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Access Challenges & Considerations Associated with Professionally Administered Biologics

Announcer:
Welcome to ReachMD.

This medical industry feature, titled “Access Challenges and Considerations Associated with Professionally Administered Biologics” is sponsored by Janssen Pharmaceuticals.

Here’s your host, Dr. John Russell, who will be discussing treatment access with Rheumatologist Dr. Aaron Broadwell and Michelle Owen, who have received compensation for participation in this program.

John Russell, MD:
Gaining access to treatment can be a complex process, and it’s our job as healthcare professionals to help patients navigate through the steps and obtain the treatment they need. This is ReachMD, and I’m Dr. John Russell. Joining me to discuss treatment access are Dr. Aaron Broadwell and Michelle Owen. Dr. Aaron Broadwell is a rheumatology specialist in Shreveport, Louisiana. Dr. Broadwell, thanks for being here today.

Aaron Broadwell, MD:
Thanks so much for having us.

John Russell, MD:
And Michelle Owen is practice manager for Arthritis and Rheumatology Associates of Palm Beach, Florida, and a board member of the National Organization of Rheumatology Managers. Michelle, it’s great to have you with us.

Michelle Owen:
Thank you so much for having me today.

John Russell, MD:
So let’s jump right in with our core topic today: treatment access. So, based on your experience, Dr. Broadwell, how do you define access?

Aaron Broadwell, MD:
Access to me is a very complicated process. It ultimately involves the patient’s ability to receive a particular medication. I think a lot of it really starts with affordability. In today’s healthcare system, patients have more and more concerns about affordability as far as their different treatment options. Second is the ability to actually access the medication based on insurance. Patients are becoming astute to the fact that many times their insurance may actually dictate which medications they can be on or not be on. Next is this idea around effort. So, effort has a few different aspects. One very important one is the amount of time that a patient has to spend either talking with our office or with an insurance company or a specialty pharmacy to ultimately access their medications. Lastly, then selection is very important as well. Different patients are going to prefer different mechanisms or modes of administration when they are looking at all their various medication considerations.

John Russell, MD:
And how do you define access, Michelle?

Michelle Owen:
Well, my perspective on access is a little bit different from a doctor’s perspective. Affordability is of course one of the biggest issues, and

that brings us right into insurance. The first thing I always look at is the insurance. That will tell me what the odds are for accessibility to that particular product prescribed. The product and payers' rules will determine the effort and the selection, because if the product is first tier on the formulary, it will go through very quickly. However, if the product is not on first tier or requires step edits, there will be multiple steps that need to be completed before the patient can access the product prescribed. Coverage should never be an issue for patients if they have the diagnosis, prescription and insurance. The question is, which drug?

John Russell, MD:
So that's very interesting. It seems like the process can be different for each patient but navigable if they have the right care team in place. I'm curious. Has your definition of and experience with access evolved over time? Let's start with you first, Dr. Broadwell.

Aaron Broadwell, MD:
Increasingly, pharmacy benefit managers, or PBMs, impact what products are covered on formulary and ultimately what products are prescribed to patients. Over the years I've learned to become familiar with my local and regional insurance plans so that I can give my patients a better up-front idea about which treatment they might be able to be on and which ones they can ultimately access.

John Russell, MD:
And, Michelle, what's your experience been?

Michelle Owen:
So my experience over time has really evolved as more and more products come to market and the patient and the physician have more choices. When that happens—Dr. Broadwell is very correct—we have to meet in the middle between the patient and the insurance and the physician. And at the end of the day, that's really what it's all about.

John Russell, MD:
We talked about treatment access in general. Now let's talk about access for a specific treatment: professionally administered biologics. Dr. Broadwell, what tends to be a perception of access when it comes to professionally administered biologics?

Aaron Broadwell, MD:
So there are many perceptions amongst my fellow rheumatologists that due to the known step edit procedures, that a PBM may be regulating the IV or in-office formulary. For instance, many of my colleagues may think that a patient must fail 2 separate subcutaneous products before starting on a different IV product, but usually, access to IV or in-office products are actually regulated by the insurer and not the PBM, so you wouldn't normally have to step through subcutaneous products to get to an IV product. I always recommend that offices run medical benefits. Once that decision has been made, see what's accessible for your patients.

John Russell, MD:
Michelle, what's your perspective here?

Michelle Owen:
Well, I have found, especially now, that access is much better for the in-office IV patient in a lot of ways because patients do not have to sift through multiple drugs in order to find the one that works best for them. There are a lot more guardrails around insurance approvals on the SubQ side in my experience than there are on the IV side.

John Russell, MD:
Dr. Broadwell, what are the primary access-related considerations when it comes to selecting IV and subcutaneous biologics for your patients with RA and PsA?

Aaron Broadwell, MD:
First we're going to consider whether the patient has access under their insurance program or through a pharmaceutical company's program. Then we're going to look at affordability. This could differ vastly from commercial payers to government-associated programs. I specifically try and educate myself on reimbursement and various types of insurance so that I can present the bulk of information to the patient about affordability, etc., up front. I want to be sure I can present all types of different treatment options that would be available based on my knowledge of a particular patient's insurance.

John Russell, MD:
Michelle, what are the most common concerns voiced by patients during your conversations with them about access to treatment options?

Michelle Owen:
Well, I have to say, the most common question from a patient is, "Will my insurance cover this?" followed by, "How long will it take for my insurance to cover this?" We have found that setting clear expectations, especially with brand new patients who have never had a

biologic before and do not understand what a prior authorization is, will lead to a happier patient and a happier office.

John Russell, MD:
Those are very good points. On a related note, Dr. Broadwell, what factors or variables are considered when you're suggesting one biologic over another for your patients?

Aaron Broadwell, MD:
So IV or in-office administered therapies are often times better suited financially for Medicare patients over subcutaneous therapies due to the reimbursement structures involved in the Medicare program. For commercial patients though, I find that both IV and subcutaneous therapies are available options. At times, IV treatment may actually be more affordable than subcutaneous therapy. It's very important to ask patients with commercial insurance what their preference is. Many actually prefer some of the attributes of the IV process versus subcutaneous options.

John Russell, MD:
So, would you say that IV tends to be more suited for a Medicare patient and subcutaneous is more suited for a commercial patient? Dr. Broadwell, what are your thoughts on this?

Aaron Broadwell, MD:
Yeah, so I think we as rheumatologists often times think of our Medicare patients when we're thinking of IV therapies for rheumatic diseases, but we don't really look at that commercial insurance population. We don't ask them about their preferences. So, I'll give you an example. So I saw a patient last week, young female with an active rheumatic disease that needed biologic therapy. I told her what her insurance would possibly cover, and ultimately, she chose to get in-office therapy even though she lives nearly 2 hours from our office because she felt that that was a better therapy suited to her. So, in my clinic I make sure that we keep the option open for our patients and try not to close down our minds about professionally administered treatments.

John Russell, MD:
And, Michelle, what about your perspective on this?

Michelle Owen:
Well, I personally do think that a lot of physicians have a perception that for commercial patients SubQ options are easier to access compared to the IV. And, whenever I run into a physician who says that, I always have to smile because I know that their staff is overburdened. It is difficult to get SubQ medicines. And then I also had many patients who have called and asked, "Can I leave it on the counter? Is it okay?" "I'm having a party, and I don't want anybody to see it in my fridge. What do I do with it?" Many times that patient would rather have something in the office where they don't have to keep it in their home and answer uncomfortable questions.

I would add that in a small office it definitely is a trickle-down effect. The attitude from the staff can add to the doctor's perception on how difficult it is to receive or get access to that medicine. I have had many conversations with physicians who told me that the staff told them they could not get a certain drug, and my response is always, "Well, that's just not true, and you need to ask them, 'Why not?'" The "why not" can be reasons such as it's too burdensome for the staff or the patient didn't answer the phone or there was too much paperwork involved or many other reasons that had nothing to do with access.

John Russell, MD:
So those are very important insights. So, Michelle, throughout these conversations, how do you manage patient expectation about the fulfillment process and their role in it?

Michelle Owen:
Well, for patients who are more sophisticated with the process, we may just provide the phone number for the pharmacy, but some patients do require a little bit more handholding, and we may have to follow-up with the patient many times to make sure they have all the information they need.

John Russell, MD:
That makes a lot of sense and brings me to my next question. How should a practice approach its benefits investigation process of professionally administered biologics versus subcutaneous biologics?

Michelle Owen:
Well, I have one word: accountability. Somebody in the office needs to be accountable for this so when the patient calls they know who to talk to and they're not shuffled all over the office trying to figure out where it is. You want to make sure that there is somebody who is following that process in the office from start to finish.

John Russell, MD:

How important is it to collect accurate and complete information when processing a benefits investigation, and how can that be done?

Michelle Owen:
It's very helpful to have an established process, practice and training on both, and one of the most important components should be documentation from the physician. I will tell you, and I cannot emphasize this enough, I can get whatever I need for my physicians, but I'm only as good as the documentation they provide me. And it is a team effort. It's you and the physician and the patient. We all have to work together to make this a success and to get the medicine to the patient in a timely manner.

John Russell, MD:
When you discuss the benefits investigation process with your colleagues, what are some of the most common challenges, and how can these challenges be addressed? Dr. Broadwell, let's start with you.

Aaron Broadwell, MD:
If it's access, it's mostly the "can you get it or not?" dealing with peers, etc., but when we're talking benefits, I think for me it's making sure that I have that benefits investigation team in our clinic that mainly deals with our in-office biologics. This is a team that I can rely on and know that they're able to investigate different insurances and estimate out-of-pocket costs for the patients.

John Russell, MD:
Michelle, what are your thoughts on this?

Michelle Owen:
Well, the benefits investigation is sometimes very confusing for people, so the first thing you have to say is, "Okay, let's just look at it box by box, section by section. Let's see what it has." That's when you really want to drill down into it and make sure that it has both the pharmacy and the medical benefits on it, and the #1 challenge for a benefit investigation is running it. I know, right? Everybody should be running it, every patient, every time, but once you run, the #1 challenge would be, can you read it? Can you understand it?

Because if it doesn't have both, you are doing a disservice to the patient if that drug comes in both formulations, or it could be more accessible to a patient regardless of the pharmacy or the medical benefit.

John Russell, MD:
So, when you think a product is covered under medical versus pharmacy, do certain challenges come to mind?

Michelle Owen:
Yes, always. When you're considering it, you want to submit it through both medical and pharmacy benefits to make sure you have accurate benefits, and patients need to go with the best medication that will work for their personal disease based on the decision that the doctor and the patient have made.

John Russell, MD:
We've talked a lot about treatment access, and I'd like to pause here and address those who've just tuned in. For those just joining us, you're listening to ReachMD. I'm Dr. John Russell, and today I'm speaking with Dr. Aaron Broadwell and Michelle Owen about access challenges and considerations associated with professionally administered biologics.

We spoke a lot earlier about how to address these challenges. Now let's talk about how you've navigated these complex processes in our current environment. So, given the current environment, Michelle, do you take a different approach when you start patients on a new therapy?

Michelle Owen:
Yes, but the first step is always talk to the patient. You need to talk to the patients. They feel much more comfortable when they come in, have any of their concerns addressed, and have that touchpoint on a more consistent basis. Our new patients on biologics have been very receptive to coming in. They trust that the medication that they and the doctor have chosen is the right one for them, and they want to get on their medication as soon as possible.

John Russell, MD:
Dr. Broadwell, what about you? Do you take a different approach when you start patients on a new therapy?

Aaron Broadwell, MD:
I think in the current environment the experience varies greatly and really depends on the patient. Some patients really prioritize their health. Others seem to have it on the back burner these days. I think highlighting the heterogeneity in all of our patients and even regions is highly important.

John Russell, MD:

So that brings me to my last question. Are there any additional insights that you can share? And what are the biggest takeaways from our conversations today that you want to leave some of your fellow rheumatologists? Dr. Broadwell, why don't you start us out?

Aaron Broadwell, MD:
Yeah, thanks. So, one additional thing I think that's very important is that you make sure and involve your patients in shared decision-making, but in order to do that, you have to have some sort of knowledge about what the patient is going to be able to have. You need to learn a little bit up front so that you can save time in the end. This is something I've really tried to get out to the masses, like the other—my fellow rheumatologists, and I've had a lot of resistance from many of them because they think that's their staff's job. To me, by my learning a little more about the insurance process, I can not only make my staff's job easier but make my job easier and actually be able to put the patient on what I recommended during that clinic visit.

John Russell, MD:
And finally, Michelle, what are your biggest takeaways from today's conversation?

Michelle Owen:
Well, I absolutely agree with Dr. Broadwell. A lot of physicians don't realize that they need to learn about insurance, but once they do, I think they are going to be very surprised. New doctors have shared with me that they are always surprised that the patient actually does have a true opinion in the treatment decision, and it's important that the discussion with the patient about treatment options is complete and addresses safety and efficacy. I think it's important that we take the time to have these conversations as well as those around access.

John Russell, MD:
Those are some great insights for us to think about as we come to the end of today's program. I want to thank my guests for helping us better understand access challenges and considerations associated with professionally administered biologics. Dr. Broadwell and Michelle, it was great speaking with you both today.

Aaron Broadwell, MD:
Thank you so much, Dr. Russell.

Michelle Owen:
Thank you so much for having me.

John Russell, MD:
It was great talking with you both. I'm Dr. John Russell. Thanks for listening.

Announcer:
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