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COMMENTARY

Who are these guys?

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Is there a dermatologist who doesn't think tretinoin works for acne or that combination therapy with benzoyl peroxide and clindamycin is not better than benzoyl peroxide alone? Is there a dermatologist who thinks acne surgery is "experimental or investigational?" Is there a dermatologist who thinks that clobetasol propionate can be substituted for pimecrolimus on the face? You would have to think so, because most of the insurance companies are relying on a dermatologist somewhere in their ranks to advise them on formularies and other cost control strategies, and these are their actual recommendations.

How about isotretinoin? How many times must I plead for extensions of isotretinoin therapy with insurance companies who still don't understand cumulative weight-based dosing? I got a call the other day from a patient because her insurance company would only pay for tetracycline or minocycline, not doxycycline. Who are these guys? Are they the only ones who didn't hear that tetracycline is no longer available in America? Probably the same advisers who told me to consider using a "generic immunomodulator" before they would consider paying for brand-name Elidel/Protopic.

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I understand the argument that prior authorization may be required for expensive medications. What I don't understand is why we have to get a new authorization each time we escalate dosage for an isotretinoin patient, which makes no sense and wastes everyone's time. In each and every

case, we have to explain this increase to insurance companies as if we were the first physician's office to ever call about it. How does a dermatologist not know this, and if he doesn't know this how is he allowed to be a consultant for an insurance company? I want to know that guy's name. I want to know whose idea it was to require a prior authorization for a 1-week course of prednisone. I refused to call the insurance company, but relented just to have the opportunity to tell the company what I thought of this request.

When an insurance company rejects a request for bare-bones therapy or a simple treatment for acne, the first thing I ask is who is your dermatologist? Who told you this was acceptable? I am still waiting for a reply. I think the late Dr. Bernie Ackerman <http://www.nytimes.com/2008/12/11/health/11ackerman.html?_r=0> had it right when he wrote about dubious and dishonest expert dermatologic testimony in the courts. You can sell your professional opinions for a price, but that price should include public disclosure of your identity. We should hold these people's feet to the fire. Either defend why they think generic benzoyl peroxide/clindamycin and generic tretinoin are not essential first-line therapies, or get out of the way and allow us to prescribe them without wasting 20 minutes on the phone for each patient.

It may be getting worse: A pharmacist told me that this year, insurance companies will stop paying for any form of combination benzoyl peroxide for patients older than 18 years. Ordering online or using specialty pharmacies are temporary fixes and miss the point. It is possible that some of these companies don't consult with a dermatologist at all. In that case, shouldn't that physician consultant be held to the same standard as a dermatologist? To consciously hire a consultant who has incomplete knowledge of the specific needs of specialists is dishonest and unethical. That company and the consultant should be exposed.

The entire specialty of dermatology, through our professional organizations, should insist that if dermatologists are going to manage cases of eczema, acne, and other common skin conditions, that a basic list of required medications be available to us with no hassle, that there be limits on the numbers of medications that require prior authorizations, and that there be justifiable common-sense reasons for limiting access to these necessary and useful medications.

It is ridiculous that we must pay nurses to spend hours on hold with insurance companies so our patients can have access to basic generic medications. The dermatologists or other physicians who believe these medications need prior authorizations should have to explain and justify this once and for all, or be accountable for what can only be described as unprofessional and dishonest conduct, detrimental to patients everywhere.

How about topical tretinoin for adult women? Huge numbers of women need and use this valuable medication for acne, but insurance companies are allowed to deny it to females older than 29 years because some of them use it for photoaging, another of its Food and Drug Administration–approved indications. How is that allowed? It is sexist and insulting and I can't believe this policy is allowed to stand. If I say a patient has acne and needs tretinoin cream, then that should be enough. We should have a formulary of generic medications for the most common conditions that we treat, and every insurance company should be forced to use a minimum formulary list with no restrictions. Expensive medications can have cost controls and should have reasonable limits but the approval process needs to be streamlined.

How do you combat this waste of time? It's not as if these prior authorizations are aimed at responsible cost containment or better patient care. We can have an honest debate about the place for Yervoy and Zelboraf for metastatic melanoma, but you can't debate the place for Elidel and Protopic for chronic eczema on the face. If a company wants to exclude commonly used, relatively inexpensive medications, then they should be forced to reveal exactly who is giving them advice on dermatologic formularies. If the advice runs counter to the universally accepted standards for practice within our specialty, then that dermatologist should be compelled to explain his or her reasoning. I suspect that, in many cases, there is no dermatologist, but that is what transparency and accountability are all about. Exposing insurance companies and third-party pharmacy managers that are misleading us and our patients is an important mission for the future.

There is only one thing I am sure about: It is a waste of time for us to fight these battles one patient at a time. It's time for big fights with big players to fix this problem in a comprehensive manner.

Dr. Goldberg is a dermatologist in private practice in White Plains and Bronxville, N.Y. He has been a member of the Skin & Allergy News <http://www.edermatologynews.com> editorial advisory board since 1995, and he has no financial conflicts to disclose.

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