The potential impact of same-class substitution of topical steroids on health care spending

To the Editor: We enjoyed the detailed review by Nguyen et al[1] of drug pricing factors that shape the care of our patients and agree that while dermatologists share a responsibility in understanding the financial consequences of their prescribing habits, "careful prescribing is not easy." Here, we highlight a significant challenge familiar to many dermatologists—prescribing cost-efficient topical steroids—and propose achievable reform.

As alluded to in the Nguyen et al[1] article, topical steroids are the most prescribed medications in dermatology, and Medicare Part D and patient out-of-pocket expenditures surrounding these have risen dramatically over the past several years. As a result of these increases, spending on topical steroids by patients and payors within the Medicare Part D system was $877.7 million in 2015.[2] The primary driver of the increase in costs during this period appears to be the rapid rise in price of some popular generic topical steroids. Had prescribers written for the cheapest topical steroid within a given potency class, an estimated $448.3 million could have been saved in 2015 alone.[2]

Realizing these savings is made difficult, in part, by dynamic and unpredictable drug price fluctuations associated with a lack of competition among generic manufacturers and poor transparency of costs to prescribing physicians.[3] When physicians write prescriptions, they may not be aware of the cheapest option or may be making decisions based on outdated information. There is no feedback to physicians on costs. If a patient does not complain to a physician, he or she may never realize the true cost of a prescription.

Flexibility in substituting similar medications at the point of sale would eliminate this challenge. At present, interchangeability between generic and biosimilar products—a practice codified in most states—is based on a lack of meaningful clinical differences between drugs with similar structure, safety, and efficacy profiles.[4] Biosimilar substitution is projected to reduce spending on biologic drugs by $54 billion between 2017 and 2026.[5]

We propose that these policies should be extended to allow for same-class substitutions with topical steroid prescriptions. This simple solution would allow physicians to prescribe topical steroids either by name and vehicle (eg, clobetasol ointment) or by class and vehicle (eg, class I ointment). Unless a physician specifically denotes "no substitution," a pharmacist would be enabled to select the least expensive option for the patient within the same steroid class and vehicle at the point of sale. This system would preserve physician autonomy while naturally increasing competition between generic and brand manufacturers. Any dramatic change in cost, whether from market contracture or malicious intent, would be mitigated by an automatic shift to the cheapest medication.

The resulting system could operate independently of any electronic medical record and free clinicians from the burnout-generating tasks of monitoring the ever-changing costs of topical steroids. This self-regulating system would reduce physician burden and patient costs while eliminating delays and administrative efforts from unanticipated prior authorizations. Future work should focus on assessing physician, patient, and pharmacist attitudes toward this proposed solution and evaluating mechanisms as well as legislative or regulatory options for intervention.

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