

Compendia:

The Bridge Between FDA Approved Indications and Off-Label Usage



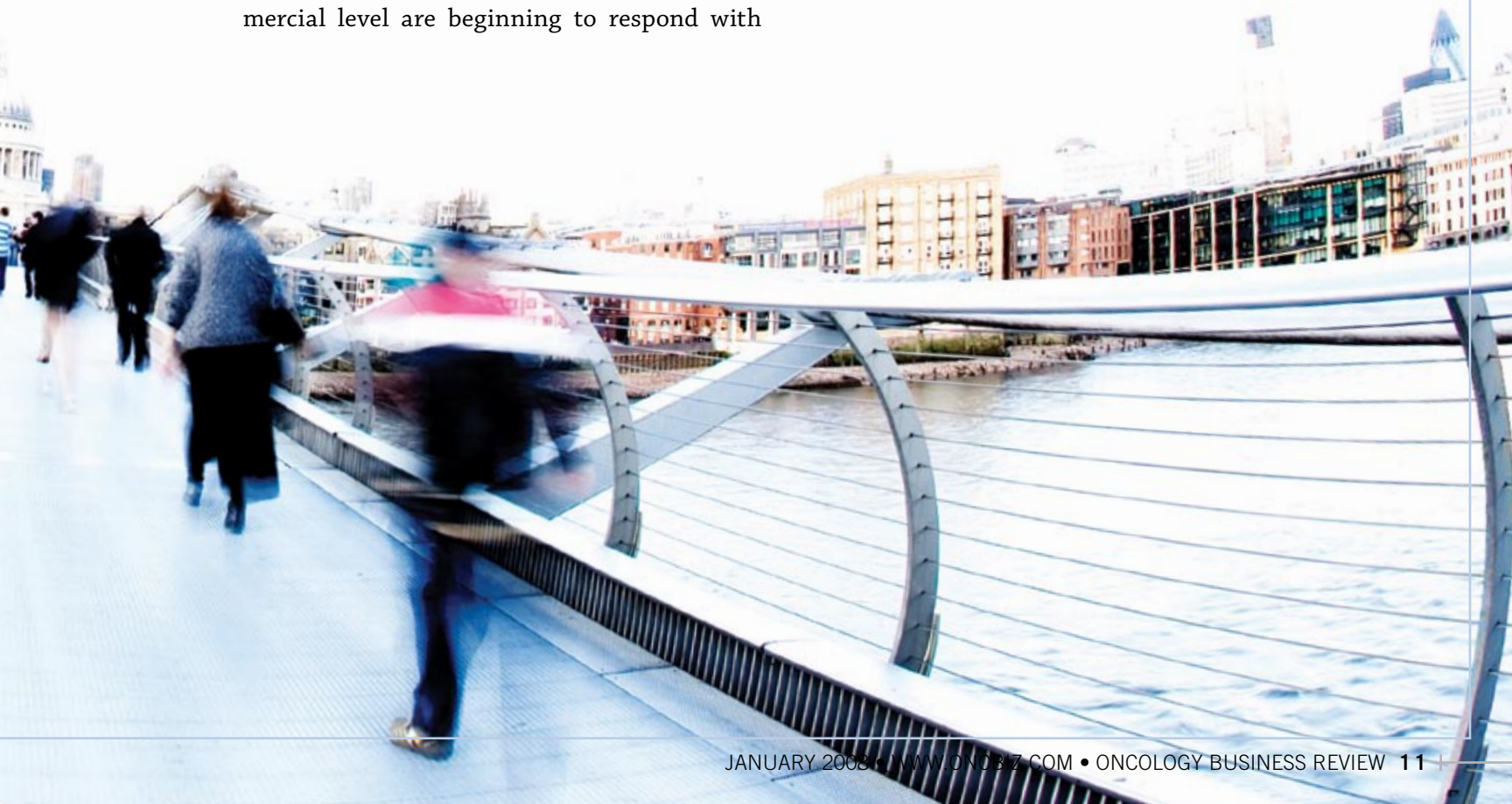
By Bryan Cote

On behalf of OBR, author Bryan Cote contacted 1000 oncology practices via a private e-mail survey featuring 10 questions. Disseminated in September 2007, 104 oncology practices responded; of which 68 were practice managers, 21 physicians, 11 pharmacists, and 4 administrative/billing managers. In October, the author followed up with 20 of the 104 respondents by telephone, 14 oncologists and 6 practice managers, to gather more in-depth responses. Here are the results of the survey.

Introduction

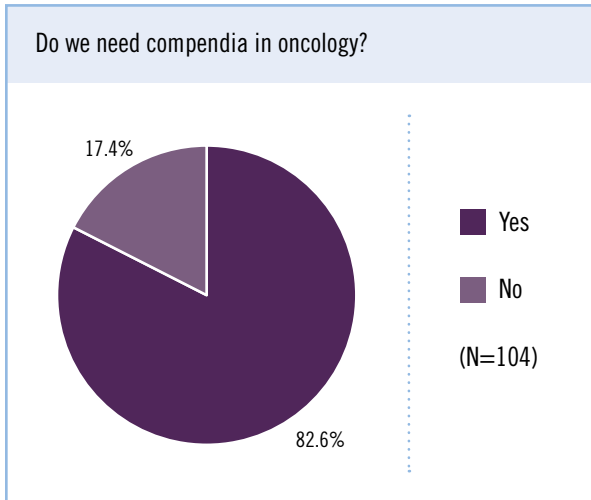
Roughly 60 percent of oncology drug use can be considered off-label, and inefficiencies have been an unfortunate staple of the compendia-based reimbursement process, affecting the entire oncology-care continuum. Armed with evidence that outdated compendia can negatively affect healthcare system costs and care, payers at the federal and commercial level are beginning to respond with

policies more favorable to the oncology business. For all their inherent value as a patient access benefit and reimbursement bridge to new FDA approved uses and indications for patients with cancer, drug treatment compendia recommendations and interpretations have at times been as wildly inconsistent as Phil Mickleson's tee shots. [cont. on pg 12 >>](#)



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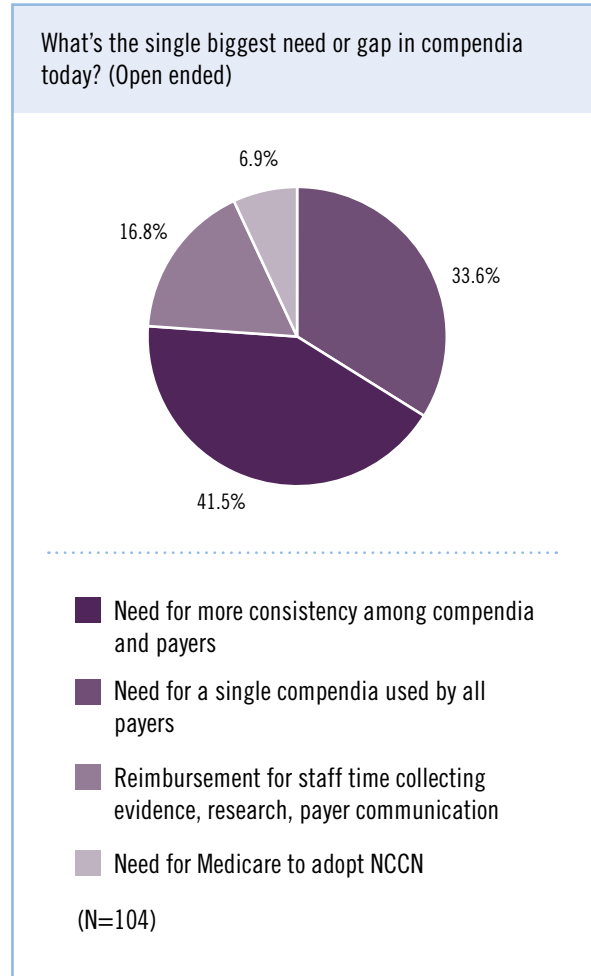


Compendia treatment recommendations—those on which oncologists and payers frequently rely to assess off-label reimbursement decisions—are at times different enough such that medical directors handling peer-review cases and appeals for the same plan will interpret the same compendia differently. As a result, oncology and hematology business operations suffer.

“There’s often a lack of clear guidance when the accepted compendia differ in their assessment of efficacy and safety, and it hurts our business,” says Cheryl Hoechner, a pharmacist with Tunnell Cancer Center, in Lewes, Delaware.

Potential Value in a Gold-Standard Model

Emerging from all the back-room reimbursement battles between provider and payer is a solution—a blueprint that may bring greater stability to the compendia business model, and appease payers, providers, biopharmaceutical companies, and even the investment community. According to 81 percent of the 104 surveyed in September, CMS and com-



mercial payers should adopt the National Comprehensive Cancer Network’s (NCCN) compendium as the gold standard in oncology compendia.

In a unique move, that if successful could become a model among other payers, United Healthcare (UHC) is expected to do just that and adopt the NCCN Drugs and Biologics Compendium and its recommendations in January as it’s only accepted commercial business compendium. “NCCN will be our gold standard,” says Lee Newcomer, MD, chief

Editor’s Note: We finished this article at the end of December with the most recent news from CMS and Congress. Given the fast pace in Washington D.C. some of the information may have changed since printing.

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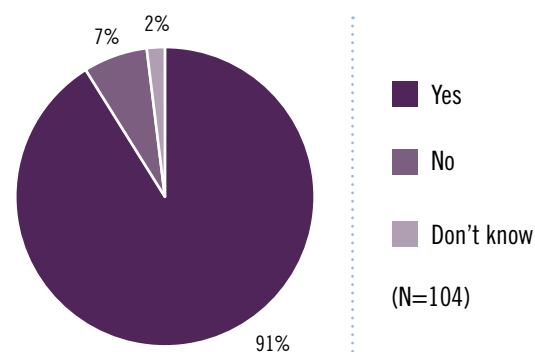
However, endorsing only one compendium carries with it some potential limitations. According to Gerald McEvoy, PharmD, Assistant Vice President of Drug Information and Editor of the American Hospital Formulary Service (AHFS-DI), the NCCN compendium does not carry guidelines for several orphan cancers. Moreover, unlike the AHFS, which updates its compendium monthly and addresses non-oncology uses for cancer drugs, the NCCN’s compendium does not.

Demand for NCCN recognition is only part of the story. AHFS, one of the original, multi-disease government-approved compendia, is currently the only CMS-approved compendia recognizing new uses. This all started when Thomson Healthcare purchased the other most often used compendia—USP-DI—then obtained a license to continue using the USP name through 2007, but not beyond. Congress has amended the 1993 off-label statute to require CMS to recognize the USP-DI successor publication, known as DrugPoints®, but CMS has not yet implemented the law. “CMS needs to instruct carriers to recognize DrugPoints as the successor publication so there is no confusion,” says Joseph Bailes, former ASCO president and current Chair of ASCO Government Relations Council.

Hiring Additional Staff to Sort Through Various Compendia

At the time of the survey in September, more than half of respondents said that the compendia they use most often—the former USP-DI, AHFS-DI, DrugDex®, and NCCN—regularly differ in their guidelines. (This

Have you had to hire staff or pay an outside person to research literature when the treatment is not listed in the payer’s accepted compendia?



finding is supported by the Duke University and New England Medical Center study commissioned by CMS in 2006 that evaluated all compendia.)

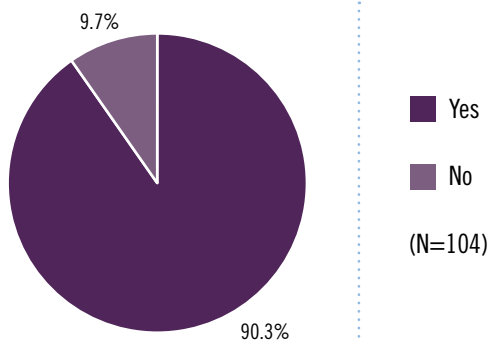
Many practices (including 92 percent of those surveyed) have hired staff to research literature in hopes of securing reimbursement for a patient’s treatment. Results of these efforts are not always fruitful, and yet almost always costly.

Colleen Lindsey, CPC, director of network coding for University Health Systems in Knoxville, Tennessee says, “There have been many breast cancer patients for whom the physician has tried to use the second-level chemotherapy drug, because the compendia-approved drug did not work and caused adverse events in some cases.” In one case she recalled, “BlueCross denied the second-line upfront as experimental because the drug was not on the compendia. We spent several days dealing with this one case and without a good financial result for the patient.” [cont. on pg 14 >>](#)

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If you base your coverage argument on compendia, in your experience, do you have a better chance to get paid for your treatment decisions?



Irrked over the inconsistent coverage process and out-of-date compendia, Anne Campbell-Maxwell, SLA, head nurse for Oncology of Chesapeake Regional Medical Center, in Virginia, has had to devote considerable nurse time to evidence-gathering, researching payers' compendia policies, and searching for alternatives when a payer, such as Medicare, won't accept the compendium she is using.

In the survey, 82 of the 104 practices reported spending more than 20 percent of their office days on the phone researching coverage decisions, compiling evidence, and in many cases calling payers multiple times to recheck compendia coverage.

UHC's Solution to Confusing Compendia

During visits to four oncology practices in Georgia, UHC discovered that this was a major problem. Dr. Newcomer was informed that an oncology practice could contact a UHC call center in one state at 11 A.M., get a denial for an anti-cancer drug treatment, then call a dif-

ferent UHC state-center three hours later and get an approval.

Under its old system, if available guidelines didn't have an answer, UHC turned to medical literature. "In some cases our medical directors would be looking at the same literature, but there would be different interpretations from the same article," says Dr. Newcomer. Failing literature proof, UHC turned to state rules or employer guidelines for a decision.

Thus, UHC's new policy will be the product of a two-year initiative lead by its new oncology business unit. Purportedly cleaner and void of conflict, UHC is expected to accept three of NCCN's evidence levels: 1, 2a, and 2b, for 16 anti-cancer oral agents, and for injectables. For now, it won't accept level 3 given the gaps in terms of the evidence of the drugs in this grouping.

Survey respondents cited UHC as one of the three payers most restrictive and difficult to work with for oncology treatment medical necessity, behind only Aetna and Medicare, which tallied the most votes among government payers. Time will tell if its new policy may carve away at this perception.

Economics of Conflicting Compendia

Meantime, most practices continue to work within the system, relying heavily on cancer drug compendia for off-label uses (87%), commercial payer reimbursement (81%) and Medicare coverage (71%). However, survey respondents expect to increase the need to use compendia to get paid for their growing Medicare populations.

"We cannot remain economically viable until the inefficiencies and inconsis-

According to the 2008 Medicare physician fee schedule, there is only one authorized compendia for Medicare—AHFS...

tencies in the system are fixed,” says Cheryl Skinner, MD, of Signal Point Hematology in Middletown, Ohio. She uses the Association of Community Cancer Centers (ACCC) accumulation of approved compendium—a majority favorite among respondents as a compendia reference.

Skinner’s biggest issue: reimbursement detective work when compendia differ. This taxes the staff and at times leads to denials. She would like to see the process streamlined across payers, with a caveat. “If they are not up-to-date, then we [should be able to] submit information to justify uses.”

Almost two-thirds of the practices (64%) say by having a website or single, gold-standard compendium across payers would save them as much as 12 hours in staff time per week, or about one and half days. Most would at a minimum free up a staffer and nurse time for other work, including patient care.

Is a Single Compendium a Conflict?

In the instance of the NCCN compendium, some medical directors note that it is not as evidence-based as ASCO. “For everyday guidance,” says Myron Goldsmith, MD, who peer reviews oncology treatment plans as chief medical officer for New Century Infusion Solutions, “NCCN keeps incredibly current... but it’s not as evidence-based as ASCO, which is more finite in their selection.” For example, Dr. Goldsmith points out that NCCN’s consensus panel may recommend multiple stages for colorectal cancer, compared with a single stage recommendation by ASCO.

AHFS sees other issues: “NCCN’s scope is far more limited than AHFS’s compendium,” says McEvoy. “Notably absent is [its] focus

on medication safety. The strength of a recommendation for a given off-label use can be greatly affected by its toxicity profile relative to other therapies, and potentially can obscure clinical evidence findings either positively or negatively.”

The AHFS is published by the American Society of Health-System Pharmacists® (ASHP) with no apparent vested interest in any one patient population or disease. “Our mission is to provide an evidence-based foundation for safe and effective drug therapy,” says McEvoy. “NCCN is a not-for-profit consortium of major academic cancer centers, drawing from the expertise of clinicians at its own member institutions, whereas we use a broader-base of experts comprised principally of physicians and pharmacists without regard to membership in ASHP.”

In its comments to CMS on the Medicare Part B proposed rule, the ASHP strongly recommended that safety information be added to its list of desirable characteristics for a drug compendium. However, there was no mention of this in the final Medicare physician fee schedule rule for 2008.

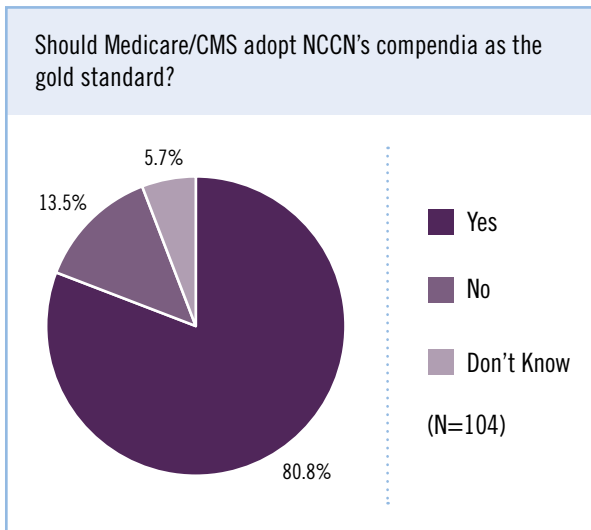
CMS Position

According to the 2008 Medicare physician fee schedule, there is really only one authorized compendia for Medicare—AHFS—and so CMS is seeking suggestions, using MedPAC criteria to decide which compendia it will use for the Part B program.

Kate Tillman, of the agency’s coverage office, said that CMS may add NCCN to its covered compendia by the fall of 2008. Tillman anticipates several stakeholders will officially request NCCN’s addition to [cont. on pg 16 >>](#)

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the covered compendia in January, as part of the agency's new process to update compendia used to determine medically-accepted off-label uses of drugs and biologics in chemotherapy regimens. Based on a CMS supported technology assessment conducted in 2006, the NCCN compendium received top quality scores among all compendia.

When asked if NCCN would become a gold standard, Tillman said, "I think that's probably going to come, but these things have to work themselves through."

The National Patient Advocate Foundation and the ACCC are among the organizations that have urged CMS to include the NCCN compendium with the drug compendia that CMS already recognizes as sources of drug utilization review and reimbursement for unlabeled uses.

To comply with CMS rules, the NCCN changed its compendium formatting from a disease list to a drug list. This will place them on the Medicare-approved compendia around mid-July, at the earliest. When asked

why the addition cannot happen any earlier, Tillman said, "It has to run through the process." Furthermore, the CMS general counsel reported that even compendia no longer published cannot be removed until these add/delete regulatory reviews take place.

CMS will consider requests to review compendia annually during a 30-day window starting January 15th each year. It reserves the right to conduct an immediate compendia review, if necessary, said Tillman.

In comments to CMS, several providers urged the agency to regulate a timeframe for compendia to update recommendations. "We do not believe we should establish regulation-specific timeline requirements at this time, but will now consider a compendium's timeliness as an additional criterion in the review process," CMS wrote in its final Medicare ruling.

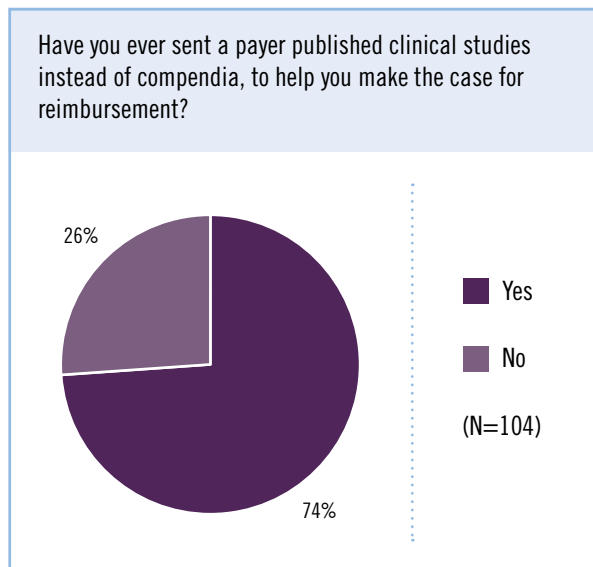
Compendia's Ongoing Role in Reimbursement

As these changes unfold, it's clear—to at least 83 percent of respondents—that compendia remain critical to the oncology business. According to Wendy Andrews of the Arizona Cancer Center in Tucson, Arizona, "Compendia allow the best therapies to be available; it takes too long for a pharmaceutical company to go back and get an FDA label approved."

Furthermore, Tunnell's Hoechner says, "If reimbursement is based on compendia listings, we need them; without compendia, doctors will be discouraged in prescribing very promising treatments and regimens, until there's consensus of proof of efficacy and safety."

To make the case for reimbursement in the absence of a drug on compendia, 74 percent of

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respondents reported sending payers a published study—often because the compendia were either conflicting or did not cover the product’s specific indication/use. One practice sends both the published study and compendia to get reimbursed, but the process is time consuming.

Hoechner has used published studies in lieu of compendia, like the time Tunnell Cancer Care used bortezomib [Velcade®; Millenium and Johnson & Johnson] for a multiple myeloma case. “There was a good deal of evidence to support its use,” she says, “but there was a lot of work; FDA approved the drug one month after Tunnell issued its first treatment.”

Industry Perspective

Changes emerging at the payer and CMS level are beginning to dominate discussions outside the practice—a sign that compendia businesses will drive more than treatment decisions. At recent biopharmaceutical company earnings calls, investment analysts

have asked questions about a product’s compendia status. For instance, Howard Liang, an analyst with the equity research firm Leerink Swann of New York, considers to what extent a new compendium helps a biopharmaceutical company expand its market and influence physician behavior. Rachel McMinn, an analyst for the Wall Street investment firm Cowen and Company, questions if practitioners should expect new compendia and new CMS compendia rules to have a rapid impact on treatment decisions.

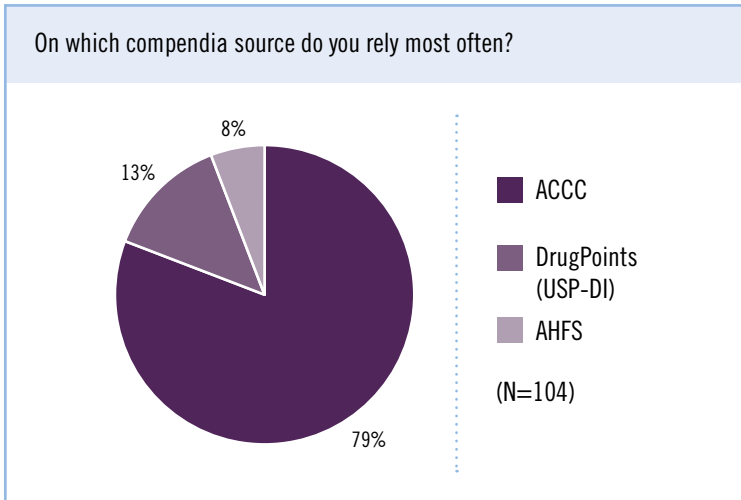
In looking at multiple myeloma treatments, Revlimid® [lenalidomide; Celgene] and Velcade, for answers, drug compendia DrugDex and DrugPoints, list Revlimid in combination with dexamethasone as an off-label frontline therapy for myeloma. Currently, Revlimid is FDA approved only for myeloma patients who have had at least one prior therapy. Medicaid and Medicare Part D use DrugDex and DrugPoints as legally approved guidance documents.

“We should not see a reimbursement challenge for patients in the US who want it and doctors who want to prescribe it. We obviously can’t promote it regardless of compendia listings. But it should not be a reimbursement challenge as it was prior to getting the compendia listing,” says Robert Hugin, President and Chief Operating Officer, Celgene.

In Medicare Part D, however, physicians and patients struggle to get reimbursement for noncompendia, nonspecific labeled drugs, adds Sol Barer, Chairman of the Board, Celgene. “We still have to work on the compendia listing because it’s frustrating for a physician and the patient to decide this is the right therapy, but not be able to be reimbursed,” says Barer. [cont. on pg 18 >>](#)

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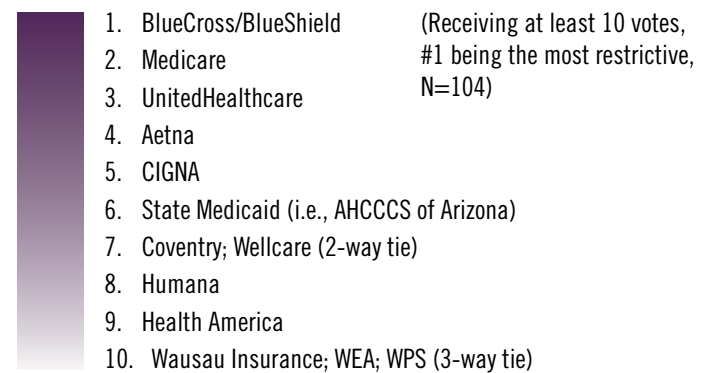


On the other hand, Millennium Pharmaceuticals received a compendia listing in the fall for Velcade, for use in frontline myeloma. “We were listed in the DrugPoints compendia and [this] generally gives full coverage across all states. We had about 27 states that have made local carrier decisions,” says Deborah Dunsire, MD, President and CEO, Millennium Pharmaceuticals.

“We haven’t really counted on compendia listings because we believe that it’s really the full approval and the promotion of the frontline data that really changes the physician prescribing behavior,” she says. “We’ve seen that pretty consistently and heard from our physicians that in the IV setting, approval is a key kind of milestone for them to be able to feel very comfortable about using the product.”

Biotech ImClone Systems Inc. expects market share growth following a compendia listing for its colorectal cancer treatment Erbitux® [cetuximab; ImClone Systems Inc., Bristol-Myers Squibb, Merck], indicated for the refractory setting, says Michael Bailey, Senior VP of Commercial Operations. “In the firstline, I think the biggest barrier is going to be reimbursement. We want to get a label in that setting as soon as possible in the compendia.”

RESTRICTIVE PLANS: Which payers are the most restrictive and difficult in their reimbursement and medical necessity policies for oncology? Provide up to 5 answers.



In Conclusion

As with any online survey, there are some limitations that should be considered when evaluating findings. For example, most respondents in our survey were administrators and practice managers, not clinicians; however, of the 68 practice managers who responded, 59 filled out the survey as a practice—with input from the physician.

Although the 104 responding facilities represent a small segment of the total market, the insight from both practice managers and clinicians give us some ideas of how to improve the compendia business. Compendia is no doubt a key reimbursement ingredient for providers, but with different compendia recommending different guidelines, and payers relying on multiple compendia, payment for anti-cancer treatment is a time consuming puzzle. And, by only having one approved compendium there will be less sources to help in the approval of off-label usage and more hesitancy to prescribe off-label which is a detriment to patients. **BC**

The stakes are high for all oncology stakeholders when it comes to compendia. Please don't hesitate to visit our website at www.oncbiz.com and post your comments on this article.