BEST PRACTICES IN: The Role of Copay Reduction Programs Within a Physician's Practice

Medication nonadherence, as well as incorrect or incomplete utilization of prescription medications, is a recognized problem in health care.[1–5] Adherence can break down at any point in the chain of actions required for patients to receive and correctly use prescribed therapy. A prescription may never reach the pharmacy for filling. Patients may not obtain the medication from the pharmacy after the prescription has been provided to the pharmacy. They may obtain a generic or other alternative due to insurance coverage provisions or other cost issues. Some may not take the medication as prescribed or may not refill a prescription at the correct time.

Among patients with psoriasis, reported rates of nonadherence to topical therapy have been associated with poorer long-term outcomes after psoriasis clearance.[5] One study documented a self-reported nonadherence rate of 40% among 53 patients using topical corticosteroid therapy for psoriasis.[2] Among the reasons for using treatment less often than prescribed was "medication too expensive." This ranked above "medication felt unpleasant" and "developed side effects" in a patient survey.[2]

The first step in adhering to prescribed therapy is obtaining the medication from the pharmacy. The rate at which patients covered by commercial health plans abandoned new prescriptions for brand-name medications (ie, did not purchase prescriptions submitted to the pharmacy) reached 8.6% in 2009, according to a Wolters Kluwer analysis (**Figure**).[6] This represents an increase of 23% over 2008 and 68% compared to 2006. Even generic prescriptions are being abandoned, with the abandonment rate for generics in 2009 similar to that for branded medications in 2007 (5% to 6%).[7] The authors attributed this in part to economic pressures during the recent economic downturn.[6]

Studies have documented the impact of patient cost share on adherence to therapy. A review of 132 publications found that for each 10% increase in patient cost sharing (eg, copays, coinsurance, coverage caps), prescription drug spending fell by 2% to 6%, depending on the drug class and patient's condition.[1] For patients with congestive heart failure, lipid disorders, diabetes, or schizophrenia, a higher patient cost share for medications was associated with increased use of inpatient and emergency medical services. The National Council on Patient Information and Education highlighted the need to improve medication adherence in a 2007 report, stating that "Lack of medication adherence…leads to unnecessary disease progression, disease complications, reduced functional abilities, a lower quality of life, and even death."[3]

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The impact of cost share on adherence to therapy surfaced in my practice when a number of patients returned for follow-up visits demonstrating little or no improvement in their conditions. Questioning revealed that some had never obtained the prescription ordered for them due to cost. Others had received a generic or over-the-counter product, sometimes one of lesser strength than the therapy prescribed for them. Many did not understand the difference between the prescribed medication and the one substituted. Some did not realize that they had not received what had been prescribed for them. When asked what they are using, patients may recall applying "a white cream that comes in a tube" or other general descriptions that do not allow a provider to determine the product used.

Asking patients to bring to their visits the medications they are taking can help a clinician determine whether the patient received the treatment chosen for them. Some patients who are not responding to therapy bring in generic or over-the-counter medications rather than the ones that I have prescribed. I have learned to consider the possibility that lack of improvement may suggest that the patient has not received the correct medication. For example, I sometimes prescribe a branded steroid cream for inflammatory or pruritic dermatoses. When patients whose conditions are not improving bring in their medications, I find that some have received the generic that is half the strength of the branded product prescribed.

Patient incentive or copay reduction programs offer a tool to address one aspect of this problem. Some operate by reducing patients' maximum copay by up to a certain amount.[8] Others reimburse patients' out-of-pocket costs up to a certain amount regardless of whether that cost represents a copay.[9-11] Most apply to patients with private insurance (ie, not federal or state insurance programs).[8-11] The **Table** summarizes a few examples of programs with which I am familiar. Typically, the intent is to narrow or close the gap between the patient's cost for a brand-name drug and the cost for a generic. Our office uses roughly 20 such programs.

Communication is key to implementing these programs. Rather than simply handing patients a card or form, physicians or other clinical staff need to explain why a given medication is prescribed for them, and that the rebate card or other documentation that you provide should reduce their cost. My practice places the copay reduction program forms in examination rooms rather than at the reception desk to ensure that conversations such as the one described above take place when providing forms or cards to patients. Patients also must understand how to use the cards. Some programs require card activation by phone or the Internet;[8,12] others require the patient to mail in a receipt.[9,10]

I encourage the patient to contact the office if they have any problem with filling the prescription as written, and urge them to phone from the pharmacy if something is unclear to them or to the pharmacist. Implementing copay reduction programs does involve clinician and sometimes clerical staff time. I find it worth the effort because it increases the likelihood that my patients will receive the medications that I have selected for them.

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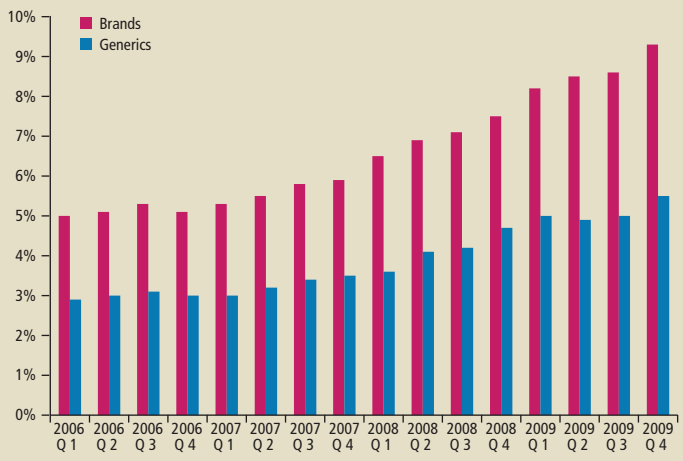
Figure. Prescription Abandonment Rates



Source: New and Commercial Claims Only, % Claims Reversed, All Products, Brand/Generic Indicator, All Claim Types

Table. Examples of Copay Reduction and Patient Rebate Programs

Medication	Company	Copay Reduction/Rebate*	Procedure
Eletone® (nonsteroidal topical emollient); Pramosone® (hydrocortisone acetate and pramoxine HCl); Clinac® BPO 7 (benzoyl peroxide gel USP, 7%)[9]	Ferndale Laboratories, Inc.	The Treatment Assurance Program reduces copay to $10 for most insured patients. Uninsured patients receive $50 off	Patient presents card to pharmacy; good for unlimited refills
Solodyn® (minocycline HCl) extended-release tablets; Vanos® (fluocinonide) cream, 0.1%; Ziana® (clindamycin phosphate 1.2% and tretinoin 0.025%) gel; Loprox® (ciclopirox) Shampoo 1%[10]	Medicis Pharmaceutical Corporation	Up to $35 off Solodyn®, Ziana®; up to $25 off Vanos®, Loprox®; no indication of limitation to insured patients	Patient completes form; good for limited time and/or number of prescriptions
Solodyn®, Vanos®, Ziana®, Loprox®[8]	Medicis Pharmaceutical Corporation	MediSAVE Program reduces copay to $10 for insured patients	Patient activates card via phone or Internet; valid for a limited number of prescriptions
Taclonex® (calcipotriene 0.005% and betamethasone dipropionate 0.064%) ointment and (scalp) topical suspension[11]	Warner Chilcott	Up to $50 rebate for copay or other patient out-of-pocket cost	Patient mails in rebate form after purchase
Taclonex® ointment and (scalp) topical suspension[12]	Warner Chilcott	Taclonex® Patient Savings Card Program reduces patient cost to ≤$50	Patient activates card and presents to pharmacy with prescription; good for limited number of prescription refills

*Prescriptions purchased under federal or state programs (eg, Medicare, Medicaid) excluded.

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