FROM THE EDITOR

"Off Label" Does Not Mean "Off Limits"

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It happened so slowly we initially didn't notice. Soon it declared itself as a nemesis. But by then, it had established itself as a powerful force with which to be reckoned. Today it is a false mythology, designed to wreak misery on any prescribers in the US who want access to all FDA-approved medications to provide the best clinical treatment for their patients. This mythology has constructed numerous obstacles to interfere with a competent medical prescriber's intent to choose the best dosage of the most appropriate medication to get our patients better. The primary work horse of this mythology is the dreaded medication formularies designed to limit drug prescribing to a subset of available medications. Regrettably, this subset of medications often excludes the preferred medication that competent clinicians would choose as part of a treatment plan that they deem best for their patient.

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The false mythology, which remarkably is believed as fact by a minority of prescribers, is that a trained medical professional, duly licensed and with prescribing privileges, CANNOT prescribe a medication off label. This mythology interferes with good clinical practice and often contributes to poor outcomes for patients. **There are many corollaries to this false mythology:**

1. A drug cannot be prescribed in doses that are outside of the doses listed in that drug's FDA-approved product insert.
2. A drug cannot be prescribed for an indication for which it is not FDA approved.
3. Some drugs can only be prescribed after numerous failed trials of other drugs, which often include drugs with more adverse effects, poorer tolerability, or with contraindications for a particular patient.

This, of course, is the short list. In my editorial in last month's issue of *Psychiatric Times* I focused on all of the clinical facts that render corollary 1 a false mythology.[1] This editorial will elaborate on corollary 2, which can be simply restated as the false narrative that a drug is off limits for diagnoses that are off label.

One of my favorite articles, "An Analysis of the High Psychotropic Off-Label Use in Psychiatric Disorders: The Majority of Psychiatric Diagnoses Have No Approved Drugs," published in 2009, nicely places corollary 2 in its clinical perspective.[2] The authors report that only 11.8% of DSM-IV-TR diagnoses have an FDA-approved drug. So, do we not treat the 88.2% of DSM-IV-TR diagnoses that do not have an FDA-approved medication? Also, with the publication of DSM-5 in 2013, it is likely that the percentage of FDA-approved drugs for DSM-5 diagnoses has dropped even further. A good example is the lack of any FDA-approved drugs for the DSM-5 novel diagnosis Disruptive Mood Dysregulation Disorder. Does that mean we cannot treat this disorder with medications?

Can you imagine working in an ICU, where you are likely to treat many patients suffering from acute delirium, and the hospital pharmacist and the patient's insurance company tell you that there are no FDA-approved drugs to treat delirium, so don't prescribe any; or if you do, the insurance company will not pay for the medication. Or maybe you work in a long-term care facility with a large population of individuals suffering from behavioral or psychotic complications of advanced dementia—too bad—there are no drugs that you can prescribe.

Let me state very clearly that I am not saying that a prescriber can use any FDA-approved drug to treat any condition—this would result in prescribing anarchy, which is both unethical and dangerous. However, when a disorder or condition does not have a FDA-approved drug, it is our duty to prescribe a medication that has been shown to be helpful in this setting. Additionally, there should be a consensus from experts in each specialty to recommend a subset of medications that are reasonable and show effectiveness in these situations. Even when these recommendations from experts exist, it is common practice for insurance companies to deny payment if these medications are not on their formulary. However, the prescriber is always invited to begin the time-intensive and frustrating process of submitting a prior authorization form.

A second common scenario is when a patient has a specific diagnosis for which there exists one or more FDA-approved drugs. In this setting, the FDA-approved drugs should be used first. Once all of the trials of FDA-approved drugs have failed, or the remaining FDA-approved drugs are contraindicated for a medical reason, then it is our duty to move beyond the labels and prescribe medications that are considered to be reasonable by our peers and that show evidence of being effective.

This approach of prescribing FDA-approved drugs off-label has been supported by the American Medical Association, established law in the US, and by the FDA. Furey and Wilkins[3] published a case of an older woman with dementia, which gets complicated by waxing and waning symptoms of confusion, agitation, and paranoia.[3] Her psychiatrist begins an atypical antipsychotic that significantly helps these symptoms. The case explores the initial conversation between the patient and her psychiatrist, and then the subsequent conversation after the dementia has progressed and the patient is joined by her daughter to discuss treatment. The daughter is confused as to why the psychiatrist prescribed a medication to her mother that was off-label and had a specific black box warning about the increased risk of death when this drug is used in patients like her mother.

THE AUTHORS CONCLUDED:

Off-label prescribing is a common and legal practice in medicine. This practice is justified when scientific evidence suggests the efficacy and safety of a medication for an indication for which it does not have FDA approval and when the practice is supported by expert consensus or practice guidelines.

Practicing clinical medicine is challenging and stressful enough without the additional burden of being handcuffed by ever-changing medication formularies. I am sure that we could fill an entire issue of *Psychiatric Times* with war stories from you, our readers, about fights with insurance companies and medication formularies to gain approval for the best medication for our patients. **When we view this daily stress and frustration through the lens of the actual facts:**

- Once a drug is FDA approved for one indication, a prescriber in the US can prescribe that drug for any indication.
- Most psychiatric diagnoses do not have FDA-approved medications.
- Experts agree that off label prescribing is usually utilized when it is the best option for our patients.
- Medication formularies change year to year, likely based on the cost of the medications to the formulary and not based on clinical effectiveness of the drugs.

We seriously need to ask ourselves why we allow this false mythology to perpetuate.

REFERENCES

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