

Navigating Barriers to Medication Access

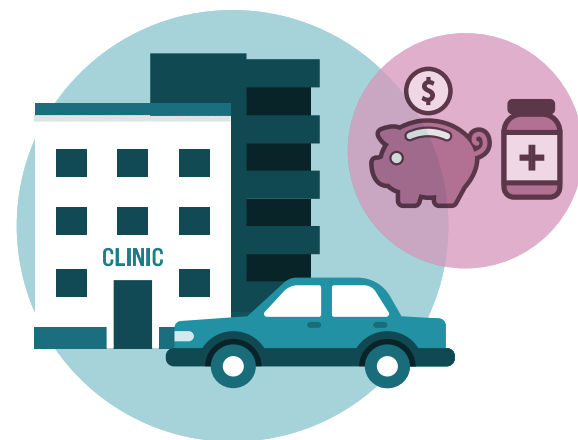
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Patients who face barriers to obtaining medications may be unable to meet A1C goals despite the availability of new pharmacotherapies for diabetes. While there are many **barriers to medication taking** that should be addressed with patients, this document addresses barriers specific to medication access.



These barriers include understanding and navigating insurance coverage, medication costs, and physical access to medications (e.g., difficulty accessing pharmacies because of transportation or delivery service issues). Potential solutions for primary care teams to address these barriers are provided in this document.

Health Insurance and Prescription Drug Benefits

Insurance plans and coverage vary, and health insurance companies' coverage of medications is plan-specific, which can be a challenge for both prescribers and patients. Clinicians can assist patients in understanding the coverage available to them under their specific plan so that they can obtain appropriate and covered therapy more quickly. Ensuring open lines of communication between the patient, provider, and pharmacy, and educating patients on how to understand their coverage can positively impact patient outcomes and experience.

Key Components of Health Insurance

Formulary: Each insurance plan sponsor (commercial, Medicare, or Medicaid) has a list of covered medications for each plan, referred to as the plan's formulary. The formulary is not always publicly available for a specific plan. However, each covered member has access to the formulary for their plan through the Pharmacy Benefit Manager (PBM) but may need to log in through an online portal to access it. Ohio Medicaid and Medicaid Managed Care Plans follow a publicly available Unified Prescription Drug List¹ (**Figure 1**) (see **Additional Resources**).

Understanding how to utilize the formulary can assist primary care clinicians in choosing lower-cost alternatives, knowing the preferred agent within a specific class of medications, and providing more detailed and relevant counseling on a particular agent’s potential risks or expected side effects. Access to the formulary can also decrease the need for prior authorizations that often delay a patient’s acquisition of medications.

Formularies follow a tiered system, with the lowest tier (Tier 1) being the most preferred and usually least costly to the plan and the patient (Figure 2). If a PBM has a three-tiered formulary, it will often be organized in the following way:

- Tier 1: Generic medications
- Tier 2: Preferred brand medications
- Tier 3: Non-preferred brand medications

Prior Authorization: Prior authorizations (PAs) may be required when higher-tier and/or more costly medications are prescribed. PAs mandate that additional information (e.g., lab values, prior failed treatments, or clinic notes) is provided for review by the PBM prior to coverage approval.

Step Therapies: Step therapies are utilized by PBMs to encourage cost-effective medication usage. These are often detected as the pharmacy bills the insurance. For example, a step therapy may require a patient to try and fail metformin prior to a sodium-glucose cotransporter-2 inhibitor or glucagon-like peptide 1 being covered.

Quantity Limits: PBMs utilize quantity limits on certain medications to enhance safety and discourage misuse, waste, and abuse.

Figure 1. Snapshot of Ohio Medicaid Unified Preferred Drug List for 2024

Endocrine Agents: Diabetes — Non-Insulin		
	Preferred	Non-Preferred
Metformin	Glucophage XR (metformin ER)	Fortamet (metformin ER), metformin sol
Sulfonylurea SFU	glimepiride, glipizide, glyburide	
Glucagon-like peptide-1 receptor agonist GLP-1 RA	Trulicity (dulaglutide), Victoza (liraglutide), Byetta (exenatide twice daily)	Adlyxin (lixisenatide), Bydureon (exenatide once weekly), Rybelsus (semaglutide), Ozempic (semaglutide)
Sodium-glucose cotransporter-2 inhibitor SGLT2i	Farxiga (dapagliflozin), Invokana (canagliflozin), Jardiance (empagliflozin)	Steglatro (ertugliflozin)
Dipeptidyl peptidase-4 inhibitor DPP-4i	Januvia (sitagliptin), Tradjenta (linagliptin)	Nesina (alogliptin), Onglyza (saxagliptin)
Thiazolidinedione TZD	pioglitazone	
Amylin analog		SymlinPen (pramlintide)
Alpha glucosidase inhibitor AGI	acarbose, miglitol	
Glinide	nateglinide, repaglinide	

Adapted from Ohio Department of Medicaid Unified Preferred Drug List.¹ Not an all-inclusive list.

Figure 2. Snapshot of ExpressScripts 2024 Medicare Formulary

Diabetes Therapy	Tier	
Acarbose oral tablet — 100 mg	1	MO; QL (90 per 30 days)
Acarbose oral tablet — 25 mg	1	MO; QL (360 per 30 days)
Acarbose oral tablet — 50 mg	1	MO; QL (180 per 30 days)
Alcohol Pads	2	
Bydureon BCISE	2	PA; MO; QL (4 per 28 days)
Byetta Subcutaneous Pen Injector 10 mcg/dose (250 mcg/ml) 2.4 ML	2	PA; MO; QL (2.4 per 30 days)

MO = mail order drug; PA = clinical prior authorization required; QL = quantity limit

Adapted from Express Scripts. Medicare (PDP) 2024 Formulary.² Not an all-inclusive list.

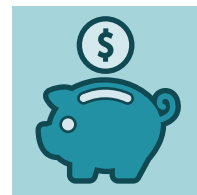
Medication Cost

Medication cost is one of the most common barriers to medication access.³ The remaining cost of a medication after the insurance company has contributed is the patient's responsibility to pay and is either a copay or coinsurance. The following factors can affect the copay for medications: the pharmacy used, the medication formulary tier on the patient's insurance, excluded medications, insurance plan deductibles, and any available coinsurances. The copay amount is often not known until the pharmacy processes the prescription through the patient's insurance plan. For situations in which there is a high copay or coinsurance even after the insurance has contributed, the following resources may help alleviate the burden of medication cost:

Copay Cards: Manufacturers of branded (non-generic) medications often provide copay cards to reduce the patient's out-of-pocket expense. Depending on the program, it can save the patient anywhere from a few dollars to the entire copay amount. Each program has various stipulations. For example, most copay cards cannot be applied if an insurance plan does not cover a medication. If a patient is eligible, they must go to the manufacturer's website to sign up for the copay card and bring the card information to the pharmacy.



Savings Programs: Savings programs, such as GoodRx and SingleCare, are used in lieu of insurance. These programs can provide relief for patients who utilize medication not covered under insurance, as the cost through a savings program can sometimes be lower than insurance copays. To use these programs, patients may need a phone app or website to compare prices and/or obtain a coupon to take to the pharmacy.



\$0/\$4 Medication Lists: Some pharmacies may offer specific medications for low set prices, sometimes lower than patient insurance copays. Each pharmacy has its own list with different prices and included medications. For example, Kroger offers certain blood pressure and diabetes medications for no charge. Other pharmacies may offer certain medications for \$4 for a 30-day supply (\$10 for a 90-day supply). Patients and primary care offices can ask local pharmacies which low-cost medications they offer. For a list of participating pharmacies in Ohio, see [Additional Resources](#).



Patient Assistance Programs: Pharmaceutical companies run Patient Assistance Programs (PAPs) to provide medications at a deep discount to qualifying patients. Each program has varying requirements decided upon by the pharmaceutical company, but most are based on income. An application is filled out and sent to the manufacturer to review. If approved, the patient will get these medications directly from the manufacturer at a steep discount or no cost. For a list of common PAPs, see the [Additional Resources](#).



Figures 3 and 4 outline proposed processes for supporting patients with medications that are too expensive or not covered.

Figure 3. Decision-Making Tree for Troubleshooting Patient Options When Medications Are Not Covered

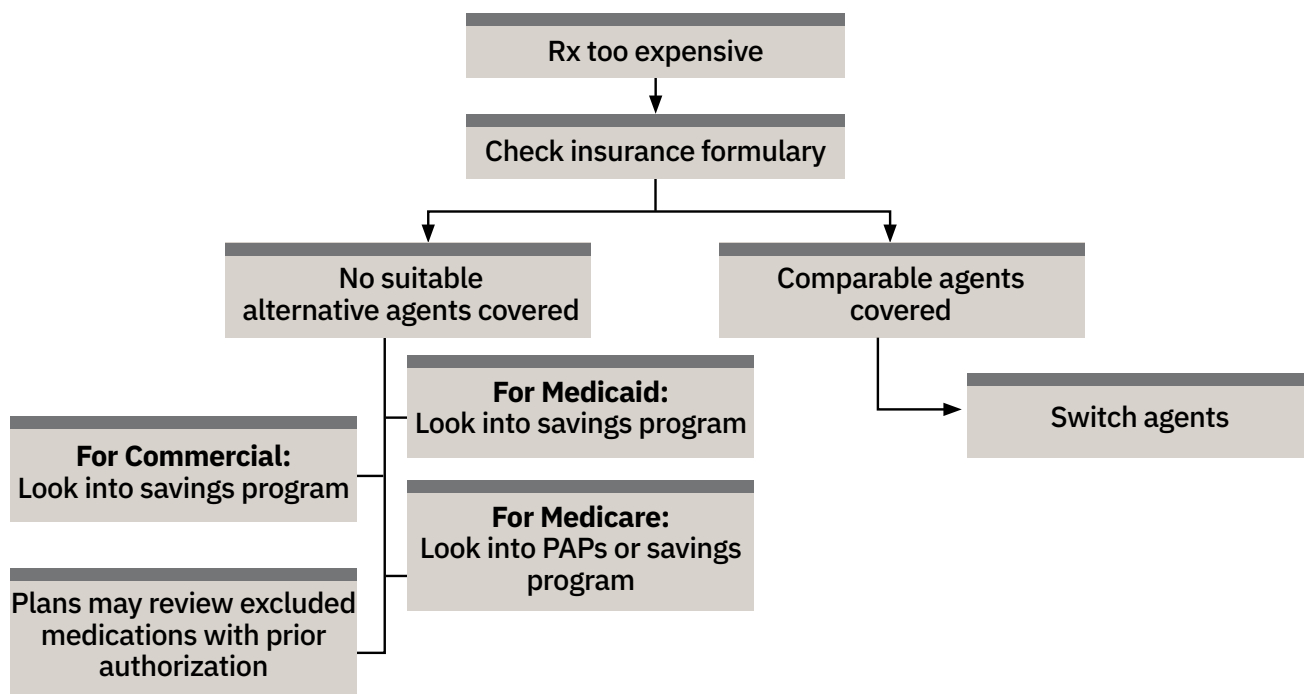
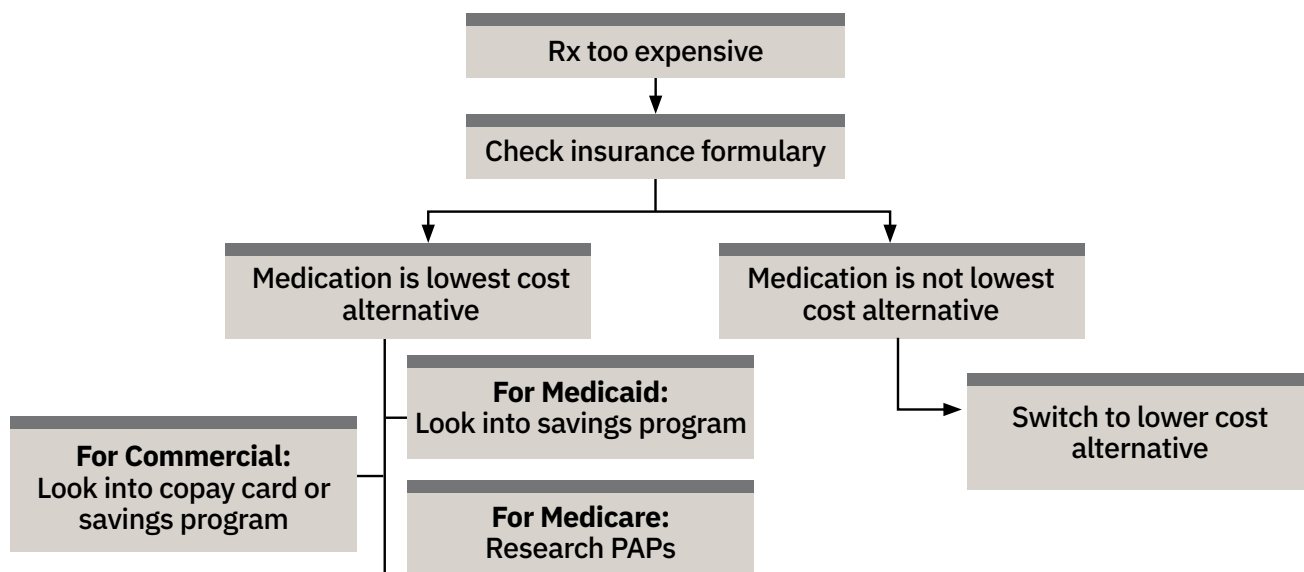


Figure 4. Decision-Making Tree for Troubleshooting Patient Options for Covered Medications That Are Too Expensive



Physical Access

Availability of health care providers can be a barrier to obtaining medication when needed. In 2020, the United States faced a predicted national shortage of 91,000 physicians.⁴ Getting an appointment for a refill can be a challenge when providers do not have available appointments for weeks or months. This is more problematic in rural areas. In 2010, the Agency for Healthcare Research and Quality published data from the census that showed most health care providers are in urban areas.⁵ Access to providers can be improved in offices that are a patient-centered medical home (PCMH) because adequate access is a requirement for PCMH designation.⁶

Even where there are available health care providers, patients may experience barriers due to lack of transportation or limited mobility. While public transportation may be an option for patients who do not own cars in urban areas, those who live in rural areas may not have this option. Telemedicine is another model of care that can circumvent several issues related to access and transportation by allowing the patient to stay in their home.⁷ The landscape of telemedicine continues to evolve rapidly and will likely be a valuable tool in reducing barriers to health care access for vulnerable populations.

Patients who live in rural areas may have even more limited options for pharmacies. Some rural towns may only have one pharmacy, while urban areas can have over 100 pharmacies.⁸

Despite these barriers, primary care offices can improve access to medications so patients can acquire what they need to be successful in their diabetes management. Tactics to limit trips to the pharmacy include:

- Prescribing a 90-day supply of medications for chronic diseases.
- Working with the pharmacy to synchronize medications so that most medications can be obtained in one trip.
- Providing information on home delivery through mail-order pharmacies or local pharmacies.



Access to medications is not just impacted by health insurance and cost. Patients can have difficulty finding available providers or pharmacies, lack transportation, or have medical conditions that lead to limited mobility.

Additional Resources

- Find a Medicare Plan
[medicare.gov/plan-compare/#/?lang=en&year=2024](https://www.medicare.gov/plan-compare/#/?lang=en&year=2024)
- Ohio Unified Preferred Drug List
medicaid.ohio.gov/stakeholders-and-partners/phm/unified-pdl

Discounted Medication Lists

- Kroger
krogerhealthsavings.com/
- Walgreens
walgreens.com/images/adaptive/pdf/psc/Value-Priced-Medication-List-English.pdf
- Walmart
walmart.com/cp/4-prescriptions/1078664

Patient Assistance Programs

- AbbVie
abbvie.com/patients/patient-assistance.html
- Boehringer Ingelheim
boehringer-ingelheim.us/our-responsibility/patient-assistance-program
- Lilly Care Foundation
lillycares.com/available-medications#available-medications
- Merck
merckhelps.com
- Novo Nordisk
novocare.com/diabetes-overview/let-us-help/pap.html
- Sanofi
sanofipatientconnection.com

References:

1. Ohio Department of Medicaid. Unified Preferred Drug List. https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/PHM/drug-coverage/20240701_UPDL_v2_Clean_APPROVED.pdf. Published July 1, 2024. Accessed July 3, 2024.
2. Express Scripts. Medicare (PDP) 2024 Formulary (List of Covered Drugs). <https://www.ohsers.org/wp-content/uploads/2019/10/Express-Scripts-Medicare-Formulary.pdf>. Published August 2023. Accessed July 3, 2024.
3. Sobeski LM, Schumacker CA, Alvarez NA, et al. Medication access: policy and practice opportunities for pharmacists. *J Am Coll Clin Pharm*. 2021; 4:113-125. doi.org/10.1002/jac5.1373.
4. Zhang X, Lin D, Pforsich H, Lin VW. Physician workforce in the United States of America: forecasting nationwide shortages. *Hum Resour Health*. 2020;18(1). doi:10.1186/s12960-020-0448-3.
5. Agency for Healthcare Research and Quality. The Distribution of the U.S. Primary Care Workforce. <https://www.ahrq.gov/research/findings/factsheets/primary/pcwork3/index.html>. Reviewed July 2018. Accessed October 21, 2021.
6. Agency for Healthcare Research and Quality PCMH Resource Center. Five Key Functions of the Medical Home. <https://pcmh.ahrq.gov/page/5-key-functions-medical-home#accessServHeader>. Reviewed September 2021. Accessed October 21, 2021.
7. Health and Human Services (HHS). Benefits of Telehealth. <https://telehealth.hhs.gov/patients/understanding-telehealth/#benefits-of-telehealth>. Updated February 29, 2024. Accessed July 3, 2024.
8. GoodRx. Find a Pharmacy Near Me. <https://www.goodrx.com/pharmacy-near-me/all/oh>. Updated 2024. Accessed July 3, 2024.

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