AMERICAN ACADEMY of DERMATOLOGY | ASSOCIATION

Regulatory Relief from Burdensome Regulations Affecting the Practice of Medicine

Prior Authorization

ISSUE OVERVIEW:

Prior authorization requires physicians and other providers to obtain approval before providing a covered service or medication in order to qualify for payment. Prior authorizations for medications are often required for both generic and specialty drugs in dermatology. Sometimes a drug that a patient has taken for years will suddenly require an annual re-authorization by the insurance carrier. Most physicians consider prior authorization an expensive and time-consuming process that questions their clinical judgment, siphons resources away from patient care, and often results in treatment delays and/or negative patient health outcomes.

Dermatologists treat patients suffering from chronic and disabling skin diseases and conditions. For many of these diseases and conditions, medications are specialized, highly nuanced and their efficacy is dependent on a number of patient factors. Prior authorization policies that place a third party, with no knowledge of the complexity or full history of a patient's condition, in a decision making position are not only inappropriate but also impede patients' access to the most effective treatment. The choice of therapy should be between a physician and his or her patient where consideration of all factors – efficacy and safety of all treatment options, co-morbidities, and support system – are taken into account and fully discussed and vetted.

The AADA's 2016 survey of dermatologists and dermatology practice administrators revealed a significant burden on physician time and resources in responding to drug prior authorization requests. Survey respondents report prior authorizations consume hours of physician and staff time that could otherwise be spent on patient care. Below is a snapshot of the survey results:

- Most respondents claim to process six or more prior authorizations daily.
- Not being listed on a formulary, or being listed on a higher tier, are key reasons for prior authorizations with some also citing step therapy and cost as reasons.
- A sizeable portion of prior authorizations are processed online, but they are also often processed via fax or telephone.
- Biologic prior authorizations typically take longer to process for staff, compared to non-biologics, regardless of processing method.
- The majority have seen an increase in the number of drugs requiring prior authorization and the subsequent delays in patient treatment.

Prior authorization and appeals policies should not unduly burden physicians or patients in accessing optimal drug therapy.[1] According to the American Medical Association, 79 percent of physicians are sometimes, often, or always required to repeat prior authorizations for prescription medications when a patient is stabilized on a treatment regimen for a chronic condition.[2] Delays can cause irreparable harm to patients in need of specific treatments. Standardizing the process by which prior authorization determinations are made and quantifying and minimizing the delay of determination would help alleviate this burden and facilitate patient access to the therapies they need.

The Centers for Medicare and Medicaid Services (CMS) could alleviate the burden on physicians to complete prior authorizations for medically necessary drugs by placing reasonable requirements on Medicare Advantage and Medicare Part D participating plans. The AADA recommends shortening the turnaround time for prior authorization decisions, encouraging plans to allow for electronic prior authorizations (ePA), and requiring detailed explanations for prior authorization or step therapy override denials as well as the clinical rationale for adverse determinations. The AADA also recommends that plans, if issuing denials, provide information on the plan's covered alternative treatment and detail the provider's appeal rights.

LEGISLATIVE ASK

Support legislation that streamlines and reduces delays for prior authorization approval in Medicare by requiring CMS to provide for the development of an ePA standard for Medicare Advantage and Part D plans.

HOUSE:

Support creating a standardized electronic prior authorization form for Medicare prescription drugs as found in Sec. 6062 of H.R. 6, the "SUPPORT for Patients & Communities Act." The House passed H.R. 6 on June 22 to help address the opioid crisis. These provisions are based on the "Standardizing Electronic Prior Authorization for Safe Prescribing Act of 2018" (H.R. 4841), which the AADA supports. That bill was introduced by Representatives Dave Schweikert (R-AZ), Ben Ray Luján (D-NM), Bill Johnson (R-OH), and Mike Thompson (D-CA) earlier this year.

SENATE:

Cosponsor and vote for the "Electronic Prior Authorization in Medicare Part D Act" (S. 2908), introduced by Senators Pat Roberts (R-KS), Tom Carper (D-DE), and Charles Grassley (R-IA).

---

[1] H-285.965 Managed Care Cost Containment Involving Prescription Drugs; AMA Policy Compendium 2015
[2] 2017 AMA Prior Authorization Physician Survey