Amgen Inc. - Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.

Interview conducted on March 06, 2023

Topics

Field Reimbursement Manager, Patient Access, Barriers to Therapy, Benefit Verification, Prior Authorization, Collaboration, Co-pay Reimbursement

Summary

A Tegus Client speaks with a former Field Reimbursement Manager at Amgen, Inc. to understand the role of an FRM in helping healthcare providers (HCPs) get patients on therapy. The FRM's workflow starts with a list of offices that have ordered and they rely heavily on their sales team for information. They also check for consent from both the clinic and the patient before providing their services. The expert suggests reordering the steps, with gathering case info from the hub/portal as the first step, followed by gathering information on the patient, and then contacting the clinic. In step three, the expert examines barriers to starting therapy and organizes strategies to overcome them. In step four, the expert determines how to overcome the barriers to therapy and decides how to contact the clinic and patient. The expert explains steps five, six, and seven, which involve revealing either the prior auth submission, the appeal, the letter of medical necessity, or preparing for a peer-to-peer review to eliminate barriers, verifying the account and understanding how to overcome barriers and tracking the account's progress in overcoming barriers, and moving on to the next strategy if the initial strategy doesn't work. The expert also explains the process of closing out a case.

Expert Details

Field Reimbursement Manager - Oncology/Hematology at Pharmacosmos Therapeutics and former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc., leaving May 2022. Expert can speak to their experience overseeing field reimbursement at both Pharmacosmos Therapeutics and Amgen, Inc.

Field Reimbursement Manager - Oncology/Hematology at Pharmacosmos Therapeutics. The expert is responsible for overseeing field reimbursement across 14 states in the West region. The expert serves as the National Trainer - Monoferric Patient Solutions, training new hires on all medical, commercial, reimbursement, and access functions.

Prior to Pharmacosmos Therapeutics, the expert was the Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc., leaving May 2022. The expert was responsible for reducing access and reimbursement barriers for patients and providers to optimize access to dermatology and rheumatology products. The expert executed the collaborative territory strategic plan through partnership with internal and external stakeholders, HUB, sales, and market access.

Q: What are your current top 3 goals/focuses in your current role?
A: 1. COLLABORATION: Coordinates cross functionally with Matrix team (Sales Account Representative, Key Account Manager, Market Access, and Nurse Educator) to minimize access and reimbursement barriers for patients and providers and optimize access to Monoferric and help get on formulary. Maintain an expert level knowledge of local payer status & actively engage with customers on current information and plan changes.
2. EDUCATION: Proactively calls on clinically convicted IDNs and Community Oncology accounts to ensure understanding of reimbursement process, field reimbursement services, payer landscape, and patient support program. Onboard and educate new Monoferric customers to MPS and how to best utilize all resources offered (best practices, digital enrollments, electronic signatures, etc.)
3. CASE SUPPORT: Demonstrates unwavering support and consultative approach to help offices obtain insurance authorization and/or reimbursement of Monoferric for identifying appropriate patients. Support offices Financial Counselor & Reimbursement Staff with Claims, Prior Authorization & Denial Support.
4. LIASON: Between Monoferric Patient Solutions Hub and provider office- to provide access to patient

assistance and access support services. Identify areas of opportunity and implement customer support initiatives. Ensure timely case processing & turnaround time on program offerings (copay, PAP etc.)

Q: What is the job title of your boss/the person right above you in your org? (e.g., Directly reporting to the VP of Market Access)
A: The job title of my boss is : Director of Monoferric Patient Solutions. Her boss is VP Market Access.

Q: What are the job titles of the people you manage/your direct reports? (e.g. Regional Account Manager)
A: I have no direct reports but am above the Key Account Managers and Specialty Account Reps who are “selling.” Laterally is the National Account Director who calls on the payers only.

Tegus Client
Hi, thanks so much for speaking with me. Today, I want to understand the role of an FRM and understand how FRMs help HCPs get patients on therapy. So just starting from the top, can you just briefly describe your current role and your day-to-day?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Yes. So I'm a Field Reimbursement Manager. I cover the Western region, 14 states. My primary goal is to help patients gain access to therapy. So from everything with explaining payer coverage to benefit verification, supporting with appeals, prior authorizations, getting patients enrolled in co-pay assistance or patient assistance programs, visiting customers in person and also virtually, whatever they feel most comfortable with, ultimately to help the patient get started on therapy.

Tegus Client
Got it. And in your current role, what do you see is your ultimate goal? Is it removing barriers for a patient to help them start getting therapy? Or is it actually helping a patient start therapy?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Well, the current product I support is favorable with some payers, but not favorable with other payers. So for some offices, if it's a heavy Medicare population, then I find myself trying to provide help with enrolling the patient, getting them started on therapy because we know we're on the CMSP schedule for Medicare.

But if it's another payer like UnitedHealthcare, where there are step therapy requirements, payer policies in place that are trying to force the office to try sometimes up to three other treatments before my treatment can get covered, it's then removing barriers. So it does depend on the office. It also depends if it's a community clinic versus an institution. My day is spread 50-50 between both community oncology offices as well as IDNs.

Tegus Client
So I want to understand your steps in helping a clinic or a patient, get the patient on to specialty medication. So just starting with step one, how does your workflow starts? So how do you first find out that a clinic or a patient needs your assistance?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
I rely heavily on my sales team. So the sales team provides me with a list of offices that have ordered. I support a buy-and-bill drug. And so I receive a weekly accounts with order reports. And I use that report to proactively call on offices that have ordered. I introduce myself on the phone as their field reimbursement manager. I noticed you recently ordered. I want to make sure you get reimbursed, you get paid. And that patient that you ordered it for that we're able to get it covered.

And that's when I introduce our services. We've got a portal. We talk about enrolling the patient for copay

assistance. We will do the benefit verification. We'll determine if a prior auth is needed or not. If a prior auth is needed, we'll tell your office how to do the prior auth. We'll identify the prior auth form. We won't do it for you, but we'll teach you how to fish. We'll hold your hand along the way. We offer billing and coding assistance. So any time an office of using this off-label, we can't support off-label usage. So I'll provide a billing and coding guide and ask if any of the on-label codes apply so that your patient can gain access to the co-pay program.

So my day is driven by, we do a lot of proactive outreach to accounts that have ordered. We also focus on imminent accounts that the sales team has deemed as a hot account. They're ready to order. They are clinically convicted, but they just have some questions about or concerns about payer coverage about the authorization process about cost.

I talk a lot about reimbursement rates. We are in a very fortunate space where we have pass-through status. So we're taking advantage of that, educating with some of the 340B hospitals. So it's a mixture between proactive outreach as well as reactive when the phone rings and there's a problem. I can't get it covered, I got a denial. So it's 50-50.

Tegus Client
So when you think about just step one, are these legitimate steps in the beginning of your workflow?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Yes, I rely on the sales team for that information. I rely on them for both. Usually, we do receive the account with order list without the sales data. But that usually is the first step is who needs help. If they're not calling me, I kind of look at that list that's sent weekly to me. I worked for other companies. I supported drugs for Pfizer and Amgen where they actually gave the FRM target list and said, "Here are people that you need to call on and KPIs on how much and how frequently you need to call on them."

I disagree with that because I was calling on people that had never prescribed, and they were like, "So are you the new rep" and I'm not because now I'm being utilized as a sales tool. So I do like receiving a list of people that have actually ordered or they're hot imminent accounts ready to order.

Because at that point, the salespeople have done their job. They're clinically convicted, they've ordered or they're about to order, and now I can help provide clarification and I'm not selling it versus Pfizer and Amgen, I'm given a list of 100 or 200 or 300 people and calling them once a quarter and some of these people have never prescribed.

Tegus Client
Got it. So when you think about step one, what else has to be defined, determined or planned before you can move on to step two?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Well, do I have consent? So a lot of times, these offices are enrolling patients in the pharmaceutical manufacturer's hub. And so there's some sort of consent that has to be signed. So I'm usually checking to see if they've consented and need to see access to this information. I'm also trying to understand what their institutional policy is.

So a lot of these IDNs go through Reptrax, IntelliCentrics, Vendormate, different policies where I have to be credentialed and specific steps to set up an appointment with some of these hospitals, whether it's in person only or you're not allowed to leave information or it has to go through P&T before you can bring it. There are all sorts of rules before you can even call that, are you approved? So compliance is always at the front of my mind before I even make contact with an office.

Tegus Client
Got it. And when you're talking about the consent, are you talking about the clinic has to give you consent to contact them? Or are you saying their patient has to give content to you to talk about their case?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
There are both. I've been an FRM for three companies now. Every company has different types of consent and acknowledgment. But when you're enrolling a patient in a co-pay program, there's usually consent at some point that's part of the process. Sometimes the signature is needed by the patient.

I've worked for companies where that was needed. Sometimes the doctor's signature is needed. Sometimes an office can sign on behalf of the doctor, but you need to get the DEA number and set up e-signature prior. So they have to be, there's consent with built-in allowing the manufacturer to work with the site to help support the patient with the least amount of PHI possible.

Tegus Client
So like who specifically do you have to get consent from? Is it from the patient? Or is there someone else you also have to get like signed consent from?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
It depends. So sometimes some manufacturers require the patient to sign. When I worked for Amgen, the patient had to sign or could call in to the Amgen hub and verbally consent. They had to listen to the terms and conditions of the program and the recording was four to five minutes long, and they can pause at any point and ask questions.

So it was a real pain, but the patient had to give consent there. All, the other two companies that I worked for, the doctor or someone at the office can sign on behalf of the doctors, it's an attestation form to give consent. Pfizer actually has a form. You have to bring into an office and the sales reps can get it signed.

The team, the FRM can get it signed before you're even allowed to help. So every company has their own rules where I currently work, consent can be given by a representative at the office. So it's a little bit more lenient and they can sign electronically to allow the FRM to help provide our services to that office and use the most minimal amount of PHI possible.

Tegus Client
Got it. So you think about the items in step two, are these legitimate steps for you?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Gather info on the case from the hub, yes. So ideally, for step 2c, we would like to have the same visibility, the same view that the hub can see. I've worked for companies where the FRM team had a limited view, and we didn't get to see hub call notes. It's very prohibitive and time-consuming for us to call the hub and get a weekly or even daily or multiple times a day report on what's the most recent information on the case. So gathering info from the hub should be something we can do online, we can log into our portal and see where the case stands.

Gathering info on the case from the sales reps, the sales reps should not have any information on the cases. So at all the companies I've worked for, sales reps some of them have hub logins, but a lot of them don't and so trying to involve the sales rep with a hub case, I think, is a big problem.

It could lead to a HIPAA violation. I've seen it lead to a few where the office gets confused and calls the sales rep who has been bringing them lunch every month for a couple of years, and they know very well and says, "Oh, here are the insurance cards." And now the sales rep has to report compliance.

So I rarely reach out to the sales reps regarding a hub case. I'll reach out to them. If it's a new site that has ordered and asked, have you visited, who should I reach out to? Can you do a warm introduction, can we visit in person together, but I don't involve them on specific cases because it's a slippery slope.

Step 2e, gather info of the case from the clinic, yes, so a lot of times missing information requests. They enroll the patient through our hub. They forgot to sign step six, they forgot to put the insurance information. It happens all the time. They didn't put the patient's last name. I've seen, or they put an off-label diagnosis code.

So I'm always gathering information, especially if a prior authorization is needed and not on file. I mean, I'll talk to them about some of the step therapy requirements that, that payer of the patient has so that we can submit a very clean PA because you only get one chance to do the prior auth.

So I'll tell them before you submit it, let's talk about it to make sure it's a very clean submission process. So E sounds correct. F, locate the clinics, contact info, sure. I mean that should have been done in step one. So I would have, but yes, the hub portal enrollment should have the contact info for the site already.

I recommend e-mail as well as phone number and the ability for the FRM to e-mail and, with whatever secure e-mail server you need to is key because these people are so busy trying to do phone only is a waste of our time as FRM, locate the patient's contact info that should be there right when we log into our portal.

And then gathering info on the case from the patient, I have never worked at a company or I've spoken with patients, never. And I'm grateful for that because then you're getting calls at all hours of the day from several people, it's a barrier. So the hub speaks to the patient. I'm a liaison between the office and the hub, I do not ever speak to patients. And I've never worked for a company, big or small, that allows speaking to patients.

Tegus Client
Is there anything else that you have to locate or gather in step two before you can move on to step three?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Well, step three examined barriers to starting therapy, organized strategy is to overcome the barriers to therapy. So step two, I'm envisioning, okay. So I'm envisioning step one, an office has ordered. So I'm now reaching out to the office and introducing myself, you've ordered or you're ready to order, you're ready to utilize.

Here's the enrollment form or here, let me set you up on the portal. Step two, they send a patient in, they enroll a patient, so they're enrolled and they enroll a patient. And then I'm thinking step three is when our team at the hub does a benefit verification and investigates insurance plan coverage. Is that, is this kind of in line with what you're thinking? Or are you thinking more broadly?

Tegus Client
I think I was thinking, you have that kind of cookie-cutter workflow from start to finish, but an issue can come to your attention at any point in the workflow. Let's just say you get an issue at any point in the workflow. What are your steps to figuring it out and resolving it?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Yes. I understand. So in step two, I would also add for gathering info on the case from the clinic, it depends who I'm working with at the clinic. I used to be a sales rep. So my, as a sales rep, I would only meet with the physicians, for the most part or nurse practitioners, PAs.

As a field reimbursement manager, identifying, maybe this is for step one or perhaps step two, identify who in the office handles the prior auth, who handles the billing, do have a financial counselor at the hospital? A lot of these are different departments. Sometimes, they even have an auth team and a benefit team.

Sometimes there's a PAP, patient assistance-free drug program team. So trying to find out who is the correct person that I need to reach out to so that I can gather this information from step two. That's a lot of times half the battle is trying to find out who the right person is because if you call and speak with someone in a call center and they transfer you to the site and they don't really know you speak to the receptionist.

It's her first day on the job, and she has no idea and then you leave a voice mail with the office manager and you never hear back. You're not going anywhere. So at that point, I do rely on my sales team to point me in the right direction so that when I'm gathering info on the case, I can help streamline it and quickly respond to something if there's action needed.

Tegus Client
When you think about step two, is this the right order of steps?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
No. Not at all.

Tegus Client
How would you order them?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
So I would eliminate the sales rep. Maybe gather info of who the key stakeholder is in the office from sales rep. That might be more in step one because the sales reps love to be involved when you're calling on their site. When I hear of an issue, I always first log into my portal, which is what my hub is using.

So I'll look at all the info on the case from the hub. So that's what you have step C, determine account's procedures for setting up an appointment. Contact info and calling them, I think contact info kind of at the end, I never locate the patient's contact info that's up to my hub if they need to reach out to the patient, maybe the patient didn't give consent.

So I think for step two, the first thing I would put, I would move up is C. I keep that first, gather case info from hub/portal because my portal, I don't even need a call the hub. So C is correct and in C, after C, that's when I look at I, info on the case for the patient. And then after I, I look at who am I calling at the clinic. So my portal tells me office contact. So that's when I look at F, gather information about the case from account's staff. This is clinic contact info and that's also E, which is gather information on the payers' coverage for the patient So it's a little bit out of order and some of them eliminated.

Tegus Client
No problem. And just to clarify, when you said I, you're not gathering the info directly from the patient, you're gathering information on the patient from your hub portal. Am I understanding that correctly?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Yes, that's correct. FRMs are not hub vendors. So the hub, whether it's McKesson or Cardinal or Labcorp, ConnectiveRx or Lash Group, those are all hubs, or even Stellar Rx is a new one. Those are all hubs providing hub, McKesson hub services to pharma. So they're calling the payer, they're calling the patient. They're enrolling in co-pay. They're doing PAP enrollment. But it's the FRMs, our role at every company I worked for is a liaison between the office and the hub.

Tegus Client
Got it. I'd love to move on to step three. Are these legitimate steps in step three?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Examine barriers to starting therapy, organize strategies to overcome the barriers to therapy. So in step three, at this point, I'm looking at the benefit investigation or benefit verification that had been done for this drug that I'm supporting. So I look at the payer, I'm looking at the benefit verification results. Is a prior auth required? Yes or no. That's imperative.

What are the patient's benefits? Does this cover your pharmacy benefit or medical benefit? I look at that. I've supported drugs that go both ways. Where does the patient stand? If it's covered, fantastic. Do they have a 20% co-insurance? Is it a 50% co-insurance? What is their out-of-pocket max? Are they eligible for co-pay? That's what I'm also looking at in step three.

And for J, examine barriers to starting therapy, utilization management criteria, prior authorizations are barriers to therapy, step therapy is a barrier to therapy. I'm looking at, does this payer have a step therapy in place. Has the patient done it? I asked the office, have they done any of the following treatments.

I ask them, do they have a contraindication, intolerance or inadequate response, CII. Inadequate response means they could have tried it once and had a headache. I have a headache every day, so I don't have my coffee. Do they have a headache after trying that drug once? Do they have an allergy to it?

Is there a drug-to-drug interaction with a different drug they're on? Are they on a heart med that might interact with this preferred drug that UnitedHealthcare is preferring? So I'm trying to eliminate those barriers at this point based on the benefit verification that the payer did to help get the patient started.

For K, confirm that sales rep knows their account will be contacted, you have organized strategies, those are all the strategies I'm thinking of. One strategy is an appeal letter, a letter of medical necessity. For a pharma company to be successful, they need to have multiple versions. I thought one just for UnitedHealthcare because they are one of the biggest payers in the U.S. and they've got very stringent criteria for my medication.

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We've also got one that's more ambiguous for some of the other easier payers like Blue Cross Blue Shield or Aetna. So those are the tools as well as my billing and coding guy makes sure we're using some on-label codes there that I'm utilizing when helping overcome the barriers and organize our strategy to tackle it so this patient can get started quick.

Tegus Client
Got it. Is there anything else in step three that you have to prepare or organize before you can move to step four?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Well, I would ensure that a benefit verification had been done by our team. So every company is different. Some companies require patient to be enrolled for the pharma company's outsourced team to do the benefit verification. So that's one. Also, is there a bridge to free drug.

They call it a bridge to commercial offers. So it's for commercial patients typically who are awaiting approval, where maybe the site got a denial, is the patient on the bridge program? Are they eligible to get free drug? And maybe they're on a sample, I supported drugs where they're on samples.

Because sometimes payers will, if they're on the medication in the past and if sample counts and they had a favorable response and that's documented in the chart notes, sometimes they'll allow that as proof of therapy working and they'll call it a continuation of therapy. So I would add those to step three when kind of evaluating and organizing the strategy. Some questions that I might be asking.

Tegus Client
Got it. And just to clarify, like, why do you need to kind of collect all of that information? What's like your ultimate goal with all of that?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
My ultimate goal is I'm assuming that there is a barrier to starting therapy. So based on what you're saying, examining barriers to start therapy, if there wasn't a barrier then I'm not involved, they don't need an FRM, but payers are quite annoying in the fact that they've got policies in place to prohibit branded specialty medication.

So I'm asking, are they on a free drug? Are they on bridge? Have they had a good experience with my product? Do they have contraindication, intolerance, inadequate response to the preferred agents based on the benefit verification we did? I'm gathering all this info. It's like I'm a detective in this step so that in your next step that I can now decide how to use this information to overcome the barrier.

Tegus Client
Got it. So if I understand this correctly that like all of these things that you're talking about, these all fall

under how you're going to think about the strategies to overcome the barrier?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Yes, questions I'm asking the applicable person, I'm gathering the info and I don't always provide them an answer right then and there. I tell them I'm calling to gather some info and I'll get back to you within a business day. So sometimes there are unusual payers, employee carve-out plans, where I need to get my National Account Director involved to see if he or she has had an experience with this type of plan. So it's cross collaboration approach that our company and all the companies have worked for have used to help pull things through.

Tegus Client
Is that the right order for you?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Well, if you only have two in step three, examine barriers and organized strategies, yes.

Tegus Client
Yes. If you just think of those high level or broadly, if that's the right order.

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
I think so. After examining barriers, then I would add all of the detective work questions that I just added and then put K, organized strategies based on the barriers found in the benefit verification if that makes sense.

Tegus Client
Got it. So then moving on to step four, are these legitimate steps for you in step four?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Determine how to overcome the barriers to therapy, decide how to contact the clinic and how to contact the patient. Deciding how to overcome the barriers, so finding out what the payer is requiring, which was typically found out in step three and then how I'm going to overcome.

So I'll work with the patient benefit reps at the office to submit a prior auth, if that's what the payer is saying you need a prior auth. I will work with the medical assistant to get the treatment notes, the clinical regimen, tried and fail. Sometimes payers want specific lab work.

I'll work with that nurse, the infusion nurse to get the lab work that's needed and then I'll make sure that it's a clean prior auth submission. Now if it's not a prior auth, maybe the office, a lot of times they get me involved after they did the auth and the auth is denied. And they've got the opportunity to appeal.

So in step four, I'm trying to now strategically appeal with a letter of medical necessity to overcome the barrier to therapy. You only get one chance to appeal for most payers. If you blew it with the prior auth, you want to make sure it's a very robust appeal. So it's important that the pharma company has a PharmD who wrote a very good letter of medical necessity.

And then I worked with the site before you're going to send it in, I want to read it. Can you share your screen? Can I read it? Can I make sure that you're, based on what the payer is asking, I help them include the auth denial and star, star number one, star number two, star number three because the person reviewing it, if it's star and so simple, then they're going to have a hard time denying it.

But if you're sending a very unorganized, lengthy appeal document, that's not right there in your face with star numbers lined out, then you don't have a better chance at approving it. How to contact the clinic? I already found that out in step two because I have the clinic contact info. Most of this is over the phone. Sometimes it's e-mail. Sometimes it's in person.

It's really what the clinic decides and what they feel most comfortable with. Unorganized clinics require in-

person PLC because they need us to hold their hand because they are completely unorganized. And then I never contact the patient, but my hub team contacts the patient. Sometimes there is missing information like patient income. If it's a free-drug patient, we need their household size. We might need a tax return. We might need income information, so that would be up to our hub team to receive that information, not the FRM.

Tegus Client
Did I catch that correctly that you're not deciding if you have to call or go in person that you're almost always just basically calling?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Well, I cover 14 states and as an FRM, I cover just part of California where I can just hop in my car and drive. If it's a missing information request, I can drive the location and get there in 10 minutes. But this morning I had missing information. So I'm on the phone because tomorrow, I fly to somewhere else.

So I can't, I'm booked for the next four months, booked out pretty packed agenda, 14 states. I go to two states a week. It's exhausting. So a lot of times, if cases are popping up, I'm providing phone support, air support, e-mail support. Sometimes I called the person on their cell phone, and she'll say, "Hey, can you just e-mail me."

So I do my proactive education, scheduled well in advance, tell the rep, I will be in your territory, let's line up as many meetings as we can, breakfast, lunch, dinner, work me 12 hours that day. And then I'm doing two jobs. I'm also doing all the casework behind the scenes while I'm in the field.

I'm the only one on my team who works 80 hours a week. In addition, I'm the trainer for the company. So I go to the home office, doing all new hire training for sales and field reimbursement. So really doing three jobs, but a lot of FRMs are not in the field like me. There are, a lot of them think this is an easy job. They can retire from sales, be an FRM and work from home. So it really depends on if your FRM has the tenacity and has the will that drive to succeed, it's a very ultraistic will because we're not paid on.

Tegus Client
When you think about step five or when you review step five, are these legitimate steps for you in step five?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Contact the clinic to share strategies for overcoming barriers, contact the patient to share strategy, share supporting materials to overcome barriers. I've now had step four, I've created the strategy. Step five, I'm revealing either the prior auth submission, the appeal, the letter of medical necessity or preparing them for a peer-to-peer review to eliminate the barrier.

So we'll have a meeting on the phone, in person, if I happen to be in the area in person, and we'll talk about how we're going to overcome the barrier. I'm not contacting the patient, but sometimes my hub team will call the patient and let the patient know where they stand in the process and then share supporting material.

I would also add, keep the sales rep in the loop. So whenever I've worked for companies and I call on the office, I let the sales rep know or my key account manager, my hospital rep, I'm going to be calling on your account. I let them know one or two weeks in advance. And then I do a follow-up afterward. After I call on them, I keep them in the loop. I called on them. I'm working on a case, all is good or I'm working on a case and it might not be going good, but I don't give them details, but sharing supporting materials, this is where the letter of medical necessity comes into play. Sometimes it's a claim issue.

So I have an annotated CMS-1500 claim form that a lot of times my community oncology clinics are using. I have got an annotated enrollment form. I've got the billing and coding guide. So we've got a lot of co-pay information materials that I'm sharing with the site. So I think those three are in order minus contacting the patient.

Tegus Client

Got it. And when would you contact the sales rep? Would it be at the end? Would it be at the beginning of step five?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
I talk to all my reps multiple times a day because I'm calling on their offices. So a lot of times, I'm with the sales rep in the field, but say I've got incoming inbounds from other parts of the territory. I let them know, hey, I just got a call from your site. I talked to so and so's office about a case or they brought a question about payer information and I'm looping in the National Account Director or the office manager calls me and wants to do lunch.

Are you available on this day? I keep an open line of communication with the sales team. I am not directed by sales, and that's important to note that. but I'm allowed to be with the sales team. They just can't hear me speak about patients, so they leave the room if it goes that route.

Tegus Client
Got it. It sounds like it's very dynamic for you when you involve the sales rep. But in the ideal situation, would you contact the clinic and then like share, close the loop with the sale rep or would you do that before you contact the clinic?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Well, the sales rep, I would tell them I'm about to call on your accounts because they're part of my routing so they know that I'm going to make contact with the account. And then after I visit in person or on the phone and submit, help submit the appeal letter, I call the rep and close the loop. So there are constant touch points pre- and post-call with the rep. A lot of it's on the phone because of compliance.

Tegus Client
And are the steps in step six legitimate for you in your role? 6q, Verify the account and understand how to overcome barriers and 6r, track the accounts progress in overcoming barriers?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
I see flaws with step six because a lot of times what we need to talk about is a lot of these offices, they have an auth team, either on or off-site that's dedicated to doing authorizations and benefits verification. So for small offices, I'm verifying that they know how to overcome barriers. But for these big offices, they are a well-oiled machine. They get this. All they're doing all day long is authorization. They're calling payers, they're doing appeals. They're doing a peer-to-peer review setup.

So I think it depends if it's a community oncology, community site versus a hospital site. Are they part of a big group? Or are they a small clinic? I am making sure that they're aware of all the service offerings and there are always new people in the office. So I'm constantly re-educating, every time I go in there, someone new in re-educating. And then step six part r, so tracking the patient's progress in overcoming barriers.

So I think it's important to have a portal where for co-pay assistance, where you can see how much of the co-pay benefit the patient has used, especially if it's a monthly or weekly or bi-weekly medication. And then for the FRM to have their own tracking system.

It's an account planning document that I think is important for the FRM to also share with the sales team. So it talks about you can have the account, the key stakeholders like, for me, I deal with Director of Pharmacy. I deal with Billing Manager, I deal with Authorization Manager, patient benefit rep, a lot of high-level account information and then where they stand.

Has the account been signed up on the portal? I think portals are great as long as the portal works. So does the site have the portal? Have they used the portal? This is where I'll put the patient ID numbers for different cases. So for each site, there's an account planning document that I think is important that we can use and share with matrix partners to track progress status.

But then from my PHI documents that I have that are just for my eyes only, that's where I'm able to, I have a

document by payer, so for Anthem, for United, for Blue Cross by state, by Medicaid, Medicare, HMO, POS, point of service plan or PPO plan where I can get into the detailed granular data on specific cases and where do they stand? Has the first appeal been submitted? If so, great. I move them to the next level, second appeal. So it's my own tracking metric I've got in place that really has helped me accelerate and provide the white glove customer service that our customers deserve.

Tegus Client
How do you actually track all of that? Is there like a Veeva system that you basically just use or track at all?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
So we log our calls in Veeva. We do have a four-call per day metric. A call can be an in-person call, could be a Webex, Teams call. It can be a phone call. It could be a text message or an e-mail. So four individual sites per day. But for tracking the case information, Veeva is not a good platform because sales Veeva.

So which, it was great that the sale, I can see if the sales rep made a call or the nurse educator, even our medical team uses Veeva for logging calls. So I know who last contacted the office and who was contacted at the office because they log the call and affiliated the person they called on. But for all of the case information, I have my own Excel file and I move them along.

But for the account planning information, our company has provided account planning documents that are HIPAA compliant. There's no patient info. It's just patient IDs and it's super helpful, kind of goes back to our earlier steps one and two, we're sharing information. We're able to work cross-collaboratively with other matrix partners so that I can do my job to the best of my ability and help the patients, help their customers, help the.

Tegus Client
And what about in step seven, move on connect strategy if the initial strategy doesn't work, is this a legitimate step for you?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
Well, what do you mean next strategy?

Tegus Client
Let's say, I think I was under the impression that if a patient has some barriers, it might be multifactorial.

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
That's true. Yes, it could be. So let's say prior auth is required, and that was in step three, we identified a prior auth is required. And we did all of this and the prior auth came back denied. It happens all the time, not medically necessary. Then in step eight or step seven, we are moving on to the next strategy, the appeal. We're going to then do the second appeal. We'll then do the peer-to-peer review.

So we'll even do the court case if that's an option. So I do think step seven to move the patient down the continuum before we get to the end, the final denial, not going to happen. That's when PAP comes into play as the last resort. That's the free-drug program, where the patient if they meet income requirements and have commercial insurance or government insurance, but they just don't have coverage. That's where we ship a free medication out.

Tegus Client
So then just to round this out, what do you have to do to properly finish the process of a single case, and I realize you're juggling a lot of cases probably simultaneously, but to actually bring one case to closure, what do you actually have to be to finish that process. Do you have to document anything? Do you have to verify anything?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.

Yes. So we've got, we close out, any case we're working on, we open up the case in our system. So I guess it's kind of part of Veeva, but it's not part of the Veeva but the sales team. It's not the logging call. So every case I'm touching through the hub, we open it up and we are putting updates in so that our hub team can also see where we stand.

So patient receiving therapy, you would think would be the end of the road but it's actually not. So I don't close a case if a patient receives therapy. That's great that they got their first dose. However, the reauthorization. So once someone starts, I've always supported meds that are not one and done. These patients have these chronic diseases where they're going to continue needing.

So I now have a calendar pop-up, typically, these are three-month authorization. So 60 days from now, I'm reaching back out, let's do the reauthorization and provide the payer updated notes so that we get a reauthorization for the medication. Something else is if the patient is a commercial patient, let's now talk about the co-pay assistance claim.

So for every company, you can receive co-pay assistance, it's for commercial patients and we need the EOB and the claim form. So for medical benefit, you need, there's typically the electronic funds transfer option or a physical check. There's also the debit card, which is loaded with the exact amount that the patient is responsible for that the office, the billing manager or billing team can run that card.

So I'm making sure that, yes, this patient started therapy, but now I'm trying to pull through, did we get the EOB? Did we get the claim form? Is the claim form billed correctly for the right number of units? A lot of times, I'm helping with claim appeal assistance. So there's, am I closing out a case if the patient dies, yes, I'll close it out. As that's happened, these are oncology patients but we're trying to get them continuously on therapies so that they can live longer.

Tegus Client
I think I just have one real quick last question, why do you need the claim form and the EOB?

Former Field Reimbursement Manager, Immunology (CA/HI) at Amgen, Inc.
So for co-pay reimbursement. So for commercial patients, the only way a pharmaceutical company can pay and reimburse is to have the exact amount. So our current co-pay vendor, ConnectiveRx have also used McKesson at other companies as co-pay vendors.

After the patient has received therapy, it takes 14 days for Medicare and Medicaid and up to 21 business days for commercial payers to send the billing site at the office, EOB, explanation of benefits. The billing manager then prints out their electronic copy that they did electronically of their CMS-1500, the claim form and also sends us EOB so that we can get the patient reimbursed for the amount that they are due. Most offices will not bill the patient, and they're waiting for this co-pay money to come in. If they're a small clinic, unfortunately, a lot of patients are stuck with the bill and then the reimbursement comes a month or so after the fact.

Tegus Client
Thank you so much. Well, look, have a great rest of your day and great week. Thank you so much for the time today.