Prior Authorization: Are there real savings?

Anti-Prior Authorization

Bureaucratic issues
Case studies of five states: California, Georgia, Oklahoma, Oregon and Washington. Beneficiaries face changes in their drug regimen and potential multiple trips to pharmacies and/or providers. Providers complain of communication issues with management firms and complexity of navigating new formularies.

Editorial on the inefficiencies of the Canadian PA system. Begins with the original Individual Clinical Review (ICR) forms, which are handwritten requests by providers, followed by the formulary system with numerical codes to be provided by the providers and confirmed by pharmacists. This last part added more communication headaches. Noted that the study the authors examine (Jackevicius et al., 2008) could not cover patients who received the drug/reimbursement through other channels, a method that is nearly encouraged by the Canadian PA system inefficiencies. The authors then cite another study of clopidogrel in an environment with no explicit limitations to its prescription, and found that the drug was often prescribed contrary to the drug’s ideal candidates, resulting in increased costs and in some cases higher risks of complications.

Clinical pharmacists interviewed 141 physicians identified as moderate or high prescribers of cerebral or peripheral vasodilators, propoxyphene or cephalaxin as identified by state Medicaid prescribing records to document motivations for their records. One-hundred ten responses were elicited, with 46% acquiescing to patient demand, 24% employing the placebo effect and 26% based the decision on their own clinical experience, despite the lack of evidence in the literature.

Lack of savings
Based on one study on the prior authorization policy in Maine, higher rates of discontinuation of atypicals were observed, with no significant impact on costs. The authors compare the effects of the policy on atypical antipsychotic prescriptions in West Virginia and Texas as compared to 27 states without the policy using data from the US Centers for Medicare and Medicaid Services from the 2002 to 2005. Second generation antipsychotics accounted for all increases in numbers of daily doses and reimbursement costs of all antipsychotics during this time period. Examining the Medicaid market share, West Virginia saw an immediate 3.4% drop after the initiation of prior authorization
policies, with subsequent drops of 1.3% per quarter from then on. Two years after the
initiation, the estimated market share of atypical antipsychotics dropped an overall 13.8%.
In Texas, atypicals initially dropped 2.6%, but the trend did not reach statistical
significance. Texas had different agents under prior authorization than West Virginia, so
the two are not entirely comparable. Market shares for first generation antipsychotics in
both states did not change after the initiation of the policy. Reimbursement costs for both
states showed no statistically significant changes. The authors conclude that a large factor
in lack of savings after initiating prior authorization policies is the lack of generic
alternatives to second generation antipsychotics. Suggestions for further research include
examining possible increases in polypharmacy or increased dosages of first generation
antipsychotics, increases in administrative costs associated with policy implementation,
increased burden among prescribers, and adherence issues.

Adherence issues
Soumerai SB, Zhang F, Ross-Degnan D, Ball DE, LeCates RF, Law MR, Hughes TE, Chapman
D, Adams AS: Use of atypical antipsychotic drugs for schizophrenia in Maine Medicaid
following a policy change. Affairs (Millwood) 2008;27:w185-95.
Looked at Medicaid data in Maine from 2001-2004. Maine instituted a PA, Step-Therapy
policy in which newly-prescribed patients were allowed nonpreferred aripiprazole or
olanzapine after failing risperidone first then ziprasidone and quetiapine. New Hampshire
data were used as the comparator group with no restrictions. Data showed an initial
decrease in nonpreferred atypical use, which rebounded shortly afterwards.
Discontinuation rates also appear to be higher in the Maine sample after restriction
policies were initiated. Slight savings appeared in both states. Authors suggest higher
discontinuation rates due to administrative issues creating barriers to treatment or
undesirable side effects associated with the preferred drugs.

Zhang Y, Adams AS, Ross-Degnan D, Zhang F, Soumerai SB: Effects of prior authorization on
medication discontinuation among Medicaid beneficiaries with bipolar disorder.
Compared Medicaid claims data of second-generation antipsychotics and anticonvulsants
for bipolar patients in Maine (PA state) and New Hampshire (comparison state) from
January 2001 to December 2004. During the eight-month period when the PA policy was
in effect in Maine, use of non-preferred drugs dropped 8 points. Once the policy was
repealed, the downward trend of non-preferred antipsychotics stopped and remained
stable, but the downward trend of non-preferred anticonvulsant use persisted. Use of
preferred drugs increased slightly in both states during the policy period, and dropped
slightly in Maine after its repeal. In Maine, drug savings during the eight-month period
totaled $144,072 while New Hampshire continued its increase of $2.80 per patient per
month. When PA ended, the spending trend was similar to that seen in New Hampshire.
Use of preferred drugs in Maine during the PA period saw no change. Discontinuation
rates were significantly higher in Maine during the policy period as compared to the pre-
policy period, with a hazard ratio of 2.28. These results are consistent with the authors’
previous study on Maine PA policy and patients with schizophrenia.

Administrative costs offset savings:

Reviewed effect of step-therapy programs in commercial prescription benefits plans for proton pump inhibitors, SSRIs, and NSAIDs. Compared to plans with no step-therapy programs, employers saw a $0.83 per member per month in savings, while the comparison group saw a $0.10 per member per month increase. Paying for brands out of pocket or receiving no medication at all is associated with lower satisfaction levels with the plan. Of note is the study’s estimate that each appeal results in administrative costs of $20.


Cited article states each PA request can cost between $10 to $25.


Authors developed a model to describe potential effects of a PA policy on newer non-benzo insomnia treatments, based on national estimates and market-scan reports. The model uses a hypothetical managed care organization with 500,000 insured patients. Based on their default inputs, losses were estimated in $600,000 to $700,000 range in the PA situation as compared to non-PA situation. Even when adding a 5% rejection rate, decrease of generic first-generation non-benzos and decreasing cost of each appeal to $20, losses were still present, at about $100,000.

LaPensee KT: Analysis of a prescription drug prior authorization program in Medicaid health maintenance organization. *J Manag Care Pharm* 2003;9:36-44.

Reviewed claims data from a managed care organization with 250,000 members in the NorthEast for one month. Reject rate was only 4.4%, less than 1,000 of the monthly 10,000 to 12,000 requests. Top six PA drugs were antypsicals, antacids, antidepressants, antihypertensives, anticonvulsants, and Cox-2 inhibitors. Fifty-five-point-three percent of all PAs were for branded products. Rejection rates for nonformulary drugs was significantly higher than for formulary drugs (7.1% vs 3.7%).


[No access to this article] Take home point: Their economic model states shows threshold rate of rejection in PA programs must be higher than LaPensee’s 4.4% to be break even. High PA rejection rates seem to be contrary to real-world data though.


Surveyed large managed care organizations to ascertain restriction policies and their reasoning. PA came in as second most common policy. Drug cost was only one of several factors considered in policy decisions, and it was not the most endorsed reason. Of note: Authors considered several brand drugs in their survey questions, and several of the respondents dropped PA altogether for these drugs because of administrative costs.

PA for Tretinoin is based on age, set at 25 years. The assumption is that its use for acne is associated with younger age, meaning most PAs would come from those under age 25. Data comes from the National Ambulatory Medical Care Survey. Results show an average cost of $28 unit cost per prescription, with unit expense of $7.50 per single PA. The association between lower age and PA was confirmed, but also increased cost per PA request. Authors conclude the PA policy for tretinoin is not cost-effective unless the age threshold is set higher, to age 35. Total costs (tretinoin plus administrative costs) changed little with age. Elimination of the policy would see a small increase in costs, but authors state the cost is offset by clinical outcome.
**Misc, Background**

*Healthcare is expensive:*
US spends more on healthcare per capita than nearly every other nation in the world.

*Newer drugs are worth the money:*
Data based on 1996 Medical Expenditures Panel Survey (MEPS) Prescribed Medicine Event file (171,587 observations), which includes source and amount of payment for the prescription and the NDC code. Newer drugs can be referenced from the NDC code by considering when the active ingredient was approved by the FDA. A majority of these observations are linked to the MEPS Medical Conditions file, which documents the onset, course, and outcome of the illness, including any hospitalizations or missed work or school days associated with the condition. The author controlled for medical condition, comparing drugs across classes. Newer drugs were found to be more expensive. Multiple prescriptions and conditions were positively associated with mortality. The overall mortality rate of the sample was low, but it did indicate that patients using newer drugs was significantly less likely to die than patients on older drugs at the end of the observation period (t =2.76; p=.0058). In terms of mortality issues, patients on newer drugs were less likely to experience work-loss days (t=3.32; p=.0009), as well as significantly fewer and reduced lengths of hospitalizations. The savings are much greater (estimated total nondrug medical spending reduction of $72) than the estimated average increase of $18 per new drug, the author estimates, with an offset effect of $54.

Zhang and Soumerai reexamine Lichtenberg’s original analysis of the 1996 MEPS data using different methodology. They updated the age of the drugs in question, using the FDA as a direct source rather than tracing NDC codes. Drug spending was recalculated to include number of dosages rather than the original number of unique drugs prescribed. Severity of illness was considered. Finally, the authors considered models other than the original linear regression used by Lichtenberg. Their new analysis revealed a higher cost of new drugs ($28 vs the original $18), with an increase of $57 for every drug age unit (log of drug age). Cost-offset in this reanalysis was only 20% of the total reported in an updated Lichtenberg study using 1998 data. The authors conclude that the more reliable data is necessary before drawing any conclusions.

*Prescribers don’t follow guidelines often:*
Elderly Medicaid population drawn from the Pharmaceutical Assistance Contracts for the Elderly (PACE) in Pennsylvania to examine the factors influencing prescriptions of cox-II inhibitors and NSAIDs. No policy restrictions were in place during the study period.
between 1998-1999. Analysis showed that guidelines, which state specific risk factors that should be present before the use of the more expensive cox-II inhibitors, were not statistically significant with cox-II prescriptions. Factoring in prescriber preference, based on the rates of cox-II prescription rates of the prescriber, boosted the discriminative power of the regression model to significance.

**Formulary Exceptions:**
Koyanagi C, Forquer S, Alfano E: Medicaid policies to contain psychiatric drug costs. *Health Aff (Millwood)* 2005;24:536-44.
Reviews drug limitation policies of all 50 states. Of note: antipsychotics and SSRIs are most likely to be excluded from exemptions.

**Policies don’t seem to follow guideline updates:**
Examines the effect of an FDA advisory in 2005 warning of the increased mortality rate in elderly patients with dementia taking atypical antipsychotics. Over a year later, there was no change in any state PA programs in response.