

Round Two

Included with this winter issue of *ManagedCare Oncology* is our second edition of ICORE Healthcare's 2011 Medical Pharmacy & Oncology Trend Report™. As you know, the trend for traditional pharmacy costs (predominantly oral medicines paid under the pharmacy benefit) has been flat or even negative. In contrast, most payors today are experiencing high single-digit increases in provider-administered injectable medicines, those generally paid under the medical benefit. Similarly, a few years ago, traditional pharmacy products were trending at high single-digit increases, while medical benefit injectables were hovering just short of 20% annual increases.

Why is this occurring? Well, those managing (and ultimately paying for) traditional pharmacy products have had a real windfall lately: It's called products going generic, as shown in the chart below. Injectable products, on the other

hand, do not have this opportunity (it's called a biosimilar – a totally different scenario, nowhere near the windfall, and a topic for a separate discussion). Moreover, many of the medicines in the stable of the near-term pharmaceutical pipeline are injectable. Even more interesting is that the majority of these soon-to-market products will fall under the medical benefit and not under the scope of traditional pharmacy benefit management.

What's the message? If you are in the business of managing pharmaceutical costs, you better take a hard look at what you are doing and what results have been produced for provider-administered injectable products. Various traditional pharmacy benefit managers are contemplating how to best enter this market today.

In the attached Medical Pharmacy & Oncology Trend Report™, there were several key findings. Here are a few that should pique your interest:

- Payors spend an average of \$145 million per million lives in provider-administered injectables (this does not include the cost to administer these drugs, which increases the cost by at least 20%).
- Most payors have at least some cost-management program in place to address this spend.
- The impact of discouraging provider office-based administration is severe: The drugs get administered in the facility at two to three times the office-based cost.
- Member contribution will be significantly higher for these products in

2012 when compared with 2011 – a 39% increase in copays and a 20% increase in coinsurances.

- While it is great for niche-coding vendors to raise suspicion, the codes for drugs without codes (dump codes) are much to do about nothing; J3490 represents less than 1% of costs.
- Member contribution parity, the notion that the portion of drug cost that is paid by a member should be consistent across all benefits, improved by 100% when compared with last year.

Please, take some time and look at the report. As you know, I try to make this editorial personal for our payor readership, so here you go: These are the only benchmarking statistics available. Compare your results to see if it is time to rethink your provider-administered injectable management strategy in 2012.

Have a terrific winter season! I will be thinking of you from Orlando!



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2008 Rank	Off-Patent	2012 Rank
Lipitor	2011	Nexium
Nexium	2014	Enbrel*
Plavix	2011	Neulasta
Advair	2011	Epogen
Seroquel	2011	Abilify
Singulair	2010	Remicade
Enbrel*	2014	Lovenox*
Actos	2011	Avastin
Prevacid	2009	Rituxan
Neulasta	2015	Cymbalta
Epogen	2013	Aranesp
Abilify	2014	Crestor
Effexor XR	2011	Humira*
Remicade	2018	Vytorin
Lexapro	2011	Procrit
Lovenox*	2004	Lantus*

Green = oral
Purple = injectable
Asterisk = self-injectable