Pharmacy Prior Authorization, New Trends Transforming an Old Concept

Pharmacy Prior Authorization is not new. A 2009 meta-analysis by Holtrof et. al. [BMC Health Service Res. 2009; 9: 38. 2009 February 25] found 10 peer-reviewed studies on the financial and/or clinical impact of PA. Today, almost every major health plan in the US has some pharmacy PA process in place. So why is there so much renewed interest in it by payers nationwide, including exploration by State governments like Minnesota?

While RxEOB does not have a definitive answer to this question, working with our health plan clients, we have begun to hear several key themes, including:

- A perceived explosion of high-cost specialty meds, many of whose indications are highly targeted to very specific sub-populations, and many of whom have lower cost options,
- An increased employer/purchaser demand for reduced variation in prescribing behavior and better adherence to evidence-based care,
- Greater adoption of clinical information systems and ASP-solutions by physicians, including e-Prescribing and Computerize Physician Order Entry—exacerbating doctor aversion to paper-based processes,
- A need to better satisfy consumers across the care process, including making managed-access programs more transparent, and,
- Several real-world examples of how the PA process can be effectively automated, increasing throughput many fold with only fractional addition of clinician time.

With more complex, higher-cost drugs on the market there is more pressure on payers to manage them aggressively. The natural solution is to expand Prior Authorization programs. Unfortunately, current manual workflows do not cost-effectively scale. RxEOB research suggests that the average health plan performs annually 40 to 200 PAs for every 1,000 members, varying greatly by line-of-business. Doubling or tripling this rate may not be enough. In some cases, a many-fold increase may be called for. To date, such dramatic expansion is not only expensive for health plans, and burdensome to prescribers, it is also disruptive to consumer marketing efforts.

To resolve this conundrum, several plans have chosen to change the PA process entirely— not simply doing more of the same. In particular, leading plans are embracing e-enabled PA collaboration, including:

- **Initiating PA requests during the care encounter, not at the pharmacy counter.** This creates "sentinel effects" with prescribers while improving the consumer experience. More generally, it allows health plans to inform the prescribers on the evidence use at the most opportune time,
- **Using already digitized consumer health information for the PA process.** Data from existing claims histories, medical management, and provider-based systems can all be used to streamline PA. Doing so improves guideline compliance while eliminating the "paper-chase",
- **Applying rules-based automation to "auto auth" when appropriate.** Doing so increases throughput while allowing pharmacy staff to focus on the more complex clinical situations,
•**Integrating Prior Auth processes with benefit design.** Designing an effective utilization management program requires the synthesis of benefit levels, prior authorization and other managed-access programs—all supported by actionable analytics.

•**Changing how prescribers and consumers access the PA process.** Leading plans are moving from slow, often discarded paper letters/faxes to real-time self-service via the Internet.

Future articles in our RxEOB newsletter will address tactically how plans have accomplished some or all of the above, as well as explore the challenges and decision-points they have faced along the way. Topics will include what criteria to use, auto vs. manual auth, best practices for ePrescribing integration, and reporting & analytics support.

In the meantime, if you are interested in discussing your health plan's PA program with RxEOB, please contact us at newsletter@rxcob.net