Prior Authorization Anecdotes from
Maryland Psychiatric Society's Member Listserv
Extracted 8/25/17 as
Follow up to Recommended Questions for 3rd MIA Survey on Parity

These are excerpts from a private email service that is used by participants who opt in to informally solicit advice, raise issues, share ideas, etc. Psychiatrist names and some other identifying info has been omitted. We have hundreds of individual posts on this topic over many years. This includes a sample of those beginning in 2016 or later. Posts and replies are grouped together. Prior authorizations are clearly taking up a lot of psychiatrists' time and causing a lot of frustration.

August 2017:
Preauths revisited

- Not sure if this has ever come up, and as I have a small clinical practice, I rarely have to do this. Pt is a 69yoF whom I've treated for >20 years. Clear history of ADHD dating back to childhood (I started seeing her in her 40s, so no record reviews, but the history she gave was unequivocal). FHo ADHD as well (son). Initially I was skeptical, but she had a robust and immediate response to methylphenidate when I started it for her. She's been on various forms of this medication since 1997. Currently is on one of the long acting methylphenidate preps. Prior to tx, she only held jobs that required short bursts of attention, like bartending. After tx initiated, she completed college, got a FT job in her chosen field, and worked for about 10 years until serious and unrelated medical conditions arose. She's now quite impaired orthopedically. Anyway, I was told this week that I had to do a preauth for a specific med preparation she's been on since 2014 or so, and doing well on. The auth was denied, telling me I had to try her first on an amphetamine product, notwithstanding her long successful tx with a methylphenidate product. Has anyone seen this? I've asked for a Doc-Doc review, but so far I've heard nothing. In this case it is Optum RX. I contacted Optum RX through their website. starting pt on regular release in the meantime.

- What kills me is that there's no logic here. this is not a fail first policy. This is a "succeed first, then fail years later, then leave doctor and patient to pick up the pieces" policy.

- I think it depends on whichever suppliers the medicare PBM has done a deal with. Last year, they were refusing to prescribe adderall, and were only authorizing Ritalin preparations. Then after January 1, they did an about turn, to adderall preparations. It's obviously financially driven and has no basis in any particular clinical algorithm.

- This month, they denied authorization for vyvanse when i called to renew authorization when auth expired in one year. They denied! I spent an hour with a supervisor, who said that the review will be sent to the committee. Many days later, I got a form in the mail for me to fill out, then have the patient sign the form, then sent it to them in the mail. Then a few days afterwards, before i filled a form, another letter arrived that it was authorized.... the poor patient had to wait and anguis

- I've run into this problem not just with the stimulants but with SSRI's etc as well. It can be based on availability and therefore the cost to insurance companies. When there's a shortage of one stimulant its cost goes up. That's why in the past some generics were denied but the brand was allowed.

- I had problems with Zyprexa.

- I have also always thought that these prior auth "games" of insurance companies border on crossing, or actually cross (denials), the line of practicing medicine without treating/maintaining chart/record) on the patient. (It seems especially egregious to me when I have been through the quite extensive credentialing processes of the insurance companies... they have "vetted" me in that process, but then continue to second guess me and or tell me what to do... without knowing, seeing the patient... and not even a first-line MD on the other end of the prior auth request... presumably it is the Medical Director overseeing the prior auth process who is culpable; is there medico-legal liability of this med director person for the pain and suffering and sometimes lost work or worse of the patient?) In my opinion, insurance companies should be legally required to employ an actual board certified/etc MD to be the FIRST-LINE ACTUAL REVIEWER of any prior auth request from the get-go... this would increase accountability of the insurance company, and also shift some of the financial burden and change the math involved in the whole process... (otherwise, they ought only be allowed to send those annoying "suggestion" letters... "doctor have you considered..." but nothing more than that) I currently spend hours weekly on prior auth mess... lost productivity for me... losses for patient... I think insurance companies will only bear more of burden when required by law... or laws that shift the financial burdens more evenly (as my suggestion above about prior auths needing to be directly to another MD, with some liability regarding the outcome of the insurance MD's decision--)

July 2017:
Prior auth need to prescribe LESS medication!!!

- Here's a new one. I wanted to give a patient a 30 day supply with a on maintenance medication (a long standing benzo prescription). I never like to provide a 90 day supply for certain medications like benzos, so I can monitor usage. For the first time ever, his Caremark insurance WON'T PAY FOR A 30 DAY SUPPLY, ONLY A 90 DAY Supply. I would have to get SPECIAL AUTHORIZATION to get them to cover 30 pills instead of 90 pills!! There is no alternative. Just NO COVERAGE for 30 pills, only 90. The pharmacist says that this is not a new thing, but it sure is to me. Has anyone else had this paradoxical situation? I want to spend LESS of the insurance company's money, and they automatically disallow that without authorization! [Maybe it's not less money for them, due to bulk discounts?]. This is one of the crazier situations I've encountered recently. Have others experienced this?

- I've had that before, but never in benzo. They pay a dispensing fee to the pharmacist, so 30d x3 = 3 dispensing fees, versus only one with a 90d. So, it does cost them more money to give less.

- If you call to explain, the PBM should auth for 1 year. Kick it to the CMO if they balk.
  I have been seeing this for the past year or so. It is most troublesome to me when I am only 30 days into the start of a new medication and I am still searching for a maintenance dose. Sometimes this occurs even with the very first prescription of a new medication. Prior authorizations are time-consuming enough that I have begun charging patients $20 to cover the cost of our administrator's taking the necessary steps. I often just go ahead and prescribe 3 months' worth, but there are times when I have to put my foot down. This seems to me to be an inappropriate intrusion on our capacity to provide medical care. I have not had the energy or political understandings of how to challenge this practice. Does anyone else?

- I've seen that with Express Scripts and other mail-order pharmacy plans. They allow two 30 day refills at retail pharmacies at the same dose. After that, 90 day fills of mail-ordered prescriptions are requested. It is often the patients requesting the 90 day supply because ES charges the same amount to the patient per delivery (regardless if it is 30 or 90 day supply). Clearly there is an argument to be made that in many scenarios, medications are not safe or appropriate to dispense in 90 day quantities. I have yet to contest this with insurers but won't hesitate when the time comes.

- This is not new-- has been happening for YEARS... benzos and otherwise. Thankfully most benzos are generic and relatively inexpensive OOP-- so sometimes tell patient they will have to pay out of pocket (or compensate for time battling insurance company, usually a lot more expensive) until a time when appropriate hopefully to do larger supply (or not). Use GoodRx to tell pt pharmacy with lowest price for month supply (and double check that med available at reasonable price). For example, clonazepam and lorazepam are available usually for $8-10 for 30 day supply. I have been doing this for years... It is a bigger problem with expensive meds.

June 2017
Preauthorizations

- I just wanted to share a new level of arcane wackiness with a preauthorization experience I had. I have a patient diagnosed with Sjogren's syndrome, depression and extreme fatigue, which I thought might respond to modafinil. I went to fill out the not unexpected preauthorization request from Expresscripts, and ticked the most appropriate indication they offered; "extreme daytime fatigue due to chronic illness". Apparently, however that was a trick question, as that's not actually a covered indication. In the meantime, my patient received the results of her outstanding sleep study. Not unsurprisingly, given the nature of her disease, she also has sleep apnea, which IS a condition Espresscripts will allow modafinil to be prescribed for. Simple, right? I just call them up, ask for a reconsideration of the case, given this new diagnosis, and send the results if needed……WRONG!!! I cannot initiate a new request, based on this new information for a period of six months, and must file an appeal in writing to the powers that be in order for a reconsideration. Why the arbitrary six months? Why do they offer indications which are not actually covered?????

- I have not found a good RX.com to be that accurate. They give the prices with the coupons, and I do have many such coupons in my waiting room, but they don't seem to be helpful to patients with insurance. I have discovered a number of things over time: The price for 200 mg (30 day supply) of Provigil is $899 at CVS, and $34 at Costco. I have no explanation for this. For Abilify, I've tried a number of things. The patient can send the prescription to Canada, and it's it's much cheaper. I don't know how legal, but plenty of doctors have told me they do this, especially in California. One of my patients did it without problem. The second option for a very low-dose of Abilify is that you can have a compounding pharmacy reduce one 30 mg tablet, which costs $42, to a smaller dosage, as long as it's not a dosage that is available through the manufacture. This cuts the cost by hundreds of dollars per month and is kosher. Finally, again for Abilify, I've had patients get prescriptions through Health warehouse online – – where the price is considerably cheaper than through a drugstore. There is also a service I recently learned about from a patient called the Blink Health. The patient goes on line and pays the service for the medication and can then pick it up at any drugstore from a select list. I believe the patient who got Abilify through Health warehouse said it cost $35. The patient who went through blink health said she got it from CVS where the cash price was $800 and the blink health price was $80. Both of these patients had health insurance. For reasons unclear to me, neither asked me for a pre-authorization, but I believe they said that even with their health insurance the medication would still run $200 a month

January 2017
More preauth headaches

- I have a new prior authorization story that I haven't heard before! Just when you thought you'd heard it all. I've been seeing a patient regularly since 2010 -- she came to me during an episode of severe depression which resolved. She was on Ritalin LA, prescribed by her internist, and I spoke with the doctor and just continued it. No issues with abuse or overuse, no side effects, she skips it if she doesn't need to concentrate on anything specific, but finds it helpful for focusing

and organizing and has a lifelong story of disorganization and unmet goals. So on 1/1, her insurance company says this medication, which the patient has been stable on for over 7 years, needs prior authorization and the Clinical Review team denied it because they want *documentation* of symptoms before the age of 12. The patient is 49. And there is no option for a peer-to-peer discussion with the reviewer. I'm just sharing the story... when I tried to get provigil for a patient who ended up being hospitalized, I went through weeks of appeals, calling the APA, my senator's office, and the insurance commissioner in 3 states and I wrote an article on this...I'm not up to all of that again, I just faxed a letter to the pharmacy benefits manager.

- I had same type of problem recently and wrote my congressman. It is insane and we all need to complain about it. New law in Maryland only deals with first fail generics. Not brand names which some people need for efficacy and side effects. We have a lot of loop holes.

- A few days ago, I had to call for prior auth for Ativan 0.5mg #30, hs prn anxiety. His primary insurance is medicare and secondary BCBS.

December 2016
approval for Latuda

- I've been trying to get approval for a long-term patient who has bipolar II disorder and who has done remarkably well recently on Latuda. Her prescription was rejected because she hasn't been on any other antipsychotic and Medical Assistance regulations ,(according to the Dr. of Pharcaceutics I talked to on the phone) forbids approval based on success with samples. I would like to take it to the next level, but that requires reference to a peer-reviewed article or two that shows Latuda is superior to the other antipsychotics for treatment of this disorder. I called the company that makes it, but haven't gotten the response I need. Has anyone gone through this process successfully? Does anyone have an article or two I can use? I recall the legislature was discussing a bill last year that would forbid this kind of maneuvering by any managed care company, once the patient is on a medication that works, but I don't know if that passed. Does anyone remember? It's my impression that Latuda has helped several of my patients with subtle bipolar disorder or "refractory depression", and I have no intention of taking any of these patients off it so that I can try another antipsychotic that probably would not work. I believe this kind of situation raises legal and ethical questions that we need to address some day.

- I am as frustrated as everyone else. However, we should not lose sight of the other side of this argument regarding ways to manage limited resources. Would any of us object now to the law that requires a generic to be dispensed as a default unless otherwise written by the doctor? That default law saves billions, because many of us (myself included) often reflexively write the familiar brand names. Similarly, shouldn't there be some mechanism to preserve resources by encouraging less expensive, but approved and effective meds to be tried first? When my son was treated for ADHD, I was shocked to find that the first prescribed medication cost $700 a month (That was my out-of-pocket costs) and the $60 a month medication was not tried and, in my clinical opinion, there was no reason not to try it. But I am a psychiatrist, so I knew that. What if I weren't and didn't know? So, I don't think that docs can be counted upon to think about cost and resources as a first consideration, and sometimes, we just reach for the samples we have, Maybe because we got good results. But those samples are often the newest, most expensive, and nonformulary meds. Honestly It is tempting to reach for the boxes and boxes of bring Trintellex samples before writing for citaloptam. What's the solution? Is it enough for payers to just beg doctors to think about this, sponsor widespread CME courses on economic considerations in prescribing, or to turn to the state to say --please help us by letting us do step therapy, the way you helped with generic – first laws. If the payer is the state itself, as in Medicaid, I can see that being an especially significant pressure on legislators. So step therapy protocols are not necessarily insane.

November 2016
Prior auth for dosage change

- Today, I wanted to lower a patients Vyvanse from 70mg to 60mg. I had prior auth for the 70mg, but it didn't apply to 60mg. I have to re-do it. Does anybody have a clue as to why it would be cost-effective for an insurance company to put in the human capital to re-authorize a dosage change for a medication. Why are authorizations for a specific dosage, when it is such a common practice in medicine to make dosage changes based on side effects and responses? How could this possibly save the insurance company money? Are they really going to deny a 10mg change in a previously APPROVED medication?

- I have had to do many PA's for stimulant dosage changes. Unbelievably maddening! I thought it might be because they are controlled substances and they want to universally discourage use

- As a matter of fact, I remember specifically doing prior auth about 1 and 1/2 years ago on stimulant dose change. Pt dropped out of treatment about 8 months later. It was vyvanse. She needed higher than recommended dose about 80 or 90. Yep. They are illegally continuing to use algorithms on our patients. One of our pm execs we invited to a payer relations meeting admitted it. He was corrected by a member.

October 2016
prior authorization nightmare story

- May I add a story to the mix? I don't have the form but by all means, feel free to fill it out for me. I have a patient who was hospitalized in 2008 for many months (4-6) at Hopkins. She got better but was discharged on a strange cocktail of meds, including Provigil. I tried taking her off some of the medications because she gained 100 pounds. I would have left Provigil, but at some point, her insurance changed, they wanted prior authorization, I answered 13 questions and they said No because she didn't have sleep-related diagnoses, and she seemed okay without it; I prescribed stimulants instead. In the past couple of months she has crashed. I am out of ideas, and decided to put her back on the meds Hopkins discharged her on (alas, she never lost the 100 pounds anyway) and think Provigil might be good choice. My attempts: The insurance rejected it. I tried to prescribe nuvigil but that also needs preauthorization. I think I spent 16 minutes on the phone with the pharmacy, but I could be wrong. I called the prescription company, Catamaran in Las Vegas. I spent 23 minutes on the phone with them and they rejected the authorization because she has not had polysomnography or a multiple sleep latency test. They told me to call the insurance company Wellmark in in Utah. I asked for an appeal and was told to go on their website and they would get back to me within 15 days. I said that was not acceptable and I wanted to speak with someone. I was then channeled to a peer-to-peer option and told someone would call me within 48 business hours (that was Thursday). That call to Wellmark lasted just over 19 minutes. Today (6 days and just a tad over 48 hours later), I was called by a pharmacist (the peer-to-peer) in Las Vegas from a number in Illinois. I spent 15 minutes on the phone with her, and was told the patient couldn't have the medication because Wellmark has strict criteria and she nixed it based on the same questions that I had answered for Catamaran. The pharmacist was sympathetic and thought it was possible the medication might get authorized on an appeal with documentation and she admitted this was an extreme story, but she had no leeway to approve anything outside of the standard diagnoses with the standard tests-- so this was simply a repeat of the call I'd had last week. I can appeal the process and was directed to two forms on the computer which I printed out: an appeal form, and an authorization form that the patient needs to sign for me to appeal. The patient lives in PA, an hour and a half away, but she is computer illiterate and doesn't have a fax machine, so I will not see her to get the form signed for a week. I was assured that if I sent the appeal form without the permission form

then they would not even consider it. She thought maybe if had the patient call that she could get the signature form bypassed, but she didn't actually know that, and I wasn't sure she wasn't placating me, and the patient is just not up to it; she is waiting for bed availability on the same unit at Hopkins. What possible justification could there be for 2 review processes without needing a written authorization from the patient, and suddenly a third appeal needs this? So by my count, so far I have had 4 phone calls and spent just over 73 minutes on this, with no resolution in sight; I suppose when I see the patient next week I will have her sign the forms and continue with the appeal. One of those calls may have been with the pharmacy because of course the prescription company needed the insurance information, which I didn't have, so I had to call the pharmacy back to get it. Thank you to anyone who listened to my rant.

- I had a similar problem getting provigil for my patient who has MS. His neurologist was eventually able to get approval. In the meantime I was able to get nuvigil samples from the drug company.

- I did have a problem getting a stimulant for a patient for depression. They rejected it because she didn't have ADD. I appealed it but it was still rejected. I gave up and sent a new request saying she has ADD. It's a bad idea to do this too often but if I end up on the phone multiple times I end up trying to destroy the phone. My poor phone is just a victim of all that displaced frustration

- Going through the exact same right now with provigil/nuvigil with Johns Hopkins US Family Health Plan. Except my patient has sleep apnea and I sent them the sleep study and repeat after cpap optimization and they denied it for reason of needing cpap optimization. Supposedly I will hear from the peer reviewer tomorrow but it has taken 3 weeks. I never get denied when I code shift work sleep disorder.

- I went thru exact same problem and same medication with a pt in about February this year. It took months to get her provigil. My pt was taking it for sleep apnea along with her other psych meds. Prior auth denied it then she had to go thru med chi payer relations then was referred to md ins commission where she filed a formal complaint and eventually received it. It took 2 months

- Provigil is one of the difficult medications to get approval for. I guess because it is so expensive. I have two patients with MS and depression one of them gets the approval from insurance the other one buys it out of pocket as her insurance will not pay for it.

September 2016
new prior auth twist

- for a prior auth for a pt (caremark) i was just asked this question: "Has the patient had a prescription for the requested drug paid for within the past 180 days? If yes, please submit documented proof of a paid prescription (receipt showing prescription, documentation from the pharmacy showing paid claim, etc) for the requested drug. Samples are NOT considered adequate justification." this is bizarre. i do not keep receipts from pharmacies for folks i send prescriptions to; what physicians do?

March 2016
Prior auth

- a pt was on adderall xr it was wearing off too soon so i wrote rx for vyvanse. these are the prior auth questions (verbatim). this is absurd.

Is the request for Initial Therapy OR Reauthorization?

☑ Initial Therapy ☐ Reauthorization

Is the member 12 years of age or older?

☑ Yes ☐ No

What is the diagnosis for the medication being requested?

☑ Attention-deficit hyperactivity disorder (ADHD) or attention-deficit disorder (ADD) ☐ Autism Spectrum Disorder ☐ Depression ☐ Narcolepsy ☐ Other hypersomnia of central origin ☐ Moderate to severe Binge Eating Disorder (BED) ☐ Other

Does the patient meet BOTH of the following? Patient has had binge eating disorder for 3 months or longer, Patient has between 4 and 13 binge-eating episodes per week

☐ Yes ☑ No

Does the patient meet three (3) or more of the following? Patient eats much more rapidly than normal, Patient eats until feeling uncomfortably full, Patient eats large amounts of food when not feeling physically hungry, Patient eats alone because of feeling embarrassed by how much one is eating, Patient feels disgusted with oneself, depressed, or very guilty after binge-eating

☐ Yes ☑ No

Is there documentation of positive clinical response (for example, meaningful reduction in the number of binge eating episodes or binge days per week from baseline, improvement in the signs and symptoms of binge eating disorder) to Vyvanse therapy?

☐ Yes ☑ No

Has the member been on this medication or used the product in the last 180 days?

☐ Yes ☑ No

Does the prescriber confirm, based on his/her professional judgment, that the requested drug or product has been effective in treating the patient's disease/medical condition?

☐ Yes ☑ No

What is the requested quantity per day/fill/prescription/month? [i.e. 1 kit (6ml) per 23 days, 3 tablets/capsules per day, 15 ml per day, 3 teaspoonsful per day]

What is the reason for exceeding the plan limitations (if applicable)? (i.e. titration purpose, patient is on dose alternating schedule, requested strength/dose is not commercially available)

Does the physician acknowledge that the potential benefit outweighs the risk associated with the higher dose or quantity (if applicable)?

☑ Yes ☐ No

Has the member been on this medication or used the product in the last 180 days?

☐ Yes ☑ No

Does the prescriber confirm, based on his/her professional judgment, that the requested drug or product has been effective in treating the patient's disease/medical condition?

☐ Yes ☑ No

What is the requested quantity per day/fill/prescription/month? [i.e. 1 kit (6ml) per 23 days, 3 tablets/capsules per day, 15 ml per day, 3 teaspoonsful per day]

What is the reason for exceeding the plan limitations (if applicable)? (i.e. titration purpose, patient is on dose alternating schedule, requested strength/dose is not commercially available)

Does the physician acknowledge that the potential benefit outweighs the risk associated with the higher dose or quantity (if applicable)?

 Yes

- I have just gotten a form from CVS inquiring about a pt's scripts. It was concerned about pain meds and benzos but I was sent a list that covered every 'script from all docs since November. I only saw this girl twice on an urgent basis. I do not have an authorization to communicate with the pharmacy. They want to know if that is what I prescribed (it was), if this is still my patient (no) and when was the last date I saw the pt. I am to fax the info. Has anyone gotten one of these? Can I reply? Should I?

January 2016
Obtaining antipsychotics

- Is anyone else having problems obtaining antipsychotics due to prior auth? I had problems getting a generic anti psychotic med to a patient who had been stable on it for 10 years. Long story but wasted 6 hrs of time . He finally received it 6 weeks after script was written. He had a history of violence just prior to this med was increased to current dose 10 years ago. Stable ever since.

buprenorphine/naloxone vs buprenoprhine alone

- i have a pt with narcotic addiction i prescribed buprenoprhine/naloxone for him) aka generic suboxne) (fda approved product) insurance would not pay it said preferred product is buprenorphine alone (sl) (aka subutex) interesting they demand a non fda approved product for the indication rather than the fda approved product. i didn't know they are allowed to do that.

- Pbm last week refused to fill patients ziprasidone after granting 2 years prior authorization 6 months ago. Pt tried to commit violent crime on the Med 10 yrs ago at lower dose. These issues are beyond complaint stage. These are scenarios that require immediate action. For example, we need to create a flow chart that any doctor or staff can use to eliminate fixable issues or problem solve. For example I discovered some meds requiring prior authorization are cheap anyway. Such as Ativan generic. Only $2.51 at pharmacy for 1 month. We should be calling pt pharmacy first to get 1 month cost before spending 1 hr with prior authorization. We need to save emergency cases like antipsychotic denials for an urgent contingency plan.

- Ziprasidone. Script was written 11/16/15. Pt did not get it until today 12/28/15. Same patient was denied lorazepam 0.5 mg. He was able to get it and paid out of pocket for a grand total of...wait for it...$2.50 for 30 day supply. Same company recommended Rozarem for him. Retail price (I checked it for another patient) would have been $420 for 30 day supply. We have no power over this insanity. But I have thought about this and what we can do at the local mps level is come up with a game plan about how to better handle prior auths. I heard APA is working on this but I can't wait for them. I have already started calling the pharmacy first to get the 30 day price for the med. If the patient can afford it, they pay for it out of pocket. I also notice that non clinical questions prior auth associates ask like: has the patient ever paid for it before -- is none of their business. They use this to justify denials because it has street value for the person. So I just tell them no. If they ask if the pt can afford it, I just tell them no. These are income discriminatory questions. I did not know there was such a thing as income discrimination until a few months ago.