

## A Perspective on Cancer Drug Pricing and Volume

by Bryan Cote

Affording and delivering cancer treatments has become increasingly difficult as cost of healthcare continues to rise. In response to the rising cost issue, oncologists and payers are seeking an improved drug cost to therapy benefit ratio—one with greater patient advantage, therapeutic efficacy and outcomes in exchange for their cancer drug dollar. Many stakeholders have criticized manufacturers for lack of innovation and assume prices have been intentionally set high to ensure a return on investment, and also as a way to secure the monies needed to further product development.

We did a comparative analysis of Medicare-reported average sales prices (ASP) for 11 branded intravenous anti-cancer agents in three tumor types: breast, non-small-cell lung, and colorectal cancers from the years 2005 through 2009 to identify how a drug's price may affect total treatment cost. For the years studied, several themes emerge including:

- The 5-year ASP values varied significantly—in some cases holding flat—while total annual cost of treatment per line of therapy escalated for breast and non-small-cell lung, but not colorectal.
- In the last 5 years, three high volume drugs for breast and non-small-cell lung had markedly different ASP tracks: Avastin [bevacizumab; Genentech] increased 1.19% vs. Gemzar [gemcitabine; Eli Lilly] 23% and Taxotere [docetaxel; sanofi-aventis] 16.11%.

- Total treatment costs per line of therapy for breast and non-small-cell lung increased 15% and 26%, respectively from November '06 through October '09. As a result, it appears non-Avastin expenses, such as Gemzar and Taxotere, and possibly the entry of new products into each of these tumor types, contributed to the increase—this during a time when use of some expensive branded-agents increased as the use of lower-cost generics decreased.
- ASPs are not uniform across companies, can increase or decrease by year and quarter, and a single company's ASP between products can vary significantly—i.e., Genentech's Avastin (basically stable) and Rituxan [rituximab; Genentech/Biogen Idec] (27% increase over 5 years). Only sanofi-aventis' Taxotere and Eloxatin [oxaliplatin] show a similar price evolution when evaluating company averages.
- Some drugs used most frequently by oncology practices had the greatest increase in price over the time period studied.

### ASP Analysis Takeaways

Before tracking the Medicare-reported ASPs in Table 1, we interviewed 28 oncology professionals (10 community oncology practices, 10 hospital executives, and 8 health plan professionals) and asked, "In your opinion, how have average sales prices for each of these 11 products trended in the past 5 years?" All but four incorrectly predicted 8% to 10% per-year ASP increases across the [cont. on pg 22 >>](#)

### >> INTERPRETING TABLE 1

The dollar amounts in Table 1 illustrate manufacturer-reported baseline ASP to Medicare by quarter since 2005. Rates equal the Medicare allowable payment divided by 1.06, or the ASP for the quarter, and reflect Medicare's dose. To determine the acquisition price for a typical dose/treatment, multiply the common dose by the body surface

area (BSA) to get the overall dosing. Then divide Medicare's unit payment into the overall dose and multiply that by the ASP. For example, Rituximab for Q1 '05: 375 mg x 1.6 (BSA) = 600 (overall dose) divided by 100 (Medicare dose) = 6 (units) x \$416.99 (ASP) = \$2,501.94 (ASP per typical dosing).

**Table 1. Intravenous Oncolytic Drug Pricing Trends (based on Medicare ASP 2005-2009)**

	Bevacizumab	Trastuzumab	Rituximab	Gemcitabine	Pemetrexed	Cetuximab	Docetaxel	Pegfilgrastim	Azacitidine	Oxaliplatin	Paclitaxel (albumin-bound)
Brand Name	Avastin	Herceptin	Rituxan	Gemzar	Alimta	Erbix	Taxotere	Neulasta	Vidaza	Eloxatin	Abraxane
Common Strength	5 mg/kg	4 mg/kg	375 mg/m <sup>2</sup>	1000 mg/m <sup>2</sup>	500 mg/m <sup>2</sup>	400 mg/m <sup>2</sup>	75 mg/m <sup>2</sup>	6 mg/6 syringe	100 mg/sdv	10/20 ml/sdv	100 mg/sdv
CMS Allowable Strength	10 mg	10 mg	100 mg	200 mg	10 mg	10 mg	20 mg	6 mg	1 mg	.5 mg	1 mg
<b>2005</b>											
Q1	\$53.84	\$49.99	\$416.99	\$108.81	\$38.24	\$46.83	\$280.74	\$2,145.22	n/a	\$7.77	n/a
Q2	\$53.88	\$49.99	\$414.92	\$108.79	\$38.25	\$46.85	\$278.95	\$2,060.00	n/a	\$7.79	n/a
Q3	\$53.87	\$50.88	\$430.11	\$108.70	\$38.16	\$46.83	\$278.55	\$1,969.53	n/a	\$7.82	n/a
Q4	\$53.87	\$51.31	\$430.12	\$109.33	\$38.37	\$46.94	\$277.02	\$1,960.44	n/a	\$8.04	n/a
1-year change	0.05%	2.64%	3.15%	0.48%	-0.34%	0.23%	-1.33%	-8.61%		3.47%	
<b>2006</b>											
Q1	\$53.76	\$52.06	\$436.70	\$110.65	\$38.96	\$47.04	\$278.25	\$1,974.94	\$3.83	\$8.04	\$7.86
Q2	\$53.67	\$51.99	\$443.07	\$111.03	\$38.95	\$47.04	\$280.46	\$2,036.02	\$3.90	\$8.06	\$7.80
Q3	\$53.67	\$51.99	\$443.55	\$114.66	\$40.18	\$47.04	\$284.11	\$2,015.78	\$3.90	\$8.27	\$8.29
Q4	\$53.66	\$52.99	\$454.42	\$114.44	\$40.08	\$47.04	\$285.55	\$2,028.24	\$3.98	\$8.27	\$7.98
1-year change	-0.19%	1.79%	4.06%	3.43%	2.87%	0.00%	2.62%	2.70%	3.91%	2.86%	1.53%
<b>2007</b>											
Q1	\$54.22	\$53.55	\$459.01	\$117.50	\$41.20	\$47.01	\$288.80	\$2,021.61	\$3.98	\$8.41	\$8.18
Q2	\$54.27	\$54.59	\$468.13	\$118.08	\$41.31	\$46.31	\$289.45	\$2,030.30	\$4.06	\$8.47	\$8.17
Q3	\$54.28	\$54.65	\$468.43	\$120.74	\$42.25	\$47.02	\$292.10	\$2,053.10	\$4.07	\$8.67	\$8.24
Q4	\$54.22	\$55.72	\$480.38	\$121.25	\$42.37	\$47.07	\$296.05	\$2,042.97	\$4.14	\$8.71	\$8.37
1-year change	0.00%	4.05%	4.66%	3.19%	2.84%	0.13%	2.51%	1.06%	4.02%	3.57%	2.32%
<b>2008</b>											
Q1	\$54.21	\$55.68	\$479.87	\$124.20	\$43.47	\$46.97	\$301.34	\$2,067.37	\$4.14	\$8.93	\$8.38
Q2	\$54.18	\$56.68	\$491.10	\$124.32	\$43.58	\$46.99	\$307.06	\$2,075.66	\$4.23	\$9.38	\$8.35
Q3	\$54.15	\$56.74	\$491.51	\$127.29	\$44.44	\$46.97	\$311.06	\$2,051.89	\$4.23	\$9.04	\$8.30
Q4	\$54.12	\$58.01	\$504.40	\$127.44	\$44.62	\$46.94	\$315.70	\$2,072.24	\$4.32	\$9.02	\$8.30
1-year change	-0.17%	4.18%	5.11%	2.61%	2.65%	-0.06%	4.77%	0.24%	4.35%	1.00%	-0.95%
<b>2009</b>											
Q1	\$54.13	\$58.15	\$505.01	\$130.37	\$45.49	\$46.93	\$317.87	\$2,053.00	\$4.38	\$9.03	\$8.56
Q2	\$54.15	\$59.50	\$518.02	\$130.18	\$45.43	\$46.92	\$321.67	\$2,036.00	\$4.49	\$8.99	\$8.59
Q3	\$54.17	\$59.60	\$518.86	\$133.29	\$46.66	\$46.91	\$325.14	\$2,116.64	\$4.49	\$9.06	\$8.70
Q4	\$54.48	\$61.07	\$531.45	\$133.75	\$46.64	\$46.91	\$325.98	\$2,136.61	\$4.59	\$9.18	\$8.74
1-year change	0.64%	5.02%	5.24%	2.59%	2.53%	-0.04%	2.55%	4.07%	4.79%	1.66%	2.10%
5-year change	1.19%	22.16%	27.45%	22.92%	21.97%	0.17%	16.11%	-0.40%	19.84%	18.15%	11.20%

**Table Notes:** (1) Patient Averages to Calculate: Avg wt (kg)=95; Avg body surface area (mg/m<sup>2</sup>)=1.75. (2) ASPs shown=Medicare allowable divided by 1.06. (3) SDV=single dose vial.

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board. After showing the interviewees the ASP data, more than half said that pharmaceutical companies—while setting drug prices high—didn't appear to be raising prices haphazardly in the last 5 years.

Tables 2 and 3 below illustrate how companies varied in pricing individual products, which lowered their average 5-year increase across therapies.

**Table 2. ASP Trends by Drug (2005-2009)**

Drug	Company	5-Year Change
Rituximab (Rituxan)	Genentech / Biogen Idec	27.45%
Gemcitabine (Gemzar)	Eli Lilly	22.92%
Trastuzumab (Herceptin)	Genentech	22.16%
Pemetrexed (Alimta)	Eli Lilly	21.97%
Azacitidine (Vidaza)	Celgene	19.83% *
Oxaliplatin (Eloxatin)	sanofi-aventis	18.15%
Docetaxel (Taxotere)	sanofi-aventis	16.11%
Paclitaxel (Abraxane)	Abraxis	11.2% *
Bevacizumab (Avastin)	Genentech	1.19%
Cetuximab (Erbix)	Bristol-Myers Squibb / ImClone Systems**	0.17%
Pegfilgrastim (Neulasta)	Amgen	-0.40%

\*Based on 4-year % change \*\*Wholly-owned subsidiary of Eli Lilly

**Table 3. ASP Trend Comparison by Three Companies**

Company	Number of Products Studied	Average 5-Year Change
sanofi-aventis	2	17.13%
Genentech	3	16.93%
Eli Lilly	3	15.02%

A closer look at Table 1 illustrates additional product variances, such as:

- Rituxan's 5.29% growth in 2009 was the highest calendar-year product increase, followed by Herceptin [trastuzumab; Genentech] (5.02%), Abraxane [albumin-bound paclitaxel; Abraxis] (4.79%), and Neulasta [pegfilgrastim; Amgen] (4.07%).

- Neulasta's pricing was the most unpredictable of the 11 products with an 8% decline in 2005 over a 4-quarter period compared with its 4% increase in 2009. Vidaza's [azacitidine; Celgene] year-over-year pricing was almost rhythmic as its Q2 and Q3 ASPs were almost always identical.
- Two of the four drugs with 20% or higher 5-year growth—Alimta [pemetrexed; Eli Lilly] and Gemzar—had no meaningful increase of ASP within each year. Unlike Herceptin and Rituxan, neither Alimta nor Gemzar showed more than a 3.5% annual increase.

"These numbers are unbelievable," says Fred Pane, RPh, Senior Director of Pharmacy Affairs, Premier, a group purchasing organization for hospitals, cancer centers and a small number of community oncology providers. Due to the fact that Medicare has required manufacturers to publicly report ASP every quarter since January 2005, Pane says, "Price transparency has probably played a major factor in how manufacturers have approached pricing and held back from major increases; there's definitely a PR effect." Pane also thinks the intention of ASP was to control the amount of payout from Medicare to providers, "and these numbers, at least from a payout perspective, tell me that this goal worked."

## ASP Impact on Oncology Practices

According to the analysis, four products averaged at least a 4% ASP increase each year since 2005: Rituxan, Gemzar, Herceptin, and Alimta. Of no surprise, these four products align with practice drug spend for many of the groups contacted, but not all.

For the first 10 months of '09 for example, a six-physician hematology-oncology practice that sees 20 patients per day (2-3 new patients) and treats 100 patients per day in its infusion suite, spent \$4.4 million (Table 4) purchasing three Genentech drugs, and \$1.6 million for two Lilly drugs.

According to this practice's chief operating officer, "Purchasing volume depends on group payer mix, prescribing patterns, geography and the way manufacturers' structure contracts. For example," he said, "practices in our state



**Table 4. Practice 10-Month Drug Spend (Jan. '09-Oct. '09)\***

Company	Chief Products Accounting for Spend	Pharmacy Acquisition Spend
Genentech	Rituxan, Herceptin, Avastin	\$4.4 million
Amgen	Neulasta	\$2.8 million
sanofi-aventis	Eloxatin, Taxotere	\$2.3 million
Eli Lilly	Alimta, Gemzar	\$1.6 million
Ortho Biotech	Procrit	\$1.0 million
Novartis	Not available	\$800,000
BMS	Orencia	\$700,000
Eisai	Aloxi	\$500,000
BDI Pharma	Gammagard IVIG	\$500,000

\* Financial analysis of an actual community practice.

cannot get Abraxane paid for by most commercial payers, but some payers will cover it elsewhere.”

About 97% of the practice’s drug spend is on branded oncology products, 60% of which is for sole-source drugs. Reimbursement on drug acquisition for the practice varies widely—sometimes negative—and is increasingly difficult to determine due to numerous variables (i.e., contracting; patient insurance; payer reimbursement; administrative burdens; changing regimens; and manufacturer provisions such as rebates, which, if earned, may be paid several months after the end of a quarter). However, according to the COO, reimbursement amount per drug purchased is trending downward.

He says that the net effect of the ASP reimbursement model, “Is to encourage manufacturers to increase prices regularly, and when they do, it forces us to be a kind of bank since the distributor pays the higher price immediately, and passes the increase along to us without forewarning. We then must wait six months to receive any higher ASP payment.”

Rituxan’s ASP track shown in Table 1 illustrates the point. Larger practices that pay ASP plus 1% or 2% to acquire drugs achieve a healthy margin from commercial plans that reimburse oncologists at ASP plus 16% to 20%. However, as oncology administrators surveyed shared,

one for-profit commercial plan reimburses based on older ASP data, often two to three quarters behind. According to Joel Brill, MD, Chief Medical Officer, Predictive Health, and a member of a health plan P&T committee, a practice that bought Rituxan in Q4 '09 paid an ASP of \$531.45 per 100 mg dose (plus some percentage), whereas the plan reimburses the practice based on Q2 ASP of \$518.02.

Thus, if prices escalate quarter to quarter, the commercial plan payment lag further exacerbates even modest drug price increases, says Brill. This pressures practices to try to minimize inventories, play catch up and risk reduced or denied claims, compared to Medicare which offers a more reliable payment turnaround time. Brill said, “If commercial plans paid with the same terms as Medicare, the price increases depicted for the I.V. oncology products become less of an economic roulette wheel.”

Prompt pay laws in many states have helped reduce the lag burden. Plans in Pennsylvania must pay within 45 days, therefore a practice with around 30 days of revenue outstanding is relatively safe. However, drugs may represent about 75% to 80% of a group’s non-physician costs and may total to about \$60,000 in drugs a day, thus any payment lag is financially risky.

The ASP trends surprised some groups who do not use all the products in the analysis. At Hinsdale Hematology Oncology in Hinsdale, Illinois, Erbitux [cetuximab; BMS/Merck/ImClone/Lilly] is not widely used, but Avastin is used. “I was very surprised to see that both drugs were so similar in their path given the big difference in utilization here,” says Carolyn Spranza, Hinsdale’s business office manager. She indicated that drug prices are just one piece of a larger challenge in scrambling to treat patients and reduce the numbers that need to be redirected to hospital infusion sites.

Furthermore, according to Paul Lakomski, RPh, most recently a regional pharmacy director for Wellpoint NextRx, “the fairly flat rate of Erbitux is not surprising considering all the negative press it received when first launched.” Lakomski thinks that increasing the drug’s price consistently would have only drawn further criticism and hurt sales. “From a managed [cont. on pg 24 >>](#)

care perspective,” he commented, “I had often looked at price increases and wondered what the manufacturer was thinking. Though when I look at these numbers [in Table 1] the pricing patterns year-to-year and quarter-to-quarter are most likely based on expected sales and the profit margin the company wanted to maintain for the product balanced against what the market would handle.”

Roy Arnold, MD, Chief Medical Officer for Welborn Health Plans serving Indiana told us he expected increases closer to 10% per year, particularly with bevacizumab, trastuzumab, rituximab, and cetuximab. “These are extremely difficult and technically demanding drugs to bring to market, and I’m impressed that the companies were able to keep their per-milligram price pretty flat.”

To help oncology practices reduce cash flow burden, almost all of Welborn Health Plans’ oncology providers have begun to use the plan’s contracted specialty pharmacy. “These are mostly one or two physician groups without an ability to carry a large inventory, and they pay nothing in acquisition,” says Arnold. Welborn reimburses one of the high volume groups in its network \$75 per 30-minute infusion and \$150 per hour. “This covers seat time and more than the cost of the administration, plus they’re not out the cost of the medication.”

## Treatment Cost

In as much as oncology is one part of healthcare payment reform discussions, drug prices—including ASP—are no doubt a piece of the larger oncology cost of care vs. quality of care debate. Table 5 illustrates the year-over-year treatment cost by line of therapy for three tumor types. Like the differences in ASP by company and product, annual cost per line of therapy varies year to year and by tumor type, but overall, annual cost per line of therapy has increased.

For the cost of therapy per patient to increase, either a drug’s cost per milligram or the amount of milligrams per patient must go up. As illustrated in Table 6, for breast cancer and non-small-cell lung, cost of therapy per patient increased steadily for 3 years after November 2006—mostly due to higher use of more expensive drugs

vs. lower-cost generics, some of which can be attributed to the ASP system that began in 2003 and incentivized physicians to prescribe a higher priced drug. As a result, more patients are being given more expensive drugs and this is driving up the overall cost of therapy per patient, according to IntrinsiQ, an oncology data and analytics firm in Waltham, Mass.

To understand the reasons for therapy cost changes by tumor, we analyzed the IntrinsiQ data and discovered the following:

- **Breast:** Total treatment cost increased 15.3% over the 3-year period, but most of that (13%) occurred in November ‘07 through October ‘08, whereas cost per patient increased \$2,655. In adjuvant breast cancer, more patients received a name brand over a generic. Two other inexpensive adjuvant breast cancer treatments—cyclophosphamide and doxorubicin—declined in use. In metastatic breast cancer, bevacizumab was added to monotherapies, such as the combination of paclitaxel albumin-bound, and separately with paclitaxel, which drove up the cost.
- **Non-small-cell lung:** Overall costs increased 26.7% over the 3-year period, most interestingly jumping 16% from November ‘08 through October ‘09, whereas cost per patient increased \$2,538. A greater number of physicians prescribed pemetrexed and bevacizumab, two branded drugs, whereas fewer patients received docetaxel, a relatively less expensive drug, which made the overall market more costly.
- **Colorectal:** Total treatment costs increased less than 1% over the first two time periods, then declined 7.83%, but cost per patient increased \$677—largely due to the increase in adjuvant colorectal cancer cost.

When comparing only total metastatic patient costs, breast and non-small-cell lung show similar patterns: breast rose 28% over the 3-year period; non-small-cell lung 24%; and colorectal costs for the total metastatic line decreased almost 12% which possibly may be attributed to generic Campostar and oxaliplatin entering the market.

cont. on pg 26 >>>

**Table 5. Year-Over-Year Treatment Costs by Tumor Type**

BREAST CANCER			
Met Status	Nov-06 to Oct-07	Nov-07 to Oct-08	Nov-08 to Oct-09
	Annual Cost in \$MM (N=9,590)	Annual Cost in \$MM (N=10,504)	Annual Cost in \$MM (N=9,939)
All Patients	\$2,986.5	\$3,376.7	\$3,443.3
Adjuvant	\$788.7	\$852.2	\$787.5
Adjuvant Maint	\$386.7	\$403.3	\$402.1
Met 1st Line	\$432.7	\$470.8	\$528.4
Met 1 Maint	\$177.8	\$167.2	\$156.9
Met 2nd Line	\$331.5	\$390.1	\$461.0
Met 2+ Maint	\$123.3	\$112.9	\$114.9
Met 3rd Line +	\$652.3	\$778.6	\$836.5
<b>Total Met</b>	<b>\$1,717.6</b>	<b>\$1,919.6</b>	<b>\$2,097.7</b>
COLORECTAL CANCER			
Met Status	Nov-06 to Oct-07	Nov-07 to Oct-08	Nov-08 to Oct-09
	Annual Cost in \$MM (N=5,844)	Annual Cost in \$MM (N=6,300)	Annual Cost in \$MM (N=5,724)
All Patients	\$3,297.9	\$3,323.6	\$3,039.8
Adjuvant	\$582.4	\$674.9	\$658.4
Met 1st Line	\$930.1	\$905.4	\$870.4
Met 2nd Line	\$676.2	\$595.6	\$498.5
Met 3rd Line +	\$1,036.6	\$1,085.7	\$957.2
<b>Total Met</b>	<b>\$2,642.9</b>	<b>\$2,586.7</b>	<b>\$2,326.1</b>
NON-SMALL-CELL LUNG CANCER			
Met Status	Nov-06 to Oct-07	Nov-07 to Oct-08	Nov-08 to Oct-09
	Annual Cost in \$MM (N=6,369)	Annual Cost in \$MM (N=7,169)	Annual Cost in \$MM (N=6,960)
All Patients	\$1,708.1	\$1,865.3	\$2,163.4
Adjuvant	\$199.9	\$204.2	\$259.6
Met 1st Line	\$548.9	\$609.7	\$752.3
Met 2nd Line	\$488.3	\$519.1	\$553.6
Met 3rd Line +	\$429.1	\$476.5	\$520.6
<b>Total Met</b>	<b>\$1,466.3</b>	<b>\$1,605.3</b>	<b>\$1,826.5</b>

**Table Notes:** (1) Annual cost per IV infusion administration = milligrams for each administration divided by the vial size multiplied by the ASP. (2) Since duration of treatment is a factor in the total cost per patient, only patients who have completed therapy (treatment free for at least 60 days) within the indicated years are part of this analysis.

**Source:** IntrinsiQ

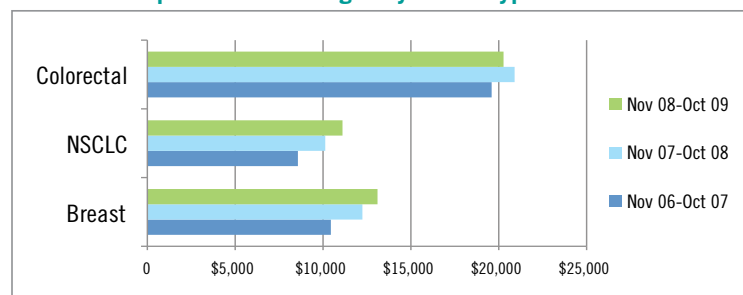
**» INTERPRETING TABLE 5**

In calculating the total cost by tumor type, IntrinsiQ divided milligrams given for each administration by the vial size, rounded up to the whole number to account for wastage, and then aggregated the data to get a total number of vials administered. Vials were then multiplied by the drug's ASP. This assumes that practitioners use the most appropriate size when possible and that there is no batching.

**NOTES:**

- Data represent ASP dollars for anti-cancer drugs, not supportive care or hormonal agents. The data only cover chemo and biologics. IntrinsiQ studied usage numbers on a drug by drug basis and compared them to IMS and/or company reported sales. The numbers do not match perfectly because IntrinsiQ is measuring things at different points in the channel. Its average validation in a 3-month window is consistently in the 5% to 7% range.
- Adjuvant patients are anyone diagnosed with stage I-III and includes any treatment received prior to becoming metastatic, whereas metastatic patients are anyone diagnosed with stage IV plus anyone diagnosed in an earlier stage but the tumor has progressed. (In NSCLC, stage IIIb patients are included in the metastatic group and not the adjuvant group).
- Maintenance therapy is determined by either (a) the doctor indicating that the drug is maintenance therapy or (b) by applying client approved business rules that look at the timing of the use of certain single agent drugs in relation to the previous course of therapy.

**Table 6: Cost per Patient Changes by Tumor Type**



**Table Note:** The total cost for all patients studied is the sum of the dollar values for each of the 12 month periods, ending in October.

**Source:** IntrinsiQ

## Final Analysis

Drug pricing will always be an emotional topic as therapies are a focal point of cancer care, and patient survival and reimbursement of these drugs play a pivotal role in the health of the oncology care system. In recent years, there has been a shift in the products being used to treat cancer. Some of the shift has been driven by new products and manufacturer price increases, and some from physicians who are switching drug combinations to achieve the best possible patient outcomes.

“Going forward, we must bring medicines to market with a deeper understanding of which patients are most likely to respond to them,” says Richard Gaynor, MD, Vice President Oncology, Product Development and Medical Affairs for Eli Lilly. “That information will help prescribers make better treatment decisions, provide patients with the right medicine, based on the specific characteristics of their cancer, and save payers money as physicians avoid prescribing costly therapies that may not be effective in an individual patient.”

Cancer therapeutic pricing has a complex mix of factors hidden behind it, but once on the market the only wiggle room for the manufacturer in terms of correlating price to value is price increases or decreases. Wholesale prices on brand-name prescription drugs increased 9% in 2009, according to an AARP Public Policy Institute report—the highest annual rate of inflation for drug prices since 1992—and despite that, it appears as though the cancer drug segment has gone against this trend. Perhaps this is because of the media attention given to patients with cancer, the increasing skepticism toward the cost of extending life by a few months, or recognition by manufacturers that the buy and bill model means that price increases can have a major impact on utilization. Cost of cancer therapy is being driven by two factors: a high price being set by manufacturers at commercialization; and the accelerated usage of new and more expensive cancer agents in an attempt to deliver the highest quality of cancer care. Seemingly, there is a cost associated with improved outcomes, but how do we stop the trend, and do we want to? **BC**

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