POST-MARKET REVIEW OF AUTHORITY REQUIRED PBS LISTINGS – Medication Services Queensland

Medication Services Queensland (MSQ) is a unit within the Queensland Department of Health. Its responsibilities include liaison with the Commonwealth on matters relating to pharmaceuticals, including the Pharmaceutical Benefits Scheme.

MSQ supports the comments of several contributors to the Terms of Reference review, in that the current criteria for Authority listing are not transparent; neither have revised criteria been released into the public domain. It is therefore difficult to comment meaningfully on this aspect of the review

MSQ offers the following observations and suggestions for consideration:

Harmonisation of Authority requirements

There should be harmonisation of Authority requirements, for Medicines listed in Section 100 (Highly Specialised Drugs) and the Efficient Funding of Chemotherapy (EFC), between the public and private sectors.

Historically, public providers have been able to confirm eligibility through a one-off eligibility statement (called an E2 form in Queensland). When the method of claiming and reimbursement transferred to PBS Online, this eligibility statement was replaced by Streamlined Authority (SLA) for public hospital prescribers. It is difficult to find any reason why private hospital prescribers should require greater scrutiny than public hospital prescribers, and why the SLA method cannot be extended into the private sector. This review gives an opportunity to revisit this situation, and reduce the amount of prescriber's (and DHS staff) time diverted from more productive activity. This particularly applies to the oncology and rheumatology fields, where a high proportion of the medicines prescribed require Authority approval.

Harmonising the arrangement would allow each item to have a single code within a Schedule, thus reducing the complexity and maintenance of the PBS Schedule overall.

Effectiveness (or otherwise) of the phone Authority process

The phone Authority facility is little more than a 'tick the box' process, and acts as a blunt instrument to discourage prescribers from opting to prescribe. Reducing such prescribing may lead to a diminished quality of care. It is counter-intuitive to believe that highly skilled prescribers' participation in a process with a clerk at DHS contributes to quality use of medicines.

MSQ recommends that the telephone Authority system is abandoned completely, and existing Authority items assigned to SLA status, or, in strictly limited circumstances on a case-by-case basis, to an updated version of the written Authority process (addressed further below).

MSQ further recommends that the risk of additional inappropriate prescribing that may occur with the removal of the telephone Authority process be addressed by reinvesting the resources released from telephone approvals to an enhanced audit process of SLA prescribing, with appropriate legal and financial penalties for any found to be abusing the system.

Written Authority

It is acknowledged that certain medicines require stringent control over their prescribing, due to their specialist place in therapy and/or their cost. This is not consistently applied – for example, Ipilimumab (Yervoy), a new treatment for malignant melanoma, already has a SLA code for public hospitals under the EFC, despite having a cost of up to $47,000 per dose.

The requirement to post applications, prescriptions and documents to the Hobart office is an antiquated method of control. Note that Australia Post is seeking to decrease frequency of deliveries, which will further increase the lead time between decision to prescribe and administration of treatment.

DHS should consider, for those medicines still deemed to require Complex Authority approval, the implementation of a web based system to allow prescribers to lodge applications via the internet, and to receive approval via an algorithmic based approval system in real time. Such an algorithm could involve credentialed approval for specified prescribers, embedded into the prescriber number file.

Again, this system should be assertively audited, using resources released from the obsolete system, to ensure that prescribing remains within the approved restrictions.

Seamless dispensing arrangements

MSQ welcomes the announcement that revised arrangements for dispensing antiretroviral medicines and clozapine will be introduced with effect from 1 July 2015. This will mean that patients will no longer be tied to hospitals for their medicine supplies, and will be able to have their prescriptions dispensed in community pharmacy if they so wish.

MSQ recommends that consideration be given to the natural extension of this reform, so that the delineation between the public and private sectors is entirely removed, and that patients may have their prescriptions dispensed at any pharmacy (community or participating public hospital). This will confer several advantages, besides the obvious convenience to patients.

- Public hospitals will no longer need to engage in complex arrangements with third party providers in order to claim chemotherapy items
- Prescribers in public hospitals will be able to use public hospital prescription forms for all patients, irrespective of whether the clinic is private/bulk-billed/public.
- Simplification of the PBS Schedule

MSQ notes that a coalition of 9 health-based organisations have called on the government to remove the delineation between the public and private sectors in this regard, and that the subject is due to be discussed at the November 2014 PBAC meeting.

Single schedule

Many items could appear on as many as five different Pharmaceutical Benefit Schedules (s85, s100 Public, s100 Private, EFC and Repatriation). Removing the distinction between s100 Public and s100

Private would reduce this to four. Given that all items are claimed the same way (via PBS Online), is there any justification for continuing to maintain separate schedules? Items could be listed within a single schedule, with different codes and authority requirements for different indications where appropriate.

A further example of duplication is the entry of several Authority-requiring items on the Palliative Care schedule, which are unrestricted or restricted benefits on the general schedule (e.g. ibuprofen, diclofenac). If there is a need for a separate Palliative care schedule, then it should only contain items not featured on the general schedule.

Summary of response

MSQ has not made recommendations on a drug-by-drug basis, but recommends the following general principles:

1. The lowest level of control deemed suitable should be implemented
2. The telephone Authority system should be abandoned
3. All remaining Authority items should be SLA, unless the revised criteria indicate that a level of control similar to the current 'written Authority' is appropriate
4. The 'written Authority' system should be replaced with a web based (real time)approval system
5. The delineation between public and private sectors should be removed.
6. Consideration should be given to consolidating the current Schedules into a single, or reduced number of, Schedules
7. Welcome the development of transparent criteria for determining the need (or otherwise) for an Authority approval
8. Resources released from simplifying the system should be redirected to active audit of the revised arrangements, to discourage prescribing outside the agreed restrictions.