Mythbusting:
ePrior Authorization (ePA)

Designed to manage healthcare costs by creating a barrier to access for high-cost products, prior authorization (PA) has become a leading cause of frustration and treatment delays for providers and patients alike.

The Prior Authorization Landscape

Physician spending related to PA and drug formularies in the U.S. averages

$82,975
PER PHYSICIAN[1]

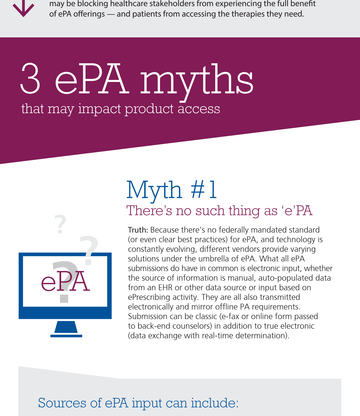
40%
of prescriptions requiring PA ARE NEVER FILLED[2]

86%
of physicians report that PA DELAYS PATIENT CARE[3]

70%
of patients encountering PA DO NOT RECEIVE the initially-prescribed therapy[2]

3x
From 2007-2013, the percentage of drugs requiring PA nearly TRIPLED[4]

The volume of PAs is increasing
20%
YEAR OVER YEAR[5]



While electronic PA solutions hold promise in terms of reducing administrative burden, reducing prescription abandonment and improving outcomes via improved adherence and speed to therapy, some misconceptions exist that may be blocking healthcare stakeholders from experiencing the full benefit of ePA offerings — and patients from accessing the therapies they need.

3 ePA myths
that may impact product access

Myth #1
There's no such thing as 'e'PA

Truth: Because there's no federally mandated standard (or even clear best practices) for ePA, and technology is constantly evolving, different vendors provide varying solutions under the umbrella of ePA. What all ePA submissions do have in common is electronic input, whether the source of information is manual, auto-populated data from an EHR or other data source or input based on ePrescribing activity. They are all also transmitted electronically and mirror offline PA requirements. Submission can be classic (e-fax or online form passed to back-end counselors) in addition to true electronic (data exchange with real-time determination).

Sources of ePA input can include:

Myth #2
Electronic = Instantaneous Result

Truth: In the current challenged state of ePA, true electronic results can only be delivered for a subset of PAs — generally, for established, widely prescribed therapies with well-defined PA requirements that need less qualitative responses. As more payers are driven to accept ePAs by the need to reduce costs, improve care and perhaps government intervention, the future state of ePAs will see more providers submitting electronically as well.

Myth #3
If it's electronic, I don't need a hub

Truth: Even true ePA will not remove all of the administrative burden of PA. Most prescribers need more information than just a status, and integration with hubs goes beyond the first fill to provide patient education, adherence and clinical support, co-pay and coverage assistance and timely reminders for re-authorization — insight that aids in improving outcomes for the patient. Holistic programs account for all stakeholders, offering white glove support to drive PAs to completion and even integrating with pharmacy software to intervene in PA when a prescription is filled to prevent abandonment.

Additional ePA Adoption Challenges

35%
35% of physicians use payer websites; only 14% use EHR or direct electronic submissions[7]

67%
More than two-thirds (67%) of physicians report it is difficult to determine which drugs require PA[8]

$
Vendors charge EHRs for ePA connectivity — a cost sometimes passed along to physicians

As if the state of ePA isn't confusing enough, manufacturers are marketed to with varying claims about what vendors are capable of. What can be done to ensure the best pull-through? The fact is, no one approach fits all.

What's really possible?

Many options exist for supporting therapies that face PA:

- Specialty pharmacy PA services
- "Bridge" or trial support during PA process
- Traditional reimbursement hub & portal
- Automated PA services at pharmacy
- Online PA form aggregators

What should manufacturers be thinking about?

- How will you reach providers with their preferred mode of assistance?
- What is the distribution channel/ point of sale?
- Where does extra support make sense?
- Where can all parties coordinate for a cohesive patient experience?

(1) Cover My Meds. ePA National Adoption Scorecard. October 2015. Accessed 2 December 2015. Available online at https://epascorecard.covermymeds.com/

(2) Ibid.

(3) Ibid 1.

(4) The Henry J. Kaiser Foundation. Medicare Part D Prescription Drug Plans: The Marketplace in 2013 and Key Trends, 2006-2013. 11 December 2013. Accessed 14 December 2015. Available online at http://kff.org/medicare/issue-brief/medicare-part-d- prescription-drug-plans-the-marketplace-in-2013-and-key-trends-2006-2013/

(5) Maryland State Medical Society (MedChi). Prior Authorization Protocols: Impact on Patient Care in Maryland. July 20, 2011. Accessed 14 December 2015. Available online at http://www.medchi.org/sites/default/files/MedChi%20Prior%20Authorization%20Survey%202011.pdf

(6) Ibid 1.

(7) NCVHC Subcommittee on Standards Review Committee. Prior Authorization: The Physician Perspective. 16 June 2015. Accessed 14 December 2015. Available online at http://www.ncvhs.hhs.gov/wp-content/uploads/2015/06/ MCCOMAS-AMA-Panel-1.pdf

(8) American Medical Association. Standardization of prior authorization process for medical services white paper. June 2011. Accessed 14 December 2015. Available online at http://massneuro.org/Resources/Transform%20form%20old%20it/AMA%20White%20Paper%20on%20Standardizing%20Prior%20Authorization.pdf

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