# Medicaid policies vary widely for rheumatoid arthritis drugs

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Patients with inflammatory diseases such as rheumatoid arthritis now have many more treatment options than in the past, including biologic disease-modifying antirheumatic drugs (DMARDs). These drugs, derived by modifying substances found in humans or animals, slow progression of the disease rather than simply treating the symptoms. The cost of biologic DMARDs is a major concern because a one month's supply may cost 100 times more than a year's supply of older, non-biologic DMARDs.

While Medicaid regulations do not permit states to completely exclude subsets of drugs, they are able to implement policies controlling the use of selected medications. Prior authorization is one commonly used tool for containing drug spending, with the goal of allowing access to these medications for selected patients while avoiding inappropriate use in others. However, little is known about how such policies are developed or how they affect drug use. A new study examined Medicaid prior authorization policies for biologic DMARDs along with use of selected medications before and after policy implementation. The study was published in the November issue of *Arthritis Care & Research* (http://www3.interscience.wiley.com/journal/77005015/home).

Led by Dr. Michael A. Fischer of Brigham and Women's Hospital and Harvard Medical School, researchers collected data from 49 states and the District of Columbia to determine whether their Medicaid programs had a prior authorization policy for six biologic DMARDs between 1999 and 2005 (before Medicare Part D). For those that had one, they

determined which medications required authorization, when the policy had been implemented and what criteria needed to be met for payment to be approved. The study also included data from the Centers for Medicare and Medicaid Services on drug utilization by Medicaid programs, including all outpatient prescriptions for which Medicaid provided reimbursement.

The results showed that 32 states had implemented or planned to implement Medicaid prior authorization policies for biologic DMARDs, with wide variability as to which drugs were included and the criteria required both in terms of the amount of detail requested and how authorization was determined. In 1999, total Medicaid spending on DMARDs was just over $200 million, a figure which increased to $567 million in 2005. The study also showed that states with prior authorization programs in place at the beginning of the study period had relatively low use of biologic DMARDs initially, but use increased sharply over the years studied, which raises a question about the sustainability of such policies.

"Our results have implications for prescription drug reimbursement policy, both for Medicaid and for other programs," the authors state. For Medicaid, they acknowledge that while clinical decisions regarding the use of biologic DMARDs for inflammatory diseases are complex, the wide variability in authorization criteria reveals limitations in policy development. "It is not clear how state agencies determine which clinical factors are included in the prior authorization rules or how closely these rules adhere to clinical evidence," they note, which may be of particular concern with the transition of many patients to the Medicare Part D program as it would be likely to complicate their care.

"Policy-makers must weigh the costs imposed by these policies in terms of professional time and patient delays of therapy against potential savings on these expensive medications," the authors conclude, adding

that further examination "will be critical to fostering the development of more rational policies in the future, for Medicaid and for all drug insurance programs."

Source: Wiley