Report on the 9th Annual Conference of The Pharmacy & Therapeutics Society

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The Promise of Comparative-Effectiveness Research

Rising healthcare costs, lack of standardized practice and variation in practice by geographic area (including failure to follow clinical guidelines), patient nonadherence, and continued perceptions of poor value for the money that is spent continue to plague healthcare performance, according to Joshua S. Benner, PharmD, ScD, Engelberg Center for Health Care Reform, The Brookings Institution.

He believes that comparative-effectiveness research (CER) will significantly improve healthcare performance by solidifying our knowledge of what clinical interventions work best. The Obama administration also has placed its hopes on CER, betting $1.1 billion in its economic stimulus bill that it can improve healthcare performance.

Dr. Benner believes that efficient use of CER is a "game changer." He would like to see the proliferation of CER supported through a new entity that independently allocates CER funding, with a focus on the areas of care that need it most (ie, those where practice outcomes are uncertain). Importantly, Dr. Benner emphasized the need to implement liability protections for providers who adhere to treatment guidelines supported by CER information.

Comparative-effectiveness research does not represent the "research as usual" mentality. "If CER is going to make a difference in your health system and nationally, what we study has to reflect the most important clinical and policy decisions," Dr. Benner said. It must address critical care questions, using real-world settings. The results must apply "to the patient in front of me," he commented. "The most critical question perhaps is how to translate and disseminate the CER evidence available today, from organizations like the Agency for Healthcare Research and Quality, to specific policy decision makers (such as members of the P&T Society) in a way that they will use it." Decision makers also will need incentives for its use.

He concluded that CER done right "will help P&T committees improve outcomes and control costs."

The REMS Factor

The US Food and Drug Administration (FDA), in its efforts to speed the medication approval process, has sought to balance the need for speed and the need to adequately ensure public safety with relatively few data. Congress gave some support to the FDA options in late September 2007 when it passed the Food and Drug Administration Amendments Act, which expanded the agency's power to require postmarketing studies and clinical trials. Dean Erhardt, MBA, principal, D2 Pharma Consulting, reported that a key piece of the act requires compliance with the FDA's new Risk Evaluation and Mitigation Strategy (REMS), which can affect all those who make decisions about coverage.

One of the most important points when considering REMS is that "any new product [drug or biologic] seeking approval must submit a REMS at the time of filing a new drug application, abbreviated new drug application, or biologic license application, if the FDA deems appropriate during its clinical development," according to Mr. Erhardt.

If a branded product is approved contingent to a REMS program, Mr. Erhardt pointed out, once that product goes off patent, the generic agent also will have to meet the REMS requirements associated with the original product. At the conference he presented a paper called "Risk Evaluation Mitigation Strategy Initiatives: Evaluating Safety" in which he named the elements needed to ensure safe use of drugs in REMS programs:

Provider requirements

- Healthcare providers who prescribe the drug have specialized training and experience and/or are specially "certified."

Channel requirements

- Pharmacies, practitioners, or healthcare settings that dispense are specially certified.
- Distribution is restricted in certain healthcare settings (perhaps 1-2 specialty pharmacies in some cases).

Patient requirements

- Drug may be dispensed to patients with evidence or other documentation of safe use conditions (eg, laboratory test results).
- Patients using the drug are subject to certain monitoring.
- Patients using the drug are enrolled in a registry.

Mr. Erhardt stated that REMS can truly influence the formulary process. "If a product doesn't have a REMS requirement," he believes, "it may be placed on a lower formulary tier, just because it is less complicated to utilize." The REMS also can change the classic dynamic of generic drug pricing relative to that of branded products—a REMS requirement for a generic drug may raise the price of the agent, narrowing the price difference between that and the branded version.

Pipeline Perspectives

According to figures from the Pharmaceutical Research and Manufacturers of America, the number of products in the pharmaceutical pipeline doubled to 3000 from 1997 to 2007, and that number is still increasing. Products to treat cancer lead the way, with roughly 850 compounds in development, according to Raulo S. Frear, PharmD, director, pharmacy services, The Regence Group, followed by products to treat neurologic disorders and infectious diseases. Products to treat cancer also top the list of investigational specialty agents.

"For years, the cost to develop 1 new drug was quoted to be approximately $800 million," said Dr. Frear, "but it is now reported to be up to $1.3 billion. For every 1000 compounds evaluated in phase 1, one reaches the approval process. This calls into question some of the ROI [return on investment] in the pipeline," he said.

Based on an analysis by his organization, the actual value of the agents being approved by the FDA may be questioned. They found that from 2004 to 2008, the vast majority of FDA approvals were for products deemed to improve convenience of dosing or added "no additional value."

Personalized Care and Practice Guidelines

Oncology practice may represent today's leading edge in the front lines of "personalized care." Personalized care represents many challenges for oncology, according to Phil Johnson, MS, RPh, director of pharmacy at H. Lee Moffitt Cancer Center & Research Institute, in terms of practice guideline development and use, but the oncology community may be up to the task.

Mr. Johnson noted that the use of clinical guidelines is proving to have multiple major benefits. "They promote the use of proven treatments, they serve as a basis for evaluation and comparative-effectiveness research, they serve as a practitioner education tool, and they facilitate patient education," he said. In addition, financial benefits accrue from the use of guidelines—they help executives prospectively budget the resources necessary to treat the expected number of patients with certain disorders. They help in managed care contracting, and guideline utilization can reduce the number of denied claims and improve rates of treatment preauthorization. Further, guideline use may provide a "protected harbor" from litigation. According to the National Comprehensive Cancer Network, the largest new requestors of the organization's practice protocols are attorneys.

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The reason that oncology is one of the first areas to explore personalized care is that cancer is such an individualized disease. "Cancer comprises at least 130 different diseases," said Mr. Johnson. "Five hundred known genes are possibly related to cancer, but at least 40 may be implicated in any one type [and whether any 1 gene is switched on or off]."

For the oncologist interested in genomic-based treatment plans, "we need to consider genomic expression, cancer pathology, and staging, in addition to whether the patient will undergo curative or palliative treatment (and of which type)," according to Mr. Johnson.

These considerations imply a much greater focus on diagnostic technology than is seen today. The FDA does not currently scrutinize or regulate diagnostics as carefully as it does pharmaceuticals. If personalized medicine in cancer is to advance significantly, Mr. Johnson suggested, this will have to change.

Who will pay for these specific tests and subsequent drug treatment? "In some cases, it will cost more to develop the gene test than to develop the drug based on the findings," he believes.

Closing General Session—Political Prospects for Health Reform

Of the prospects for health reform, Dean Rosen, partner, Mehlman, Vogel, Castagnetti, Inc., said, "It's hard to figure out which way we're going, but we're getting there fast!"

What is slowing the legislative process for passing health reform is the administration's condition that any provisions must be fully paid for over the 10-year federal

budget window. "This means that it is awfully hard to pass legislation—there are not a lot of places to get the money," stated Mr. Rosen. Cuts to Medicare, cuts to subsidies for Medicare Advantage, increased taxes on "Cadillac plans," and rebates from pharma industry are the basic possible sources, but in each case "somebody takes a hit—the problem is that somebody is often a Democrat now," he said.

What is expected, however, is that a consensus bill will be on President Obama's desk for signature before the State of the Union address in late January. ajpb

The above are select session highlights from The Pharmacy & Therapeutics Society's 9th Annual Conference. For a complete listing of all the educational sessions presented at the conference, please visit the Society Web site at www.pandtsociety.org. You also may contact the Society at 860.657.3207.