Payer trends in drug utilization and molecular testing have been the focus of several posters presented at the 2012 Educational Conference of the Academy of Managed Care Pharmacy, October 3-5, Cincinnati, OH.

No Consistency in Payer Policies for Targeted Drugs, Tests

Payers have adopted a variety of policies for covering expensive targeted oncologic therapies and associated pharmacogenomics tests, according to a comparison of 4 large insurers—Aetna, Cigna, Humana, and UnitedHealthcare. A search for policies related to 27 drugs and 23 oncology-related pharmacogenomics tests showed little consistency among these payers, according to a poster presentation by Angela Luong, PharmD, of OptumInsight, Shakopee, MN, and colleagues. Drugs and genetic tests were covered by a mix of medical and pharmacy policies.

In only 2 cases did all 4 insurers have policies for the drug and its related genetic test: vemurafenib and crizotinib. The location of the policy—under the medical or the pharmacy benefit—differed among the companies. The analysis revealed inconsistencies across benefits and payers. None of the payers had policies covering all of the drugs and related tests.

Pharmacogenomics tests offer a means to identify patients whose tumors harbor genetic mutations that increase the likelihood of response to treatment with a specific targeted therapy (so-called druggable mutations). Appropriate use of pharmacogenomics tests has the potential to minimize side effects and to increase drug efficacy, thereby reducing costs.

The US Food and Drug Administration now requires drug manufacturers to include pharmacogenomics information in the New Drug Application for every targeted therapy.

Using information available on each company’s website, Dr Luong and colleagues searched for coverage policies pertaining to 27 targeted oncologic therapies and 23 related pharmacogenomics tests, all approved since April 2011.

Of the 27 targeted drugs included in the study, the largest number of policies included in medical benefits for any of the 4 companies was 17, including 13 policies that required associated tests. The largest number of drug policies included under the pharmacy benefit was 15, of which 9 required a related pharmacogenomics test.

Regarding the 23 tests included in the study, the researchers found that the largest number under medical policies was 18, and the highest under pharmacy benefits was 6. The medical benefit had the largest number (ie, 11) of policies requiring pharmacogenomics test results for approval of the drug, whereas the requirement topped out at 6 among pharmacy plans.

Aside from variations in the 4 companies’ policies, the investigators found inconsistencies in the timing of policy development and in coordination across pharmacy and medical. They recommended further evaluation of policies and policy development to achieve more effective cost management and more appropriate use of pharmacogenomics tests to optimize targeted drug therapy. [Luong A, et al. Analysis of 4 large commercial payers’ policies regarding oncology drug-related pharmacogenomic (Pgx) tests.]

Policies to Manage Biologics Use Have Minimal Impact on Costs

Implementation of a step therapy policy for the use of biologic agents had little if any impact on costs over a 5-year period, a review of 4 large health plans showed.

Of 5 biologics included in the study, costs decreased for 2 and increased for 3, resulting in a net cost increase of 10.3%. The findings suggest that policies designed to manage utilization of biologic therapies require careful assessment of the cost of implementing the policy versus the potential cost-savings, reported Mike Ingham, MSc, of Janssen Scientific Affairs, Horsham, PA, and colleagues in a poster.

Step therapy policies establish the order in which medications will be reimbursed, Mr Ingham and colleagues noted. A recent survey of health plans showed that almost 75% of the companies had policies related to step therapy for specialty products (www.specialtydrugbenefitreport.com/executive-summary.html).

Noting that more payers are adopting policies affecting intravenous biologics, Mr Ingham and colleagues assessed utilization patterns from 2006 to mid-2011 for
Costs of Specialty Drugs Continue to Rise at Fast Pace

The cost of using specialty drugs to treat multiple sclerosis (MS) rose substantially from 2008 to 2010, accounting for much of the overall increase in medical and pharmacy costs associated with the condition, investigators reported.

The total per-person-per-year (PPPY) cost of care for all patients with MS increased by approximately $7000, driven primarily by a $6000 increase in the PPPY pharmacy costs for MS specialty drugs. The proportion of total PPPY costs attributable to specialty drugs increased from 48.1% to 54.7%.

For the 70% of patients with MS who were treated only with specialty drugs, the PPPY total cost of care increased by almost $9000. Specialty drugs’ share of the total cost increased from 61.4% to 67.4% over the 3-year period, according to a poster presented by Patrick P. Gleason, PharmD, and colleagues, of Prime Therapeutics, Eagan, MN.

Wholesale acquisition costs (WACs) for individual MS specialty drugs increased at a compound annual growth rate (CAGR) of 10% to 22.6%. For some of the drugs, the WAC increased by ≥2-fold.

Specialty drugs, many originally developed for rare diseases, have been used with increased frequency in chronic diseases, such as MS. Specialty drug costs have risen faster than healthcare costs in general. A 2009 study showed the PPPY cost of treating MS with a specialty drug was $37,592, with pharmacy costs accounting for 56.8% of the total (Schafer JA, et al. J Manag Care Pharm. 2010;16:713-717). Another study showed that the cost of MS drugs for one large insurer increased by 15.2% from 2010 to 2011 (2011 Drug Trend Insights report. Prime Therapeutics, LLC. www.primetherapeutics.com/PDF/2011PrimeDrugTrendInsights.pdf; 2011 Prime Therapeutics, LLC, internal data).

To establish a complete accounting of MS cost of care, Dr Gleason and colleagues reviewed total medical and pharmacy costs for patients with MS within a single commercial health plan covering 1.2 million patients. They searched the insurer’s integrated records for patients aged <65 years and who had ≥2 medical claims associated with an MS code.

The prevalence of MS was 1742 (0.17%) in 2008, which did not change significantly through 2010. Use of specialty drugs for patients with MS increased from 70.8% in 2008 to 71.8% in 2010. Glatiramer was the most frequently used specialty drug, accounting for 28% to 30% of the health plan’s members with MS.

For all members with an MS diagnosis, the PPPY total cost increased from $29,751 to $36,901 over the 3-year period, resulting in a CAGR of 11.4%. Combined medical and pharmacy costs for MS specialty drugs increased from $14,311 to $20,200, representing a CAGR of 18.0%. Pharmacy costs for specialty drugs accounted for $13,745 of the PPPY for combined MS specialty drug costs in 2008 and $19,130 (94.7%) in 2010, which also translated into a CAGR of 18.0%.

An analysis limited only to the 70% of patients with MS treated with specialty drugs showed that the PPPY total cost increased from $32,883 in 2008 to $41,760 in 2010, representing a CAGR of 12.7%. The combined medical and pharmacy costs for MS specialty drugs accounted for $20,201 (61.4%) of the PPPY total cost of care in 2008, increasing to $28,152 (67.4%) of $41,760 in 2010, yielding a CAGR of 18.1%. [Starner CJ, et al. Multiple sclerosis specialty drug utilizers cost of care trends 2008 to 2010: an integrated medical and pharmacy claims analysis.]