

February 8, 2017

Senator Vicki Schmidt, Chair
Senate Public Health and Welfare Committee
Re: SB 82 Proponent

Re: Support of SB 82

Dear Chair and Committee Members:

My name is Amber Wagon. I have been practicing as a Nurse Practitioner at Neurology Consultants of Kansas, the largest private neurology practice in KS, for nearly 7 years. I am writing at the request of the National Multiple Sclerosis Society in support of SB 82, which proposes a clear process for medical provider appeals and exceptions to step therapy formularies for prescription drug access. I believe the passage of SB 82 will have a positive impact on patients affected by multiple sclerosis.

MS is one of the top two diagnoses treated at my office. In 2016 we treated over 2200 patients with MS. My experience treating patients with MS has given me valuable insight to the topic of step therapy, as it something I deal with on a daily basis.

To many outside the MS world, it may seem like a relatively easy process to start treatment for MS. Many think it is like treating any other illness where you simply select an approved medication and try it. However, if that's your assumption, you're wrong. There are several factors which must be considered when selecting the appropriate treatment for a patient with MS, including consideration of potential side effects (injection reactions, worsening of depression, cardiac arrhythmias, birth defects even if taken by a male, etc.) ability to administer such medication, access to care for regular monitoring, all of which have potential to affect a patient's ability to succeed with treatment.

A typical office visit includes spending an hour, face to face, with a newly diagnosed MS patient, discussing his or her disease prognosis and deciding which treatment option is most appropriate. This is in addition to providing written education materials and obtaining any necessary labs/testing required prior to starting treatment. Finally, I am able to make a treatment recommendation which best fits my patient's needs and the enrollment process can begin. My recommendation is then often met with resistance from insurance providers stating that the patient must try a cheaper alternative.

I have no incentive for choosing one particular medication over another for my patient. Step therapy procedures by insurance providers are nothing less than undermining, when they have no actual knowledge of the particular patient and his or her needs. They have no concern that such actions are also negatively impacting the patient's confidence in me as their provider. In management of a chronic disease, a good patient/provider relationship is equally as important as choosing the right medication. My job is to keep my patient safe, to be their advocate, and to ensure that they are successful with treatment in effort to reduce risk for MS relapse and progression to disability. It is essential for me to take swift action to do what it takes to help patients maintain their ability to perform activities of daily living, including their jobs, hobbies, and interaction with family/friends. Compliance with MS treatment is crucial, and when insurers add extra steps to the process, they are setting the patient up for negative consequences that can be detrimental to his or her livelihood.

Examples of situations I have personally encountered as a provider where step therapy protocols have contributed negative patient outcomes.

1. Female in early 20's working in the medical field. MRI evidence of disease affecting both brain and spinal cord, but without significant clinical episodes. She had been struggling with medication com-

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Attachment 2-1

pliance with her injectable MS therapy due to trouble tolerating painful injections. I felt that an oral medication was necessary in her case, to increase compliance with treatment so she would obtain full efficacy thereby slowing disease progression and risk for disability. The prescribed treatment was denied by insurance, stating need to trial and fail at least 1-2 more injectable therapies first. I wrote an appeal letter requesting reconsideration. Interestingly, the medical director from the insurance company called me personally a few weeks later, apologized for denying the requested medication, and was going to approve it. His reason for reconsideration was that his mother had MS so he felt a personal connection. What if his mother had Parkinson's or some other disease and he knew nothing about MS? I think we all know the answer would have been a denial of the medication, a continued struggle with poor medication compliance, and potentially irreversible disease progression.

2. Male in 40's. Father of three. Full time employee at a major factory and also coach of his son's football team. He had been stable on an approved daily injectable therapy for years. Unfortunately, his insurer required that he switch to the new formulation of that medication, which requires injections 3 times weekly. With his hectic schedule he has struggled with compliance with 3 times weekly injections, and his insurer will not allow him to return to the daily formulation of the same medication which he prefers. Consequently, he has suffered worsening of his MS, including new balance and gait difficulty, to the point that he has had to give up his coaching job.

3. Female mid 30s. Mother of a two-year-old, wife, and teacher. This patient experienced 2 major clinical relapses two weeks apart in November, while being treated with a first line injectable therapy. Symptoms of relapses included weakness, dexterity issues, and imbalance from vertigo. She didn't feel safe driving or even carrying her toddler. MRI scans confirmed significant increase in disease activity. Based on the new rapid progression of disease, my clinical recommendation was that she be switched to a monthly infusion, which is designed for treatment of rapidly progressing disease and or those that have not responded to a first line treatment. Insurance denied the prescribed infusion, because the patient had not tried and failed other "cheaper alternatives." I wrote an appeal letter and got no response for two weeks. Finally, I called and was told it would be another two weeks before a decision was made on coverage. Later I was told the medication had been denied and that I could write a second appeal letter, and then wait 2-4 weeks for determination of it. Given patient's disease progression, I felt this option was unacceptable. So over the course of several days, I personally spent multiple hours on the phone trying to reach a medical director to perform a peer to peer review in hopes of speeding up the process and obtaining coverage for the infusion that my patient desperately needed. Each phone call was met with a promise that I would hear from someone within 24-48 hours. To this day, I have not received a call back from her insurer. Fortunately, the infusion drug company came through allowing one year of free medication to this patient.

I understand that most insurers deem a Step Protocol as a cost saving measure. However, I challenge you to ponder whether Step Protocols are really cost saving or cost shifting? Requiring treatment with a medication not recommended as the best treatment by the medical provider will result in more rapid progression of disease, leading to increased frequency of office visits, hospital stays, and eventually disability. All of these things will also be costly to the insurer. Instead why don't we allow the medical provider to do his or her job, which is to make an educated recommendation for the patient including an FDA approved treatment that is tailored to meet the specific patient's needs.

I'm not asking for the authority to prescribe a crazy off-label treatment. I'm asking for the removal of unnecessary red-tape to allow me to care for my patients who have entrusted me with their well-being.

Amber R. Wagon, APRN
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