

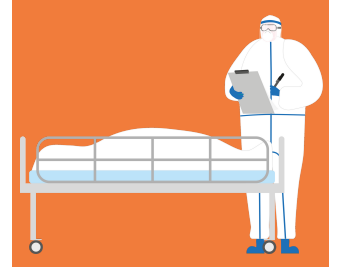
NORTH CAROLINA MEDICAL SOCIETY

PRIOR AUTHORIZATION

STORIES

PRIOR AUTHORIZATION CAUSES PATIENT DEATH.

“After diagnosing the patient with treatable cholangiocarcinoma (bile duct cancer), the physician ordered a standard treatment for the patient. One week later, the insurance company requested a peer-to-peer meeting to discuss the treatment plan. Despite the standard-of-care plan, the insurance company stated that the prescribed regimen was not on its treatment algorithm and would not be approved.



The physician inquired as to alternative options on the insurance company's formulary that would be approved. The physician received no information, with the insurance company citing its 'proprietary' nature. The insurance company then recommended submitting a second treatment plan.

After submitting a second plan, which was also on the NCCN guidelines and considered a standard of care, the insurance company requested another peer-to-peer meeting. The physician's second plan was also refused, and another week passed. The physician asked again for approved treatment plans, and no information was provided.

Two weeks passed before a third peer-to-peer meeting could be scheduled to discuss another treatment alternative. The patient was now one month without any treatment; and his cancer was progressing, his liver function was worsening, and his pain was increasing. With a third call, the physician received the same response that the treatment plan was not on the insurer's algorithm.

The patient's insurance company rejected all of the FDA and NCCN- approved drugs and combinations for this patient's cancer. There were no other recommended therapies.

With no other options, the physician submitted a compassionate use request to the pharmaceutical companies to provide the medications for the patient, which can be a two-week process. A pharmaceutical company ultimately provided the drugs for free, but after nearly six weeks. As a result, the patient's condition worsened, he was no longer eligible for treatment, and he went to hospice.”

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PRIOR AUTHORIZATION

STORIES

PRIOR AUTHORIZATION CAUSES BURNOUT.

“As a board-certified dermatologist, I prescribe medications I feel would be most effective and safe for patients, some of which are biologics for conditions including psoriasis, atopic dermatitis and alopecia areata.

In nearly every instance, a prior authorization is triggered where I must demonstrate to an insurer or PBM why the patient should have coverage for this medication instead of a less effective, less safe, but cheaper medication. It must be explained what medications have been tried, when they were tried, and whether or not they were successful.



I am largely satisfied with my job as a dermatologist, but DEEPLY FRUSTRATED AND DISSATISFIED with the current prior authorization processes. I can understand why a large number of medical providers are burnt out, many of which have left medicine altogether. I am convinced that the process is purposely onerous to dissuade prescribers from using newer, more effective and safer, but more expensive, medications.”

PRIOR AUTHORIZATION CAUSES ADMINISTRATIVE BURDEN.

“When I started practice over 12 years ago our group had one person in our office who spent part of their day scheduling procedures and obtaining insurance pre-authorizations, among other clinical tasks. Now we have two dedicated employees who spend a majority of their day obtaining insurance authorization. They do not have time to work on other clinical tasks in our office and we have had to hire an additional MA as a result. Much of their time is spent on the phone on-hold or filing paperwork for this purpose.



This has increased the cost of overhead expenses in our practice and it unnecessarily delays medically necessary care for our patients.”

NORTH CAROLINA MEDICAL SOCIETY

PRIOR AUTHORIZATION STORIES

PRIOR AUTHORIZATION INTERFERES WITH OPTIMAL CARE.

“Most of my patients are covered with Medicare, and of the options available for overactive bladder treatment, there are only two medications that do not also increase the risk of memory impairment. Often times, my patients experience significant delays in treatment because of the need for prior authorization of these medications. In addition, the guidelines that insurance companies are utilizing in order to judge the need for specific medications are outdated.



Several studies have demonstrated memory impairment with the use of anticholinergic medications in patients over 65. Unfortunately, the majority of the medications that are covered by Medicare and similar plans are on the list that can cause irreversible memory impairment. We are asking our patients to decide between their dignity, their safety and their pocket books.”

PRIOR AUTHORIZATION CAUSES DELAYS IN TREATMENT.

“I had 50 yo woman with a complex ovarian mass on ultrasound suspicious for ovarian cancer and referred her to a gynecologic oncologist who asked me to order a CT scan to expedite her care. Not only was a prior authorization required but I had to speak with a physician from her insurance company and argue about the necessity of performing a CT scan for a patient with a high likelihood of having ovarian cancer. He asked if I had done a biopsy! I explained to this uninformed physician why that would be malpractice.



Another 65 yo patient of mine with breast cancer had her lumpectomy delayed for 2 months due to prior authorization issues.

I am frustrated on a daily basis by insurance coverage obstacles which is extremely frustrating but more importantly the lives of my patients are being jeopardized for the 'bottom line'.”