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Rx newsletter

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Market trends

A population health approach to diabetes costs

Diabetes is the most expensive chronic condition in the U.S.

34 million Americans—just over 1 in 10—have diabetes. $1 out of every $4 in U.S. health care costs is spent on caring for people with diabetes. According to the Centers for Disease Control, $237 billion is spent each year on direct medical costs and another $90 billion is lost to reduced productivity totaling $327 billion as the total annual cost of diabetes. The total economic cost of diabetes rose 60% from 2007 to 2017.

Given the strong prevalence and devastating economic impact of diabetes as a disease, it is considered an epidemic. Diabetes is a chronic disease behind global healthcare challenges, which highlights the need for population health management. Through population health management, providers and healthcare organizations may have the ability to improve quality of life and reduce the cost of diabetes care.

What is population health?

Population health is defined as "the health outcomes of a group of individuals, including the distribution of health outcomes within the group."[1] It is determined through multiple factors beyond clinical care, including, but not limited to social determinants. Because population health is person-centered, data can be leveraged to implement solutions based on each person's risk status. This facilitates the development of risk-level-appropriate clinical and psychosocial management pathways and interventions.

How a population health approach can drive cost savings in diabetes management

There is a range of personal, economic, environmental, and social factors that affect diabetes health outcomes and this data can be used as a tool to drive cost savings. For example, data can be leveraged to stratify risk levels allowing the allocation of resources to those most in need.

A local hospital system in North Carolina collaborated with a health insurer to implement a population health program geared towards diabetes costs. A population health approach to diabetes emphasizes elements like being proactive instead of reactive, a value-based care system, paying for quality rather than paying for volume, and stratifying populations by risk.

The program showed how pharmacists can use data to enhance value-based care efforts; according to a case study presented at AMCP Nexus 2021.[2] Through analytical reports, pharmacists were able to translate data into savings through strategies like identifying opportunities to move patients to more affordable, clinically equivalent medications; prescribing more affordable and effective combination therapies; and implementing real-time benefit checks. The program found $36,800 in savings by transitioning to a more affordable, clinically equivalent alternative medication. The initial savings projection of $64,509 shows there are still opportunities to implement further education and real-time benefits checks.

Sources:

1. Kindig, D, Stoddart, G. What is population health? Am J Public Health. 2003;93(3):380-383 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447747/

2. "Population Health Drives Cost Savings in Diabetes", Pharmacy Practice News, accessed February 22, 2022, https://www.pharmacypracticenews.com/Operations-Management/Article/01-22/Population-Health-Drives-Cost-Savings-in-Diabetes/65881

Pharmacy 101

Dispense as written (DAW)

What are DAW codes and why are they so important?

As the pharmacy benefit continues to rise in cost, the need to help drive utilization has become more evident. While there are multiple levers a plan can use to decrease spend, one of the easiest is pushing for high generic utilization.

DAW programs

Since dispensing a generic is almost always the more affordable option for a plan, some plans use dispense as written penalties to steer members toward lower cost generic drugs.

These programs are designed to incentivize members to select generic equivalents when available. If the member chooses to stay on the brand product when a generic is available, then the member is responsible for the difference in cost between the brand and the generic.

If the member chooses the generic, then there is no cost share impact to the member. In either case, the plan is only responsible for the net cost of the generic. These programs can generate some noise as members become accustomed to the brand option.

The program can be administered a few ways. First, DAW 2 only option is where a member/patient requests the brand, but the prescriber has said generic substitution is acceptable. In this scenario, the member pays their brand copay and the remaining amount between the cost of the generic and the brand. There is also the DAW 1, where the prescriber requests the brand. In this version, even if the prescriber requests the brand the penalty is still in place. In general, most PBMs recommend both DAW programs to fully maximize the generic opportunity.

In addition to paying the penalty, it is important to add one more layer to the program. Most PBMs recommend that the amount paid towards the penalty does not apply towards the deductible or out-of-pocket limits. This prevents the member from hitting their deductible or out-of-pocket maximum on dollars spent outside of the plan design. For example:

- Name brand Lipitor costs $460 and the generic costs $10 after the contracted discount.
- The member pays a higher non-preferred brand drug copay of $40, plus the difference between $460 and $10, which is $450.
- The total cost to the member to receive the Lipitor prescription would be $490.
- Only the $40 from the copay applies to the out-of-pocket maximum.

DAW penalty outcomes

Generic Dispense Rate (GDR), which is the number of generics processed in comparison to the total number of claims, is often used to determine the success of a DAW Penalty program. Industry norms have shown that for every percentage point the Generic Dispense Rate increases, the plan spend will typically decrease by the same amount.

Contact your account team if you are interested in hearing more about DAW penalty programs.

Disease spotlight

Alzheimer's in America

According to the CDC, in 2020, as many as 5.8 million Americans were living with Alzheimer's disease.

With the near constant advances in medicine most diseases are seeing gradually decreasing death rates. Prime examples are conditions such as heart disease, cancer, and HIV/AIDS. However, this is not the case with Alzheimer's.

What is Alzheimer's disease?

The CDC states Alzheimer's is the most common type of dementia, and a "progressive disease, beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment".

While the disease itself is not lethal in the same way a heart attack can be, the side effects are what typically drive Alzheimer's-related fatalities. Worryingly, the amount of people with Alzheimer's is increasing at a steady pace.

- The number of people living with Alzheimer's disease ***doubles*** every five years beyond age 65.

As the disease's symptoms start to notably impact the afflicted person's daily life, the need for a part-time or full-time caregiver becomes apparent.

- In 2018, 1 in 5 adults were reported as being caregivers in a non-career capacity.

Treatments, cures, and costs

As of 2020, the costs of treating Alzheimer's in the United States is estimated to fall between $215 billion and $379 billion. While the age of the afflicted is predominantly over 65 years or older, the costs of treatment is not isolated to Medicare and Medicaid alone.

As older Americans remain in the workforce, the necessary treatment and their costs becomes more of a focus for employers.

- While there are various drugs to treat the symptoms of Alzheimer's, only one has been approved to treat the underlying biology of the disease.
- Aduhelm, which received accelerated approval from the FDA in June of 2016 originally announced a price point of $56K.
  - After public backlash, Biogen reduced the price to $28K.

As the U.S. pharmaceutical giants continue to roll out new drugs with wider clinical reach, employers will continue to receive pressure to cover these drugs regardless of their cost, and in some cases, their efficacy. While the future of medicine is bright, the bill is equally high.

Clinical spotlight

mRNA vaccines enter the fight versus HIV

What are mRNA vaccines and how do they work?

Vaccines help prepare the body to fight foreign bacteria, viruses or pathogens to prevent infection. Most contain a weakened or dead bacteria/virus to trigger an immune response. Scientists have now developed a new type of vaccine using a molecule called messenger RNA (mRNA for short). mRNA is a type of ribonucleic acid (RNA) necessary for protein production, which uses the information in genes to create a blueprint for making proteins.

mRNA vaccines work by introducing a small piece of mRNA that corresponds to a viral protein. Using the mRNA as a blueprint, cells produce the viral protein. During a normal immune response the protein is seen as foreign, triggering the production of antibodies, which are specialized proteins that recognize and mark foreign entities for destruction. (The mRNA vaccine does not expose individuals to the virus itself, nor can they become infected by the vaccine.)

Are mRNA vaccines new?

No. While this technology became famous during the COVID-19 pandemic, mRNA vaccines have been worked with for decades; and previously studied for the flu, Zika, rabies, and cytomegalovirus (CMV). Since these vaccines are developed in a lab with readily available materials, they can be developed and produced in large quantities faster than other methods.

Clinical trials for mRNA HIV vaccine

In January of 2022, Moderna announced it has launched early-stage clinical trials of an HIV mRNA vaccine. Almost 38 million people worldwide, including roughly 1.3 million in the U.S., are living with HIV. HIV, or human immunodeficiency virus, can lead to the potentially fatal disease AIDS. While HIV is more manageable in recent years with new medications, no vaccine has ever been developed.

Researchers developed a primary vaccine and a booster that delivers molecules that elicit an immune response, called HIV immunogens. The hope is this process will induce B cells, a specific type of white blood cell, to turn into broadly neutralizing antibodies to neutralize the virus.

Phase I of the trial began at George Washington University and includes three other locations: the Hope Clinic of Emory Vaccine Center in Atlanta, the Fred Hutchinson Cancer Research Center in Seattle, and the University of Texas-Health Science Center at San Antonio.

Of the 56 healthy HIV-negative adults at each site, 48 will receive one or two doses of the mRNA vaccine, and 32 also will receive the booster. The remaining eight will receive only the booster. Following their last dose, participants will be monitored for six months.

Sources:

1. "Moderna launches clinical trial for HIV vaccine that uses mRNA technology," ABC News, accessed February 18, 2022, https://abcnews.go.com/Health/moderna-launches-clinical-trial-hiv-vaccine-mrna-technology/story?id=82510807

2. "What are mRNA vaccines and how do they work?" MedlinePlus, accessed February 18, 2022, https://medlineplus.gov/genetics/understanding/therapy/mrnavaccines

3. "Understanding mRNA COVID-19 Vaccines?" Center for Disease Control and Prevention, accessed February 18, 2022, https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html.

Pipeline

Pending drug approvals

Drug name	Manufacturer	Indication/use	Expected FDA decision date
sintilimab	Eli Lilly	Nonsquamous non-small cell lung cancer (NSCLC)	March 2022
ganaxolone	Marinus	CDKL5 deficiency disorder-related seizures	3/18/2022
ublituximab	TG Therapeutics	CLL/SLL (in combination with umbralisib)	3/25/2022
axicabtagene ciloleucel (Yescarta®)	Gilead	Large B cell lymphoma (R/R, 2nd-line)	4/1/2022
vutrisiran	Alnylam	Polyneuropathy of hereditary transthyretin-mediated amyloidosis	4/14/2022
ruxolitinib (Opzelura™)	Incyte	Vitiligo	4/18/2022
tisagenlecleucel-t (Kymriah®)	Novartis	Follicular lymphoma (R/R, 3rd-line)	4/27/2022
edaravone	Mitsubishi Tanabe	ALS	5/12/2022
cantharidin	Verrica	Molluscum contagiosum	5/24/2022
tapinarof cream	Roviant	plaque psoriasis (PSO)	5/26/2022
spesolimab	Boehringer Ingelheim	Psoriasis (pustular flares)	6/1/2022
tebipenem pivoxil hydrobromide (HBr)	Spero	Complicated urinary tract infection (cUTI)	6/27/2022
tauroursodeo-xycholic acid/sodium phenylbutyrate	Amylyx	ALS	6/29/2022

Brands losing patent

While these drugs are nearing the end of their patent term, the release of generics may be delayed due to litigation or exclusivities.

Brand name	Generic name	Indication/use	Date generic available
Cholbam	cholic acid	Adjunctive treatment of peroxisomal disorders (PDs)	Mar 2022
Vimpat	lacosamide	Osteoarthritis, Rheumatoid Arthritis and Ankylosing Spondylitis	Mar 2022
Jatenzo	testosterone undecanoate	Hypogonadism	Mar 2022
Spiriva	tiotropium bromide	COPD	April 2022
Zoladex	goserelin acetate	Prostatic carcinoma, endometriosis	April 2022
Combigan	brimonidine tartrate; timolol maleate	Open-angle glaucoma	April 2022
Ionsys	fentanyl hydrochloride	Short-term management of acute postoperative pain	April 2022
Fragmin	dalteparin sodium	Venous thromboembolism (VTE)	May 2022
Alimta	pemetrexed disodium	Non-squamous non-small cell lung cancer	May 2022
Yosprala	aspirin; omeprazole	Secondary prevention of cardiovascular and cerebrovascular events	May 2022

For more information about Rx and other solutions from MMA, visit www.mmaeast.com, or contact your local representative.

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