Effective Specialty Drug Strategies for the Pharmacy and Medical Benefits

Thursday, August 11, 2016

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About the Speakers

DEBBIE STERN, R.Ph., is Senior Vice President of medical oncology and specialty drugs at eviCore healthcare, where she is responsible for developing and executing new business and program strategies that focus on the incorporation of evidence-based guidelines in oncology and specialty pharmaceutical management with payers. Ms. Stern is a nationally recognized expert on the integration of biotechnology and specialty pharmaceuticals into the payer marketplace. Previously, she served as Vice President and President of Rxperts, a managed care consulting firm dedicated to helping clients better understand the dynamics and market forces affecting managed pharmaceutical benefits. For more than 15 years, Ms. Stern consulted in the areas of pharmaceutical and specialty pharmacy marketing, clinical program development, market assessment, strategy development and strategy execution. Prior to Rxperts, she was a senior level director at two national PBMs, spent five years in the pharmaceutical industry and 10 years in retail pharmacy. Ms. Stern regularly serves as a guest speaker for PCMA, AMCP, NASP, AIS and Armada/ Asembia. She initiated the concept of the EMD Serono Specialty Digest in 2004 and was its author and editor for the first 11 editions. Ms. Stern currently serves on the editorial advisory board of Atlantic Information Services’ Specialty Pharmacy News. She has a BS degree in pharmacy from the University of Cincinnati and is actively involved in the Academy of Managed Care Pharmacy where she previously served on the board of directors and chaired the program planning committee. Ms. Stern is a guest lecturer to the USC School of Pharmacy, UC Irvine MBA program and Western School of Pharmacy. Contact Ms. Stern at dstern@evicore.com.

BECKIE FENRICK, Pharm.D., M.B.A., is the national pharmacy practice leader at Cambridge Advisory Group. Previously she was senior director of clinical pharmacy programs at Blue Cross Blue Shield of Florida, Inc. (BCBSF), where she was responsible for the oversight and development of the plan's clinical pharmacy programs, medical pharmacy operations and specialty pharmacy management. Dr. Fenrick has had extensive professional experience with product launches, rebate negotiations, formulary development, pharmacy operations, medical pharmacy management, oncology management and vendor oversight. In addition, at BCBSF she managed all clinical pharmacy program development and was a representative of the pharmacy and therapeutics committee, medical policy coverage committee and chairperson of the pharmacy policy committee. Prior to joining BCBSF in 2007, Dr. Fenrick was vice president of clinical services at Innoviant, a Wisconsin-based PBM. She has more than 25 years of experience as a clinical pharmacist specializing in pharmacy benefits administration. Dr. Fenrick earned her B.S. in pharmacy from the University of Wisconsin-Madison, M.B.A. from the University of Wisconsin-Whitewater and Pharm.D. from the University of Florida. She is a member of the Academy of Managed Care Pharmacy, the National Council of Physician and Pharmacist Executives and the International Society for Pharmacoeconomic Outcomes Research. Contact Dr. Fenrick at bfenrick@cambridge-works.com.

Moderator: Angela Maas, managing editor of AIS’s Specialty Pharmacy News and Drug Benefit News

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Presentations should run approximately 60 minutes, with 30 minutes of questions and answers. Questions may be submitted in three different ways:

Prior to the Webinar
(1) Email your question(s) to moderator Angela Maas at amaas@aishealth.com or

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(2) To send a question from the Webinar page, go to the Chat Pod located in the lower left corner of your screen. Type your question into the dialog box at the bottom and then click on the blue send button or
(3) Dial *1 on your phone keypad and an operator will connect you to the moderator so that you can ask your question(s) “live” with the Webinar participants listening
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AIS publishes several highly practical publications that address specialty drug management strategies, including:

• **SPECIALTY PHARMACY NEWS** is a monthly newsletter packed with 12 pages of business news and management strategies for containing costs and improving outcomes related to high-cost specialty products. Designed for health plans, specialty pharmacies, pharma companies, providers and employers, the hard-hitting newsletter contains valuable insights into benefit design tactics, the emerging biosimilars market, specialty markets for certain conditions, formulary decisions, merger and acquisition activity, payer-provider partnerships, patient adherence strategies, and new products.

• **DRUG BENEFIT NEWS** is a hard-hitting newsletter for health plans, PBMs, pharma companies and employers. Published biweekly, it delivers both timely news stories and in-depth accounts of cost management strategies that are being employed by drug purchasers. Coverage includes news of performance-based pricing, the emerging biosimilars market, pricey drug launches, soaring specialty costs, insurer and PBM consolidation, generic inflation, exclusionary formularies, narrow pharmacy networks and more.

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WEBINAR MATERIALS

Specialty Medications: Managing Utilization and Cost ..............................................................page 1
  Presentation by Beckie Fenrick, Pharm.D., M.B.A.

Effective Specialty Drug Strategies for the Pharmacy and Medical Benefits ...........................page 15
  Presentation by Debbie Stern, R.Ph.

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WEBINAR OUTLINE

  • Benefit designs
  • New specialty medication evaluation
  • Cost management
  • Biosimilars
  • Utilization management

Part 2: Debbie Stern, R.Ph., eviCore healthcare
  • Market challenges
  • Strategies to manage medical benefit specialty drugs
  • Site-of-service management
  • Claims management

Part 3: Questions and Answers
Specialty Medications: Managing Utilization and Cost

presented to

AIS Webinar
August 11, 2016
Dr. Beckie Fenrick is the national pharmacy practice leader with Cambridge Advisory Group. Her extensive professional experience with health care system innovation, vendor contract negotiations, care model development, alternative payment model innovation, financial modeling and assessment, pharmacy program development, pharmacogenomics, product launches, drug rebate negotiations, formulary development and assessment, pharmacy operations, medical pharmacy management, oncology management, and vendor oversight is an asset to her role. Prior to joining Cambridge Advisory Group in 2012, Fenrick held several positions at Blue Cross Blue Shield of Florida, including Senior Director of Medical Operations, and Senior Director of Clinical Pharmacy. Prior to her tenure at Blue Cross she was Vice President of Clinical Services at Innoviant, a Wisconsin-based PBM and Director of Pharmacy for Dean Health Plan in Madison, WI. She has over 25 years of experience as a clinical pharmacist specializing in pharmacy benefits administration. She has authored numerous publications on pharmacy benefit management and medical pharmacy management. In addition she regularly speaks on pharmacy benefit management topics. She serves as a peer reviewer for the Journal of Managed Care Pharmacy. Dr. Fenrick earned her Bachelor of Science in Pharmacy degree from the University of Wisconsin, Master of Business Administration degree from the University of Wisconsin-Whitewater, and Doctor of Pharmacy degree from the University of Florida. She is a member of the Academy of Managed Care Pharmacy.
Specialty Drug Pipeline Highlights

**Hepatitis C**
- ZEPATIER™ (elbasvir and grazoprevir) tablets
- EPCLUSA® (sofosbuvir and velpatasvir) tablets
- VIEKIRA XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir) extended-release tablet

**Liver Disease**
- OCALIVA (obeticholic acid) tablets indicated for the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA, or as monotherapy in adults unable to tolerate UDCA

**RA**
- Biosimilars: INFLECTRA (infliximab-dyyb) for Injection
- Adalimumab biosimilar
- Etanercept biosimilar

**CROHN’S**

**PSORIASIS**

**ETC**
Benefit Designs Working Into The Future

- Affordability through high quality networks and high quality medical services
- Access to medications and other services
- Appropriate use and appropriate location of service
- ACA impacts on benefit design; deductibles, cost shares, out of pocket maximum. Other regulatory impacts, oncology parity legislation

A key consideration for specialty, oncology and biologic medication coverage is appropriate member cost share on both the pharmacy and medical benefit.
Benefit Designs

Cost Share Tiers
1. Single or multiple specialty tiers
2. Per claim max or min

Deductible
1. Aggregated with medical benefit
2. Impact on adherence
3. Specialty cost impact

Out Of Pocket Maximum
1. ACA mandated
2. Aggregated with or segregated from medical benefit
A successful specialty drug management strategy goes beyond benefit design and thoughtfully integrates drug product usage, channel management, consistent UM and innovative member engagement tools and care models.

<table>
<thead>
<tr>
<th>Monitoring and Evaluation:</th>
<th>Formulary and Rebates:</th>
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<tbody>
<tr>
<td>You can’t manage what you don’t measure</td>
<td>Preferred product selection impacts formulary and rebates</td>
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<tr>
<td>Pharmacy Benefit as well as Medical Benefit</td>
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<tr>
<th>Channel Management:</th>
<th>Utilization Management:</th>
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<tr>
<td>Medication costs vary significantly across different access channels</td>
<td>Step edits, prior auth and quantity limits</td>
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<tr>
<th>Optimize Unit Cost:</th>
<th>Care Management:</th>
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<tr>
<td>Sole or preferred providers for specialty pharmacy, including oncology</td>
<td>Multiple contact points for members (Specialty Pharmacy, PBM, Health Plan, Prescriber)</td>
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<td>Indication dependent drug pricing</td>
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New Specialty Medication Evaluation

Premarket Launch
- Pipeline Monitoring
- Partners assist; Specialty Pharmacy, PBM
- Focus on medications expecting approval in the next six months
- Monitor clinicaltrials.gov

New to Market
- Medication Assessment (self administered, specialty, oncology and UM recommendation and monitoring)
- P&T (self administered product clinical evaluation)
- Business Team (Tier Status and UM pharmacy benefit)
- Pharmacy Policy Creation (Medical Coverage Guidelines, UM Criteria)

Existing Products
- P&T reviews all drug classes at least annually
- Identify UM programs and evaluate at least annually
- Review Medical Coverage Criteria for medications at least annually
Cost Management

Channel Management
- Restricted Networks
- Incentive Networks

Discounts
- Fee Schedule
- Net Effective Discount
- Minimum Discount Guarantee

Rebates
- Specialty Rebates: Is your PBM sharing them? What about exclusions for biosimilars?
- Inflation Protection/Predictability
- Indication Based Pricing
## Immune Globulins Example

<table>
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<tr>
<th>Product</th>
<th>AWP/Gram</th>
<th>Mail/Specialty Price Per Gram (AWP less 15%)</th>
<th>Mail/Specialty Price Per Gram (AWP less 17%)</th>
<th>ASP/Gram</th>
<th>Medicare Price (ASP plus 6%)</th>
<th>ASP plus 25%</th>
<th>ASP plus 80%</th>
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<tr>
<td>Gamunex-C</td>
<td>$123</td>
<td>$104.55</td>
<td>$102.09</td>
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<td>$88.55</td>
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July 5, 2016, the US Court of Appeals affirmed a decision that an applicant for a biosimilar “must provide a reference product sponsor with 180 days’ post-licensure notice before commercial marketing begins, regardless of whether the applicant provided the (2)(A) notice of FDA review.”

ZARXIO™ (filgrastim-sndz) injection: first biosimilar to enter the US market

INFLECTRA (infliximab-dyyb) for Injection received FDA approval April 5, 2016

Pipeline includes biosimilars for Adalimumab and for Etanercept

Benefit Design Considerations: implications for a single specialty tier

PBM Contract Considerations: Biosimilar guarantee and pricing exclusions

Prescriber acceptance
Copayment Assistance Programs

**Member Cost Share**
- Reduces Member Out Of Pocket
  - Improve therapy adherence
- Impact on Formulary Compliance

**Benefit Design Impact**
- **Deductible**
  - Should the copayment apply to the deductible?
- **Out Of Pocket Maximum**
  - Should the copayment apply to OOP Max?
Member Engagement

**Specialty Pharmacy**
- Order Scheduling
- Clinical Outreach
- Disease State Education
- Medication Education
- Therapy Adherence Support

**Prescribing Practitioners**
- Clinical Outreach
- Disease State Education
- Care Coordination

**Health Plan**
- Care Management
- Disease Management
- Case Management
Questions
Effective Specialty Drug Strategies for the Pharmacy and Medical Benefits

Debbie Stern, RPh
SVP, Medical Oncology and Specialty Drug Management
eviCore healthcare

August 11, 2016 – AIS webinar
EVICORE HEALTHCARE PROVIDES MEDICAL BENEFIT MANAGEMENT ACROSS A WIDE RANGE OF MODALITIES

LAB MANAGEMENT 19M lives
RADIATION THERAPY 19M lives
MEDICAL ONCOLOGY 14M lives
SPECIALTY DRUG 50K lives
RADIOLOGY 65M lives
MUSCULOSKELETAL 19M lives
SLEEP 13M lives
CARDIOLOGY 46M lives
POST-ACUTE CARE 145K lives

90M members managed nationwide
12M claims processed annually
2015 FDA Approvals Breaks Record

4 Categories Responsible for 63% of Approvals

- Cancer
- Infectious Disease
- Hematology
- Rare Diseases

- 45 New Molecular Entities
- 39% Biologicals
- 39% Novel Mechanism of Action

Market Challenges
Drug Trend and Spend Continue to Grow for Specialty Drugs

Medical specialty trend rising

Specialty drug spend expected to exceed 50% of total Rx and medical costs by 2018\textsuperscript{2}

1. Express Scripts Drug Trend Report 2015

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Specialty Drugs Are Complex

Benefit design, route of administration, and site of administration impact drug management.

- Benefit Coverage
  - Pharmacy Benefit
  - Medical Benefit
  - Both

- Specialty drugs are used for the treatment of complex chronic health conditions.

- Route of Administration
  - Oral
  - Intramuscular
  - Subcutaneous
  - Inhaled
  - Infused

- Site of Service
  - Home
  - MD office
  - Hospital outpatient
  - Ambulatory infusion center
>44% of medical specialty drug spend is for non-oncology indications

**2014 Commercial Medical Benefit Spend**

- Oncology, 48%
- Immune Modulators, 14%
- Immune Globulin, 7%
- Multiple Sclerosis, 2%
- Enzyme Replacement, 2%
- Hemophilia Factor, 4%
- All Other, 22%

**2014 Medicare Medical Benefit Spend**

- Oncology, 56%
- Immune Globulin, 6%
- Multiple Sclerosis, 2%
- Osteoarthritis, 2%
- Immune Modulators, 6%
- Ophthalmic, 9%
- All Other, 20%
Strategies to Manage Medical Benefit Specialty Drugs
Market challenges are driving a need for better cost and utilization management

**Utilization Management**
- Prospective UM
- Pathways
- Preferred Products
- Integrated disease and care management
- Early identification of at-risk patients

**Unit Cost Management**
- Site of service redirection
- Rebates
- Post service pre-payment edits
- Risk contracts
- Value-based management
Payers can customize management based on specific cost and utilization challenges

Target specific drug management challenges related to:
- Challenging coverage criteria
- Site-of-service shift
- Small patient population
- Rebate & preferred drug opportunity
- Need for genetic testing for coverage

Provide ability to include management of the following criteria:
- Diagnosis
- Safety
- Genetic testing
- Comorbidities
- Dosing
- Quantity
- Duration
- Step therapy
- Drug interactions
Process Flow for Medical Benefit Creates Management Challenges for Payers

Pharmacy Benefit
- On-line, real time claims adjudication
- UM and claim edits built into adjudication process
- Managed by PBM
- May be part of EMR – generate e-RX
- ePA protocols developed by NCPDP
- All relevant data captured for post service reporting, retrospective UM
- Drugs obtained through retail or SP pharmacies

Medical Benefit
- Post-service claims adjudication
- UM may be managed manually or via web portal by PBM or other vendor
- Time gap between claim submission, authorization and payment
- Not typically part of EMR – no e-RX generated
- No ePA protocols from NCPDP (under consideration)
- Difficult to capture claims data in format necessary for post service reporting, retrospective UM
  - HCPCS code rather than NDC
  - Dosing quantity and frequency difficult to measure
- MD may buy and bill or use SP
Mechanisms to Obtain PA for Medical Benefit Drugs

MD or SP calls or faxes health plan:
- Labor intensive
- Significant lag time
- Patient often has to wait for treatment
- Follow-up difficult

Single Drug PA: Web-based Portal:
- Questions relevant to condition
- Immediate authorization if criteria is met
- Treatment can begin immediately

Episode of Care: Web-based Portal:
- Relevant to cancer treatment
- Can authorize multi-drug treatment regimen and supportive care
- Includes both RX and Medical benefit drugs
Traditional PA Example: Medical Benefit

> 50 questions, random order, not customized to diagnosis

Web-Based Portal Eases Administrative Burden to MD and Payer

Clinical Review

RN/PharmD Review
1st level review
- Correct clinical information
- Medical necessity

MD Review
2nd level review
- Medical Necessity
- Redirection
- Preferred Alternative
- P2P discussion

Meets criteria

Approval
In Cancer Treatment, Traditional PA Does Not Always Capture Complete Clinical Scenario

**Typical Prior Authorization**

- Ovarian Cancer
  - Yes

**Avastin approved**

**Question**

- What is the diagnosis?
  - Ovarian Cancer

- Does the patient have persistent or recurrent disease after first-line therapy?
  - Yes

- Is disease platinum sensitive or resistant?
  - Platinum resistant

- Did patient receive Avastin as part of previous treatment line?
  - Yes

- Will Avastin be given concurrently with other agents?
  - Yes, with Gemcitabine

**eviCore Oncology Pathway**

- Avastin NOT approved
  - Gemcitabine approved as monotherapy
Medical Oncology Pathway Can Define a Complete Episode of Care: Colon Cancer Example

Disease-Specific Clinical Information
- Diagnosis at onset
- Stage of disease
- Clinical presentation
- Histopathology
- Comorbidities
- Patient risk factors
- Performance status
- Genetic alterations
- Line of treatment

Collect patient and disease-specific clinical information

80 unique attributes for colon cancer

>1000 different traversals depending on clinical attributes

45 NCCN treatment regimens

Patient Specific Treatment Regimen

2-5 minutes to enter a complete case
Identification of High-Risk Patients Can Activate Care Management

Risk factors identified through pathway:
- Cancer type
- Disease stage
- Metastases
- Comorbidities
- Performance status
- Line of treatment

System-generated alert to care management and provider
Site-of-Service Management
Outpatient hospital drug costs are >2x other sites of service

Commercial Cost per Claim for Top Drugs by Provider Type

- Remicade: Hospital Outpatient = $8,930, MD Office = $5,002, Home Infusion/SP = $4,132
- Ocrenica: Hospital Outpatient = $5,668, MD Office = $2,230, Home Infusion/SP = $2,292
- Gammagard: Hospital Outpatient = $7,099, MD Office = $5,369, Home Infusion/SP = $4,022
- Gamunex-C: Hospital Outpatient = $7,322, MD Office = $3,684, Home Infusion/SP = $4,448
- Xgeva/Prolia: Hospital Outpatient = $3,549, MD Office = $1,415, Home Infusion/SP = $959
- Botox: Hospital Outpatient = $2,079, MD Office = $918, Home Infusion/SP = $1,055
How to Manage the Site of Service

Three main strategies to manage site of service:

- **Post-Service**: Retrospective review and communication with prescriber.
- **Member Engagement**: Member communication prior to or after 1st infusion; education on convenience and cost savings.
- **Hard Stop**: Restricts site of service to specific infusion providers or excludes specific providers by drug therapy (subject to clinical guidelines).
Claims Management
Enhanced edits go “narrower” and “deeper” than health plan edits

Components

Coding and Billing Rules

Authorization matching

NOC claims

Claim repricing/contract

Duplicate reconciliation

Units adjustment
Payment Integrity Example: Remicade Billing and Unit Variations

Variation in units billed and cost for one commonly prescribed drug

Dose for a 220 lb. male (50-100 units)

Expected reimbursement $5,000-$10,000

Reimbursement

Outpatient
Office
Home

eviCore Data on File: Reimbursement based on AWP -15% (Reimbursementcodes.com)
Future Management Trends for Medical Benefit Specialty Drugs

- Integrate UM process within EHR
- Pathway approach across other disease categories
- More integration between RX and Medical benefit management
- Value-based determination of drug therapy
  - What is source of value determination?
  - How can it be applied to health plan management?
- Episode of care or bundled case management
- Comprehensive cancer management
  - Diagnosis → Treatment → Supportive Services → Survivorship
Aggressive Contracting Helps to Keep Down Medical Costs


The medical cost trend for 2017 is projected to rise 6.5% — the same as for 2016 — partly due to aggressive contracting over drug costs and the lack of any blockbuster specialty drugs in the pharma pipeline, according to a recent report from PwC’s Health Research Institute. But payers need to continue to look beyond only costs to make sure patients are getting the best clinical value for their medications.

“2017 will be a tough balancing act for the health industry,” says the report, titled Medical Cost Trend: Behind the Numbers 2017. “Healthcare organizations must simultaneously increase access to consumer friendly services while decreasing unit cost. Employers, worried that this current trend is at an inflection point that could turn back up, will demand more value from the health industry. When medical growth outpaces general inflation, a flat trend is not good enough.”

The report cites the growing use of more convenient sites of care such as retail clinics and urgent care centers as one contributor to a higher medical cost trend. In addition, more access to behavioral health care “will unlock pent-up demand, inflating medical cost trend in the short term, but should also help reduce costs in the long term.”

Hepatitis C Drugs’ Impact on Medical Cost Trend Soon Will Start to Drop

The impact of Hepatitis C therapy on medical cost trend declines after 2016 as the number of patients treated declines

SOURCE: Medical Cost Trend: Behind the Numbers 2017, PwC Health Research Institute, released June 2016. PwC Health Research Institute estimate based on National Health and Nutrition Examination Survey and 2012 Truven Health Analytics claims data from employers.
Another potential deflator of that trend is the increased implementation of narrow provider networks that also may have outcomes-based agreements tied to them. Among employer respondents that the Health Research Institute interviewed for the report, 43% said they are considering putting in place a high-performance network in 2016, up from 37% in the previous year. In addition, aggressive negotiations over drug costs — such as in the hepatitis C class — have helped keep the medical cost trend down. And with no blockbuster specialty drugs in the near-term pharma pipeline, payers aren’t expected to face cost drivers such as they did with the hepatitis C class, for example. In fact, the impact from that class, according to PwC, is projected to decline as the number of patients treated with these costly therapies is expected to drop (see chart, p. 39).

“Everyone’s had their eye on specialty pharmacy as a significant impact on benefit costs,” says Greg Mansur, principal at PwC. Costs for these therapies “continue to rise on the aggregate,” but they’re not having as much of an impact on medical cost growth, he tells SPN. “There’s nothing major in the drug pipeline that’s threatening.”

And although “not everyone really has their hands around the medical channel,” more employers are “taking pretty strong steps” to manage specialty drugs through tactics such as step therapy, quantity limits and prior authorization, he says, citing a supplemental PwC report, 2016 Health and Well-being Touchstone Survey.

When plans and employers are contracting with PBMs and specialty pharmacies, it’s “key,” says Mansur, to look at not only pricing information but also the “clinical management programs available” and their “ability to drive people to effective therapies. It’s one thing to deliver on price, but it’s another thing to deliver on clinical value.”

A company “can drive a really good price on a product,” but that could mean it “may get someone on an expensive therapy that doesn’t work,” he says. “They need to get on the right therapy at the right time.”

According to the medical cost trend report, the future of contracting “points toward paying for results and cures, not the volume of drugs dispensed. The contracts and terms being negotiated may be more complex compared to simple volume discount models. Companies should develop strategic plans for sourcing and procuring drugs. The need for an alternative to the tiered formulary has also been created by coupons that companies issue to reduce out-of-pocket costs and thwart the incentives for patients to use the less costly, preferred drugs.”

Contact Mansur through Stephanie Ross at stephanie.ross@edelman.com.

Survey: Oncology Management Is Still an Important Payer Challenge


Managing oncology drugs and service, determining specialty drugs’ value and making sure treatments are clinically appropriate were the top reported challenges in 2015 from health plan respondents, according to the recently released EMD Serono Specialty Digest.
This year’s digest, the 12th edition, contains data from 58 commercial plans nationwide, representing more than 140 million covered lives. In June, EMD Serono will make available a new oncology-specific supplement to the digest.

Among the findings are the following:

◆ **41% of respondents said managing sites of care for infusions** was their least successful challenge last year, followed by 30% who said managing oncology. Conversely, 58% said that ensuring clinically appropriate use of drugs was their most successful challenge.

◆ **22% said that implementing new or enhanced utilization management or prior authorization was the “single most important initiative”** their company undertook in 2015, followed by implementing a site-of-care initiative at 19%.

◆ **44% said they were using site-of-care programs**, with 35% saying they would implement such a program within the next 12 months. Among those with programs in place, the main tactic was requiring a preferred site with some medical exceptions (68%), followed by contacting members to recommend alternate sites (44%), providing lower member cost sharing for preferred sites (32%) and requiring white bagging of drugs (20%).

◆ **Use of oncology pathways increased, with 38% of respondents using at least one pathway, up from 21% in 2014.**

◆ **93% of respondents’ plans have a preferred agent among the new hepatitis C therapies**, an increase from 53% the prior year.

◆ **23% of respondents used episode-of-care or bundled payments in 2015, up from 11% the previous year.** However, 65% say they have no plans to implement such a reimbursement model.

### Most Likely Design Strategies for the Coming Year

<table>
<thead>
<tr>
<th>Most likely design strategies include required use of lower-cost infusion sites and enhanced PA based on clinical appropriateness. Enhanced formulary review of new medications is also highly likely. Enhanced clinical PA predominates as the single most likely design strategy.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q: Which 3 benefit design strategies are you most likely to implement during the coming year?</strong></td>
</tr>
<tr>
<td><strong>Increased/enhanced PA based on clinical appropriateness</strong></td>
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<tr>
<td><strong>Increased/enhanced formulary review of new drugs</strong></td>
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<tr>
<td><strong>Increased/enhanced PA based on drug cost</strong></td>
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<tr>
<td><strong>Implement ePA</strong></td>
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<tr>
<td><strong>New/enhanced oncology clinical pathway</strong></td>
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<tr>
<td><strong>Require use of less expensive infusion sites</strong></td>
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<tr>
<td><strong>Contact members to encourage use of lower-cost infusion sites</strong></td>
</tr>
<tr>
<td><strong>Use cost sharing to incentivize use of lower-cost infusion sites</strong></td>
</tr>
<tr>
<td><strong>Increase OOP cost for branded drugs</strong></td>
</tr>
<tr>
<td><strong>Reduce OOP cost for biosimilars</strong></td>
</tr>
</tbody>
</table>

SOURCE: **EMD Serono Specialty Digest, 12th edition, EMD Serono, released May 2016. Available at www.specialtydigest.emdserono.com.**
14% have at least one outcomes-based contract for a specialty drug, with 30% planning to implement this within the next 12 months.

42% of respondents use partial-fill programs for specialty drugs, and 32% plan to implement this tactic within the next year. For oral oncology drugs — the most common therapeutic category to use this strategy, followed by oral hepatitis C drugs — the most common requirement is a partial fill for the first fill only (48%), followed by 19% requiring it for the first two fills.

Increased or enhanced prior authorization that’s based on a therapy’s clinical appropriateness and requiring members to be infused in less-costly sites of care were among the most likely design strategies that respondents said their companies would implement in the coming year (see chart, p. 41).

Changing their PBM, reducing member out-of-pocket costs for biosimilars and implementing new or enhanced oncology clinical pathways were some of the least likely strategies to be implemented in the next year.

Download the digest at www.specialtydigest.emdserono.com. For more information, contact Melissa Manganello at (781) 681-2393.

Illinois Blues Plan and Oncology Group Form Intensive Medical Home


Two long-time partners recently launched a new oncology program to better manage patient care. Blue Cross and Blue Shield of Illinois (BCBSIL) and Illinois Cancer Specialists (ICS) are collaborating on what they say is the first oncology intensive medical home pilot program in that state.

ICS, which is in The US Oncology Network, “has been a partner of ours for a long time,” says Lee McGrath, senior director, provider network strategy for BCBSIL, and the group has provided “excellent quality of care for our members.”

For its part, “ICS chose to work with BCBS because the organizations were very aligned in improving community based oncology care,” says Brian Field, director of managed care for The US Oncology Network. “We approached them because they were already working on a medical home project in another specialty. We also pursued this with BCBS because of the influence in the Chicago market, as well as their place in our practice market share, [where] they are second behind only Medicare. We feel in an era to drive quality, outcomes and value that the specialist market, specifically oncology, can drive improvement. After sharing our program and resources available to us, BCBS felt we could make that difference as well.”

Crohn’s Pilot Has Promising Early Results

The Blues plan has other intensive medical homes, and its first specialty one was a pilot for Crohn’s disease with the Illinois Gastroenterology Group that was launched in late 2014 (SPN 11/14, p. 1). Early results have been promising: Cost of care declined by 10% over the
first 10 months of the program, and there was a 57% reduction in hospitalization payments and a 53% drop in emergency room payments (SPN 4/16, p. 6).

McGrath clarifies that the “goal of a patient-centered medical home and an intensive medical home are the same: managing and coordinating the care of a patient.” But with a patient-centered medical home, “there is a governing body that says you have to do these 10 things, and now you’re a PCMH.”

BCBSIL members eligible for the oncology intensive medical home are those who are receiving chemotherapy or hormone therapy and have a diagnosis of breast, colon, lung, pancreatic or prostate cancer or non-Hodgkin’s lymphoma. Those conditions were selected because they “are the most prevalent at that practice,” explains McGrath. BCBSIL “looked at our claims” and is partnering with ICS “based on who they are seeing....We want to make sure we’re covering as many patients as we possibly can.”

The groups are hoping to enroll 150 to 200 patients per year. Enrollment is not automatic, though. According to Field, “We must first educate the patient about the program, and secure a signed consent and share that with BCBS.” Enrolled patients will be in the program for six months at a time and will be treated at one of the 10 ICS locations. If treatment needs to be provided for a longer period of time, McGrath says those members can continue in the program. “We want to support patients in any way possible.”

McGrath tells SPN that BCBSIL has been talking with other oncology practices about other pilots. In fact, in April the plan signed an agreement with one that she cannot disclose at this point.

At ICS, “our goals are quite simple,” Field tells SPN. “The program is designed to help meet the needs of patients, payers, and providers. We have sought to improve efficiency and quality by following evidence-based medicine, leading to the development of a patient-centered, value-based cancer care program.”

The providers are following the National Comprehensive Cancer Network’s NCCN Guidelines. “Our goal is to provide evidence-based validated, outcome-driven patient care,” says Field. “This type of quality care also has to meet the national quality standards that follow cost-effective pathways to provide access and affordability to patients — access to cancer care that is coordinated with the central focus on patients and their entire medical condition.”

McGrath says the Blues plan is looking for a “very, very, very high” percentage of compliance with the guidelines, but she notes that it will never be 100%. The practice of medicine “is an art, not [solely] science,” she tells SPN.

A “big differentiator” between care provided through the pilot and care that a member normally would receive is ICS’s use of a nurse care manager (NCM), says McGrath. This is an oncology certified nurse who can proactively manage patients.

According to Donna Krueger, clinical services administrator at ICS, “There is one care manager for all sites, and she is an employee of ICS.” The NCM, also known as a supportive care nurse (SCN), “is responsible for following up with all patients receiving chemotherapy (IV or oral) for the six major disease types chosen. She calls after each chemotherapy [treatment] at a minimum. Higher-risk patients or those having significant toxicity from treatment are called more frequently.”

Krueger tells SPN that “If the patient is having a problem that the SCN feels needs additional medical attention, she contacts the patient’s primary care site for further intervention.
Examples include dehydration, fevers, inability to eat or protracted nausea or vomiting. These patients are brought into the office for intervention, which can often eliminate the need for an ED visit or an inpatient hospitalization. Education is also a high priority to help patients from getting into these situations — for example, discussing the need for good hand washing and staying away from sick people when their white blood cell counts are low, calling with fevers greater than 100.5 degrees, etc.”

BCBSIL and ICS plan to meet on a quarterly basis to “exchange information and discuss if the [intensive medical home] is a sustainable model for benefit and care delivery services,” says the Blues plan. “Some of the information discussed will include metrics on hospital admission rates, hospital days, ER visits, office visits and home health visits.”

Contact McGrath through Kristen Cunningham at kristen_cunningham@bcbsil.com and Field and Krueger through Christy Sullivan at christy.sullivan@usoncology.com.

Site-of-Care Program Saves Two Plans $1 Million Over Six Months


As payers struggle to contain the ever-growing costs of specialty therapies, one tactic that some are turning to is site-of-care management. And with more and more drugs being administered in the hospital outpatient department, which can apply quite the markup on therapies compared with other locations such as physicians’ offices or patients’ homes, this may be a challenging yet ultimately effective strategy to take.

Magellan Rx Management recently unveiled the early results of its clinical site-of-care program for two regional health plans — savings of more than $1 million over the first six months of the offering.

“Savings was calculated based on the difference in the member’s infusion drug cost when administered in the hospital outpatient facility versus the alternate site of service chosen (either physician office or home infusion provider) — both values are derived from the health plans’ medical benefit paid claims data,” explains Adam Wiatrowski, senior vice president and general manager, Magellan Rx Specialty. The drugs included in the calculation were those “used to treat autoimmune disorders, immunodeficiencies and rare diseases.”

According to the sixth edition of Magellan’s Medical Pharmacy Trend Report, “for both commercial and Medicare administration codes, the most spend occurs with administration of IV chemotherapy. Analysis of drug administration code spend is inclusive of all sites of service (home infusion/specialty pharmacy, hospital outpatient, and physician office) and as expected, administration of medical benefit drugs is more costly in the hospital outpatient facility than other outpatient sites of care. Frequently, it is four times more expensive in the hospital than physician office setting for commercial members; for Medicare, it is frequently twice as costly in the hospital.”

Based on health plan claims data, Magellan found, for example, that Remicade’s (infliximab) cost per claim was $4,132 in a physician’s office, $5,002 through home infusion or specialty pharmacy and $8,930 in the hospital outpatient department. And the cost per claim for
Neulasta (pegfilgrastim) was $3,741 in the physician’s office, $3,731 through home infusion or specialty pharmacy and $7,207 in the hospital outpatient setting.

**Nurses Reach Out to Patients**

Through Magellan’s site-of-service program, which is run by a care team consisting of nurses, pharmacists and doctors, a referral center nurse will reach out to a patient receiving infusions to discuss all of the administration sites available, as well as benefits that each offers. “Payer and member savings are generated when the patient chooses a more cost-efficient location,” says Magellan. “Member affordability and convenience are the most common considerations for selecting an infusion provider.” In addition, people whose immune systems already are compromised are not putting themselves at risk for a hospital-acquired infection when they choose an alternate site.

Within the two health plans, there were “multiple transitions” of members from the hospital outpatient setting to physician offices and their own homes, Wiatrowski tells *SPN*. “The office-based practices with infusion suites and home infusion providers are both equally advantageous for members for different reasons.”

Wiatrowski says that he cannot reveal the plans’ identities or the regions in which they are located, but he does say that “the two health plans are located in different regions, proving the program works in different geographic areas, each containing their own unique networks and dynamics.”

For payers evaluating their medical pharmacy benefit management strategies, a site-of-service program is “a very important initiative, especially as we’re seeing hospitals buy physician practices and billing at the hospital rates, in addition to the growing pipeline which will further exacerbate this challenge,” he says. “It’s important for a health plan to have a medical pharmacy management strategy that consistently reviews and optimizes site of service.”


Contact Wiatrowski through Colleen Flanagan Johnson at CEFJohnson@magellanhealth.com.

**Zarxio Pickup Is Happening, but It’s Been Slow Going So Far**


One year after the FDA approved the first biosimilar drug, Zarxio (filgrastim-sndz), the Sandoz, Inc. drug is making some headway within the short-acting granulocyte colony-stimulating factor class of drugs. But there are some lessons that other biosimilar manufacturers may want to take to heart as they attempt to break into the U.S. market.

Zarxio’s uptake “is tracking pretty much in line with our expectations,” says Kate Keeping, senior director of biosimilars research at Decision Resources Group (DRG), although it’s “not gone as well as would have been liked.” Last year after the drug gained FDA approval March 6 (*SPN* 3/15, p. 1), DRG surveyed oncologists in the United States about their expected use of the biosimilar, and “about half expected to use it within six months of
launch.” In the half year since its Sept. 3 launch (SPN 9/15, p. 8), about half of the oncologists DRG recently surveyed had used Zarxio, she tells SPN.

At this point, “there’s not enough evidence to say payers are forcing” providers to use the product, she says. That said, Zarxio’s cost, which is 15% less than that of its reference product, Neupogen (filgrastim), is a “key driver of uptake” among physicians, who see it as a way for both their patients and their practices to save money. But among payers, the “general feeling is that a 15% discount is not enough” to force a shift.

The class also contains Granix (tbo-filgrastim), which in Europe is considered a biosimilar but received FDA approval through the traditional Biologics License Application route because the biosimilar designation was not yet available here. “For the most part, it seems that it’s Neupogen taking a hit [from Zarxio’s presence] and Granix to a lesser extent,” Keeping says.

Granix’s presence on the U.S. market, as well as its biosimilarity designation in Europe, is a challenge to Zarxio’s uptake. The drug “has been on the market for a few years now,” and many physicians like to “stick with what you know,” says Keeping. However, physicians “may be less inclined to stick with Granix now that Zarxio has been on the market a little longer.”

She adds that “the key difference” between the two is Granix’s label. “It has no indication extrapolation, so it’s not the full [Neupogen] label” that Zarxio has. And although Granix’s average sales price is actually 24% less than Neupogen’s, this means that Medicare actually reimburses for it at a lower rate because of the ASP +6% payment methodology used in Part B.

**Management Is Mainly by Prior Authorization**

Among commercial payers that DRG has surveyed, “a lot” say Zarxio falls under both the pharmacy benefit and the medical benefit, so various maintenance tactics are used. In the medical benefit, payers use “prior authorization to control use,” and although other strategies can be applied to drugs in the pharmacy benefit, “prior authorization is still the most common strategy” there as well, says Keeping. “There is no evidence that payers are using more aggressive tactics yet like step edits requiring that providers have to use Zarxio” before Neupogen.

Biosimilar manufacturers can learn a couple of takeaways from Zarxio’s experience, she says. “Knowing your market is very important — it’s important for any product.” According to DRG provider surveys, “a disproportionately large proportion” of oncologists in hospitals didn’t think they had access to Zarxio.” That could be because they didn’t know they actually had access or because they really didn’t have it.

Another lesson, Keeping says, is “not overestimating what physicians really know about biosimilars” and understanding “how much education is needed around biosimilars, particularly in the U.S.”

Interestingly, DRG found that “the majority of oncologists” surveyed had not seen a sales rep from Sandoz or parent company Novartis AG one month after Zarxio’s launch, she says.

Contact Keeping through Briana Pontremoli at bpontremoli@teamdrg.com.
FDA Approves Inflectra, Biosimilar of Remicade; Pfizer Is Planning 2016 Launch


In a little more than a year after the FDA approved the first biosimilar, Zarxio (filgrastim-sndz), reference drug Neupogen (filgrastim), the agency has approved a second drug that used the 351(k) approval pathway. On April 5, the FDA approved Celltrion, Inc.’s biosimilar Inflectra (infliximab-dyyb). The infusible monoclonal antibody is a biosimilar version of Janssen Biotech, Inc.’s Remicade (infliximab), which received its initial FDA approval in 1998. In terms of health care system savings, a biosimilar Remicade is likely to be much more significant than a biosimilar Neupogen, as inflammatory conditions routinely rank at the top of specialty drug spend categories for payers — and increased costs and utilization for this class of drugs show no sign of slowing.

The FDA approved Inflectra to treat moderately to severely active Crohn’s disease in adults and children, moderately to severely active ulcerative colitis in adults, moderately to severely active rheumatoid arthritis, active psoriatic arthritis, active ankylosing spondylitis and chronic severe plaque psoriasis. Those are the same indications that Remicade has, except the reference drug also has approval for moderately to severely active ulcerative colitis in pediatric patients.

According to an industry expert who asks not to be identified, “I think [the approval] was expected, but I never take it as a given,” even though on Feb. 9 an FDA advisory committee voted 21-3 in favor of approval (SPN 2/16, p. 1). Indication extrapolation wasn’t a given either even though the committee supported it.

The European Commission granted the product full indication extrapolation, but Health Canada approved it for only the rheumatologic indications. Based on the FDA’s definition of “highly similar,” the agency “can’t cut the baby in half like Canada did,” says the source.

Express Scripts Holding Co. has estimated that biosimilar versions of Neupogen and Remicade could bring about a combined $22.7 billion in savings over their first decade on the U.S. market. Biosimilar Neupogen is projected to make up $5.7 billion of that total, with biosimilar Remicade responsible for $17 billion. The estimates assume a 30% discount in price for the biosimilars and use by 30% of patients new to therapy rather than people switching over from the reference products.

“A single dose of Remicade can cost from $1,300 to $2,500,” says Stephen Cichy, founder and managing director of Monarch Specialty Group, LLC, with the number of vials needed per dose varying due to the patient’s weight.

According to Steve Johnson, Pharm.D., senior director for health outcomes at Prime Therapeutics LLC, “Remicade is the top drug by spend on the medical benefit and one of our top 10 drugs in overall spend. For context, Remicade is approximately a $10 billion drug nationally.” He says its most common uses are for Crohn’s, rheumatoid arthritis and ulcerative colitis.

And even without the pediatric ulcerative colitis indication, “My speculation is that U.S. payers won’t require regulatory approval for all brand indications in order to prefer a biosimilar like Inflectra,” says Cichy.
“Payer costs among anti-inflammatory biologics are very high on a per-member per-year basis, and any new drug that has potential to lower the unit cost of therapy is likely to be taken seriously,” Cichy maintains. “In today’s market, payer management of Remicade is most often limited to medical-necessity criteria plus step-therapy requirements that specify for a patient to have failed or be intolerant to certain prior therapies.

“I wouldn’t expect for the payer management approach for Inflectra to be anything different than Remicade — at least to start,” he says. “Over time, it’s possible that certain payers might take the position of listing Inflectra in a preferred position on their payer formularies. If this were to occur, I’d anticipate this to be due to a net price difference, rather than difference in list price, per se. This is because of contracted rebates by Janssen that might potentially limit an economic incentive (or ability) of payers to prefer Inflectra on formulary.”

Although Remicade and Inflectra are administered by health care professionals, so they mainly fall under the medical benefit as opposed to the pharmacy benefit, “Prime is unique as a PBM in that it supports our health plans in managing drugs on both the medical and pharmacy sides,” spokesperson Karen Lyons tells SPN. “We actually receive medical claims and utilization data from our plans so we can obtain negotiated rebates for them and track trends. Despite this drug being on the medical side, we will review it through our standard P&T [i.e., pharmacy and therapeutics] process to help guide its use compared to other products on the market. We will also evaluate the rebate opportunities with the manufacturers and decide how to proceed forward.”

Cichy notes that Remicade has “prescription assistance programs and patient rebate programs such as the Janssen RemiStart Program that can reduce costs for eligible patients, and that a drug like Inflectra will need to contend with.”

**Prime Works With Plans, Providers**

Johnson tells SPN that “Regarding our education around biosimilars, we have been talking with our plans about biosimilars and their potential savings and challenges/uncertainty that remains in the FDA rules (e.g., interchangeability and naming), if providers will see them as safe and be willing to prescribe them and how patent litigation may slow biosimilars from entering the market. Through our specialty pharmacy sales team, we are also working to coordinate with providers and educate their physicians to help drive use of the lowest cost drugs including biosimilars.

“While the biosimilars landscape is in its infancy, if we can help physicians be more comfortable with biosimilars and help them negotiate competitive rebates, we should be able to increase prescribing of them and yield savings from this competition,” he continues. “We also work with our health plans to assist with the management of Remicade through appropriate use and dosing, establishing fee schedules for administration through physician offices and to reduce the use of Remicade infusions at high-cost sites (i.e. facility outpatient locations).”

In 2009, Hospira, Inc. entered into an agreement with Celltrion for several biosimilars, including Inflectra, for which it has exclusive commercialization rights in the U.S. and other countries. This past September, Pfizer Inc. acquired Hospira, giving considerable marketing and commercialization clout to Inflectra.

“Pfizer is not an inexperienced company,” says the unidentified source. “We’re in for a different game” than what has been seen with the marketing and commercialization efforts around Zarxio.
Pfizer Is Planning for Inflectra Launch This Year

“While launch timing will ultimately depend on a number of factors, we are moving ahead with the preparation of our launch plans for 2016,” Rachel Hooper, a Pfizer spokesperson, tells SPN. “These various commercial and other factors include marketplace conditions, payer dynamics, expected timing for entry of other products and intellectual property-related considerations, among others.”

According to Hooper, “We cannot comment on our future development and commercialization strategies for Inflectra at this time. Each biosimilar molecule has specific drivers that determine market price. The overall cost savings and generally positive reception of Inflectra in other markets to date is consistent with our belief that biosimilars can be an important and a welcome option for patients, prescribers and payers.”

“It’s been widely speculated that the price of Inflectra will be 20% to 30% below that of Remicade in the U.S., but Pfizer will have a big say regarding the final price after discussions with Celltrion,” says Cichy. “Inflectra has prior pricing experience in numerous countries where it’s already been approved, but I don’t think we can reliably use pricing information from this prior experience to relate to the U.S. — at least to start. I’d anticipate for the key driver of payers regarding Inflectra to be net cost, and required payor discounts are likely to be north of 30% in order to gain preferred status.”

Still, for all the excitement around biosimilars, a lot of uncertainty remains. And there have been only two drugs approved through the biosimilar process, even though the FDA had 59 proposed biosimilars to 18 reference products within its Biosimilar Product Development Program as of Jan. 21, according to Feb. 4 testimony by Janet Woodcock, M.D., director of the FDA’s Center for Drug Evaluation and Research.

In a statement, Prime says that “While this approval is a welcome milestone, Prime remains cautiously optimistic about the biosimilars market and its ability to drive down drug prices in the near future.” According to David Lassen, chief clinical officer for Prime, “Inflectra’s approval comes more than a year after the first biosimilar was approved in the U.S. If approvals continue to be this slow, it will be many years for biosimilars to have an impact on high drug prices. Americans can’t afford to wait and more needs to be done to slow the unsustainable growth in drug costs.”

“What happened to the other” biosimilar applications at the FDA, wonders the source. “What happened to the ones that had action dates in August? Where are the epo [i.e., epoetins]? Some of these products have had “hundreds of millions of patient days in Europe…. The obvious ones being stuck don’t make me more confident for the less obvious ones.”

It’s frustrating that the FDA is “not using the confidence of science,” says the unnamed source, who points out that “the product we know the least about is the truly innovative product.” The source notes that Remicade has undergone 50 manufacturing changes, and yet each batch is still considered acceptable to sell as that product.

“That comparability means we do understand these products….We’ve done a lot over the last 20 years. Stop panicking.”

Contact Cichy at scichy@monarchsp.com, Hooper at rachel.hooper@pfizer.com and Johnson and Lassen though Lyons at klyons@primetherapeutics.com.
Report: Trend Toward Separate Medical, Pharmacy Deductibles Grows


As drug costs have continued to rise, so have cost-sharing levels for many health plan members, as payers hope that a greater awareness of health care costs will prompt wiser spending. “The idea behind patient cost sharing is making patients pause” in order to assess their options and “make informed treatment decisions,” says Melinda Haren, senior director of access strategies at Zitter Health Insights. But as more pharmaceutical manufacturers offer copay programs that cover either all or a portion of patient cost shares, that approach has undermined the strategy, prompting payers to try new approaches, such as separate pharmacy and medical deductibles.

“We’re not seeing a huge move toward coinsurance in place of copays,” she says. There’s “not a wholesale shift of payers insisting that all drugs move to a percentage of the...copay.” But the firm has seen a “shift to pharmacy-specific deductibles,” notes Haren.

Specifically, says Marie Hollowell, senior manager of syndicated research at Zitter, in the Managed Care Biologics and Injectables Index, fifth edition, for which data was fielded last summer, there was a shift from the fall 2014 edition of payers “moving away from comprehensive deductibles to distinct [ones for] medical and pharmacy benefits.”

The Index found that among responding payers, there was a drop in those offering a comprehensive deductible covering both the medical and pharmacy benefits, as well as a rise in those offering separate deductibles for each benefit.

Contact Haren and Hollowell through Katherine Dodier at kdodier@zitter.com.

Deductible in Most Representative Commercial Benefit Design: Plan Year 2015

Although not statistically significant, payers with a comprehensive deductible spanning both medical and pharmacy benefits have dropped from 50% to 42% from q4 2014 to now

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<tbody>
<tr>
<td>We have a comprehensive deductible that spans both the medical and pharmacy benefits</td>
<td>42%</td>
<td>50%</td>
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<tr>
<td>We have a separate deductible for the medical benefit and pharmacy benefit</td>
<td>21%</td>
<td>16%</td>
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<td>15%</td>
<td>10%</td>
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<td>We do not have a deductible in place for either the medical benefit or pharmacy benefit</td>
<td>13%</td>
<td>16%</td>
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<tr>
<td>Unsure</td>
<td>3%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Average most common individual comprehensive deductible:

- Edition 5 - 2015: Mean = $2,038.89 (N = 36, Unsure = 7)
- Edition 4 - 2014: Mean = $2,216.89 (N = 37, Unsure = 14)

Average most common pharmacy benefit deductible:

- Edition 5 - 2015: Mean = $921.75 (N = 20, Unsure = 5)
- Edition 4 - 2014: Mean = $829.17 (N = 12, Unsure = 4)

Average most common medical benefit deductible:

- Edition 5 - 2015: Mean = $1,340.44 (N = 23, Unsure = 14)
- Edition 4 - 2014: Mean = $3,314.33 (N = 15, Unsure = 11)