

TO THE EDITOR

As in past issues, the October 1999 issue contained several articles dealing with the high cost of prescription medications and the various means used by hospitals and insurers to control costs.¹ The subtext to these articles is that pharmaceutical companies need to charge high prices to compensate for the high cost of developing new drugs and payers want to limit the choice of medications available to physicians by establishing formularies. What is left out in these discussions is the effect on the patient-physician relationship when these formularies are instituted.

When I choose a medication for a hospitalized patient, I take into consideration his or her medical history, the current illness, and their current medications, and I then explain to the patient what I will be ordering and why. If I happen to choose a nonformulary medication (and of course each hospital has a different formulary), it will be discovered by the pharmacist, who then calls my office, requiring me to interrupt a patient visit to authorize the switch. Next morning, I must then explain to the patient why they did not receive the medication we had discussed.

In the office, I find that most of my patients do not know what type of prescription drug benefit they have. In some instances there is separate prescription card, but in many cases the prescription plan is administered by a company that is only identified by a few small initials on their health insurance card. The patient must find their card, then we have to figure out what plan they have. I must then leave the exam room and go to my office and sort through my formulary guides to find

the correct guide. This in itself is no small task, as there is no uniformity in formulary guide size, some being 8 1/2" x 11" sheets, some being "pocket-size" books (imagine my pockets with 4 of these stuck in each pocket), and others being 5" x 8" booklets. Then I must figure out if the guide is arranged alphabetically by brand name, alphabetically by generic name, by disease state, or by drug class. Then and only then can I actually decide which medication of those on the formulary will be best for my patient. This does not even account for the procedures needed if the medication requires "step therapy" or prior approval. These formulary guides are usually published every 1-2 years, but substitutions and deletions seem to occur on a weekly basis, depending on how the newest "me too" drug is priced in comparison to the preferred formulary drug, adding another frustration to the task of choosing a medication.

I suggest that future studies on the effect of formularies should include analysis of physician satisfaction with the administration and ease of use of the formulary and the effect of the formulary on the physician-patient relationship.

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1. Quinn CE, Barisano A. Understanding, creating, and working with formulary systems. *Am J Manag Care* 1999;5:1311-1319.