Specialty pharmaceuticals are quickly commanding a growing share of prescription market share dollars and consequently a greater amount of attention from payers. It is becoming increasingly important for payers to fully understand the nuances of cost control within the specialty pharmacy space before developing a contracting and formulary strategy for specialty pharmaceuticals. Although the contractual unit cost (eg, an average wholesale price [AWP] discount) established between a specialty pharmacy and a payer is still an important aspect of managing specialty pharmacy spending, the unit cost should not be used in isolation as a strategy to manage specialty pharmacy costs.

From our perspective as one of the largest specialty pharmacies in the United States, the following 4 questions regarding specialty pharmacy competencies can influence a payer’s specialty drug costs:

1. How does the specialty pharmacy encourage patient compliance, minimize side effects, and educate each individual patient who is prescribed a specialty drug?
2. How does the specialty pharmacy minimize the “cost to treat” each individual patient?
3. Does the specialty pharmacy offer a competitive unit-price discount?
4. What solutions does the specialty pharmacy offer to manage drug costs within the medical benefit?

In this article we address the first 3 questions. In our next article we will provide a thorough discussion on managing drug trends within the medical benefit.

**Defining a Specialty Drug**

An industry-standard, consistent definition for a specialty drug has yet to be universally accepted. According to an EMD Serono survey of payers, the determining factors defining a specialty drug include high cost, requiring special handling, availability from certain pharmacies only (ie, limited distribution), requiring ongoing assessment of response, treating a rare disease, and requiring...
the monitoring of side effects. The route of administration of a drug is typically immaterial, because specialty drugs can be self- or provider-administered.

Although this definition has yet to evolve into an industry-accepted standard, by and large payers agree on the assignment of the “specialty” status for most drugs. Some disagreement can be found in therapeutic areas such as transplantation and HIV medications, which some payers do not consider specialty drugs, because these medications are often dispensed from retail pharmacies.

The specialty drugs that are on the market today are used to manage or cure diseases that previously had minimal or no effective treatment. However, the smaller patient populations for these drugs, coupled with the more complex manufacturing process inherent in producing most specialty drugs, result in a cost per prescription well in excess of the cost for a nonspecialty drug.

The average retail prescriptions for generic and brand-name drugs cost $44 and $167, respectively; by contrast, we see the average specialty prescription now costing more than $2200. The inherent high cost per specialty drug prescription substantially changes how payers need to evaluate “the best” specialty pharmacy with which to partner to help control specialty drug spending. The best specialty partner is one that can provide a competitive unit-price discount, while also maintaining a “one patient at a time” perspective, considering that each prescription dispensed that is not properly used costs a retail pharmacy $21,000, the resulting additional discount from pharmacy A would be $52,920 had pharmacy A been servicing the patient.

Our clinical program intervenes with prescribers before dispensing any telaprevir prescription beyond the 12 weeks of typical therapy. (Of note, sometimes the extended length of therapy is simply the result of a prescriber writing a prescription for telaprevir intending the patient to take it for 12 weeks before calling in refills. The result is that the expected $315 of savings by utilizing pharmacy A’s utilization management program for telaprevir prescription substantially changes how payers need to evaluate “the best” specialty pharmacy with which to partner to help control specialty drug spending. The best specialty partner is one that can provide a competitive unit-price discount, while also maintaining a “one patient at a time” perspective, considering that each prescription dispensed that is not properly used costs a retail pharmacy $21,000, the resulting additional discount from pharmacy A would be $52,920 had pharmacy A been servicing the patient.

Let us consider a very simple utilization management program to illustrate how focusing exclusively on “unit cost” when choosing a specialty pharmacy vendor can backfire. Consider bids from 2 competing specialty pharmacies for the drug telaprevir (Incivek), a hepatitis C virus (HCV) infection therapy used in conjunction with ribavirin and peginterferon. Telaprevir has a well-documented treatment algorithm (response-guided therapy) that dictates that therapy should generally not exceed 12 weeks.

The price for telaprevir from pharmacy A is AWP –16%, whereas pharmacy B offers a slightly more deeply discounted price of AWP –16.5%. With a monthly AWP for telaprevir of approximately $21,000, the resulting additional discount from pharmacy B is $105 per prescription, or $315 for a 12-week course of therapy. However, pharmacy B does not have a utilization management program for telaprevir, whereas pharmacy A does.

At Walgreens, we continue to see physicians prescribing telaprevir for more than 12 weeks of therapy. Our clinical program intervenes with prescribers before dispensing any telaprevir prescription beyond the 12 weeks of typical therapy. (Of note, sometimes the extended length of therapy is simply the result of a prescriber writing a prescription for telaprevir intending the patient to take it for 12 weeks before calling in refills. The result is that the expected $315 of savings by utilizing pharmacy A’s utilization management program for telaprevir prescription substantially changes how payers need to evaluate “the best” specialty pharmacy with which to partner to help control specialty drug spending. The best specialty partner is one that can provide a competitive unit-price discount, while also maintaining a “one patient at a time” perspective, considering that each prescription dispensed that is not properly used costs a retail pharmacy $21,000, the resulting additional discount from pharmacy A would be $52,920 had pharmacy A been servicing the patient.

Case Example: Why the Lowest Unit Cost May Not Provide the Lowest Net Cost

Assume a patient receives a telaprevir prescription for 16 weeks of therapy. Pharmacy A has a utilization management program in place that monitors the length of telaprevir therapy and intervenes with the prescriber when it is appropriate to stop therapy. Although pharmacy B may appear less expensive upon initial consideration, because of the lower unit cost, consider the impact to the payer’s overall cost of therapy as a result of pharmacy B’s lack of a utilization management program.

Unless they are directed otherwise, most patients would attempt to fill the fourth month of telaprevir therapy, because they would see on their prescription label the number of refills remaining and would order a refill when the number of tablets is low. The end result is that the expected $315 of savings by utilizing the lowest unit-cost provider has backfired, and the pharmacy cost to treat the patient with telaprevir would become $70,140 for 16 weeks of therapy versus $52,920 had pharmacy A been servicing the patient. Pharmacy A’s utilization management program would have prevented the fourth month of therapy from being dispensed, which would have saved $17,220.

Clinical Programs: Maximize Clinical Outcomes

The first responsibility of a specialty pharmacy should always be to ensure that patients who are prescribed a specialty therapy receive the maximum clinical benefit of that therapy. Although specialty drugs may cost a payer from $20,000 to more than $200,000 annually per person, a patient who is consistently adherent to therapy will gain the maximum benefit from the therapy, ultimately decreasing the downstream medical costs associated with the disease progression.

Therefore, it is very important that when selecting a specialty pharmacy, payers understand how rigorously that organization works to keep patients adherent to their therapy. A specialty pharmacy must be dedicated to investing in and developing rigorous and structured patient-facing clinical programs, as well as developing an internal culture of clinical excellence through the use of specially trained technicians, nurses, and pharmacists. Reviewing a specialty pharmacy’s reporting package can prove helpful in evaluating the organization’s commitment to maximizing clinical outcomes.
Utilization Management Programs: Minimize the Cost to Treat

The second responsibility of a specialty pharmacy should be to work on behalf of the payer to minimize the “cost to treat” each patient. A thorough understanding of manufacturer programs, the clinical literature, and the standard of care within each disease state is essential.

A specialty pharmacy should have active utilization management programs that intervene with the prescriber if a clinically equivalent but more cost-effective treatment is available for a patient. These programs augment a payer’s existing prior authorization and formulary strategies.

A specialty pharmacy should have a variety of utilization management strategies in place, including dose-level monitoring, dose-frequency monitoring, formulary compliance programs, and waste minimization programs.

For example, the drug ustekinumab (Stelara) is commercially available in a 45-mg and a 90-mg dose. The AWP of the 45-mg dose is approximately $27,000 annually, and the AWP of the 90-mg dose is approximately $54,000 annually. According to data documented in the US Food and Drug Administration (FDA)-approved labeling, the 90-mg dose provides limited clinical efficacy improvement compared with the 45-mg dose for new patients weighing <220 pounds. As such, a specialty pharmacy that develops programs that increase the dispensing rate of the 45-mg dose in the population of patients weighing <220 pounds can dramatically impact the payer’s cost to manage patients who are using ustekinumab.

A payer should understand all the utilization management programs and the accompanying reporting provided by the specialty pharmacy when selecting the best partner. This is especially important in oncology. As the number of FDA-approved oral cancer drugs continues to climb, and their labels expand to include additional indications, it is critical that the specialty pharmacy have a program in place to manage the side effects and waste associated with this expensive class of drugs.

The Importance of Unit-Price Competitiveness

The contractual discount that a specialty pharmacy offers a payer still plays a very prominent role in lowering a payer’s specialty pharmacy spending. However, this is not a factor that should be used on its own to determine which pharmacy can deliver the lowest specialty pharmacy cost.

Pricing pressure on specialty pharmacies is intense, and the margins within the specialty pharmacy industry have compressed to a point that teeters on unsustainability. Payers feel pressure from their customers to lower costs and continue to look aggressively for the most cost-effective provider. To accomplish this, a few payers unilaterally choose to work with specialty pharmacies that offer the lowest unit cost per drug, but as demonstrated in the case example, that strategy could introduce unintended and insidious consequences. A few basis points (ie, a unit of measure used to describe the percentage change in the value or rate of a financial instrument; 1 basis point is equivalent to 0.01%) of unit-cost improvement will be quickly eroded if a pharmacy does not have clinical and utilization management programs in place to ensure that every prescription is dispensed in a clinically and economically appropriate fashion.

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Specialty Pharmacy Contracting Models

The specialty marketplace is dominated by 3 companies—Express Scripts Inc/Medco, CVS/Caremark, and Walgreens. These 3 companies comprise two thirds of the revenues driven by specialty pharmaceuticals. Consolidation continues in the marketplace, and many payers, such as Humana and Cigna, are providing specialty pharmacy distribution through company-owned pharmacies.

Health plans and employer groups use various models to contract with specialty pharmacies. These models include exclusive (1 specialty pharmacy provider), narrow or limited network (2 or 3 providers), open access network, and disease-specific contracting with various vendors.

Exclusive Model

Some payers choose to work with 1 specialty pharmacy provider. The advantages of the exclusive model are better pricing, better control of the process, a more streamlined approach, better communication, and ease of use for physician networks. Another advantage would be aggregation of data, allowing for ease of implementation of clinical programs and possible savings guarantees. The disadvantages include a lack of competition and a lack of an immediately available backup vendor when the exclusive vendor suddenly cannot provide services.

Narrow Network

Some payers choose to work with 2 or 3 specialty pharmacy vendors in a narrow network. The advantages
of this model include vendor competition (because the vendors must compete for business), choice of specialty pharmacy providers, expanded access to limited-distribution drugs, and deeper pricing discounts than in an open network. Vendors with otherwise average customer service may work harder to pull through business, resulting in higher-quality service. The disadvantages include network confusion, data segregation, dealing with different operational processes, and the day-to-day issues in dealing with multiple vendors.

Open Network
Some payers use an open network for specialty pharmacy providers. The advantages include a broad choice of vendors, the inclusion of local businesses and hospital partners, and ease of use for patients. The disadvantages include the poorest pricing, confusion, differing levels of quality, lack of control, and fragmented data reporting.

Disease-Specific Contracting
Some payers prefer to contract according to disease state. For example, a payer could use one vendor for multiple sclerosis drugs and another vendor for growth hormone. The theory is that vendors who demonstrate superior outcomes for specific disease states win the business. This could be called the “best practices” model. The advantages include benefiting from the highest-quality and most cost-effective models available. The disadvantages include cumbersome contracting, confusion among prescribers about which specialty vendor to use, and nonoptimal pricing.

Selecting a Model
Legislative factors, network considerations, and contracting philosophy all influence a payer’s selection of a given contract model. However, if payers want to maximize cost-savings and clinical outcomes, the exclusive model is usually selected, as a result of the following reasons:
1. Best pricing
2. Consistent data capture and reporting
3. A natural spirit of partnership between the specialty pharmacy and the payer
4. Greater utilization and intervention reporting
5. Consistent utilization management and clinical programs. Often, guarantees can be developed for specific programs, such as oral oncology split-fill programs or HCV infection programs, where interventions are made with providers on proper dosing of protease inhibitors. An exclusive vendor is able to demonstrate that the interventions made are resulting in consistent and measurable savings. Payers can then negotiate savings guarantees.

Conclusion
A specialty pharmacy that offers the lowest cost per unit is not necessarily the lowest-cost provider. By using an exclusive specialty pharmacy provider, a payer can maximize unit-cost discounts and implement programs that drive savings far beyond what can be realized with the unit-cost discounts alone. Choosing the right specialty pharmacy partner can improve patients’ clinical outcomes, decrease downstream medical costs for the healthcare system, and minimize the cost to treat patients through intelligent prescriber interventions that are driven by rigorous utilization management programs.

Author Disclosure Statement
Mr Einodshofer is an employee and stockholder of Walgreens. Mr Kansler is an employee of Walgreens.

References
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