

SPECIALTY PHARMACY NEWS

Multiple Copays, Management Tools May Influence HIV/AIDS Patients' Compliance

As more therapies for HIV/AIDS hit the marketplace, there is even more of a need for payers to make sure they do not have barriers to patient care.

According to the Pharmaceutical Research and Manufacturers of America (PhRMA), almost 100 medicines are in various stages of development for HIV/AIDS (see chart, p. 2). PhRMA also notes that 30 drugs have been approved to treat HIV since the virus was first identified in 1983, including three approved since last August.

"The pipeline is very rich with new products," says **Richard Tinsley, a partner with consulting firm Putnam Associates**. "The treatment regimen is likely to change very significantly over the next 10 years."

"If you look back at the late 1980s, there was one class" of HIV/AIDS drugs, says Glen Pietrandoni, program manager for HIV/AIDS and hepatitis at Walgreen Co. 1996 saw the first protease inhibitor — "the class that changed everything," he says. The next year saw the first decline in HIV/AIDS deaths. "Within 10 years, in that class we have improved so much," including more simple regimens and fewer side effects, he adds.

Much of the difficulty treating the disease stems from the fact that "the virus becomes resistant to drugs over time," says Ed Pezalla, M.D., national medical director for Aetna Pharmacy Management. When the virus becomes resistant to a drug, this generally eliminates that entire class of therapies as potential treatments.

"Like antibiotics, the more you use them, the less options you have," says Lynn Nishida, director of clinical pharmacy services for The Regence Group.

In the second half of 2007, the FDA approved two first-in-class therapies.

Pfizer Inc.'s Selzentry (maraviroc) tablets came onto the market last September, following an Aug. 6 FDA approval (*SPN 9/07, p. 6*). The drug, a CCR5 inhibitor, is taken in combination with other antiretroviral drugs by adults with CCR5-tropic HIV-1 who have been treated with other HIV medications and have evidence of an elevated viral load. A diagnostic test can determine whether a person has this particular strain. Rather than fighting HIV inside white blood cells, the medication prevents the virus from entering uninfected cells by blocking the CCR5 co-receptor, the predominant route of entry.

The other new class is integrase inhibitors. On Oct. 12, Merck & Co.'s Isentress (raltegravir) became the

first drug approved in that class (*SPN 11/07, p. 11*). It is indicated as a combination therapy with other antiretroviral agents for patients who have developed resistance to other medications.

Each drug costs approximately \$10,000 annually.

"There has been no new class for 10 years, so this is huge," says Pietrandoni.

These newer therapies are "designed to help suppress the virus and minimize the symptoms," says Nishida.

And most recently, on Jan. 21, the FDA approved the Tibotec Pharmaceuticals, Ltd. drug Intelence (etravirine) for treatment-experienced adult HIV patients resistant to a non-nucleoside reverse transcriptase inhibitor (NNRTI) and other antiretroviral agents (*SPN 2/08, p. 6*). Its annual cost is almost \$8,000. The novel nucleoside reverse transcriptase inhibitor is the third in that class, but it has shown activity against strains of the virus that are resistant to the other NNRTIs. "Intelence opens the class up," says Pietrandoni.

Evaluating New Approvals

Regence "look[s] at utilization [of HIV/AIDS drugs] very carefully," Nishida says. "It seems like we evaluate a new HIV medication every month."

The FDA views HIV/AIDS drugs as "high-priority medications that need to be approved, similar to oncology medications," she says. The drugs are "filling an unmet need for patients with no options." From the FDA's perspective, "the goal is to have efficacy and safety outweigh the harm. Health plans want to make sure of the science behind it and the overall efficacy."

Some of the clinical trials for these drugs "don't necessarily follow standard designs," says Nishida. "Usually medications are compared to no treatment at all, but you can't do this" with HIV/AIDS patients. "In a clinical trial, the first [tenet] is 'do no harm,'" says Tinsley, which makes not treating these patients impossible.

This means the drugs are studied by adding them to other medications, says Nishida, which makes it difficult to know cause and effect and the benefits a drug provides.

Utilization of the newer HIV/AIDS drugs "is not like a new medication for lowering cholesterol," she says. "We've seen a trend where the utilization doesn't

pick up dramatically in the first few months" a drug is available. "There is reserved use for these [newer therapies]. The intent of these medications is not first-line use....Doctors recognize these are the last line" of defense.

Because of this treatment approach, plans do not generally have utilization management tools in place for these therapies, she explains. "Utilization has not been an issue yet," she says. But if plans were seeing these drugs "used more than they should be, plans would put these [tools] in place."

Multiple Copays May Be Barrier to Care

Although compliance is crucial to the health of these patients, patients face potential barriers to care.

For one, patients taking multiple drugs will need to make multiple copayments. "The copay issue is huge," says Pietrandoni. He says that when Atripla (efavirenz/tenofovir/emtricitabine), a pill composed of three HIV/AIDS drugs, became available, "patients had one copay, which made a huge difference. If you have a \$25 copay, and you fill six or eight prescriptions a month, you may not have \$200 a month for your copays," he says. Atripla made this aspect more manageable.

Pietrandoni says that when a lot of plans place the newer drugs on a high formulary tier, this is "a barrier to adherence" as well.

Plans generally do not use prior authorization (PA) on these drugs. Al Heaton, Pharm.D., director of pharmacy at BlueCross BlueShield of Minnesota, says his plan has "had a mixed bag on PA and basically is moving away from that management tool."

And with Selzentry has come another issue: The diagnostic test to determine whether a patient will respond to the drug costs about \$1,500. "This is a life-saving drug, but most insurance companies don't pay for the test," says Pietrandoni.

Although the costs for HIV/AIDS drugs are relatively low compared with many other specialty pharmaceuticals, they are not inexpensive, especially with the number of drugs patients may be on. Still, "Selzentry and Isentress are priced similarly to the average protease inhibitor," says Tinsley. "The manufacturers could have priced them higher. The economics would have supported that." While payers may view the drugs as expensive, he says, "they are cost effective. This can get lost in the mix."

Before the newer classes were available, says Pietrandoni, annual costs for an HIV/AIDS patient's medications might have run around \$18,000. "But \$24,000 per year is not unusual for patients nowadays. And you also need to consider what other drugs they may be taking," which may include medications for blood pressure, cholesterol, diabetes, pain management and neuropathies, he says. "HIV/AIDS has changed from a death sentence to a chronic, manageable disease," says **Paul Bogorad, Ph.D., senior manager for Putnam Associates**, so patients will be staying on their medications for many years.

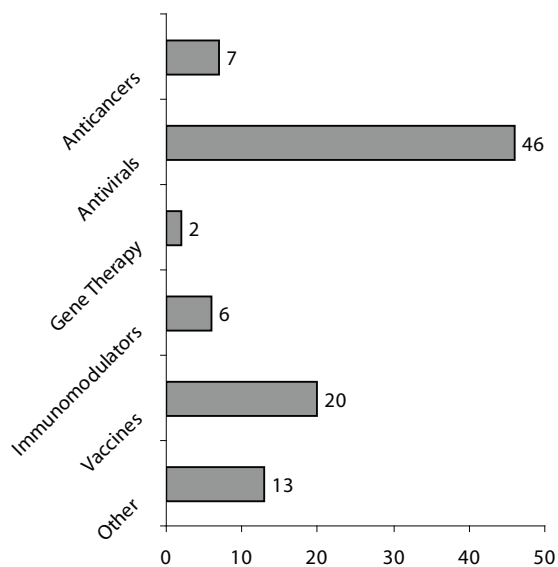
PhRMA also shows 20 HIV/AIDS vaccines are in development.

"A vaccine will be extraordinary in that it will reduce the number of people who are exposed to the virus," says Pezalla. "This is how we ultimately eliminate disease within a population," such as with smallpox and polio in some parts of the world.

"A vaccine has always been the Holy Grail," but there have been a lot of setbacks in the quest, says Bogorad. Most recently, during a clinical trial for a vaccine last fall, the vaccine not only failed to prevent infection but also may have increased some trial participants' risk of acquiring the disease by altering their immune systems.

The virus is "hard to vaccinate against because it is always evolving and changing," says Bogorad. "It is hard to develop a vaccine to cover all of the strains."

Medicines in Development for HIV/AIDS



NOTE: Some medicines are listed in more than one category.

SOURCE: Pharmaceutical Research and Manufacturers of America, 2007 Report: Medicines in Development for HIV/AIDS, November 2007.

Tinsley notes that “the goal of a vaccine is prophylaxis. If you have a safe drug that helps the body fight off infection, that will have the same impact as a traditional vaccine.”

“A vaccine is what we all hope will happen,” contends Pezalla. In the meantime, he says, it is important for people to understand that while HIV/AIDS is treatable, this knowledge can also be somewhat of a hazard if people let down their guard a bit and not be as careful. And even vaccines “don’t usually eliminate the chance of getting a disease in 100% of the population,” he adds.

Ironically, more effective treatments can be a barrier to preventing the spread of the virus. Societal perspective can be a challenge, says Bogorad, who notes that “in some communities, there is complacency that getting HIV is not a big deal.”

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