TRENDS IN COMPARATIVE EFFECTIVENESS OF TOP 20 HIGHEST SELLING DRUGS

Aagard S, White N, Stevans C
PARSDO, INTERNATIONAL, Bethesda, MD, USA

OBJECTIVES: The recently made coverage decisions by UK’s NICE, SCOTLAND’s SMC and the allocation of $1.1 Billion for comparative effectiveness research by the United States, are strong indicators of trends in pricing and reimbursement that are likely to be observed in the future. To gain an additional insight into these trends, we analyzed the cost effectiveness studies for the top twenty highest selling drugs (~$160B worldwide sales)

METHODS: Drugs were categorized as primary care, specialty, small molecules, biologics, therapy areas and availability of generic alternatives. Cost effectiveness ratios (CERs) published in peer-reviewed journals and technology assessments conducted by payers were used for this analysis.

RESULTS: There is a large variability in CERs for same drugs for different indications, in some cases also varying by biomarkers. Primary care drugs had lower and less variable CERs than specialty drugs. For example, CERs for clopidogrel range from $13,000 to $32,000, whereas for bevacizumab, it ranged from $125,000 to $350,000. Most striking was the CER for epoten alpha, which was ~$55,000 for Hb target levels of 11.0–12.0 g, but increased dramatically to ~$613,015 for target Hb of 12.0–12.5 g. Our analysis of ‘generic alternatives’ and the ‘new clinical evidence’ shows that previously deemed cost effective drugs could be re-assessed as being not cost effective when generics or new branded drugs with comparable efficacy become available (e.g. CATIE trial data for quetiapine). This would play a major role in the future, as more payers, including the US extended the CMS, explore ways to design a continuum in the coverage making process; implying that updated cost effectiveness ratios could change previously established coverage policies.

CONCLUSIONS: This analysis shows the range, variability and methods used for calculation of ICER values for these high budget impact drugs and provides lessons for executives and policy makers.

PRICING AND REIMBURSEMENT (P&R) IN BRAZILIAN COUNTRIES

Shepelev J, Richard L
GfK Healthcare, London, UK

OBJECTIVES: To review the procedure and requirements for P&R of pharmaceuticals in Brazil, Russia, India and China. METHODS: A review was conducted of the official websites of governmental and public health institutions in the countries of interest. This review was complemented by interviews with key stakeholders in the respective countries. RESULTS: Free pricing of pharmaceuticals exist in general terms in Russia and India. In India, free pricing applies to non-scheduled drugs and pricing restrictions may apply to new drugs on the National Essential Medicines List. In China, prices are fixed by central government; whereas in Brazil external drug pricing is used as the major cost-containment measure. In Brazil, hospital drugs are reimbursed if they are on the Essential Medicines List and expensive therapies for cancer and chronic diseases are provided by the Exceptional Medicines Program. Reimbursement of retail drugs is limited to the Popular Pharmacy Program and the majority of costs are covered out of pocket. Similarly, the most drugs costs are covered out of pocket in India; with only established generics being reimbursed. Russia saw the federal reimbursement system developed in 2003 to provide pensioners, invalids, and patients suffering from chronic diseases access to new therapies. In 2008 the DLO program was split into two subprograms: the expensive medicines program covering seven typical services provided for free at community pharmacies.

METHODS: Typically services provided at no charge to patients with chronic diseases need to be decided on the basis of decision makers’ roles and responsibilities (70.8%) and the deficient definition of decision makers’ roles and responsibilities (70.8%) and the deficient management of information between evaluation entities and decision makers (62.5%). In addition, patients satisfaction identified in phase I. The present situation as well as desirable (D) and feasible (P) future scenarios were considered. Consensus was reached when given statements were scored 7.5 or higher by 75% or more of the participants.

CONCLUSIONS: An important gap exists between mechanisms for assessing health technologies (HT) have gone through major regulatory changes over the last five years in Spain. This study aims to determine the consensus level amongst decision makers and experts on the present and future of health technologies’ assessment. METHODS: This is the second part of a two-phase study. A sample of participants and experts in HT evaluation was invited to participate on a two-round Delphi consultation (phase 2) about the most relevant and controversial issues identified in phase 1. The present situation as well as desirable (D) and feasible (P) feature scenarios were considered. Results: Decision makers (n = 16) and experts (n = 8) participated in the study (mean involvement in HT assessment: 12.4 [SD: 7.7] years). Present: Consensus was reached on that: 1) the absence of established mechanisms to set priorities and define needs (83.3%), and the scarce political support (79.2%) explain the little influence of current legislation on HT implementation; 2) safety and efficacy (79.2%) are always considered to decide the implementation of HT. Coincidence of opinions existed for the poor definition of decision makers’ roles and responsibilities (70.8%) and the deficient management of information between evaluation entities and decision makers (62.5%). Future: 1) Importance of value dossier and impact budget estimates (D: 95.8%, P: 12.5%) to support implementation; 2) efficiency and cost-effectiveness data will determine decisions (D: 91.7%, P: 12.5%); 3) benefits for patients (D: 87.5%, P: 17.6%) and equity improvements (D: 91.7%; P: 16.7%) will be prioritised; 4) patients satisfaction preferences and health related quality of life (HRQL) will deserve special attention (D: 73%; P: 12.5%) CONCLUSIONS: An important gap exists between desirable (D) and feasible (P) future scenarios. Agreement upon implementation mechanism is mandatory. Patients results are not relevant.