ELMCRx Solutions

Slowing the Specialty Rx Freight Train
These Red Flags May Indicate Derailment Ahead

Many HR executives, welfare fund administrators and benefit consultants have healthy cynicism when it comes to PBM's being a trusted financial steward of their Rx spend. The truth is that a PBM could be executing its' job exactly as contracted but Total Rx Spend could still be ready to jump off the tracks. The following provides some insight into systemic weaknesses in the specialty Rx prior authorization (PA) process and identifies some warning signals to look for.

To drive efficiencies, PBM's rely on algorithms and or skip logic to help determine if a specialty drug is applicable to a specific member and their disease state. However, no algorithm can account for all individual patient complexities. In other words, there is a limit to the value of technology in assessing clinical appropriateness due to the complex nature of the disease states for which Specialty drugs are administered.

During the PA process, most PBM's never request verifying documentation. They simply rely on verbal statements from a prescriber's staff or an electronic check list representing that the needed criteria have been met. In addition, the larger PBMs are touting their automated Clinical PA capabilities that completely eliminate the expertise of experienced Clinical Pharmacists.

Related to the above, most PBMs use pharmacy technicians, who may have as little as 3 months of subject matter training, to execute the PA process and not clinical pharmacists who usually have at least 3 to 4 years of education and often another 1 to 2 years of resident training.

When a PA is ready to be renewed, many PBM's are not requesting new labs, requesting updated medicals records nor researching contraindications with new scripts issued to the patient since the original PA was approved.

Finally, it is a common occurrence that appropriate genetic testing isn't being executed. In some instances, this may be related to a loosening of clinical criteria by the PBM in return for price breaks on the cost of a drug from the manufacturer and in return for a better formulary position.

The above practices result in an estimated 20% of PA requests for the most expensive Rxs being approved erroneously, costing employers millions. That's approximately 6-10 Rx's per 1,000 members at an average cost of roughly $40,000 per script or $250,000 to $400,000 in avoidable spend per 1000 members.

Symptoms that a plan may have a problem include Total Rx Spend exceeding 25% of Total Healthcare Spend, Specialty Rx Spend exceeding 35% of Total Rx Spend and requested PA approval rates exceeding 70%. Look for these red flags as indicators of an opportunity to significantly improve plan performance.

A sound Clinical PA review program can eliminate the above inefficiencies, help protect patients clinically and plan sponsors financially. Talk to your consultant about your specialty Rx spend and act on the red flags when they're waving.

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