

# Deciphering Prescription Plans

Helping patients navigate Medicare Part D may improve their compliance with medical therapy.

BY LOUIS B. CANTOR, MD

**A**s a glaucoma specialist, my primary responsibility is to preserve my patients' vision. I am also concerned, however, about how the cost of glaucoma therapy and other aspects of the care I provide affect their quality of life. This article discusses how I work within the parameters set by insurance companies to design treatment regimens that meet my standards of care without straining patients' financial resources.

## DEMYSTIFYING MEDICARE PART D

In January 2006, the Centers for Medicare & Medicaid Services (CMS) rolled out its Part D prescription drug benefit with much fanfare. Designed to give Medicare beneficiaries access to affordable medications, the new program earned mixed reviews from patients and physicians.

Initially, patients were overwhelmed by the enrollment process, and, despite assistance from the CMS, they struggled to choose the plan that best suited their needs. By May 2006, however, more than 31 million of the 42 million beneficiaries who were eligible for drug coverage had enrolled in Part D plans.<sup>1</sup>

I welcomed the introduction of Medicare's Part D program, because I believed it was the next logical step in providing healthcare to older adults. I anticipated that such a huge undertaking, especially one that had a large bureaucratic infrastructure, would initially encounter problems, but I remain optimistic that most Medicare subscribers can benefit from Part D coverage.

The introduction of Medicare Part D was also good news for many of my patients. Approximately 50% of the Medicare beneficiaries in my practice have enrolled in the program. Before the CMS implemented Medicare Part D, most people who used glaucoma medications had to pay full price for their prescriptions. That could mean \$50 to \$120 for a 1-month supply of a single brand-name IOP-lowering drug. Generic medications usually cost less (between \$30 and \$50 per drug per month), but the agents that physicians prefer to use for first-line therapy are usually not avail-

able in these less costly formulations. A lack of prescription benefits could be particularly onerous for the more than 50% of patients who require adjunctive therapy to keep their IOPs low and prevent glaucomatous progression.<sup>2,3</sup>

Under Part D, the CMS contracts with an insurance company to provide prescription coverage to Medicare beneficiaries. In addition to paying a monthly premium to the carrier, participants pay a flat fee (copayment) for each prescription they fill. The copayment varies according to a company's tiered system. Patients generally pay the least for tier 1 (generic) and the most for tier 4 (specialty) drugs. Most companies categorize glaucoma drugs as tier 2 (brand-name drugs, determined by cost and effectiveness) or tier 3 (brand-name drugs that are not usually used as the first line of treatment or that have a generic equivalent).

Patients who can successfully navigate Medicare Part D can pay significantly less for their prescription drugs—unless they hit the dreaded “donut hole.” The standard benefit model for Part D for 2008 includes an initial coverage limit of \$2,510. If patients choose this model and exceed this predetermined threshold, they will be required to pay full price for their medications until their out-of-pocket expenditures total approximately \$3,216. The insurance company will reinstitute a copayment only if patients exceed the out-of-pocket threshold and qualify for catastrophic coverage.

I try to prescribe glaucoma medications that will not only lower my patients' IOPs effectively but will also reduce their risk of encountering their coverage gap and incurring financial hardship. My goal is twofold: (1) help patients save money and (2) improve their compliance with glaucoma therapy.

## BALANCING EFFICACY AND COST

Because independent local and regional companies administer Medicare Part D, their prescription formularies and tiering systems vary. My staff and I try to keep current with the requirement of the plans we encounter most frequently. I also visit the Medicare Web site (<http://medicare.gov>)

TABLE 1. SELECT MEDICARE PART D FORMULARIES IN INDIANA

|                      | Formulary Status (Tier)      |                               |                          |                               |                                |                        |                            |
|----------------------|------------------------------|-------------------------------|--------------------------|-------------------------------|--------------------------------|------------------------|----------------------------|
|                      | AARP Rx Medicare D Preferred | AdvantraRx Medicare D Premier | Aetna Medicare D Rx Plus | Anthem Preferred Premier Plan | Humana PDP Standard Medicare D | United Health Rx Basic | Wellcare Access Medicare D |
| Alphagan P 0.1%      | 2                            | Not covered                   | 2                        | 2                             | 2                              | 3                      | 2                          |
| Azopt 1.0%           | 2                            | 2                             | 2                        | Not covered                   | 3                              | 2                      | 2                          |
| Cosopt               | 2                            | 2                             | 2                        | 2                             | 2                              | 3                      | 2                          |
| Lumigan 0.03%        | 2                            | 2                             | 2                        | Not covered                   | 2                              | 3                      | 2                          |
| Timolol maleate 0.5% | 1                            | 1                             | 1                        | 1                             | 1                              | 1                      | 1                          |
| Travatan Z 0.004%    | 2                            | 2                             | 2                        | 2                             | 3                              | 2                      | 2                          |
| Trusopt              | 3                            | 3                             | 3                        | 2                             | 2                              | 3                      | 2                          |
| Xalatan 0.005%       | 3                            | 3                             | 2                        | 2                             | 2                              | 3                      | Not covered                |

*Note: Information valid as of January 2008. Alphagan P and Lumigan (Allergan, Inc., Irvine, CA); Azopt and Travatan Z (Alcon Laboratories, Inc., Fort Worth, TX); Trusopt and Cosopt (Merck & Co, Inc., Whitehouse Station, NJ); Xalatan (Pfizer, Inc., New York, NY).*

periodically and keep updated printouts in my office and other strategic locations in our clinic.

I always try to minimize patients' copays, especially if I suspect that financial factors may be affecting their level of compliance with therapy. The medications I prescribe most commonly—prostaglandin analogs—are usually classified as tier 2 (\$25 to \$35 copay) or tier 3 (\$50 copay) agents by my local Part D plans (Table 1).

If I discover that a patient is not refilling his prescriptions because they are too expensive, I will review his insurance information and, whenever possible, prescribe a less expensive drug that will offer the same IOP-lowering efficacy. Keeping patients' copays low may help them avoid hitting the "donut hole" in their Medicare coverage.

## CONCLUSION

Studies suggest that patients' persistence with glaucoma therapy may reduce IOP and thus lower their risk of disease progression<sup>4,5</sup> and that several factors, including the cost of medicines, affect these individuals' adherence to therapy.<sup>6,7</sup> As glaucoma specialists, we can work with our patients to minimize the cost of medical therapy, but we must also consider where they rank glaucoma among their health concerns. Many of my patients take as many as six drugs for cardiac and pulmonary disease. The Part D plan that offers patients the least expensive glaucoma drugs may not have the best coverage for their other medications. Patients often must choose a plan that provides the best overall benefits, even if they end up paying more for their glaucoma medication. Anything I can do to simplify their IOP-lowering treat-

ment regimens—medically and financially—may slow the progression of their glaucoma and improve their overall quality of life. □

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1. Bach PB, McClellan MB. The first months of the prescription-drug benefit—a CMS update. *N Engl J Med*. 2006;354:2312-2314.
2. Kass MA, Heuer DK, Higginbotham EJ, et al. The Ocular Hypertension Treatment Study: a randomized trial determines that topical ocular hypotensive medication delays or prevents the onset of primary open-angle glaucoma. *Arch Ophthalmol*. 2003;120:701-713.
3. Lichter PR, Musch DC, Gillespie BW, et al. Interim clinical outcomes in the Collaborative Initial Glaucoma Treatment Study comparing initial treatment randomized to medications or surgery. *Ophthalmology*. 2001;108:1943-1953.
4. Gillespie BW, Niziol LM, Cashwell LF, Lichter PR. Factors associated with intraocular pressure before and during 9 years of treatment in the Collaborative Initial Glaucoma Treatment Study. *Ophthalmology*. 2007. [Epub ahead of print].
5. Schouten JS, van de Borne BW, Webers CA. Noncompliance with ocular hypertensive treatment with glaucoma or ocular hypertension: an evidence-based review. *Ophthalmology*. 2005;112:953-961.
6. Tsai CT, McClure CA, Ramos SE, et al. Compliance barriers in glaucoma: a systematic classification. *J Glaucoma*. 2003;12:393-398.
7. Tsai JC. Medication adherence in glaucoma: approaches for optimizing patient compliance. *Curr Opin Ophthalmol*. 2006;17:190-195.