Prescribing Pitfalls Part I: Navigate the Changing Landscape of Brand Name Drug Prescribing

Prescribers increasingly need to understand drug pricing, pharmacy policies, insurance coverage, and coupon offers to ensure patients get the medications they need.

BY STEVEN LEON, MS, PA-C

Health care costs are increasing, and brand name drugs are becoming more difficult for our patients to obtain, due to increased co-pays, more prior authorizations, or more drugs just not being covered. There is also a growing trend toward insurance policies having brand name and even generic drug deductibles. These restrictions result in more pharmacy call backs, more frustrated patients, and poor outcomes when patients can’t get the medications they need. This affects not only brand name medications but also more expensive generics. Despite more restrictive insurance coverage, patients still expect the prescription to be filled hassle-free and at a reasonable price. They expect the prescriber to be knowledgeable enough to know if the prescribed medication will be covered or not. More and more, their expectations are not being met as they leave the pharmacy empty-handed and upset. This is an increasing daily problem for us and our patients.

While there is a vigorous debate around the use of brand name vs. generic (when a generic equivalent exists), the fact remains that we all use some brand name drugs and with increasing frequency are encountering problems getting them filled, even when a coupon is used. The goal of this article is to offer a basic understanding of insurance coverage for brand name drugs, then to understand how drug coupons work and under what circumstances they won’t work as advertised. This new knowledge base will give us the ability to use specific techniques to become more effective prescribers, with the ultimate goal to enable our patients to be more successful getting the medications we want them to have (or an acceptable substitute) at the lowest price on the first trip to the pharmacy.

WHAT’S AT STAKE
Put yourself in the patient’s shoes. You have an itchy rash and have waited two weeks for an appointment. Now you have a prescription and relief is in sight. You get to your pharmacy at 6:00 pm, wait in line 15 minutes, and are told your medication is $300 and not covered. The pharmacy tries to call your dermatologist but the office is closed and you walk away empty-handed, itchy and upset, wondering why you were prescribed an expensive medication that wasn’t covered.

Shouldn’t the dermatologist have known this could happen? Many patients don’t have the time or resolve to try to work through these problems with your office or the pharmacy. Some give up only to return for follow-up with poor outcomes. Because of his/her experience, the patient may view you as less of an expert. Even worse, they may complain to their referring providers. A recent conversation with a pediatrician revealed that he stopped referring to a particular dermatologist because, among other things, too many patients had complained about prescriptions that weren’t covered with out-of-pocket expenses sometimes exceeding $300. When you write for a brand name prescription or expensive generic, having some basic knowledge about costs, coverage, and coupons can greatly increase your prescribing effectiveness and avoid unwanted outcomes.

HOW MUCH DOES THE DRUG COST?
This basic information, how much the drug costs is becoming more important—and not just for cash patients. The more expensive the drug, the higher co-pay tier it tends
Some insurance plans do not have co-pay tiers; instead patients pay a percentage of the cost of the medications. According to a 2012 study, 13 percent of people with employer-provided health coverage have drug coverage with a separate prescription drug deductible, averaging $145—usually higher for brand names and lower for generics. In addition, 11 percent of workers have prescription drug coverage and a separate annual out-of-pocket limit for prescription drugs, which averages $1,722. (The study is available at: http://www.managedcaremag.com/archives/1301/1301.formfiles.html.) Drug cost information can be obtained from various internet sites or apps like goodrx.com, Epocrates, and costco.com, to name a few.

In an ideal scenario, physicians would be able to find out exactly what a patient’s insurance will pay for various drugs in a quick and easy way. Unfortunately, only a pharmacist can access that information. The closest we can come is Epocrates, which has the formulary and co-pay tiers for some insurance plans. This is a useful guide to educate yourself on which drugs may not be on formulary, which need prior authorization, and what various sizes and forms of medications cost. Another great source is your patients. When the patient presents for follow-up and you see that prescribed medications that aren’t always covered, ask them, “Were you able to get those medications? Were they very expensive?” Many times patients won’t tell you that they were unable to obtain the medication you prescribed and you will only find out when you ask. Now you have a second chance to get the patient on the regimen you originally intended.

**EDUCATE AND RE-SET EXPECTATIONS**

Whenever you prescribe a brand name medication, there is a significant chance it will require prior authorization, will not be covered, that the co-pay will be unaffordable, or the coupon you have given doesn’t turn out to be helpful. We need to inform the patient that these obstacles may occur just like we inform a patient about a common complication from a procedure or side effects from medications. The first step is to tell the patient that you are prescribing a brand name medication. Then briefly state why you are prescribing this brand name medication versus a generic (better formulation, extended release, better vehicle, no generic exists, etc). Choose your words carefully here. It’s better to present it as a “one is excellent and one is good” scenario. This way the patient will be happy with whatever medication they are able to get. Once you inform the patient that you are prescribing a brand name medication, a small percentage of patients will immediately tell you that they only want a generic due their brand name deductible or high brand name co-

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For patients who do not express an objection to a brand name, the next step is to tell them that because it is a brand name there is a chance the co-pay will be high, it may not be covered, or they may need a prior authorization. Then you tell them what to do if any of these things happen (covered more extensively in part two of this article). Manufacturers’ coupons play a key role in mitigating many of these issues and will be discussed next.

**COUPON CONFUSION**

“$0 co-pay,” “Pay no more than $20 dollars,” “Free trial offers,” “Maximum benefit cap of $350.” These are common claims we see on coupons populating our sample closets. These coupons frequently work as advertised, which makes the prescriber look great in the patient’s eyes as well as saving them money. However, we have all had many experiences of these coupons failing where we thought they would succeed. Pharmaceutical representatives often blame the coupon shortcomings on the pharmacist, who didn’t or won’t process them correctly. The pharmacist tells us that the medications aren’t covered, needs prior authorizations, or, even after the coupon was applied, the co-pay is still $80. We are left confused, not knowing what to believe or tell our patients.

Brand name drug coupons came into existence as a tool for pharmaceutical companies to make their drugs more affordable as they moved to higher co-pay tiers, needed more prior authorizations, or were just not covered. The
coupon codes are inputted at the pharmacy alongside the patient’s insurance information as a kind of secondary insurance provided by the drug manufacturer. My interviews with pharmacists revealed that they do not like these coupons at all and for perfectly understandable reasons. The main reason is the coupons increase processing time two- to five-fold. This time delay is a huge problem for pharmacies that, due to diminishing profit margins, need to process hundreds of prescriptions a day to remain profitable. In addition, coupons often do not work as advertised. The prescriber may tell their patients that these coupons should work unconditionally. Then the pharmacist has a lot of explaining to do to angry patients who expect to “Pay no more than $10” but actually have to pay $50 or more.

You may think a pharmacist would love to fill a $500 brand name prescription even with a coupon because the high dollar amount makes it very profitable. Surprisingly, these are among the least desirable types of prescriptions for a pharmacist to fill. The profit margins on brand name drugs are half those of generics. Brand name dermatology drugs are rarely kept in stock due to their high prices, which raise inventory costs. They, however, can be ordered and are usually available in the next one to two days. Generics are usually in stock. The extra step of special ordering and lower profit margins, in addition to increased processing time of a coupon, creates a strong preference for generic over brand name prescriptions at the pharmacy.

Often times, a pharmaceutical representative informs us that a coupon should work for all insured patients but we still get many pharmacy callbacks. This, along with the preference for generics and increased workloads created by coupons, has led to speculation that pharmacists are intentionally not processing coupons. My research has revealed that the number one reason that coupons don’t work is that many brand name drugs need prior authorizations or are not covered. The second reason is that even with the coupon properly processed, the co-pay is still too high for patients to afford. Coupons can be complicated to process. There can be technical difficulties and lack of time to resolve them. This certainly accounts for some of the failure rate.

I have detected no large scale efforts by pharmacists to not honor the coupons our patients present. Although they view coupons as a hassle, they also view them as just another part of their job and have just as much stake in patients' satisfaction as we do. Just like any matter related to patient care, we need to be the experts and understand the details of the coupons we give to patients. This way, when the pharmacy calls to inform us that a coupon didn’t work, we can intelligently discuss the processing issues and advocate on our patients behalf if necessary. Many times these issues can be resolved or at least understood and the patient will be grateful for your help and expertise.

In order to understand how these coupons work in different situations, I conducted numerous interviews with pharmacists and pharmaceutical representatives. I also called many pharmacy help lines for drug discount programs (the best sources of information). The most frequent phrase I heard in all these discussions was, “it depends.” Most often it depends on the patients insurance, the pharmacy’s software, or on the detail of the discount offer.

Drug discount programs are dynamic programs that sometimes change their terms after the cards are issued. One thing is for sure, we should never give the patient the impression they will get exactly the co-pay or discount on the card, as it may not always happen and can leave them disappointed. There are, however, many things that can be understood about drug coupons.

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cards can work most of the time if the patient has a normal or even high co-pay. If they have a very high co-pay, they may pay more than the coupon’s face value. The most common reason these cards don’t work is that the medication requires prior authorization (once you complete it, the card will work) or is not covered. These cards do not override these common occurrences.

We all know that prior authorizations take time for our staff and 24-48 hours for the insurance company to process it. If approved, the coupon should work. If the patient is not willing to wait, you do not want to take up staff resources to do the prior authorization, or you anticipate a high failure rate, then substitute an acceptable generic when you get the prior authorization notification from the pharmacy. Of course, keep the patient informed of these changes. If it is not covered, the situation is cut and dry and you will have to pick something else. When you get these cards from your pharmaceutical rep, the first thing you should ask them is “will this card work if prior authorization is needed or if it isn’t covered?” The answer should not be “it depends.” It should be “yes” or “no.”

The best coupons will override prior authorizations and work even if the drug is not covered. Most do not have this vital feature but a few do. These cards usually have instructions to the pharmacist that say: “If the primary insurer rejects the claim for any reason (i.e., Requires a prior authorization or step edit),” and then will list instructions on how to bypass it or will tell the pharmacist to call a drug coupon help line where they will be provided the proper codes. If you get a phone call from a pharmacy when you give a patient this card and they say it is not covered or needs prior authorization, ask if they called the helpline. If they say they did and it still didn’t work, advise your patient to go to a different pharmacy, preferably one you have a personal relationship with and is proficient at processing coupons. These coupons may or may not have a maximum benefit, which is discussed below.

Maximum benefit is a key piece of information. The maximum benefit is the value of the coupon. The closer the maximum benefit is to the cash price of the medication (there may be multiple maximum benefit amounts for different sizes/forms of the medication), the more likely it is that your patient will really “pay no more than $XX” if the medication is covered. Let’s look at two examples:

Example #1: “Pay no more than $30 on co-pays up to $280*.” When you read the text under the asterisk, the maximum benefit is $250. This drug has a cash price of $800. If your patient’s co-pay is $280 or under, they will have a $30 co-pay. For example, if their co-pay is $350 they will have a $100 co-pay. If they have not met any of their brand name drug deductible yet and the deductible is $1,000, they will pay $550 ($800 - $250) with the coupon.

Example #2: “Pay no more than $25*.” When you read under the asterisk the maximum benefit is $170. The cash price is $205 for 45 gram size and $400 for the 90 gram size. This is an excellent maximum benefit amount for the smaller size but a patient with a very high co-pay or unmet brand name drug deductible may have a very high cost for the larger size. In this case prescribing the 30 gram tube would avoid potential sticker shock at the pharmacy.

THE VITAL QUESTIONS TO ASK ABOUT A COUPON

When you are trying to understand how a coupon works, you need some key questions answered. You can obtain these answers from reading the coupon cards themselves and talking to the drug representatives (sometimes). The definitive, most up-to-date information can be obtained by calling the customer service number on the back of the cards. Remember, drug discount program details can and do change at any time and the customer service number has the most up-to-date information. Here are the questions you need to have answered:

- Does it override prior authorizations and will it work if the drug is not covered?
- What is the maximum benefit for all sizes/forms?
- What is the drug’s cash price for all size/forms?
- Epocrates is a good source for pricing information.
- What is the expiration date? Usually when it is not listed on the card it is > 1 year.
- How many refills is it good for? Often times trial offers provide generous benefits but provide no refills, so when the patient needs a refill they get sticker shock and you get a call from the pharmacy.

Understanding how much a brand name drug costs and how those costs may be reduced by coupons is a vital skill set every provider needs. This skill set will become increasingly valuable to your patients as insurance coverage becomes more restrictive. This foundational knowledge can be translated into specific and effective techniques that you will learn about in part II of this series. These techniques will increase your prescribing effectiveness and your patients’ ability to get the medication you want or an acceptable substitute on their first trip to the pharmacy. These techniques include forming a personal relationship with a pharmacist, writing a “back up” prescription, understanding common prescribing mistakes, better training your staff, and exploring compounded medications.

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