

Managing Drug Utilization and Patient Care in Lymphoma AND Beyond

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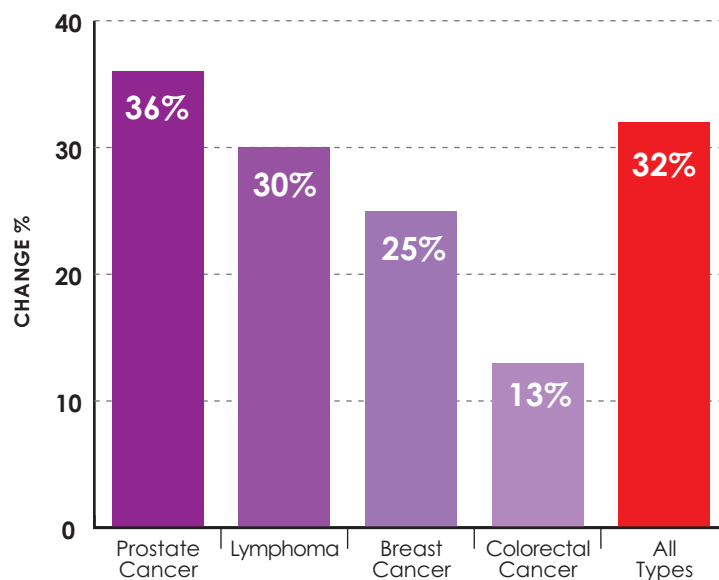
Currently, there are several dynamics at play in managed care oncology that have culminated in costs rising at unprecedented rates. Of course, rising drug costs remain an undeniable factor in addition to costly targeted therapies that have been recently introduced, with more awaiting approval in the pipeline. Beyond these obvious influences, advances in treatment modalities have led to some cancers becoming curable while even more still have evolved into manageable chronic conditions. As a result, the number of cancer survivors in the U.S. rose by 20% between 2001 and 2007, with nearly 65% of survivors living at least five years beyond their diagnoses by 2007.¹ Furthermore, the number of cancer survivors is expected to rise an additional 32% by 2020 in conjunction with a 22% increase in incidence.^{2,3} This latter increase in incidence will likely be a direct effect of an aging population in which the absolute number of individuals diagnosed with cancer will increase faster than the overall population.⁴ Experts have postulated that these factors may

synergistically result in cancer costs rising at a faster rate than overall medical expenditures.⁴

Among the leading cancers with extended survival is lymphoma, which is estimated to experience a 30%

increase in survivors by 2020, second only to prostate cancer (Figure 1).² Despite representing only the seventh most common cancer site, lymphoma ranks fourth in terms of annual treatment expenditures and tallied upward

Figure 1. Projected Percentage Increase in Cancer Survivors Between 2010 and 2020²



of \$10 billion in 2006.^{4,5} This puts the oft-overlooked oncologic condition in the midst of the big three – breast, colorectal, and lung – in terms of cost, and ahead of prostate cancer, despite being seldom mentioned in the same breath (Figure 2).⁴ With an increasing incidence, an increasing number of survivors, and an aging population, lymphoma is poised to continue its profound impact on the bottom line in managed care oncology well into the future. In addition, the pipeline is rife with agents under investigation for various forms of the disease, including both new molecular entities and new indications for currently marketed treatments (Table 1).⁶ Many of these agents will likely carry high costs, such as brentuximab vedotin, the recently approved Hodgkin lymphoma and anaplastic large-cell lymphoma therapy. At an approximate cost of \$13,500 per dose and a median of eight doses in a course of therapy, total costs for the anti-CD30 monoclonal antibody will often reach \$108,000 per patient.⁷ With more agents such as this in the pipeline being added to an already diverse armamentarium of targeted therapeutics, utilization management interventions for lymphoma will likely require increased attention from plan stakeholders. Furthermore, the emerging realization of lymphoma as a chronic disease requiring ongoing long-term care will likewise continue a trend toward more intensive disease management by payors in the oncology specialty.

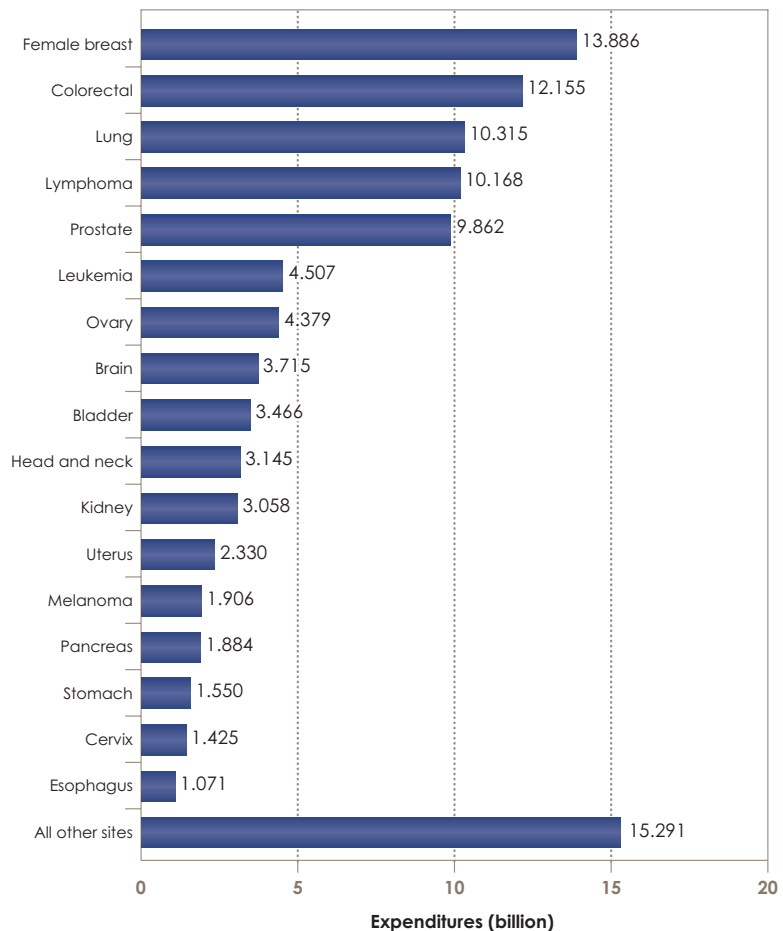
DRUG AND CARE MANAGEMENT AT BLUE CROSS AND BLUE SHIELD OF FLORIDA

At Blue Cross and Blue Shield of Florida (BCBSFL), plan stakeholders work with providers to develop medical coverage policies through feedback from a designated committee

Table 1. New Agents and New Indications Under Investigation for Lymphoma with Approval Anticipated Within Two Years⁶

New Agents	
Drug Name	Indication
Everolimus	B-cell lymphoma
Lenalidomide	Non-Hodgkin lymphoma
Temsirolimus	Mantle cell lymphoma
New Indications	
Drug Name	New Indication
Mechlorethamine gel	Cutaneous T-cell lymphoma
B-cell lymphoma vaccine	Follicular lymphoma and mantle cell lymphoma
Panobinostat	Hodgkin lymphoma
Belinostat	Peripheral T-cell lymphoma
Fodosine	Lymphoma

Figure 2. Estimates of U.S. National Expenditures for Cancer Care in 2006⁴



Sources: Based on methods for estimating and projecting cancer prevalence by phase of care described in Mariotto AB, Yabroff KR, Feuer EJ, De Angelis R, Brown M. Projecting the number of patients with colorectal carcinoma in initial, monitoring, and last year of life phase of care in the U.S.: 2000-2020. *Cancer Cause Control*. 2006;17:1215-1226. Methods for estimating costs by phase of care are described in Yabroff KR, Lamont EB, Mariotto A, Warren JL, Meekins A, Topor M, Brown ML. Cost of care for elderly cancer patients in the U.S. *J Natl Cancer Inst*. 2008;100:630-641. Cost estimates expressed in 2006 dollars using Centers for Medicare & Medicaid Services cost adjusters and adjusted for out-of-pocket expenditures, including copayments and deductibles. Estimates for the population younger than 65 were developed using ratios of cost in the younger than 65 and older than 65 populations from studies conducted in managed care populations.

of physicians and pharmacists. The policies are evidence based and determined by looking at the U.S. Food and Drug Administration's approved indications, as well as other indications where there is sufficient data to support so-called off-label use. In general, off-label use is managed by prepayment claims editing on the medical side and prior authorization (PA) on the pharmacy side. All the plan's policies are reviewed at least once a year but may also be reviewed more frequently when new indications or changes in the compendia and national guidelines warrant a potential revision. BCBSFL also has a process in place to annually look at the effectiveness of its clinical programs, such as utilization management interventions. Specifically, the plan looks at the appropriateness of utilization management in the form of

PA to determine if it is truly necessary, appropriate, and effective. This degree of regular review and careful oversight, coupled with the providers' involvement in determining medical coverage policies, helps ensure there is minimal negative feedback from the physician community regarding the plan's evidence-based PA criteria. In addition, BCBSFL has access to the services of an oncologist who conducts peer-to-peer discussions with providers seeking guidance in the PA process or in the event of a denied claim.

Rather than taking the traditional segregated-pharmacy and medical-benefit approach, BCBSFL aims to eliminate the silo perspective from drug management across all disease states. On a therapeutic class basis, the plan manages oncology, rheumatoid arthritis, anemia, etc., instead

of pharmacy- and medical-covered drugs, with most classes having drugs managed on both sides. This revised approach at BCBSFL complements the rise of oral oncology agents being witnessed in recent years, since it focuses on managing medications across all provider types and benefits. The driving factor behind this strategy is to ensure the plan has the necessary controls to ensure appropriate use, and with oral agents in the oncology class, these controls come in the form of PA on the pharmacy side. For example, among oral oncology drugs, vemurafenib was recently approved for the treatment of BRAF V600E positive metastatic melanoma and is being covered under the pharmacy benefit at BCBSFL. An assay exists to determine BRAF V600E mutation status, so the test is built into the PA criteria for vemurafenib to ensure appropriate use and maximize the quality of care.

Another initiative being employed to maximize the quality of oncology care at BCBSFL is the availability of care management nurses – with access to a care management contingent – to assist members diagnosed with cancer. These care management nurses essentially optimize the members' benefits, optimize the selection of sites of care, and guide members in accessing the appropriate care. The services provided by the plan's care management nurses are extremely member focused and ensure that patients receive the most cost-effective care possible by guiding the treatment selection process in addition to guiding the setting in which members can receive care at the lowest member cost share. Of course, clinical considerations remain the utmost priority, but the care management nurses at BCBSFL are trained to assess coverage issues and the financial bearing that treatment will have on





the patient when therapeutic options are otherwise comparable. Furthering the member-centered efforts of the care management nurses, the plan proactively reaches out to members diagnosed with cancer to ensure that they are aware of the availability of this service.

While the guidance of these care management nurses is not exclusive to members with lymphoma, the chronic nature of the disease and the necessity of ongoing care fit well with the benefits of such interventions. In addition, BCBSFL strives to maintain up-to-date coverage guidelines and reasonable reimbursement for providers, coupled with the use of cost-effective delivery channels facilitated by the care management nurses. Top-of-mind therapies for lymphoma – such as targeted biologics – are managed in a manner similar to other oncology drugs, with a focus on appropriate use and dosing. As such, coverage policies are based primarily on diagnosis and drug dosing to ensure evidence-based care in lymphoma and beyond.

WHAT THE FUTURE HOLDS

As specialty drug costs – and, specifically, oncology drug costs – continue to rise, many plans are looking at their benefit design and how it impacts their member cost shares. With some medications being accessed on the medical benefit and some being accessed on the pharmacy benefit, managed care organizations should strive to arrange the member cost share in such a way that they are not introducing an unintended consequence for choosing an oral therapy over an infused therapy or vice versa. Taking these factors into consideration, a lower cost share is available when members access drugs through BCBSFL's normal specialty pharmacy: a trend that has been observed with other managed care organizations across the country. Furthermore, in many of their benefit plans, BCBSFL has placed a monthly out-of-pocket maximum on the cost to the patient for drugs accessed on the medical benefit as a function of the coinsurance. These initial steps toward minimizing the financial burden on

the patient are, hopefully, a sign of things to come in managed care, in conjunction with increasingly stringent measures to encourage appropriate drug selection and use.

Opportunities may also exist for plans seeking to control costs via rebates in oncology and related therapies. Currently, the trend appears to be taking hold in the supportive care arena, where rebates have been made available by manufacturers and are being used by payors to designate preferred agents. Thus far, little has been observed in terms of rebates on chemotherapy, but emerging biosimilars may change this trend in the future. Ultimately, the payors' goals should be aligned with those of the providers and even the patients for the provision of high-quality, cost-effective care in the treatment of cancer. As therapeutic options continue to advance and patients with lymphoma and other forms of cancer experience extended survival, a concerted effort by all managed care stakeholders will prove increasingly more important.

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