Two Part D Plans Cover AD Drugs With Less Red Tape

BY MARY ELLEN SCHNEIDER
New York Bureau

Two major Medicare Part D drug plans recently stopped requiring prior authorization for coverage of Alzheimer's medications, according to officials at the Alzheimer's Association.

RxAmerica and Medco no longer will require physicians to go through the prior authorization process before they prescribe Aricept (donepezil), Exelon (rivastigmine), Razadyne (galantamine), and Namenda (memantine) for Medicare Part D beneficiaries over age 65.

RxAmerica and Medco no longer will require physicians to go through the prior authorization process before they prescribe four AD drugs for patients over 65.

With these announcements, SilverScript, a subsidiary of Caremark, becomes the only national or near-national Part D drug plan sponsor that still requires prior authorization, according to the Alzheimer's Association.

The nine other national or near-national plans do not require prior authorization. Caremark spokesman Dale Thomas said the company is in contact with officials at the Centers for Medicare and Medicaid Services and the Alzheimer's Association but had no further comment at press time.

This summer, officials with the Alzheimer's Association wrote to CMS citing problems that beneficiaries had experienced in getting access to Alzheimer's drugs after the end of the initial Medicare Part D transition period on March 31. The group also noted in its letter that it was "unrealistic and unreasonable" for prior authorization denials to be addressed through the appeals process.

"Neither frail patients nor their physicians can be expected to navigate the plan system and file additional documentation in order to obtain these medications that are on the plan's formulary," Stephen McConnell, vice president of advocacy and public policy at the Alzheimer's Association said in the letter. "The unfortunate consequence will be that patients will not receive the medications from which they will benefit."

Officials at the Alzheimer's Association sent copies of the letter to the three Part D drug plans and received quick responses from RxAmerica and Medco about plans to change their policies, according to Leslie B. Fried, director of the Medicare Advocacy Project of the Alzheimer's Association. While officials at Caremark have yet to make a change in their policy, Ms. Fried said they are in contact with the company and are hopeful they will reverse the policy. "Now they are really an outlier," she said.

Removing prior authorization is vital, according to Dr. Marc Nuwer, professor of neurology at the University of California in Los Angeles. For every prior authorization request, the physician has to go back over the patient records looking for dates and other treatment information. "It's a hassle," he said.

The change being made by some companies is recognition not only that removing prior authorization requirements is good medicine and good public relations, but also that it's good business for the plans, Dr. Nuwer said. ■

Prescribing Generics Can Cut Costs for Part D Beneficiaries

BY TIMOTHY F. KIRN
Sacramento Bureau

SEATTLE — With generic prescribing, a little can go a long way. In fact, by using generics 10% of the time, the Medicare Part D program could reduce drug spending by as much as $2.3 billion, according to an analysis presented at the annual research meeting of Academy Health.

If the generic prescription rate were increased by 10%, it would save the beneficiaries a mean of $41-$55 in out-of-pocket costs annually.

That could be important because the analysis also showed that about 22% of Medicare beneficiaries who used to receive a $600 subsidy for prescription drugs under the previous Medicare program will no longer qualify for a subsidy and 16%-23% will probably end up in what is called the "doughnut hole" of Medicare Part D, where they will have no drug coverage, said M. Christopher Roebuck, an economist with CareMark, Hunt Valley, Md., a leading pharmacy-benefits management company.

To conduct the analysis, Mr. Roebuck and colleagues used data from 37,425 individuals enrolled in Medicare drug discount card programs for at least 6 months, and who had filled at least one prescription. The researchers then assumed those same usage patterns, with some increase in usage when out-of-pocket costs go down, and applied a 3.5% annual rate for inflation.

"We think one of the strong points of our research is that it is based on actual claims data," he said.

The enrollees filled a mean of 19 prescriptions per year, 10 of which were for generic medications and 9 for brand name. The mean total cost for their prescriptions was $849, of which they paid a mean $538 out of pocket.

Depending on the assumption used to estimate how the new coverage might increase use, the analysis suggests that out-of-pocket costs could increase for these beneficiaries by $38 to $187 annually.

Those beneficiaries who are low income and currently qualify for the $600 subsidy could face an increase in out-of-pocket costs in the range of $58 to $86 annually, provided they still qualified for the subsidy.

Those increased costs could mean that some would choose to forgo some prescriptions, decisions that could have health consequences.

On the other hand, if the generic prescription rate were increased by 10%, it would save the beneficiaries a mean amount in the range of $41-$55 in out-of-pocket costs and would decrease the amount spent by Medicare on each beneficiary by $62 to $71.

Extrapolating that to 33 million beneficiaries, Medicare could reduce its spending by $2 billion to $2.3 billion annually, Mr. Roebuck said.

The 10% increase in the use of generics would also reduce the number of these beneficiaries who would get into the doughnut hole by 1%-2%.

The so-called doughnut hole—where Medicare Part D stops coverage—kicks in when a patient has spent $2,250 on drugs and lasts until they have spent $5,100, at which point coverage begins again. ■