How to Get Prior Authorizations for HCV Treatment Removed in Your State

This guide was adapted with permission from [Patients Rising Now's Drug Utilization Review Toolkit] to serve as an advocacy launchpad for anyone who wants their state Medicaid programs to remove prior authorizations requirements for hepatitis C (HCV) treatment.

Key Terms

Prior Authorization: rules put in place by health insurers that require patients to get formal approval from a medical professional before their insurance will pay for a certain medication or type of care.

P&T Committees and DUR Boards: groups that must exist in every state per Federal Medicaid rules to determine their local Medicaid program's drug formulary.

Drug Formulary: a list of generic and brand name prescription drugs covered by a particular health insurance plan.

Drug Utilization Review: the process where DUR Boards and P&T Committees decide what medications their state's Medicaid program will cover and the scope of that coverage.

What are DUR Boards and P&T Committees and why do they matter for HCV elimination?

Federal Medicaid rules require each state to have a Drug Utilization Review (DUR) program that routinely assesses the use, quality, cost, and appropriateness of medications. In some states, the DUR program is run by a DUR Board, and in others, it is run by a Pharmacy and Therapeutics (P&T) Committee. Many places have both entities, and their functions differ state-by-state.

These groups often put rules in place to limit or restrict what medicines their state's Medicaid program will cover. Examples of those rules include prior authorization (PA) requirements, age requirements, and quantity limits. HCV elimination, in part, has been impeded due to the time-intensive process patients must go through to secure a PA that will unlock access to treatment.

That burden has disproportionately hindered access to HCV treatment among people of color, people who use drugs, people who have a history of incarceration, and people experiencing homelessness. Consequently, these historically marginalized communities routinely experience worse health outcomes, including liver damage, liver cancer and death.

How did these people get put in charge of making Medicaid coverage rules?

The people serving on DUR Boards and P&T Committees are typically appointed by their state's governor or the head of their Department of Health. Generally, they aren't required to have any expertise regarding the specific diseases or conditions treated by the drugs they're evaluating, and they may or may not have medical experience. They are required to disclose conflicts of interest to avoid any interference with formulary decisions.

How do DUR Boards and P&T Committees make decisions about medication access?

Again, the specifics of this process vary across jurisdictions, and that's why it's important to know which group(s) are responsible for making these decisions in your area so you can direct your advocacy at the appropriate group(s).

DUR Boards and P&T Committees deliberate their decisions about local Medicaid coverage at meetings that are open to the general public. In these deliberations, they're weighing a potential coverage choice's estimated clinical, economic, and quality of care impacts.

When do these groups meet?

Some meet at regular intervals, and others meet as needed. Schedules are available on each state's Medicaid website and usually posted in the pharmacy section. Typically, states make decisions about entire classes of drugs (like HCV treatment drugs) once a year, but they can do so at any time.

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Ways you can take action

While each state's process is a little bit different, here are some ways to make your voice heard:

Attend a meeting: All of these meetings are open to the public, whether they are occurring in person or virtually. Some states require you to register in advance to attend the meeting. Check the Medicaid website for meeting dates.

Speak at a meeting: Each state has a different process for allowing people to speak at the actual meeting, but assume that you'll have to register in advance. Usually speakers are limited to five minutes at most, so plan accordingly! Practice and time yourself so you have a good sense of how much you'll be able to say.

Submit a statement in writing: Most states have a process in place to submit statements in advance of meetings. Visit your state's board or committee website to see if there are instructions, and if you can't find any, call and ask for help. Be sure to observe any deadlines and requirements on submission length or formatting.

Tips for giving an effective public comment:

Make sure you understand any requirements for the statement. These could include:

- time, page, or file size limits
- format or file type requirements
- how submissions are accepted
- the deadline for submissions

Familiarize yourself with the current board or comittee members ahead of time.

Start by introducing yourself and explaining your connection to the disease.

If possible, draw on personal experience to illustrate what access to treatment would mean for you or a loved one.

Use data and statistics you can verify to highlight the value of expanding treatment access in your state.

Finally, clearly and directly state your request for the board or committee to support Medicaid coverage for this treatment without unnecessary restrictions.

Public Comment Template*

My name is XXX. I am a [patient/caregiver/loved one/health care professional] who has spent XXX years [living/working with/caring for someone] with hepatitis C. [If relevant, add professional background.] I am asking you to remove prior authorization restrictions for hepatitis C medications. Hepatitis C affects XXX people worldwide, and it is simpler to treat hepatitis C than it is to treat diabetes, hypertension and in some cases asthma. Yet, patients and providers must jump through hoops to access lifesaving medication. [Insert statement about how prior authorizations have resulted in delays, denials, and/or interruptions to care].

While [insert state] has made great progress in increasing access to treatment for hepatitis C, prior authorizations continue to be a significant barrier to accessing treatment. Utilization management strategies, including prior authorization, are commonly used to facilitate guideline-adherent therapy of complex and costly therapies. However, as currently employed, they disproportionately restrict access to care for and unintentionally perpetuate stigma against the very communities who need treatment most. As such, I request that the Committee remove prior authorizations for hepatitis C treatment.

*Additional examples of public comment letters that NVHR has submitted to state Medicaid programs and state and federal officials can be found here.

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If you encounter resistance when advocating for prior authorization removal, consider these strategies:

Activate your network: Get as many other patient-focused organizations and individuals involved as you can. Establishing a steady drum beat of support for patients can make a huge difference!

Reach out to state officials and legislators: These rules are made at the state level, so reach out to officials and tell them how you feel about your state's policies. Call, (e)mail, or use whatever other means they've made available to get in touch. Also consider contacting the following people in your state: Medicaid Advisory Committee, Medicaid Director, Secretary of Health, Governor.

Leverage local media: Consider teaming up with other advocates on an op-ed or letter to the editor. Alternatively, you could reach out to a local reporter with background about the stakes this decision has for you or a loved one and give them a tip that you'll be speaking your mind at the next DUR or P&T meeting.

Post on social media: Whether you're documenting your experience, spreading awareness about an upcoming meeting, or drawing attention to recent proceedings, social media can help you spread the word and connect with other advocates. For best results, be sure to tag any people or organizations mentioned, and make use of any relevant hashtags.

Citations

[1] Drug Utilization Review Toolkit. Patients Rising Now. (January 2021). https://patientsrisingnow.org/drug-utilization-review-overview/dur-documents-for-download/.

[2] Drug Utilization Review Toolkit. Patients Rising Now. (January 2021).

[3] Drug Utilization Review Toolkit. Patients Rising Now. (January 2021).

[4] State Medicaid Preferred Drug Lists. Kaiser Family Foundation. (July 2019). https://www.kff.org/other/state-indicator/medicaid-preferred-drug-lists/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[5] Examining Prior Authorization in Health Insurance. Kaiser Family Foundation. (May 2022). https://www.kff.org/policy-watch/examining-prior-authorization-in-health-insurance/.

[6] Use of Pharmacy Vendors and PBMs for Medicaid Fee-for-Service Benefit. Kaiser Family Foundation. (July 2019). https://www.kff.org/other/state-indicator/use-of-pharmacy-vendors-and-pbms-for-medicaid-fee-for-service-benefit/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[7] Ciccarello, C. (May 15, 2021). ASHP guidelines on the pharmacy and Therapeutics Committee and the formulary system. American Journal of Health-System Pharmacy, 78(10), 907-918. doi:10.1093/ajhp/zxab080.

[8] Drug Utilization Review Toolkit. Patients Rising Now. (January 2021).

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