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Editorial

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Many of us remember when a dermatology practice was cash only, and $5 cash was considered appropriate for a specialist. The general practitioner received $2 for an office visit and $4 for a home call. If you recall those days, "dearie you are much older than I." [1]

Not so long ago, the practitioner was confronted with obtaining a referral from the Health Maintenance Organization (HMO) in order to see the patient. Some plans permitted only four such referrals for specialists, annually, so the patient, who might have had a visit or two for gastritis and a similar number of visits for an eye infection, was just out of luck if poison ivy appeared on the scene. [2]

Therapeutics

Dermatologic practice has morphed from concocting a gimish of cream - Was it oil in water or water in oil? - in the side room to electronically transmitting a prescription to the pharmacy, no longer the corner drug store. If we wanted to add 1% menthol to a steroid lotion, the pharmacist could accommodate us, even if there was the possibility of disturbing the emulsion. [3, 4] Along came the insurance company providing the prescription benefits, and the all-powerful benefits representatives decided that this might be dangerous. After all, 10% sulfur in a preparation for treating acne is not permitted, because there had been no clinical studies to demonstrate its benefit. Sulfur had been grandfathered by the Food and Drug Administration (FDA), but the insurance company has issues with its efficacy. [5] The end result is that effective treatment

formerly administered cheaply and promptly are now prohibitively expensive or are unavailable altogether.

Prior Authorization

Few physicians, let alone dermatologists, can quibble with the outlandish costs of prescriptions. Even many generic topical steroids carry prices that might be worthy of a night at a five-star hotel. Insurance company A will pay for the ointment but not the cream; another pharmacy benefit provider will only pay for a different product that they deem similar. Even with the discount coupon provided for the first line treatment, the price is either exorbitant or requires prior authorization or both. [6]

For the topical steroid, this predicament can be circumvented or solved, but for biologics there is a different story. The advent of these agents has proven to be a G-d send. Patients with moderate to severe psoriasis can now lead a normal life, no longer being plagued by scaling or indeterminable itching. Their quality of life has markedly improved, but what happens had when they become refractory to their current biologic. The insurance company only approves of agents in the same class. We now know that if a patient breaks through with one TNF-inhibitor that it is futile to prescribe another. [7] Unfortunately, whoever is reading the request at the insurance company if oblivious to the observation. If it is not on their formulary for reasons that we can only suppose, then the patient is out of luck, that is, unless the dermatologist and the office staff have an all-out battle to obtain the prior authorization. The denial may be reviewed by an alleged outside source where published support is limited to studies done in the United States and published within five years in an American journal.

The problem has become more complex with the approval of a biologic for the treatment of hidradenitis suppurativa. [8] The use of this biologic has improved the quality of life for these patients 100-fold, but the insurance company has zero understanding, as shown in this denial. [9] [10, 11]

> Chart notes documenting your condition including documentation of attempt to control condition with non-pharmacologic interventions such as diet, smoking cessation, temperature control, and antiseptic wash and documentation (including dates dose and duration) of topical antibiotic (such as clindamycin) and/or antibiotics (such as doxycycline, minocycline, amoxicillain-clavulinic acid, clindamycin, rifampin, dapsone) and/or intralesional triamcinolone injections…….

Imagine telling the patient that the soreness, tenderness, and sleeplessness from the axillary or genital lesions is just psychosomatic – stress management could cure the problem. [12] Antiseptic washes, while useful to reduce the bacterial load, are not a panacea, let alone a cure.

Let's go one step further. A simple prescription is not sufficient to authorize a biologic. The application often rivals the army's form for requesting temporary leave (vacation time). Not only

is paperwork redundant and confusing, but it is used for delay and obfuscation. As an example, the initial application was submitted on October 1st. On November 5th, it was returned, due to the need for the patient's signatures. The revised form was returned, once more, only to learn on November 30th that the patient neglected to sign in a fifth space. "Just fax the form, and we'll sign in the spot." "Oh, no! We can't permit this!" George Orwell's *Animal Farm* is alive and well! In our new "improved" health care delivery system, it is almost an afterthought.

Conclusions

What would have happened in the mid 1940's after penicillin had become available? [13] Would the patient with syphilis have been subjected to a year or more of long courses of arsenicals? [14] While medicaments should be used judiciously and there is a limitation to available resources, the welfare and quality of life of the patient should become paramount.

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