

E. Comments from Survey Respondents

In this appendix, we provide selected comments that we received from survey respondents. The comments have been organized according to the topics discussed in Chapter 5 and are divided into three sections—general comments from direct-care system prescribers; comments from direct-care prescribers specifically in response to a question on changes they would make to the content, policies, and/or procedures of their MTF’s formulary; and general comments from purchased-care system prescribers.

NOTE: Some of the comments listed in this appendix apply to more than one topic category, and therefore they appear more than once.

General Comments from Direct-Care System Prescribers

Pharmacy Staff

- [My MTF’s] pharmacy is exemplary. They are attentive to the patient’s time, restrictions, and physician prescribing habits, and go the extra mile to provide comprehensive reviews of efficacy and cost analysis prior to addition or deletion of any pharmacy item. Working with the constraints of funding and ability to provide, they graciously exhaust all their manpower. And may I say, they do it so gracefully. Never a complaint. Never a quiver.
- Our pharmacy staff is very approachable, friendly, and responds to all requests. We have our own pediatric pharmacy for non-controlled substances 8 to 4 Monday through Friday. The CHCS ORE system is wonderful. There is little or no difficulty in dealing with our pharmacy staff—they are very helpful. The only problem yet to be solved is the VERY long wait to have a prescription filled (up to three hours) at the main pharmacy. Automation improved this to 30 minutes, then it relapsed right back to horrible. We lose patients because of this and [because of limited] parking.
- I think our P&T committee does an excellent job with cost control but needs to communicate better with physicians so they are more a part of the process and not made to feel like their hands are being tied.
- Our pharmacy is top notch!

- Quicker pharmacy lines.
- The pharmacy is one of the *best* departments at my MTF.
- The formulary is NOT a problem. What is a problem is the chronic undermanning of our pharmacies. Those who are in our pharmacies are often poorly trained. If you want to do something useful for us providers, look at the manning of our pharmacies. I think you'd be shocked at the dangerous undermanning, which results in poor patient and provider satisfaction, increased errors, and patient harm.
- The main difficulty I have is in communications with the pharmacy—getting in touch with someone in the know about the formulary. Military pharmacists are quite busy, I know, but generally I can call a civilian pharmacy and, within a reasonable period of time, talk with the pharmacist for advice, availability of medication, etc. It is not so with the military pharmacies.
- As a provider and a customer/user of the system, I think it is much better than the outside civilian pharmacies.
- In general, I have been pleased with military pharmacy services.

Formulary Content

- The pharmacy is so slow to put LAWH on the formulary or drugs like Glitazone.
- Our pharmacy has been very receptive to the needs of the HIV-positive patients in keeping the latest antiretrovirals in stock.
- Make cold packs available to active duty [personnel] and dependents.
- I work at two area MTFs, geographically separated by approximately 30 miles. The formularies differ dramatically, and the rules regulating NMOP/local civilian pharmacy use and amounts of “chronic use” medicines given vary so dramatically that both doctors and patients find it confusing. Local P&T committees differ, and personal experience will often influence committee decisions. I feel policies and formularies should be standardized to the maximum extent, and the NMOP should provide variability and flexibility.
- On several occasions, medicines that are on our MTF formulary are not actually in the hospital. One of these medications was needed on an urgent basis. I have had to refer [patients] to a pharmacy outside the MTF because the medications were not available for over two weeks.

- Some formulary decisions are mandated by changes in the Triservice formulary. This can lead to changes that affect thousands, such as at our MTF.
- Suggest eliminating all OTCs [over-the counter medications] to decrease overall workload for providers and pharmacy.
- (1) One of the greatest problems is the frequent formulary changes. In my six-year cycle here, I have experienced [many] changes: These changes do not occur at the same time and require patient contact [simply] to change medications. Also, I get very offended as a board-certified internist when I am restricted from prescribing medications outside of my subspecialty. (2) Stop switching formulary drugs so often. (3) Don't switch brand names on patients' prescriptions (i.e., substituting one brand name or generic drug with another one when patients refill prescriptions).

Cost

- Reasonable cost containment has been abandoned at the provider level. Rather than a proper history and physical exam, unnecessary expensive testing is performed and unnecessary expensive drugs are prescribed (e.g., the emergency room will prescribe Ofloxacin at \$0.97 per tab when Septra at \$0.12 per tab will suffice. I find this offensive and the result of physician laziness.
- I have heard that the pharmacy budget drains our resources in the MTF due to the large number of prescriptions [that are] filled. Perhaps charging a co-pay on some or all medications would ease the financial burden. The co-pay could be minimal, e.g., \$1.00.
- I attended P&T committee meetings when I first arrived here and became completely frustrated by the process, the lack of insight, the lack of willingness to listen to reason, the attitude that the job of the P&T committee and the formulary was to save the hospital's budget and discourage outside providers [from] writing the medications they desired for their patients. I have had my prescriptions changed by the pharmacy without my being informed—at the expense of the patient's health (this is practicing medicine without a license, as far as I'm concerned). Waiting time at any MTF for outpatient prescriptions, especially because of restrictions on the duration of prescriptions [is long], even for [medications for] chronic conditions that need to be refilled monthly; will not be dispensed [if the patient] shows up [two or three days early]—must be after 30 days.

Quality of Life

- Bigger hindrance is promotion. I will get out as soon as my 20 years are in. No problems in my files, just haven't done CGSC, which didn't use to be a requirement. Changing the rules in midstream is inappropriate. More and more administrative [hurdles].
- I am currently risking burnout with increased administrative demand and the increased number of patients I see. I am not sure how long this increased operational tempo can continue.
- We are doing more traveling to see patients at local clinics. Each local MTF formulary is different. We need to have a Triservice formulary that is the same for all local MTFs. MEDCEN formularies are more comprehensive and should also be equal at [all MTFs]. Many times, the electronic screens are not current. A drug will be listed as non-formulary, but when I call the pharmacy, the drug is on the shelf. Pharmacy courier services are provided from [my MTF] to [most MTFs in this area but not all]. This is inconvenient to patients [in those MTFs] who have to drive to [my MTF] to pick up a drug [their MTF] does not carry. Short of a special drug request, this decreases available manpower time due to patient travel time to pick up medications. Also, the local MTF pharmacies often cannot make an automatic refill number the default for certain drugs without going through [my MTF]; this is inconvenient. We waste time doing it manually each time we prescribe—carpal tunnel syndrome occurs!! Thanks for doing this. Hope this is helpful.

Outside Prescription/Pharmacy

- [My MTF] has done a very good job of balancing the many competing factors of funds, accessibility, and formulary. However, the outside prescriptions are a tremendous drain on dollars and create a vast drain on personnel resources and on parking within the facility. Again, outside prescriptions should go to outside-TRICARE no-co-payment pharmacies for TRICARE Prime patients and to co-pay [pharmacies] for non-Prime [patients].
- The MTF providers often have our prescriptions scrutinized more closely to [generate] cost savings to compensate for off-base Rxs that are cost inappropriate.
- Outside prescribers should have the same restrictions as military providers.
- Civilian providers seeing MTF beneficiaries outside the MTF tend to prescribe more expensive agents as first line [medications].

Quality of Care

- Overall, I think our pharmacy does an incredibly good job in meeting the medication needs of the patients. I think that patient satisfaction, and more than just monies, should impact the formulary. Also, patient compliance with daily medication is more apt to occur than with a cheaper QID [four times a day] medication, for example. Also, community standards need to be addressed, especially in oncology. If we can't prescribe Rituxan, even though it is FDA approved, we need to be able to refer patients to places where they can get life-saving treatments.
- Some formulary decisions are mandated by changes in the Triservice formulary. This can lead to changes that affect thousands, such as at our MTF.
- I attended P&T committee meetings when I first arrived here and became completely frustrated by the process, the lack of insight, the lack of willingness to listen to reason, the attitude that the job of the P&T committee and the formulary was to save the hospital's budget and discourage outside providers [from] writing the medications they desired for their patients. I have had my prescriptions changed by the pharmacy without my being informed—at the expense of the patient's health (this is practicing medicine without a license, as far as I'm concerned). Waiting time at any MTF for outpatient prescriptions, especially because of restrictions on the duration of prescriptions [is long], even for [medications for] chronic conditions that need to be refilled monthly; will not be dispensed [if the patient] shows up [two or three days early]—must be after 30 days.
- I think my patients have excellent pharmacy benefits, even though they may not appreciate it.
- Half of my time is spent with a fleet (ships assigned active duty). This population often has difficulty (still) obtaining their medications for six-month deployments—especially expensive prescriptions (regardless if it is a formulary or basic core formulary drug). This is an obstacle to care that must be eliminated. Our active duty fleet patients are why we exist. I have found that this large MTF is much more difficult to prescribe from than the medium-size MTF and branch medical clinic MTF that I have been assigned to, which I find interesting since they [the latter two] have more pharmacy budgetary constraints. I do not prescribe an outside provider's Rx and will not do so if I am not following the patient [over the course of] this diagnosis. I feel it is bad medical/prescriptive practice.
- The formulary is NOT a problem. What is a problem is the chronic under-manning of our pharmacies. Those who are in our pharmacies are often

poorly trained. If you want to do something useful for us providers, look at the manning of our pharmacies. I think you'd be shocked at the dangerous undermanning, which results in poor patient and provider satisfaction, increased errors, and patient harm.

- We are doing more traveling to see patients at local clinics. Each local MTF formulary is different. We need to have a Triservice formulary that is the same for all local MTFs. MEDCEN formularies are more comprehensive and should also be equal at [all MTFs]. Many times, the electronic screens are not current. A drug will be listed as non-formulary, but when I call the pharmacy, the drug is on the shelf. Pharmacy courier services are provided from [my MTF] to [most MTFs in this area but not all]. This is inconvenient to patients [in those MTFs] who have to drive to [my MTF] to pick up a drug [their MTF] does not carry. Short of a special drug request, this decreases available manpower time due to patient travel time to pick up medications. Also, the local MTF pharmacies often cannot make an automatic refill number the default for certain drugs without going through [my MTF]; this is inconvenient. We waste time doing it manually each time we prescribe—carpal tunnel syndrome occurs!! Thanks for doing this. Hope this is helpful.
- Part of my time is spent with a small population of chronically ill pediatric young adult adolescent patients who are much healthier with the new medications that are available. These medications are very expensive but markedly improve quality and quantity of life. Our MTF has supported our availability of these medications after appropriate provision of the information on research showing the effectiveness [of these medications]. I am grateful on behalf of these patients.

Non-Formulary Approval Process

- There needs to be an expedited approval for “minor meds” that cost less than \$20 to \$30 per average prescription. This would allow more flexibility in adding/changing medications with little impact on overall cost.
- CHCS is an incredible help in prescribing for my patients. Overall, I am very pleased with the formulary and process to get non-formulary meds.
- The MTF pharmacy is generally accessible and willing to prescribe appropriate non-formulary medications.
- In my specialty practice, I am never denied medications that I have determined are most appropriate for my patients.
- I [utilize] mail order when drugs are expensive or not carried on our formulary.

Other/Miscellaneous

- [Respondent named two health plans] are the worst TRICARE contractors in terms of pharmacy benefits that I've experienced. Their first and only priority is to pinch the patients access to top-quality pharmaceuticals and frustrate providers trying to help the patient.
- I would love to have the PDR [Physician's Desk Reference] incorporated into CHCS so that it could be easily accessed without going out of the program.
- (1) The electronic prescribing on CHCS *can* be very helpful, especially in regard to allergies and interactions. *This* is a good feature. (2) Time is a big problem—15-minute appointments for geriatric patients on multiple medications means squeezed assessment time for medication review. (3) Formulary is a good idea and contains cost, but not enough physicians are consulted [on it].
- I think our pharmacy/formulary is a very reasonable one, and non-formulary requests, when reasonable, are handled positively and expeditiously. The single most frustrating aspect of my work is spending time on tasks which could/should be done by others—such as faxing, photocopying, and helping people get appointments—because the “system” is obstructive.
- While CHCS has been helpful, it has never been easy to determine which [drug] choices in a particular class were available.
- CHCS is getting more burdensome. More and more typing and sitting at the computer by physicians hurts patient care.
- As a specialist, I prescribe only the drugs that are my specialty and refer all other issues back to the primary care manager—hence, my knowledge of the “formulary” is really limited to the drugs I use for my scope of practice. Likewise, I request that those drugs that I feel necessary for my practice be added to the formulary. Therefore, all the questions you ask regarding my satisfaction or familiarity really reflect my or my colleague's endeavors to place whatever we need on the formulary.

Comments from Direct-Care System Prescribers in Response to Question on Recommended Changes to MTF Formulary

Question 18. If you had the opportunity, what changes would you make to the content, policies, and/or procedures of your MTF's formulary?

No Problems

- None. I think our system works quite well.
- Formulary is reasonable for my needs.
- None at this time. We have a pretty good system at present.
- I am basically satisfied with the contents of our formulary.
- No significant changes [to recommend].
- Our prescribing is all computer-based. All medications are labeled as formulary or non-formulary. Special drug requests are honored with reasonable speed and accuracy. The occasional glitch is [usually something like] a misplaced piece of paper when special requests are submitted.
- I have not encountered any roadblocks to prescribing medications at [my MTF]; however, my subspecialty has a narrow range of medications [that are] used.
- None. They have been very responsive.
- I have found that I can get almost any non-formulary drug my patients need by submitting a request and justifying the need of the medication.
- None.
- None presently.
- [My MTF] pharmacy is doing a good job of supplying medications requested. Non-stocked items are available to the patient in 24 to 48 hours. For the types of medications that I prescribe that are non-formulary, this has not created any detriment to the patients' health. A system is in place to automatically evaluate the addition of frequently requested non-formulary items to determine the advisability of adding them to the formulary. A non-formulary prescription requires a handwritten prescription that is signed by staff (trainees cannot sign). [Supervisory body] evaluates and educates providers on appropriate drug usage. This is the best system for meeting the needs of the patient and the provider that I have seen in 16 years of active duty.

- Have more personnel to run the pharmacy as they are overworked. Yet, despite all this, they've done an outstanding job!! It will also help the facility have a person working in the after-hours clinic.
- MTF is doing a fine job. When medical necessity dictates them, drugs have been obtained.
- I feel that our pharmacist and P&T committee do an excellent job of supporting provider ordering. Have no complaints with present system.
- I am satisfied as they are now.
- No change. Pharmacy is doing an excellent job.
- None—works well as is with minimal problems.

Cost

- Drop expensive drugs that have no therapeutic advantage, e.g. (1) Ortho 777 is more than \$15 per pack versus Trileven at \$1.25 per pack; (2) Preman is \$0.22 per tab versus Estrace at \$0.02 per tab. Stop pharmacy rep visits to physicians.
- For higher-priced medications, I have a comment about possible cheaper alternatives. [Respondent listed several alternative medications in the write-in section of the survey.]
- Have an automatic annual review by pharmacy and medical department of medications for addition or deletion from the pharmacy. Currently, it occurs every few years. To protect the MTF budget and expand the formulary, I would like to see all outside prescriptions filled by TRICARE (private) pharmacies or by the mail order national pharmacy—with no co-pay for TRICARE prime but co-pay for non-prime.
- Have retail cost of drug printed out at the time the medication is dispensed. This may educate patients about actual costs, may cut down on waste, and may inspire patients to appreciate their pharmacy benefits.
- Requests for non-formulary items are taking up to a month at present to be processed! This is a change from the previous four to five days. This is burdensome for the patient and doctor. This process needs to be facilitated! Increase education on pharmaceutical costs and pricing.
- Prefer that when formulary changes are made, everyone is not forced to use a new drug if the old drug is working. It seems penny wise and pound foolish to subject thousands of patients to a different drug if their previous prescription worked well. It generates a lot of visits, phone calls, and confusion. [It also generates] repeated lab tests and [there could be]

additional side effects (i.e., with Lipitor versus Baycol; Prevacid versus Protonix).

- Non-TRICARE beneficiaries pharmacy budget should not come out of MTF money. This places a burden on the MTF to not add new drugs to the formulary due to concerns of misuse by civilian providers locally. In the end, TRICARE Prime beneficiaries suffer due to restrictive formulary policies that cannot control civilian prescribing patterns!
- Develop a policy by which a patient pays the difference in the cost of a drug if a formulary alternative exists but the patient demands [the drug] anyway.
- Increase the pharmacy budget to allow physicians to prescribe more current, proven, state-of-the-art medications.
- Encourage drug companies to offer better discounts on drugs.
- I would be interested in knowing how much money is spent on OTC medications prescribed.
- More money!
- If the DoD mandates that the MTF must fill all prescriptions presented by outside providers, then the DoD should fund the MTF to cover the expense.
- Capitated costs to my MTF severely hamper my ability to practice medicine as compared with a large tertiary center.
- Cost is not the bottom line at all times.
- Pharmacists' role is only to give pharmacologic and cost information, not guidelines on use.
- Pharmacy funding DoD-wide needs to be worked out so that [the MTFs] are not always "going under" at the end of the fiscal year.
- Filling outside scripts has made the MTF formulary more "restrictive"—expensive drugs such as Cox 2's are "available" only through NDRs (new drug requests). To place [such a drug] "in formulary" opens it to all, and the outside providers may not be following our guidelines. Our MTF has at least "streamlined" the process and has made it relatively easy to submit NDRs. Patients in our system do not have any incentive to help contain cost—the providers are sandwiched in between the patients demanding the "new drug" and the pharmacy demanding cost be contained; a co-pay system would help this.
- No closed categories; better funding.
- Cost comparison analysis across a class of drugs such as AEM (including medication costs and lab tests needed, as well as [costs arising from] complications), as well as efficacy comparison [are recommended].

Non-Formulary Issues

- The oversight for special purchase/non-formulary items is too strict. Other than that, I think we have an outstanding formulary and pharmacy staff.
- A DoD formulary is a good goal, but the newer drugs should be obtained by the requesting provider until the type of drugs in a class has a track record.
- I usually don't get notified if a non-formulary drug is denied until the angry patient calls. Need more feedback from pharmacy.
- I understand the need for cost containment but feel that if there is a medicine that better suits a patient, it should be easily accessible. While the process has been improved, I feel it still has too much red tape binding the providers' hands.
- Less administrative [procedures] to get non-formulary drugs.
- Requests for non-formulary items are taking up to a month at present to be processed! This is a change from the previous four to five days. This is burdensome for the patient and doctor. This process needs to be facilitated! Increase education on pharmaceutical costs and pricing.
- A formulary in hard copy. Update to new medications on the market. Less hard copy paperwork for non-formulary drug.
- Simply, if a drug is truly required clinically and is not formulary, the approval process should be simpler and more streamlined.
- Publish an updated formulary on the Web every month that is easy to look up, especially by drug classes and therapeutic categories. Allow "key access" to "restrictive drugs" universally to the most senior staff.
- I would distribute the minutes of meetings to providers along with regularly scheduled updates of formulary change. Would review policies regarding the process for requests from specialty clinics for non-formulary prescribing. At our facility, the number of subspecialty clinics with the ability to prescribe Vioxx is so large that they can't fit the list [of subspecialty clinics] on a single line. Patients are inappropriately placed on [Vioxx] and then expect us to continue prescribing it.
- [The pharmacy should] have cardiac medications that are supported by evidence-based medical efficiencies, regardless of cost.
- Make changes to non-formulary MTF drugs available electronically, as long as they are electronically signed by a staff physician (not resident/intern/trainee). Why? Because most non-formulary drug requests are not denied, you might as well do them electronically and allow any denials to occur electronically to provide feedback to the provider.

- Some drugs are placed on special order status only to restrict their use, even though the P&T committee knows their use is justified in some cases. Doing a special drug request for these [special orders] is annoying.
- Decrease the amount of time taken to process a new drug request. Some medications I requested be added to formulary, which I routinely use (e.g., DDAVP nasal spray/tablets for bed-wetting), were denied for cost issues or alternative forms (e.g., Claritin tablets were denied even though we have Claritin liquid on formulary), so I have to write civilian prescriptions for [Claratin tablets], which I assume cost more. But overall I am a member of our P&T committee and very pleased with the overall responsiveness to cover newer, more-effective medications even though it may be more costly.
- The problem is NOT the formulary. We have a retrospective review process for non-formulary requests. Thus, the patient is never kept waiting while approval is obtained. The prescribing physician is the approval authority. The P&T committee reviews non-formulary requests after the fact to identify [questionable] provider patterns. This process has not been abused by our providers. Also, if a non-formulary drug is being ordered by multiple providers on a routine basis, this medication is automatically discussed at P&T [committee meetings] for possible addition to the formulary. Prospective review of non-formulary requests is irritating to providers and has the potential to harm patients. It should be eliminated throughout the Navy.
- The ordering of non-formulary items at [my MTF] is very easy, but there is still a three- to five-day delay in starting [these prescriptions]. So, I just send [the orders] downtown. I wish we could shorten the time to med to one day.
- Not having to resubmit special requests for “off-formulary” drugs that are refills.
- Most frustrating are the irrational restrictions on my prescribing practice. Fully certified M.D.’s should not be held to same restrictions as physician’s assistant’s, nurse practitioners, and other non-M.D. providers!! I am a board-certified pediatrician and am fully trained to prescribe medications for reflux, asthma, allergies, antibiotics, etc. At [my MTF], I am unable to prescribe many of these drugs without specialty approval. Also, Zyrtec standard dosing is one-half tab per day, which is ineffective for many and not what is recommended by the manufacturer. The acne medications and eczema topicals that are available are inadequate at best, and many of the useful products that I use in my private practice I have to refer my military patients to dermatology or allergy [specialists] or send [them] to an outside pharmacy.

- I am a primary care provider. I am restricted from prescribing medications for common medical problems because they can only be prescribed by specialists (e.g., Vioxx, risedronate, Celexa, Lamictal). Therefore, in order to refill or prescribe these medications, I am forced to send [patients] to a specialist or write a non-formulary drug request. This is frustrating to me because my prescribing patterns are actually more cost conscious than those of most specialists and [this process] requires more visits and more time spent per patient.
- I believe physicians should be able to prescribe what they deem best suits their patients. I try to use cheaper agents first, but I should be given more freedom to switch [based] on my clinical judgment.
- Decrease the time and paperwork associated with prescribing non-formulary drugs.

Formulary Content

- Maybe consider adding some pediatric preparations.
- Add Lipitor. Certainly a pharmacy committee that does not have physician/nurse practitioner representation for an MTF should not be allowed to make changes to the formulary. And at least, any proposed changes should be distributed to ALL providers in that MTF PRIOR to the changes being made.
- Add glucosmine and chondroifin sulfate.
- We need to re-examine the choice of antibiotics we are carrying; update them with much better pediatric choices. Need to be able to make changes in a more time-efficient manner.
- My biggest complaint is how difficult it is to add or change a formulary item. It takes several hours of my time to write up/type the request (I have no secretary who can do it). I have to cancel clinic time to attend the P&T committee meeting. Most times, the request is denied the first time around. I have to get more supporting data and return to the P&T committee. This is a time-consuming process that takes a concerted effort over several months to add or change one medication. Often that [process] provides only a “trial period,” and I have to return with more data to justify final approval. This is true for all medications—there is no easy way for me to get experience with a new therapy. NDRs require me to fill out the form, submit it, wait to hear if it is approved, and wait to get a message that the medication is available, and then I have to enter the prescription and personally call the patients so they can pick up the Rx. This process is so burdensome that I almost never try

new acne creams or other advances, and as a result my patients “get by” with older therapies. No doubt the hospital saves money by keeping the system burdensome for the providers. I wish I could give out samples, like all other dermatologists.

- Stop the frequent changes to formulary. I often have to change a patient’s Rx about once a year to adjust for formulary shifts and not for medical reasons.
- Add Lipitor back to the formulary; the automatic switch caused loss of control of lipids (in previously controlled population), more monitoring costs, and a lot more provider time to check LTTs and monitor previously stable lipids. (Baycol is not as effective.)
- More choices for hormone replacement therapy.
- Add Cox-2 NSAIDS.
- Don’t know. I am satisfied with what we have, although the formulary could be more complete and current.
- As a dermatologist: (1) I would add Differin Gel (Adapalene); (2) I would add a quality sun block to use in high risk patients; (3) I would add Valtrex to treatment for Herpes Zoster and herpes simplex virus [HSV].
- I would distribute the minutes of meetings to providers along with regularly scheduled updates of formulary change. Would review policies regarding the process for requests from specialty clinics for non-formulary prescribing. At our facility, the number of subspecialty clinics with the ability to prescribe Vioxx is so large that they can’t fit the list [of subspecialty clinics] on a single line. Patients are inappropriately placed on [Vioxx] and then expect us to continue prescribing it.
- Add Suprax liquid; add Vasotec.
- Easier availability of Viagra, when clinically indicated.
- I have not encountered any roadblocks to prescribing medications at [my MTF]; however, my subspecialty has a narrow range of medications [that are] used.
- I think our system works well and is responsive to the requests of physicians and the needs of patients. In a perfect world, there would be no budgeting limitations, and I could prescribe any brand of medication I wanted (any type of growth hormone, for instance). Also, it would be nice to hand out some OTC items (e.g., alcohol swabs, etc.). What is challenging here is that there are four to six different facilities on the same computer system, but their formulary contents are all different!

- [The pharmacy should] have cardiac medications that are supported by evidence-based medical efficiencies, regardless of cost.
- Quicker addition to the formulary of medication on the market that civilian providers use to practice [their] standard of care.
- I would revamp the entire formulary to begin with, acquiring a list from providers of the medications they WANT to prescribe, with justifications. Emphasize the cost-savings to the U.S. Army that would be realized by purchasing and prescribing through the MTF, rather than through NMOP or outside pharmacies. Make those cost savings available as increased pharmacy budget monies to the MTFs.
- Take ALL over-the-counter medications off the formulary! Placing orders for these is a big waste of provider time!
- Discontinue all OTC products and unproven remedies.
- Addition of a Cox-2 Inhibitor and Viagra.
- If you can justify stocking the pill form, it seems a bit schizophrenic not to stock the liquid form for patients (i.e., children) who can't swallow pills (for example, biasin).
- Larger selection of clinically effective meds with different dosing options, such as once a day instead of four times a day, rather than basing selections of drugs solely on costs.
- Increase variety and patient options.
- No closed categories; better funding.
- None. Possibly quit supplying OTC meds to save money.
- Make formularies within different military MTFs consistent. [My MTF] pharmacy carries different ACE [angiotensin converting enzyme] than [other MTFs within the same system]. This makes it difficult to prescribe medications for patients to pick up at other sites.

Patient Issues

- Make prescribing policies clear to patients.
- While avoiding "fads," it is important to update available treatments for chronic illness (i.e., diabetes or HIV).
- Once a patient is on a certain medication and it's working, and both the patient and physician are satisfied, then the patient's medication should not be changed to another drug in the formulary, even if the new drug is equally effective.

Process

- I usually don't get notified if a non-formulary drug is denied until the angry patient calls. Need more feedback from pharmacy.
- Reduce redundant paperwork!
- Currently, we use electronic prescribing via CHCS. This works adequately and is fairly easy for me to tell what is on formulary and what isn't while prescribing. The one thing that could improve it would be a more friendly user interface! (This is a CHCS-wide problem, not one limited to formulary or prescribing concerns, however.)
- Not having to deal with DoD mail-order system—took two hours for them to fax me forms!!
- Allow optimization of CHCS so that I may be allowed to order a prescription for a beneficiary from another MTF within our region, allowing me to choose the MTF easily within CHCS. The pharmacies within our region and DoD have suboptimal reimbursement practices.
- Choose a single mechanism for prescribing all non-formulary drugs. [Now, the] procedures for approval change based upon which drug is involved. Procedures seem to vary even with the same drug from week to week. I end up completing all possible procedures/forms to ensure medication is approved. I am also provided with little feedback to know if medication is approved or not. I assume no news is good news!!
- Prefer that when formulary changes are made, everyone is not forced to use a new drug if the old drug is working. It seems penny wise and pound foolish to subject thousands of patients to a different drug if their previous prescription worked well. It generates a lot of visits, phone calls, and confusion. [It also generates] repeated lab tests and [there could be] additional side affects (i.e., with Lipitor versus Baycol; Prevacid versus Protonix).
- Renewal of current prescriptions works well. I wish renewal of expired or discontinued prescriptions could be retrieved and renewed as easily rather than having to generate a new Rx in CHCS.
- Not certain why the day's supply and quantity are not linked in an Rx. Many inpatients receive Rx on discharge with two-weeks' supply with refills, but are unable to get the refills because the phone-in refill [service person] thinks it's a 30-day supply and [the refills] are denied. This generates a lot of extra work and/or the patients stop using the medication because they had trouble refilling it.

- Our formulary should be listed by drug category with the preferred (low-cost) drug listed first over less-preferred (high-cost) drug. For example, I could type in “anti-depressant” and gets lists of SSRIs [selective serotonin reuptake inhibitors], tricyclics, MAO [inhibitors], and then click on SSRI and see a list with Paxil, Prozac, and Zoloft with their relative costs. It is difficult to find what drugs are on a formulary by classes. There are times when patients have requested medications, and I have had them filled outside the MTF even though they have recently been added on our formulary [because they were added] without my knowledge.
- When new drugs are established as the drug of choice for certain classes, policies for automatic substitution should be instituted for appropriate patient education. This responsibility should fall to the MTF and not the individual provider.
- The electronic (CHCS) formulary is not user friendly. We should be able to type a category and get options. If a drug is not on the formulary, we should be told the alternatives.
- Quicker addition to the formulary of medication on the market that civilian providers use to practice [their] standard of care.
- The only difficulty is when a given drug in a particular class is the “preferred” drug for a while (like Zycotec), only to be replaced by something else (like Allegra) as the preferred drug. I am not going to change all the medications for patients who are doing well on the original.
- Evaluate the necessity of having new medications [that are] more efficacious, on the formulary, especially if the patient has tried other medications and [they are] not helping.
- Pharmacy and Therapeutics [committee] should get input from the specialist for adding or deleting medicines.
- Eliminate unnecessary drugs (now being done here) and unavailable drugs.
- Easier access to new drugs and have them added to the formulary more quickly.
- Have more physician involvement in order to integrate clinical and patient care concerns. I find it offensive that pharmacists are controlling my prescribing activities and limiting my practice of medicine by instituting narrow-minded and dogmatic pharmacy protocols. “Value” in your questionnaire is assumed to denote dollars. There is more to medicine than money. I am able to stay within the confines of our formulary most of the time, but my choice to prescribe outside that formulary should not be

bureaucratically challenged, especially by pharmacists and non-clinical personnel.

- Combine the formularies in the National Capitol Area. Patients should be able to visit the closest MTF and get refills or new prescriptions.
- Cut back on non-Prime prescriptions from non-MTF (civilian) providers.
- Electronic requests for non-formulary drugs.
- Removal of OTCs or OTCs available to patients without a prescription.
- Allow SPP medication requests to be filled at satellite clinics for the patient's convenience.
- DoD should have one formulary—most conversions are started due to [transfers] from one MTF to another.
- Make it easier to add medication to the formulary.
- (1) Standardize the process. (2) Different medications [should not] require different forms. (3) Pharmacy never gives the patient the form, so I have to try to find one. Clinic does not always have one. (4) Sometimes I'm not sure what form is needed.
- Need more coordination of formularies in the National Capitol Area (Washington, D.C.) between the Air Force, Army, and Navy. Particularly for consultants, it can be difficult to care for people if they can't get a drug refilled at their local MTF and have to get it at consultant's MTF only or [through a] civilian source.
- (1) Get rid of OTCs—patients waste valuable appointment slots for “refills” of OTCs. (2) DoD should allow for samples—it's the only way we can gain experience with new drugs.
- [There should be] electronic processing of “special drug requests.” These requests [now] require the physician to hand-carry the form through the approval process or [else] it gets left on someone's desk indefinitely.
- Better, searchable drug database with classes of drugs and costs available [in the database]. Needs to be quick and easy to use.
- (1) Updated formulary. (2) Updated computer program for prescribing.
- Computerized formulary with drug class groups.

Rules/Restrictions

- Lessen the number of restrictions.
- Remove specialty restrictions for some drugs and place such drugs under request for approval by specialist.
- Disallow Rx by civilian providers of patients who are *not* TRICARE Prime.
- Non-TRICARE beneficiaries' pharmacy budget should not come out of MTF money. This places a burden on the MTF to not add new drugs to the formulary due to concerns of misuse by civilian providers locally. In the end, TRICARE Prime beneficiaries suffer due to restrictive formulary policies that cannot control civilian prescribing patterns!
- Restrict less medications to specific services. Rather, educate providers in regard to cost, side effects, and appropriate use. Give feedback as needed to providers in regard to their use of expensive/third-line medications.
- Don't block any Rx from specialists, only family doctors.
- I would allow certain medications to be restricted by specialty. This would prevent overutilization of some expensive medications by providers who might not have the training to appropriately prescribe certain medications. [But it would still] allow the specialist the ease of routine prescription writing rather than going through the non-formulary approval process.
- Certain drugs are controlled by the pharmacy by permitting only certain subspecialists to use them. Examples include sumatriptan, mirtazapine, and celecoxib. I find this more exasperating than obtaining a new drug order request to circumvent restrictions on non-formulary drugs. If these drugs are to be tried on a trial basis, a consult [to a specialist] has to be generated.
- Less restriction of prescribing (i.e., specialists only prescribing for Vioxx or Metrogel is ridiculous).
- Restrict beneficiaries with non-MTF prescriptions from using MTF pharmacy. Require that they use the non-MTF options that are now widely available. That would allow the MTF formulary to expand without the concern that the budget would go out of control because of prescriptions by non-MTF providers.
- Do not restrict drugs to specific specialties.
- Restricting drugs to subspecialists results in consults to them that may be unnecessary (for asthma and allergy medications in particular).
- The formulary in "theory" is fine. A problem occurs if you need to step outside the formulary. Many times I have experienced the attitude from pharmacy staff and commanders that [they think] I don't know what I'm

doing. As a result, many requests get denied. The main concern seems to be money, and only “lip service” is given to quality/standard of care. Pharmacy policies are only one of the many reasons I am leaving the DoD.

- Most frustrating are the irrational restrictions on my prescribing practice. Fully certified M.D.’s should not be held to same restrictions as physician’s assistant’s, nurse practitioners and other non-M.D. providers!! I am a board-certified pediatrician and am fully trained to prescribe meds for reflux, asthma, allergies, antibiotics, etc. At [my MTF], I am unable to prescribe many of these drugs without specialty approval. Also, Zyrtec standard dosing is one-half tab per day, which is ineffective for many and not what is recommended by the manufacturer. The acne medications and eczema topicals that are available are inadequate at best, and many of the useful products that I use in my private practice I have to refer my military patients to dermatology or allergy [specialists] or send [them] to an outside pharmacy.
- I am a primary care provider. I am restricted from prescribing medications for common medical problems because they can only be prescribed by specialists (e.g., Vioxx, risedronate, Celexa, Lamictal). Therefore, in order to refill or prescribe these medications, I am forced to send [patients] to a specialist or write a non-formulary drug request. This is frustrating to me because my prescribing patterns are actually more cost conscious than those of most specialists and [this process] requires more visits and more time spent per patient.
- Avoid prescriber limitations for refills—some drugs are limited-prescription medications, limited to specific subspecialists. When I try to help a patient with a refill, I am blocked [from doing so], and the patient must contact the sub-specialist.

Communication

- Make prescribing policies clear to patients.
- I usually don’t get notified if a non-formulary drug is denied until the angry patient calls. Need more feedback from pharmacy.
- After each P&T committee meeting, e-mail to ORE a list reporting the summary actions taken/considered. Actually, it would be good for all committees to have a brief summary reported to the affected community after each meeting. Communication always enhances function.
- A formulary in hard copy. Update to new medications on the market. Less hard copy paperwork for non-formulary drugs.

- Our formulary should be listed by drug category with the preferred (low-cost) drug listed first over less-preferred (high-cost) drugs. For example, I could type in “anti-depressant” and get lists of SSRIs [selective serotonin reuptake inhibitors], tricyclics, MAO [inhibitors], and then click on SSRI and see a list with Paxil, Prozac, and Zoloft with their relative costs. It is difficult to find what drugs are on a formulary by classes. There are times when patients have requested medications, and I have had them filled outside the MTF even though they have recently been added on our formulary [because they were added] without my knowledge.
- Publish an updated formulary on the Web every month that is easy to look up, especially by drug classes and therapeutic categories. Allow “key access” to “restrictive drugs” universally to the most senior staff.
- I would distribute the minutes of meetings to providers along with regularly scheduled updates of formulary change. Would review policies regarding the process for requests from specialty clinics for non-formulary prescribing. At our facility, the number of subspecialty clinics with the ability to prescribe Vioxx is so large that they can't fit the list [of subspecialty clinics] on a single line. Patients are inappropriately placed on [Vioxx] and then expect us to continue prescribing it.
- The electronic (CHCS) formulary is not user friendly. We should be able to type a category and get options. If a drug is not on the formulary, we should be told the alternatives.
- Currently at my facility, there is no list. The only way to see if a drug is on formulary is to try to order it and see if it is there. An actual listing would be helpful.
- Make changes to non-formulary MTF drugs available electronically, as long as they are electronically signed by a staff physician (not resident/intern/trainee). Why? Because most non-formulary drug requests are not denied, you might as well do them electronically and allow any denials to occur electronically to provide feedback to the provider.
- More information on the cost of drugs versus alternative drugs within the same class.
- Updating *printed* formulary would be helpful—can better see the big picture. Online CHCS drug data are fine. Sometimes I'm unaware of treatment options and relative costs within a drug category. This needs to be in print form.
- It would be beneficial to have a hard copy of the most current formulary and key policies for prescribing medications at the MTF. These vary from place to

place, and now in large MTFs many things are left to the provider to figure out as they go along. Not everyone in the facility has easy access to the pharmacy Web page. In addition, things out of stock or changes are not sent to the provider via CHCS e-mail. Again, one finds out through department meetings or [when] trying to order things.

- Make the formulary readily available, either printed or electronic, with updates of drug preparations and dosage strengths available.
- Notification of medical house staff prior to removal of drugs from the formulary to generate feedback and practical discussion of implications and alternative agents (with the overall goal of maintaining optimal patient care).
- (1) Publish regularly in electronic/Web and printed formats. (2) Allow visualization of all drugs in one class in CHCS. (3) Notification to physician that special medication is not only approved (we receive this [in a timely fashion now] through CHCS SPP requests), but that the medication has been obtained and “delivered” to patient.
- (1) Open format for all physicians to have input (*not* just the director). (2) Regular meetings with pharmacist. (3) Dissemination of information to patients on why certain drugs are included or excluded. (4) Better feedback when requesting non-formulary drugs. (5) Provide prescribing patterns through quarterly reports.
- Give feedback on commonly prescribed non-formulary medicines. Trends may indicate a need to amend the formulary.
- Better, searchable drug database with classes of drugs and costs available [in the database]. Needs to be quick and easy to use.
- Just send out updated formulary drug lists. Also, directions on the correct procedure to acquire non-formulary medications if needed.
- Please provide current hard copy formulary book on all drugs in our formulary plus a field-specific one as well. Local MTFs in our area all have different formularies, making it hard [for doctors] to know what’s available when they travel to local MTFs or staff clinics. We need to be on the same formulary. Too much time is wasted in seeing what is available at a given MTF.
- Remind providers about the non-formulary process; update [the physician/prescriber] on additions via CHCS.

Miscellaneous

- Better responsiveness and pro-activeness regarding the Advance Practice Nurse's formulary.
- Weighted criteria list.
- Hiring more pharmacy personnel to cover the after-hours clinic will help the providers to better concentrate on the patient care instead of dispensing actual (limited) medications, thereby reducing errors, which are increasing because of the pressure!!
- I do not agree with the policies on the HMG-CoA reductase inhibitors statins.

General Comments from Purchased-Care System Prescribers

Pharmacy Issues

- It would be nice for the patients if I could call or fax in prescriptions. The local MTFs accept only written prescriptions. I don't think it could be too hard to change this policy, and it would make it more convenient for the patient.
- I am very unhappy with the fact that the military base does not provide a copy of a formulary. I cannot prescribe medications on the formulary if I do not have knowledge of what is on the formulary! Furthermore, it is almost impossible to get any help by phoning them. They will not allow refills by phone or fax like real pharmacies. My patients are very upset when they drive 30-plus miles to the base to fill a prescription and are told that the prescription is not on their formulary. In my opinion, it is a poor excuse for a pharmacy, but I guess that the price is right!
- Frustration is sometimes expressed [by patients] that [their] prescriptions cannot be filled 100 percent on base.
- Having an in-house pharmacy that accepts TRICARE is very helpful. The formulary from the local MTF is readily available and helps with prescribing.

Insurance Burden (Formulary Burden)

- We participate in 30 different insurance plans. It is impossible or at least very impractical to keep track of the insurance plans' formularies because of the extra time involved. We already spend as much time with insurance paperwork as we do providing medical care and would actively resist any additional regulatory burden.
- I find it impossible to keep up with formularies, as we see patients from so many plans and have little time to track down formularies, look up drugs, and such. I write prescriptions with no regard to what may or may not be on a formulary, and let the pharmacist call me if there is a problem.
- Medicine, in general, is becoming less and less attractive due to insurance and medication dictates, hassles, and constraints. I think many physicians would retire ASAP if they had the means. I still enjoy my work, but probably less so than five years ago. I was planning on working into my 70s, but I am now reconsidering. I feel our medical system is really broken, and the [broken] pieces multiply each year.

- Formularies are basically a good idea; however, with the large number of insurers each having a formulary, to look up the prescriptions on every patient is time consuming and therefore not done. Additionally, when considering medications on formularies, frequently medications available for one-to-two times a day dosing are left off in favor of four-times-a-day cheaper medications. Few people take [medications] four times a day, [which] minimizes the therapeutic effect. Dosing frequency or ease of administration must be considered an important factor when generating formularies.
- It is difficult to keep up with all the insurance companies' formularies. I always ask my patients if they know if a certain medication is available at [the MTF]. I do sign all of my prescriptions on the "product selection permitted" side [of the prescription form]; however, this seems unacceptable at the [MTF]. By signing this, it should allow the pharmacist to make the substitution. I don't have this problem with commercial pharmacies.
- Patients are on health insurance plans that keep changing periodically, and formulary lists also keep changing very frequently. Given the immense number of plans that our staff has to deal with, it is very difficult to check on formulary plans every time one writes a prescription. Besides, patients who have used a certain medication for many months (in some cases for years) should not be changing their medications.
- I suppose formularies are a necessary evil to contain costs. I find them, however, to be extremely burdensome. Most of my TRICARE patients have the mindset, "If I can't get it for free (or very cheap), I don't want it." I try to prescribe the best and safest medicine, which at times means it is more expensive. I would like to see doing away with blanket rejections and onerous obstacles. Instead, [I would like to see] a tiered system where the patients can still get what is best and safest for them just by paying a bit higher co-pay. Then, I would have to do fewer unnecessary lab tests and additional office visits, [and I would have] fewer hoops to jump through. Bureaucrats don't know why a certain medication is best for a certain patient. They don't know the long history of what has been tried and failed or associated with side effects already. I do.
- I usually don't have time to consider a patient's insurance during our encounters. I will often ask the drug reps if their products are on all the formularies or not. If one formulary doesn't cover [a drug], I tend not to use it because I can't keep track of all the different lists. Also, because I practice in a group, I may not be the one who has to change a medication because it isn't on the formulary. The pharmacist may speak to a nurse who "runs it by" another doctor. Even if a drug is the most cost effective in its class, it may

not work well for an individual. There needs to be more leeway [in what we can prescribe].

- Formulary/preferred drug programs are a pain!! Busy practices with contracts with multiple insurance programs/health care systems are overwhelmed with drug formulary/preferred lists (our practice [has] over 30 [contracts]); it is impossible to keep up. Additionally, most [plans] routinely deny appropriate drug coverage.
- Formularies and tiered systems are *very* cumbersome for the practitioner. We see many insurance company patients and many formularies, which seem to change all the time.
- A burden is placed on physicians by faxed letters of rejection to switch brands of medication to “formulary”[medications]. However, a better idea is to have patients know about alternative brands and let them decide on trying a new agent (often when the incentive is the money that could be saved). Being a middle person between insurance [companies] and patients is difficult. If the insurance plan wants to save money with the patient’s OK, then approval by the physician would be appropriate and time saving.
- Generally, I feel that formularies are useful for insurance companies. However, in a busy practice, it is very time consuming to check formularies for each prescription. We care for patients [covered by] most insurance companies. Plus, every patient has his or her own preferences, effectiveness profiles, etc.

Quality of Life

- Medicine, in general, is becoming less and less attractive due to insurance and medication dictates, hassles, and constraints. I think many physicians would retire ASAP if they had the means. I still enjoy my work, but probably less so than five years ago. I was planning on working into my 70s, but I am now reconsidering. I feel our medical system is really broken, and the [broken] pieces multiply each year.
- I am made bitter by the over-regulation; it is an abuse of our profession! When I go through a medical process, I want my decision to be respected as it is!

- Since EMTALA [Emergency Medical Treatment and Active Labor Act] has made emergency physicians the only legally mandated slave labor in the United States, there are far too many rules, regulations, formularies, and contracts we are supposed to be familiar with, and not enough hours in the day.

Cost

- We are frustrated by TRICARE's abysmal reimbursement. Most doctors in this geographic area are not [TRICARE] providers because of this. We fought with TRICARE over depoprovera coverage. I have to buy 96 units of depo to get the lowest price of \$41.20 each. TRICARE pays \$45 plus \$12 copay. What business can survive with such a narrow profit margin? TRICARE is the worst payer for depoprovera. [TRICARE] used to pay \$31 [each], and I almost dropped my provider status over this. I feel military personnel should get the drugs prescribed at no cost to them. When I was in active duty, I served in the P&T committee and we were responsive to patient needs and costs; it worked well. But managed care P&T committees are dishonest, and I cannot deal with the myriad formularies shoved my way. I have never seen a TRICARE formulary.
- Drug costs are very, very important and need to be contained because they are driving the increasing cost of medical care. On the other hand, drug companies would not increasingly be coming out with truly miraculous, new, and safer medications if they didn't think they could make large profits [after] the tremendous costs of R&D and going through the FDA approval process. I don't know the correct balance of these two important aspects of the problem.
- To get quality physicians to this area, where the population is significantly military related, the emphasis has to shift from discounted fee for service to quality physicians (specialty based, board certified). With the emphasis on discounted fee for service, it is difficult to recruit quality physicians. This is a disservice to not only the CHAMPUS beneficiaries but also the community at large. Quality physicians cost less [in the long run] by providing better care. Especially now that TRICARE payments [are more] in line with Medicare rates, the system should move away from who-gives-more-of-a-discount to who-are-the-better-physicians.
- TRICARE patients are a welcome addition to our practice! Due to exceptionally low reimbursements in the other plans, we can only accept TRICARE Standard. To expand patients' opportunity for quality care and

resources, [TRICARE should] consider raising reimbursements in a competitive marketplace.

- I don't have a problem with a tiered co-pay for medications, but I have a real problem with a formulary that won't pay any of the cost of a medication when other less-expensive medications have been tried and failed. The main examples are Concerta or Metadate, Adderall, Diflucan, Xapenex, and Pulmicort (not just with TRICARE, but in general), and some formularies won't pay for any antidepressants that I prescribe for my adolescent patients; [then] the patient has to see a psychiatrist.
- Patients need to be *educated* as to (a) why they have a formulary and (b) what the cost of their *medications* is. They are currently too removed from the true cost of their health care, including drug costs.
- Most patients confuse *price* (cost) with *value*.

Formulary Content

- We are frustrated by TRICARE's abysmal reimbursement. Most doctors in this geographic area are not [TRICARE] providers because of this. We fought with TRICARE over depoprovera coverage. I have to buy 96 units of depo to get the lowest price of \$41.20 each. TRICARE pays \$45 plus \$12 copay. What business can survive with such a narrow profit margin? TRICARE is the worst payer for depoprovera. [TRICARE] used to pay \$31 [each], and I almost dropped my provider status over this. I feel military personnel should get the drugs prescribed at no cost to them. When I was in active duty, I served in the P&T committee and we were responsive to patient needs and costs; it worked well. But managed care P&T committees are dishonest, and I cannot deal with the myriad formularies shoved my way. I have never seen a TRICARE formulary.
- As a fertility specialist, it does not make sense to me that TRICARE patients can have certain fertility drugs or treatment only if they are seen at a base facility. The drugs should be covered wherever the patient is seen if they need it.
- I don't have a problem with a tiered co-pay for medications, but I have a real problem with a formulary that won't pay any of the cost of a medication when other less-expensive medications have been tried and failed. The main examples are Concerta or Metadate, Adderall, Diflucan, Xapenex, and Pulmicort (not just with TRICARE, but in general), and some formularies won't pay for any antidepressants that I prescribe for my adolescent patients; [then] the patient has to see a psychiatrist.

- I usually don't have time to consider a patient's insurance during our encounters. I will often ask the drug reps if their products are on all the formularies or not. If one formulary doesn't cover [a drug], I tend not to use it because I can't keep track of all the different lists. Also, because I practice in a group, I may not be the one who has to change a medication because it isn't on the formulary. The pharmacist may speak to a nurse who "runs it by" another doctor. Even if a drug is the most cost effective in its class, it may not work well for an individual. There needs to be more leeway [in what we can prescribe].

Quality of Care

- To get quality physicians to this area, where the population is significantly military related, the emphasis has to shift from discounted fee for service to quality physicians (specialty based, board certified). With the emphasis on discounted fee for service, it is difficult to recruit quality physicians. This is a disservice to not only the CHAMPUS beneficiaries but also the community at large. Quality physicians cost less [in the long run] by providing better care. Especially now that TRICARE payments [are more] in line with Medicare rates, the system should move away from who-gives-more-of-a-discount to who-are-the-better-physicians.
- Patients are on health insurance plans that keep changing periodically, and formulary lists also keep changing very frequently. Given the immense number of plans that our staff has to deal with, it is very difficult to check on formulary plans every time one writes a prescription. Besides, patients who have used a certain medication for many months (in some cases for years) should not be changing their medications.
- The big complaint by patients in the Denver area is that the closest MTFs that provide drugs are the Air Force Academy and Ft. Carson; both are in Colorado Springs. Buckley AF base has an MTF (albeit small), but it does not provide pharmacy coverage to the numerous dependents and retirees in the Denver area.
- It is not reasonable to refill prescriptions by mail/fax. When this is done, patients frequently do not return for office appointments and checkups on their blood pressure, glucose, etc.
- I suppose formularies are a necessary evil to contain costs. I find them, however, to be extremely burdensome. Most of my TRICARE patients have the mindset, "If I can't get it for free (or very cheap), I don't want it." I try to prescribe the best and safest medicine, which at times means it is more expensive. I would like to see doing away with blanket rejections and

onerous obstacles. Instead, [I would like to see] a tiered system where the patients can still get what is best and safest for them just by paying a bit higher co-pay. Then, I would have to do fewer unnecessary lab tests and additional office visits, [and I would have] fewer hoops to jump through. Bureaucrats don't know why a certain medication is best for a certain patient. They don't know the long history of what has been tried and failed or associated with side effects already. I do.

TRICARE Program

- We are frustrated by TRICARE's abysmal reimbursement. Most doctors in this geographic area are not [TRICARE] providers because of this. We fought with TRICARE over depoprovera coverage. I have to buy 96 units of depo to get the lowest price of \$41.20 each. TRICARE pays \$45 plus \$12 copay. What business can survive with such a narrow profit margin? TRICARE is the worst payer for depoprovera. [TRICARE] used to pay \$31 [each], and I almost dropped my provider status over this. I feel military personnel should get the drugs prescribed at no cost to them. When I was in active duty, I served in the P&T committee and we were responsive to patient needs and costs; it worked well. But managed care P&T committees are dishonest, and I cannot deal with the myriad formularies shoved my way. I have never seen a TRICARE formulary.
- It is very difficult to find specialists to refer our TRICARE patients to. TRICARE takes a long time to approve our referrals. Of the hundreds of insurance companies we deal with in our office, TRICARE is by far the *worst* insurance company.
- I am a veteran. I have 3X years for pay purposes. I was a Navy corpsman during the Korean conflict, a Navy surgeon in Vietnam, and retired as an O-6 chief of surgery. I was recalled (from retired status) for Desert Shield/Desert Storm for most of 1991. Losing my private practice in the process, I was in civilian practice from 197X-197X, 198X-199X and since the end of 199X. I believe I'm in a position to judge, both from military and civilian standpoints, comparative medical systems. TRICARE is an abomination; virtually no physicians will accept TRICARE Prime due to the extremely low reimbursement rates. I haven't received an updated provider's directory in three years. The personnel at the local office are unresponsive and often rude. The referral process is by far the most cumbersome. To my knowledge, there is no intermediary "representative" between TRICARE and physicians. In brief, it is the worst third-party carrier with whom we deal.

- Most parents do not go to military facilities for drugs because the waiting time is *too long*, and when you have a sick child, you want to start treatment ASAP.
- I am very unhappy with the fact that the military base does not provide a copy of a formulary. I cannot prescribe medications on the formulary if I do not have knowledge of what is on the formulary! Furthermore, it is almost impossible to get any help by phoning them. They will not allow refills by phone or fax like real pharmacies. My patients are very upset when they drive 30-plus miles to the base to fill a prescription and are told that the prescription is not on their formulary. In my opinion it is a poor excuse for a pharmacy but I guess that the price is right!
- It is difficult to keep up with all the insurance companies' formularies. I always ask my patients if they know if a certain medication is available at [the MTF]. I do sign all of my prescriptions on the "product selection permitted" side [of the prescription form]; however, this seems unacceptable at the [MTF]. By signing this, it should allow the pharmacist to make the substitution. I don't have this problem with commercial pharmacies. We have more problems with TRICARE referrals than with the formulary.
- TRICARE provides poor coverage compared with other providers.
- I suppose formularies are a necessary evil to contain costs. I find them, however, to be extremely burdensome. Most of my TRICARE patients have the mind-set, "If I can't get it for free (or very cheap), I don't want it." I try to prescribe the best and safest medicine, which at times means it is more expensive. I would like to see doing away with blanket rejections and onerous obstacles. Instead, [I would like to see] a tiered system where the patients can still get what is best and safest for them just by paying a bit higher co-pay. Then, I would have to do fewer unnecessary lab tests and additional office visits, [and I would have] fewer hoops to jump through. Bureaucrats don't know why a certain medication is best for a certain patient. They don't know the long history of what has been tried and failed or associated with side effects already. I do.
- TRICARE management programs waste many hours of precious patient and staff time (e.g., attempting to micromanage first- and second-order clinical decision-making processes and testing). We are in the process of considering dropping this program because it [has a large] hassle factor and pre-approval, which wastes time, money, and efficiency. Actually [TRICARE's] drug program, which is full of micro-management holes, is better than their medical decision and pre-approval program—you should have run a survey for that!

Communication

- The formularies or preferred drug lists need to be in an easy-to-use format and on the Net or available through touch-tone phone—[then one could] spell out the medication to see if [it is] approved.
- Patients need to be *educated* as to (a) why they have a formulary and (b) what the cost of their *medications* is. They are currently too removed from the true cost of their health care, including drug costs.
- Provide the patient with a list of formulary alternatives for their problem.
- Justify formulary rejection to the provider and *patient*.

Miscellaneous

- I notice that my TRICARE patients are very well behaved and respectful compared with their peers—God Bless Our Military!
- Each health insurance product has a different formulary or preferred drug list and process for approving non-included medications. It is impossible for anyone to keep these lists current. If everything is equal, I will try to prescribe the covered or less-expensive drug, but often there are small but important differences [that would warrant prescribing] other medications. If the pharmacist or patient approached me regarding the alternative, I would be able to explain the reason for the choice. Systems that increase paperwork/staff time and patient activities decrease the use of needed medications, [but there] is still increased cost for health care [at a non-pharmacy level].
- I am retired from the Army, and even when I was on active duty I was unable to get a copy of the mail order formulary. I do keep copies of local military formularies when available but would love a copy of the mail order formulary and its prescribing rules. Thanks.
- The problem is taking the time to look up a patient's drug in all the different formularies we have to keep up with.
- The field of neurology—especially in epilepsy treatment—is changing rapidly. I do not feel that a formulary can keep up with rapidly evolving pharmacopeae.
- I am usually not aware of the type of insurance my patient has.
- Occasionally patients will say they're from the military base and are going to their pharmacy there. However, they have not mentioned any restrictions with formulary medicines.

- Military people and dependents deserve the best medical care for the job they do. They work in bad weather conditions, under lots of stress, and sometimes risk their lives for their country! Thanks.
- I have only had one military personnel patient, and he has moved out of town. I hate formularies. I have enough to do to practice medicine without the added burden of consulting formularies. I routinely throw away formularies!
- There are too many *different* formularies for different insurance companies.