Aetna Tests the Weight-Loss Drug Waters With New Pilot and Pharma Collaboration

While many insurers and plan sponsors have been taking a “wait-and-see” approach to two relatively new anti-obesity medications, all eyes may now be on Aetna Inc. as it embarks on a clinically supported pilot to test the benefits of Vivus, Inc.’s Qsymia (phentermine and topiramate extended-release) and Eisai Inc.’s Belviq (lorcaserin HCl). The newly launched program, which is the first partnership of its kind for the drug makers, will evaluate the benefits of either agent “combined with lifestyle support.”

Qualifying members of self-insured plans that participate in the pilot will receive the drugs at a preferred brand copay and have access to mobile and other applications to help them stay on track with fitness, diet and other lifestyle goals. Doctors must prescribe the drugs, and Aetna will apply prior authorization criteria that are consistent with the drugs’ approved use by adult patients with an initial body mass index of 30 or greater or overweight adults with a BMI of 27 or greater who also suffer from at least one weight-related comorbid condition (e.g., high blood pressure, high cholesterol, type 2 diabetes). Aetna will provide information about weight-loss options to all employees of plan sponsors who chose to participate in the pilot, and will conduct outreach to high-risk members about their covered weight-loss options through existing wellness programs.

This is the first time Aetna is testing anti-obesity drugs as part of an overall weight-loss management program, which includes the use of CarePass, an application that allows members to “choose from curated applications in the areas of weight tracking, medication compliance, creating and following a physical activity plan and following a

continued on p. 4

PerformRx Goes Behind the Scenes to Get a Better Picture of Patient Adherence

Insurers, PBMs and pharmacies have myriad ways to make sure patients physically obtain their medications, from monitoring patients at the point of sale to automatic mail-order refills. But how can anyone be sure what happens once the patient is at home with that medication?

“That’s the piece that has always been missing in medication adherence,” observes Mesfin Tegenu, R.Ph., president of PerformRx, LLC, a wholly owned subsidiary of the AmeriHealth Caritas Family of Companies. And adherence is especially important for those “who are on multiple medications, who are confused about how many pills to take or when to take them,” he asserts. “So our goal is to see how we can help patients comply and how we can make sure that they take their medications.”

Moreover, when you consider that 5% to 10% of members account for about 70% of overall resources, it makes sense from a return-on-investment (ROI) perspective to target at least 5% of that group, he points out. As a result, the PBM has recently deployed three new information-gathering technologies to target nonadherent members who have some of the highest overall health care costs. They are:

continued
(1) PillStation. Through a unique, camera-based technology, members are armed with a box that can accommodate a seven-day supply of multiple medications (each day is separated into morning, afternoon and evening). When the tray is opened, “an image of activity” triggers an alert to the PillStation service center, where people are literally “watching what’s going on in those pill boxes,” explains Tegenu. “They know that the pills are still there [if the box hasn’t been opened]. I think it’s the missing link between medication adherence, where you get the prescription to the patients and we don’t know what happens after this. Now we can help them take the medication properly.”

About a year ago, PerformRx began working with SentiCare, which developed the technology and has since been acquired by RxAdvance, to ship PillStations to more than two dozen members who were taking at least 15 prescription medications. Patients who were identified for the pilot were given the opportunity to opt out and “a few” indicated that they were not interested, he says. If the service desk observed noncompliance, it notified PerformRx, whose pharmacists would follow up with the members’ physicians while SentiCare nurse case managers would reach out to patients. “That coordination makes a difference and works really well,” stresses Tegenu. At the same time, the box is Bluetooth-enabled so that if patients have a question about their medication they can press a button and be connected to the service center, he adds.

The results were impressive enough for the PBM to expand that pilot this year to more than 100 patients. All patients who used the tool demonstrated improved compliance and there was an overall reduction in health care costs, says Tegenu. And at the end of the year, many participants were ultimately disappointed that their boxes were going away. Many of the “polypharmacy” users targeted in the initial pilot had diabetes or congestive heart failure, but the pilots are not limited to those conditions, he clarifies. Plan sponsors pick up the cost of the boxes, which run about $800 per member per year, he adds.

If results from the new pilot show a significant reduction in health care costs and improvement in quality, PerformRx will consider incorporating the tool into its Drug Therapy Management program.

(2) TMED Hepatitis C Management Program. PerformRx has also partnered with TMED to put 3G-enabled tablet computers in the hands of newly diagnosed hepatitis C patients on triple therapy to help them monitor their condition by responding to a daily health survey. Through a simple application on the tablet, patients can enter information such as when they take their medications and what side effects they’re experiencing, and PerformRx is able to run reports to view patient responses and quickly identify those who show “early warning signs to proactively address problems before they become emergencies.” The company can also set up medication reminders for patients to view on the tablets. “Eventually our goal is for people to load an application into their smartphones” that would allow PerformRx to collect this information, explains Tegenu.

Adherence rates to the Response Guided Therapy protocols for members included in the program will be compared to similar hepatitis C members not included in the program. An increase of 5% or more in patients achieving optimal adherence will be considered successful, while secondary outcomes include 10% of patients remaining on triple therapy until sustained virologic response is achieved, and overall referral to case management and/or health care professional for coordination of care. The first year of this initiative will cost approximately $1,200 per member, but avoiding medical costs associated with treatment failures for hep C far outweigh those estimated costs, he says.

(3) Memotext. The third initiative PerformRx is employing to “ultimately change medication-taking behavior” targets members diagnosed with asthma. Members subscribed to the service will receive text-message reminders, personalized messages and questionnaires. Through that program, the PBM has the ability to gather information about patients’ attitudes toward health and potential barriers to following their medication regimen...
fully through responses sent via text. This model allows PerformRx to tailor its outreach methods in real time — based on current patient data — to meet specific patient needs, and increases the likelihood that the intervention will succeed in improving health-related outcomes, maintains Tegenu. The PBM expects to achieve a 299% ROI through the use of this technology.

Contact Tegenu via Helene Nelson at hnelson@performrx.com.

Rebranded Magellan PBM Aims To Manage ‘Total Drug Spend’

Following the October 2013 close of its previously announced acquisition of midsized PBM Partners Rx, Magellan Health Services Inc. has emerged with a new pharmacy services solution that encompasses its specialty pharmacy business, ICORE Healthcare, and Magellan Medicaid Administration. Under the new name Magellan Rx Management, the “integrated pharmacy business” could fill a gap in the middle market that’s been opened by increasing consolidation, suggests one consultant.

Magellan in September 2013 unveiled plans to acquire Partners Rx, a privately held, full-service commercial PBM, for $100 million in cash (DBN 9/13/13, p. 8). The addition of the Scottsdale, Ariz.-based PBM contributed more than 300,000 pharmacy lives and roughly $240 million in annual revenue. The newly rebranded and reorganized division will be led by former Partners Rx President and CEO Robert W. Field, who will serve as CEO.

Integrating the commercial, Medicaid and specialty pharmacy operations into one organization will allow Magellan Rx Management to “leverage our collective sale and expertise in managing total drug spend, while ensuring a clear focus on the specific needs of each market segment,” said Magellan CEO Barry Smith during a Dec. 17, 2013, conference call to discuss 2014 financial guidance. Magellan also offers behavioral health services and radiology benefits management.

“Our objective here is to be able to manage any drug whether it’d be spent on the medical claims side or in the traditional PBM pharmacy side, at any site of service, whether it’s in a physician’s office, a facility, an institution or at home or any method of administration. So whether it be an infused, oral or inhaled medication, we want to be able to manage the entire drug spend,” Smith added during a presentation at the 32nd Annual JP Morgan Healthcare Conference in New York on Jan. 14. What Magellan believes makes it unique to the health care industry is its ability to manage the medical pharmacy component, which it already does on behalf of 8 million lives, he added.

That medical pharmacy management allows Magellan to “dig in and look at how the drugs are being managed and work with payers to change utilization strategies [in the medical benefit]. And they have a familiarity with medical data. It’s where the market’s moving and I think it was a good strategic move by Magellan to bring in a customer-centric PBM like Partners Rx,” observes Rob Shelley, president of PSRx Advisors, LLC, and senior vice president at pharmacy data, analytics and consulting firm TRICAST, Inc. “Because of all the heavy

**PBM Contracts: How to Use Audits and Market Checks to Improve Your Bottom Line**

- What contract language should plan sponsors add to their contract terms to ensure effective audits and market checks? What provisions should be avoided?
- What are audits typically looking to uncover? When should they be conducted?
- What are the pros and cons of real-time vs. retrospective claims review?
- What are market checks? When is the best time to perform them?
- What information will be needed to perform the market check analysis?
- What level of savings can you expect to achieve by performing audits and market checks?


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industry consolidation, there is a vacuum for a significant midsized PBM to really come to the forefront. So I think that is the opportunity overall, to try to establish some presence as that entity.”

The Magellan PBM, formerly known as Magellan Pharmacy Solutions, serves state and commercial clients with approximately $15 billion in drug spend. The company touts the new division as offering a “full-service platform,” with services ranging from customized formulations, claims processing and mail service to targeted clinical solutions and specialty pharmacy management.

Thanks to some new contract wins that take effect this year and the Partners acquisition, the company stated during the Dec. 17 conference call that it should have about 400,000 commercial PBM lives as of Jan. 1. The company also projected 2014 revenue to be between $3.61 billion and $3.8 billion. That was “surprisingly high” compared to analysts’ expectations of $3.4 billion, observed securities analyst Carl McDonald in a Dec. 17 research note from Citi Research. “With only a quarter of Maricopa County revenue and a half year of Horizon Blue Cross [Blue Shield] of New Jersey revenue in 2014, we anticipated revenue would drop next year,” wrote McDonald, referring to two contracts slated to expire in 2014.

Contact Magellan spokesperson Colleen Flanagan Johnson at Johnson@magellanhealth.com and Shelley at rshelley@psrx.com.

Join Shelley and Brian Anderson of Milliman at a Jan. 28 webinar on using PBM audits and market checks to improve your bottom line. For more information or to order, visit http://aishealth.com/marketplace/c4p04_012814.

Aetna Launches Obesity Drug Pilot
continued from p. 1

diet plan, including access to menus, and other important features,” explains Edmund Pezalla, M.D., national medical director for pharmacy policy and strategy. Depending on the plan sponsor, there are other wellness products that may complement the pilot, such as Aetna’s metabolic screening program and Aetna Healthy Lifestyle Coaching programs, he tells DBN. Moreover, pilot enrollees will have support programs offered through the manufacturers that will be supplied by mail, Internet and phone.

Patients using Belviq will get a free premium membership to the Lose It! app that is available through CarePass. While the basic version of Lose It! is available to anyone using CarePass, the premium edition has some additional features, which Eisai will sponsor for the first year, clarifies Pezalla.

For the first time in 13 years, both medications were approved as adjunct therapies to reduced-calorie diets and exercise (DBN 8/24/12, p. 1). Belviq hit the market in June 2013, while Qsymia became available only through certified mail-order pharmacies in September 2012, then was cleared to sell through certified retail pharmacies in May 2013, after the FDA had approved its amendment to the Risk Evaluation and Mitigation Strategy. While the insurer was in talks with both firms for several months, Pezalla says the timing is good to launch this type of pilot now that both drugs have been on the market for at least six months, giving physicians enough time to learn more about them and the FDA to start looking at some post-market surveillance.

Aetna Foresees Fewer Surgeries

“Aetna has contractual arrangements for the drugs in the pilot. Weight loss and other clinical and economic measures will be evaluated but not used in reimbursement,” explains Pezalla. The insurer will measure potential improvement in overall health outcomes, productivity and medical costs, and expects to have results by the end of 2014. “Then, hopefully we would be able to continue [the pilot] for another year or so to give us a good picture of how patients do on the medications and further assess health and financial benefits to using them,” he adds.

The insurer says it will evaluate medical costs by comparing spending on weight-related disorders for the member population as a whole to expenditures for members who used one of the medications, both for the pilot year and the year prior. Aetna anticipates that there will be short-term cost savings from the pilot group due to “members’ improved control of diabetes, which may include less need for medications,” Pezalla explains. “If members with diabetes lose weight they likely become relatively more sensitive to the insulin that they produce and to the medications that they’re already taking.”

In the “medium term,” Aetna may see a decline in the number of members opting for bariatric surgery because they have been successful with weight loss through this program, he says. Compared with surgeries that can cost tens of thousands of dollars, the retail cost of a 30-day supply of Belviq ranges from about $110 to $118 with the use of a coupon, while 30 tablets of Qsymia runs about $167 to $178 with a discount, according to GoodRx.com.

And while they can’t be assessed during the pilot, Pezalla says longer term results could include fewer patients developing diabetes or significant hypertension, joint disease and other weight-related conditions.

“At a initiative such as this could be an effective approach if the copay incentive is perceived as significant
by the member and the mobile app is intuitive and provides meaningful information to the program enrollee. The question the pilot must answer, however, is if the weight loss observed in the pilot program was due to the medications, or was it due to the lifestyle coaching provided through the mobile app,” advises Craig Oberg, R.Ph., managing consultant with The Burchfield Group.

“The pilot would also need to assess if the weight loss of the combined approach was superior to either medications or coaching alone,” he adds. “The answers to these questions would only emerge if the pilot contained the appropriate control groups. Quality data should drive the plan sponsor’s decision.”

**Plans Remain Reluctant to Cover Obesity Drugs**

Many insurers and plan sponsors are still wary of the new drugs, given the poor track record of their predecessors “fen-phen” (fenfluramine/phentermine) and Meridia (sibutramine), which were both removed from the market in the last decade due to cardiovascular concerns. A 2013 survey of managed care pharmacy directors conducted by Decision Resources Group found that nearly half of health plans excluded or blocked access to all weight-loss drugs, and one-third indicated that they would not cover an obesity drug without demonstration of long-term benefit (DBN 4/26/13, p. 1).

WellPoint, Inc., for example, has placed Belviq and Qsymia on its national drug list at the least preferred and highest copay for nonspecialty drugs. And while it uses the FDA indications as a starting point for appropriate use criteria, the insurer has the option of tightening prior authorization criteria in the future if deemed necessary by its pharmacy and therapeutics committee, explains WellPoint spokesperson Lori McLaughlin.

Nevertheless, while most benefits offered by its affiliated health plans generally follow the WellPoint formula, she says weight loss drugs are not included in its standard plans and are generally not reimbursed through most of its customers’ benefits due to historical concerns around high-risk side effects.

**Prime’s New Physician-Directed Alliance Targets Adherence**

Prime Therapeutics LLC on Jan. 13 unveiled a new partnership with MDdatacor, Inc., a technology solutions company, that it says will enable the delivery of “enhanced drug therapy opportunities” to health care professionals who are enrolled in a pay-for-performance (P4P) network monitored by the MDinsight tool.

Through the new collaboration, the PBM will use medical and pharmacy claims data to identify drug therapy opportunities from its GuidedHealth clinical rules platform that will then be integrated into MDdatacor’s web-based physician portal, MDinsight, to provide doctors, nurses and other providers with comprehensive, patient-centered data, explains the Blues plan-owned PBM.

Physicians enrolled in a P4P network administered by Prime’s health plan clients will be prompted to work with certain patients on various drug therapy management opportunities, not just limited to adherence. Such interactions may include:

- **Identifying opportunities to manage pharmacy underutilization.** This would include the identification of high-risk members based on specific chronic conditions that are either not adhering to prescribed drug therapy or need additional drug therapy (i.e., gap in care),” according to Prime. “The drug therapy opportunity would not only alert the applicable physician to the adherence issue, it would provide a historical set of data such as the proportion of days covered along with claim history for an individual patient.”

- **Identifying members with a history of overutilization.** This would include utilization patterns that point to potential misuse or abuse of controlled substances, patterns of off-label indications, polypharmacy and/or excessive duration of therapy.

- **Identifying members with potential safety concerns** such as direct medical contraindications to drug therapy (i.e., FDA MedWatch program).

- **Identifying opportunities for the member to save money** by providing generic and/or preferred drug alternatives.

Reward targets will vary by the health plan’s predetermined quality measures, which could include ACE/ARB utilization in diabetes, controlled substance utilization, preferred product use and medication gaps in care, explains Chief Clinical Officer David Lassen, Pharm.D., in a follow-up email to DBN. Return on investment will be measured by “the number of drug therapy opportunities resolved as a result of physician interventions and associated total cost of care savings,” he adds.

For more information, contact Prime spokesperson Kelly Sheehan at ksheehan@primetherapeutics.com.
“Overall, these drugs have demonstrated modest weight loss and significant risk. The FDA has acknowledged safety concerns with these drugs in both adult and pediatric populations in its requirement for post-marketing studies,” adds McLaughlin. As a result, the insurer has opted to combat weight loss through various partnerships aimed at empowering people — in particular, children and their families — to make healthy lifestyle choices, and has just embarked on a new pilot to encourage better self-management of diabetes, which is typically associated with obesity. That program features workshops offered as part of a Stanford University study.

Preferred Networks Continue to Net Enrollees…but for How Long?

Three out of four Medicare beneficiaries enrolled in a Prescription Drug Plan (PDP) for the 2014 Part D plan year have selected one with a preferred pharmacy network, according to a preliminary analysis of CMS enrollment data performed by Pembroke Consulting, Inc. While enrollment in these plans has been on a steep incline in recent years, Pembroke President Adam Fein, Ph.D., warns that this may be the final year of rapid growth if proposed regulatory changes take effect.

In a Jan. 17 Drug Channels post, Fein analyzed CMS enrollment data accepted through Dec. 4, 2013, to determine that preferred network PDPs have already enrolled a total of 13.9 million people, or 75% of the total enrollees for 2014. Fein says that’s “incredible growth” from 2013, when 43% of seniors chose plans with preferred networks (DBN 1/25/13, p. 4). The 2014 open-enrollment period began on Oct. 15 and ended on Dec. 7, so the final data may differ.

Of the 106 stand-alone PDPs that gained enrollees as of Dec. 4, 60 plans have a preferred pharmacy network design, up from 16 out of 190 PDPs in 2013, according to Fein. The 10 largest PDPs with preferred pharmacy networks accounted for 62.5% of total Part D enrollment, he estimates (see table, this page). For the second year in a row, UnitedHealthcare’s AARP MedicareRx Preferred plan gained the lion’s share of enrollees, with 20.5% of total PDP enrollment, while Humana Inc.’s rebranded legacy product with Wal-Mart Stores, Inc., the Humana Preferred Rx Plan, remained in the No. 2 spot with 9.6% of overall enrollment.

“Alas, preferred networks have flown too close to the sun. CMS is targeting preferred networks for tighter regulation and expanded oversight,” points out Fein, referring to a new proposed rule that includes re-defining preferred cost sharing in network pharmacies to ensure that preferred networks deliver lower costs to Medicare and to enrollees (DBN 1/10/14, p. 1). “2014 will likely turn out to be the peak year for preferred pharmacy networks in Medicare Part D,” he predicts.

The new PDP enrollment data can be found at http://tinyurl.com/94nzqh4.

For more information, visit www.drugchannels.net or contact Fein at (215) 523-5700, ext. 15.

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PDP = Prescription Drug Plan
Totals may not sum due to rounding.
\(^{1}\)2014 data reflect enrollment as of Dec. 4, 2013.

SOURCE: Pembroke Consulting analysis of data from the Centers for Medicare & Medicaid Services (CMS). Analysis excludes: Employer-sponsored plans; Medicare Advantage PDPs (MA-PDP); Plans from U.S. territories; Employer/Union only group plans.
Published on Drug Channels (www.DrugChannels.net) on Jan. 17, 2014.

Web addresses cited in this issue are live links in the PDF version, which is accessible at DBN’s subscriber-only page at http://aishealth.com/newsletters/drugbenefitnews.
While Capital BlueCross agrees with Aetna that weight loss management is more effective with multiple approaches, Clinical Services Pharmacy Manager Lisa Frost says Capital would consider promoting the new anti-obesity agents only after “there has been more experience, and safety has been further established.”

Frost tells DBN, “Medications should not be used as first-line therapy but in conjunction with diet, nutrition, and exercise. So we are in agreement with the basis of the new pilot program. Given that there have been safety concerns with the use of older weight loss agents in the past, Capital BlueCross believes a certain degree of caution should be taken with the newer agents that have become available.”

Meanwhile, Premera Blue Cross says it has no immediate plans to integrate weight loss medication into any of its wellness initiatives and generally does not cover obesity drugs, unless a group client has requested it, clarifies a spokesperson.

In addition, a Cigna Corp. spokesperson says the insurer “offers health coaching and support to achieve a healthy weight, and employers have the discretion to cover weight loss drugs.”

Pezalla says that some Aetna plans do cover the drugs on a nonpreferred tier, but most — including the self-insured groups — exclude them from coverage. The pilot is only available to self-insured plan sponsors at this time “because it is easier for them to make changes to their benefit designs to accommodate the medications and predict the cost of the care among their employee populations,” explains Pezalla. The insurer may consider extending the program to its fully insured businesses depending on its findings.

Two other drugs — Novo Nordisk’s Victoza (liraglutide), a once-daily injectable medication that is already on the market for the treatment of type 2 diabetes, and Orexigen Therapeutics, Inc.’s Contrave (bupropion and naltrexone) — are also seeking FDA approval to treat obesity. Pezalla says Aetna would likely consider including those drugs in the program or in a separate pilot after data from the manufacturers become available.

“Part of the reason for us wanting to do this pilot is because there are other drugs coming into the market, we want to understand something about how they function, about their impact on medical outcomes and members’ utilization. We can then give our plan sponsors better guidance on how to cover these medications,” he adds.

Contact Frost via Joe Butera at joe.butera@capbluecross.com, McLaughlin at Lori.McLaughlin2@anthem.com, Oberg via Christine Hanson-Ehlinger at chanson-ehlinger@burchfieldgroup.com and Pezalla via Tammy Arnold at arnoldtd@aetna.com. ♦

**NEWS BRIEFS**

*◆ The five largest dispensing pharmacies — CVS Caremark Corp., Walgreen Co., Express Scripts Holding Co., Rite Aid Corp. and Wal-Mart Stores, Inc. — accounted for about 65% of U.S. prescription dispensing revenues in 2013, according to the new 2013-14 Economic Report on Retail, Mail, and Specialty Pharmacies compiled by Drug Channels Institute, a division of Pembroke Consulting, Inc. The firm also projects total 2013 retail, mail and specialty pharmacy revenues of $287 billion, up 1.6% from 2012, and estimates that market share concentration in 2013 was slightly greater than that of 2012. Visit [http://drugchannelsinstitute.com/files/2013-14-PharmacyIndustry-Overview.pdf](http://drugchannelsinstitute.com/files/2013-14-PharmacyIndustry-Overview.pdf) for an overview of the report, which provides analysis of the pharmacy channel and its interactions with other participants in the health care system.*

*◆ FDA’s Cardiovascular and Renal Drugs Advisory Committee has recommended Merck’s investigational antiplatelet medicine, vorapaxar, for approval to reduce atherothrombotic events, when added to the standard of care, in patients with a history of heart attack and no history of stroke or transient ischemic attack, according to Merck. Under the proposed trade name Zontivity, vorapaxar would be a first-in-class protease-activated receptor-1 antagonist designed to inhibit the formation of blood clots, explains Merck. The basis for the committee’s approval was a 26,499-patient clinical trial that showed a 13% reduction in the first occurrence of cardiovascular death, MI or stroke in patients receiving vorapaxar 2.5 mg. For more information, contact Merck’s Pamela Eisele at (267) 305-3558.*

*◆ New research conducted by CVS Caremark and Brigham and Women’s Hospital confirms the effectiveness of the widely used standard that patients must achieve a medication possession ratio (MPR) of at least 80% to reach optimal adherence, suggests the pharmacy health care provider. The new study, which appears in the January issue of the American Heart Journal, looked at the impact of adherence on clinical outcomes for more than 4,100 myocardial infarction (MI) patients and found that those*
who achieved adherence equal to or greater than 80% MPR were less likely than the control group to experience a major vascular event such as a fatal or nonfatal acute MI or undergo revascularization (e.g., coronary bypass, stenting). For example, patients with optimal adherence to at least one of the study medications (e.g., statins, ACE inhibitors) were 24% more likely not to be readmitted to the hospital for heart-related symptoms. Meanwhile, patients who achieved moderate adherence (60% to 79% MPR) following a heart attack showed no significant reduction in clinical outcomes compared with the control group, even though they had higher levels of adherence. CVS Caremark says it plans to use these results toward ongoing efforts to identify, develop and pilot breakthrough interventions to help improve medication adherence. Contact CVS Caremark spokesperson Christine Cramer at (401) 770-3317.

Millenium Laboratories, Inc. on Jan. 13 said it acquired RxAnte, a health care predictive analytics and decision support company that improves population-level medication adherence on behalf of health plans, PBMs, pharmacy chains and health care providers. The companies did not disclose terms of the transaction. RxAnte, whose platform now manages the medication adherence of over 8 million unique patients, will operate as a wholly owned subsidiary of Millennium, which offers medication monitoring using urine drug testing and pharmacogenetic testing to health professionals treating pain, substance use disorders, psychiatric disorders and other chronic diseases. While the companies will continue to grow their respective core businesses, Millennium and RxAnte also plan to collaborate on new products and services to help payers and health care providers further personalize drug therapy management, improve population health, and reduce the avoidable costs of medication misuse, said the companies. For more information, contact Nicole Beckstrand of Millennium Laboratories at (858) 217-1192 or Leigh Canavan of RxAnte at (703) 677-6459.

PEOPLE ON THE MOVE: Express Scripts Holding Co. hired Cathy Smith as executive vice president and chief financial officer, effective Feb. 10. Smith comes from Walmart, where she has served as executive vice president of strategy and CFO of Walmart International since February 2010. Express Scripts had announced a CFO transition plan in July 2013, which involved the departure of the prior CFO, Jeff Hall, who was replaced on an interim basis by Matthew Harper. Former FDA Commissioner Andrew von Eschenbach, M.D., has joined health economics and policy consultancy Precision Health Economics.

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