

## Protect your drug plans with enhanced PAs

Mike Sullivan | July 12, 2011

I followed my father's footsteps into the pharmacy industry. When he first started practicing pharmacy it was common place to smoke behind the dispensary counter, prescription labels were carefully crafted using a typewriter, the arsenal of medications was a fraction of the size that it is today, and most importantly, pharmacists weren't allowed to tell the patient what kind of medication they were taking.

Looking at the evolution of the profession over the years and thinking about it from the perspective of the patient and the pharmacist, it has been an incredibly exciting period with a plethora of important innovations. However, given our role of assisting plan sponsors, advisors, and other stakeholders in the provision of drug benefits it isn't the innovation in drug therapy that's most interesting and notable, it's the complete transformation of the role of the patient.

New therapies are not what will bring the next wave of challenges to employer sponsored drug plans, it is the patient—the plan member. We are in the midst of a period of relative calm before the storm, but the storm is coming and it is not far off.

Plans that are not prepared for this next generation of member-driven plan challenges are going to be hit hard.

### **The power of the fingers and the palm**

I experienced the beginnings of the end of the previous generation of patient in the pharmacy when I first started practicing in Saskatoon. These were the patients who referred to their medications by their shape and color, but had very little appreciation for what their medications did or why they were important. The questions I asked in the pharmacy back then were very straightforward (relatively speaking), and patients took your recommendations without question a vast majority of the time because you were their sole source of drug information.

Now, the impact of having internet access at people's fingertips is remarkable. Plan members have access to an unprecedented amount of information, and have become far more informed about the conditions that impact them and their families. The indirect consequence to plan sponsors of this information revolution is starting to take shape in ways we have never seen before.

A few months ago, a friend of mine emailed me to seek my advice. She has a family member dying of terminal pancreatic cancer that has spread all over the body who had exhausted every approved drug treatment option. The family is acutely aware of the reality and gravity of the situation, but like any loving family, they are determined to keep looking at other options.

To my absolute surprise, I was being asked via email what my thoughts were on various clinical trials looking at the role of three different medications in treating stage IV pancreatic cancer. Embedded in the email were detailed descriptions about the ongoing research related to each trial.

I was stunned reading all of this information.

Here was a friend who spends her day as a senior marketing professional, writing to me and sounding like a competent healthcare professional. The other aspect of the email that caught my attention was that the oncologist in charge of the patient was happy to support the family in their bid to have the employer-sponsored plan cover any of these therapies given that the provincial program would not support any alternate treatment regimen.

The access plan members have to drug information, clinical research, patient opinions/feedback on therapies and alternate treatment options is unprecedented, as is their ability to influence treatment decisions. And this is starting to put significant pressure on employer plans that do not have established criteria for coverage, like most public plans have.

### **The need for enhanced prior authorization**

Last month we received a request for coverage for a medication from a plan member who's spouse has a very serious illness that would appear to be terminal. According to the oncologist, the patient has tried but now failed on two other therapies to treat this particular cancer and wanted to prescribe a new agent—a high-cost, oral cancer medication that is not covered by the provincial cancer program for this type of cancer.

What makes this case interesting is that the oncologist and the patient do not want to use the next most appropriate treatment option because of concern with respect to side effects.

Understandably, they want to try this new oral cancer drug alone as monotherapy in order to maintain quality of life even though there is no evidence yet to support its use in this way. While anyone who puts themselves in the shoes of the member—looking to try anything to treat their spouse, even when there is little to no evidence to support its use—would likely do the same thing. But, how many people are considering the plan sponsor's position?

This plan sponsor has an administrative services only (ASO) plan design with a high-stop loss threshold, meaning that virtually every dollar paid for this therapy will come out of the plan's pocket.

This is not a group that has the resources to allow any plan member to take whatever therapy they would like, whenever they would like. These costs are very material to the plan sponsor. While this employer would like to be in a position to assist all of its plan members however they can, there are limits to what it can do.

We used to field cases like this very rarely. Now cases like this happen on a monthly basis. The storm is on the horizon.

A traditional prior authorization (PA) program for a new medication like this typically requires the plan member to have a specialist fill out the appropriate paperwork in order to have the medication covered. It is very rare to see detailed criteria used to assess a traditional PA claim. This is understandable because areas like cancer, multiple sclerosis, rheumatoid arthritis and Crohn's disease are very dynamic—new therapies are released regularly to the market and research into the use and effectiveness of existing products is ongoing.

In a case like this where you have an ASO group with a high stop-loss threshold, what is the incentive to not pay for a PA claim of this nature, especially in cases where both the physician and the patient are pushing aggressively for coverage? As a result, PA programs have become more administrative tools than strategic plan management tools.

Plan sponsor, their advisors, and their associated vendor partners need to realize how significant a threat to cost containment this new era of patient empowerment is.

It is terrific to see members so much more educated about their conditions and treatment options, however, the downside is that members don't always have the ability to interpret and gather all of the relevant clinical information. As a result, we are more commonly seeing cases where members are pushing the envelope and moving into the realm of the experimental, even with drugs that are already on the market and indicated for other uses.

If plan sponsors do not get serious about implementing meaningful enhanced PA programs with meaningful approval criteria to ensure that only those who are likely to benefit from a therapy have access to it, they may be forced into investing significant financial resources into areas where there is very little (if any) evidence of efficacy, and this could threaten the long-term sustainability of the plan for all members.

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