Acuerdos de acceso gerenciados (MEAs)

Mirada de una compañía farmacéutica

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Novartis Argentina

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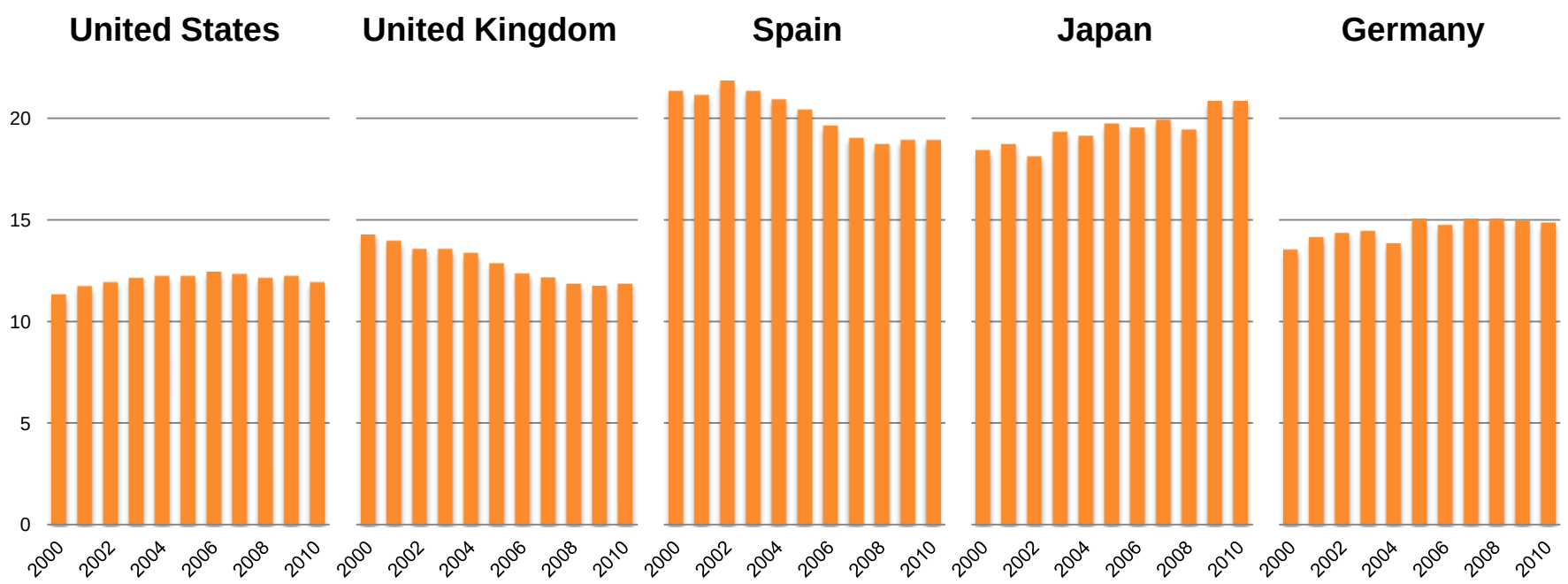
Los medicamentos atraen una atención desproporcionada

Gasto total farmacéutico como % del gasto total en salud (2000-2010)



Parece haber más foco en los costos farmacéuticos que en determinantes mayores del costo como costos de internaciones y servicios profesionales.

Source: OECD Health Data 2012 http://stats.oecd.org/Index.aspx?DataSetCode=SHA

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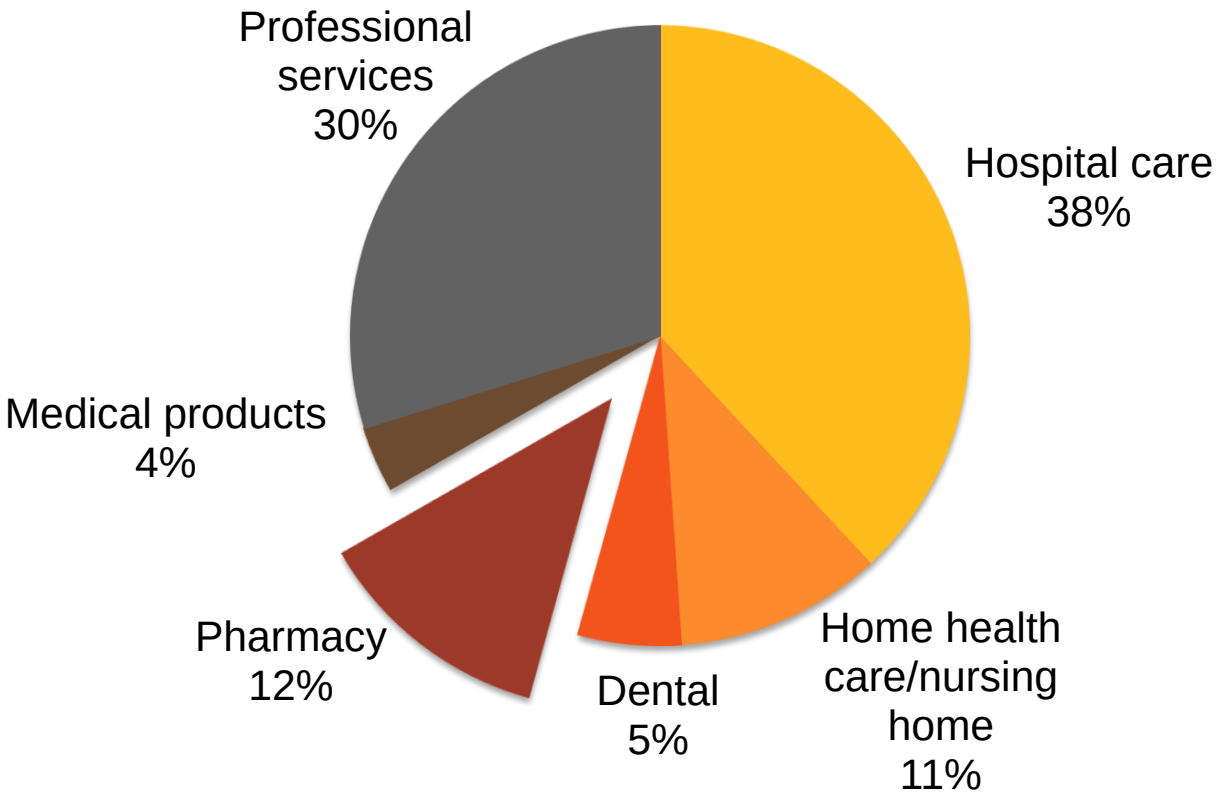
Pero es verdad que son la parte más “gerenciable”

US healthcare spend by category, 2008



Source: Centers for Medicare & Medicaid Services,

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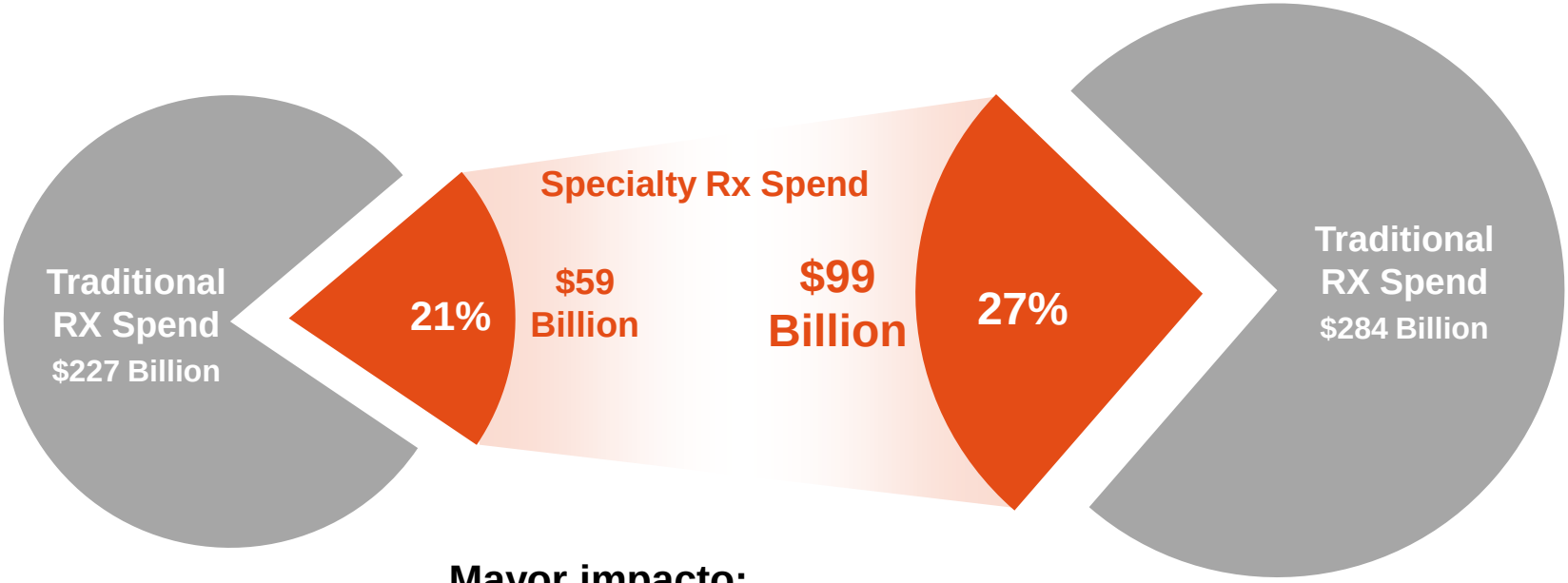
El crecimiento proyectado en productos de alto costo también aumenta el foco sobre el gasto farmacéutico

2007
Total Spend $286 Billion

2011
Total Spend $383 Billion



Mayor impacto:

- **Nuevos productos**
- **Nuevas indicaciones**
- **Expansion a enfermedades crónicas**

Sources: CMS National Healthcare Expenditure Projection: 2003-2013

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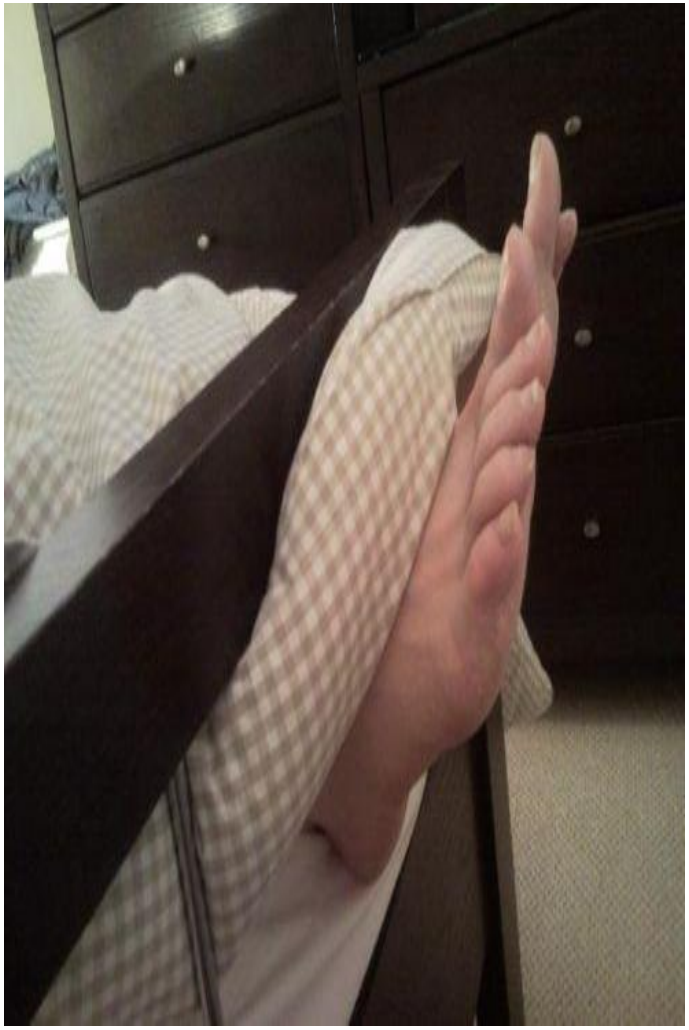
La “manta corta regulatoria” es aplicable al reembolso



Drug Approvals and Deadly Delays

For example, consider FDA's incredibly long delay in approving beta-blockers to reduce the risk of second heart attacks. By the mid-1970s this had been documented in clinical trials, and a number of beta-blockers were approved for this use in Europe. But in the U.S., FDA imposed a moratorium on beta-blocker approvals due to the drugs' carcinogenicity in animals. (Among the staffers involved in this delay was that fastidious driver, John Nestor.[2, p 195]) In effect, FDA was denying needed cardiac drugs to people at high risk of heart attacks because of the unproven possibility that those drugs might cause cancer years in the future.

Finally, in 1981 FDA approved the first such drug, boasting that it might save up to 17,000 lives per year. That meant, of course, that as many as 100,000 people may have died waiting for FDA to act[5, p 118]—an explosive point, but one that very few journalists pursued. For all practical purposes, these people were invisible in a very literal sense—we've all seen photographs of thalidomide victims, but I suspect that not one of us has ever seen a photograph of someone who suffered or died because of FDA's beta-blocker moratorium.

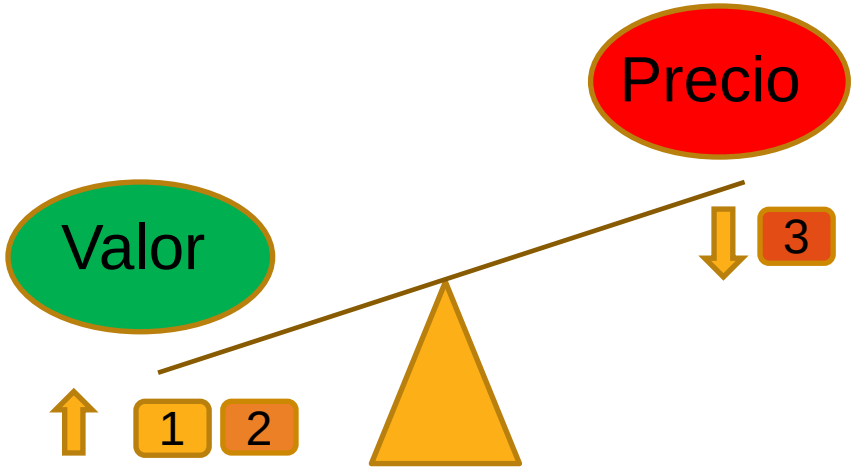
Journal of American Physicians and Surgeons Volume 15 Number 4 Winter 2010

Objetivo: minimizar el gap entre la evaluación de valor del pagador y la incertidumbre de la evidencia disponible

Evolucion de los Acuerdos de acceso gerenciado

- Incremento en la sofisticación de las evaluaciones de valor hecha por los pagadores. (impacto presupuestario, farmacoeconomía, etc.)
- Mayor predisposición de las compañias farmacéuticas a negociar uno a uno según características intrínsecas de cada pagador.
- Aumento en el número de acuerdos a nivel global enfocados en terapias de alto costo.

El objetivo es resolver los desafíos del pagador a la propuesta de valor del productor ...



INTL. J. OF TECHNOLOGY ASSESSMENT IN HEALTH CARE 27:1, 2011

1	Disminuir la incertidumbre sobre el beneficio terapéutico/costo-efectividad effectiveness
2	Gerenciar la utilización para mejorar la performance
3	Limitar el impacto presupuestario

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Un Acuerdo de acceso gerenciado intenta achicar el gap entre 2 percepciones de valor

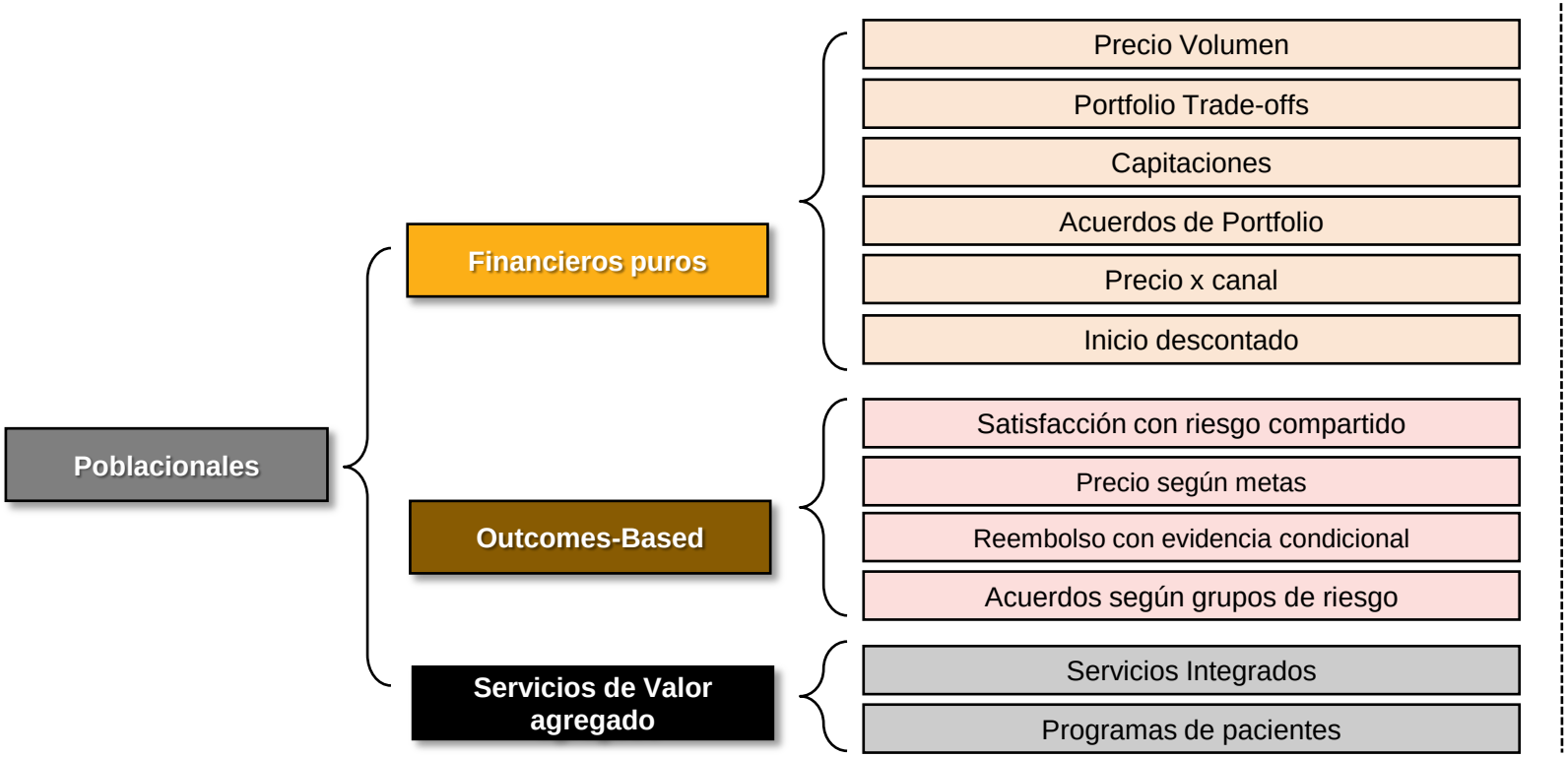
Definición geralmente aceptada[1]

Un acuerdo de acceso gerenciado es un contrato entre un productor y un pagador/proveedor que permite el acceso a una tecnología medica sujeto a condiciones específicas. Estos acuerdos usan una variedad de mecanismos para lidiar con

- la incertidumbre en la performace de la tecnología,
- gerenciar la adopción de la misma para maximizar el beneficio resultante o
- limitar el impacto presupuestario.

[1] Intl J of Technology Assessment in Healthcare; 27:1, 2011

Propuesta de taxonomía



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Mas alla de los seductores, los acuerdos relacionados con outcome son menos prácticos.

Market	Volume based	Outcome based	Commentary
	⊕	⊖	▪ Mixed views, low awareness of risk sharing approaches other than price/volume agreements ▪ Outcomes-based risk sharing perceived as difficult to measure outside a clinical trial setting
	⊖	⊖	▪ Negative perception of risk sharing amongst payers: costs of administering thought to exceed savings & paperwork seen as a high burden on clinicians ▪ Disease management programs only worthwhile for high prevalence diseases, not considered relevant in immunosuppression
	⊕	⊖	▪ Outcomes-based risk sharing negatively perceived and difficult to implement in a disease area with subjective outcomes ▪ Volume-based risk sharing perceived more favourably
	⊖	⊖	▪ Risk sharing models not considered relevant: manufacturers focus on traditional lobbying activities to negotiate price and get drugs on formulary
	⊕	⊖	▪ Outcomes-based risk sharing negatively perceived and difficult to implement in a disease area with subjective outcomes ▪ Volume-based risk sharing perceived more favourably
	⊕	⊖	▪ Negative perception of risk sharing amongst payers: costs of administering thought to exceed savings & paperwork seen as a high burden on clinicians ▪ More favourable views on volume-based agreements i.e. dose cap scheme
	⊕	⊖	▪ Outcomes-based risk sharing negatively perceived and difficult to implement in a disease area with subjective outcomes ▪ Volume-based risk sharing perceived more favourably

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PHARMACEUTICALS

By Peter J. Neumann, James D. Chambers, Françoise Simon, and Lisa M. Meckley

Risk-Sharing Arrangements That Link Payment For Drugs To Health Outcomes Are Proving Hard To Implement

DECEMBER 2011 30:12 HEALTH AFFAIRS

ABSTRACT Risk-sharing agreements, under which payers and pharmaceutical manufacturers agree to link payment for drugs to health outcomes achieved, rather than the volume of products used, offer an appealing payment model for pharmaceuticals. Although such agreements have been widely touted, the experience to date mainly demonstrates how hard they are to implement. Barriers include high implementation costs, measurement challenges, and the absence of a suitable data infrastructure. Risk-sharing arrangements could gain traction in the United States as payers and product manufacturers acquire experience with the concept and as measurement techniques and information systems improve. For the foreseeable future, they are likely to remain the exception as drug companies pursue payment models unconnected to data collection or performance assessment.

La evolución del NICE marca tendencia...o carece de innovación

Date	Drug	Agreement	Disease
10/07	Bortezomib	Pharma pays for non responders	Multiple Myeloma
08/08	Ranibizumab	Capping per eye	WetAMD
11/08	Erlotinib	= cost as Docetaxel	Lung Cancer
04/09	Lenalidomide	Pharma pays after 25th cycle	Multiple Myeloma
06/09	Cetuximab	16% discount	Metastatic colorectal cancer
08/09	Ustekinumab	= price for 45mg and 90mg	Psoriasis
09/09	Sunitinib	Pharma pays first cycle	GIST
12/09	Trabectedin	Pharma pays after 5th cycle	Soft Tissue Sarcoma
01/10	Certolizumab	Pharma pays first 12 weeks	RA
05/10	Gefitinib	Fixed priced agreed	Lung Cancer
02/11	Pazopanib	12.5% discount + CED on COMPARZ trial	Renal cell carcinoma

Date	Drug	Agreement	Disease
03/11	Azacitidine	Discount	Myelodisplastic Syndrome
04/11	Golimumab	= cost for 50mg and 100 mg	Psoriatic Arthritis
04/11	Romiplostin	Discount	ITP
10/11	Mifamurtide	Discount	Osteosarcoma
12/11	Tocilizumab	Discount	RA
01/12	Nilotinib	Discount	2nd line CML
02/12	Tocilizumab	Discount	SJIA
04/12	Nilotinib	Discount	1st line CML
04/12	Fingolimod	Discount	MS
06/12	Erlotinib	Discount	Lung Cancer
06/12	Abiraterone	Discount	Prostate Cancer

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El uso de Real World Evidence apoyo el reembolso de Xolair en Francia

- Francia usa acuerdos de precio volumen luego de la evaluación de valor ASMR. Esta evaluación de valor detecta incertidumbre en la evidencia que podría modificar si existiese nueva data.

- Issue: incertidumbre en la efectividad debido a disbalance en los grupos comparados
- Tecnología: tiene potencial para un mínimo gap eficacia-efectividad en una población bien definida
- Modelo: reembolso con evidencia condicional.

Aun cuando el regulador creyó...el pagador siguió escéptico

Table 2. Asthma history in previous year (primary intent-to-treat, PITT population)

	Omalizumab ($n = 209$)	Placebo ($n = 210$)
Admitted to hospital overnight for asthma, *n* (%)	83 (39.7)	79 (37.6)
Admitted to intensive care unit for asthma, *n* (%)	22 (10.5)	19 (9.0)
Admitted to an emergency room for asthma, *n* (%)	118 (56.5)	116 (55.2)
Ever had mechanical ventilator or throat tube for asthma, *n* (%)	29 (13.9)	13 (6.2)
Any of above (=high risk for asthma mortality), *n* (%)	143 (68.4)	136 (64.8)
Number of emergency room visits for asthma, mean (SD)	1.68 (2.61)	1.48 (2.47)
Number of urgent doctor office visits for asthma, mean (SD)	4.9 (5.66)	4.9 (6.11)
Number of work/school days missed due to asthma, mean (SD)	27.7 (48.59)	34.0 (58.53)
All exacerbations (previous 14 months), *n* (%)		
0	2 (1.0)	0
1	31 (14.8)	32 (15.2)
2	90 (43.1)	100 (47.6)
3	47 (22.5)	55 (26.2)
4	19 (9.1)	13 (6.2)
5	11 (5.3)	5 (2.4)
6	4 (1.9)	3 (1.4)
7	3 (1.4)	2 (1.0)
9	1 (0.5)	0
14	1 (0.5)	0
Mean (SD)	2.64 (1.56)	2.41 (1.09)

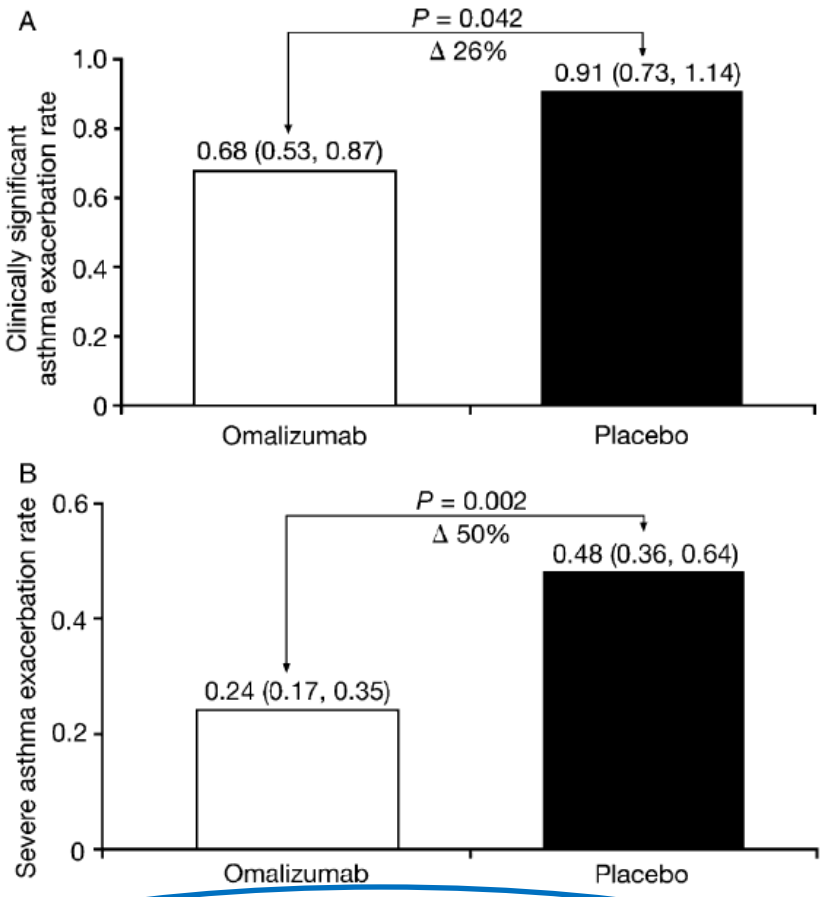

Figure 1. (A) Effect of omalizumab treatment on the rate of clinically significant asthma exacerbations (adjusted for baseline exacerbation history) during the 28-week treatment period

Un grupo independiente seleccionado por el pagador hizo un estudio observacional con un aporte financiero de Novartis

PAX Study
Pharmacoepidemiology of Asthma & Xolair®

Lucien Abenhaim,
Chairman, LA-SER Group

LA
SER

El estudio observacional confirmó lo mostrado en los estudios pivotales

366 events- 1208.7 patients-years

Person-years	NON XOLAIR	XOLAIR	P value/95%
N events	304	62	
Rate / 100 p-y.	**33.4**	**20.8**	0.0003
Relative Rate*	1	**0.56**	0.43-0.74

*Multivariate Cox PHM- Anderson & Gill Method for autocorrelated data controling for past and recent hospitalisation or ER visits, reflux, allergic rhinitis, antileucotriene, allergic status

La clave es linkear el problema con una potencial solución

Challenges		Financieros Puros					
		Descuento confidencial	PV	Capita por paciente	Capita poblacional	Portfolio *	Inicio descontado
Contención de costos	Tamaño del mercado	X	●	X	X	X	X
	Vial splitting	X	●		X		
Incertidumbre de uso	Fcia de tto		X	●	X		
	Duración del tto		X	●	X		
Efectividad	Impacto						
	Limites en la capacidad						
Competencia	Xxxxxxx messaging			●	X		
Incentivos al proveedor	Incentivos para usar otros terapéuticas				●		

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Solo algunos problemas son solucionable con acuerdos outcome-based

Lucentis Challenges		Outcome Based				Servicios de valor agregado
		Riesgo compartido	Precio según metas	Reembolso condicional	Grupos de riesgo	
Contención de costos	Tamaño del mercado					
	Vial splitting					
Incertidumbre de uso	Fcia de tto	X	X		X	
	Duración del tto	X	●		X	
Efectividad	Impacto	X	●	X	X	X
	Limites en la capacidad					●
Competencia	Xxxxxxx messaging	X	X		X	●
Incentivos al proveedor	Incentivos para usar otros terapéuticas					●

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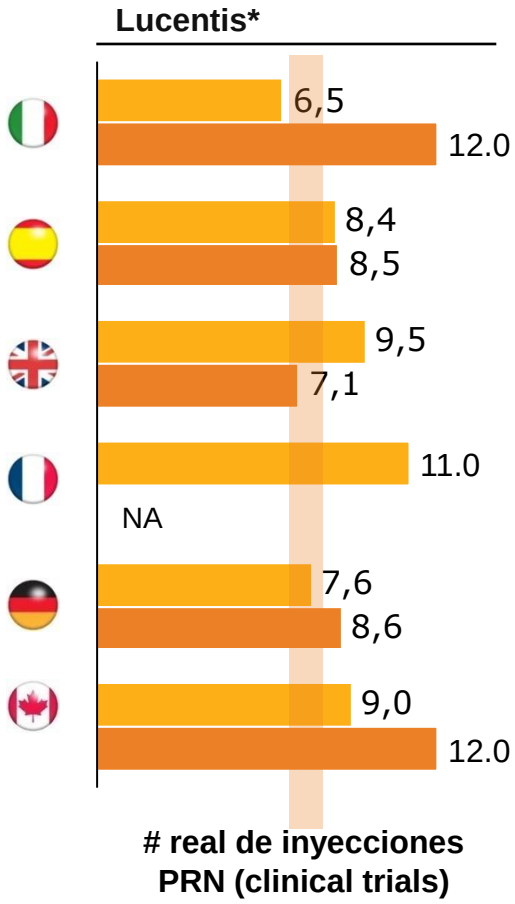
Hay incertidumbre sobre la frecuencia de uso con impacto en el presupuesto

inyecciones por paciente por año



- Mas alla de las diferencias de percepción en los pagadores locales y los regionales, todos tienden a sobreestimar el consumo real en DMAE

IMS payer research: N=62; 9 National payers, 19 Regional payers, 22 Local payers and 12 PA-KOLs; team discussion

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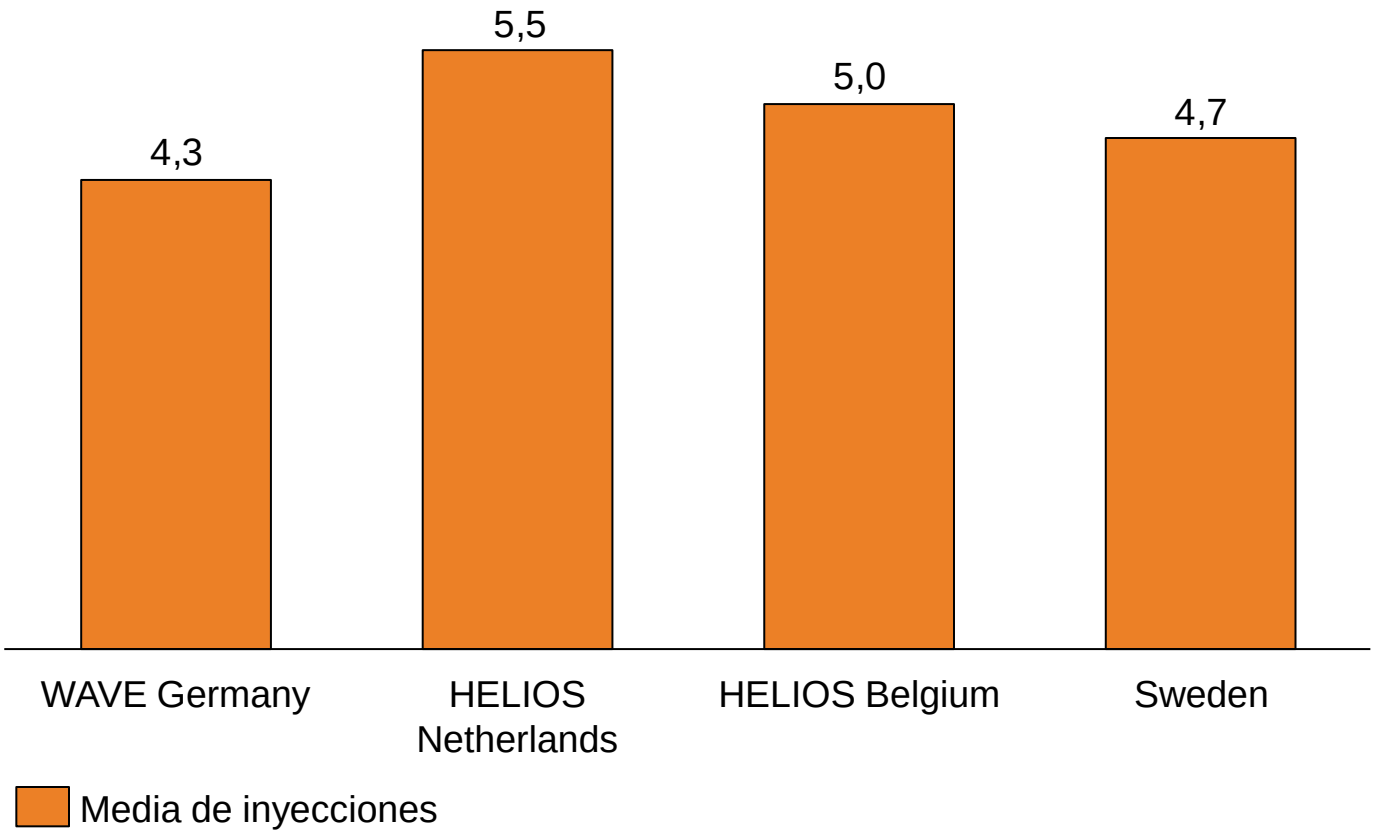
El uso enla vida real es bajo debido a la adherencia, logística y la capacidad de los centros de aplicación

Tratamiento a los 12 meses en el registro Luminous



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Diferentes esquemas con el mismo concepto se implementaron diferente con resultados...diferentes

YYYYY	XXXXX	OOOOO	MMMMM
Terms: Vial cap • Promedio 9 viales / paciente por año • + cap Duración • Contrato anual Monitoreo: • Registro de Novartis • Terminacion: Renegociación cada año	Terms: Vial / Sales cap • 18 viales /paciente durante el contrato • Reembolso de pacientes sobre el cutoff • Pacientes pre-tratados permitidos • + sales cap Duración • 5 años Monitoreo: • El pagador provee según un muestreo de prescripciones Terminacion: • Acuerdo mutuo	Terms: Vial cap • 8 /6/4 viales / ojo por año 1, 2 y 3 • NO sales cap Duración • 3 años Monitoreo: • Solo se provee hasta el capping Terminacion: • No especificada • Re-evaluacion en 3 años con real life data	Terms: Vial cap • 14 viales / ojo en 3.5 años • NO sales cap • Pacientes naive Duración • 3.5 años Monitoreo: • Registro del pagador Terminacion: • No especificada
Moderado	Alto	Moderado	Moderado

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Ilaris Ontario listing is an extraordinary win

FIRST ever rare disease public listing at Novartis CANADA

No rare disease framework in Canada

1. Ilaris is indicated for an orphan disease of 1 in a million (~35 patients in Canada)
2. Significant time spent with CORD[1] to understand CAPS and needs of patients
3. Ontario piloted only provincial rare disease framework, Drugs for Rare Diseases (DRD)

First product reviewed by DRD

1. Ilaris was one of first molecules reviewed by committee
2. DRD reached out to CORD to understand rare disease issues; CORD brought in a CAPS patient as part of onboarding
3. After rigorous review and face-to-face discussions on clinical arguments, committee agreed to recommend listing in 2 most severe phenotypes (MWS and NOMID)

Dedicated multi-disciplinary team collaborated for breakthrough wins

1. Significant time invested to deeply understand the complexity and implications of data and market access agreement options in rare disease where risks are high for both parties
2. Tremendous focus by multi-disciplinary team (Market Access, Medical, Marketing, Finance, Legal, Global) to create agreement that was win-win for both parties (innovative solutions)

FIRST Novartis rare disease listing and ***FIRST*** Outcomes-based agreement

1. Convinced committee to include patients who tested negative on genetic test to be eligible for Ilaris
   - ***WIN:*** 25-40% of patients can test negative but still have CAPS, we leave no patient behind
2. First Novartis "Outcomes-based" agreement & multi-cap agreement (per patient and annual cap)
   - ***WIN:*** > $1 million upside, clear criteria for response (SAA testing) and Novartis shows confidence behind our 97% response rate
3. Novartis was able to help committee define strict eligibility criteria so the *RIGHT* patient is on drug
   - ***WIN:*** Novartis set up the very first SAA lab test in Canada to create refined criteria specific to CAPS which translates into minimizing risk to Novartis
4. Succeeded to have "responder period" widened & adapted to each phenotype from 1 month to 6 months & 1 year
   - ***WIN:*** now patients who are "partial" responders won't lose eligibility by being categorized as a non-responder . MDs have time to adjust dose or frequency immediately to bring patient to full response

Buenas herramientas...no para cualquier cosa!!

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