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My name is Sherrie Sharp and I am a child and adolescent psychiatrist. I work at Child and Family Agency of Southeastern Connecticut. My practice is in a Health Professional Shortage Area recognized by the National Health Service Corps.

Recently implemented policies requiring 90-day mail order prescriptions have turned out to be significant barriers to treatment in the case of certain vulnerable populations. Many minors are negatively impacted by this recent change in insurance practice.

The most vulnerable groups are patients at risk of committing suicide who should not have access to 90 days worth of potentially lethal medications. It is also unsafe and unethical to prescribe this quantity of medication to those for whom safe compliance with instructions is a clinical issue. Supplying 90 days worth of medication to minors, who may be suffering dramatic mood swings in the setting of unstable family and social supports, is also irresponsible.

In my practice these families have found that their health insurance prescription plans have been a detriment rather than a benefit in their children's care. When these families have been provided a prescription for a thirty-day supply for appropriate clinical reasons, they have been given the run-around from their prescription drug plans and have incurred very significant costs.

More than one patient had medication supply interrupted several times due to insurance companies stalling responses or just plain misleading parents with messages that the medication was in the mail when it definitely was not.

When it is not appropriate for clinical reasons to provide such lengthy prescriptions, families end up paying the full cost of the medication at the pharmacy. For families with compliance issues this is an annual expense.

Given my former career in business I fully appreciate that mail order medication supply is cost- effective for patients, employers, and insurers. There are many instances in which 90-day-supplies of medication would be practical and without such significant risk.

However, this is often not the case in community psychiatry practices. Specifically, this is becoming a critical issue in child and adolescent psychiatry as more and more medications are only covered for an inappropriate abundant supply and prescription drug companies are blocking physicians' efforts at clinically based exceptions on case by case basis.

This is a serious dilemma for physicians who do not want to burden families with paying out-of-pocket for medication, but who bear the ultimate liability if a patient harms himself. Unfortunately, this burden is likely to result in the higher risk patients not being treated as physicians reflect on their oath to "first do no harm," when the only treatment option is to arm their patient with 90 days worth of a lethal mood stabilizer, for example.

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Let me tell you about one of my patients:

I will call her Sarah. She was a 17-year-old who presented at the end of May when graduating from high school. She had recently broken up with her boyfriend, was leaving the safe environments she'd known for years, and her relationship with parents had become distant as they were consumed by her brother's complicated medical illness.

Sarah's pediatrician started her on an SSRI until she could initiate care with me. At the intake she confided for the first time that she had been suicidal during the recent weeks of her current depression and had identified a tree in her neighborhood that she planned to crash her car into in order to kill herself. She drove herself by the tree daily and thought of hitting it often.

Her treatment continued and I learned that her parents still wanted her to go out of state to college in August. I expressed my concerns about Sarah moving away so soon after considering suicide. We discussed my recommendations for setting up care in advance of her move, and checking in with Sarah frequently if they did send her to college.

Come mid-August her prescription drug plan's policy changed and suddenly required prescribing 90 days worth of medication at a time. At our last office visit I was pressured by the plan administrators to provide the 90-day-supply. I told them that it was not appropriate and they directed me to complete and submit a form. I did so twice and my request was denied. I followed up with a call and informed the representative supervisor why a large supply was inappropriate in this case. The supervisor assured me that it was all set and she would override the requirement; however, after the patient was away at college, we received retroactive notification that it was not covered.

Given the combined risks of weak relationships with parents, recent break-up with a long-term boyfriend, and the stressors involved in having all new social and academic demands at college so soon after being suicidal, no child psychiatrist would recommend giving Sarah a quantity of medication that large. I find it atrocious that unwitting parents, such as Sarah's, pay for prescription drug policies that are executed without regard for their dependents' health and safety.

Besides Sarah, too many children are poorly supervised at home and are responsible for administering their own medications despite recommendations to the contrary. As physicians we have little control over the behavior of our patients or their parents when they are in the community yet we are responsible for their outcome. The only control we have is whether the amount of medication we prescribe can cause organ damage or take a life.

While the insurance companies may tell you they have a policy in place to address this, it is not effective. Their employees or subcontractors don't even know that it exists or how to access it. Repeat requests to speak to the Medical Director or the clinical person who can address an appeal bears no results. My experience is that the patient's family is left paying exorbitant prices. It's up to us to see that this changes.