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ARE OUT-OF-POCKET PAYMENTS FOR ORAL ONCOLOGIC THERAPIES TOO HIGH?

HIGHEST UPDATED RESULTS FROM A U.S. CLAIMS DATA ANALYSIS

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OBJECTIVES: Oral oncologic therapies increasingly are becoming part of treatment options for cancer. These agents often fall within the pharmacy benefit, with the potential for increased out-of-pocket payments (OOPP) for patients. This study evaluated patient OOPP for oral oncologic therapies in US managed care plans.

METHODS: Patients aged 18+ years with 1 of 22 oral oncologics (altretamine, bexarotene, capetitabine, cyclophosphamide, dasatinib, erlotinib, etoposide, everolimus, gefitinib, imatinib, isosfatinib, lapatinib, lenalidomide, leucovorin, nilotinib, sorafenib, temozolomide, thalidomide, topotecan, troxerutin, tretinoin, vorinostat) were identified from 2009 in a nationally-representative medical and pharmacy claims database of over 100 US health plans. OOPP were calculated as the allowed amount (dollars a health plan allows for a therapy, including member liability) minus the paid amount (dollars paid by a health plan for a therapy). Mean/median per-claim OOPP were reported for each oral therapy and stratified by geographic region, plan type, and payer type.

RESULTS: A total of 17,483 patients with at least 1 oral oncologic were identified in 2009. Mean age was 38 years, 44% were male, and 85% had a commercial payer. Per-claim OOPP for the 22 oral oncologics varied. Median OOPP ranged from $0 (altretamine) to $42 (bexarotene); average OOPP were $9 (leucovorin) to $523 (dasatinib). Overall, 79% of patients were paying $50 or less per claim; 13% were paying $100 per claim. Among the majority of therapies, the highest average OOPP were found in the Northeast and South. PPO and indemnity plans had the largest OOPP for almost two-thirds of the therapies.

CONCLUSIONS: Increase in short-term costs are not necessarily bad in patients receiving MM treatment due to the improvement in chemotherapy administration. However, evidence supporting the cost-effectiveness of PFG-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly. Neutropenia also increases costs due to hospitalizations and aggressive systemic anti-biotics administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia. However, evidence supporting the cost-effectiveness of G-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly. Neutropenia also increases costs due to hospitalizations and aggressive systemic antibiotic administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia. However, evidence supporting the cost-effectiveness of G-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly. Neutropenia also increases costs due to hospitalizations and aggressive systemic antibiotic administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia. However, evidence supporting the cost-effectiveness of G-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly. Neutropenia also increases costs due to hospitalizations and aggressive systemic antibiotic administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia. However, evidence supporting the cost-effectiveness of G-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly.

RESULTS: Administration of PFG-CSF during the first course of chemotherapy was associated with 57% increase in costs during the study period, despite an 11% drop in neutropenia hospitalization costs. Forty-one percent of the increase in costs is due to increase in chemotherapy costs during the year after the start of chemotherapy.

CONCLUSIONS: A significant part of increase in immediate medical costs in breast cancer patients receiving PFG-CSF is due to the improvement in chemotherapy administration. Therefore, in short-term costs are not necessarily bad in patients receiving MM treatment due to the improvement in chemotherapy administration. However, evidence supporting the cost-effectiveness of PFG-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly. Neutropenia also increases costs due to hospitalizations and aggressive systemic antibiotic administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia. However, evidence supporting the cost-effectiveness of G-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly. Neutropenia also increases costs due to hospitalizations and aggressive systemic antibiotic administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia. However, evidence supporting the cost-effectiveness of G-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly. Neutropenia also increases costs due to hospitalizations and aggressive systemic antibiotic administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia. However, evidence supporting the cost-effectiveness of G-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly. Neutropenia also increases costs due to hospitalizations and aggressive systemic antibiotic administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia. However, evidence supporting the cost-effectiveness of G-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly. Neutropenia also increases costs due to hospitalizations and aggressive systemic antibiotic administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia. However, evidence supporting the cost-effectiveness of G-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly. Neutropenia also increases costs due to hospitalizations and aggressive systemic antibiotic administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia. However, evidence supporting the cost-effectiveness of G-CSF is not conclusive and ASCO guidance states the need for establishing cost-savings in high-risk groups like the elderly.