Understanding Payor Drug Use Management Initiatives

The U.S. health care system is fragmented and diverse

Data access differs with each type of payor

Health plan	Pharmacy benefits manager (PBM)	Integrated delivery network	Self-insured employer	CMS
Pharmacy data (real time/daily) Medical data (4-6 month lag)	Pharmacy data (real time/daily) Medical data* (4-6 month lag)	EMR (real time) Pharmacy data (real time) Medical data (real time)	Pharmacy data (monthly-quarterly) Medical data (4-6 month lag)	Pharmacy & medical data access depends on state Medicaid program and Medicare coverage

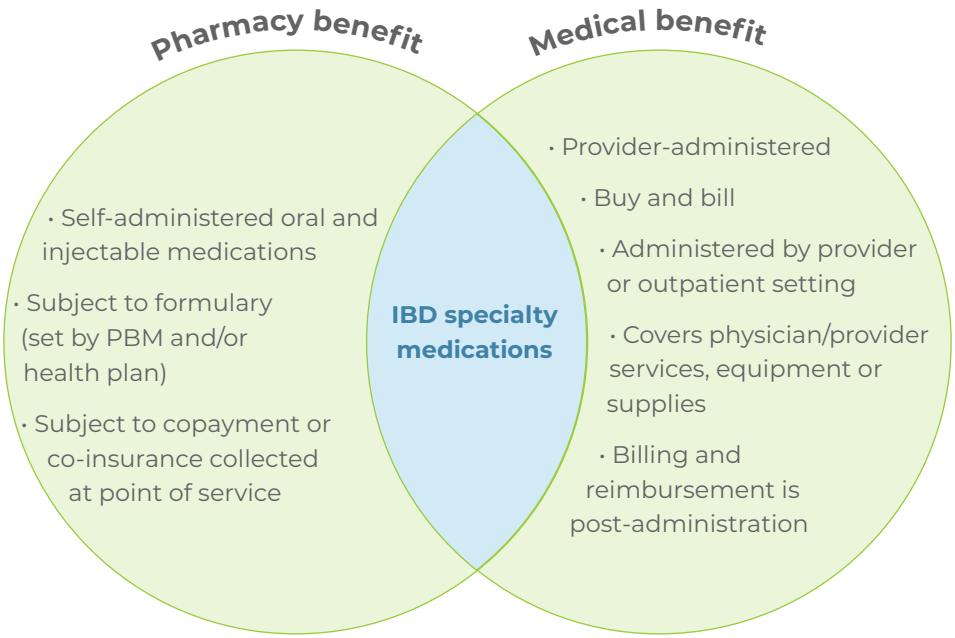
Incentives may be different for different types of payors. Coverage decisions made by payors are influenced by many factors such as line of business, employer purchasing decisions, and the need to provide competitive offerings. Such factors also impact the degree to which payors make decisions to spend today to save money in the future.

CMS = Centers for Medicare & Medicaid Services
EMR = Electronic medical record
*PBMs and specialty pharmacies may have access to medical data if provided by or vertically integrated with the health plan.

Lines of business vary with each payor

- Commercial
- Medicaid
- Medicare
- Health exchange

IBD drugs may be covered via the pharmacy benefit or the medical benefit[1-2]



Drug use management

Goal: To ensure appropriate medication use

Common utilization management strategies:[3]

- **Prior authorization (PA):** Allows clinical review ensuring appropriate use
- **Step therapy:** Requires lower-cost, first-line therapies
- **Quantity limits:** Assures appropriate dosing, prevents waste
- **Duration limits:** Limits how long a therapy is covered by insurance
- **Channel management:** Limits to specific pharmacies or providers

Utilization management strategies for a given drug take into account:

- Pharmacy & Therapeutics (P&T) Committee evaluation
- Randomized clinical trials
- Practice/society guidelines

Prior authorization process[4]

Complete eligibility check of patient's current insurance & select correct PA forms (pharmacy vs. medical)

→ Submit PA form to payor*

→ Payor review/ determination (turnaround 24-72 hrs**)

→ **APPROVED:** medication is covered

→ **DENIED (non-Medicare):** may submit appeal with letter of medical necessity (LMN)

→ **Payor makes decision**

→ **DENIED:** request peer-to-peer, make verbal appeal why med is necessary

→ **DENIED:** use alternative med and resubmit PA in 6 months

→ **DENIED (Medicare):** may submit appeal with LMN (within 60 days)

→ **Medicare makes decision** (turnaround 72 hrs-7 days)

→ **DENIED:** submit appeal to contracted external company for review

→ **DENIED:** must use alternative medication

Document every step of all PAs

*Consider providing complete medication history, including past failed treatments; letter of medical necessity; guidelines and/or other reputable sources with PA form.

**Expedited request based on condition and patient status turnaround 24 hours; 72 hours is standard turnaround.

Tips for successful PAs[4]

Identify top 2-3 payors in your practice. Be familiar with formularies, PA processes, and policies.	Obtain a copy of payor formularies.	Identify a single point of reliable contact for each top payor.	Dedicated staff person(s) to handle PAs in the practice can develop relationships with payor contacts.	AGA is a resource.	Patient can assist in advocacy and following up with payor.

Appeals (redetermination) process tips[4]

- Appeal within 60 days for Medicare*
- Emphasize severity of patient's disease and consequences of ineffective therapy
- Communicate the total cost of care (e.g., risk of hospitalization) if the disease progresses
- Outline why requested treatment is more appropriate for patient (contraindications, safety, intolerance)
- If patient is needle phobic, reference possibility of non-adherence with injectable medications
- Provide additional data (progress notes, labs, endoscopic reports, imaging results and past/current therapies)
- Cite society guidelines that support requested treatment
- Keep patient apprised of status; they may be able to help with follow-up

*Appeal timeline may differ with other payors

Supporting documentation for redetermination[4]

- Severity of disease
- Markers of active disease
- Previous therapies used and related outcomes
- Safety, intolerance or contraindications to other available medications
- Data from recent studies and clinical trials
- Describe how limiting access to requested medication may impact patient (disease progression, increased costs, decreased quality of life)

Key messages

- Know the top payors in the area and their corresponding formulary, PA processes, and policies.
- If possible, have dedicated staff to handle PAs and other utilization management requirements.
- By keeping the patient updated on the status of approval, they can advocate for themselves with the payor.

References

1. MMIT Reality check on Crohn's Disease (1Q2023). https://www.mmitnetwork.com/aishealth/reality-check/mmit-reality-check-on-crohns-disease-1q2023/. Accessed May 2024.
2. National Association of Medication Access & Patient Advocacy. https://www.namapa.org/medical-vs-pharmacy-benefit, Accessed May 2024.
3. Happe LE, Edgar BS. A primer on managed care pharmacy. *Manag Care Spec Pharm*. 2023. 29(12): 1371-76.
4. Bhat S, Zahorian T, et al. Advocating for patients with inflammatory bowel disease: How to navigate the prior authorization process. Inflamm Bowel Dis. 2019;25(10)1621-1628.

Additional Reading

Hernandez I, Hung A. A primer on brand-name prescription drug reimbursement in the United States. *J Manag Care Spec Pharm*. 2024. 30(1):99-106.

Prior authorization and utilization management concepts in managed care pharmacy. *J Manag Care Spec Pharm*. 2019. 25(6):641-644.