Step-Up Therapy Program for Anti-Inflammatory Biologic Agents Does Not Increase Cost Nor Adversely Affect Patient Outcomes

By Wayne Kuznar, Medical Writer

The step therapy requirement for adalimumab coverage does not lead to increased cost to the health plan or increased utilization, according to a retrospective claims-based study by Kyle Burcher, PharmD, UnitedHealthcare Pharmacy, Minnetonka, MN, and colleagues from UnitedHealthcare and OptumInsight. They presented their data at the 2013 annual meeting of the Academy of Managed Care Pharmacy.

Biologic agents have been a top driver of pharmacy costs over the past decade, a trend that is likely to continue in the future, according to Dr Burcher and colleagues. The lack of head-to-head trials showing superiority of one biologic agent over another in terms of outcomes has created opportunities for health plans to implement utilization management programs to control cost while maintaining access to current therapies.

UnitedHealthcare introduced a step therapy program in 2012 for the treatment of rheumatoid arthritis, psoriatic arthritis, psoriasis, ankylosing spondylitis, and Crohn’s disease. The program requires that member prescribers first try 1 or more of the step-1 self-administered biologic anti-inflammatory agents included in the program—certolizumab, etanercept, golimumab, and ustekinumab—before UnitedHealthcare would provide coverage for the use of adalimumab.

The mean medical costs during the 180 days after the index claim were $3233.18 in the intervention group versus $1343.32 versus $847.76 in the control group—$1343.32 versus $847.76 (P = .005). The mean medical costs during the 180 days after the index claim were $3233.18 in the intervention group versus $2874.99 in the control group, a nonsignificant difference.

All secondary end points were also not significantly different between the 2 groups. Dr Burcher and colleagues compared the health and cost utilization outcomes of 149 members in the intervention group who were affected by the step therapy program and 317 members in the control group who were not affected by the program.

The intervention group had a step therapy edit for adalimumab in the first quarter of 2012, followed by a paid claim for a step-1 agent within 30 days. The members in the control group (who were not affected by the program) had a paid claim for adalimumab during the same time. Members in the 95th to 100th percentile by total cost were removed from the analysis to mitigate the impact of outliers.

Psoriasis was the most frequent (26%) diagnosis in the study sample, followed by rheumatoid arthritis (22%). Approximately 25% of the sample members had multiple diagnoses. The mean Charlson comorbidity indices were 0.50 in the intervention group and 0.52 in the control group.

Economic and Health Impact

In the 180 days before the index claim, no significant difference was evident between the 2 groups in mean medical cost, but the mean pharmacy cost was significantly higher in the intervention group compared with the control group—$1343.32 versus $847.76 (P = .005).

The mean medical costs during the 180 days after the index claim were $3233.18 in the intervention group versus $2874.99 in the control group, a nonsignificant difference. All secondary end points were also not significantly different between the 2 groups. In the intervention group, the mean number of pharmacy claims for nonbiologic disease-related therapies (ie, nonsteroidal anti-inflammatory drugs, corticosteroids, and immunosuppressants) was 3.38 compared with 2.98 in the control group (P = .821); the mean number of ambulatory visits was 9.35 versus 8.50, respectively (P = .276); and the percentage of members with an emergency department or inpatient visit was 16.8% versus 16.2%, respectively (P = .889).

“Outcomes studies like this are necessary to show that the resultant pharmacy savings do not lead to unintended increases in medical utilization and cost,” suggested Dr Burcher and colleagues.

Reference