HEALTH PLAN BEST PRACTICES

Targeted Therapies to Deliver Improved Patient Outcomes in Oncology

Health Plan Best Practice	Contextual Considerations

1. Create coverage policies for targeted therapies after careful review of published scientific literature, practice guidelines, emerging evidence, and consultation with clinical experts and patient groups.	· Limitations in clinical evidence include the lack of data from RCTs and follow-up time
	· May need to consider basket trials
	· Continued FDA approval may be contingent upon confirmatory trial(s)
	· Clinical experts may include local oncologists, large cancer treatment centers, and manufacturers
	· Use the clinicaltrials.gov database to stay up to date
	· Time to assemble and synthesize information can be considerable
	
	Cautions Against
	· Limiting coverage criteria to FDA-approved indications only
	  · If the FDA label is used to guide coverage, engaging clinical experts and patient representatives becomes more valuable
	· Limiting coverage based on inclusion in practice guidelines/position statements
	  · Data are published continuously and guidelines may not reflect current clinical practice standards

2. Visual dashboards support drug value assessments of targeted therapies in oncology.	· Evidence limitations due to under-representation of minority populations in clinical trials · Seek input on benefits/harms due to biological, cultural, or social reasons · Ensure coverage criteria have not gone beyond reasonable use of clinical trial inclusion/exclusion criteria
3. Provider qualifications and site-of-care restrictions are appropriate in coverage criteria for ADCs to ensure patient safety.	· Accurate diagnosis and use of ADCs require specialist training · Potential for serious side effects of therapy · Dosing, monitoring for side effects, and overall care coordination require specialist training · Site-of-care policies can be used to support safety and manage the costs of intravenous drugs
4. Proactively provide coverage for and guidance on pre- and supportive medications for ADCs to prevent toxicity and adverse reactions. 5. Proactively build decision support tools on ADC dose reductions to quickly addressing toxicity or adverse reactions.	· Managing toxicities of ADCs are essential to their successful use · Unmanaged adverse effects may lead to treatment discontinuation · Ophthalmology-related care may be needed under the medical benefit if vision coverage is not available · Review UM on supportive medications (e.g., eye drops) and remove coverage barriers (e.g., quaintly limits)
6. Use multidisciplinary collaboratives or disease-specific working groups to better manage the growing complexity of cancer care.	· Multidisciplinary teams can meet regularly to review clinical trial information · Teams can monitor trends, inform P&T, and support treatment pathways, including treatment sequencing · Teams can support understanding evolving clinical evidence more quickly and facilitate timely formulary/pathway updates
7. Make clinical criteria and coverage policies for ADCs readily available to patients and providers on the payer website and provide rationale and references.	· Clinicians and patients should be able to easily find criteria and supporting clinical rationale · Coverage policies are treated by some payers as competitive assets and held in confidence; while other payers post their coverage policies publicly · Greater transparency demonstrates a commitment to the appropriate application of clinical evidence to insurance coverage policies
8. Use major compendia, clinical efficacy, side effects, and cost to build preferred pathways and treatment sequencing.	· Maximize patient survival, minimize toxicity, and manage the total cost of care · NCCN treatment guidelines do **not** address the optimal sequencing · Increasingly complex with new agents and ongoing evidence gaps · Integrate treatment pathways into the EHR system to better support prescribing decisions
9. Pharmacists and EHR case management modules support ADC-related care coordination and can help address social determinants of health.	· EHR modules can increase administrative efficiency, coordinated care, and track patient outcomes over time · Pharmacists can recommend prophylactic medications to mitigate toxicity and follow-up with patients after infusions
10. Patient education on adverse effects and supportive medications is an essential element of high-quality cancer care.	· Patients need access to high-quality information, including cost and toxicities · Effective education requires an element of anticipation and preparation that can be easily missed if it is not incorporated into clinical workflows
11. Optimal patient selection strategies require consideration of intratumor heterogeneity of target antigen expression and changes in expression with treatment and disease progression.	· Patient selection based on tissue expression of target antigen · ADCs have also shown clinical activity in patients with low levels of target antigen expression
12. Develop coverage policies that create a broader package of benefits so that patients who face financial or logistical hurdles can have equal access to specialized cancer care.	· All stakeholders have a responsibility to reduce health inequities · Individuals at a higher risk of not receiving adequate education about their condition, face a longer time between diagnosis to initiation of any therapy, are often late to receive guidance regarding new treatment options, and may have trouble accessing highly specialized therapies · Expand telemedicine coverage and creating parity (e.g., out-of-pocket costs) between in-person and remote care · Recognize that, in addition to often steep out-of-pocket costs for cancer treatments, there are ancillary costs that can become barriers to care and exacerbate inequities.

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