Best Practices in Controlling Prescription Drug Costs

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Session Highlights

- Drug Pricing
- Exclusionary Formularies
- Benefit Design
- Prior Authorizations
- Specialty Drugs
- Coalition Pricing and Clinical Review
1 Drug Pricing
Managing the Impact of AWP Increases
Average Wholesale Price (AWP)

- Usually expressed as a discount off of AWP
  - AWP-17% for brands and AWP-82% for generics
- Not an actual market price
- Can be reported by the manufacturer or calculated by the publisher based on a mark-up on wholesale acquisition cost (WAC)

Average Wholesale Price (AWP) is the pricing benchmark used by most payers
Average Wholesale Price (AWP)

- Market price of brand drugs is typically about 16.6% less than AWP
- Market price for older generics can be significantly less than AWP
  - Up to 80% or 90% less than AWP
- As AWP prices increase, the cost of drugs to payors increases
- Manipulation of AWP prices can result in large profits for manufacturers, pharmacies and PBMs
A New Model for Drug Pricing

• The manufacturer of Daraprim
• Used for the treatment of toxoplasmosis and acute malaria
• Prior to the acquisition by Turing, was $13.50 per pill
• After acquisition, price increased to $750 per pill—5,456% increase
Tracking AWP inflation on an ongoing basis will showcase claims that are anomalies and outliers.
Exclusion Example—Glumetza

- In 2015, there were significant AWP increases of Glumetza of over 800%
- Glumetza is a unique oral extended release tab used to prevent and manage hyperglycemia in Type II diabetics
  - There is not a substitutable generic, but Metformin is available as generic with the same clinical effectiveness

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan Cost Estimate</th>
<th>Average Drug Cost per 30 DS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glumetza</td>
<td>$40,448</td>
<td>$3,370.64</td>
</tr>
<tr>
<td>Metformin HCL</td>
<td>$44</td>
<td>$3.70</td>
</tr>
<tr>
<td>Metformin HCL ER</td>
<td>$396</td>
<td>$33.00</td>
</tr>
</tbody>
</table>

*Based on PSG’s Book of Business Utilization Summary – Post-Change (6/19/2015 – 10/26/2015)
Exclusionary Formularies
Explanation and Benefits
Exclusionary Versus Open Formulary

Open Formulary

- All drugs covered
- May have varied tiers for member cost share

Exclusionary Formulary

- Targeted drugs in therapy classes where multiple similar products are not covered
- Creates competitions
- May have varied tiers for member cost share
Exclusionary Formulary

Exclusionary formularies have been gaining in popularity over the past several years

• The competition created by excluding targeted drugs has increased the rebate levels from manufacturers
  – Higher cost in covered drugs offset by rebates

• Most PBMs will offer both open and exclusionary formularies
  – Prefer formularies with exclusions
Exclusionary Formulary

• Experience so far:
  – Many plans have elected to implement
  – Member disruption is generally minimal
    • Typical disruption levels are 2-3% of members or less
  – Typical difference in rebate guarantees with exclusionary formularies offered by PBMs is 25-30%
Exclusionary Formulary

- Considerations before implementation:
  - **Disruption will occur** but is minimal and declines within 120 days after the initial implementation
    - Have your PBM provide a disruption report
  - **The formulary will change** each year:
    - Additional excluded drugs are added while others are reinstated
    - Transfers some control of drug coverage to the PBM
  - **Primary savings is due to increased rebates** however, some contracts between manufacturers & PBM include inflationary caps
    - Due to the lag in rebate payment schedules, the benefit of increased rebates is delayed
Benefit Design
Impact on Utilization and Costs
Establish a reasonable cost share

- Common overall cost share goal is 20%
- On a percentage basis, the cost share is typically higher for inexpensive generics and lower for specialty

Steer members to the most cost-effective delivery channel for mail, retail, specialty, medical

Promote utilization of cost-effective products for brand, generic and specialty
Plan Design: Tiers

- Additional Tiering:
  - 4 and 5 tier plan designs have become more common
  - Feature higher tiers for specialty drugs and an additional tier for higher cost generics

<table>
<thead>
<tr>
<th>Tier</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Low Generics</td>
</tr>
<tr>
<td>2</td>
<td>High Generics</td>
</tr>
<tr>
<td>3</td>
<td>Preferred Brands</td>
</tr>
<tr>
<td>4</td>
<td>Non-Preferred Brands</td>
</tr>
<tr>
<td>5</td>
<td>Specialty</td>
</tr>
</tbody>
</table>
Effective Delivery Channel

Utilize most cost effective delivery channel

• Discounts provided by PBMs are typically better at the mail channel versus retail
  – To recognize increased discounts copays for mail need to be 2.5x the Retail copays for a 90-day supply
  – Consider mandatory mail for all maintenance drugs

• For certain drugs, **pricing through the medical channel can be superior to a specialty pharmacy:**
  – Referral of J Codes to medical claims supervisor and subsequent review of specialty pharmacy pricing revealed lower rates at physician’s office where injections were done. J 7316 Supartz, J 7321 Hyalgan, J 7323 Eufflexxa, J 7324 Orthovisc, J 7325 Synvisc

• Pricing for specialty drugs is typically better **when filled at an exclusive specialty pharmacy** than at retail
  – Consider restriction on access to specialty drugs at retail
Promote the utilization of the most cost-effective products

- In general, generic drugs are less expensive than brands
- **Plans should be achieving Generic Dispensing Rates (GDR) in the mid-80% range**
  - Some plans have achieved GDRs approaching 90%
- To incentivize members to use generic drugs when available, **having a minimum of $20 or 20% difference between brand drugs and generics is necessary**
- "**Member Pays the Difference**" programs require members to pay the difference between the brand and the generic if they choose a brand when a generic is available. These programs promote the use of generic drugs
Prior Authorization
Maximizing Use and Utilization Management
Prior authorization rules are established to prevent the fill of a prescription absent certain criteria:

- Appropriate diagnosis
- Clinical/lab test outcomes
- DNA markers
- Failure of prior courses of treatment (other prescription drugs)
- FDA approval
- Dosage
# Use of PAs in Management of Specialty Drugs

## Ultimate Goal: ENSURE APPROPRIATE USE

<table>
<thead>
<tr>
<th><strong>Intent of Prior Authorization</strong></th>
<th><strong>Drug Examples</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limit off-label use</td>
<td>Oral oncology</td>
</tr>
<tr>
<td>Limit misuse</td>
<td>Growth Hormone, Botox</td>
</tr>
<tr>
<td>Ensure appropriate use of first-line therapies</td>
<td>TNF inhibitors, OA of the knee drugs</td>
</tr>
<tr>
<td>Limit treatment duration</td>
<td>Hep C</td>
</tr>
<tr>
<td>Ensure compliance with nationally recognized treatment guidelines or standards of care</td>
<td>Synagis, Hep C</td>
</tr>
<tr>
<td>Confirm diagnosis through labs or tests</td>
<td>PAH, HAE</td>
</tr>
</tbody>
</table>
Prior Authorization Denials

• **Script for Humira Pen**, four 40 mg doses, 28-day supply for the treatment of Crohn’s Disease
  – **Denied:** “Coverage of Humira (adalimumab) for the treatment of Crohn’s disease is limited to one 40 mg dose every other week.”

• **Script for Praluent SOPN 75.0MG/ML**, 2 doses 28-day supply for treatment of hypercholesterolemia
  – **Denied:** “Continued coverage of Praluent requires documentation of a 50% or greater reduction in LDL-C levels by week eight of therapy. This information was not supplied by your provider for review of this request.”
Questions To Ask . . .

- Are your PAs properly enforced?
- Is it check-the-box or is documentation required?
- Are your current PAs effective?
- Do you receive reporting on PA approvals and denials?
- How often do you require PAs?
How Can I tell if PAs Are Effective?

Review and monitor

- PA activity
  - Number of requests, approvals and denials
  - Monthly, quarterly
- Ensure guidelines
- Ensure proper administration
- Beware of conflicts
- Be diligent
- Consider a PBM consultant or pharmacist to assist in reviewing, monitoring PA activity or recommending PA criteria
Clinical Management Programs

Participate in clinical management programs that make sense for your plan and participants.

- Actively engage your PBM to provide annual evaluations on available programs
- What type of clinical management programs are available that I have not implemented?
- What is the estimated patient disruption for each of these programs?
- What are the projected savings for each of the clinical management programs?
- What are my savings from my current programs?
- Be aggressive: High cost drugs can be eliminated from certain therapeutic classes.
Clinical Management: Stelara Client Example

- Stelara is available in 2 strengths: 45 & 90mg
  - 90mg dose is indicated for patients who weigh > 100kg (220lbs)
  - According to U.S. Census Bureau 23% adult males & 11% adult females weigh > 100kg
- Client example above—49% claims were for 90mg dose
  - Client conducts biometric screenings and has documented weights for all members
  - Based on weights obtained through biometric screening, 43% or 14 patients on 90mg dose weighed < 100kg
  - PBM will notify patients and prescribers they will only be authorized for Stelara 45mg going forward

<table>
<thead>
<tr>
<th>Strength</th>
<th>Members</th>
<th>Claims</th>
<th>Plan Paid</th>
<th>Avg. Cost/ Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>45mg</td>
<td>34</td>
<td>104</td>
<td>$836,937</td>
<td>$8,047</td>
</tr>
<tr>
<td>90mg</td>
<td>32</td>
<td>100</td>
<td>$1,619,524</td>
<td>$16,195</td>
</tr>
</tbody>
</table>

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Coverage and Exclusions of Drugs

• Market change in philosophy to cover everything
• Drugs need to demonstrate value
• Different than formulary exclusions
• Funds are doing this by:
  – Pipeline managing and reviewing drugs prospectively instead of retrospectively
  – Tracking AWP inflation for drugs
  – Assessing “Me Too” Drugs
Certain Specialty drugs have high incidences of discontinuation or dose changes due to significant side effects or lack of efficacy

- Most common with oncology drugs
- Many of these drugs can have discontinuation rates up to 30-40% in the first 3 months
- Dispensing a 30-day supply can lead to waste
Implementing a split fill program for targeted drugs can reduce waste

- Members receive a 15-day supply generally with a pro-rated copay for the first 3 months of therapy.
- Specialty pharmacy will contact the member prior to the scheduled next fill to determine if the therapy has been discontinued, changed or put on hold before sending the next 15-day supply.
- After 3 months, the member can receive a 30-day supply if tolerating and receiving the prescribed drug.
- Must require members to utilize the same specialty pharmacy for all specialty drugs to be effective.
# Client Example: Specialty Split Fill Program

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th># MEMBERS STOPPED AFTER 1 FILL</th>
<th># MEMBERS STOPPED AFTER 2 FILLS</th>
<th># MEMBERS STOPPED AFTER 3 FILLS</th>
<th>POTENTIAL SAVINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GLEEVEC</td>
<td>1</td>
<td>2</td>
<td></td>
<td>$23,430</td>
</tr>
<tr>
<td>IBRANCE</td>
<td></td>
<td></td>
<td>1</td>
<td>$4,942</td>
</tr>
<tr>
<td>IMBRUVICA</td>
<td>1</td>
<td></td>
<td></td>
<td>$3,071</td>
</tr>
<tr>
<td>MEKINI ST</td>
<td></td>
<td>1</td>
<td></td>
<td>$1,279</td>
</tr>
<tr>
<td>NEXAVAR</td>
<td>1</td>
<td></td>
<td>1</td>
<td>$12,219</td>
</tr>
<tr>
<td>POMALYST</td>
<td></td>
<td></td>
<td>1</td>
<td>$5,970</td>
</tr>
<tr>
<td>REVLI MID</td>
<td>2</td>
<td>1</td>
<td></td>
<td>$19,967</td>
</tr>
<tr>
<td>SPRYCEL</td>
<td>1</td>
<td></td>
<td>1</td>
<td>$10,254</td>
</tr>
<tr>
<td>SUTENT</td>
<td></td>
<td>2</td>
<td></td>
<td>$6,413</td>
</tr>
<tr>
<td>TEMOZOLOMIDE</td>
<td>1</td>
<td></td>
<td>1</td>
<td>$5,774</td>
</tr>
<tr>
<td>VOTRI ENT</td>
<td>2</td>
<td></td>
<td></td>
<td>$7,661</td>
</tr>
<tr>
<td>ZYKADIA</td>
<td></td>
<td></td>
<td>1</td>
<td>$6,855</td>
</tr>
<tr>
<td>TOTAL, ALL PRODUCTS</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>$107,836</td>
</tr>
</tbody>
</table>

- Data from a single large employer client case study.
- Savings assume that ½ of the last fill would not be dispensed under the split fill program, and thereby ½ the cost would be avoided (15 days of therapy for most claims).
Utilization Management Strategies for Specialty Drugs

Must manage both utilization and cost

1. Use preferred specialty pharmacy
   - Eliminate first fills at retail—require dispensing of specialty drug from specialty pharmacy once specialty drug is prescribed
   - Maximize contracted rates specific to each drug
   - Set reasonable default contract rate for newly approved specialty drugs and minimum timeframe to establish a contracted rate

2. Select preferred therapies in therapeutic classes with sufficient specialty drug therapy options
   - Maximize manufacturer rebates for preferred products
   - Utilize specialty pharmacy for patient and provider communication for pull through to maximize rebate contracts
Utilization Management Strategies for Specialty Drugs

Must manage both utilization and cost *(continued)*

3. Limit dispense quantity to max 30-day supply, consider split-fill for therapeutic categories such as oral oncology
   - Require patient outreach to confirm patient needs drug, ensure there are not side effects or any issues/concerns and that patient is supposed to continue on therapy, before specialty drugs are dispensed

4. Ensure appropriate use through evidence-based prior auth policies as well as quantity limits
   - Require collection of documentation for criteria requirements
   - Limit duration of auth to allow for assessment that patient’s condition is benefiting from drug therapy
   - Implement quantity limits based on FDA approved dosing and package sizes
5

Specialty Drugs
Managing Delivery Channels
Site of Care Considerations
Why Manage Specialty Drugs?

- **HIGH COST**
  - Average cost $4,500/month
  - Increasing trend continues

- **UTILIZATION**
  - Small number members driving large percentage of costs

- **PIPELINE**
  - Robust pipeline continues to represent significant advances in treatment
Medical Versus Pharmacy Benefit

- Nearly half of benefit spending is within the medical benefit
- Traditional PBM utilization management strategies are no longer enough to manage spend

Plan sponsors must consider proactive strategies to manage pharmacy spend across both the pharmacy and medical benefits.

Source: EMD Serono Special Digest, 12th Edition
## Specialty Drugs—Benefit Differences

<table>
<thead>
<tr>
<th>Component</th>
<th>Pharmacy</th>
<th>Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjudication</td>
<td>Real-time</td>
<td>Delayed</td>
</tr>
<tr>
<td>Drug Code</td>
<td>NDC</td>
<td>J code, etc.</td>
</tr>
<tr>
<td>Pricing Source</td>
<td>AWP</td>
<td>ASP, billed charges</td>
</tr>
<tr>
<td>Pricing Variability</td>
<td>Minimal</td>
<td>High</td>
</tr>
<tr>
<td>Other Fees</td>
<td>None</td>
<td>Admin, Facility</td>
</tr>
<tr>
<td>Typical Cost-Share</td>
<td>Copay</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>Clinical Policies</td>
<td>Many</td>
<td>Fewer</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>Specialty Pharmacy</td>
<td>MD-dependent</td>
</tr>
</tbody>
</table>
## Drug Pricing By Channel

<table>
<thead>
<tr>
<th>Drug</th>
<th>Primary Use</th>
<th>Pharmacy</th>
<th>MD Office</th>
<th>Outpatient Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remicade 10mg</td>
<td>Arthritis</td>
<td>$8.38</td>
<td>$7.90</td>
<td>$11.99</td>
</tr>
<tr>
<td>Neulasta</td>
<td>Neutropenia</td>
<td>$3,842</td>
<td>$3,983</td>
<td>$5,817</td>
</tr>
<tr>
<td>Rituxan</td>
<td>Cancer</td>
<td>$7.20</td>
<td>$6.42</td>
<td>$10.66</td>
</tr>
<tr>
<td>Herceptin</td>
<td>Cancer</td>
<td>$8.71</td>
<td>$7.45</td>
<td>$13.02</td>
</tr>
<tr>
<td>Tysabri</td>
<td>MS</td>
<td>$4,126</td>
<td>$3,901</td>
<td>$6,390</td>
</tr>
<tr>
<td>Sandostatin</td>
<td>Cancer</td>
<td>$139</td>
<td>$116</td>
<td>$229</td>
</tr>
</tbody>
</table>

Pharmacy is typically a HIGHER price than the physician office.
Site of Care Management: Overview

- Site of care management focuses on redirecting specialty patients to the lowest cost and most clinically appropriate location for their infusions.
- These programs are typically voluntary for the patient and/or physicians.
- For most plan sponsors, site of care represents the single biggest savings opportunity across specialty drug management.
Site of Care Challenges

- Costs vary between site of care
- Utilization is moving to more expensive sites of care
- Patient convenience is not the same by site of care
- Clinical outcomes can be different by site of care
- Pricing transparency is challenging to find

All of these challenges can result in higher cost without improved clinical outcomes
Savings Opportunity From Site of Care Management

- Average annual savings per patient is $25,000
- Savings represents 12-25% of total medical specialty drug spend, depending on whether oncology drugs are included
- Savings total $25-$50 PMPY across all the entire membership

<table>
<thead>
<tr>
<th>Lives</th>
<th>Number of Patients</th>
<th>Annual Savings Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,000</td>
<td>1</td>
<td>$25,000</td>
</tr>
<tr>
<td>10,000</td>
<td>10</td>
<td>$250,000</td>
</tr>
<tr>
<td>100,000</td>
<td>100</td>
<td>$2,500,000</td>
</tr>
</tbody>
</table>

Site of care management is typically the single biggest savings opportunity
Site of Care Management

Conversion Rates vs. Incentive Amount

- 100%
- 75-100% (Mandatory)
- 50-70%
- 25-40%
- 15-20% (No Incentive)

H13-41
Site of Care Program Details

Target Drugs
- Remicade
- Neulasta
- Prolia
- Rituxan
- Lovenox
- Immunoglobulin
- Hemophilia Factor
- Select Chemotherapy

Patient Attributes
- Candidate for home infusion
- Stable on therapy (for voluntary program)

Savings Criteria
- Threshold of $5,000 or more annually is typical
Plan sponsors should evaluate their savings opportunity available through the sites of care and implement a voluntary program to optimize pricing.
Alliance Pricing and Clinical Review
Alliance Pricing: Bigger Is Better

- Seek opportunities for growth in numbers beyond recruiting new members
  - International labor organizations
  - State or regional labor coalitions
  - Employer coalitions

- Partner with a PBM consultant to engage in the RFP process, contacting, market checks, monitoring of PBM guarantees including pricing, rebates and services.
Clinical Review

• Professional, timely and non-biased clinical review is an essential tool in managing and maintaining an effective and cost-conscience benefit plan design

• Seek opportunities for clinical review and development of coverage rules outside the traditional PBM environment if possible
Clinical Review

• January 1 2013, the United Brotherhood of Carpenters International Union in conjunction with plan sponsors, Pharmaceutical Strategies Group and fund administrators, launched the UBC Clinical Advisory Committee (CAC).

• The Committee members include independent physicians and pharmacists. Fund administrators of the UBC Steering Committee are able to participate in the quarterly CAC meetings.
<table>
<thead>
<tr>
<th>Drug Name/Class</th>
<th>Recommendation</th>
<th>Potential Savings</th>
<th>Additional Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetracycline Agents</td>
<td>Do not cover branded medications in this category; generics only</td>
<td>$93,828</td>
<td></td>
</tr>
<tr>
<td>Topical acne/antibiotic combinations and benzoyl peroxide combinations</td>
<td>Do not cover branded medications in this category; generics only</td>
<td>$107,366</td>
<td></td>
</tr>
<tr>
<td>Topical antifungal class</td>
<td>Do not cover branded medications in this category; generics only</td>
<td>$251,724</td>
<td></td>
</tr>
<tr>
<td>Proton pump inhibitors</td>
<td>Do not cover branded medications or generic equivalent of Nexium</td>
<td>$1,090,778</td>
<td>Generic Nexium priced higher than brand</td>
</tr>
<tr>
<td>Natpara (parathyroid hormone)</td>
<td>Do not cover</td>
<td>N/A</td>
<td>Drug rushed through FDA and skipped Cardiac Advisory Panel Review. No statistical evidence to support efficacy at this time.</td>
</tr>
<tr>
<td>Spiritam</td>
<td>Do not cover</td>
<td>N/A</td>
<td>Multiple generic formulations of this drug readily available.</td>
</tr>
<tr>
<td>Tuzistra XR</td>
<td>Do not cover</td>
<td>N/A</td>
<td>Multiple generic formulations for cough/cold available with codeine today.</td>
</tr>
<tr>
<td>Farydak</td>
<td>Do not cover</td>
<td>N/A</td>
<td>Committee will continue to monitor. 8% of trial patients died and 36% discontinued therapy due to adverse reactions.</td>
</tr>
</tbody>
</table>
Session #H13

Best Practices in Controlling Prescription Drug Costs

• Promote use of safe, effective, low-cost medications.
• Steer utilization to the most cost-effective delivery channel.
• Manage specialty drug spend with split fill program, preferred specialty pharmacy, preferred products by specialty class, and rigorous prior authorization rules.
• Consider site of care management.
• Partner with other funds or entities to leverage negotiating power.
• Engage a PBM consultant, physician or pharmacist for clinical review program.

Website Resources

62nd Annual Employee Benefits Conference
November 13-16, 2016
Orlando, Florida
2017 Educational Programs
Health and Welfare

63rd Annual Employee Benefits Conference
October 22-25, 2017
Las Vegas, Nevada
www.ifebp.org/usannual

Certificate Series
February 27-March 4, 2017
Lake Buena Vista (Orlando), Florida

July 24-29, 2017
Denver, Colorado
www.ifebp.org/certificateseries

Health Care Management Conference
May 1-3, 2017
New Orleans, Louisiana
www.ifebp.org/healthcare

Certificate of Achievement in Public Plan Policy (CAPPP®)
Part I and Part II, June 13-16, 2017
San Jose, California
Part II Only, October 21-22, 2017
Las Vegas, Nevada
www.ifebp.org/cappp

Related Reading
Visit one of the on-site Bookstore locations or see www.ifebp.org/bookstore for more books.

Self-Funding Health Benefit Plans
Item #7563
www.ifebp.org/SelfFunding