Lowering Rx Drug Costs In Dermatology

Going generic may not be a panacea after all.

BY MARK KAUFMANN, MD

The rising costs of prescription drugs is a hot-button issue for patients, providers, and politicians, and many stakeholders are actively working on solutions to help make potentially life-saving medications more affordable. Prescribing generics instead of brand name drugs is often touted as a possible solution, but a recent article in the *Journal of the American Academy of Dermatology*[1] suggests that this is not a particularly effective strategy for dermatologists.

THE DATA

The researchers performed a cross-sectional analysis of population-based claims data from the 2015 Medicare Part D Prescriber Public Use and Summary Files, which contain prescription brand name, generic name, claim count (including refills), and total Medicare spending organized by National Provider Identifier. All generic and branded medications prescribed by dermatologists were identified and divided into seven classes: anti-infectives, anti-histamines, biologics, immunomodulators, retinoids, topical steroids, and other.

Dermatologists comprised 11,769 (1.4 percent) of all providers, accounted for less than one percent (0.8 percent) of prescription drug claims, and $841,534,934 (0.8 percent) of total drug cost. Among prescriptions written by 71 dermatologists, just 2.56 percent were for brand medications, which accounted for 44 percent of the total cost. Less than half (35.6 percent) of dermatologists account for all brand-name prescriptions.

Dermatologists represent a small percentage of Medicare prescribers and account for an even smaller proportion of Medicare Part D drug costs. Compared to other specialties, dermatologists have low rates of prescribing brand medications, with 97.4 percent commonly prescribing generics.

SHARED DATA, SHARED SCREEN

It's hard to draw any other sweeping conclusions from this article. The study authors organized the Medicare Part D data on dermatologists in a useful manner, but the study does have its share of limitations, namely, as the authors point out, the data only represent patients and providers in the Medicare Part D program, which may not be generalizable to all commercial payers. After all, none of the discounts, coupon cards, and other incentive programs that pharmaceutical companies have developed to curb costs are used within the Medicare program. While cheaper than brand names, generics are also costly in their own right, largely because of reduced competition due to consolidation. Given both the rise in generic drug costs, as well as the day-to-day variability in pricing, are we really saving money by shifting from brand name to generic products? Another pertinent issue in the not-too-distant future will be whether biosimilars prove to have any significant savings over their brand counterparts.

Lastly, how often do our patients actually get what we prescribe for them? As a private practice dermatologist, I believe that this is a significant safety issue. Our patients are routinely dispensed a second or third alternative medication, not the one actually prescribed, and this information rarely makes it into the patient's medical record. I can see no reason why physicians should not be able to access the same computer screen that the patient's pharmacist can see at the point of dispensing.

One thing is clear: It is time for the entire House of Medicine to advocate for this technical innovation in an effort to put physicians at the center of the drug cost-containment effort. ■

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1. Powell HB, Adamson AS, Medicare Part D payments for brand and generic drugs prescribed by Dermatologists, Journal of the American Academy of Dermatology (2018), doi: 10.1016/j.jaad.2018.02.041.