Make it easier for patients to get the medications they need

Many patients with chronic conditions such as diabetes, asthma, ADHD, overactive bladder and enlarged prostate are unaware of prescription prior authorization. Prior authorization is how physicians seek health plan approvals for medications to be covered by a patient's insurance.

One of my patients with a bladder infection was delayed treatment for several days because prior authorization was required for a simple antibiotic, Augmentin. In another instance, one of my elderly patients with mild dementia was required to try an overactive bladder medication, one of the side effects of which was dementia.

Some of my patients have been required to try two and even three different medications before being given access to the medication I feel is right for them. This "fail first" approach can be detrimental to a patient's heath. It also imposes physical and emotional burdens from the stress of changing a treatment plan that is working to one that may not work or was previously found ineffective, not to mention the increased risk of side effects from the different medications and the expense of multiple copays.

When changing health plans or simply re-enrolling in the same plan (as hundreds of thousands of Virginian's just did, with plans effective Jan. 1, 2015), health insurers can dictate that patients are required to repeat failed therapies in order to gain access to a medication that has already proven effective for them. Known as step-therapy, the patient is required to follow a medication sequence chosen by the insurance company based on clinical criteria before the patient can have access to certain medications prescribed by their physician.

Insurers also use tiering and higher copays to steer patients to the plan's preferred medications, even if they are inferior generics. Not all generics are identical to the name brand, as the FDA allows different medication formulations and different rates of release and absorption. Unless it is an "authorized" private label generic, you may get more or less active medication from a generic, the binders and fillers may be different, the pills may dissolve and absorb differently, and some patients may even be allergic to the binders or fillers.

All these different aspects of prescription prior authorization have created an incredible bureaucracy for physicians and their staff, taking precious clinical time away from patients with a staggering amount of paperwork required to get patients optimal medications.

Virginia Urology has 1.5 dedicated full time employees to prescription prior authorization alone. In addition to these employees, each of our 32 registered nurses complete and submit upwards of 400 prescription prior authorizations per week. At our three largest

offices, this ranges from 50-100 prescription prior authorizations per day. These RNs are being taken away from direct patient care to complete and submit the forms and work with our patient accounting department. In the meantime, insurance companies have 14 days to respond to a prescription request, and patients do not understand why they are not getting their medications.

As physicians, we take on the responsibility of protecting the patient. Not only do we need to be highly skilled, we must use the latest technologies for diagnosis and treatment. This also means we must get our patients the medications they need, when they need them. Unnecessary interference in this relationship can jeopardize patient care and undermine the patient-physician relationship, which is the cornerstone of the practice of medicine. One such interference is prescription prior authorization.

Chronic disease and mental health patients who are medically stable on a medication, have completed step therapy or have received prior authorization from a previous health insurance carrier should be exempt from prescription prior authorization. In addition, prior authorization should be waived for most generic medications.

To ensure timely delivery of medications that require prescription prior authorization, health insurance carriers should be given a 48 hour deadline to approve, deny, or request supplementation of a prior authorization request and a 24 hour deadline to approve or deny the request upon receipt of supplementation. In addition, those requiring prior authorization should automatically receive a three day supply of prescription mediations in an emergency situation.

To free up clinical staff, health insurance carrier transparency of prescription medication formularies, prior authorization forms, prior authorization procedures, and reasons for prior authorization denials is needed as is the development of universal prior authorization forms and electronic prior authorization that is interoperable with electronic medical record and electronic prescribing platforms.

The Medical Society of Virginia (MSV) has joined with various health care stakeholders to pursue reforms to the health plan prior authorization process. Del. Greg Habeeb (R-Salem) is sponsoring HB 1942 and Sen. Steve Newman (R-Lynchburg) is sponsoring SB 1262. I hope that Virginia lawmakers act promptly to enact legislation that ensures patients get the prescription medications they need, when they need them.

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