

Kansas Department of

# **Social and Rehabilitation Services**

Gary Daniels, Acting Secretary

**House Social Services Budget Committee**  
March 7, 2005

**House Bill 2107 - Prior Authorization for  
Prescription Drugs**

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Madame Chairperson and members of the Committee, I am Scott Brunner, Director of Medical Policy/Medicaid, in the Kansas Department of Social and Rehabilitation Services (SRS). I am here to speak to you regarding HB2107, which would amend KSA 39-7, 120 (a) to change the process for placing prescription drugs on prior authorization or a restricted formulary.

**Background:**

The Federal government allows states to utilize a prior authorization program for prescription drugs and Kansas has used a prior authorization program for pharmaceuticals for many years. Prior authorization (PA) of medications is based on safety, efficacy, indication, potential for abuse, and cost. Before a drug is placed on PA, the Drug Utilization Review Board (DUR) reviews evidence-based information regarding clinical efficacy, safety, Kansas Medicaid utilization data, and input from drug manufacturers. The DUR Board then makes recommendations on the PA criteria for each medication. Kansas Medicaid makes the final determination on whether a drug is placed on the PA list.

The process of placing a drug on prior authorization is considerably lengthened through K.S.A. 39-7,120(a), which requires that any drug recommended for placement on the PA be reviewed through the normal rules and regulation process, including opportunities for public comment and review by the Rules and Regulations Committee. The same statute also requires a 30-day delay in implementing PA for a drug after comments are received from the Drug Utilization Review Board. The process takes anywhere from three to six months. In FY04, 45 drugs were sent through the rules and regulations process. None were rejected.

In 2002, the Kansas Legislature passed K.S.A. 39-7,121(a), which allowed the SRS to develop a preferred drug list (PDL). Implementation of the PDL has significantly increased the number of drugs on prior authorization, because drugs designated as non-preferred on the PDL require prior authorization. As of today, 20 different drug classes are on the PDL and two more new classes will be added in April 2005. Many other drugs require PA (separate from the PDL) to ensure appropriate clinical utilization. Furthermore, drugs in specific classes on the PDL are reviewed annually for new clinical information, new drugs in the class and changes in net pricing. The PDL is a fluid

process and when changes occur in a drug class, drugs that were previously preferred might now become non-preferred and require PA or vice versa. Ten drugs not associated with the PDL were added to require PA in FY04. Currently, there are eighty non-preferred drugs.

### **Benefits of the Change:**

Removing the rules and regulations process for drugs being placed on prior authorization would result in cost-savings to the State, increased safety for the beneficiaries, and decreased bureaucracy.

The cost-savings to the State would result from being able to collect supplemental rebates sooner and shifting the market to the preferred (less costly) drugs sooner. Drug manufacturers offering the State supplemental rebates will start paying these rebates as soon as the preferred/non-preferred drugs in a class has been implemented. For example, in October 2004, the PDL Committee reviewed four classes of drugs. Supplemental offers were made, preferred drugs were chosen and the DUR Board reviewed them in November 2004. The Rules and Regulations process was started and the anticipated date to implement the changes was February 1, 2005. However, the process will not be complete until April 1, 2005. Therefore, collection of the additional supplemental rebate is delayed by six months.

Additionally, when new, expensive medications that are not a part of our PDL are brought to the market, the State would be able to place these on prior authorization sooner if there are clinical concerns with appropriate utilization and/or cost. All drugs placed on prior authorization would still be reviewed by the Drug Utilization Review Board for clinical recommendations. Also, the change would provide more flexibility and increase the ability to react quicker to changes in the health care market.

Another important benefit to the State is the ability to react quicker to serious clinical issues surrounding a drug. The ability to place a drug on PA would allow the State to protect the beneficiaries of Kansas Medicaid. Black box warnings are an example of this. Adalimumab is an immunomodulator for rheumatoid arthritis. It has a black box warning that the drug may increase the risk of serious, life-threatening infections. Patients should be evaluated for latent tuberculosis prior to initiating therapy with the drug. Another example is the drug Accutane, which has a black box warning that there is an extremely high risk of birth defects when pregnant women take this drug. There are many more examples of drugs that have black box warnings and many times these warnings are put on the drugs after they have been on the market for some time. The FDA is currently looking at several drugs currently on the market and considering whether to add black box warnings for various reasons, including increased risks of suicide, liver failure, serious infections, and cardiac problems. It is in the beneficiary's best interest for the State to be able to respond to these warnings in a timely manner.

The proposed change would reduce staff time and paperwork for SRS, Attorney General's Office, and the Department of Administration as well as the Joint Committee on Rules and Regulations. This would decrease bureaucracy and assist in a more efficient State government.

In summary, the proposed changes would be beneficial to the State by increased cost-savings, increased safety for the beneficiaries, and decreased bureaucracy.

Thank you Madame Chairperson. I would be happy to answer any questions concerning the changes.