

Dear Patients,

As of May 2008, we have formalized our policy regarding requests for **prior authorizations** for medications. First, we would like to answer several frequently asked questions regarding **prior authorizations**.

(1) What is a **prior authorization**? The concept of **prior authorizations** was developed by third-party payers, better-known as “health insurance companies.” A **prior authorization** is essentially a denial of payment for a medication prescribed by one’s physician. This denial is not based on the effectiveness of the prescribed medicine. Rather, the denial is based on the medicine being “non-preferred” according to the third-party payer. Whether a medicine is preferred or not largely has to do with the cost of the medicine and negotiations between pharmaceutical companies and third party payers.

(2) What happens when payment for my medication is denied and my doctor and I get notified of the need for a **prior authorization**? When this happens, your third party payer sends you and your doctor a form stating that the medication is not covered, but that the doctor may call and/or write back answering a series of questions, and after review the medication “may” be approved.

(3) When a doctor performs a **prior authorization**, what is the process like? The typical process involves approximately 30 minutes of paperwork and telephone time, including the doctor’s and nurse’s efforts, a great deal of that time being spent waiting on hold on the telephone. More often than not, if the patient has not tried a medication on the “preferred” or formulary list provided by the third party payer, the request is denied.

(4) Why do my insurance company and sometimes even my pharmacy tell me that all that my doctor needs to do for a **prior authorization** is to fill out simple paperwork and the process will be complete, allowing me to get my medicine? We do not know why these things are often said. These statements simply are not accurate. If third party payers simply needed an “authorization” from the doctor, it seems that they would accept the doctor’s prescription as that authorization.

(5) Why can’t my doctor keep up with the medicines my third party payer prefers so that **prior authorizations** can be avoided? An insurance company’s preferred medicine list changes frequently, based on cost and negotiations with the companies that make the medicines in question. As stated above, this preferred list has nothing to do with the quality of the medication. Physicians simply cannot keep up with these demands, in addition to taking care of patients and reading to stay up to date with new advances in medicine. Remember, **prior authorizations** involve a series of steps created solely by third party payers.

(6) What should I do if I get notice of a **prior authorization** for one of my prescribed medications? You should contact your third party payer and get a list of preferred medications recommended as alternatives to the one your doctor prescribed for you. Then you should make an appointment with your doctor to fully understand all options available to you. You and your doctor will be more able to make sure you receive appropriate, cost-efficient medical care. Often, a less expensive alternative is appropriate. Sometimes it is not. An office visit can help make sense of an otherwise frustrating, confusing process.

(7) Are there exceptions when I might not need an office visit to address a medication denial by my third party payer? Usually, an office visit is necessary. Occasionally, the doctor may feel the situation does not necessitate an office visit. In these cases, the doctor may attempt to address the **prior authorization** request without an office visit. Because of the significant amount of time required to perform the **prior authorization**, there will be a \$25.00 fee to cover some of the expense. Unfortunately, this fee is not covered by third party payers.

Thank you. We value you as patients and we appreciate your compliance with our new prior authorization policy. We are saddened that the health insurance corporations have created this very frustrating requirement.