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Overcoming Obstacles to Medication Access in Dermatology

**Dr. Cheeley:**
Many obstacles can stand in the way of achieving optimal patient outcomes, such as insurance, medication affordability, and health literacy. However, medication access is critical for patients to achieve optimal outcomes. So how can clinicians ensure that their patients receive the needed medications?

Welcome to *DermConsult* on ReachMD. I'm Dr. Mary Katherine Cheeley. And joining me today to discuss the challenges and strategies for providing medication access in dermatology is Dr. Justin Cheeley. He is an assistant professor in the departments of General Internal Medicine and Dermatology, as well as the Director of Inpatient Dermatology at Emory School of Medicine.

Dr. Cheeley, welcome to the program.

**Dr. J. Cheeley:**
Thank you for having me, Dr. Cheeley.

**Dr. Cheeley:**
Let's start off with some background. What are the typical disease states that you treat in your practice?

**Dr. J. Cheeley:**
So I kind of have two practices. I practice outpatient general and medical dermatology, but then I also practice inpatient dermatology on a consultative role, and so those two worlds kind of collide, and the inpatients whom I see I will manage longitudinally outpatient after consulting on them, so I have a pretty wide variety of different diseases and conditions that I see and treat, and I do enjoy the variety. I see anything from acne to hair loss to psoriasis to atopic dermatitis, as well as different forms of connective tissue disease; ulcerative conditions, such as pyoderma gangrenosum; thrombotic conditions, such as calciphylaxis; so a wide assortment of the more straightforward and mundane and those that are more involved and complex.

**Dr. Cheeley:**
All of those disease states are treated with a myriad of restricted medications, even your acne medications, as well as some of the more complex biologics. So how challenging has it been to get those approved by insurance companies?

**Dr. J. Cheeley:**
It's very challenging. Even the more mundane straightforward medications, such as topical steroids or topical antibiotics used in our bread and butter dermatoses—such as atopic dermatitis and psoriasis or an acne—can be very challenging. Sometimes those are just as challenging as getting the pricier biologic medications. From a prescriber's standpoint, prescribing on the patient's formulary is somewhat opaque. It's difficult to see what is going to be covered at the point of writing the prescription, and furthermore, it's difficult to know what the patient is going to have to pay out of pocket. Just because the medication is covered and we get a little green check mark next to the prescription that we write, it doesn't mean that the patient won't have to shell out several hundred dollars for a small

tube of cream, so it's challenging both for topicals as well as for systemic medications.

**Dr. Cheeley:**
That's a great point. Just because we get something covered doesn't necessarily mean that the patient can afford it at the pharmacy, and we're going to come back to that because I want to talk through that some more, but let's first talk through the initial submission. Can you share with us any tips on how to get meds approved through that initial submission?

**Dr. J. Cheeley:**
So I think having an electronic medical record that interfaces with Surescripts is very helpful because that can give me at least a rough estimate of what is covered and what is not at the point of writing the prescription. I have a panel of medications that I have saved as favorites in my little electronic medical record, and it serves as a menu that I have available to treat said patient, and I can see there what is covered through Surescripts and what is not covered, so having that integration is very helpful.

The other thing that is helpful is my documentation. So I know what insurance companies like to check off with their criteria, and I try and document those check boxes, such as tried-and-failed medications, body surface area of involvement. If there are any standard scoring systems that rate severity of a particular condition, I'll try and include those in my documentation, as well as sites involved. So certain body sites are of higher impact to the patient, but then also to the insurance company where genital, hand, foot, and facial involvement carry with it greater weight and are additional check boxes that these mysterious people behind the insurance curtain check off in order to approve or deny the medication I'm prescribing.

**Dr. Cheeley:**
For those of you just tuning in, you're listening to *DermConsult* on ReachMD. I'm Dr. Mary Katherine Cheeley, and I'm speaking with Dr. Justin Cheeley about the challenges of medication access in dermatology.

So let's jump back into the next step in the process. Say you get a denial. I know it's hard to believe. I know you do a great job. But let's say you get denied. Talk me through that appeal step. How would you manage that?

**Dr. J. Cheeley:**
So denials come in different flavors. Sometimes the denial is because of the vehicle I prescribed. So if I prescribe an ointment and the insurance company only covers a cream or I prescribe a spray and it only will cover a gel, then the denial letter usually and hopefully, comes back with the preferred formulary agents, vehicles, concentrations, quantities, quantity limits, dispensation amounts, and then I can easily make that change. Now that's not without its frustrations because the patient is without their medication, and it takes a while to get that letter back.

Other denials can be more challenging, particularly with conditions that don't really have an FDA-approved medication, especially when those medications are expensive, such as biologics and infusions. Those can be quite challenging because the insurance companies like to use FDA approvals; they like to use certain types of drugdex and different guidelines, which may or may not be accurate or up-to-date to base their decision about what is medically appropriate and medically necessary, and so in that situation I'll need to draft a letter of appeal with literature citations of things that are in the peer-reviewed medical literature about why my medical decision-making, choosing said medication is valid and appropriate for the patient.

**Dr. Cheeley:**
Any advice on getting through that denial? Do you have form letters that you use? Or do you just send them back the progress note that you already sent them the first time?

**Dr. J. Cheeley:**
So getting the denial letter is very important because that denial letter tells me precisely why my prescription was denied, and so knowing what criteria the insurance company is basing off of and not just guessing why they denied it is crucial, so making sure my office staff receive that denial letter is important because then I can line by line address those check boxesBut then drafting these letters

of appeal is very time-consuming. I do have to go through a literature search and try to find high-impact journals because it's not enough to just get a peer-reviewed journal to justify my medical decision-making. So when I spend all that work, all that time trying to draft a stellar letter of appeal, I try and immortalize that, so I'm like, "I'm not going to let this work go to waste." And so I have a compendium that I've been compiling where I just remove the specifics regarding the patient's situation, but I have just the general justification for why certain medications need to be given or dosed for a particular condition with the citations already there. That way next time the medication is denied for the same condition, I can just copy/paste some of that information.

**Dr. Cheeley:**
So now let's make a hard left and switch gears. I want to talk about ordering and setting up and getting medications that are given through an infusion center because I know you have those patients as well.

**Dr. J. Cheeley:**
I do. I had the luxury of working in a healthcare system in an academic health center that has its own infusion center, and so communication with the infusion center, them being able to see my documentation, my notes, labs, and so forth, them being able to communicate with me freely, that's great. It's all unified and under one system. However, some patients' insurance companies do require that they go through an insurance-approved infusion company or even like a home infusion company. That's where it gets a little bit sticky because if we thought prescribing on the patient's formulary was opaque, well, knowing what infusion company is covered by the patient's insurance is even more opaque. This is where I really need the patient's buy-in, and unfortunately, I need some medical savviness on behalf of the patient to call their insurance company, ask them which infusion companies are covered and approved and to circle back with me and give me those names of the infusion companies so that I can prescribe the infusion directly through those companies. So there's two different avenues I use. One is our healthcare system infusion company or infusion center, which is more straightforward. Then the other avenue are home infusions, which are much more, I think, feasible, cost-effective, convenient for the patient—especially, when they have to receive frequent infusions, such as IVIg, intravenous immunoglobulins, every month for a couple consecutive days each month but the home infusions, figuring out which home infusion company is covered and approved, that's the challenge.

**Dr. Cheeley:**
So as we end our discussion, do you have any closing thoughts or perhaps more feelings on medication access that you'd like to leave our audience with today?

**Dr. J. Cheeley:**
My personal experience and then what I'm reading in the literature suggests that prior authorizations and denials are skyrocketing. They're really increasing exponentially. I think I saw a statistic the other day where back just 10 years ago dermatologic prescriptions required prior auth in about 15 percent of cases, and now about 70 percent of cases require prior authorization, so it is a challenging landscape.

There's questionable utility with regards to saving money overall. Millions upon millions of dollars are spent in the healthcare system for acquiring staff members to be able to navigate this really complicated field and to spend all this time and manpower to try and get medications covered, and ultimately, it disrupts the physician-patient or provider-patient relationship because the patient is counting on me to give them a prescription that they can obtain, that will be effective for them, that won't induce side effects, that are going to be hard stops for them; but that prior authorization, that medication coverage, the medication access, that's the first taste that they get in their mouth after they leave my office. They go to the pharmacy. Medication is not there. They don't usually get explained why the medication can't be given to them. They think it's some fault on our part that we didn't send in the prescription, and then that fractures that relationship and delays the patient getting better.

Overall, I have negative feelings with regards to medication access and these hoops that patients, providers, and office staff have to jump through, but it is a reality, and there are definitely tips and things I've learned along the way to make that process a little bit less painful.

**Dr. Cheeley:**

And having a wife for a pharmacist definitely helps.

**Dr. J. Cheeley:**
Totally helps.

**Dr. Cheeley:**
So those are some great takeaways when it comes to helping your dermatology patients gain access to the right medicines. I want to thank my guest and my husband, Dr. Justin Cheeley, for sharing his experiences and insights. Thanks for joining me on the couch today.

**Dr. J. Cheeley:**
My pleasure. Thank you for being on my couch.

**Dr. Cheeley:**
For ReachMD, I'm Dr. Mary Katherine Cheeley. To access this episode and others from DermConsult, visit ReachMD.com/DermConsult where you can Be Part of the Knowledge. Thanks for listening.