Neurology® Clinical Practice

Formularies, costs, and quality of care

Nitin K. Sethi, MD, New York–Presbyterian Hospital: I read with interest the debate between Labiner and Drake vs Jones about formulary restrictions, in particular for epilepsy.[1,2] While the authors have taken polarized views on the subject for the sake of fostering a lively debate, clearly the answer lies somewhere in between. At its most basic level, a formulary may be defined as a book containing a list of pharmaceutical products with their formulas and means of preparation. One of the main functions served by formularies today is to specify which medicines are approved to be prescribed for a particular ailment. I agree with Labiner and Drake that formulary restrictions often limit physician autonomy, thereby forcing us to modify our drug of choice. This is especially evident in the care of the patient with epilepsy, where physicians are compelled to prescribe generic as opposed to brand name anticonvulsants. That said, physician prescribing practices vary widely based on the level of training (resident physician in training vs one just out of residency vs an experienced physician), the practice setting (rural vs urban), and finally the availability of drugs. For the old-timers among us, sodium valproate may still be the drug of choice for patients with primary generalized epilepsy, while the young ones (young in age, not necessarily in experience!) may prefer lamotrigine. Formulary restrictions play a vital role in maintaining quality and consistency of care. To that end, I also agree with Dr. Jones that limiting formularies is not harmful to all our patients.

Disclosures: N. Sethi serves as Associate Editor for *The Eastern Journal of Medicine*.

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1. Labiner DM, Drake KW. Formularies, costs, and quality of care. Formulary restrictions are not the answer, especially for epilepsy. Neurol Clin Pract 2013:71–74.
2. Jones WN. Formularies, costs, and quality of care: limiting formularies is not harmful to patients. Neurol Clin Pract 2013:75–77.

Author Responds: **William N. Jones, MS, RPh, The University of Arizona, Tucson:** I thank Dr. Sethi for his interest in the point-counterpoint of the impact of restrictions on formularies. I would add to Dr. Sethi's comment that formularies can also improve safety by ensuring more established therapy is considered before new therapy. Serious adverse effects that are unknown in clinical trials occur when used in a very large number of patients. As a note of proof, the FDA just announced that ezogabine (Potiga) can cause blue skin pigmentation and retinal abnormalities after several years of treatment. The FDA is recommending that patients have baseline and regular ocular examinations and that skin discoloration is a reason to contact their neurologist urgently. The 2 adverse effects have been seen independently, and it is unknown whether they are reversible. Formularies can also help to avoid sound-alike and look-alike drug confusion. Formularies should be evidence-based. When there are gaps in the evidence, research should be done to narrow those gaps. Conducting projects addressing unknowns will help improve care and the formulary.

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