Adventures (actually mis-adventures) in prior drug authorizations

By ACSH Staff — August 4, 2014

An op-ed in today's New York Times by an internist affiliated with the NYU School of Medicine expresses her anger and frustration at dealing with health-insurance-mandated prescription drug formularies, with their levels of coverage requiring pre-approval for the more expensive brands. Really a cri-de-coeur rather than a rational essay, Dr. Danielle Ofri vents her rage at having to spend what must have been hours on the phone with a variety of insurance company minions, trying with increasing desperation to obtain the necessary approval for a needy, complex patient.

The essay, Adventures in Prior Authorization [1], used the example of one particular patient's case: Mr. V has diabetes, kidney disease, heart (valvular) disease and resistant hypertension (high blood pressure), and an unfortunate propensity towards developing side-effects of treatment. So, over the years (yes, years!) of trial and error, Dr. Ofri and her patient have at last arrived at a multi-drug regimen that fulfills the needed criteria: a--efficacy at treating/controlling his ailments; b--lack of serious adverse effects; c--non-prohibitively expensive.

But, aha, here lurks a problem: he requires double the amount of [drug X] 90 per month instead of the approved 45 pills per 30 days. Why? Well, humans are not machines and an individual's dose-response to a medication is not entirely predictable.

Tell that to an insurance coverage expert on the phone, when pleading for flexibility in the preferred coverage listing. Not so fast, Dr. Ofri was informed. And informed again, despite her fervent pleas and assurances that this combination and amount was actually necessary to keep her patient well, out of the hospital (thus saving the insurance company big-time but at some unknown future date). Eventually, her rational, reasoned discourse coupled with loud vituperation and several slammings of the phone worked! Extra medication coverage: Approved! (several hours later).

ACSH's Dr. Gil Ross had this comment: How many doctors, no matter how devoted and concerned, have both the time and the patience to deal with such obstacles? As Dr. Ofri points out, this type of "tiered", multi-level coverage was designed to save insurance companies money...
by switching patients over to less expensive (including generic) medication when possible, medically. She goes on to emphasize, however, that in cases like her Mr. V., if a doctor cannot breach the insurance walls around the most effective therapies, the long-term danger of exacerbating medical conditions will overwhelm the transient savings of cheaper drugs. This is a problem that will only get worse as more and more patients with coverage no matter how leaky enter the system thanks to the ACA, making the drag on over-worked doctors time more and more acute.


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