AMCP Webinar
Market Insights
Future Treatments in Hemophilia
Guest Speaker
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Chief External Affairs Officer
National Hemophilia Foundation

Patient Champion Award: Patient Advocate

NATIONAL HEMOPHILIA FOUNDATION
for all bleeding disorders

FINALIST

EyePharma Awards 2019
Dec 11, 2019 | Bellevue Hotel, Philadelphia
Mission Statement

The National Hemophilia Foundation is dedicated to finding the cures for inherited bleeding disorders and to preventing and treating the complications of these disorders—through education, advocacy, and research.
CCSC: A Hemophilia Quality Improvement and Cost Management Initiative Sponsored by NHF

- Formed in 2014 with a prominent group of HTC directors, clinicians, and administrators along with payer/managed care medical and pharmacy directors

- CCSC’s vision is to augment the sustainability of HTCs through the following:
  - Overcome communication gaps to increase connectivity between payers, purchasers, and providers
  - Broaden access to extensive hemophilia-related outcomes data from HTCs
  - Disseminate rigorous standards of care, quality, and cost management for hemophilia
  - Improve the recognition of HTC-derived value
  - Obtain advanced analytics on a rare, high-cost disease and gain insight on actionable best practices
Rationale for the CCSC Initiative

**HTC**
NHF has long since recognized the HTC integrated comprehensive care model as the gold standard of clinical management for patients with rare, chronic bleeding or clotting disorders.

**340B**
Many HTCs depend on 340B program revenue from the sale of clotting factor replacement products to maintain and grow integrated care programs.

**SPP**
HTCs are challenged to access specialty pharmacy contracts due to current trends:
- Factor coverage is increasingly being shifted from the medical to the pharmacy benefit
- Pharmacy benefit managers (PBMs) are acquiring their own specialty pharmacies (SPs) and encouraging plan sponsors to allow the SPs to become the exclusive provider of specialty drugs.
CCSC Bridges the Communication Gap Between Providers and Payers/Purchasers

HTCs

Advocacy

Health Plans

Outreach

Employers
How CCSC is Helping HTCs Address Market Trends

Value-Based Contracting

- Provide data demonstrating improved outcomes and lower costs

Copay Accumulator Adjustment Programs

- Leverage CCSC payer education materials and outreach

Gene Therapy

- Become centers of excellence for the administration and follow-up of gene therapy
Market Insights Meeting Overview

- Clinical Overview: Hemophilia A—Evolving Role of Factor
- Clinical Overview: Hemophilia A—Inhibitor Management
- Clinical Overview: Emergence of NonFactor Treatments
- On the Horizon—Pipeline and Gene Therapy
- Employer Perspective- Self Insured and Reinsurance
- Impact of New Treatments on Delivery of Care
- Partnering in Hemophilia

Expert Presenter:
Tammuella Singleton, MD
Assistant Professor of Pediatrics
Department of Pediatrics
Children's Hospital
New Orleans, LA

Expert Presenter:
Michael Baldzicki
Executive Vice President, Growth & Strategy
AscellaHealth
Objectives

• Collect Insights to help payers manage access and product utilization amidst the introduction of new hemophilia treatments

• Define the role of factor replacement, emicizumab and future gene therapies in patient outcomes

• Understand changing business models for care management as non-factor product use increases

• Collect and disseminate best practices for evaluating hemophilia outcomes and value of specific therapies and interventions
Methodology

- 7-hour live meeting on November 1st at 2019 AMCP NEXUS, National Harbor, MD
- Roundtable format, with presentations and group discussion

Lives covered ranged from 135,000 to 35 million.

Pharmacy directors, medical directors, clinical pharmacist, Hemophilia Alliance, Specialty Pharmacy, National Hemophilia Foundation
With respect to the upcoming AMCP Market Insights program on hemophilia, what are your key objectives in attending this program? (Select all that apply)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Learn clinical information and pipeline products for hemophilia treatments</td>
<td>45.45%</td>
</tr>
<tr>
<td>Understand best practices in the treatment of hemophilia</td>
<td>27.27%</td>
</tr>
<tr>
<td>Understand diagnosis and patient criteria for future hemophilia treatments</td>
<td>18.18%</td>
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<tr>
<td>Understand the implications of future treatment options (Options A-D)</td>
<td></td>
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<tr>
<td>A) For my patient population</td>
<td>45.45%</td>
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<tr>
<td>B) For my plan pharmacy budgeting</td>
<td>36.36%</td>
</tr>
<tr>
<td>C) For physician uptake</td>
<td>18.18%</td>
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<tr>
<td>D) For educational needs for other areas of the health plan</td>
<td>18.18%</td>
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Payers identified numerous needs for increased knowledge about hemophilia
Key Questions from Participants

• How do we integrate gene therapy within existing benefit structures, and how do you integrate it functionally?

• How do you manage costs and patient expectations?

• How do you manage emicizumab and other products in the pipeline, and how will they all fit together?

• How can all stakeholders collaborate?

“I hope to gain a better understanding of how collectively everyone is going to approach the shift in management of hemophilia.”

“What's the role of all of the different players, and how does that change with this moving into the gene therapy realm?”

“There's just no standard of care in what you're supposed to do in hemophilia, which makes it difficult.”
Participant Perspectives on Factor Utilization Management

Payers-identified issues

- Factor usage and spend
- Many use PA for extended half-life products
- High levels of month-to-month variability makes utilization unpredictable
- Starting to look at pharmaco-kinetics for dosing
- Majority monitor wastage through assay management
- Many participants can link and analyze pharmacy and medical claims
- Participants may adjust plan decisions as new products enter the market
- There are no established standards of care
Evolving Issues With Factor Replacement Treatment

Treatment must be individualized based on specific patient characteristics

**Issues impacting factor use**

- Patients can have the same genotype but different phenotypes in severity of bleeding
- Early and appropriate treatment of each bleeding episode is critical to minimize complications
- Consider impact of weight on dosing on amount of replacement required
- Early refills may be appropriate, especially after bleeding episodes
- Bleeding episodes can result in significant and permanent consequences for patients—treatment goal should be no bleeds
- Products are not interchangeable- not a lot of data for switching

**Who should receive prophylaxis**

- All severe patients are candidates for prophylaxis but not all receive it
- Self-infusion with factor is a goal, but access can pose challenges, particularly for young patients and those with psychosocial issues
- Risk of microbleeds resulting in joint damage must be considered for mild and moderate patients
- Typically don't start prophylaxis until after a severe hemorrhage, a joint bleed, or certain other situations, such as intracranial hemorrhage

“90% of those with severe hemophilia have chronic degenerative changes due to recurrent hemarthrosis in at least one joint by age 25.”
Prior Authorization and Factor Use

Issues to Consider

• Most PAs follow dosing provided in package inserts - when possible
• Patient type, severity, inhibitors, body weight are considered
• Total factor use and variations in dosing based on individual patient factors

Factor use is highly variable

• Varies from month to month based on frequency of bleeds, prophylactic use
  – Even patients with mild disease may experience a severe bleed
• Consider impact of factor use on medical utilization and ability to review total cost of care
• Most plans cover all products; most HTCs purchase all products to individualize

Category/ utilization review processes

• Annually, quarterly, or monthly
• As part of specialty pharmacy category review
• Assay management reviews

“When we’re starting to do any type of budget predictions for the next year, we do look at the factor utilization and if we’ve had any significant changes in that trend. And we actually look at it on a monthly basis.”
## Monitoring and Reporting

### Real world evidence
- Can be a challenge for payers to manage data
  - Few data are currently available
- Inventory management most common - not much outcome-based analysis available
- Quality of life issues are most common e.g., activity level, psychosocial issues
- Limited ability to separate patients by characteristics (e.g., severity, age, bleeds)

### Reporting requirements
- Monitor bleeds
- Behavioral health components of patient care
- Pharmacy reporting of dispensing information - may not match prescribing
- HTC reporting—share various levels of data with plans - however challenges remain

### Digital strategies
- Can be used to collect data
- Some programs have proprietary software for tracking outcomes
  - Can review dispensing history
  - Patient reported outcomes
Factor Site of Care Implications

- Many patients receive care through HTCs, other in outpatient treatment centers that also treat benign hematology
- Many patients store factor at home for self-administration—concerns of stockpiling remain
  - Some specialty pharmacies still auto-ship product
  - Patients have reasonable fear about ensuring they have products on hand
  - Should a patient have multiple types of Factor (SA and EHL) at home?
- Impact of 340b pricing on hemophilia treatment centers and ability to provide supportive services
  - Concern about the shift to specialty pharmacies and/or non-factor treatment may impact quality of care and HTC revenue streams
- Patients are encouraged to bring factor with them to ER
- Goal is to optimize treatment regimens and avoid wastage

“There's so much variance in care, it's hard to have management strategies.”
“There is no standard of care of what exactly you are supposed to be doing”
Other than confirmation of diagnosis which, if any, restrictions does your organization have on access to products for prevention of bleeds in members with hemophilia? (select all that apply)

On concomitant use of emicizumab with a Factor-replacement therapy?
No participant had any policy for concomitant use, but were positive about concomitant use, as it confirmed to them that bleeds were being treated.
Emicizumab and Inhibitor Considerations

**Inhibitor development**
- Inhibitors may develop more frequently with recombinant products
  - SIPPET trial: recombinant FVIII associated with an 87% higher incidence of inhibitors)
- Immunotolerance therapy is an option to try to eradicate the inhibitor
  - 60% to 70% effectiveness; high cost

**Consider use of emicizumab initially to avoid inhibitor development**
- Can start emicizumab in newborns
- Can use emicizumab in patients with inhibitors
- May be more appropriate for highly active patients

**Possible emicizumab PA requirements**
- Documentation of hemophilia diagnosis
- Why they are not a candidate for factor, or
- Why emicizumab is needed with factor

“Emicizumab changes the question about whether to do immunotolerance therapy.”
Products on the Horizon

**Fitusiran (ALN-AT3)**
SC-administered small interfering RNA (siRNA) therapeutic targeting antithrombin (AT)
In phase 3 trials

**Concizumab mAB 2021**
High affinity monoclonal humanized antibody specific to the KPI-2 domain of TFPI – binds all forms of TFPI in blood and cell bound TFPI
In phase 3 trials

**Gene Therapy**
Potential approvals in 2020, several additional products in phase 1, 2, 3 trials
## Considerations Regarding Gene Therapy

### Unmet needs addressed
- Steady, ongoing concentrations of factor
- Reduction or elimination of spontaneous bleeds
- Reduction or elimination of dependence on frequent infusions

### Potential Limitations
- Not all Hemophilia A patients will be candidates or will want to receive gene therapy
- Still need treatment for bleeds
- There are viable options for treating patients now
- Patients who receive gene therapy may not be cured in the sense that they may still need treatment with factor under certain conditions
  - Trauma, surgery
- Treatment will not reverse joint damage
- Durability of treatment remains unknown; will patients require more than one treatment? Will antibodies develop?

### Patient candidates
- On prophylaxis but having difficulty optimizing
- Able to participate in significant follow up
- BMI? Re-dose?

### How will Gene Therapy change Hemophilia A category management?
- Concern about durability of effect
- Also from a patient management perspective, gene therapy was noted as creating a lot of “mild patients with hemophilia”, as such will still have to manage bleeds and be prepared
Financial Implications of Gene Therapy and the Potential for Improved Outcomes and Reduced Health Care Service Utilization

• The specialty drug trend continues to outpace that of traditional pharmaceuticals and remains a key priority of payer management

• Gene therapy forecasts demonstrate a significant cost impact on the specialty trend, including in hemophilia

• Value in health care innovation lies in the result of the innovation rather than the innovation itself

• The juxtaposed needs and concerns of payers, providers, and patients must all be carefully weighed when evaluating the role and coverage of gene therapy in future care interventions

• Consider impact of newly-approved treatments on underwriting assumptions
Proposed Payment Models Aligned with Appropriate Use for Hemophilia Gene Therapy

• The anticipated high cost of gene therapy, in addition to the potential for patient migration between health plans, necessitates innovative payment models
  – Consider potential impact of gene therapy cost on access to other treatments

• Potential strategies
  – Outcomes-Based Agreements
    • Consider need for collection and tracking of real-world evidence
    • Gene-therapy manufacturer becomes responsible for other treatment costs (e.g., any necessary Factor costs) within a defined time period
  – Alternative Payment Models: Annuities and/or Risk Pools
    • Some reinsurance providers laser hemophilia

• New types of provider entities are likely to emerge

• The eventual choice of innovative access scheme will ultimately depend on individual health plan environment and characteristics

“There has to be alignment on risk.”
Considerations Reinsurance/Stop Loss Payment Options

• Secondary insurers assume financial risk above a specific threshold
  – On average, self insured organizations cover the first $300,000 of a specific claim

• Stop Loss Carriers have realized a significant increase in catastrophic claims, or those above $1M
  – Patients with claims of more than $1 million represented only 2% of the total number of stop-loss claims from 2014 to 2017, but roughly 20%, or nearly $600 million, of the total $3 billion in stop-loss reimbursement
  – In 2018, hemophilia resulted in $67.9 million in stop-loss claim reimbursements

• Stop Loss Carriers utilize several techniques to minimize their risk in high dollar cases which ultimately adversely affect the plan sponsors
  – Techniques may limit access for patients with hemophilia

• Because the drug treatment protocols for conditions like hemophilia are more maintenance-like than curative, those $10 million to $20 million claims are becoming annuities
2019 NHF Goals to Address Gene Therapy

- Community education
- Relationship building – rare disease organizations
- Increase knowledge of the science of gene therapy
- Raising the profile of NHF as an important voice in the rare disease and policy and regulatory space
Educating the Community on Gene Therapy

• Established an External Working Group
  – 4 HTC physicians, 2 patients, 1 caregiver and 1 social worker

• Frequently Asked Questions (FAQs)

• In-depth lexicon of gene therapy terms

• All About Gene Therapy Video

• Website strategy outlined

• 3 Sessions at NHF’s Bleeding Disorders Conference on Gen
  Innovative Therapy
  – Multiple sessions in provider track

• Gene Therapy Summit held in November 2019
Future in Hemophilia Treatment
Impact of Care Delivery Models
The HTC Model of Care Strives for Greater Integration of Services

HTC Care Coordination Pathway

CLINICAL ASSESSMENT → INTERDISCIPLINARY CARE PLAN → IMPLEMENTATION / INTERVENTIONS

EVALUATION / REASSESSMENT / OUTCOMES → OUTCOMES ANALYSIS & REPORTING

Key Learnings of HTC Role in Managing Care and Costs

• Most centers fund unbilled care services such as telephone triage, medical care coordination, and case management/psychosocial services almost entirely through 340B

• Greater frequency of education with upstream touchpoints (PCP level and other specialties) to identify bleed prevention, including with social workers and ancillary care providers to stem costs
  • Once controlled, live visits to HTCs decrease to 1-2x annually, and the majority of care is teleservice

• Currently, approximately 30% of patients do not go to HTCs; these primarily consist of mild disease and older members; geographic challenges within state and lack of local hematologist availability avail HTC as a resource
Most HTCs fund unbilled care such as telephone triage, medical care coordination, and case management/psychosocial services almost entirely through 340B.

- Telephone Triage: 76% in [90%-100%], 14% in [50%-90%], 10% in [0%-50%]
- Medical Care Coordination: 80% in [90%-100%], 10% in [50%-90%], 10% in [0%-50%]
- Case Management and Psychosocial Services: 70% in [90%-100%], 13% in [50%-90%], 16% in [0%-50%]

N=31 HTCs with established 340B programs.

Care Models for Hemophilia Therapy

• Persons with hemophilia receive the best care when seen annually at an HTC, in addition to their primary hematologist
  – A CDC study of 3000 people with hemophilia found that patients seen at an HTC were:
    • 40% less likely to die of a hemophilia-related complication
    • 40% less likely to be hospitalized for bleeding complications

• HTCs are seeing margins from 340b products shift due to increased used of non-factor products

• Novel treatments that reduce factor use may further impact HTCs

• Need to consider new care and reimbursement models
  – How to continue to support high quality care?

“HTCs need to come up with a new model-everyone else is changing”

About half of Participants Believe HTCs Provide Better Care than SPs

Which of the following sites of care do you think provides better patient management and outcomes, while dispensing medication, for hemophilia patients?

- Specialty Pharmacies: 45.45%
- Hemophilia Treatment Centers (HTCs) with pharmacies: 45.45%
- Neither-both provide equal quality of care: 9.09%
Participant Perspectives on HTC Reimbursement

**How strongly to you agree with the statement that HTC pharmacies and SPs should receive the same hemophilia drug reimbursement rates?**

- No Agreement
- Slightly Disagree
- Neutral
- Slightly Agree
- Strongly Agree

**Would you pay Hemophilia Treatment Centers directly for patient management / comprehensive care and outcomes separately from drug reimbursement?**

- Yes
- No
Preparing to Manage Patient Needs in an Evolving Treatment Paradigm

• **Treatment Access and Quality**: Health plans should anticipate hemophilia care in network management and medical management strategies, to ensure access to specialized medical and pharmacy providers and support appropriate care as revenue streams shift.

• **Care Management**: Health plans should consider how best to coordinate multi-disciplinary outpatient and home-based services for members with hemophilia, determine what oversight and additional care coordination are needed and clearly designate accountability.

• **Cost Management**: Plans need to consider factor pricing and cost-effective approaches for administration of costly factor replacement products, while allowing for individualized treatment.

• **HTC and SP**: Need to consider new payment reimbursement models- monthly fee per patient, reduce services in rate were noted.

• **Pharmacy Management**: Plans should evaluate the full spectrum of services required to manage hemophilia, and contract with the most appropriate pharmacy to provide cost-effective and timely factor replacement services for routine and emergency needs.

• **Risk Adjustment and Risk Management**: Plans may need to work with the advocacy community and states to anticipate enrollment of members with hemophilia. These stakeholders can proactively recommend financing solutions to ensure member access to appropriate care; this may include risk adjustment or carve outs to avoid risk selection adversely impacting plans and members.
Questions?
marketinsights@amcp.org
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