

Payer Reactions to Newly Presented Clinical Trial Results

By Rhonda Greenapple, MSPH

It is becoming increasingly apparent that payers are placing their focus on branded cancer therapies to manage costs. And as a result, some payers are responding to new market entrants with growing controls on utilization. To measure the impact the release of new clinical trial data are having on adoption of coverage decisions, Reimbursement Intelligence conducted a survey with private insurance payers immediately following this year's ASCO annual meeting.

In particular, perspectives on the latest clinical data and requirements for coverage of such drugs as Provenge®, Tarceva®, and Rituxan®, respectively, were explored. Medical and Pharmacy Directors (N=50) who represent the top 50 commercial and Medicare health plans participated in the survey.

For the purposes of this article, formulary evaluation and perspectives on management of key tumor types (prostate, non-small cell lung, and non-Hodgkin's lymphoma, specifically) were considered.

Measureable improvements in overall survival (OS) and progression free survival (PFS) are important when payers evaluate new

clinical data. As shown in Figure 1, when payers were queried what incremental survival benefit would they expect to see for a new drug in order to demonstrate a clinical benefit over the standard of care, over 70% indicated they would want to see a greater than 5-month incremental survival benefit over current standard of care.

Prostate Cancer

In the case of castrate resistant prostate cancer (CRPC), Provenge [sipuleucel-T; Dendreon] has been recently approved by the U.S. Food and Drug Administration for the treatment of asymptomatic or minimally symptomatic metastat-

ic, castrate-resistant (hormone-refractory) prostate cancer. Results of the Phase 3 IMPACT study showed that Provenge extends median survival by 4.1 months.

Dendreon is pricing the immunotherapy at \$31,000 per infusion for a total of \$93,000 for a course of treatment (*Wall Street Journal*, April 29, 2010). Although the majority of payers have not had a formal formulary review for Provenge, respondents indicated they are aware of the cost.

According to the research, payers indicated that they will have utilization restrictions that limit access through prior authorization

Majority of Payers Expect to See a Greater Than 5-Month Incremental Survival Benefit to Demonstrate a Clinical Benefit Over the Standard of Care

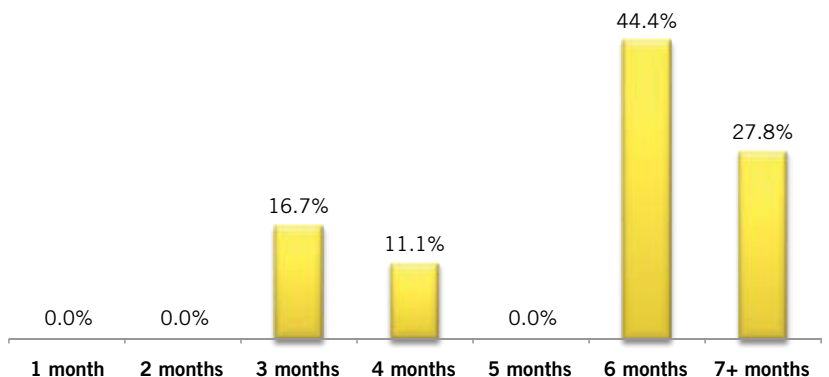


Figure 1. Source: Reimbursement Intelligence

(PA) requirements to ensure appropriate use. Further, as was announced on July 1, CMS has initiated an evaluation process to determine national coverage of Provenge for Medicare patients. Figure 2 illustrates how payers responded when asked, “If you plan to restrict access to Provenge, please specify how you will restrict access.”

Non-Small Cell Lung Cancer (NSCLC)

The integration of patient characteristics such as EGFR mutation, overexpression, and squamous vs. nonsquamous to guide treatment selection and improve outcomes has increased the complexity of NSCLC therapy. According to the survey, over 75% of payers expect the use of combination therapy in the treatment of NSCLC in the next one to two years. NCCN guidelines include the following targeted agents as NSCLC first-line choices in certain patients dependent on patient characteristics:

- » The addition of erlotinib [Tarceva; Genentech/OSI Oncology] as a first-line treatment option for EGFR mutation positive patients with advanced or metastatic disease.
- » Bevacizumab [Avastin; Genentech] and cetuximab [Erbix; Bristol-Myers Squibb/ImClone] have been added as treatment options for continuation maintenance with a category 1 designation.
- » Pemetrexed [Alimta; Eli Lilly & Company] and erlotinib have been added as treatment options for switch maintenance with a category 2B designation and docetaxel [Taxotere; sanofi-aventis, U.S.] has been added with a category 3 designation.

Based on Tarceva’s FDA expanded indication as a maintenance treatment for patients with locally

advanced or metastatic NSCLC whose disease has not progressed after 4 cycles of platinum-based first-line chemotherapy, its use is projected to increase. In the survey, payers were asked, “Has your plan implemented any utilization restrictions for maintenance use of Tarceva?”

Approximately 50% of respondents had no restrictions on maintenance use for Tarceva, and for those respondents who had utilization restrictions, they were related to histology and specific patient segments. In light of limited restrictions for appropriate use, it is unlikely that they will impact market uptake in NSCLC (Fig. 3).

Non-Hodgkin’s Lymphoma (NHL)

In NHL, there are numerous clinical trials evaluating new treatment options with studies comparing traditional chemotherapy i.e., CVP or CHOP with high-dose regimens. Rituxan [rituximab; Roche/Biogen Idec] used in combination with CVP or CHOP is approved by the FDA.

In the relapsed setting, Treanda [bendamustine; Cephalon] is used for patients with indolent B-cell NHL that has progressed during or within 6 months of treatment with rituximab or a rituximab-containing regimen. The NCCN guidelines also include benda- [cont. on pg 32 >>](#)

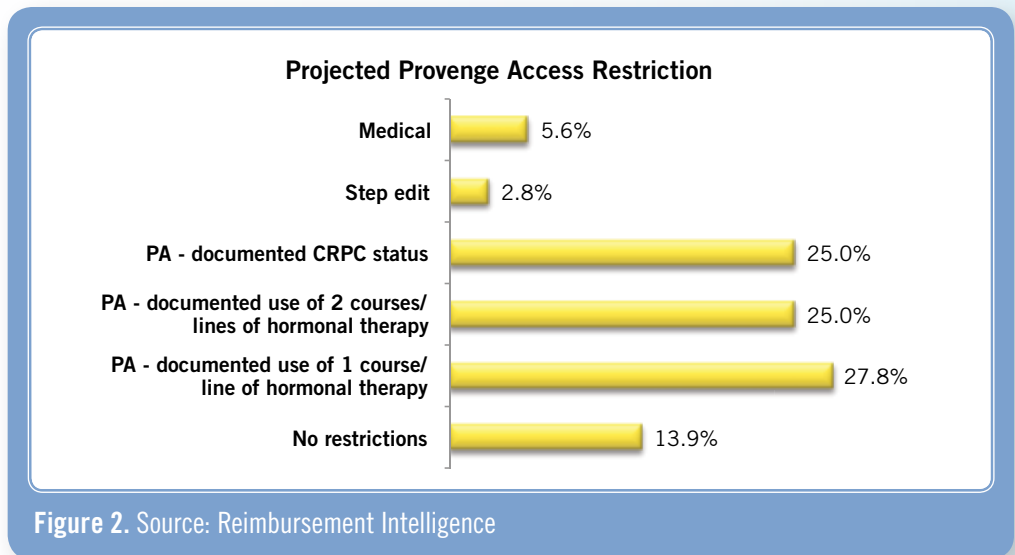


Figure 2. Source: Reimbursement Intelligence

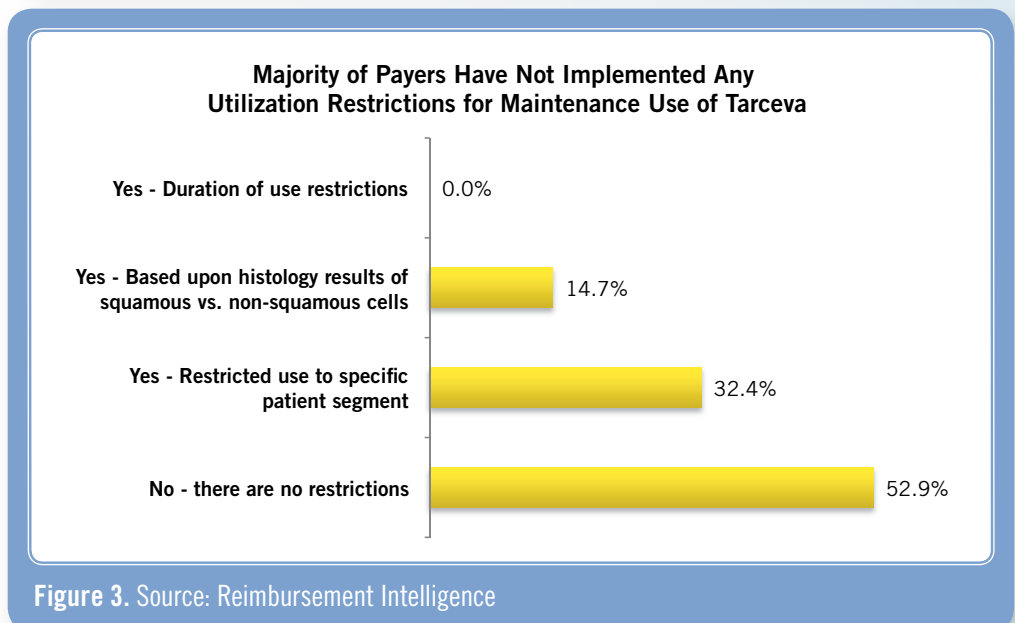


Figure 3. Source: Reimbursement Intelligence

mustine as an option for the second-line therapy for follicular lymphoma (FL) and mantle-cell lymphoma (MCL) with a category 2B designation with or without rituximab.

In two Phase 2 studies evaluating the combination of bendamustine plus rituximab (B-R) in patients with relapsed/refractory indolent or MCL, promising results have been observed (Robinson et al., JCO. 2008:4473-4479; Rummel et al. JCO. 2005:3383-3389). In order to further investigate the role of the combination B-R, Rummel and colleagues initiated a multicenter randomized Phase 3 study to compare efficacy and safety of B-R vs. CHOP plus rituximab (CHOP-R) as first-line therapy for patients with FL, indolent lymphoma, and MCL.

The findings presented at ASH '09 indicated that the bendamustine plus rituximab combination increased PFS and complete response rates, and showed better tolerability as a first-line therapy option for patients with FL, indo-

lent lymphoma, and MCL (Rummel et al. 2009;ASH. Abstract 405).

For payers, this means the bendamustine plus rituximab combination has the potential to become a new standard first-line treatment option for these NHL entities, and paying for two branded therapeutics as first-line therapy is likely to significantly increase the cost of care. Yet, when payers were asked, "Do you perceive the outlined data to offer sufficient rationale for clinicians to use bendamustine plus rituximab as the first-line treatment option instead of CHOP?" almost 70% responded positively and indicated "Yes" (Fig. 4).

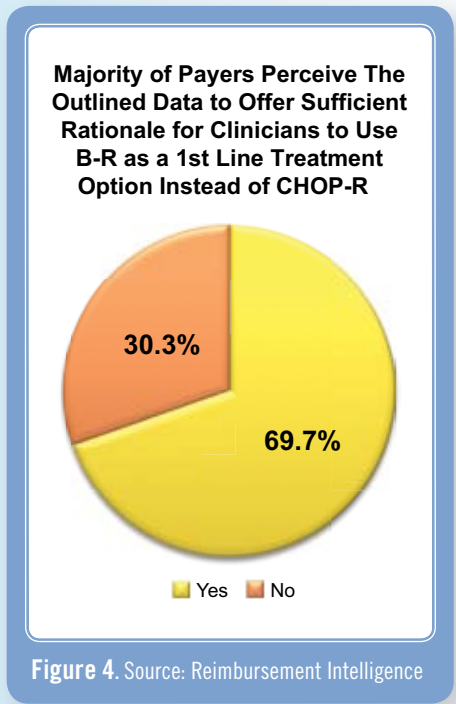
In Summation

According to IMS Health, oncology drugs had sales of more than \$48 billion in 2008, and as the use of branded oncology therapeutics continues to rise, payers will increasingly look for ways to manage oncology pharmacy budgets. In fact, most of the cancer drugs being approved today cost more than \$20,000 for a 12-week course of treatment (Nelson R. Medscape Medical News. May 11, 2010).

It is against this backdrop that oncologists practice evidence-based medicine in an attempt to provide the best therapy for patients while payers must approve coverage for their customers based on the same evidence-based medicine. Undoubtedly, the interpretation of new clinical study results by the oncologist and the payer—and the question of how much those improved months of survival are worth—may create disagreement between oncology stakeholders.

The newly approved health-care reform legislation includes additional funding for comparative effectiveness research, and perhaps that is an indicator of the shifting tide toward economic management of oncology in the future. While once oncology was a "hands off" physician prescribing decision, it appears that payers, both government and private, will play a greater role in determining coverage and prescribing decisions in oncology.

In spite of this pro-active management environment, the results of the survey indicate that new clinical study findings can lead to quick adoption by payers if the outcomes and clinical benefit are robust and indisputable. **RG**



About the Contributor



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The CMS launched a "National Coverage Determination" process to review Provenge's® reimbursement after Medicare contractors indicated they needed guidance on the \$93,000 prostate cancer vaccine. (*Forbes ScienceBiz Blog, 7/1/10*)

U.K health watchdog NICE advised against the use of Herceptin® in metastatic gastric cancer, Afinitor® in advanced kidney cancer and against higher doses of Gleevec® in metastatic gastrointestinal stromal tumors (GISTs) in recent draft and final appraisals. (*The Pink Sheet Daily, 7/7/10*)