Generic Drug Substitution: Is it Penny-wise but Pound-foolish?

Generic drugs have the potential to save a significant amount of money, but could also compromise our patients’ health if we don’t take a big-picture approach.

Prescription medications are not getting any cheaper these days. Between the rising costs of insurance premiums for a good plan, skyrocketing copays and raised deductibles, more and more families have to make a choice between their medications and their groceries. Unfortunately for our patients faced with such a dire choice, it’s unlikely that they would comply with their much-needed drug regimen. Treatment compliance is difficult enough to achieve, particularly in epilepsy patients, given efficacy and side effect issues inherent in most regimens. The last thing we need is to give patients another reason to neglect their medication regimen.

Many patients in this position—and some who are more thrifty than desperate—will ask for a generic prescription so they can save money. When one looks at the prices in a direct number-to-number comparison, it becomes clear that the savings could be substantial and could possibly save patients a considerable amount of money. For physicians providing service in capitated plans, generic drugs offer a tantalizing way to lower per-patient expenditures. However, as a physician you know that the cheapest drug is almost never the best bet for patients, especially with the sorts of treatment-resistant conditions our specialty has to confront on a daily basis.

The temptation to prescribe a generic version of a medication is great, but just like finding a builder for your new home, cheaper is not always necessarily better. There are many factors to consider before making the decision whether or not specify a brand name on the prescription pad. In this article, we’ll look at what should go into the decision-making process when we compare minimum spending with maximum benefits. Most of the examples I’m using are derived from my experiences as an epilepsy specialist, but they can be adapted to other conditions by placing the principle in a new context.

Review of Pharmacology Therapy 101
One of the most basic facts for any practitioner is that each patient’s medication profile must be individualized, and that the many variables of patient care must be taken into consideration before prescribing. For my specialty, epilepsy, this means diagnosing the seizure type, the specific epilepsy syndrome, knowing all concomitant medications, any potential drug interactions, and the side effect profile of the medications one has in mind to prescribe. This gives us a basis of information to start thinking about substitutions.

The savings for using a generic medication instead of a trade name medication are not trivial. Some comparison numbers from one of my local pharmacies demonstrates this point quite well. The cost of an 800mg daily dose of generic carbamazepine is $18.32 for one month. In contrast, Tegetrol, the trade name formulation, is $92.00 for a one-month supply. Another example is generic depakene at 500mg BID, a fairly standard dose, which would cost $19.74 per month. Under its official trade name of Depakote, it comes in at $160.00 for a one-month supply. Finally, generic gabapentin is a big hitter at $117.10 per month for a 2700mg/day regimen, while brand-name Neurontin tops out at $480.00 per month. Using these three examples of generic medicines versus trade name formulations, the ballpark average savings for the patient is around 80 percent.

While some drugs aren’t available off-brand, there are similar choices that can be used when the objective is to cut down on costs. For example, extended-release carbamazepine (Tegetrol XR or Carbretrol) does not have a generic equivalent, so opting for generic carbamazepine requires more frequent dosing. This can mean there will be more fluctuation in blood levels, such as we often see when depakene is substituted for Depakote, so we would have to work periodic monitoring into the treatment plan.

To Switch or Not to Switch?
 Suddenly, treating epilepsy looks like it got a whole lot easier, which would eliminate that budgeting and compliance problem we started talking about in the beginning. Sounds like we should switch our patients to generics, doesn’t it? But this is too simple a solution to be practical or beneficial for some of our patients. We have to be cautious, because just as saving a nickel now could cost a dollar later, an inappropriate medication chosen based purely on its low price could cost a life.

The circumstances that allow for generic medications are really quite well understood as a matter of common sense throughout the medical community. While not set in stone, these give us criteria for decision-making. The law states...
that a brand-name medication can be prescribed by a physician, but could be substituted by a pharmacy (due to patient request or insurance formulary constraints) and given to a patient, unless, a big caveat, DAW (dispense as written), is written on the original prescription, which directs the pharmacy to dispense only what is written.

In my personal experience as an epileptologist, the only time I believe the use of generic medication is a more appropriate option than a brand-name medication is when I have complete control—namely, monotherapy using a medication that has a generic option. If the patient has been completely controlled on a brand name medication for a year, it may be reasonable to start considering a generic alternative. It seems ill advised to switch to a generic substitute when a patient is not completely controlled.

Why must we be so meticulous about the use of generics? Basic pharmacology training also tells us the FDA requires a minimum of 80 to a maximum of 125 percent bioequivalence from a generic to the brand-name product, which may be insufficient for the delicately controlled epilepsy patient or anyone else with an intractable condition. This is quite a range of equivalence, and for some patients it is simply too much. Therefore, it is best to take the conservative route: if a patient is completely controlled on one brand-name drug (with emphasis on the “completely”), a transition to a generic after one year appears to be reasonable. I think this is an appropriate course of action given the current regulations towards generics.

Relative Savings
Unfortunately, this conservative course of action will exclude many of our patients from receiving generics. They may bemoan the short-term expenses, so you may have to explain to them that using generics may be penny-wise but pound-foolish.

I know the cost of medication is a significant factor in epilepsy treatment. I hear this again and again from my patients and colleagues, but I counter by explaining that a visit to the emergency room, an ambulance ride to the hospital or additional office visits and lab work needed to monitor drug levels can negate any savings that can be achieved by the use of generic medication. Remember, an emergency room visit can cost well over $2,000, which puts paying for even the most expensive drugs every month into perspective.

The use of generics has a limited application. It can lead to some significant savings if it does work for an individual patient without compromising the treatment strategy. In others, it can endanger health. Yet it still remains a safer choice than purchasing prescriptions from mail-order foreign pharmacies or other supposedly cheaper measures of questionable safety and/or legality.

In the conventional model of treating epilepsy, and other neurological conditions, we operate with the two equally important goals, those of controlling the symptoms while managing the adverse effect profile. Now, though, we may find ourselves worrying about how to accomplish these goals without bankrupting our patients as drug prices continue to rise while insurance carriers slash their formularies and/or benefits. Generics can help in some situations, although these should be viewed as one possible option instead of an easy solution. PN