Viability considerations in implementing same-class topical steroid substitution

To the Editor: We appreciate the comments and interesting proposal by Gupta et al.[1] We share their frustration about the rising, erratic prices of topical steroids and the secondary formulary restrictions, which makes prescribing basic therapies unpredictable. The authors propose to prescribe by potency class and vehicle rather than by specific drug as a potential solution to this issue. Although we share similar goals, we have concerns regarding the viability of the proposed suggestion. To explore this issue further, one of us (J.A.) consulted with his pharmacy department, which identified the following issues that will be important to address in any implementation efforts:

1. Under current regulation, a physician cannot prescribe a drug category. The prescription has to be for a specific drug, concentration, vehicle, etc.
2. An automatic substitution, such as what is proposed by Gupta et al, is only possible within institutions (eg, for inpatient use), and even then, a second prescription or order is often suggested by the pharmacy. Commercial pharmacies are not presently allowed to execute automatic substitutions.
3. Although one could attempt to address this issue by prescribing a range of same-class steroids to see which is covered (eg, prescribing halobetasol, clobetasol, and betamethasone augmented creams simultaneously), this approach could result in all prescriptions being rejected as duplicate therapy if more than one is indeed covered.
4. If multiple medications are prescribed, even if they are not filled, all prescriptions remain active in the patient's profile. Ensuring closed-loop communication to determine which medications are ultimately received by the patient would be important to reduce the risk of medication errors.
5. Currently, the pharmacist can contact the prescriber to suggest another agent by fax or phone but cannot send a prescription of a formulary alternative to authorize.

As a result of these potential issues, in the short-term, an approach addressing point 5, that is, creating mechanisms to engage the pharmacy in identifying formulary alternatives in the same-class and vehicle may be the most feasible option. Such an approach would not interfere with basic prescribing rules and would allow a substitution that is quickly executed, administratively simple, can be confirmed by the prescriber, and can be communicated to the patient to ensure coordination of care. In essence, it achieves what Gupta et al propose but preserves the integrity of the prescription process. The other identified issues may be open to future legislative and administrative solutions.

In conclusion, we think that in the current legal framework, a push for pharmacies to be active in suggesting same-class formulary alternatives may be the most likely intervention to be successfully implemented to achieve the objective proposed by Gupta et al of lowering the cost of topical steroids, which we share.

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REFERENCE

1. Gupta S, Menge T, Lachance A, et al. The potential impact of same-class substitution of topical steroids on health care spending. *J Am Acad Dermatol.* 2020;83(6):e439-e440.

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