Patient Assistance Programs (PAP)

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PRESENTED BY:

ALEXANDER LUONG, PHARM.D. CANDIDATE 2015

PRECEPTOR:

DR. CRAIG STERN, PHARM.D., MBA
PRESIDENT, PRO PHARMA PHARMACEUTICAL CONSULTANTS, INC

Outline

- Intro: What is a PAP and how does it benefit the community?
- Current obstacles
- Describing PAP and the system
- General Issues on PAP
- Conclusions

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The Problem

- Pharmaceutical companies charge extremely high prices for certain medications, some of which can potentially *cure* or *treat* a *life-threatening disease*.
  - Investment vs Profit
  - Ex: Hepatitis C – The "cure"
    - Sovaldi – 84,000$ x 12 weeks (~1,000$/pill/day)
    - Viekira – 83,319$ x 12 weeks (~1,000$/day)

- Many people lack adequate health care insurance → Cascade
  - **Cannot pay** for medications
    - **Cannot obtain** medications
      - **Cannot be treated** for their disease

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The Reality

- Uninsured adults and their families are twice as likely as insured adults to underuse their medications in order to lower drug costs.
  - *One in five adults had not filled at least one prescription*
  - *One in seven (14%) admitted taking a smaller dose than prescribed*
  - *16 % said they had taken medications less frequently than prescribed*

- Skipping or lowering doses will lead to serious health complications, increased visits to the ER, and increased mortality

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A Solution?

PAP (Patient Assistance Programs)

- **Who:**
  - Pharmaceutical companies
  - Government Programs
  - Non-Profit Organizations
- **What:**
  - Provide free (or low cost) medications to underprivileged patients
    - *Most brand name medications are found in these programs (and some generics as well)*

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Why Is PAP Important for You?

- We are healthcare professionals and consultants
  - **Financials**
    - *Save health plan's bottom line*
  - **Patient Benefit**
    - *Allow patients to obtain the medications they need*
  - **Managed Care**
    - *Serving the population with affordable, effective treatment*

Examples of PAP Programs

- Examples: Pharmaceutical Companies

Brand Name	Manufacturer	Program #
Abilify	Bristol-Myers Squibb Company	(888) 922-4543
Clozapine (generic)	Teva Pharmaceuticals	(800) 507-8334
Seroquel XR	AstraZeneca Prescription Savings Program	(800) 292-6363

- Information for patients:
  - www.pparx.org (Partnership for Prescription Assistance)
  - www.rxassist.org
  - Company websites

Table excerpted from www.nami.org/content/contentgroups/helpline1/prescription_drug_patient_assistance_programs.htm

General Statistics

- In an electronic review of PAPs (2010)[1]:
  - **285 unique programs** – of which 188 (79%) are drug company sponsored programs
  - Of top 10 medications in US in 2006 – **all are covered** by at least one program (except Zocor which is now generic)
  - **88% provide direct coverage** to the medications
  - 2% provided direct coverage and assistance with copayments
  - 8% gave discount cards
  - 1% gave rebates
  - 1% only copay assistance

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Eligibility and Enrollment

- These programs typically require:
  - Doctor's consent and prescription
  - Proof of **financial status** and US citizenship (or green card)
  - Proof of **limited or no Rx drug coverage**
    - *If limited Rx coverage, some will only cover medications if*:
      - Medications not included on formulary of current plan or
      - Medicare part D beneficiary in the doughnut hole
  - Specific eligibility requirements per program

- In a survey of Medicare Beneficiaries
  - **1.3% report program participation**

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Example of PAP Enrollment Process

- Abilify Tablets
  - **Indication:**
    - For Schizophrenia, recommended dose is 10 – 15 mg once daily – may be increased to maximum 30 mg once daily
  - **Cost (Lexicomp)**
    - 30 mg tablets (package size 30) = ~1500$
      - X 12 months = 45,000$ /year

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Bristol-Myers Squibb | PATIENT ASSISTANCE FOUNDATION

Sign-up Form for the Bristol-Myers Squibb Patient Assistance Foundation

What is the Bristol-Myers Squibb Patient Assistance Foundation?

- Bristol-Myers Squibb Company (BMS) established the Bristol-Myers Squibb Patient Assistance Foundation, Inc. (BMSPAF) to help patients who need help paying for medicines prescribed by their healthcare providers. BMSPAF is a non-profit organization that helps certain patients get, free of charge, the medicines that are listed in this application.
- Patients who meet certain rules will be able to get their prescribed medicines free of charge for up to one year. Every year, you must reapply, and be accepted, to continue in the program.
- Once approved, some medicines can be shipped to your home or to your healthcare provider's office.

What medications are available from the Foundation?

ABILIFY® (aripiprazole)
ELIQUIS® (apixaban)
NULOJIX® (belatacept)
ORENCIA® (abatacept)

Am I able to get medication free of charge?

You may be able to get medicine free of charge through the Bristol-Myers Squibb Patient Assistance Foundation if:

- You are being treated as an outpatient with one of the medicines listed in this application.
- You live in the USA, Puerto Rico, or the U.S. Virgin Islands.
- You meet the income limits for your medicine. You will need to send your most recent Federal Tax Return or other proof of income.
- You do not have insurance coverage for your BMS medicines or you are signed up for a Medicare Part D plan and have spent at least 3% of your yearly household income on out-of-pocket costs for prescription medicines this year.
  - You can request a report from your pharmacy that shows your out-of-pocket costs (co-pays) for this year.
  - You can submit that report with your application.

These are just some of the eligibility requirements - - if you meet the criteria listed here, it does not guarantee you will be accepted.

How do I apply?

If you think you may be able to get medicines free of charge based on the criteria above, complete the form that follows, and return it with your proof of income statement by mail or fax to:

Bristol-Myers Squibb Patient Assistance Foundation
PO Box 220769
Charlotte, NC 28222-0769
Phone: 800-736-0003
Fax : 800-736-1611

- ✓ **Don't forget to sign the form, submit your proof of income and out-of-pocket prescription costs for the year.**
- ✓ **If you have questions about the Bristol-Myers Squibb Patient Assistance Foundation or how to fill out the form, you can get in touch with the Foundation at 800-736-0003 between 8 a.m. and 8 p.m. Eastern Time Monday through Friday.**

ABILIFY is a trademark of Otsuka Pharmaceutical Co., Ltd.
ELIQUIS, NULOJIX, and ORENCIA, are trademarks of Bristol-Myers Squibb Company

SECTION I: Patient Information (to be completed by patient)

Patient Name:	Social Security Number: *Providing Social Security Number is optional.	
Date of Birth:	Gender: ☐ Female ☐ Male	
Patient Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Best Time to Call:
Alternate Contact Name:	Relationship:	Phone:
Allergies:		
Current Medications:		

Do you have insurance through (check all that apply)?

☐ Medicaid	☐ Medicare A or B	☐ Medicare Part D
☐ VA or Military	☐ Private Insurance	☐ None
☐ State Assistance Program for Medication	☐ Other:	

Insurance Name	Phone #	ID/Policy #	Group #	Policy Holder
Primary:				
Secondary:				
Prescription Coverage:				

NUMER OF PEOPLE IN YOUR HOUSEHOLD:
(Include yourself, your spouse and your dependents)

TOTAL ANNUAL HOUSEHOLD INCOME: $	OR	MONTHLY INCOME: $

- ✓ Please include a copy of your most recent Federal Tax Return, Social Security Statement, or other documents that support the income amount provided above.
- ✓ If you have a Medicare Part D plan & have spent 3% of your annual income on out-of-pocket prescription costs, please provide proof of those expenses. Your pharmacy can provide you with a report that shows what you have spent.
- ✓ If you have indicated no income ($0), your application may be subject to audit or request for additional documentation.

PO Box 220769 Charlotte, NC 28222-0769 Phone 800-736-0003 Fax 800-736-1611

Patient Agreement and Consent

By signing below:

I promise that:

- All of the information I provided in this sign-up form and the copies of the income documents or other information about me that I may provide are complete and true.
- If I am approved to get free medicine (enrolled), I will not try to get reimbursed for the free medicine from anyone else, including from a prescription insurance program or any other charity.
- If my insurance coverage changes in any way, I will immediately tell the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF).

I give my permission to:

- The BMSPAF and the companies that BMSPAF uses to administer the program for free medicine (its Administrators) to use my information, and share it with my healthcare providers, my insurance company, and other organizations or companies that might be able to help me, so that the BMSPAF and its Administrators may:
  - Decide if I am eligible for this program,
  - Help me enroll (if I am eligible) and help get the free medicine to me for as long as I am enrolled, and
  - Find out whether I may be eligible for, or am already enrolled in, another program (including a prescription insurance plan or another charitable program).
- My insurance company and healthcare providers and others who may be helping me apply to this program to share information about me with the BMSPAF and its Administrators.

I understand that:

- The BMSPAF and its Administrators may ask for additional documents and information at any time, even if I am already enrolled, so that they can decide if the information on this sign-up form is complete and true.
- The BMSPAF and its Administrators will only ask for the information that is needed to process my sign-up form, to help me with free medicine if I am enrolled, and to renew my sign-up form when my enrollment is going to end.
- If there is missing information on my sign-up form, if I have not provided the right income documents, or if I do not respond to requests for additional documents or information, BMSPAF and its Administrators can delay my enrollment, decide I am not eligible, or stop providing me with free medicine.
- The BMSPAF and its Administrators will only share my information as described on this form or as required or allowed by law.
- If I am enrolled, the BMSPAF will only give me free medicine for a short time and I will have to re-do my sign-up form before my enrollment ends if I still need help with free medicine.
- I have the right to revoke my promises and permissions at any time by writing to the BMSPAF at the address in this sign-up form.
- If I revoke my promises and permissions, I will no longer be eligible for this program and my enrollment will end.
- I may not be eligible for free medicine if I have prescription coverage that will pay for my medicine (other than Medicare Part D).
- This program may be changed or stopped at any time without notice.

Patient Signature: ______________________ **Date:** ____________

SECTION II: Treatment and Prescribing Information (to be completed by provider)

Patient Name:

MEDICATION WILL BE SHIPPED TO:
☐ Patient (available only for oral & subcutaneous injection medications)
☐ Healthcare Provider

Product Requested:
☐ ABILIFY® (aripiprazole) ☐ ELIQUIS® (apixaban)
☐ NULOJIX® (belatacept) ☐ ORENCIA® (abatacept)*

* If you are prescribing a patient both Orencia SC and IV, please complete the physician-administered intravenous infusion section and include a prescription for Orencia SC.

For oral and subcutaneous (SC) injection medications: Please attach a new prescription for the patient named above. Prescriptions may be written for up to a 1 year supply, subject to eligibility period limits. Specify the number of refills needed. Up to a 90-day supply is available per shipment.

For physician-administered Intravenous Infusion medications: Provide the following information for up to a 4-week supply. If additional medication is needed after the initial shipment, orders must be requested from the Foundation.

Drug Name:____________________ BSA/Weight__________ Patient ICD-9/Diagnosis:___________________

Dose(s) and Dosing Schedule/Frequency:

Scheduled Administration Dates*:

* The BMSPAF may request proof of administration of product received through this program, including flow sheets.

SECTION III: Physician Information (to be completed by provider)

Physician Name:	Physician State License #:	Physician NPI:
Facility Name:	Facility Phone:	Facility Fax:
Facility Address, City, State & Zip:		
Primary Contact Name/Title:	Primary Contact Phone:	Primary Contact Fax:

Preferred Method of Contact ☐ Phone Only ☐ Fax Only ☐ Phone and Fax

Facility Shipping Address:

Shipping Contact Name:	City:	State:	Zip:

State License # of the Shipping Address Location *(if different from the Facility Address noted above)*

I certify that treatment with this medicine for this patient is medically necessary, based on my independent clinical judgment. I authorize this prescription. I represent that any information I have provided about this patient is complete and accurate. I certify that I have the authority to disclose this patient's information and have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization for the disclosure. I understand that the BMSPAF and/or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or other public or private programs or is unable to afford the cost-sharing requirements associated with their insurance coverage for the indicated medication. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payer (private or government) for the medication. I understand that the BMSPAF reserves the right to modify or terminate this program at any time. I understand that the BMSPAF reserves the right to verify all information provided by healthcare professionals, suspend participation where inadequate information is provided, and limit enrollment based on available resources. My signature certifies that the medication received from the BMSPAF will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that BMSPAF reserves the right to recall or discontinue product at any time without notice.

Physician Signature: ____________________________ **Date:** ____________
Physician or Licensed Prescriber Signature (required - no stamps)

Please remember to include a new prescription for oral and subcutaneous injection medications.

Why aren't these programs being used more often?

- Many of the patients who require the assistance of a PAP are **underprivileged** and **may lack education and/or health literacy.**
  - Unknown knowledge about these programs
    - *Willingness to talk to their doctors about their financial burdens*
    - *Doctor-patient communication and relationship*
  - On average, applications forms are written at *10th grade level*

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Why aren't these programs being used more often?

- Complicated process
  - Different application for each company/drug
  - **Paperwork, paperwork, paperwork**!
    - For both patient and doctors
    - Health Literacy and unwillingness to spend the time
  - Many patients require aid from clinics to apply for PAP on their behalf – of which is very time burdensome
    - Average of 1 hour of personnel time per medication per patient
      - *Especially time consuming for patients with multiple comorbid conditions and medication profile (>5 medications)*

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Looks can be deceiving….

- Potential ramifications of PAP
  - May lock patients into a particular brand name product
    - *Higher overall individual and public drug spending*
  - May undermine the need for healthcare reform/policy solutions

- How do we know they work?
  - No formal tracking of PAP utilization
  - Companies are not required to submit any public information on their PAP programs and relative statistics

- ***Why are they giving free drugs?***

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Conclusion

- PAPs can be potential safety nets for underprivileged patients
- Reviews show that PAP enrollment assistance + additional medication services (eg. Counseling) is associated with improved disease indicators for patient with chronic diseases
- Patient awareness and education is essential

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