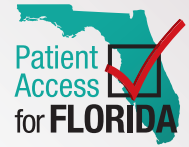


Patients Need the Right Medicine at the Right Time.



“My physician has been treating me for ten years. She knows what my diagnoses are, and how to best treat and cure those illnesses that can be cured. To have my excellent care disrupted with fail first and prior-authorization bureaucratic action is unconscionable and unacceptable.”

- As a Type II diabetes patient prescribed Victoza, Edith had to go through a prior-authorization process twice with her new insurer to receive the same medicine she had been taking, forcing her to go weeks without medication. Her other option was to fail first on a medication that she had never taken and wasn't prescribed to her.
- A health advocate was a necessity for her in wading through the complications of the system.



Edith Gendron
Orlando, FL

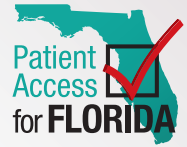
HER STORY

Edith's physician prescribed Victoza for treating her Type II diabetes. She was using this medication when covered by her insurance company. However, upon transfer to a new insurance company, she was unable to obtain a refill in a timely manner due to their determination that this medication needed a prior-authorization. Edith was unable to afford the cost of the medication. She was forced to go two weeks without her medicine or fail first on a medication that she was not prescribed.

“Patients in our state suffer because they have to adhere to limitations on access to medications, prioritizing health secondary to cost. These restraints on access to treatment do not protect patients; they only serve to interfere with the doctor-patient relationship. The treatment decision should be between the doctor and the patient, without bureaucratic interference.”



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“Psychiatric medications are different than other types of medication in that there is more room for trial and error. Most people do not respond equally to the same medication. In fact, it may take as many as three or four tries at particular medications before the psychiatrist finds the appropriate fit. It is very difficult to have a trial and error period due to fail first restrictions”

- David is a Licensed Master Social Worker who has practiced as a social worker for 15 years, and a clinical social worker for 8 years.
- He has worked in a variety of settings, including: outreach programs for mentally ill homeless, outpatient day treatment program for severely mentally ill, and involuntary adult inpatient psychiatric care, as well as in community mental health clinics. He has seen the mental and physical effects that fail first protocols bring his clients.



David Steingart
Tallahassee, FL

HIS STORY

In working with different populations, David has noticed certain commonalities regarding client availability to medications—individuals, who need medication, can’t obtain those specifically prescribed to them by their psychiatrist or physician. This is due to the insurance companies fail first protocols.

“In psychiatric medicine, we must ensure that every client who is prescribed a medication is taking the optimal one that will help manage their symptoms. The key is that each patient must be able to try a range of medications to find the right medications and prevent relapse. The system must allow for the prescriber to override fail first restrictions if we deem the treatment to be ineffective, or detrimental to the patient.”

Often what occurs is the client takes a generic, less effective form of the medication due to fail first protocols. The psychiatrist is then faced with rigorous prior authorization protocols to obtain the most effective medication.

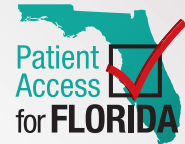
David believes that if a person becomes mentally ill, they should have access to top tier psychiatric medications that work best for their condition—not those determined by a insurance companies protocols.

“Because of being forced into fail first, the number one reason why I see clients hospitalized is that they stop taking medications that aren’t working for them. They are taking less than optimal medications, but they are finding no relief and they cease taking them at all and often slide into relapse. With relapse comes hospitalization and with hospitalization comes greater costs for Florida’s society at large.”



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“We, as physicians, know what is best for our patients. Insurance companies do not.”

- As a rheumatologist, Dr. Levin has first hand experience with the chaos step therapy causes in his patients' lives and the negative health effects that can arise due to step therapy protocols.
- Dr. Levin has devoted himself to raise awareness for the need to change the step therapy procedures in order to provide a stable lifestyle for patients.



Dr. Robert Levin M.D.
Tampa, FL

HIS STORY

Dr. Levin strives to facilitate cooperation between insurance companies and physicians to benefit the patient by filing the proper prescription efficiently.

Dr. Levin is board certified by the American Board of Internal Medicine in Internal Medicine and Rheumatology.

“I don’t think it’s wrong to have approved appropriate choices for the majority of people, but there are cases that it’s not right and the ultimate decision should be between the physicians and the patient. We need some type of recourse to deal with these unique cases.”

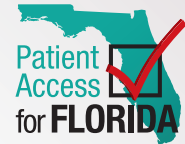
Dr. Levin believes if a patient has already failed on a cheaper alternative, insurance companies should provide patients with the proper medication during the appeal process.

Healthcare professionals have the expertise to know what is best for patients and must have access to a full range of therapeutic options to use as they see fit for their patients. They should not have to jump through burdensome bureaucratic hoops to secure the most appropriate therapy. Ultimately, healthcare professionals, not bureaucrats, should make the determination of the best course of treatment and medications for a patient. We need to ensure Florida’s patients are receiving the right medicine at the right time.



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“The doctors, not the insurers, should be the primary decision-makers in what medication should be used in my treatment.”

- Suffering through mental illness after living a completely normal life, childbirth brought Jennifer a baby and a lifetime of battling the healthcare system for access.
- A broad range of therapeutic options are essential to patient health, as patients often respond to drugs in the same class differently, making a broad choice of medicines necessary.



Jennifer H. Moyer
Navarre, FL

HER STORY

Seven years after the onset of postpartum psychosis, Jennifer was diagnosed with bipolar disorder, postpartum onset. It took several more years of understanding and treatment to become stable.

Jennifer’s previous insurer had formulary and non-formulary approved medications. Her medication, at the time she was insured by that company, was considered non-formulary.

“I would either have to fail first on a medication that was not what my physician wanted or repeatedly appeal the decision in order to gain access to my medications”

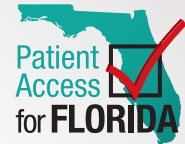
Jennifer almost had to appeal again when her dosage was changed, even though it was the same medication. She was able to talk to a supervisor, and they got the new dosage approved without having her go through the appeal process again. This time she was lucky.

“The doctors, not the insurers, should be the primary decision-makers in what medication should be used in treatment. I believe until this is addressed and changed, access to medication will continue to be a huge barrier for patients. ”



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“Patients have challenges with obtaining the medications we have prescribed, which, in some cases, are life-saving.”

- Dr. Kaplan’s patients can face challenges obtaining the life-saving medication he prescribes.
- Insurance companies often require Dr. Kaplan, like many other doctors, to justify his choice of drug when prescribing medicine his patient needs.
- Dr. Kaplan wants to see all insurance companies use a universal form for medication claims.



Benjamin Kaplan, MD
Orlando, FL

HIS STORY:

Dr. Kaplan often prescribes medication for his patients, but when a medication that he prescribes isn’t on an insurance company’s formulary or may cost that insurance company too much money, he must justify his choice of drug. This justification is documented in a form called a prior authorization, giving the insurance company direct reasoning as to why a particular patient should be on that specific drug.

Dr. Kaplan says that in the current state, it seems as though each insurance company has a different form for different medications, and these forms are always changing. This paperwork has resulted in countless wasted hours of his time that could otherwise be spent taking care of patients. Streamlining this process will allow Dr. Kaplan to get back to patient care instead of hunting for the right form.

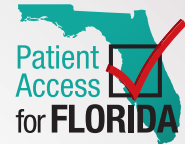
Ideally, if the bill is passed, a universal form will be created and readily available for all physicians to download from the insurer’s website. All insurance carriers would be required to accept this standard form for every claim that requires prior authorization. This would save the physician and his/her staff from countless hours of tracking down forms and filling out these forms to the insurer’s satisfaction.

“We should all find ways to work together as a team because at the end of the day we are all interested in the same thing – patient care!”



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“It took me approximately two months for the doctor’s office to get the prior authorization paperwork completed because the insurance company kept arguing with him about prescribing Reclast when there were less expensive options available to the patient.”

- The generic oral drugs for Mari’s osteoporosis were not an option due to her suffering from negative reactions.
- Mari suffered for months untreated as she waited for the medication her physician indicated was her only option .
- An advocate was essential to help her fight for her necessary medication, without having to pay substantial prices—not only financially but also with her health.



Mari Velar
Tampa, Florida

HER STORY

At a young age, Mari was diagnosed with osteopenia. Mari’s physicians attempted treating her disease with generic oral drugs, but every drug that she tried resulted in a negative reaction. Soon after the doctor’s initial diagnosis, Mari was notified that she had developed osteoporosis. After many failed attempts with insurance approved generics, Mari’s only option was Reclast, an IV drug that is infused annually. Mari’s physician made it clear that Reclast was her only option.

For several months Mari’s osteoporosis went untreated while she relentlessly battled the insurance company for authorization of a Reclast prescription. After receiving authorization for Reclast, she was faced with another hurdle. Mari was charged with the highest tier level of copay, even though Reclast was listed as a lower copay approved drug. Mari did not win the battle for lower copay.

Unfortunately for Mari, her troubles did not end there. She had to restart this burdensome cycle again when she was forced to find a new doctor and a new insurance company. Mari is prescribed Reclast annually, not the stress and troubles of receiving prescription authorization. Mari and others need to receive the care they need, when they need it.



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“The most difficult moments in my life have been watching my daughter being forced to go through step therapy and end up back in the emergency room over and over because her seizures were out of control.”

- Nicole and her daughter both suffer from epilepsy, and have navigated the health care system to ensure they get the right medicine.
- The most difficult moments Nicole has faced as a parent was to watch her daughter be forced to go through step therapy and end up in the ER because her seizures were out of control.
- Her father suffered two years due to fail first before he could get the medication to clear up his severe psoriasis.



Nicole Hill
Tallahassee, FL

HER STORY

Nicole is a mother, daughter, wife, fierce advocate and former Program Administrator for the Florida Department of Health. Her daughter was diagnosed with epilepsy six years ago, and four years later she was diagnosed with the disease as well.

The wrong medication can cause negative side effects and symptoms that affect a patient's quality of life. Side effects can include anything from tremors to personality changes. Every person's chemical makeup is different, and each medication will affect them differently. It's important that people have access to medications that work for them.

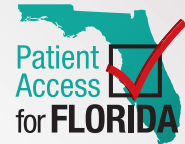
In addition to Nicole's struggle with getting the right treatments for her daughter and herself, she has seen her father struggle with receiving the right treatment for his psoriasis. He had to 'fail first' for a period of two years on a medicine that wasn't working before he was allowed to take the medicine he needed.

“Patients in our state suffer because they have to adhere to limitations on access to medications; health is secondary to cost. Patients need the right medicine, at the right time.”



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“When the formulary requirements changed, I had to fail first on one treatment, losing a year of access to advanced medicines.”

- As a long-time hepatitis C patient, Pam had to fail first on one treatment, losing a year of access to advanced medicine.
- The dangers in fail first and need for education inspired her to dedicate her life to helping other patients across the nation.
- As a patient who is high-risk for thyroid issues, she had to choose to pay for a thyroid test out of pocket instead of pay her electric bill because Medicare would not cover it.



Pam Langford
Tallahassee, FL

HER STORY

Pam was diagnosed with hepatitis C more than 40 years ago, and knows all too well the impact of this disease as president of Hepatitis Education Awareness and Liver Support (H.E.A.L.S.) of the South. She is a tireless advocate for hepatitis patients and spends most of her time educating others about hepatitis.

In December 1998, she had an issue gaining access to a newer Hepatitis C treatment. Ribavirin had recently been approved to be added to Interferon, a medicine that treats hepatitis C. However, her insurance company required her to go through step therapy. She had to take Interferon only for one year and fail first before she could get the superior Ribavirin/Interferon treatment her doctor wanted to prescribe.

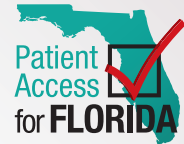
Her issues to quality care and proper care did not end there. A few years ago, Medicare would not pay for Pam's thyroid test, even when symptoms were present and the doctor ordered it. Pam had to pay \$125 out of pocket, which is a significant amount for someone on SSDI.

“These restraints on access to treatment do not protect patients; they only serve to interfere with the doctor-patient relationship. I believe any treatment decision should be between the doctor and his/her patient, without interference.”



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“I was subject to over 50 denials of specific doses of a new generation antipsychotic medication that I was successfully stabilized on in 1998. I was required to take dose levels that were cheaper but had disastrous side effects due to Fail First protocols.”

- Diagnosed schizophrenic with bipolar disorder, Peggy has struggled for years to receive the proper medication to help her stabilize, failing on over 30 medications before finding two that stabilized her.
- After over 50 denials, Peggy reached out to numerous folks to help her secure the approvals necessary to receive the medication she required.



Peggy Symons
DeLand, FL

HER STORY

Peggy is a diagnosed schizophrenic with bipolar disorder for 40 years with a history of suicide and emerging mental illness with improper medication.

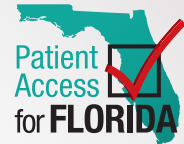
As a dual eligible Medicaid patient she was transferred to a Medicare Part D plan and was told that there would be no restrictions on her medication. Immediately after she transferred to Medicare Part D, Peggy faced barriers to her medication and repeated denials. This continued for over 50 denials despite the appeal of her physician noting the dangerous side effects from the cheaper brand of medication suggested.

After months of fighting the battle alongside her doctors, Peggy was finally approved for the proper stabilization medication. Patients need the right medicine at the right time to ensure the best and most efficient course of treatment.



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“Everyone just pointed fingers. My wife needed care, and instead we were met with bureaucracy. Patients shouldn’t have to fight to see benefits that they should receive through their insurance policy.”

- Seymour’s wife has scleroderma, and she was prescribed a medication by her doctor that needed prior authorization.
- It was very difficult for them to obtain access to medication through their insurance.
- Patients and physicians shouldn’t have to deal with long, confusing prior authorization processes.



Seymour Schulman
Boca Raton, FL

HIS STORY

Seymour’s wife has scleroderma. Her doctor wanted her to take the generic form of mycophenolate, which is prescribed to suppress the immune system for organ transplant recipients and is also used to treat scleroderma. Their insurance company required a prior authorization form.

They intentionally chose their insurer based on which they thought would make it easiest to access the medications they needed. After signing up for the program, the insurance company didn’t want to cover the medication and a long battle ensued.

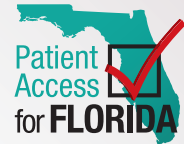
The Schulman’s went into panic mode. Seymour began to stress about how he was going to get his wife the medication she required when she needed it. It took days of calling, for the insurer to provide an interim plan for Seymour’s wife to receive only a 30-day supply of the medication, while they waited for a more permanent plan.

Patients and physicians shouldn’t have to deal with long, confusing prior authorization processes and bureaucracy to get the care they need.



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“Prior authorization and fail first protocols are primarily paper-based, and are extremely inefficient. Studies have shown that the prior authorization process is costing the health care system between \$23-31 billion per year, which equates to about \$85,000 per physician. The insurance companies utilize fail first and prior authorization protocols to save costs by delaying or denying a patient’s treatment.”

- As a rheumatologist who treats patients with chronic and debilitating arthritis, Dr. Saxe understands the importance of prescribing medications that are able to help his patients and improve their quality of life.
- Dr. Saxe believes that two protocols used by insurance companies to reduce their costs – prior authorization and step therapy – are responsible for placing a heavy burden on medical providers and unnecessarily interfere with a physician’s ability to provide effective treatment.



Philippe A. Saxe, M.D.
Delray Beach, FL

HIS STORY

Throughout Dr. Saxe’s career, he has had to deal with time consuming phone calls, emails, faxes, and inputting data to meet the prior authorization requirements in order to keep his patients healthy. Dr. Saxe understands the importance of continuity of care and the debilitating effects of fail first and prior authorization protocols. These protocols may result in a patient’s condition deteriorating and being hospitalized.

“We need a system that puts the physician in charge of fail first protocols by allowing us to override fail first restrictions if we deem the treatment to be ineffective. Insurance companies should also be required to maintain an accurate and updated list of providers on their website so that patients can make informed decisions as to which health insurance product to purchase.”

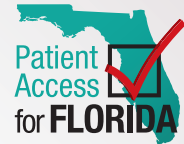
Although chronic diseases such as rheumatoid arthritis and osteoporosis cannot be cured, the specialized medical care from their rheumatologist can ease pain and improve the quality of life of his or her patients.

“It is time to reform existing prior authorization and first fail protocols which are burdensome, expensive, and inefficient. Legislators must ensure our patients receive the necessary care recommended by their physicians in a timely fashion so they no longer needlessly suffer.”



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“It was distressing and unbelievably frustrating to watch my child suffer and physically deteriorate while waiting an unreasonable amount of time for our insurance company to approve treatment, which was necessary and already proven to be successful in treating her condition.”

- Susan’s daughter, Emily Bernstein, has juvenile dermatomyositis.
- Emily had a treatment delay while waiting for the insurance company to approve her treatment on an outpatient basis.
- This resulted in a prolonged period of suffering culminating in an unnecessary and expensive hospital stay.



Susan Baum
Orlando FL

HER STORY

After suffering with increasing pain and weakness for two years with little success from numerous types of therapies, Emily’s treating physician recommended IVIG therapy. The treatment diminished the incapacitating severity of her pain and profound weakness in a remarkable fashion. Susan worked with a doctor who was willing to provide the treatment on an outpatient basis to reduce costs and better accommodate her daughter’s rigorous high school studies.

Repetitive attempts were made to obtain the authorization for outpatient treatment over the subsequent weeks from their health insurance company.

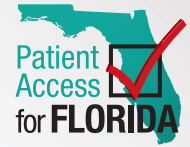
While still waiting for approval for the treatment, Emily nearly collapsed from pain and weakness at her treating physician’s office. Emily had to be rushed to the Emergency Room where she was immediately admitted for two days and provided with the IVIG treatment. The inpatient cost for that treatment was approximately \$80,000. Susan estimates that the exact same treatment that she had arranged as an outpatient at Florida Hospital Cancer Center would have cost approximately \$7,000 and prevented her daughter from having to go through weeks of suffering.

“There needs to be reasonable guidelines in place to protect patients from unnecessary delays in obtaining timely treatment which they pay for and are entitled to.”



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“The specifics of what transpires with my son’s mental illness crisis episodes are heartbreaking, scary, and costly. Stabilization is key to his health—having to wait months to navigate fail first protocols only result in extended hospital stays and an immediate decline in my sons health.”

- As a mother of a child with a mental illness, Susan has experienced the worst of the fail first program.
- After begging the hospital for an alternative to pills to treat her son, he was finally granted an injection form that was effective in controlling his illness. Because of the high cost of the injections they were unable to continue using them and were passed from hospital to hospital being given ineffective medication that made his illness regress.



Susan Joel
Odessa, FL

HER STORY

After Susan’s son had several hospitalizations in May for being noncompliant with his pill form of medication, he was administered a form of injection to help treat his mental illness. After several hospitalizations, Susan found a psychiatrist who could administer the monthly injection that her son needed. Unfortunately his new doctor was only able to administer samples of the injection because their insurance company denied the injection due to step therapy protocols.

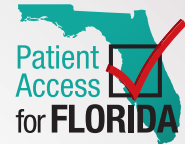
When the sample injections ran out, his psychiatrist administered a different medication which sent him into a downward spiral and within days he began to experience hallucinations and psychosis. These effects forced Susan to hospitalize her son for 16 days after which he was discharged and yet again given pills to control his illness. This lead to a stint of 30 days going in and out of hospitals with no change in medication.

Unfortunately Susan’s son is unaware of his own mental illness, but it impacts every aspect of Susan’s life. “My son needs much more than medication but if he can stay out of crisis I do not have to be as fearful of what he might do when voices are speaking to him.” Patients, like Susan’s son, need the medication they need when they need it.



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“Today, each insurance company has a different override system called ‘step therapy’ or ‘fail first restrictions’ to get drugs that are not on the approved formulary and it wastes a lot of unpaid staff time to get on the phone and talk to the insurance company for approval. I have twice the administrative staff as I have medical staff just to manage the billing and paperwork required from each different insurance company.”

- As a family physician for more than 30 years, Dr. Choisser has spent a lot of his time working to override step therapy restrictions in order to provide his patients with the medicine they need.
- Dr. Choisser believes it is a necessity to streamline prior authorizations in order for doctors to do their jobs and keep their patients healthy.



William Choisser, MD
Orange Park, FL

HIS STORY

Dr. William Choisser is a family physician with more than 30 years of experience; many of his patients have been with him from the beginning. Dr. Choisser understands the importance of continuity of care and works to build a partnership with his patients to diagnose and treat their illnesses.

“Although drugs may be in the same ‘class,’ they do not behave the same way for all individuals. To offer only one or two choices when there may be ten drugs in the same class is wrong and is a disservice to people who need an alternative. The battle for brand name prescriptions has become so tedious that most doctors now order the cheapest generics routinely even though the brand name drug would work better with fewer side effects.”

Dr. Chossier believes his practice would benefit from one uniform system for drug prescription overrides, which would make him and his staff more efficient so they are able to better serve their patients.

“We must have a uniform system to relieve doctor and staff headaches, to streamline prior authorizations, and to keep our patients healthy and out of the hospital and the emergency rooms.”



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“When you’re sick, the last thing you want to do is call back and forth trying to get your medication. I shouldn’t have to waste energy on getting my prescription when I should be focusing on getting better.”

- Jennifer Combs is a nurse practitioner and suffers from Chronic Thromboembolic Pulmonary Hypertension and Lupus. She has to take multiple drugs in order to stay ahead of her symptoms.
- When she needed a drug to treat her Lupus symptoms, her insurance company wanted her to try a different drug that interfered with her other medication.
- Jennifer had to be her own advocate in order to get the medication after weeks of fighting with her insurance company.



Jennifer Combs
Coconut Creek, FL

HER STORY

Jennifer Combs suffers from Chronic Thromboembolic Pulmonary Hypertension and has to take Coumadin in order to prevent further blood clots. When she developed Lupus, she went to see her regular rheumatologist, and he electronically sent a prescription for Pennsaid to her pharmacy to treat the pain and swelling in her hands. The next day, she called the pharmacy and they said there was a problem with her insurance and the prescription. The insurance company said she needed prior authorization in order to be prescribed the drug. After suffering for almost two weeks without medicine to relieve her pain, the insurance company wanted proof that she had tried to use other drugs to treat the pain and swelling before filling the prescription for Pennsaid.

For Jennifer, no other prescriptions would work, because everything else conflicted with the medication that was keeping her alive. It took nearly a month before she was prescribed the medicine she needed.

“If I hadn’t pushed my medication along the system, I can’t imagine how long it would have taken to receive the treatment I needed.”



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