



Prescription Policy Choices

Best Practices
model policies

PO Box 204
Hallowell, ME 04347

Phone 207-512-2138
Fax 207-622-3302

Email info@policychoices.org
Web www.policychoices.org

**MODEL POLICIES:
PREFERRED DRUG LISTS, PRIOR AUTHORIZATION, AND PROMOTING GENERICS**

PREFERRED DRUG LISTS (PDL)

According to the National Conference of State Legislatures, as of late 2005, more than three-quarters of the states had enacted, authorized or created some type of PDL as part of a cost containment strategy. At least 40 states have some PDL policies that apply to Medicaid and at least 13 states also have sought to use PDLs for other programs, such as programs to provide reduced-price drugs to the elderly or disabled.¹ Another study put the number of states with “enforceable” Medicaid PDLs at 34.² PDLs combined with a prior authorization (PA) program can effectively cut program costs without negatively affecting patient health, as long as needed medications can still be prescribed in a timely manner.

PDL and prior authorization best practices

A PDL should be based on clinical judgments about which drugs that are most effective, and have the least adverse effects, and not just list the cheapest drugs. For example, more than a dozen states are involved in the Oregon Drug Effectiveness Review Project which provides access to clinical data. New York’s PDL law required the state to join the Drug Effectiveness Review Project to insure that PDL decisions would be informed by the best evidence. Other best practices include a minimum of red tape and a quick turnaround on prior authorization decisions to avoid effectively denying access to a needed medication, special rules for the most vulnerable, and a short-term supply of medications while PA requests are pending or awaiting appeal of denial. Effective outreach to medical providers, pharmacists and patients about how the process works is critical to the success of the program. Finally, while it is important to have a transparent review process to determine the criteria used to develop the PDL, it is also important to avoid pharmaceutical industry influence and conflicts of interest in that process.

Cost savings

Maine’s PDL, which has been in place for many years and is one of the most comprehensive, has kept state Medicaid drug cost increases below 3% annually, at a time when the Federal government estimates average annual increases around 13%.³ West Virginia implemented a PDL in 2003 and saw zero percent growth in its pharmaceutical expenses in 2004 compared to a prior annual growth rate of 16%.⁴ The Georgia Medicaid program reduced its prescription-drug costs by \$20.6 million over a one-year period by requiring enrollees to get permission before filling prescriptions for anti-ulcer medications called proton pump inhibitors (PPIs).⁵ Florida has achieved significant savings for its 2.2 million Medicaid recipients with its PDL. Between 2000 and 2002, savings reached almost \$500 million.⁶

Health benefits

Some state PDL effectiveness and safety review processes flagged safety problems with drugs, such as the Cox-2 inhibitors Vioxx, Bextra and Celebrex, well before the FDA raised concerns and took regulatory action.

PROMOTING GENERICS

In 2005 data, 34 of 37 states responding to a survey reported they require the generic to be dispensed when available; most of these allow this requirement to be overridden by the treating medical provider.⁷ Generics are also promoted through preferred drug lists, lower co-pays, and counter detailing.

Major savings are likely in next few years

There is tremendous potential for greater use of generics and significant savings, especially in the next several years, because the patents of many top-selling brand name drugs are expiring - in fact more than \$38 billion in drug sales are expected to lose patents over the next 4 years.⁸ On average, a generic drug costs about \$45 less than a brand name drug and it is estimated that for each 1% increase in generic fill rate, pharmacy spend decreases by 1%.⁹

Examples of savings

According to the generic drug industry, Massachusetts saved more than \$150 million by changing a policy related to the way doctors can prescribe brand drugs when a generic is available, and Texas saved more than \$223 million simply by changing its prescription pads, making it easier for doctors to prescribe generics. Florida saved roughly \$30 million by eliminating special brand name “carve outs” in its Medicaid program.¹⁰ The Georgia prior authorization program for anti-ulcer medications increased the use of generics from 31% to 79% for net savings of \$20.6 million the first year.¹¹

(Updated April 2008)

¹ “Pharmaceutical Preferred Drug Lists (PDLs) - State Medicaid and Beyond,” Compiled by Richard Cauchi, Program Director, NCSL Health Program, revised 9/15/2005.

² Lewis, “The Oregon Blueprint,” at 13.

³ “MaineCare Cost Trend Analysis, Fiscal Years 1998-2004,” Maine Governor’s Office of Health Policy & Finance.

⁴ Pew Center on the States, “Special Report on Medicaid 2006,” accessed on September 11, 2007 at <http://www.governing.com/medicaid/drug.htm>.

⁵ See Medical News Today reporting on January 2005 study in the American Journal of Managed Care, see: <http://www.medicalnewstoday.com/medicalnews.php?newsid=18888>

⁶ Pew Center on the States at <http://www.governing.com/medicaid/drug.htm>.

⁷ Crowley & Ashner, “State Medicaid Outpatient Prescription Drug Policies: Findings of a National Survey, 2005 Update,” (October 2005).

⁸ Express Scripts Report, 2005.

⁹ Ibid.

¹⁰ Source: Generic Drug Association, accessed at:

http://www.gphaonline.org/AM/Template.cfm?Section=State_Affairs&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=1967

¹¹ Medical News Today reporting on January 2005 study in the American Journal of Managed Care, see: <http://www.medicalnewstoday.com/medicalnews.php?newsid=18888>