into the computer. At that point, if the PBM has put a block on paying for the medication, 3 things happen in sequence:

1. The computer alerts the pharmacist about the block (or that a higher copay is required).
2. The pharmacist tells the patient something about the block—although not necessarily the whole story.
3. The pharmacist tells the physician's office (by fax, e-mail, or telephone) that the PBM wants authorization and that the physician must call a toll-free telephone number to obtain that authorization.

The physician's office then makes the initial call to the PBM. That call can take

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10 to 20 minutes, answering preliminary questions. The call generates a questionnaire from the PBM that is faxed to the office, filled with questions that one could characterize as loaded. The questionnaire is intended to provide grounds for disapproval or approval—not to obtain in-depth understanding of the individual patient's needs.

Playing pieces on a chessboard

Note that the physician and pharmacist, thrust unwillingly into the middle of this gambit, spend considerable *uncompensated* time on the PA process. (Primary care physicians and their nursing and clerical staff, spent, on average, 19.8 hours a week obtaining PAs in 2006.[1])

PBMs have shifted responsibility for *communication* to physicians and pharmacists by requiring that the physician always contact the PBM. A PBM will not contact a physician directly, either to begin the PA or ask questions during the process.

If the request for authorization is denied, what's the outcome? The physician's office and the pharmacist have spent uncompensated time taking action that resulted in the PBM and the insurer improving their bottom line without benefit to anyone else.

Communication breakdown. The cumbersome, multistep PA process opens the door to miscommunication. This happens often, I've found: The physician wastes time because the pharmacist passed along an incomplete message, or a patient gives vague or confusing information in trying to transmit what the pharmacist said. Sometimes, when physicians get through to a live person at the PBM, they are told that the pharmacist misinformed the office: No, the medication didn't require PA after all.

Why can't PBMs streamline the process, sparing busy physicians' offices the time spent on initial telephone calls, by installing software that would allow the pharmacist who first encounters a payment block to, with a few keystrokes, instantly send the relevant questionnaire to the physician's fax machine or computer?

Obstacles to satisfaction

From the perspective of the patient, the word that probably best characterizes his emotional response to the PA process is "helpless." He wasn't expecting a denial; it's likely that he hadn't been fully or clearly informed at the time he selected the insurer that he might someday face such an obstacle. Even though he had a legal prescription, written by a physician, any attempt to go back to the insurer or the PBM to complain is rarely successful. If he tried, he would likely get no satisfaction: The clerk at the other end of the telephone would swiftly inform him that there were a number of complicated rules, policies, or "step programs" that must be adhered to before the PBM pays for a prescription.

Even if the medication is covered, the patient might be told that there are "quantity limits" that prevent reimbursement for the prescription as written—limits that were not made explicit when he signed up for the insurance plan. All these obstacles can generate confusion, anxiety, frustration, and anger—understandably so.

The 'safety' catch. Obstacles do not necessarily end when the medication is approved; such approval is merely a "coverage eligibility review." In addition, PBMs make it clear that every prescription also undergoes a so-called safety review by a pharmacist before it is dispensed. If the PBM's pharmacist identifies a safety concern, the medication "might not be dispensed," Express Scripts says, "or your patient could receive less than what you prescribed."

That is an ominous statement: The PBM is openly and arrogantly taking for itself the right to unilaterally determine what is safe and to override the physician's judgment as it sees fit. We all know that there are relative risks in taking most medications that we prescribe; the degree of that risk needs to be carefully calculated against the likely benefits for a given patient, whose detailed history is known to the treating physician. History and risk-benefit calculation are not available to the reviewing pharmacist. The existence of "safety concerns" by itself, outside of the full context of care, is

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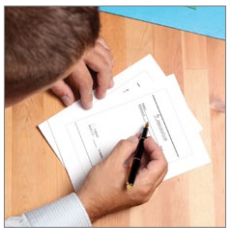

Prior authorization

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insufficient justification for a PBM to stop payment for a medication.

"Approved"—but… Equally ominous is that, after a medication has been approved through the PA process, some PBMs add these words in their notification to the physician:

> This medication is approved for coverage until [*insert date*], or until coverage for the medication is no longer available under the benefit plan or the medication becomes subject to a pharmacy benefit coverage requirement, such as supply limits or notification, whichever occurs first.

In other words, the approval is provisional, and shouldn't be counted on to remain in place for the entire period for which dispensing has been approved. Imagine the uncertainty and anxiety of a patient who reads that statement and realizes that the medication that, at last, has relieved her symptoms might be withdrawn from coverage at any time for reasons unrelated to effectiveness.

The patient can appeal the decision of a PBM or insurer that refuses to pay for a medication, but that patient, and his physician, might ask themselves whether the considerable time required to appeal is justified, given that the criteria used for denials are arbitrary and one-sided.

Serious consequences can ensue after a PBM denies coverage for a medication. Some patients cannot afford hundreds of dollars out of pocket for 1 month of 1 medicine. When their supply runs out, they become vulnerable to symptoms of withdrawal or exacerbation of underlying illness.

Armchair care. A PBM, after it has denied approval of payment, might "ask" the physician to choose another medication that the PBM does cover. For a non-physician administrator who has never seen the patient to propose such a switch is micromanagement—to say the least. Such an action is also disrespectful of the physician's judgment.

Loss of possible placebo effect. If the physician goes along and makes the switch proposed by the PBM, the patient will know that the new medication is the physician's second (or third) choice. Any potential positive placebo effect is thus lost. Does that matter? It might—a lot.

Most physicians would be glad to have a positive placebo effect assist or augment the physiologic effects of a medication, especially at the start of treatment when the patient might feel helpless or hopeless. Such negative feelings are likely to be magnified if the patient knows that he has been coerced into taking a second-line therapy. A positive placebo effect, on the other hand, might well have lowered levels of his stress hormones for a few weeks—and that effect could have made a positive difference.

Casualties for the physician are time, money, and morale. PAs consume large chunks of time. Some of the PA forms require that 20 or more questions be answered; a few of those questions can take significant time to answer, having to look through a thick chart to research prior medications.

PAs also cost money: directly to pay the salary of staff that share the PA work, indirectly by crowding out the doctor's potential billing time and replacing it with uncompensated PA work.

Worse, in my opinion, is the cost to morale. Physicians express their annoyance, aggravation, frustration, and anger at meetings and in postings at the end of journal articles on the subject. Some speak of becoming numb from the daily hassle of dealing with PAs.[2] The disrespect for the physician's decisions inherent in the PA process, the implicit humiliation of appealing to someone who doesn't know the patient to approve payment for a medication that's been legally prescribed, and the cost in time and money all provoke emotions that are damaging to morale.

Much to do in limited time

Time isn't elastic; setting priorities is vital. Most physicians would, I think, agree that their priorities are:

- giving patients adequate time at office visits
- returning calls from patients with urgent messages
- communicating with professional colleagues about shared patients
- returning calls from pharmacists who have questions about prescriptions
- researching solutions to clinical problems
- keeping up with the literature.

Physicians must decide where completing PAs—intrusive, time-consuming, and a threat to morale—fits in that list. Should PAs be allowed to supplant, or delay, the completion of other vital, positive clinical priorities?

Until we are able to introduce improvements that speed up the PA process, patients will have the supply of their medications disrupted and physicians will pay in time, money, and morale.

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