Non-Medical Switching in Dermatology

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Introduction

Non-medical switching (NMS) involves switching between non-interchangeable drugs for reasons other than poor clinical efficacy, medication intolerance, or non-adherence [1]. Payers initiate non-medical switching as a cost-containment strategy. Dermatologists often prescribe specialty drugs, which account for 2% of prescriptions but more than 50% of healthcare spending, making them targets for cost-containment via non-medical switching [2].

Methods

A PubMed literature search identified articles on non-medical switching with an emphasis on dermatology. We review the literature on push-pull factors in NMS and the financial and psychological effects of this practice.

Search terms included "non-medical switching," AND "dermatology" and ["patient" OR "insurance" OR "formulary" OR "government" OR "country"]

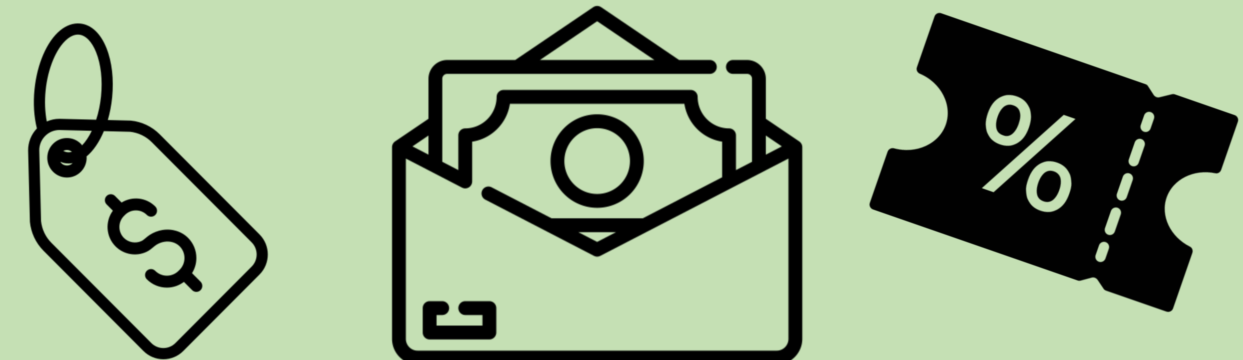
Results

Non-medical switching is encouraged through push and pull factors. Push factors make the alternative to NMS undesirable, while pull factors incentivize NMS.

Push

Formulary Switching: Following introduction of a cost-effective alternative, insurance companies often drop a medication from their formularies or move it to a higher coverage tier [3].

Pull



Cash Persuasion: Cigna® offered $500 to switch from secukinumab to ixekizumab. Prescriptions for secukinumab dropped by 17% and ixekizumab became dermatologists' most recommended psoriasis drug [4].

NMS can reduce economic burden and expand access to therapy. Switching patients from four European countries from reference infliximab to a biosimilar could save €433 million over five years [5]. The potential savings generated from biosimilar infliximab could fund treatment for 7,561 patients who might have previously forgone treatment [6]. Denmark mandated a switch from adalimumab originator to a biosimilar for all psoriasis patients. This switch was well-tolerated with no effect on drug retention and appreciable cost-savings for the health system [7]. NMS may be a minor inconvenience to some patients but can trigger long-term consequences for others. The decision to switch should be made after careful evaluation of the patient and their past medical and psychosocial history [8].

Conclusions

Non-medical switching frequently elicits negativity from both patients and providers. Physicians cite ethical concerns to the practice, believing that NMS increases side-effects, out-of-pocket costs, and healthcare utilization [30]. However, these sentiments have not been corroborated by systematic research. As cost-containment becomes an increasingly valued measure of healthcare efficacy, NMS will become increasingly popular. No treatment is universally effective or affordable, and we encourage dermatologists to treat patients using the safest and most cost-effective therapy.

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