RA patient experience: Access to medication

Patients face high costs and administrative complexities

After a patient has been diagnosed with rheumatoid arthritis (RA), the next step is to prescribe medication that can slow the progression of the disease. Unfortunately, getting medication to a patient is not easy or straightforward. The high cost of RA drugs and the administrative complexities associated with obtaining (and maintaining) insurance coverage for those drugs are significant barriers to timely and effective RA treatment.

Overview of rheumatoid arthritis medication types

The American College of Rheumatology recommends Disease-Modifying Anti-Rheumatic Drugs (DMARDs) as a first-line treatment for RA patients. DMARDs can slow the progression of RA and save joints and other tissues from permanent damage. However, they can have significant side effects, and it's difficult to predict which drug(s) will work for a particular patient. If traditional DMARDs aren't working, a rheumatologist may prescribe biologic DMARDs (called "biologics"). Biologics target the parts of the immune system that trigger inflammation. They can stop the progression of RA, but they also lower a patient's ability to fight off other kinds of infections.

First-line, or traditional, DMARDs are relatively affordable and usually covered by a patient's insurance. Biologics are far more expensive, with list prices of over a thousand dollars per week. While biologics are typically covered by insurance, usually each payer has a preferred biologic that they require patients to try first. As patients typically stay on RA medication for the rest of their lives, the total cost of biologics over time is a significant burden. Additionally, the cost of RA medications has been rising dramatically. GoodRx estimates that the list prices of all RA drugs have risen 92% from 2014 to mid-2019.

Patient stories: From diagnosis to treatment

Example patient experiences illustrate how treatment can be delayed or interrupted

Prior authorization delays

Arthur, age 58, had advanced RA due to a delayed diagnosis. He was prescribed a DMARD, but his insurance would not approve a biologic unless Arthur failed two different DMARDs[1]. After months of ineffective DMARD treatment, Arthur's biologic prescription was denied again because of problems with the prior authorization paperwork.

Switching insurers

Holly, age 37, had tried and failed several RA drugs before finding one that worked for her. She accepted a new job and switched to a different insurance company. Her new plan required her to try (and fail) several of the same options she had tried previously before approving her current medication.

Aging into Medicare

Rebecca, age 65, had been taking a biologic that worked well for her for several years when she aged into Medicare. Even though her medication was still covered, the out-of-pocket cost was too expensive for her to afford on her fixed income. She stopped taking the biologic and had to work with her rheumatologist to find a cheaper alternative.

1. Sometimes referred to as 'fail first' or step therapy, payers may require patients to try specific medications to see if their condition improves before approving a more expensive medication.

Source: Marsh, T. "Rheumatoid Arthritis Medication Prices Have Nearly Doubled in 5 Years." GoodRx blog. September 2019;

Prescribing prevalence lower than expected, recommended

Nearly half of RA patients are prescribed a DMARD, while only about a quarter receive a biologic

We analyzed 8,000 patients diagnosed with RA to determine which medications, if any, they were prescribed.[1] The relatively low percentage of patients on RA medication deviates from treatment recommendations of the American College of Rheumatology. It is also lower than the targets set by providers like Cleveland Clinic, who aim to have all their RA patients treated with conventional DMARDs and/or biologics in any given year.

However, these low numbers align with research published in *Rheumatology and Therapy* examining treatment patterns of newly diagnosed rheumatoid arthritis patients (Kern et al., 2018), which found that 45% of patients received neither a traditional DMARD nor a biologic in approximately 3.5 years following their RA diagnosis.

DATA SPOTLIGHT

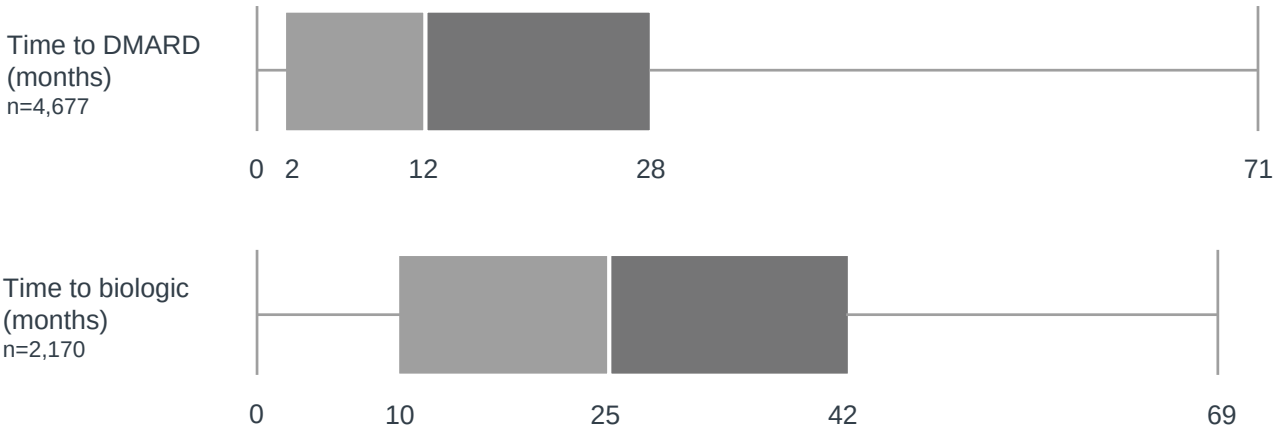
Percentage of patients prescribed a DMARD or biologic within 6 years of initial diagnosis

n=8157

Patients that were not prescribed a DMARD or a biologic during this time period may have opted against taking medication or may have other health conditions that would contraindicate RA medications.

Length of time from rheumatoid arthritis diagnosis to first DMARD or biologic prescription

Five number summary[2] of time to first prescription for patients that received a prescription within the six year study period



Most patients who were prescribed a conventional DMARD received their prescription within two years of diagnosis, with a median time to medication of 12 months. As expected, time to biologic was generally longer, as patients typically try to manage their disease first without a biologic. Nearly half of the RA patients in our cohort who were prescribed a biologic received that prescription within their first two years of diagnosis, with a median time to biologic of 25 months.

1. For a more detailed description of the methodology, see page 4.
2. Minimum, first quartile, median, third quartile, maximum; colored bars represent inner quartile range.

Source: Kern et al., "Treatment Patterns of Newly Diagnosed Rheumatoid Arthritis Patients from a Commercially Insured Population", Rheumatology and Therapy, 2018.

Administrative complexities contribute to medication delays

Prior authorizations and changing insurance coverage are major obstacles to medication access

Because biologics are so expensive, insurers understandably want to ensure that use of the medication is justified before covering it. Often they require providers to obtain prior authorization (PA) before prescribing and administering the drug to their patients. Unfortunately, PAs are administratively burdensome and can delay treatment by days or weeks.

Heard in the research

10-30 days
Time to get an RA prescription to a patient because of delays in PA

16 hours
Average physician and staff time each week spent completing PA requirements

Additionally, because each insurer and PBM[1] has their own preferred biologic products, patients who switch insurers often experience delays in care when they have to re-apply to use a medication that has been working for them. This can lead RA patients, and spouses or parents of RA patients, to avoid changing jobs for fear of losing coverage for a specific drug.

Coverage changes can also be particularly challenging for patients transitioning from employer-sponsored coverage to Medicare. One analysis found that, depending on the specifics of their drug plan, part D enrollees could have out of pocket costs for RA biologics of over $5,000 annually. Some RA patients seek alternative treatments, or delay retirement altogether in order to avoid the high out-of-pocket costs for needed medications.

Pharmacists uniquely positioned to close medication gaps

Proactively provide medication guidance

Pharmacists can identify which patients are likely to be prescribed a biologic soon. Then, before that patients' next appointment, they can let the physician know which biologic(s) would be covered by that patients' insurance.

Prepare and manage appeals for coverage

Pharmacists can help manage the transition of patients between payers by taking on the preparation of appeals if a patients' drug is denied by their new plan. An embedded pharmacist has the time and expertise to advocate for RA patients.

Closing the gap: Parkview Health embeds pharmacists in rheumatology practice

CASE EXAMPLE

Parkview Health
10-hospital health system • Fort Wayne, IN

Parkview recently embedded a pharmacist in their rheumatology clinic. The hope is to close care gaps associated with RA medications by proactively identifying which patients may soon be prescribed a biologic, letting the physicians know which biologic(s) the patients' insurance will cover, and educating patients and caregivers on the process, medication, and proper administration. Pharmacy liaisons (technicians) handle all necessary prior authorizations, appeals, communication, financial assistance and other paperwork until a pharmacists may be needed.

Results from Infectious Disease Clinic suggest model's promise in rheumatology
In Parkview's infectious disease clinic, embedding a pharmacist reduced the turnaround time for medication prior authorization approvals from 5-6 weeks to less than one day

Source: O'Reilly, K., "Survey Quantifies Time Burdens of Prior Authorization," AMA, 2017; Cubanski et al., "The Out-of-Pocket Cost Burden for Specialty Drugs in Medicare Part D in 2019," Kaiser Family Foundation, 2019;

1. Pharmacy benefit manager.

Appendix: Data analysis methods

For this analysis, we used a large clinical dataset of both commercially and publicly insured patients. We identified patients diagnosed with RA for the first time in 2012 (n=8,157). We defined the point of diagnosis as the first visit with a recorded diagnosis of RA.

We analyzed prescribing data for those patients from 2012-2017 to determine how many patients in our cohort were prescribed either a DMARD or a biologic RA medication during the six year study period. For patients that were prescribed a DMARD within the study period, we calculated the time from diagnosis to the first time a provider recorded a prescription for a DMARD (reported as “time to DMARD”). The same analysis was performed for patients who were prescribed a biologic (“time to biologic”).

Note that the reported results represent patients who were prescribed a biologic or DMARD during the study period and does not include prescription fill or claims data.

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