

eRX use of Drug Formulary

Goals:

- Formulary should be specific to patient (e.g. their insurance coverage/benefits)
- Formulary should be available using standard EHR configuration/tools without manual entry of each medication/class. This results in:
 - Reasonable expectation that it should be loaded/accessed
 - Reasonable expectation that it will be kept up to date
 - Reasonable expectation that it will fit into normal eRx workflows and used
- Measurement of compliance should automatically be calculated by EHR

Issues:

- Patient-specific formulary typically requires knowledge of patient's payor/plan
- Displaying a formulary that isn't relevant to the patient (as suggested in the NPRM) is typically not only useless, but could be counterproductive by recommending a more expensive medication
- Offering a generic substitution when a brand name is being prescribed could be automated, however in many states where generic substitution is required by the pharmacist, this would be irrelevant and result in more work for the prescriber who might unnecessarily be prompted to change from brand to generic
- Some provider organizations have their own formulary based on contracts with major payors or pharmaceutical production/distribution companies
- Electronic versions of formularies are available through multiple sources (e.g. Surescripts, MMIT's InfoScan, ePocrates, EHR vendor, payor, PBM, etc...), but each EHR is typically designed to work with only one of these sources
- Loading a formulary into an EHR doesn't necessarily mean that it was accessed during eRx
- Formularies may not necessarily be "loaded" but instead may now or in the future be accessed through "services"
- Unclear if now or in the future there may be charges to providers based on the number of formularies loaded/accessed
- Not all payors and very few provider organizations have their formularies available through a provider EHR's preferred electronic formulary source. We are aware of one case where this void represents 60% of a provider's patients and the payor has refused to make their formulary available electronically in the appropriate format. On the other hand, it may be unreasonable to expect payors to make their formulary available electronically through all of the potential eRx formulary sources.
- If we want to only display relevant formularies, then there needs to be exclusions for when a formulary is not available. EHRs can't automatically know the availability of formularies that aren't loaded, so attestation would be required to say that efforts were made to attain the formulary and it was not available in an appropriate format

Discussion:

A patient-specific formulary should be used if it's available, and there should be no requirement to display a formulary if no patient-specific formulary is available. Since **attestation will be required to denote whether formularies that weren't accessed were not available**, then there is no added benefit to also measuring which prescriptions were selected using an available formulary during the eRx measure. Thus I propose focusing on the **attestation of formulary use as a measure separate from the eRx measure, and removing formulary requirements from the eRx measure.**

Attestation Suggestion	Pros	Cons
1) Accessed all formularies that could possibly be accessed		<ul style="list-style-type: none">• It is vague as to how much manual labor could be involved using non-standard methods• It wouldn't be worth the effort and cost to go out of the way to access the formulary of a payor that represents a tiny minority of patients in the practice
2) Accessed all formularies that could possibly be accessed using the EHR vendor's standard formulary import/access functionality	<ul style="list-style-type: none">• It reduces the manual labor that would be involved in keeping formularies up to date	<ul style="list-style-type: none">• It doesn't account for the possibility that some payor may make their formulary available in a format that, through some significant work, could be transformed into the EHR's standard import format• It wouldn't be worth the effort and cost to go out of the way to access the formulary of a payor that represents a tiny minority of patients in the practice
3) Accessed all formularies that could be accessed using the EHR vendor's standard formulary import/access functionality without needing to custom transform the formulary	<ul style="list-style-type: none">• It reduces the manual labor that would be involved in keeping formularies up to date• It clarifies the intent of the measure which is to use standard functionality	<ul style="list-style-type: none">• It wouldn't be worth the effort and cost to go out of the way to access the formulary of a payor that represents a tiny minority of patients in the practice

Attestation Suggestion	Pros	Cons
4) Accessed more than 65% of the formularies used by the provider's patient population that could be accessed using the EHR vendor's standard formulary import/access functionality without needing to custom transform the formulary.	<ul style="list-style-type: none"> • It reduces the manual labor that would be involved in keeping formularies up to date • It clarifies the intent of the measure which is to use standard functionality • It accommodates scenarios where providers may have to pay based on the number of formularies accessed 	

Recommendations:

- **Separate the eRx measure from the Formulary measure**
- **Use attestation for the Formulary measure**
- **Attest that EP, eligible hospital, or CAH more than 49% of the time while using their EHR to write a prescription, electronically accessed a formulary relevant to the patient when a formulary was available that was relevant to the patient and could be accessed using the EHR vendor's standard formulary import and/or access functionality without needing to custom transform or manually enter the formulary.**

To attest to this measure, EHR vendor would report as the **Denominator** the total number of prescriptions written by each provider using the EHR, regardless of whether they were ePrescribed, faxed, or printed and regardless of whether or not they were controlled substances; but **only when a formulary could have been available that was relevant to the patient's payor/plan and could have been accessed using the EHR vendor's standard formulary import and/or access functionality without needing to custom transform or manually enter the formulary.** The **Numerator** is the total number of these same prescriptions where a formulary was actually accessed while writing the prescription. The **Threshold** would be a resulting percentage more than 49%.

Example:

Payor	Plan	Total # of prescriptions written	# Prescriptions where formulary was accessed	Formulary could have been available
A	1	100	100	Yes
A	2	75	50	Yes
A	3	N/A	N/A	No
B	1	10	0	Yes
B	2	20	0	Yes
B	3	30	0	Yes
C	1	100	75	Yes
Total:		335	225	
		Denominator	Numerator	
		Measure: 67%		