Specialty Drug Management
Getting **better** value for money.

Cory Cowan, Pharm.D.
Director, Professional Services

September 25, 2018
Specialty drugs*
Canada – less than 65

* Greater than $10,000 per patient per year
TELUS Annual Conference. Retrospective data trends and national benchmarks 2017. April 2018
## Specialty drugs
Canada – less than 65

<table>
<thead>
<tr>
<th>Region</th>
<th>2008</th>
<th>2017</th>
<th>% of total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATLANTIC</td>
<td>12%</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>QUEBEC</td>
<td>11%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>ONTARIO</td>
<td>11%</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>BC/SASK./MAN.</td>
<td>9%</td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>

TELUS Annual Conference. Retrospective data trends and national benchmarks 2017. April 2018
Increase in specialty drugs on private drug plans

FIGURE 13  Trends in the Number and Share of High-Cost Medicines, Private Drug Plans, 2005 to 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Share of total cost</th>
<th>Number of molecules</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>6%</td>
<td>23</td>
</tr>
<tr>
<td>2006</td>
<td>7%</td>
<td>31</td>
</tr>
<tr>
<td>2007</td>
<td>9%</td>
<td>41</td>
</tr>
<tr>
<td>2008</td>
<td>10%</td>
<td>45</td>
</tr>
<tr>
<td>2009</td>
<td>11%</td>
<td>45</td>
</tr>
<tr>
<td>2010</td>
<td>13%</td>
<td>56</td>
</tr>
<tr>
<td>2011</td>
<td>15%</td>
<td>65</td>
</tr>
<tr>
<td>2012</td>
<td>17%</td>
<td>72</td>
</tr>
<tr>
<td>2013</td>
<td>19%</td>
<td>77</td>
</tr>
<tr>
<td>2014</td>
<td>22%</td>
<td>95</td>
</tr>
<tr>
<td>2015</td>
<td>24%</td>
<td>107</td>
</tr>
<tr>
<td>2016</td>
<td>25%</td>
<td>126</td>
</tr>
<tr>
<td>2017</td>
<td>26%</td>
<td>154</td>
</tr>
</tbody>
</table>

Source: ICVIA Private Pay Direct Drug Plan Database (calendar year data)

Cost drivers/challenges with managing specialty drugs

- Magnitude of new drug approvals & future pipeline
- Complicated administration – intravenous, subcutaneous, intra-muscular
- Limited distribution – cold chain, restricted pharmacy networks
- Dosing regimens – cyclic, fixed days, chronic, fixed duration
- Small patient populations
- Diagnostic requirements
- Specialized monitoring
- Side effect management / adherence
- High cost
Specialty drug management

Objectives

- Maintain access to effective and high-quality care
- Ensure money on specialty drugs is well spent/invested
- Improve patient outcomes
  - HIV: chronic condition
  - Hepatitis C: cure; pan-genotypic treatments
  - Cancer survivors: metastatic melanoma, CLL/AML (leukemia)
  - RA/Crohn’s: chronic management and halting progression
  - Rare conditions: treatments now available
Specialty drug management strategies

Financial management

Clinical management

Pharmacy management
Specialty drug management strategies

- Annual/lifetime maximums

Student union sets $50,000 cap on prescription coverage

The union’s health insurer cited concerns about expenses linked to new specialty medications

Specialty drug management strategies

- **Annual/lifetime maximums**

![Graph showing annual and lifetime maximums for plan members from 2013 to 2017.](image)

- Share of Plan members:
  - 2013: 11.9%
  - 2014: 12.8%
  - 2015: 13.0%
  - 2016: 13.9%
  - 2017: 15.4%

- **Financial management**

Source: TELUS Health INSIGHTS magazine. Fall 2018
Specialty drug management strategies

- Annual/lifetime maximums
- Drug markup caps
- Maximum allowable cost (MAC)
Specialty drug management strategies

Managed formulary

- Less than 20% of lives use a managed formulary\(^1\)
- Open Rx plan + prior authorization ≠ managed formulary
- Solution: comparative and cost-effectiveness analysis (health economics) from private payer lens
- Objective: identify drugs that provide good value for money
- Implications: formulary exclusion, tiered drug placement, supports PLA negotiations

\(^1\)Source: TELUS Health INSIGHTS magazine. Fall 2018
Specialty drug management strategies

- Prior authorization/step therapy

- Need to think beyond simply indication-based PA criteria
- Incorporate use of lower cost agents in criteria (e.g. biosimilars)
- Confirmation of diagnostic markers and Bill S-201
- Considerations in Pharmacare provinces
- Evaluate which conditions/pathways can be automated
- Quantity limits – for fixed duration of use, cycle, or dosing
Specialty drug management strategies

- **Biosimilars**
  - Offer approx. 20-50% savings over originator biologics
  - Challenges: not deemed interchangeable with originator, biosimilar may not be approved for all indications, availability of other branded products, patient support programs

<table>
<thead>
<tr>
<th>Biosimilar brand name (chemical entity; reference brand)</th>
<th>% of new claimants</th>
<th>% of eligible costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1H 2018</strong></td>
<td><strong>1H 2018</strong></td>
<td></td>
</tr>
<tr>
<td>Brenzys &amp; Erelzi (etanercept; Enbrel)</td>
<td>25.9%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Inflectra (infliximab; Remicade)</td>
<td>19.1%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Grastofil (filgrastim; Neupogen)</td>
<td>45.2%</td>
<td>41.5%</td>
</tr>
<tr>
<td>Basaglar (insulin glargine; Lantus)</td>
<td>7.0%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>
Specialty drug management strategies

- **Biosimilars**

  How to best encourage biosimilar use?
  - Formulary placement
  - Prior authorization/step protocols
  - Maximum allowable cost (MAC)
  - Specialty pharmacies
  - Physician & plan member education
New vs existing patients & switching

Tiered Biologics Reimbursement Policy Flowsheet

New Patients (Biologic-Naïve):

<table>
<thead>
<tr>
<th>Select product from TIER 1</th>
<th>FAIL</th>
<th>Select second product from TIER 1</th>
<th>FAIL</th>
<th>Select any product from TIER 1 or TIER 2</th>
</tr>
</thead>
</table>

Existing Patients:

<table>
<thead>
<tr>
<th>Currently on TIER 1* product</th>
<th>FAIL</th>
<th>Select second product from TIER 1</th>
<th>FAIL</th>
<th>Select any product from TIER 1 or TIER 2</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Currently on TIER 2** product</th>
<th>FAIL</th>
<th>Select product from TIER 1</th>
<th>FAIL</th>
<th>Select second product from TIER 1</th>
<th>FAIL</th>
<th>Select any product from TIER 1 or TIER 2</th>
</tr>
</thead>
</table>


A rheumatologist’s decision to prescribe a biologic agent (biosimilar or innovator molecule) must be informed by the clinical need and must adhere to the principles of a sound therapeutic alliance. The Ontario Rheumatology Association (ORA) is aware that automatic (non-medical) switching from innovator to biosimilar molecule may achieve cost-savings to the health care system.

ORA Position on Non-Medical Switching:
The ORA recognizes that non-medical switching* from innovator to biosimilar biologic medications with approved indications for patients with rheumatic disease is safe and has the potential to save health care system resources. The ORA’s support for non-medical switching is based on the following principles:

* Non-medical switching refers to switching from one medication to another without a medical indication.

ORCID: 0000-0002-6267-8744

Switching Between Reference Biologics and Biosimilars for the Treatment of Rheumatology, Gastroenterology, and Dermatology Inflammatory Conditions: Considerations for the Clinician

Robert Moore,1,2 Volkerdo Arpaudo,1,2 Javier L. Costab,2 Thiermi Dörner,2 Elieb Mahoue,1,2 Eduardo Mijer,1,2 Marco Schneider,1,2 and Lisa Marshall1,2

Specialty drug management strategies

- Provincial Integration
  - Disease-based provincial programs
  - Coordination of drug coverage in Pharmacare provinces
Specialty drug management strategies

- Specialty Pharmacies
- Patient Support Programs
Specialty pharmacy advantages

Clinical

- Access to specially-trained healthcare providers
- Care management
- Clinical outcome measures
- Patient adherence programs
- Mobile patient engagement platforms

Operational

- Supply chain management
- Care coordination
- Reimbursement assistance
- Patient support programs
- Site of care optimization

Patients using specialty pharmacies with integrated refill reminders and comprehensive care management programs/nurse coach calls achieved higher adherence rates and lower abandonment compared with patients who do not use specialty pharmacies\(^1\)-\(^3\)

Future specialty drug management

- Electronic Prior Authorization (ePA)
- Drug Pipeline Forecaster
- Pharmacogenomics
- Alternative Payment Options
- Link to gains in productivity; reductions in STD and LTD
Specialty drug management toolbox

- Maximums
- Markup caps
- MAC
- Stop loss/high amount pooling

- Managed formulary
- Prior auth/step therapy
- Biosimilars
- Provincial integration

- Specialty pharmacies
- Patient support programs
Summary

- Proper specialty drug management requires a multi-targeted approach
- Balance between providing access to high-quality and effective products while ensuring costs are properly managed
- Goal is to improve health outcomes with promise of enhancing productivity, reducing absenteeism, and fewer disability claims
- And don’t forget to manage the other 70% of spend…
Thank you

cory.cowan@telus.com