Express Scripts? Really?

As I was leaving for the annual ASCO meeting, an article in *The Wall Street Journal* (WSJ) caught my eye.¹ Peter Loftus wrote about a new initiative by Express Scripts to pay for medications based on value. He quoted the Chief Medical Officer, Steve Miller, MD, who used an example from my own wheelhouse—erlotinib in pancreatic cancer. Mr. Loftus said that under the new model, the cost of erlotinib would be negotiated at a much lower price for use in pancreatic cancer, in which it is marginally effective. For lung cancer, for which the drug is considerably more effective, the cost would be higher.

This concept really resonated with me, and as I listened to the presentations throughout the meeting, I realized I was not alone! This year “value” was front and center in all the discussions, including a powerful plenary discussion by Leonard Saltz, MD, of Memorial Sloan Kettering Cancer Center (MSKCC). Dr. Saltz has been a vocal critic of drug pricing, and even led an effort at MSKCC to keep ziv-aflibercept, an FDA-approved drug, off the formulary because it is minimally effective in colorectal cancer.²

The idea of value-based or indication-specific pricing was first introduced by Peter Bach, MD, MAPP, Director of the Center for Health Policy and Outcomes at MSKCC (who co-wrote with Dr. Saltz about the efforts with ziv-aflibercept). Dr. Bach proposed this in an article published in *JAMA* last year,³ in which he used the example of variable pricing for cetuximab, proposing a near 20-fold variation in pricing depending on the indication.

By law, the Centers for Medicare & Medicaid Services cannot negotiate the cost of drugs with industry; however, that doesn't mean other payers can't get into the game. Express Scripts, of course, handles only oral prescription drugs. A decade ago, that would have had minimal impact on drug costs. But this is changing. Some of our newest highly active drugs, especially the broad class of tyrosine kinase inhibitors, are oral. And some of these drugs, such as imatinib mesylate for chronic myelogenous leukemia or gastrointestinal stromal tumor, need to be given continuously for chronic management. So that can really add up.

Drug companies are certainly getting the message too. While I'm not sure this is happening in the United States for cancer treatment yet, some companies are literally giving away drugs for free. Then, if the drug works, payments begin. In his WSJ article, Mr. Loftus¹ cited an example of a multiple sclerosis drug manufactured by Acorda Therapeutics, which is offered to patients free for 2 months before any charges begin. This model makes sense to me. I'm certainly not an expert in commercial enterprise, but I would think a company could shape a business model around this. And I suspect a business model like this would only support the development of drugs with really high impact. Isn't that what we need?

So go for it, Express Scripts! I hope major payers follow suit. And I encourage drug companies to come up with their own models for value-based pricing. No pun intended, but we can't afford to do otherwise.

References

1. Loftus P. New push ties cost of drugs to how well they work. *The Wall Street Journal*. May 26, 2015. Available at <http://www.wsj.com/articles/new-push-ties-cost-of-drugs-to-how-well-they-work-1432684755>. Accessed June 7, 2015.
2. Bach PB, Saltz LB, Wittes RE. In cancer care, cost matters. *New York Times*. October 14, 2012. Available at: http://www.nytimes.com/2012/10/15/opinion/a-hospital-says-no-to-an-11000-a-month-cancer-drug.html?_r=0. Accessed June 7, 2015.
3. Bach PB. Indication-specific pricing for cancer drugs. *JAMA* 2014;312:1629–1630.

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