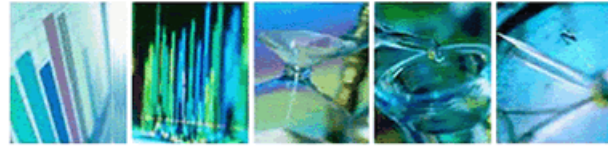




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Strategic Solutions for Managed Markets

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Understanding the True Impact of Prior Authorizations

By Andrew Pecora, Chief Operating Officer

Managed care's efforts to control the use of biologic drugs are mainly focused on ensuring appropriate utilization. The utilization of prior authorization (PA) has become the preferred tool to limit utilization of a specific drug, class of drugs, or particular mode of administration, such as infused therapies.

PA policies serve as a critical driver of – or impediment to – product success. Despite being aware of their influential nature and tracking the presence of a PA, most biopharmaceutical companies do not actively analyze or compare PA policy details, leaving a large gap in their understanding of barriers to access. The specific criteria required for prior authorization by each payer varies greatly and dictates the degree of limitation each payer exerts on access.

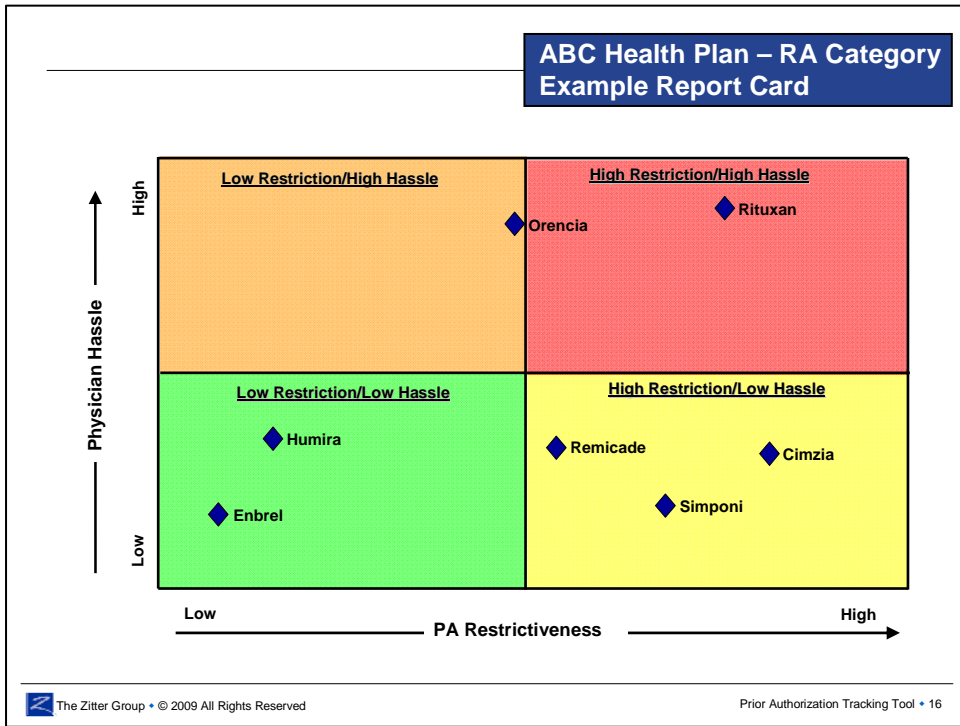
Analyzing PAs becomes paramount in therapeutic areas which have infused and injected or oral agents covered under the medical and pharmacy benefits, respectively. In these cases, drugs covered under the pharmacy benefit are much easier to apply PAs than those covered under the medical benefit. Managed care has relatively greater difficulty administering PAs for infused than self-injected therapies. The PA can be applied prior to filling the prescription on the pharmacy side but not always on the medical side as these claims are adjudicated after the fact. This creates an interesting scenario for manufacturers covered under either benefit.

Is the sheer presence of a PA fatal for a brand? The answer lies in understanding not only the payer's PA criteria but its intent. As stated earlier, payers endeavor to ensure appropriate utilization, so if the entire class of drugs is subject to PA, you're probably fine. If only select modes of administration are subject to PA, such as infused agents, payers are probably driving drugs covered by the pharmacy benefit such as self injected or orals before allowing infusions. If only select drugs are subject to PA with failure criteria for other similar modes of administration, then the payer is probably driving preferred therapies through its PA process.

Will simply understanding PAs from a policy perspective give the full picture of the restrictiveness landscape? Probably not. Some payers strictly follow their PA policies while others put PAs in place for the sentinel effect. The best way to assess whether a payer aggressively adheres to its PA policies is through understanding the resources expended by the specialty practice to fulfill the obligations of the PA – essentially, the specialist's *Hassle Factor*. This *Hassle Factor* can range from an administrative process where an administrative level staff member merely faxes a form to the payer to something as resource intensive as the specialist spending significant time on the phone with the payer's medical director. The ultimate test of the *Hassle Factor* is the influence these restrictions have on the specialist's prescribing behavior for that payer.

Once you understand the restrictiveness of a payer's PA policies for a therapeutic class and the hassle required of the specialty practice, you can segment your market and compare your product's restrictions to its competitors. Figure 1 is an example of this segmentation strategy and shows the results for a hypothetical payer in the Rheumatoid Arthritis category.

Figure 1.



Ultimately, your best access is with those payers that have low PA restrictiveness and low physician hassle. Conversely, your payer access challenges will be those with high levels of restrictiveness coupled with high physician hassles.

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