NCCN ONCOLOGY SUMMIT:

RECOMMENDATIONS FOR REMS STAKEHOLDERS

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Part 2

NCCN REMS Work Group Recommendations, Part 2

Dr. McGivney: So we're right on time and we will stay that way. And I always joke that my wrap up, you know, I'm going to summarize everything that was said today, so I obviously never do that. Say thank you and-

So anyway, so let's start this afternoon. We're going to switch a little bit here. Obviously, some very interesting discussion actually involving all constituencies this morning, but we will focus, at least in our presentations in our panel, we'll focus more specifically on the patient community and also the provider community.

So the first session, and we'll follow the same kind of outline, one, we will have two of the members of our work group present on some of the deliberations, and then secondly we'll move, we'll have some Q&A and then we'll move to the roundtable.

So to start off we're fortunate to have Dr. Sharon Weinstein who's Director of Pain Medicine and Palliative Care at the Huntsman Cancer Institute. She'll go first and then she will hand it off to Shirley Johnson who is the Chief Nursing and

Patient Services Officer at the City of Hope Comprehensive Cancer Center.

Dr. Weinstein: Well, good afternoon. I certainly want to thank NCCN for bringing us all together and for your active participation today in what I hope will be a very productive, collaborative effort moving forward.

This work group I think grew out in part from a visit that Bill and others from NCCN made to the Huntsman Cancer Institute some months ago where I expressed concerns I have as a practicing clinician. So I'm speaking to you today largely from that perspective.

I'm in pain medicine and palliative care, see patients five to seven days a week. I have a high-volume practice that includes supportive oncology in both pediatric and adult patients, prescribing opioids and other controlled substances and psychoactive medications for the purpose of relieving symptoms and meeting our mission to prevent and relieve suffering in the cancer population. So I take these matters very seriously and I think we have some important information to share with you, particularly from the prescriber's or provider's perspective that will help inform the discussion.

I'm going to try to kind of look maybe up there and maybe down here and hopefully not get too dizzy in the process.

So here are our discussion points, again, to share with you what we have learned about provider knowledge about the purpose,

benefits and challenges of REMS, again, from those Trend surveys; what we think the impact of this might be on prescribing patterns; to talk about the implications for compensating participants for the work that has to be done; and then I'll turn this over to Shirley to talk more about patient health literacy issues, how to minimize the burden, and how to see if we can forge some methods to incorporate these into our practices and get the REMS into the actual day to day clinical practice.

So what was not surprising to me out of the Trends data is that providers are largely unaware about the REMS. REMS programs are relatively immature and I'll show you some data that there's very, I would say, poor penetration so far of knowledge of REMS into clinicians' practices and we think that we may be able to better increase participation and the effectiveness of these programs with better understanding on the part of the prescribers/providers.

Here's where I may have to do this. So what we think might be needed in the near term, things to be concerned with, better data about clinicians, survey clinicians, knowledge regarding the REMS. I'll show you the preliminary information from our Trend survey. And then in the medium term to increase the provision of REMS as a continuing education topic. Mandatory education, obviously, is maybe hard to ensure, but we can certainly see ways to provide opportunities for people to get their continuing education credits by becoming more skilled and knowledgeable in these programs. And then over the long term to make this a part

of ongoing education. If REMS is here to stay, or some iteration of REMS is here to stay, which we think it would be, this is my idealist speaking that in the marathon, ultimately we will get to the end of the race where we have a healthcare system, so being familiar with these programs would be necessary and would be a part of ongoing professional education.

So this was, again to show you limited familiarity, to what extent are you familiar with the REMS regulation and different components of REMS programs. You can see that 60% were either not familiar at all or only somewhat familiar, and somewhat familiar would mean we really just wouldn't even know where to start to do this, participate in this. So the minority of clinicians in the survey were familiar.

When we broke it out by provider type, here you see the, again, this is physicians are largely unaware of what's going on. Sorry. Maybe that didn't come out right. I can speak that way being a doc.

And for the advanced practitioners, you know, maybe some of the work load is being shifted onto mid-levels in a lot of practices so they have a little bit more familiarity. Pharmacists being the ones to implement this at the point of care were much more familiar. But then another group of clinicians, this would be in the purple, also largely unaware of what's going on. So like Scott did, I'll give you a second to just digest that.

You know, 30% of physicians were moderately or familiar, so the majority are not.

Looking at prescribing patterns and access, so this would give us the concern that with the administrative burden and if there are other treatment or programs available, then, you know, that will change prescribing practices. And I want to just share with you within the last year I saw my colleague Lynn Webster here earlier. I don't know if he's here this afternoon. We had a dinner meeting, it was a community of pain and symptom management practitioners from our region through the Utah Academy of Pain Medicine within the last year and the question was asked of all the prescribers in the room, "Are you participating in REMS," and when it came to the discussion of controlled substances, not a single person in the room said they would be willing.

Now I hope that's changed, and it may have, but that's where we've been recently. Providers, the first inclination is to say, "I'm not going to do this," and we can talk more about why. So we really do think that this can lead to significant treatment disparities. Are there going to be clinicians who are willing to participate, and if they're not, what's going to happen with those patients? You saw an example from the quotation earlier.

So here what we thought to consider what might be needed, looking at the impact of REMS on the prescribing patterns, let's really see if we can get more data. I was just talking with Dr. Throckmorton, too, about what specific information can we get? How do these concerns, what's our initial reluctance, but how

does that really translate into practice? And we get some specific data through better surveys. Not just what's the attitude, but what's the downstream effect? What's going to be the actual impact on the prescribing pattern and how does that translate into access for the patient?

On the medium term, need to look at how these would affect in terms of the distribution and supply. And I know that's really out of my territory, but I'm sure that's a major concern in the big perspective here. And on the long term, can we really see what the impact is of REMS on prescribing and distribution and access? Because those ultimately are reflections of the same thing, at least from my point of view. Statements have been made that REMS prevent diversion. Well, we don't really know that. Right know we think certain REMS will prevent prescribing and that may prevent diversion. But there are other questions to ask and we need these answers and we need them as soon as we can get them.

Let me share a few more things from the survey. Okay, this yellow is, you know, I don't know, neither agree nor disagree. So, you know, fully a third of the respondents to this question didn't really even have an opinion. So that's, again, I think, showing a degree still of ignorance.

Will REMS interfere with the provision of patient care? Well, I don't know. Will this drive utilization towards drugs without REMS? I don't know. And then when you look at the providers who agree, you know, it's about a half on all of these when you add

those agree and strongly agree up. About half of the respondents agreed that REMS would interfere with provision of care, would drive utilization and so forth. And a minority of respondents, this is about 700 respondents across the board, very few disagreed that there would be an impact on practice. Again, this is just our initial survey data, but I think it's pretty powerful.

Then when you take a look at the responses by familiarity what emerges is something different. The more familiar the providers are with the programs, the more concerned they are with the interference.

I don't know if I need to maybe highlight that, so here we have agree that there will be interference. These are the respondents who are more familiar. So once they get into the understanding of how this is going to be translated or how this is going to be implemented or what the barriers are going to be, the bigger concerns they have.

I think this next thing is just a quote, again from a physician, says, "In an age where reimbursement of medication and office visits/consultation fees are decreasing, increasing paperwork," that's this person's perception of REMS, "makes practicing medicine less economically feasible." So in small practices, I think this was brought up earlier today, in smaller practices where there's very little infrastructure support there's no room to shift the workload. We don't have somebody who can add

another 4, 8, 16, 20 hours a week, whatever it's going to be, to maintain this part of the practice.

So in an already overburdened system, we see this. Again, from my perspective we've got authorization programs, we've got other sorts of regulatory reports we have to make, patient assistance programs, each of these has a different website, a different paperwork, a different progress report, a different point of contact, the rules change. You know, we've got 60 different payers with rules that change every 3 months. This is becoming impossible. I'm just going to say. This may be the final straw from the prescriber's perspective and I want you to know I'm committed to make it work, but we're very concerned.

The time that it takes, not just to get registered. If that was it, you'd just, would I be willing to be a registrant? Well, I'm a DEA registrant, of course I'm willing to be a registrant. But that isn't what's involved. If I have to register for each program, I have to keep up with the registration, this one I might have to do every three months, this one I might have to do every six months, they're all variable, what I have to do to stay current, who I have to interact with to get the patient taken care of. It might be the pharmacist, it might be the manufacturer, it might be a regulatory person, all of the above. And then everybody in my system has to keep their registration current. Did you miss your deadline? Uh-oh. Well, you know, I'm a day off so now today this patient can't get this drug. We just see it potentially as a nightmare.

The average cancer patient in the ambulatory setting has 11 symptoms and in the inpatient setting has 17. So when you're talking about the number of medications that patients are getting for their disease management and then we add on a half a dozen to a dozen medications for symptom management we're talking about what looks like an impossible task.

So how could we possibly minimize provider burden? So this has been discussed already but I think you'll see some overlap with the recommendations coming from the different sections of the work groups. We'd like to have more direct participation with FDA and this is as early in the process as we can and I'm hoping that's what's, you know, going to come out of this is maybe a little- I know we're under legislation here, talking to Dr. Throckmorton, but, you know, I would like to see kind of a time-out now. Let's find out what we need to know before we add another 200 or 300 or every drug on REMS. Let's figure out what we need to know so this will work rather than piling on more that we don't think is going to be feasible.

In the medium term, can we get a better handle on the work load? I'm going to show you some data in a minute about the time, but that's, again, just preliminary survey data. What is the work load for this? To achieve good patient care using this as a tool and in the long-term, you know, then they're going to have to look at the costs to the whole, again I hesitate to call it a system, but costs for us if we're going to start thinking like a

system. And, again, I'm really thrilled to be part of this because I think we're starting to think like a system.

Here are the time factors. Estimate the amount of time you currently spend. Well, again, if they're only using one drug, maybe the thalidomide's a good example. You know, hematologists can't practice without that REMS. They know how to do it, it's built into their practice, it's not a huge time drain.

But once you get up to four, eight, or more hours a week, that starts to be a full-time person and so, you know, we see in these surveys not everyone's doing it. And, again, out of these surveys, a lot of people just didn't even have the direct experience. They've never done it. If they were vaguely aware of it, somebody else was doing it.

Let's look at the time by provider type. This goes the same way, physicians in blue. So, you know, again, the burden, we're not doing it. We're over there. Little bit of a shift to the midlevel practitioners, and then, of course, the pharmacists spend more time. And I think I added this one up. Yeah, so you're getting onto, you know, to 20% here. Twenty percent of a person's workload, that's a lot of time to take from what else? I would say, yeah, that is the time with the patient is what's, you know, increasingly being sacrificed. And then these are the non-oncologic practitioners, same thing. They just shifted here. They're really not doing very much and that's, again, because they're not doing it.

So this is who agrees with this statement, "I don't prescribe, dispense, or administer drugs with REMS requirements." I'll let you digest that for a moment.

So capturing work load means somebody has to be supported to do that. And, again, without any margin or excess, I don't usually see people around me sitting around twiddling their thumbs looking for something to do. Does this then become an "un-funded mandate?" It's already been pointed out that nobody has accountability over a physician in a private practice, you know, and in academic practices or in other health systems we might have some accountability to the system as a whole, but there's really no feedback loop. And a little bit of basis of comparison I have also from working inside the VA system which is very different and has its own set of challenges, but one thing I don't do there is waste half of my time trying to figure out what drug might be available for this person at this moment. And the work load has to be captured so that we can put the resources to it.

Who's going to provide the compensation? I wouldn't simply say, you know, this belongs to the manufacturers or this belongs to the practices or this belongs to the hospitals. I think this is a big question, ultimately whose responsibility is it, all of ours then, you know, we have to figure the way to pool and make the most efficient use of the resources so that the clinicians can actually do this.

In terms of the compensation then, here's what we'd like to put forward for consideration in the near term. Really, you know, it's payers need to be looking at this. How's this going to affect formulary, formulary management? Questions way beyond what I could articulate, I'm sure, in your mind right now. Medium term. So we might consider if these monitoring and tracking processes could substitute for others, then we might reduce some other layers of tracking and regulatory work. And in the long term, you know, how do we tie this to work load and compensation for the people who actually do the work to get it achieved, and that goes, you know, across all of the provider clinical lines.

So I think that's all I have for my slides. I'll turn it over to Shirley and we'll take some questions after. Thank you.

Shirley Johnson, RN, MS, MBA: Thank you.

So as we've been chatting today, all of these concepts I think for many of us, there's a face that is behind the discussion that we've been having today and for me that face is the hundreds of patients that come through our inpatient and outpatient setting in the course of the day for whom some of these guidelines either now or in the future would be appropriate for. It's the face of the clinicians that I have the joy of working with, whether that be physicians, the advanced practice nurses, the PAs who are caring for, again, a phenomenal number of patients. I don't know. You know, I talk to administrators all across the country within cancer programs in all kinds of settings and I don't know

any of us who are experiencing decreases in our patient volumes and the complexity that that requires. As I look at the face of our nation in the future and knowing the demographics, knowing that there are going to be many more patients for whom cancer therapies will be very appropriate for for the future and how we respond and how we attempt to really make these tough decisions about how we will manage this care in the future is certainly very appropriate and I couldn't be more pleased with your involvement today and the discussion that's occurring.

So the final component of the conversation that we'll formally present really focuses on, again, the patient and the provider and the, you know, kind of the nuts and bolts and how you really make this happen within an organization. Some of the content that I'll cover will be a bit redundant from conversation we've had earlier this morning and build upon that, but we'll really welcome, again, I think diving a bit deeper into these issues as they pertain this afternoon so that we can flush that out a little bit more.

So, again, because of where I live at the City of Hope in southern California, the whole topic of patient health literacy, again, is very important to us. We've talked a bit about that today. We talked about the reading level in which materials are written, the challenge that that is, the challenge that it is, again, because of the languages of the patients that we serve. I could, you know, coast to coast I could just really see the various similarities. And so that face, to me, of our patients

is a patient who may not have both a literacy level of being able to read let alone a health literacy level of understanding what this therapy is all about and how they really need to be concerned and follow through with the recommendations that are being provided them unique to some of the drugs that this represents.

And the other really is of a cultural and a language perspective. So just, you know, again, the brief time that we have to review a medication guide with an individual, given that there might be translation services that are involved, that that translation might not be occurring with the actual patient because of cultural implications and the other layer of activity and concern we have when we're administering these kinds of medications in that regard takes on a different perspective I think that we need to really address for the future. So we need to ensure that documents are provided to our patients, regardless of whether that be educational information, consents, to into account the issues that are focused on health literacy and the specific populations of patients that we serve across this country.

And so, recommendations that we have had lively discussions about within our group have really talked about the near term of seeing medication guides translated into other languages and I think we could have some very nice discussion about where to start with that, but that we see as a must. That must occur.

Perform an assessment of public health literacy comprehension. Again, there has been significant amount of work among many

institutions in understanding the challenges of health literacy and how can we take that work that's already been done and apply it to this situation and really help us develop some standards for this. How can we now use our web and social media to communicate information? Talked a bit about portals this morning. Again, we talked about how we might use this and integrate it in some way with electronic medical records. I echo comments that were made this morning about the need to create some of those structures now and as we, again, continue to move forward with provider order entry, to be able to see templates established that could have standardization and consistency. Because at the end of the day, this is all about patient safety and one of the things that we've learned in our patient safety work is when we standardize and can have, again, that consistency in practice evidenced through standardization, we have a better chance of assuring a safe outcome, and this really should be no different in our approach.

And long term, establish partnerships to better develop the relationships that we have with patient advocacy groups. And again, it's that voice of the patient, the voice of the family that should be in our ear at all time and understanding the ramifications for the decisions that we make and the processes that we put in place between provider and patient. And help, have patient advocacy groups who have, again, a depth and breadth of expertise in this area to really guide our work. And conduct a longitudinal study as to how REMS will affect patients in underserved populations. Again, I echo comments that were made

earlier about will we end up with two tiers of care? You know, a care level of patients who have the ability to gain access maybe into a center that can provide a level of medication and the support that goes with that with a team of clinicians who are choosing not to opt out versus other settings who just frankly don't have the resources to accommodate much of this in a provider way.

So another kind of bubble was from a nurse practitioner who said, "I have had patients refuse to take needed medications because of fear to do the unbalanced medication guide that is targeted towards adverse events and not efficacy." So really getting at that balanced perspective. And also knowing, not news to many of us in the room, but for a number of the medications that will be coming through the pipeline, I think it's a double whammy. You know, many of those will be oral formulations you do and so that has its own challenges then adding on another layer and we know what many of the challenges have been in managing patient adherence with oral chemotherapy, again, adding on another layer of complexity for the future is something that we have to consider and really consider now to be effective in the future in that regard.

So how do we incorporate REMS into clinical practice? So, again, some significant strategic planning both from our national perspective as we're engaged with here today, but what happens at the local level? And, you know, I sometimes use a phrase, "You've seen one, you've seen one." I would imagine that this

might not be any different. You see one REMS implementation in a facility, you've seen one REMS implementation in a facility because we lack the standardization of how to really make this systematized and doable. So we need to align with others with expertise within our own organizations.

You know, again, I'm one of those program administrator kinds of folks and it has just really been within the past, you know, 9 to 12 months that I have had REMS on my radar screen, yet I have nurse practitioners who report to me, I have, again, responsibility for the outpatient clinics, I sit on safe medication practice committee; and so it was not something that was out there on the radar screen. As I talk to colleagues nationally, I think as Terry, you know, mentioned as well, it's not out there as a national initiative and I am, again, concerned that many program administrators, administrators in cancer programs aren't as aware of the work that's going on. And then if there's not the awareness, then how can the appropriate planning occur within our organizations to assure that we are effective in our implementation.

So it takes the team. It takes the team that's associated with patient assistance programs, it takes our investigational drug pharmacist for those of us that are fortunate to have those individuals, it takes our purchasing and supply chain management team to really address this from a comprehensive perspective. It takes our patient family advocacy teams, our patient education teams, and our provider groups, and how we then establish a

process to incorporate this into our broader strategy. So I'm sure many hospitals that might be represented here are really using their pharmacy and therapeutics or their formulary committees to really help in understanding what structure to put in place. And I know that that structure can be and will be and is at this point very variable across the area.

Our own institution has taken the stance that without a question we want to be able to provide these medications for our patients, but how that looks in its operational phase right now is a bit discordant. There have been teams of physicians who have said, you know, this team of physicians will take responsibility for registering for this group of meds and these are going to be the providers then of our practice who will prescribe these medications. And then in, again, our organization nurse practitioners are not allowed to order chemotherapy, so the burden for that ordering then goes back to the physician. You know, our purpose of having physician extenders is to really alleviate some of that burden, but this is an area where that's not possible.

So, again, incorporating specific processes and policies to the greater degree that we can establish some structure and some standardization, the better. And then really helping to support the institutional formulary system in that work.

So from our group, recommendations really honed in on helping to establish specific institutional practice and helping to support the formulary system to be the proactive body that oversees the

implementation of the drugs with the REMS processes and requirements and providing the opportunity, again, for our formulary systems to have that standard work that can be implemented within organization. Many of us are very focused, again, you know, across the country on how we can continue to deliver efficient and safe care using some of the LEAN concepts, if you will. This is just another example of creating standard work within our organization so that we can have consistency and performance and with consistency and the standards then hopefully better opportunity for adherence and success and ultimately with achieving the patient safety that we want to achieve with this.

Institutions should build into their medication use system triggers and alarms for compliance with REMS requirements and for quality control purposes. That, to me, screams, screams, screams work with our electronic medical record group, decision support tools that we can put in place with our provider order entry initiatives that we're doing within our electronic medical record as a way to do that. And share best practice surrounding implementation of REMS into clinical practice and really challenge us as we continue this dialog to really identify best practice and get that out there through the numerous presentations, publications that we have as the ability to do that work.

So in summary as we kind of close up our formal comments and open it up for additional commentary and input, we know that we need to continue to improve provider knowledge and acceptance of REMS.

We have the opportunity to really influence prescribing and long-term outcome and we need to be good stewards of that to assure that these drugs are used appropriately and that we can assure their safety. We need to really look at the appropriate compensation for complying with these regulations and not just have this be one more thing that could have the opportunity to fall through the cracks, particularly since at its heart is patient safety. We have to address the patient health literacy component for this to be effective and continue to minimize the provider burden that's experienced by an already burdened team and really incorporate drugs with REMS into clinical practice, again, so that we can standardize that care and that process.

So I think we're ready to have our panel join us so that we can continue this dialog.

Dr. McGivney: Not quite.

Shirley Johnson: Not quite? Okay.

Dr. McGivney: No.

Shirley Johnson: Sorry.

Dr. McGivney: We'll have Dr. Weinstein come up and we'll let you two handle some questions or comments first. I'm a control freak, I'm sorry. No.

Dr. Weinstein: Thank God somebody is.

Dr. McGivney: So same deal. We'll have the microphones scattered around the room and, again, for those of you that like to write questions out, so nobody has taken us up on this, we will have people collect questions. So please have a seat.

Speaker: I was afraid of the microphone.

Dr. McGivney: Oh, okay. All right. Any questions? I'll start off, as usual. So this issue has come up time and time again and clearly in clinical decision making decisions about any therapeutic agent we're talking about a risk/benefit analysis. The FDA itself is charged with determining that the benefits of a drug outweigh the risks significantly enough that it can go on the market to be used by clinicians. Patients, you know, are these days not only considering safety and effectiveness but also cost implications, but that's a discussion for another day. Yet, as has been pointed out and pointed out in this session, the Cancer Medication Guide focuses on major adverse events. And I think in oncology when a patient has just been told, "You've just been diagnosed with metastatic renal cell carcinoma, without this particular agent or therapy you have maybe 12 to 18 months to live," and they look at a document that says, well, in 4% of patients it may be cardiac rhythm, you know, irregular rhythms associated with this drug. I don't know, it just doesn't compute with me. Now when you're healthy-

What do you think about this? Should their not be? I mean, to me, I've already said, even when I was with a payer, the more serious and life-threatening the illness, the less the degree of

certitude about effectiveness, and the greater risk of harm that patients, physicians, and payers should accept. I mean, isn't that the whole risk/benefit analysis? And that's been left out of the equation of the medication guides. Is it or am I off base?

Dr. Weinstein: Well, I'd happily start by just from my perspective as somebody who does a lot of assisted decision making in the palliative care setting where patients are considering whether or not to proceed with their cancer treatment. So I hear from the patients a lot of their questions and concerns about side effects and toxicity versus benefit. That's one of our focuses. So I do think that patients put the information that they have in that perspective, is this going to do me any good, what is the good it's going to do me, and I do think that that framework for decision making is quite variable from the point at which somebody first gets their diagnosis, where they're starting to first be a cancer patient and stratify in their own mind what's important to them and what they now have to learn and understand in order to make their decisions, and I think that's different when somebody has their third or fourth recurrence and they're going into what we sometimes call salvage mode.

So the decision making process I don't think is uniform, I guess is my short answer to that question. I think we have to consider when we're presenting just the risk, you know, if the medication guide is just the risk information, then I'm going to see that as

that's all that is. I still have to get it conveyed, but it is only a part of what goes into the discussions over time about treatment.

Dr. McGivney: But it seems to be almost an artificial, illogical separation in the discussion.

Dr. Weinstein: Right, well then we need a discussion about benefit, right.

Dr. McGivney: Right. Because, I mean, actually to Shirley's point, you just made the point that, you know, we don't want to just kind of rubber stamp it. Okay, we did our discussion to fulfill the REMS provision here. So, I mean, how do you view it? Have you had actually these conversations with your people or with patients directly?

Shirley Johnson: So I've had conversations certainly with our clinicians, you know, and how they approach this and certainly, again, to their credit, you know, having the opportunity to have a full armamentarium of tools available and drugs to use for treatment of our patients is of utmost importance to them. But it gives them pause about what they will choose to use and if there is, again, demonstrated benefit in a clinical outcome, then by all means, they're going to, you know, choose the appropriate product and if that means, you know, jumping through a few more hoops, they're going to do it.

From a patient's perspective, again, you know, what's risk to somebody who is really wanting to fight and to continue on with

therapy? And, you know, so many times patients want to continue on, you know, regarding what the risk might be. So there's no clear cut answer. It's such an individualized discussion. I think the thing that I've heard from our clinicians is the more data that we can arm them with that really is evidence based, so again, getting to the point of getting data out now about this, it really helps them then in the conversations that they have with their patients. And, you know, and something else that has helped them is when the institution has put down its foot and has said, okay, we're going to establish a policy around XYZ that might be a particularly difficult, you know, point in the decision making that they're needing to have with their patients and, you know, so the more structure that we can provide and the more data and information that we can provide them for clinical decision making the better.

Dr. McGivney: We'll have a - oh, go ahead.

Dr Weinstein: Can I just make a quick follow on to that which is there's the emphasis on risk information in the medication guide and then the clinician also wants to talk about benefit. The clinician is also talking about interactions of this therapy with other therapies. The clinician is also taking into consideration multiple comorbidities, you know, the clinical features of their patient, their family circumstances, what burdens of treatment are going to be for them personally. So that whole discussion is an individualized discussion of which the risk of this particular treatment is just one part. And my concern as the provider would

be in speaking for the oncologists who have to have these much more lengthy discussions about the primary treatment modality is if they're perceiving this new risk management program for this drug as a burden to time, that's what it's going to take away from. It's going to take away from the individualized discussion and that clinician or doctor/patient relationship.

Dr. McGivney: Mm-hmm.

Dr. Weinstein: I think that's the provider's concern.

Dr. McGivney: What about multiple messaging? I see heads of clinical pharmacy at some of our institutions there and we've talked about this. I mean, Ray, Phil, Niesha, Emily, and obviously the two of you, you have circumstances, I know Ray and I have had this discussion where Memorial does have an extensive patient education program, say particularly for orals, but basically for drugs that have been prescribed at Memorial and you have all your materials. Yet you might have a managed care company with its disease management program and then you might have a specialty pharmacy company with its disease management program or just in terms of provision of the drug, the oral drug to the patient has, you know, information and line of communication. And then you have a REMS program that has its little, what do you call it, message. You know, does it all fit together?

Dr. Weinstein: No.

Dr. McGivney: You're right.

Speaker: They don't work.

Dr. McGivney: The risk/benefit analyses basically that are contained in all that information, I mean, are they the same? I mean, the patient may be hearing different stories. I don't know. Anybody in the row that I just named there, Phil or Ray or anybody want to comment on that or what your experience is in terms of having patients say "Stop. Just one. Maybe my doc can call me?"

Dr. Muller: Bill, it's a great point and, again, when our patients come in for their first treatment, you'd be amazed. We actually give them a folder which has parts in to talk about insurance issues, treatment issues.

Speaker: A notebook, right?

Dr. Muller: Notebook, yeah. Beautiful notebook. They really need to, you know, first of all, when they first get diagnosed, you know, right away there's a freeze there and they're scared out of their mind, etc. And then all of a sudden you start to give them the choice of different options and dozens of drugs and so on and so forth, and there is a tremendous challenge here and, you know, I think to the point is there is no cohesive coordinated way that we can ever do this and, you know, and I love your slides there. We have to at least get minimum educational levels, literacy issues, and really we all have to start to be talking the same language as well.

And one more point, Bill, again, I think the pharmaceutical companies in general do an amazingly effective job at putting together educational booklets, binders, CDs, you know, so on and so forth. But while I would urge them to try to downplay the corporate logos and the brand names and, you know, so on and so forth. We frankly, you know, even though we acknowledge that they do it, frankly, better than us, we won't use them because we don't want to be viewed as trying to push brand named products to our patients.

So, again, we have really smart people trying to take the content and making it fit into our template which, again, is incredibly inefficient.

Dr. McGivney: So just out of- Oh, Phil, please.

Dr. Johnson: Okay, and I totally agree with what Ray said and I'd just like to add one nuance to that. NCI did a study a few years ago, I can't remember how long. It showed that over 80% of all patients go onto the Internet and do their own literature search before they even come to us. And so they come with questions and there's multiple confusion. And so I think what happens after they've been inundated with all of this information is they're still, after the multidisciplinary team moves around, they're going to, you know, tug on the pharmacist's jacket or the nurse and say, "Can you come back and talk to me about it?" And the first question is, "I'm confused. What would you do?"

Dr. McGivney: Mm-hmm.

Dr. Johnson: Tell me what to do, guide me. And they really look to the healthcare providers to do that.

Dr. McGivney: Yeah. Great comments. Actually, leave the microphone there, and it's somewhat of an aside, but it's related. So what kind of information do you have and how is it developed about off-label uses? You know, God knows what the- You know, it's interesting. NCCN gets quoted, and don't take this, but I was interviewed by the *New York Times*, like, three years ago and they said, "What percentage of off-label use is there in cancer care?" and I said, "I don't know, but I read somewhere it was between 50% and 75%," which actually in my mind now is an overestimate. You wouldn't believe how many times we've been quoted, "The NCCN says," seriously. But how do you deal with that kind of information in terms of providing patients information on a use that might not be labeled or that it not labeled?

Dr. Muller: Oh, boy. This is a real tough one, but again, I will take a stab at it.

Dr. McGivney: Good. That's why you're down here.

Dr. Muller: First of all, the way we develop our patient education fact cards is a way we call on is that we describe what the drug does, how it works, side effects, and you know, so on and so forth. We do not list, for example, the specific cancer type that the drug is used for and we do that for two reasons: One, not to get into the whole off-label use, and two, not to

have to get into the challenge of updating 3,000 different educational tools every time a drug is approved. So the burden of responsibility is on the physician, the pharmacist, or nurse to actually talk about the details of the drug dosing schedule and why we're asking the patient to take this drug at this dose for the that type of tumor type.

Dr. McGivney: And just a comment, too, while you were talking about it because I believe nilotinib is one of the drugs that has a REMS, I believe, and I think at ASCO if not this year already there've been two major publications and I think dasatinib, which is not on the REMS list. But basically updating, if you will, the effectiveness, you know, as more practice and use shows nilotinib and probably I hear dasatinib too, but basically have a greater effectiveness than originally determined in say the registration trials.

So then you've still got this whole issue of the risk/benefit analysis and maybe that's not being communicated to patients, again, under this program. Phil and then we're going to talk about opioids.

Dr. Johnson: Yeah, I agree with Ray again, but two other nuances. First of all, thank goodness there's three compendia out there that actually rate off-label use based on strength of evidence, and NCCN, of course, is a leader in that. So that really helps. The other nuance is that HOPA, the Hematology Oncology Pharmacy Association, is trying to address not only individual drug toxicity and use, but looking at the protocol.

And so our standards committee is actually going over the next couple of years to develop patient information guidelines on the protocol you're on to show how the drugs working in combination have different impacts both from a toxicity and an efficacy standpoint. So that's yet another level of complexity that we have to deal with, not drug by drug individually but they're all used in combination.

Dr. McGivney: Absolutely right. Excellent point. So, oh, Niesha? Please.

Dr. Griffith: Well, I just have one quick thing to add on related to off-label and that much like I had mentioned earlier that we require our physicians to document the risk/benefit discussion when they give a drug like an ESA and we required this prior to the REMS program, that's one of the things in addition to the discussion that we have for off-label use, the education has to occur, the risk/benefit actually has to be documented, that discussion and the progress note before we actually dispense the drug.

Dr. McGivney: Okay. So let's talk a little bit about opioids with both of you. When I got my first real job, as my wife would say, there actually was legislation in 1982 or early '83 that actually had a significant chance of passing to legalize heroin for the management of cancer pain in patients terminally ill with cancer, obviously. And, you know, I learned a lot about kind of the impediments, especially regulatorily, that clinicians face and how fear of the DEA in terms of dose escalation in the face

of tolerance was a major issue and a major impediment and disincentive for clinicians to treat pain appropriately. You know, we have, what, one REMS affecting fentanyl specifically, but it seems to me we're setting up a regulatory program that may serve as an impediment barrier depending on the number of opioids that become listed or included onto the, what do you call it, onto this REMS program that clinicians, 30% might say, "You know what? If it's in REMS, I'm not using it even though maybe this might be a route of administration which is particularly applicable to this patient with a very strong opioid." So Dr. Weinstein?

Dr. Weinstein: Well, I'm considering we're among friends. Opiophobia is alive and well. We have, I think, gained some ground and lost some ground in recent years when it comes to treating pain. You were asking earlier what makes cancer different and I wanted to answer regarding specifically symptom control and what are perceived to be the risk and benefits of using opioids in cancer patients. I don't think we should be any less attentive to the risks associated with opioids when we prescribe them for cancer patients, number one. Not somebody who's going to say, you know, "They're dying, so what." You'll never hear me say that and if I hear somebody else saying that, I'm going to call them on it right then and there.

Number two is cancer doesn't prevent or preclude substance abuse. In fact, we know that certain substance use behaviors increase the risk for certain cancers so our population's probably more

likely to have substance use problems than the population at large.

That said, prescribers, particularly now, are more concerned about the risks of diversion than they are the risks of abuse because of the publicity that's been given to the prescription diversion problem. Whether that's overstated or not, it's an issue and prescribers are more reluctant. So I see this as, again, potentially another at least symbolic interference from the prescriber's perspective. If they perceived this is a collaborative approach for us to ensure patient safety and they were reassured that this isn't going to be in the hands of the regulators who are going to come after them and look at their prescribing practices and see it as, "Here's who we're going to put in jail because you wrote 25 tablets and your limit is 24."

I think these issues have to be addressed. I think the work group needs to maybe break off with a different subgroup and say, "Let's talk about the specific issues that relate to controlled substances, not only opioids, but other controlled substances." Fatigue is a prominent symptom in cancer. Patients are prescribed controlled substances for the management of fatigue that are not opioids and nobody's talking about the diversion of stimulants, which is actually a much bigger problem in the United States. You know, there are other complexities that we haven't really gotten to, but I think this is worth delving into before these products all get classed.

The representatives from the audience who were talking about this earlier are not here right now, so I'm just representing a few things they said to me. That's from the Academy of Hospice and Palliative Medicine and the American Academy of Pain Medicine.

Dr. McGivney: Shirley, any comments on this?

Shirley Johnson: So once again there are faces that come back to me and those faces are patients, you know, patients that I've talked to recently, you know, a gentleman that we're caring for now whose greatest concern is not having his pain controlled throughout his cancer care. And to have limitations placed on what a clinician would feel comfortable prescribing based on other boundaries and constrictions is of grave concern when I think about patient need, about patient care across a continuum of care where opioids are a significant part of that in those patients.

Dr. McGivney: Yeah. I mean, it just points out, you used the word complexity two or three times and it was in the slides. And the FDA is overburdened. I mean, the REMS staff I hear hasn't been increased, so you have individuals who are doing two or three different jobs and to understand when (one) maybe you're not a clinician, or (two) you're a clinician but maybe you're a nephrologist, you can't understand the issues across medicine and we're looking at, again, a very real issue, day to day issue in terms of supportive care for cancer patients in pain management. That's been addressed on the public policy front for years and

years and years and, you know, this could impact it significantly.

Dr. Weinstein: And get to the off-label issues, much of what we prescribe in pain management is off-label in terms of the non-opioids, and if that's not acceptable and that's not paid for, then we're being shifted. You know, we're getting mixed messages too. The payers, you know, use this inexpensive drug because, you know, it doesn't- I had this discussion with Doug over lunch, too, you know, the pressure to use methadone because it's inexpensive, but it has particular toxicities which may be much more of concern in a cancer population who have other reasons to have cardiac toxicity. People aren't talking about that. They're just saying use that because it's cheap. Well, I have an ethical problem with that.

Roundtable Discussion, Part 2

Dr. McGivney: I tell you what, could the panel join us? So we'll expand a little bit the perspectives here. We get the same question for me, like, how are you and what are you doing up here?

So why don't we start here? Scott Reid, who are you and what are you doing here?

Dr. Reid: Scott Reid with CVS Caremark. I'm a pharmacist and my role at CVS Caremark is I head up the corporate operations program development and a myriad of other areas that impact the

pharmacy services that we deliver through our specialty pharmacies.

Dr. McGivney: So you're, like, way, way up there, right? Like, Executive Vice President? I mean, I'm being serious.

Dr. Reid: Well, Senior Vice President.

Dr. McGivney: Senior Vice President. So you've got a lot of, as you say, a lot of different areas and a huge company under you. So we already know you, Phil. Any other comments you want to make or just happy to be back?

Dr. Johnson: Just happy to be back.

Dr. McGivney: All right, Dr. Jahanzeb.

Mohammad Jahanzeb, MD, FACP: I'm Mohammad Jahanzeb, I go by MJ. I'm a practicing medical oncologist. I restrict my practice and clinical research to lung cancer and breast cancer. And I'm still on faculty at University of Tennessee but I live and practice in Boca Raton, Florida.

Dr. McGivney: That's great. Mr. Dahlman?

George Dahlman: George Dahlman, I'm the Senior Vice President for Public Policy for the Leukemia and Lymphoma Society. We are the nation's second largest patient organization, really focused more on research as well as patient services with 64 chapters around the states and Canada. And I'm in charge of, obviously,

the public policy side of things both on the federal and the state level.

Dr. McGivney: Great. So I'm going to start with MJ and I'm going to go to George and George, your question is going to be a very general one about just the perspective of your organization as a leading patient advocacy group out there, about the REMS program, what you've heard, what your positions are on the program in general. But Dr. Jahanzeb has practiced and actually does kind of still straddle both the academic world and community practice. So I'm going to rely on your community practice background here. We've had a lot of talk about, you know, the resources that are going to be consumed in the academic center, but how is a practice of three to six to eight oncologists going to handle the extra workload and the tracking to make sure all these different patients for all these, you know, it's not a whole lot of drugs yet, but these different drugs, that they meet the requirements? What do you think?

Dr. Jahanzeb: We already heard from US Oncology that the average practice size is four and the average pharmacy support for those four doctors is zero. So you can well imagine the resources are scarce and the requirements are no different. You know, their patients' lives are just as valuable as a patient's life at an academic cancer center. So I think it's a huge challenge. It was on the slide that it's an un-funded mandate to a degree. So there will have to be some mechanisms to pay, somebody will have to pay and maybe there can be modified codes with E&M codes for

physician time. A lot of this will be delegated to others. Physicians often delegate such things to nurses, nurse managers in their office, and I think there has to be a coherent plan of their training and certification as much as the physician training and certification.

But I think it's going to be a problem. Another example is, for example, clinical trials where there's actually sometimes funding. There's not much funding with cooperative group trials, but there's a lot of funding sometimes with pharmaceutical company trials, and yet accrual to clinical trials is low solely because doctor doesn't have the time to know all the trials and sit with the patient and offer the clinical trial to the patient where there's actual value being gained.

Dr. McGivney: That's a good point.

Dr. Jahanzeb: And here they see lesser value but still time to be spent with the patient.

And another thing, not to be long-winded, but I think it's a very important aspect that our patients are focused on death more so than somebody who goes for a routine diabetes visit or hypertension visit. So to say to them, "You may die if you take the CSA," is a whole different ball game.

Dr. McGivney: They go, "No kidding."

Dr. Jahanzeb: So we actually are much less likely to then get into that type of discussion on top of the death discussion we

have already had with their diagnosis and prognosis. So I, for example, quit prescribing ESAs all together. For two years I've not prescribed any, even before this went into play because our center started requiring two years ago that we have a separate consent form. So I thought, okay, I'll transfuse some patients and that's no big deal. So it has real, major impact.

Dr. McGivney: Yeah, obviously. Before I go to George, let me get at the coverage issue or the compensation issue, and I know you don't- Well, I don't know. The reason I'm going to ask you is because you deal, half your customer base as I understand it is with payers and half your customer base is with employers. So, I mean, I just think that we're dreaming if we ever think any of these services are going to get paid for or reimbursed. I mean, am I right or wrong?

Speaker: Well, you know, to the extent that you believe or can prove that the requirements that are dictated by a REMS increase the workload, and that, most of it, frankly, it's labor related workload that we all know that can cost a lot of money. You know, how are you going to overcome or how are you going to justify or cover that cost?

Now the extent to which you can do something through automation, maybe you can, you know, take on that burden with really minimal to no impact. I haven't seen that happen yet. But I think, you know, the experience that we've had, some of these programs, certainly the more complex ones, are adding significant burden to

our cost structure. And so the question is how are you going to, you know, as you said, cover that?

I don't believe today, as much as I think the payers and the employers, you know, are learning about it and we make sure that they learn about it, frankly, of what's going on up there, especially with these drugs that have very high cost, I mean, the average cost of a specialty pharmacy prescription is somewhere in the area of $1,800 a month and it's, you know, it's driving, it's growing at, depending on who you talk to, 15% to 20% a year. It's the number one thing driving the increase in drug costs. You go to them and you're looking for relief and they kind of sit there and you don't even want to ask the question.

Dr. McGivney: Right.

Speaker: Because they feel, some of them, at the end of the day that the high cost of these drugs and some of the price increases that they see associated with some of these drugs, that's- They're already paying for it somehow, some way. So the question is where are you going to get that money from? And at this point, you know, I don't think that there's an established practice. I think, you know, the pharmaceutical industry is listening to that story. I don't know at this point they know exactly what it is they're paying for and how much they should pay, so I'm optimistic that there may be there but, you know, frankly, our worst case scenario is 50% increase in cost and that 50% increase in cost, you know, pretty much puts you under water

with every dispense and you don't make it up in volume at this juncture.

Dr. McGivney: Right. Maybe we could have, like, the pharmaceutical industry set up physician assistance programs. I'm just kidding. You know, a kick back, but it came to me. So anyway.

Dr. Weinstein: I got a bill for the patient's visit.

Speaker: There's another aspect to being reimbursed for this additional service and that's not to get paid for what you're doing but to document the expense. And without having some mechanism to document that expense, you can't really build it into your Medicare cost base, which affects your DRG reimbursement rate, and you really can't document the non-direct or maybe direct costs that are associated with some of the reimbursement formulas. So whether, you know, I think we should be allowed to bill for the service; whether we get reimbursed or not is another issue. Hopefully we would get reimbursed, but even if we didn't, we'd still be documenting the impact, the labor, the cost.

Dr. McGivney: Great. So let me get to you, George. Sorry for the delay. So what have the discussions in your organization been like? Oh.

George Dahlman: Well, when we got into this process eschewing us a lot of it had to do with, you know, most of this discussion has really centered around a lot of the mechanics of how this is

processed and I think the main interface with the patients is clearly, you know, the medication guide and that discussion that goes on. And clearly, as everyone's pointed out, it needs to be health literacy appropriate, it needs to be culturally appropriate. It needs to have, the providers need to have the time to do it and of course those are all important consideration.

I think because of the orientation of my organization, which is primarily research, I think we're worried about a couple of things. One is, and I think this came up with, Scott Gottlieb brought this up during our discussions was really concern about what the patient is not hearing. If there are providers out there that are not using REMS drugs, what options do the patient not even know that they might have, despite the risk?

And importantly, I think, for us, as I said, my organization will spend out $70 million this year advancing therapies, and the implications in the off-label use, I think, are important from a patient perspective in kind of a systemic way, that there are options and treatments that will not be developed because there is no-, because of reluctance to use REMS-type drugs. So I think that's the main focus that at least we bring to it is an awful lot of caution about the kind of a speed bump that this provides in treatments for patients.

Dr. McGivney: So, I mean, what do you think, I mean it was raised this morning, but the issue of there's got to be a threshold where, you know, we hit, as I said, six to eight

therapeutics, four to five supportive care drugs and we say, "Okay, no more REMS until we see if this works." Because you start getting, as I say, I mean, where do you stop with TKIs? Do you go backwards? I'm not an expert but if I started to look at the side effect profile of the TKIs, I don't know that I'd be able to distinguish all that well and really make a determination this one's in REMS or not. And I might be totally wrong, but let's use that as an example.

Don't you think we've got to say, okay, look. There has to be an evaluation period and it's going to be three to four years, but this is important enough because we've got docs saying we're not going to use, you know, therapeutic agents; clinicians saying we're not going to use supportive care agents, and also you said that as well; and as I say, you know, your society is supporting the development of new agents. I mean, it seems like it's kind of crazy here. We've got to have a formal evaluation period. I don't know. Thoughts? Or is it okay? Everything's cool and this is going to work?

Dr. Weinstein: I suggested to Doug maybe that we, you know, have a time out. He says, well, we're under legislation so we better hurry and get this information instantaneously then if it's going to inform the next round of REMS programs. Otherwise they're going to continue to come out without this period of evaluation that we're all talking about we need.

Dr. McGivney: Let's get our policy people. Nancy, I mean, what is your impression? Are there others out there who represent

organizations on Capital Hill? What do you think the understanding of, like, some of the staffers, never mind the members of Congress is on the kind of issues? And Mark's right there, too.

Speaker: What understanding?

Nancy Davenport-Ennis: Well, and Mark and I were chatting a bit on paper, but I agree with every word that every panelist has said. To the doctor who said, "I'm not prescribing ESAs, I'm just infusing," that's a whole issue for the patient community that we don't have time to get into. But I think our concern is that all of this is happening within a fabric of change in the insurance industry. So the insurance industry is moving to a new form of reimbursement that is bundling, which is really an extension of the DRG. So when we say we need to have reimbursement and somebody's got to pay for this, and you think about the insurance industry doing this, our concern is we can't get them to pay for basic care. There's every opportunity to look at something and say that it is experimentalist, investigational. Our concern is even the language in a REMS could become fodder for denial based on experimental/investigational. And when we look at where are the parentheses going to be put around a REMS bundle or a drug that is in a bundle and that drug carries a REMS, we're concerned.

I have to share one example that happened yesterday to illustrate the fragility of the insurance market. We had a patient call Patient Advocate Foundation, cancer patient, advanced cancer,

insured, living in Illinois, gentleman is 47 years old. He received a letter yesterday from his insurer informing him, "Effective July 1st we will terminate the policy that you have. On July 2nd we will put you and your family members in a new policy that will carry a $25,000 a year deductible per member of your family." Now for everyone in this audience, it's unbelievable. You cannot fathom that this would happen. And so for us to be having the discussion about, "How are we going to pay for REMS," against a fabric that is far broader, we look at United introducing 20 different disease episode of care models now. Where does reimbursement for REMS fit into that?

So I think it's a fragile community and I think this is a very complex discussion and we as a patient group have such empathy for our health care providers because you do need to be reimbursed. But it's going to take all of us together to move that dial to make it happen.

Dr. McGivney: Yeah. I mean, Mark, your comment on, I mean, this is just oncology. We've had some pretty complicated, complex issues with all sorts of ramifications ultimately for patients here. And again, as I've said, the FDA has to understand across all the specialties of medicine and has limited resources. They do the best they can, but what about the people that basically put in a legislation, the FDAAA? You know, I guess, do we have to go get back to them and sit everybody down in front of them and I'll ask the questions?

Speaker: Well fortunately, Bill, today we did have Amy Muhlberg from the Senate Health and Education Committee. Unfortunately she had to leave.

Dr. McGivney: Okay.

Speaker: But she and I were talking a little bit about this during the break and, you know, she said that this was a very good discussion and it did open some eyes. I wish she could've been here for the discussion about, you know, should we take a time out and perhaps try and change the deadline. So, yes, I think that we do have an opportunity to go up to Capital Hill and talk about the timeline.

The other concern that I keep coming back to is what impact is this going to have at CMS? What impact is this going to have with private plans? Are they going to say, "We've taken a look at this REMS and because the REMS is so slanted toward risks and not benefits, we're going to use REMS as a method or as a factor on whether or not to provide coverage?"

Speaker: For denial, right.

Speaker: And I think that that's just- It's beyond sort of what we're talking about today, I'm looking at down the road of how REMS are going to be used by payers.

Dr. McGivney: Okay. Well, I'm going to ask Scott how he feels about, I mean, whether that's realistic given how big your company is. We're going to go to you, Nancy. And, again, and

your interactions with all the big payers and all the big employers. But, Nancy, one more comment on it?

Nancy Davenport-Ennis: The only comment I wanted to make, I also have to say many of the plans today are already limiting formularies so that they're not going to reimburse for more than, and they fill in a number. More than five drugs per month, six drugs. We've already been told today that the number of drugs that involve polypharmacy for one oncology patient. So now if you give that plan the opportunity to say, "By the way, we're only going to pay for five drugs a month and none of them can have REMS," that's the concern that we live with as an access organization.

Dr. McGivney: So you think, again- Oh, George and then we'll go to-

George Dahlman: I was just going to add to something Mark had said, too. I mean, it's good to educate them and I think basically what Scott and Phil both brought up, too, about documenting what the experiences are and what the costs are for us who are here to be able to go back to the Hill and say, "These are the burdens that we're living under with this and this needs to be modified." Maybe take a time-out now, go back and redesign some things. So I think that documentation is going to be critical for us.

Speaker: In God we trust, everyone else has to have data.

Speaker: Right.

Speaker: Cash helps too.

Dr. McGivney: All right. So Scott, hearing all that, I mean, is that going to happen? Okay, so REMS drugs actually we have enough issues already with access because Dr. Jahanzeb and colleagues out there are making decisions. You saw the survey numbers, 33% I'm not going to, one, get involved in a REMS program, which means I'm not going to prescribe agents; and, two, you know, another 20% I may actually on certain drugs not prescribe them because I'll participate in REMS, but selectively. So are we going to add the third tier that payers say, "Sorry. FDA's made a determination for us that the risk is so great that we're going to say we're not covering?" Could that happen? Think it'll happen? Has that been talked about behind closed doors or what?

Dr. Reid: You know, I have not seen that kind of a dialog occur yet.

Dr. McGivney: Yeah.

Dr. Reid: But, that being said, you know, could that come to that? You know, I think in our world most of the utilization management programs that we have in place today which are all evidence based and we, for the oral oncologics we use your guidelines, most of those are driven around therapeutic appropriateness and whether or not this is the right drug for this patient and if not, then they should've have access to the drug and it's almost entirely around that.

Now that being said, as more of these drugs are coming to market that have significant safety risks, and maybe in the worst case scenario it's an absolute contraindication for this diagnosis with these other, you know, clinical characteristics, that patient should not get that patient. Those are beginning to weave their way into these, you know, guidelines and criteria as part of that upfront prospective process.

Let's face it. A lot of the UN programs out there today are meant to control cost, avoid unnecessary spend, and that is the number one concern of any employer or any health plan today as far as, you know, my experience. So as long as they are not feeling the financial pain right now of the cost of REMS, etc., I don't think there's a motive on their part to do that. But if they begin to, you know, feel that pain because someone says you have to pay me, that could begin to drive maybe we need to use that as a reason not to cover. You know, we joke sometimes behind closed doors and we get into debates about, you know, what else can we do to cut costs or to reduce the spend of clients and there comes a point where you have to decide. Are you in the business to treat patients on our health plans and employers in the business, at least part of the business is to provide health benefits to treat people with these illnesses? Or if you really want to cut costs and reduce spend, deny access to care. I mean, we joke about that, but I don't know that that's as much of a joke as much as, you know, it's a reality of what's coming. At what point do we deny access to these drugs for whatever reason, not just because there's a REMS plan associated with it?

Dr. McGivney: Let me ask about- So, you're talking about, you know, consideration of cost certainly in terms of what type of either precertification programs or- But what about the fact, okay, if I've got a 5% risk of being hospitalized for infection, febrile neutropenia, I mean, do companies consider that in the cost or are they just looking at the average sales price and saying, "This regimen is pretty high. We're going to put it on a pre-cert and then if it's got a REMS on top of it, we're going to kick it out?" Or are you looking at kind of the social costs, but the total cost, if you will, episode cost?

Dr. Reid: I think when you look at it purely from the pharmacy standpoint, that silo, those types of issues honestly come into the discussion. It's all about what do you got to pay for your prescription, what's my out of pocket going to be? That being said, you know, more and more of the health plans we work with, even the employers, they're beginning to, especially the largest, sophisticated ones, they're beginning to look beyond just the cost of the drug to look at what is the impact of that drug on maybe reducing total healthcare costs through better disease management.

Speaker: Thank goodness.

Dr. Reid: And it's not a far stretch to say, you know, and we've done some analytics on that trying to establish just, you know, what is that, you know, cost/benefit. If we spend $20,000 on this drug, are we seeing a concomitant reduction in other healthcare costs as a result of using it? That's been hard to

demonstrate except in a very few instances. So, you know, I think people are looking at it. I think there's going to be a demand for information around that and I can see that at some point, you know, they're going to get much broader in their view of this issue and take that into consideration.

Dr. McGivney: Yeah. Any comments on this? But I just want to give you one. I'm going to come back you. We're going to go to the audience and I'm going to ask you about, you know, so we're talking about Caremark but CVS, too, talking about specialty pharmacies, mail-order, I'm sure you guys must have everything, retail. What kind of information products and cancer care or are you just going to say cancer care is, again, too serious and life-threatening an illness to deal with? But do you anticipate your company or companies are going to provide?

Any other comments on this issue while we- All right, so there is somebody. Let me see.

Speaker: Actually, I think Bill, _____.

Dr. McGivney: Okay, that's cool.

Dr. Kolodziej: I'm Mike Kolodziej from US Oncology again. So I actually never really thought about REMS and CMS, but so let's say the FDA decides a drug warrants a REMS. Even before there was a REMS for ESA, every payer that I know of had developed their own pre-cert policy for ESAs. Could you see a world in which every payer developed their own pre-cert policy for use of a REMS drug and controlled utilization via that mechanism?

CMS aside, CMS will probably handle it via an LCD mechanism and there'll be different rules in New York and Texas and Arizona, but the payers, especially with the consolidation of the payer market, are almost certainly going to- They may actually require physicians to qualify for prescribing drugs targeted.

Mark H. Smith: Just to dovetail on that-

Dr. McGivney: Okay, wait a minute. We're good. We are going to, just so everybody knows, also it's probably- I don't know. It takes three or four weeks, but if you want a transcript, we'll provide. We are going to- Originally we hadn't planned on doing a transcript, but I think the discussion's been so great we're going to do a transcript. So if you want one, it'll be about a month or so. But, yes, Mark, sorry.

Mark H. Smith: Just to dovetail and something that is really important to take into consideration as we're talking about this is that we're talking about two different standards. FDA comes at it from the standards of safety and effectiveness, whereas Medicare and health plans come at it from a standpoint of, "Is it reasonable and necessary?"

Dr. McGivney: Whatever that means.

Speaker: Well, exactly. And that's the concern about-

Dr. McGivney: Okay, right. Never been defined, which makes-

Speaker: -how they're going to use REMS.

Dr. McGivney: Yeah. Well let me actually ask the flipside of the question, because I was going to- You know, I'm an optimist here. The glass is half full. If you've got a REMS program in effect for a drug, don't you expect that the, say, managed care companies would want to waive preauthorization because, you know, you're having that extra discussion with patients and, again, you're going to actually improve the value, you're going to improve the benefit and diminish the risks? Is that a good argument? Are you going to say, "That was nice Bill. We'll see you in about 20 years?"

Speaker: It's too early to tell, I think. You know, right now these things are being looked at as independent phenomena. But to that last comment, you know, the thing that I think needs to be done in looking at the point of development of these strategies- And it's not so much the strategy, frankly, as it is the tactic, in my opinion, because the tactic is what it is you need to do to meet, I guess, to achieve that strategy. And I would say that in the presence of evidence-based guidelines, you know, and let's say there's an organization that is practicing in accordance with those and maybe it's organizational policy that you do that and it's not always the case outside of an organized healthcare setting, but, you know, some people do think that's good medicine and they want to practice good medicine. But if those mechanisms are there, if they are being used, why can't we just add a piece of what's intended in the REMS to an existing process as opposed to having the pharmaceutical company, no offense intended, and the FDA agree on what's the right tactic to

achieve that end point and tell us you have to do it or else? And then for us it becomes an additive activity which in many instances may be duplicative or overlapping, which is just adding to the increase in cost. And this is not occurring. I mean, if you're practicing within guidelines and you can add a piece of that to ESA and you probably already have, I mean, we did. We didn't wait for the FDA to say we've got to do something here.

Dr. McGivney: Which reminds me of a CMS quality demo in 2006 that had it all but was flushed down the toilet. But anyway, such is life. Question?

Dawn Erdman, RPh: Dawn Erdman from Aetna Pharmacy Management. I'm in charge of utilization management programs at APM.

I totally agree with Scott. It depends upon the REMS program whether we will edit or not. If we feel like the REMS program is strong enough to stand on its own, we will not put pre-cert on the drug. If we don't feel that it's protective enough, we will put pre-cert on it with those additive measures.

Dr. McGivney: And protective in what sense?

Dr. Erdman: Evidence-based medicine, making sure that patient safety is taken into account and cost-effectiveness is taken into account.

Dr. McGivney: Ooh, you just introduced-

Dr. Erdman: Sorry, but that's my job.

Dr. McGivney: No, and I understand that to a certain extent but we'll leave that for another discussion in terms of what actually is in contractual language of companies like Aetna that allow you to do that or not do that. I used to work for Aetna. I used to run national coverage policy. But anyway, those were the good old days.

All right, so in the back.

Marcie Bough, PharmD: Marcie Bough with the American Pharmacists Association. I'd first just like to compliment the work group for the work that you've done as it parallels much of the work that the American Pharmacists Association has been having with many stakeholders throughout the last year or two, and much of the discussion this morning about a standardized system based approach that uses more standardized components within REMS, that we have a streamlined system to implement these within existing infrastructures in medicine and pharmacy is something, a goal that we all want to achieve. And I think having discussions like this builds on that and the more people that we can have in these discussions, the better.

I wanted to step back to a point that you were discussing just earlier on how can we influence where this is going from maybe a legislative perspective and regulatory so that the collective group of stakeholders can help FDA achieve the intended goals of the REMS, knowing that they're not going away. And two weeks ago FDA had a stakeholders meeting to receive public input on the reauthorization of the Prescription Drug User Fee Act, PDUFA.

And there was many organizations that brought up using PDUFA V reauthorization as a vehicle to address REMS issues and maybe giving FDA some additional authority that they might need to help us in achieve some of the many issues that we've all been talking about, either that or clarifying where we want REMS to go. And maybe it's, you know, let's look at the outcomes of these before we have REMS fatigue and there's too many REMS and the risks aren't being addressed because we're not implementing the programs and we're denying patient access.

So I just wanted to make sure everyone was aware that that, the PDUFA vehicle is an opportunity to discuss some of these issues with our Hill contacts and then in discussions with FDA and, again, compliment the group because we've published an APHA white paper on REMS and it's almost parallel to many of the issues that we've discussed today. Thanks.

Dr. McGivney: Great. Okay, you answer and I have a question for you, too, George. MJ?

George Dahlman: I would just point out, some of my colleagues here in the patient advocacy community probably know more about this than me and I don't see- Jeff is gone, I think, whose organization focuses on FDA. As I recall, maybe, you know, Mark too, I'm not sure. I mean, that's a great idea and if there's a legislative vehicle, that's always a great ship to sail on. I recall, and I may be wrong, but the last PDUFA there was so much emphasis on keeping it clean, making sure it was the user fees,

and let's not tag on everything else, that I don't know if it's a fact, but that might be a struggle to do that.

In the meantime, to address the other issue, I think it's important. I had brought up metrics to be able to educate the Hill and decision makers on it, and there needs to be some kind of a matrix of collecting and annotating those so that, I don't know whether that's NCCN or some other body, but there needs to be some kind of a collection point for us.

Dr. McGivney: As a follow-up, because this is the question I was going to ask you, from a public policy perspective and a legislative, which is tied in, obviously, so you have lots of issues you're dealing with all the time, is this a high-priority issue?

George Dahlman: No.

Dr. McGivney: No. So is this a medium-priority issue compared to what you're dealing with?

George Dahlman: Yes. Medium priority.

Dr. McGivney: And from the perspective of obviously people on the Hill with healthcare reform just passed, if we go up there, and I'd like Nancy's input and Mark's input, too. But, so where is this? They've got so much they're dealing with.

Speaker: We just talked about this at lunch. They don't want to see anything health related right now at all. They're done.

Dr. McGivney: They're done.

Speaker: They have caregiver burnout.

Dr. McGivney: They're fried.

Speaker: They're done.

Dr. McGivney: Done the damage and let it ride, right?

Speaker: The damage is done.

Dr. McGivney: Nancy?

Nancy Davenport-Ennis: Yeah, and I think at lunch our entire table had patient advocacy groups. We had a couple of observations. Number one, the Hill feels we're done. At worst they feel we're done right and well, and worst they feel we've done it cost-effectively and now you guys get to deal with it and implement it. And I think one of the hard and heavy lifting things that we have to do is to convince the hill that issues like REMS have not had the attention. I do think the PDUFA comments that we all have an opportunity to submit before May the 12th, they have three different sections in the guides that really are ideal places to take fundamentally 90% of all that's been discussed today and put it in your PDUFA comments and get it over to the agency.

Dr. McGivney: Okay. Mark and then-

Mark H. Smith: I would just agree with George. The last time that- The last PDUFA reauthorization, pardon me, those of us

that were trying to work on including extraneous provisions in that were told very clearly we're keeping the bill clean, we're not taking it. That said, George and I have our, Nancy, we all have our marching orders now. But just to reiterate what George said, we need data because I would say of 535 members of Congress, 532 have no idea that REMS was part of that legislation.

Dr. McGivney: Yup. Okay. We'll get you the mike right here and then we're going to go down there, and that's the last question or comment down there, and I owe MJ a comment.

Speaker: Just a comment in terms of further comments to be provided. The REMS guides document that the FDA released last year there was comments, the deadline was on December 31st of last year, but they haven't revised and released the new version so there is still time if you all feel that you have certain comments from this conference itself that could be added to that. Because I think one of the key things here is, as you can tell, you know, if you look on the FDA website, it has all of the REMS that have been approved. And as you can see even from ESAs or Nplate, there's, like, 100 pages of that document in there. And I think the theme here is from a strategy perspective. You know, you can have a REMS strategy that could allow a lot of flexibility in terms of how things are implemented, but when it's a labeling requirement, that's where the flexibility is not there. So I think I'd encourage you guys to look into that as another possibility from your perspective.

Dr. McGivney: Actually, that's a good point. And again, you know, organizations obviously some people may have taken notes here, but we are providing the slides, again, by close of business next Wednesday, we will provide the transcript. But, I mean, there's just been so much- And this is what we asked for and Dr. DeMartino down there and Dr. Li have done a great job in saying, "Okay, some of these recommendations are very good and some are general. Let's fill in the meat, the examples," and I think there's been a lot of that today.

MJ, you had a comment, then we'll go down there.

Dr. Jahanzeb: Yeah. While REMS is mostly about side effects, we're here to discuss side effects of REMS. And I think one that is-

Speaker: Well, palliative care for REMS.

Dr. Jahanzeb: So one that has not been discussed from a physician/patient interface, because that's really what matters in the end, is the skewing of the dialog because of REMS. We are in the line of work where most cytotoxic drugs, drug finding paradigm, dose finding paradigm, has been maximum tolerated dose. So we are pumping nearly poisonous doses of drugs into patients that have no REMS associated with it. And then you sit and talk about some REMS with the patient about drugs you may or may not use and ignore the 100 milligrams per meter squared of Taxotere that you're about to give to the patient. And I think it totally skews the dialog and deemphasizes the real dangers of real

therapy that we are about to give to the patient and that needs to be kept in mind.

Dr. McGivney: So after this next question, the last question is, since I can't think of anything innovative, is: Is cancer different? And you may have just answered it, but, yes, doctor?

David Chen, RPh, MBA: David Chen, ASHP. To play off your comment of side effects, my question may be to Phil or anyone on the panel. Use the case study of thalidomide. A patient gets discharged on a Sunday and he can't find a pharmacy that's registered and how the changes in supply chain have really been impacted. How do we see that being analyzed? You know, I think from our perspective as hospitals with dealing with the transitions of care, just seeing this great fragmentation of our supply chain and what are some of the unintended consequences from that?

Dr. McGivney: So Scott, is this going to affect the supply chain, I guess, and, you know, the fact that there are going to have to be certification that, well, I guess at least in the pharmacy chain that the pharmacists have the training to be able to administer the prescribed drug, etc., etc.

Dr. Reid: You know, if you have access to one of these medications from a distribution standpoint, whether you're 1 of 70,000 retail pharmacies or you're 1 or 3, I think if you're going to engage and handle those products, you have got to meet the requirements that exist today because I think in the eyes of

so many of the pharmaceutical companies, this is a legal issue for them and a compliance issue as much as anything else. And so if you decide that you're going to take that product, you're assuming certain responsibility to comply as well and I at least have found that when you have, you know, a couple products that have, you know, very complex requirements the only way that you can ensure, in the absence of failsafe systems that are going to prevent anything that you shouldn't do from happening or making sure you do the things you should, is you need to limit the number of people in your organization that are qualified to handle it. Sometimes that means you may only put it into a couple of sites and not every retail pharmacy in the country. And the people handling it, they need to be familiar with the program, they need to understand what's behind it, they need to be trained, and they need to have certain skills and abilities to deal with some of the issues that come up because as much as the physicians and the hospital staff get engaged in these discussions, many times the drugs that we see and when it gets to a pharmacy, they're not coming from a hospital. And so we have to have those same conversations and so we run into the same issues and you have to have people who are skilled in what can be very difficult and sensitive conversations, obviously.

So I think, you know, the extent to which you need to control their use today in terms of distribution, which as much as sometimes I don't like that, I understand why, because the stakes are high. It does create, you know, access issues to the

products and it's something that I don't know what it's going to take to change that, at this point anyway.

Dr. McGivney: Yeah. Well I think, I mean, this is a whole other area. So I'm going to accommodate one more question, but so everybody doesn't start running out, you know, when we finish here, as I say, we from an NCCN perspective are going to develop some type of communication that can be sent to certain regulatory agencies and insurers and others about the impact of this whole program. Again, we're going to use the transcript to do that, and as I already said, we're going to make it available to everybody.

So, we're going to take one more question. Then the last question is very succinct. So is cancer different and, you know, should it be exempted? Why? Does it disprove the need for a REMS program? Or actually, your other option is within the three sentences you're allowed you can answer any other question you might want to. Okay? So how's that for an ending? One more question down there, though.

Judi Lund Person, MPH: Hi. I'm Judi Lund Person from the National Hospice and Palliative Care Organization and I just want to really corroborate the challenge I think that we have in front of us when we're looking at the continuum of care and especially the continuum of care outside the hospital setting. So the number of patients that get released from the hospital, come home on a Friday afternoon, have no access to a pharmacy that has the drug that they need. If they haven't left the hospital with it,

they are searching the whole community to find a place to get the drug that they need. And so I think that's just a, as we look at continuity of care, as we look at availability of drugs in a variety of places, it's a huge, huge issue for our patient population.

Dr. McGivney: Excellent comment. One more thing. Please fill out the evaluations. Tells us what we did, what we did wrong. One thing that we've been certainly pleased by is and we thought we have so many experts in the audience, the interaction has been terrific and we appreciate all your input and your sharing of your expertise today.

So, can you remember my last question? Three sentences. Talk about whatever you want or talk about my question.

Shirley Johnson: So is oncology different? Absolutely. Chronic illness, the demographics, the pipeline of drugs, the inpatient/outpatient continuum. But with that said, with the drugs that we're talking about REMS programs for to assure their safety in a population, we have to attend to that in some way.

Dr. McGivney: Okay, good. Dr. Weinstein?

Dr. Weinstein: Well, it occurs to me that the other way that cancer is different is that we have NCCN and we have this kind of an opportunity, so being rather skeptical and disillusioned and quite pessimistic with, you know, the outcome of this-

Dr. McGivney: I don't like that right after NCCN's mentioned.

Dr. Weinstein: -attempt to make healthcare reform in our political system, I was just looking for some proper wording there. I'm actually very encouraged with this day and what I'm hopeful for is that if we can do this well in oncology, maybe it can be something of a model for the other aspects of our healthcare in America that is in such need of reform.

Anyway, thank you all tremendously, again, for your participation today and for your ongoing participation with what I hope will be a successful process here.

Dr. McGivney: George?

George Dahlman: Yeah. Just speaking theoretically, because that's the way I can, you know, it's interesting. As much as we talked about having buckets and standardized reporting mechanisms, I mean, cancer, especially if you're in my space, there are so many different diseases and some are easily treated and some are less so. And so as much as I would want to say, "Yeah, we're different," it's not a clean slate, so.

Dr. McGivney: We're different even within our cancers as you say.

George Dahlman: Yeah. Right.

Dr. McGivney: So Dr. Jahanzeb? So far you have the line of the day with two more people with your REMS and the side effects of REMS.

Dr. Jahanzeb: I usually am good for one line a day, so how about we just stop here?

Dr. McGivney: Oh good, I'm glad we got it out of you.

Dr. Jahanzeb: So, no, I think cancer is different because the stakes are higher, our drugs are more poisonous, our patients are more motivated, they're more focused on their end, their demise, and I think they don't need the added stress of anything that we can avoid lopping on to what's already going on. So there are many unique features but I'm very encouraged by the dialog today and by how many entities got together and I'm hoping that when a document, your transcript goes with the attachment of how many different entities were involved in this summit, that'll carry a lot of weight.

Dr. McGivney: Yeah. Great. So chairman of the workgroup here? Phil Johnson.

Dr. Johnson: The reason cancer is not different is that regardless of the disease and regardless of the drug, every patient deserves to make an informed decision on safe and effective therapy. It's only a matter of degree.

We've talked a lot about the need for data. That's what we have to do is to agree on some matrixes or some matrix, something to collect data, to collect and provide to prove our case. And the one stakeholder who's not here, and they were invited, was the informatics companies and they're the people we need to provide the efficiency that we need so we can spend time with our

patients, so we can collect the data. And to me, there's a mandate for us to do REMS, to do comparative effectiveness studies, to do patient adherence data. There should also be a mandate to somebody working in the healthcare industry who provides the infrastructure that is essential for us to do our job.

So I would like to also at some point in time address the issue that if there's a mandate on us as providers, there ought to be a mandate on the infrastructure providers as well, and they should be in lock step with our timelines. You know, they should provide the infrastructure we need as we need it to be effective. Otherwise, we cannot be effective.

Dr. McGivney: Good point. Scott? Final word.

Dr. Reid: Final word. Well, I think oncology is a focal point today of the REMS argument. I would say that it isn't necessarily the only one. I mean, there are other disease states for which medications have been developed in the last couple of years that have equally as complex and sometimes more burdensome, you know, activity than some of the oncology medications, number one.

Second point I just want to make real quickly is I noticed throughout the course of today there was an absence of any discussion about the impact of the changing rules around adverse drug event reporting, and for the most part, every REMS product, you know, has that requirement. But the rules of the game in

terms of reporting adverse events is no longer being interpreted as voluntary, number one; number two, it's not just limited to serious and unexpected adverse events. More and more these programs require reporting of every adverse event, both serious and non-serious, and with some of these oral oncologic products 80% of the patients report some type of side effect. And that to me is really the more burdensome part of this whole thing, number one, which maybe hasn't gotten into the institutions yet. I know for me it was a stark reality having practiced in hospitals at one time, but I think that's something we also have to look at at the same time because they go hand in hand.

Wrap-up/Conclusion

Dr. McGivney: Great. Thank you. I'd like to thank the work group. I'd like to thank all the speakers, some of whom were on the work group, others who have been generous in participating today. And most of all, I'd like to thank you all. This is quite a diverse group of organizations here. You can see from an oncology and cancer care perspective, certainly I had clinical pharmacists who were aware of REMS, but the oncology community in terms of the physicians, in terms of administrators, you know, somehow the information, the communications weren't reaching them. So clearly there are a lot of issues that we in oncology have to deal with specifically. There are a lot across medicine, but oncology is a huge, as I say, repository of these issues and we've illuminated and highlighted some of them today and we need to do that, as I say, further in the public policy sphere.

So, I'd like to thank you all. Remember to fill out your evaluations. Please have a safe trip home wherever you're going and a great weekend, and thank you all again. We're happy to talk with any of you about any potential collaborations or issues, so take care. Thank you.

END OF MEETING