

# Reimbursement Challenges for Oncology Products in Development: Payer & Oncology Center Perspectives

October 25, 2011

*Discussion of Selected Insights from our Oncology Reimbursement 2011-2012 Report*

# Reimbursement Intelligence Expertise

Our Team

Our Core Competencies

Our Experience

## ● MARKET ANALYSIS

- Qualitative & Quantitative Studies
- Mock P&T Meetings
- Message Testing
- Advisory Boards
- Focus Groups
- Consensus Panels

## ● TRAINING & IMPLEMENTATION

- Sales Training
- Reimbursement Support
- Meeting Logistics
- Training Materials

## ● STRATEGIC PLANNING AND CONSULTING

- Coverage Landscape Assessment
- Reimbursement and Coverage Planning
- Account Segmentation
- Distribution Models
- Decision Support Modeling
- Pricing & Contracting

## ● MARKETING COMMUNICATIONS

- Value Proposition & Message Development
- Account Management Sales Material
- Publications
- Pull-Through Pieces
- Disease Management
- Branding & Advertising

# Our Panelists



**John Fox, M.D.: Associate Vice President, Medical Affairs, Priority Health**

**Dr. John Fox** is responsible for medical technology assessment, utilization and case management, physician profiling and pay-for-performance programs at Priority Health, an award-winning HMO and provider of other group and individual health insurance plan options since 1986. He is the author of numerous groundbreaking articles on the use of cost-effectiveness in assessing the benefits of medical services, and the effect of pay-for-performance on health outcomes.

Dr. Fox, also an expert in disease management and preventive health, earned his B.S. degree at the University of Illinois, his M.S. in Health Administration at the University of Wisconsin, and his M.D. at Johns Hopkins University.

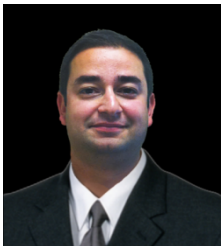


**Dean H. Gesme, Jr. M.D., F.A.C.P., C.P.E.: Assistant Principal Investigator, Cedar Rapids CCOP**

**Dr. Dean H. Gesme, Jr.** is a medical oncologist in private practice with Minnesota Oncology working at Abbott Northwestern Hospital in Minneapolis, Minnesota. He completed medical training at the University of Iowa in 1977 followed by internal medicine residency in San Francisco and Fellowship in Medical Oncology at the University of Minnesota. He is Board Certified in Internal Medicine, Medical Oncology, and Medical Management.

Dr. Gesme is past Chair of the Clinical Practice Committee of the American Society of Clinical Oncology and is on the AMA CPT Advisory Panel dealing with physician coding, and payment issues.

He has published in leading medical journals such as *the Journal of Clinical Oncology* and the *Journal of Oncology Practice*.



**Gene Trogan, Ph.D.: Director, Commercial Analytics & Market Access, Reimbursement Intelligence Moderator**

In charge of RI's research group, Mr. Trogan has worked as a researcher at New York University School of Medicine, publishing seminal work in heart disease, and in patent prosecution for pharmaceutical and biotechnology companies at Fish & Richardson, a nationally recognized intellectual property law firm. He has also worked in the investment side of the industry, managing portfolios for healthcare-focused VCs. In addition, Mr. Trogan has worked in evaluations of commercial prospects for pharma and pharma consulting firms.

Mr. Trogan holds a Ph.D. from New York University in Biomedical Sciences and a B.S. from Duke University.

# Our Agenda Today

- 45 min: Interactive discussion with panelists on selected topics
- 15 min: Q&A (questions to be submitted via online chat box)
  
- *Archived presentation will be available upon request.*

# Oncology Reimbursement Report 2011-2012

## Coverage of 23 Pipeline/Branded Products

- Online survey of 55 Medical and Pharmacy Directors (covering more than 100 million lives) from Top Health Plans/PBMs  
Responsible for formulary or coverage decisions
- National and Regional Plan Representation  
Commercial, Medicare Advantage and Managed Medicaid

### Melanoma

- Ipilimumab (Yervoy)
- Vemurafenib
- GSK436/GSK212

### Breast Cancer

- Trastuzumab-DM1
- Pertuzumab (Omnitarg)
- Eribulin (Halaven)
- Exemestane (Aromasin)
- Neratinib
- Denosumab

### Lung - NSCLC

- Astuprostimut-R
- Emepepimut-S (Stimuvax)
- Crizotinib
- MetMab
- Erlotinib (Tarceva)

### Hematologic Malignancies

- Pomalidomide
- Afutuzumab
- Inotuzumab ozogamicin

### Prostate Cancer

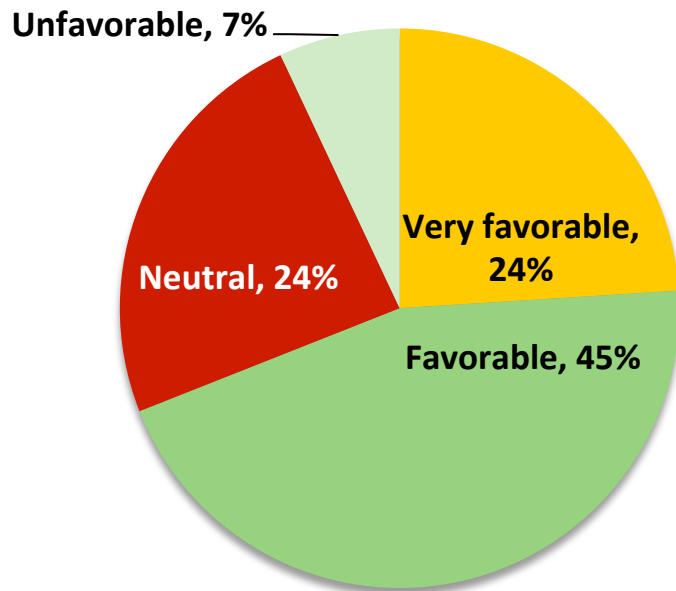
- Abiraterone
- Sipuleucel-T (Provenge)
- Prostavac
- Cabazitaxel (Jevtana)
- Denosumab

“Payers are implementing greater cost controls in what is becoming an increasingly managed category”

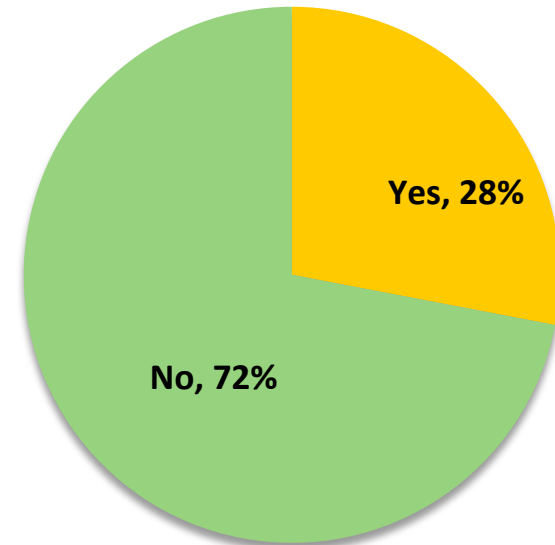
What does the future hold? How will providers respond?

# United Health's bundled payment: method of managing costs?

## Reaction to UHG policy



## Likelihood to implement similar policy



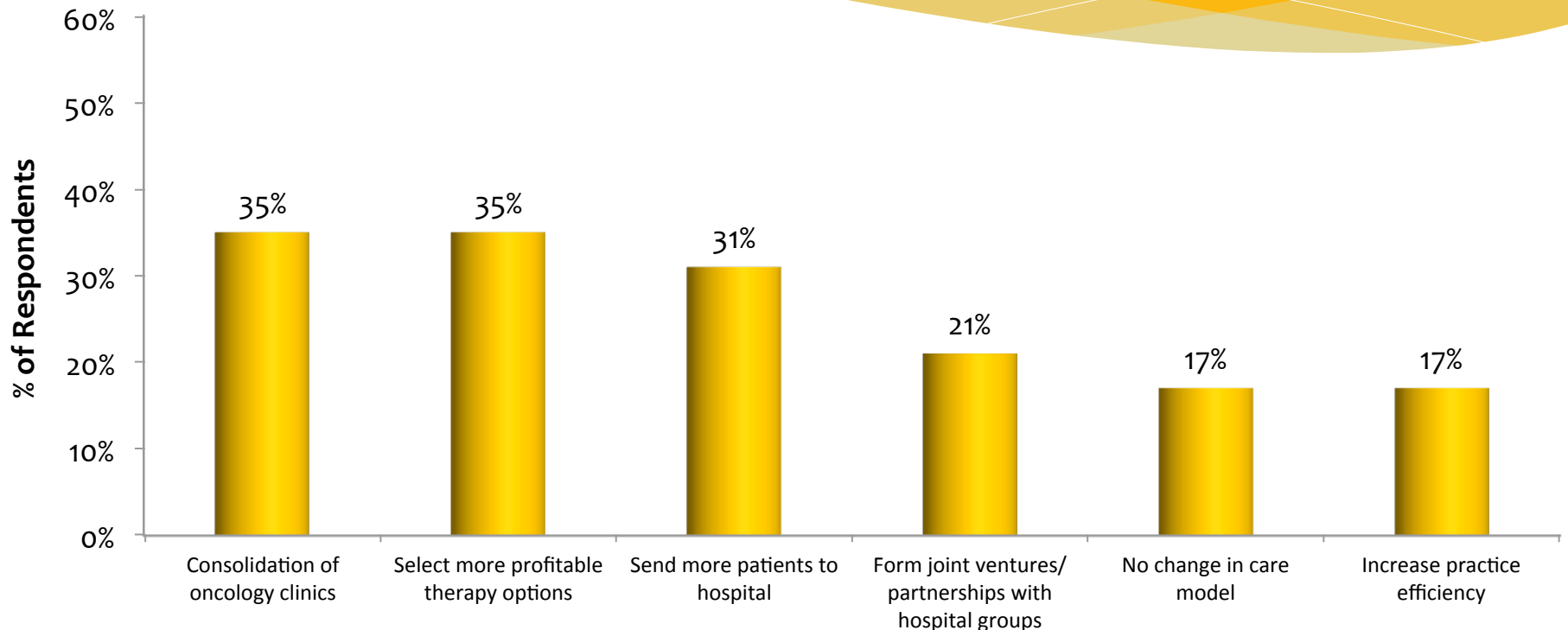
*"It will take some time, but it is the way the market is going."*

*"As costs increase, % of cost approach is inefficient and inappropriate."*

**Q1:** UnitedHealth Group has recently changed its reimbursement policy for physician administered drugs, where it now reimburses physicians for the wholesale cost of the drug plus a flat administration fee. What is your general impression of this change in policy?

**Q2:** Is your organization planning to implement a similar change in policy?

# Oncologists have responded to lower reimbursement rates by consolidating clinics and selecting more profitable therapy options

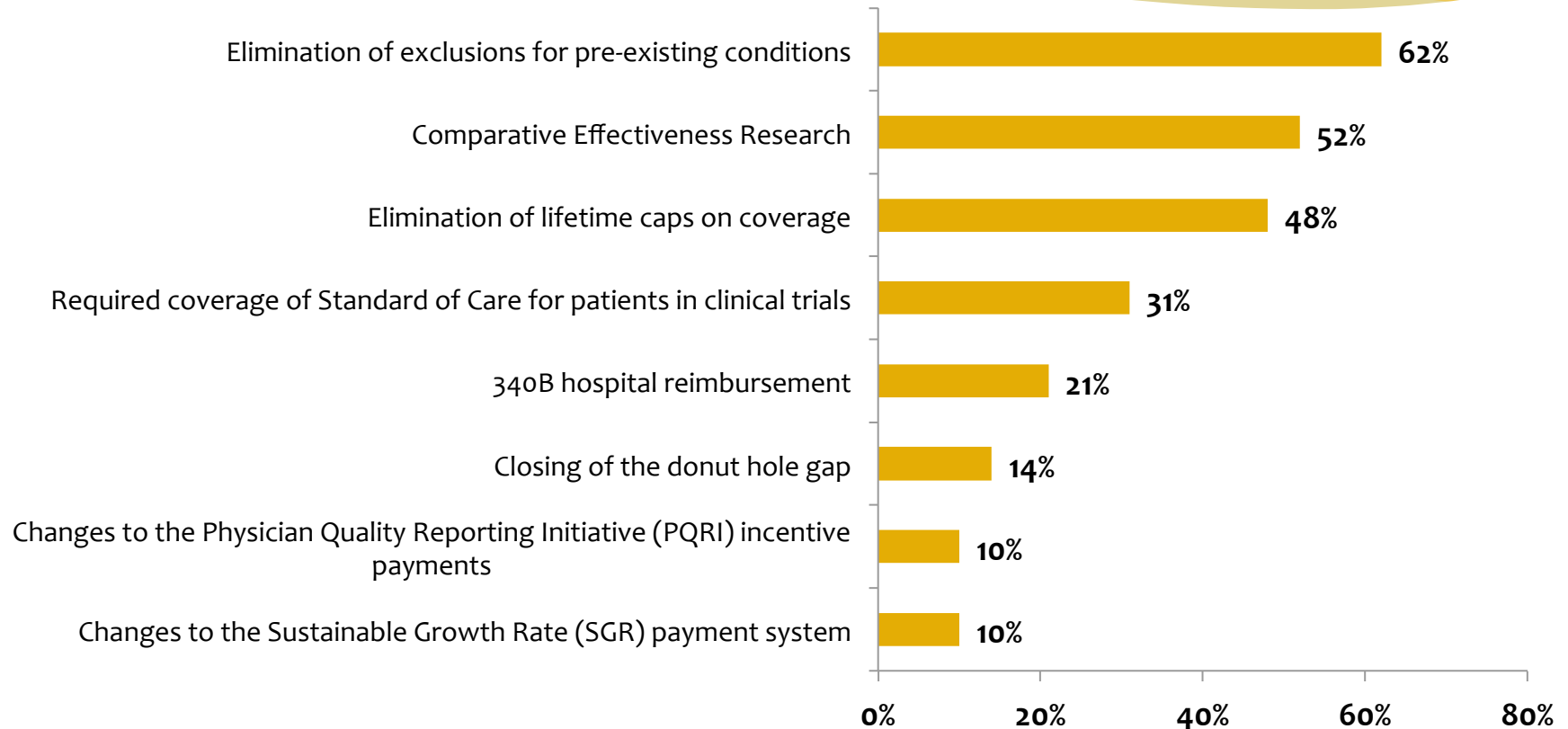


Q: How have oncologists responded to lower reimbursement rates? Please check all that apply.

“Healthcare reform policies & emerging delivery-care models are likely to significantly alter the payer-provider-patient dynamic”

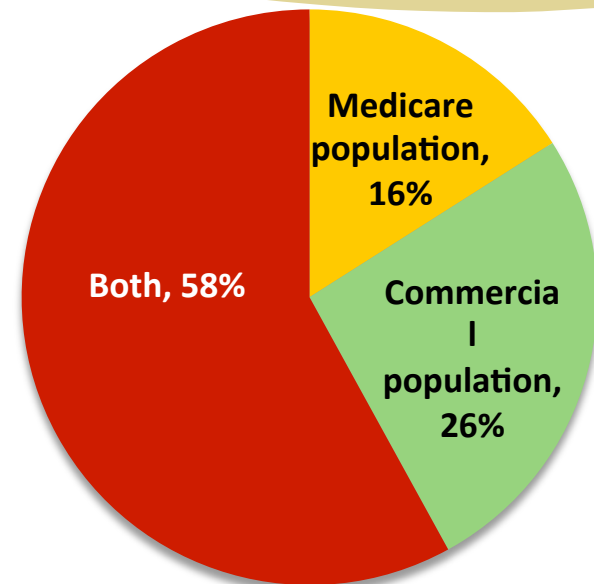
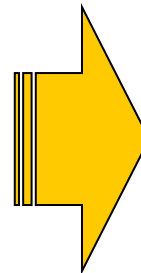
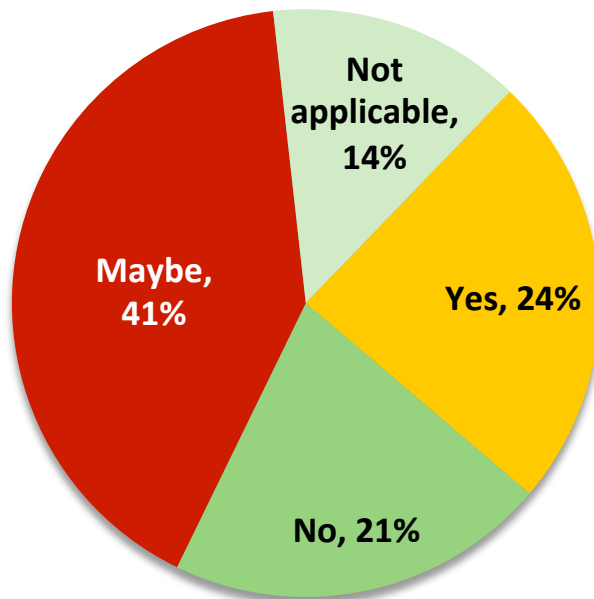
*Transformational change or small baby steps?*

# Where will healthcare reform policies have most impact?



**Q:** What aspects of the Health Care Reform Legislation will have the most impact on your approach to management of oncology therapies? Please choose all that apply.

# Majority of plans may form/partner with an ACO in the next two years



*"We have already been using a similar model."*

*"Yes, we are working on it. ACOs will provide us with a financial advantage."*

*"We will not develop ACO agreements but will work with ACO's for our members to improve efficiency."*

*"We are currently taking a wait and see approach."*

Q: Do you believe your organization will plan to partner with or form an ACO in the next two years?

Q: Which population would the ACO address?

# Perceived Drivers & Challenges for ACOs

Primary drivers for partnering with/forming an ACO	Overall Rank
Improve quality of care and performance standards	1
Increase lower cost treatment alternative utilization	2
Improve outcomes data tracking	3
Improve overall spending tracking	4
Improve patient drug compliance	5

**Q:** For oncology category, please rank in the order of importance (from highest to lowest) your organization's primary drivers for partnering with or forming an ACO.

Challenges around partnering with an ACO	Overall Rank
Reduction of overall medical costs associated with oncology	1
Creation of a viable risk sharing structure with providers	2
Improvement of coordination of care	3
Oncology practice consolidation	4
E-prescribing and EMR implementation	5

**Q:** For oncology therapies, what challenges do you expect around partnering with or forming an ACO? Please rank in the order of highest to lowest challenges

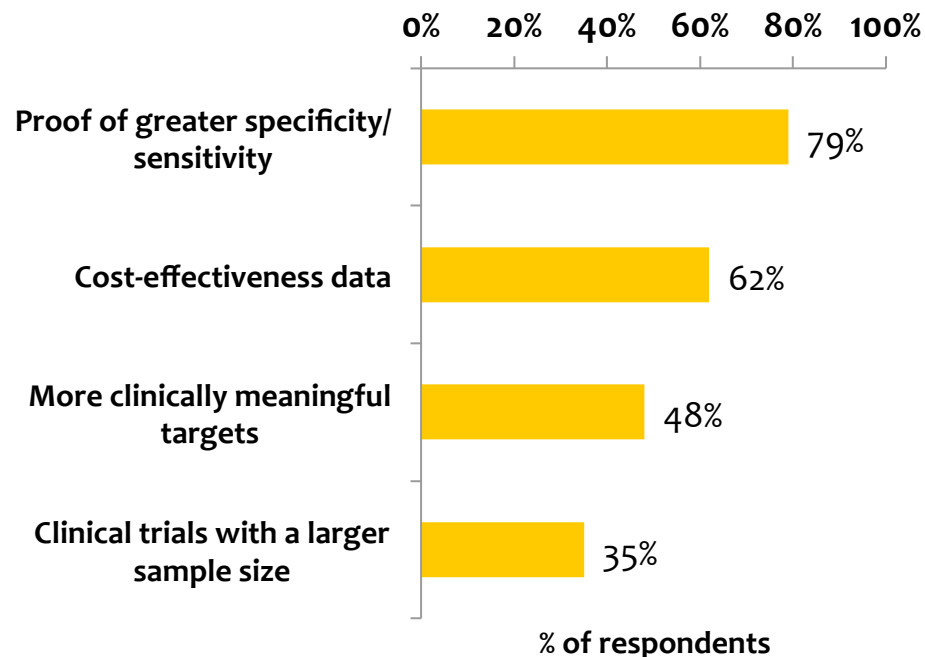
“Biomarkers will become increasingly important in cost-effectively delivering treatment that is targeted to a specific patient population”

*What are payers' expectations and what will be the impact to current treatment and reimbursement?*

# Drivers & current limitations to biomarkers for targeted therapies

Primary benefits of using genetic testing	Overall Rank
Predict efficacy of therapy	1
Select appropriate treatment	1
Predict tolerance to treatment	2
Molecular profiling for prognosis	3
Vaccine therapy specific to patient	4

**Q:** Please rank the choices below based on your perception of the primary benefit of using genetic testing in oncology from highest benefit to lowest benefit (Score is a weighted calculation. Items ranked first are valued higher than the following ranks, the score is the sum of all weighted rank counts.)



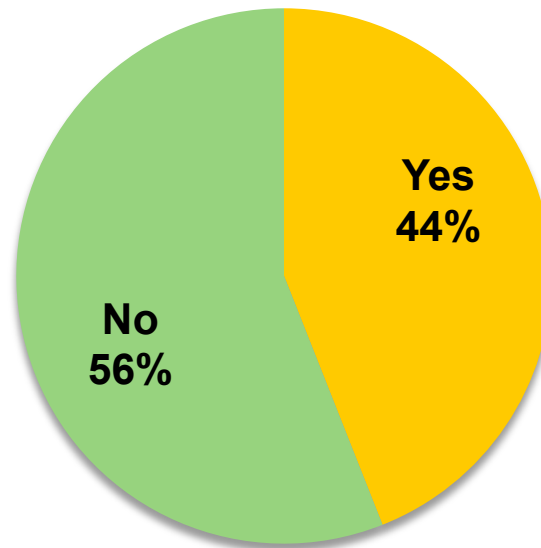
**Q:** In order for genetic testing to gain wider acceptance, what type of data will be required from the tests? Please select all that apply.

# Payers split on whether companion diagnostics will be covered similarly to stand alone tests

*“If a companion diagnostic is required in the labeling, it will be covered. If a standalone diagnostic is highly predictive of patient response to therapy, it too will be covered..”*

*“We cover the test already for various - HER2,KRAS etc. - nothing new.”*

*“We will cover virtually any companion diagnostic if it will tell us which patients are best for which drug.”*



*“All tests are covered based on their potential to improve outcomes only.”*

*“Will require prior authorization to determine if patient is a candidate.”*

*“Need more data to show they improve survival.”*

*“Some may be coupled with therapy as part of prior authorization. .”*

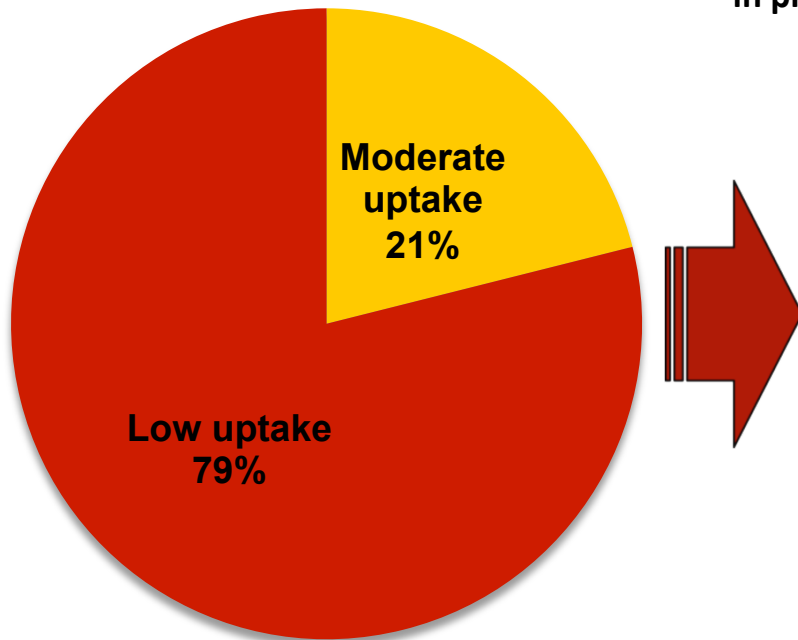
**Q:** Gene-specific targeted therapies are being developed with companion diagnostics for screening appropriate patients for clinical trial enrollment. Do you believe your plan will cover these companion diagnostics differently than standalone diagnostic tests?

“There is an upper ceiling to the price tag of future oncology biologics”

*Are increasing costs “Business as usual” or will they lead to greater management & cost control tactics?*

# Provenge uptake is low due to strict payer management and lack of physician demand

- 84% of plans cover Provenge with restrictions
- Ensuring on label use of Provenge is the main objective of management



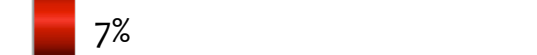
**Health plans have strict policies in place to control utilization**



**Low physician prescribing**



**Low patient demand**



0% 50%

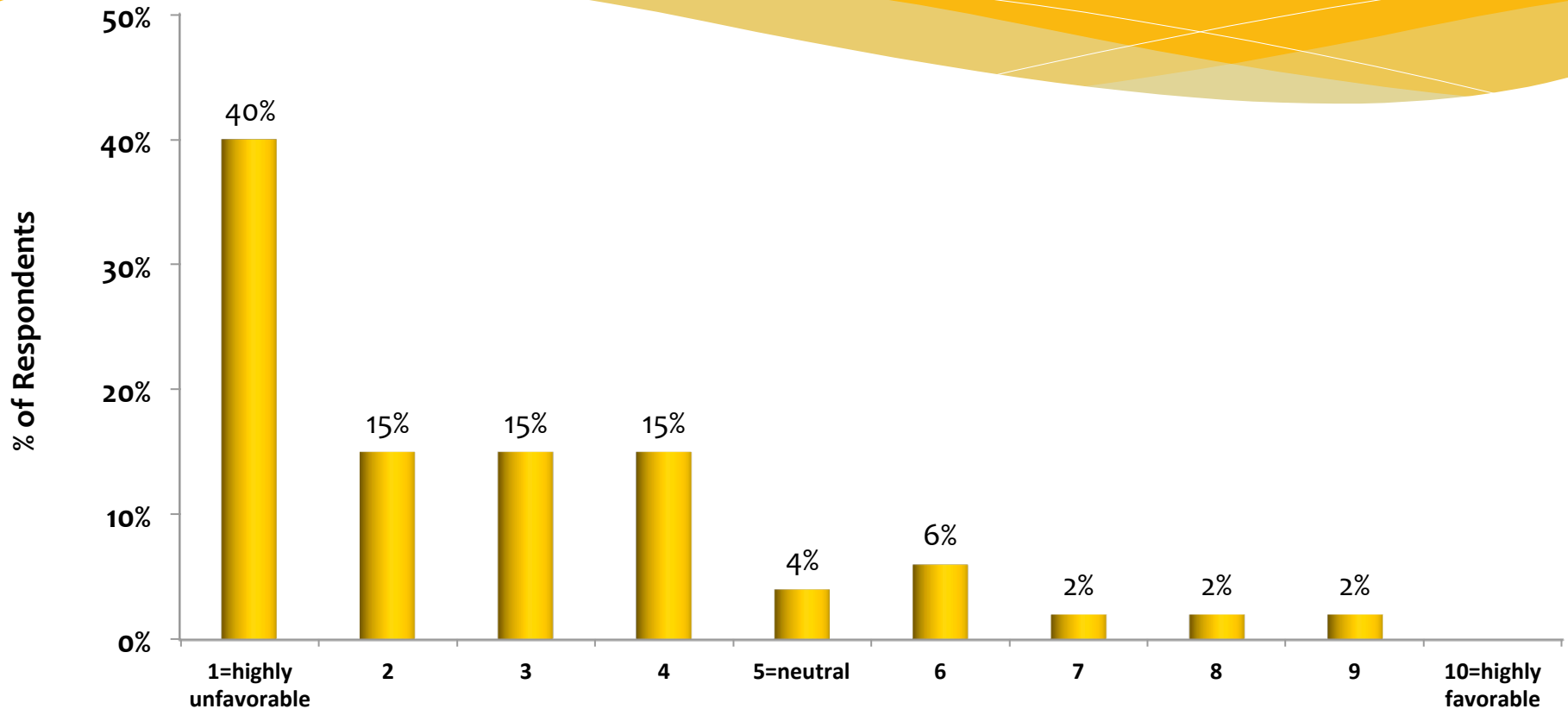
**Reasons for low physician prescribing:**

- Limited clinical value
- High cost of therapy influences prescribing
- Lack of physician confidence in the drug
- Lack of qualifying patients
- Cancer centers not yet on board with therapy

Q: How would you describe the current uptake of Provenge?

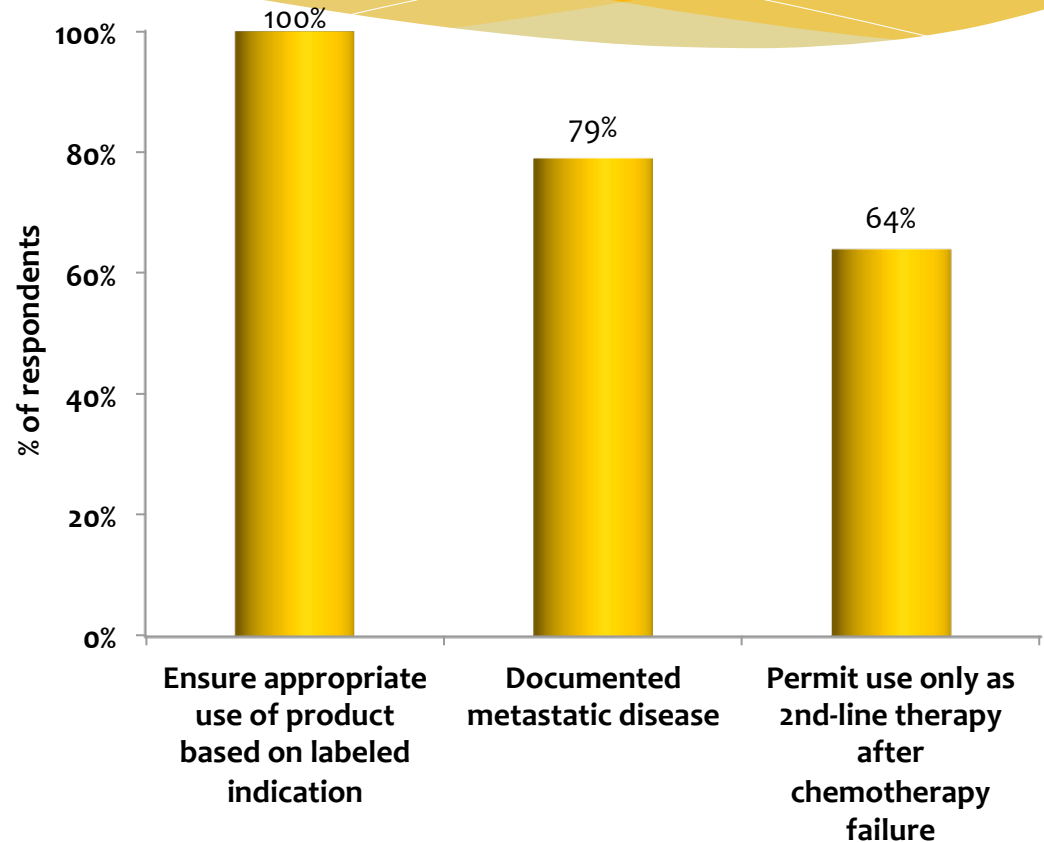
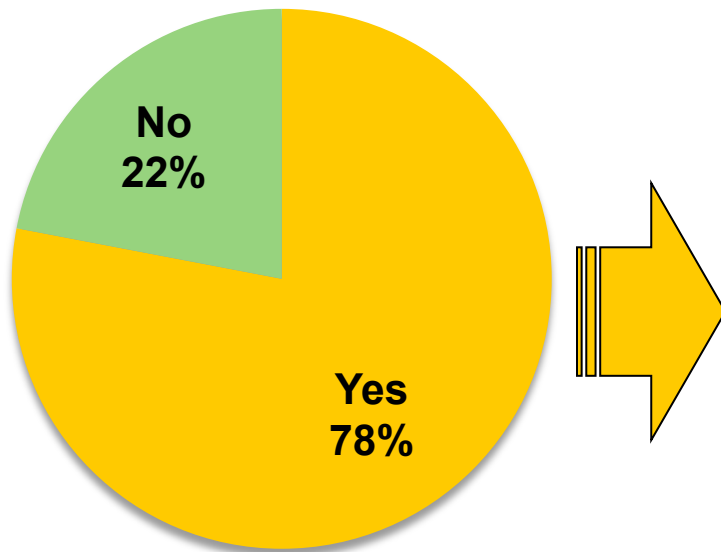
Q: Why do you think there was low uptake for Provenge? (Please check all that apply)

# Overwhelming majority regarded Yervoy as too costly



Q: Please rate your perception (on a 1-10 scale, where 1= highly unfavorable, 5=neutral, & 10=highly favorable) of each of the three metastatic melanoma therapies based on the data presented above. [Please note that where you believe a rating is not feasible on the information presented, indicate N/A]

# Majority have placed restrictions that Yervoy be used as a 2<sup>nd</sup> line after chemo-failure



Note: More than one option may be selected

# Q&A

To request additional information, please contact:

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