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PHARMACEUTICAL CONSULTANTS, INC.

Pharmacy Benefit News

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01 | Commentary: One Dose for Aspirin for Primary Prevention Is Not the Optimum!

Recent studies have called into question the one dose size of 81mg of Aspirin for primary prevention of cardiovascular events (e.g., heart attacks) is not effective for people weighing over 155 pounds (70kg). The latest studies indicate that the one size fits all is not a good clinical decision.

Patients weighing over 155 pounds required a regular strength Aspirin 325mg or higher. The study results also indicate that long-term reduction of colorectal cancer is also weight dependent and require regular strength 325mg or higher doses per day.

What about the use of Aspirin in secondary prevention, e.g., people who have coronary artery disease heart attacks, bypass grafts, or PCI? The "jury is still out" so changes cannot be made to the dose of Aspirin until further studies are performed. It is also critical that while medication therapy like Aspirin, anti-cholesterol agents, and high blood pressure control focus on comprehensive risk factor reduction, therapeutic lifestyle changes (weight management, physical activity, tobacco cessation, and dietary modification) improve risk factors.

It is critical that medications are used within the context of a multifactorial approach to disease. Risk factor control, risk factor modification, and attention to comorbid (concomitant disease) conditions are critically important to maintain health and lifestyle.

References:
Rothwell PM, et al. Effects of aspirin on risks of vascular events and cancer according to bodyweight and dose: Analysis of individual patient data from randomised trials. Lancet. 2018;392(10145):387–99.
Tyeken KN, et al. Weight-adjusted aspirin for cardiovascular prevention. Lancet. 2018;392(10145):361–2.

Analytics At Work | Maximum Allowable Cost List

Problem: Several clients have asked what to do about generic pricing in the face of new generics and many generics priced as brands. The consideration is how can the generic MAC pricing act as an anchor to the fast-rising brand pricing? Further, since MAC spread is often a significant source of revenue for PBMs, the problem was how to keep some of these margins.

A Health Plan client asked us to provide a custom MAC that detailed generic pricing on all generics including true generics, over-the-counter medications, drug store private label and store brands, extended release products, diagnostics, and medications coded as brand by the data sources, but that the client considered generic.

Methodology: We developed and created a custom MAC that met all the requirements of the problem. Pricing was set at wholesale acquisition cost (WAC) or below. The MAC is publicly available to the network pharmacies, updated weekly, and subject to change when necessary. Consideration was given to pricing at a State MAC and FUL but was not implemented in the first round due to dispensing fee contracts.

Outcome: The Plan achieved over 23% savings over the prior MAC provided by the PBM. The MAC has been in operation for several years. Trend has been consistently at minus 10%-12% and has never been lower than a minus 2% on any month.

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02 | Commentary: Now Companies Are Moving to Reduce the Prices of Drugs For Their Employees

The current war between drug manufacturers (PhRMA) and pharmacy benefit managers (PBMs) over who is responsible for rising drug prices has removed the focus from employers. Essentially, PBMs provide a portion of the drug rebate received from PhRMA to the employer.

Historically, the employer has used these rebates to lower their cost for health care benefits. Generally, the employee has not benefited directly, but potentially through lower premiums, or not at all.

Now the situation has changed. MarketWatch of 8/28/18 published the following:
"A growing number of big companies are moving to help cut the price of prescription drugs for their workers. More than a quarter of large companies will launch programs next year to offer deeper drug discounts, according to a survey of 170 large companies that employ 13 million people by the National Business Group on Health. Another 31% are looking to join in over the next 2 years. Through these programs, employees would receive immediate discounts on many drugs at the time of purchase.

Businesses want to reduce their own health care expenses and pass on some of the savings they get from drug manufacturer rebates directly to employees. The move could ultimately lead to great savings for employers and employees, according to Ge Bai, a health care accounting professor at Johns Hopkins University. Benefit managers would be cut off from a large source of profit and be forced to negotiate even steeper discounts from manufacturers, Bai says."
MarketWatch (08/28/18) Liu, Yanchun

Essentially, the move to provide lower drug costs at point-of-sale (POS) is progressing. Employees would receive the benefits of rebates at point-of-sale. This is similar to the DIR, or direct and indirect rebate, argument that is currently being waged between Pharmacies and PBMs. At the end of the day, employees could expect to receive something in the range of 10-20% discounts at POS. That sounds potentially good for traditional medications but does not solve the cost vs. affordability problem with very expensive specialty medications. This is a process, so one step doesn't solve the problem. Hopefully, stakeholders will follow up with next steps.

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03 | Commentary: Specialty Trend Up 9.4% While Traditional Drug Trend Down 4%

Doug Long of IQVIA, a health care innovation consulting firm, presented (AMCP 2018 Managed Care and Specialty Pharmacy) data indicating that specialty pharmaceutical spends increased $4.1B in the 4Q17 driven by autoimmune and oncology products.

On the other hand, traditional medication spends declined by 4% led by diabetes, respiratory and anticoagulants. Specialty innovation is expected to increase substantially due to the pipeline for oncology, nervous system and anti-infective/antivirals.

A trend of 9% in specialty reflects a doubling rate (growth of specialty injectable spend) of 8 years. However, the prior trend over the last few years was 17%. The pipeline for specialty pharmaceuticals could easily return the trend to the 17% or higher. This doubling rate is 4 years. Hence, the 2017 data is good news for the orphan products approved (the majority of new launches).

The hope for less expensive drugs is a different story. Generic drug sales have declined for almost 2 years. Drug companies have negative dollar growth. Many generics (206 products) were not launched in 2017 by the manufacturers. Biosimilars had low uptake due to current branded contracts. Hence, the ability to decrease cost will be a major challenge.

References:

https://www.specialtypharmacycontinuum.com/Operations-and-Management/Article/06-18/Specialty-Spend-Up-9-4-Traditional-Down-4-/48758sub=DBBE8A6652A457DC21E02860A95E6263322B2DC3A5B93B6DF416C856ED1447&enl=true

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