Society for Immunotherapy of Cancer

ADVANCES IN Cancer IMMUNOTHERAPY™

Practical Barriers in Cancer Immunotherapy Treatment

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AAEM AMERICAN ACADEMY OF EMERGENCY MEDICINE CHAMPION OF THE EMERGENCY PHYSICIAN

ACCC Association of Community Cancer Centers

HOPA Hematology/Oncology Pharmacy Association

Society for Immunotherapy of Cancer

#LearnACI

Disclosures

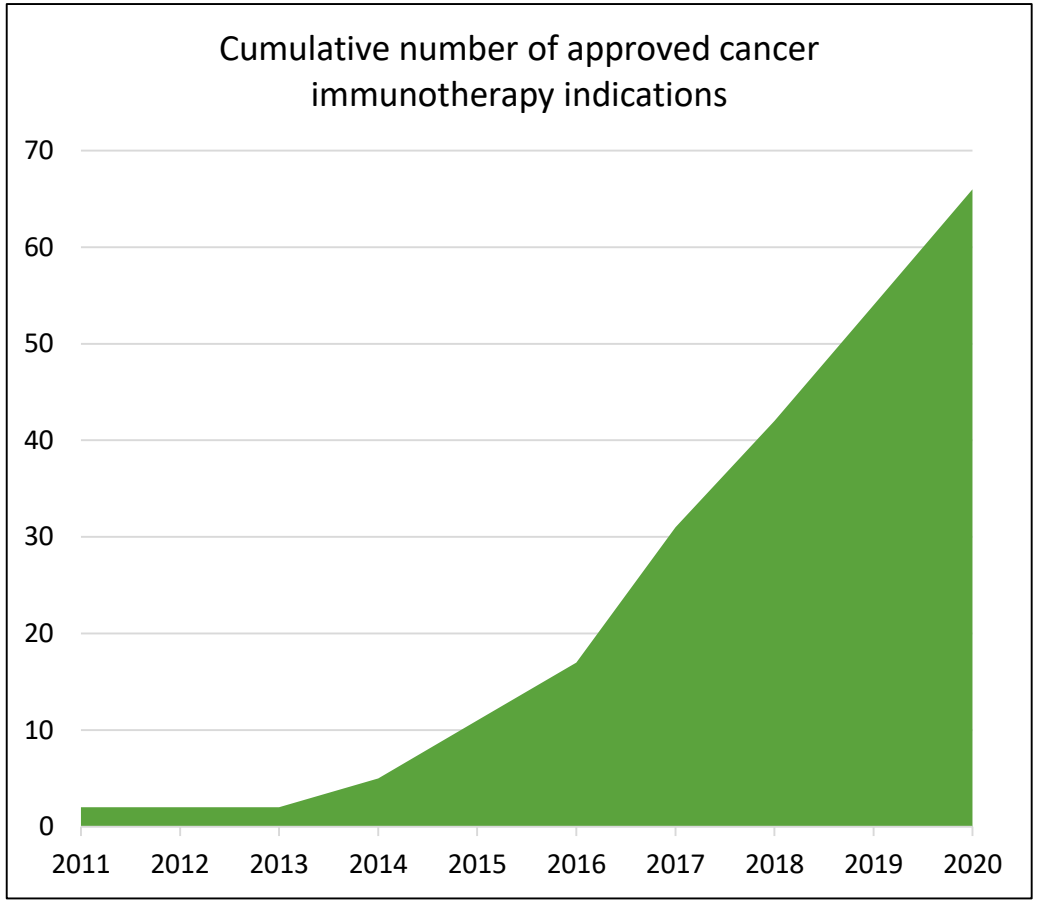
- No relevant financial relationships to disclose.
- I will be discussing non-FDA approved indications during my presentation.

Outline

- Practical aspects of immunotherapy
- Financial considerations
- Medicare reimbursement
- Commercial payers
- New considerations for cancer immunotherapy

IO Pipeline and Research

- Current products on the market are the "tip of the iceberg" when looking at manufacturers' Immuno-Oncology (I-O) pipelines
- During the next few years, we can expect a new IO product or indication every few months
- Many new combinations and regimens with approved agents as well
- Important to help patients understand that they are receiving immunotherapy



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Strategies for New Information

- Immuno-Oncology Champion
  - Identify an "Immuno-Oncology Champion" from among your providers to be the "I-O point person" responsible for all product questions and staff education (can be physician, advanced practitioner or pharmacist)
- Education group
  - Identify a core group within your practice to manage patient education, including the review of existing patient materials and/or the development of new materials specific to I-O agents and management of their adverse effects
- Staff education
  - Proactively update staff on new information and consider use of manufacturer-provided resources including on-site training/education (or attend programs like this!)
- Identify specialty providers within your institution with expertise in immunotherapy toxicities
  - Developing a network of providers to prepare for all potential side effects from immunotherapy treatments (cardiac, pulmonary, gastrointestinal, neurology, etc)

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Manage Reimbursement/Finances

- Identify a point person from within your financial or reimbursement staff to focus on I-O agents and understand the nuances of the various patient support programs
    - Manufacturer benefits verification programs, replacement programs, co-pay support programs, co-pay foundations, and patient assistance programs
- New-to-market I-O agents may not yet have specific J-Code
    - Ensure a process is in place for appropriate management/billing until J-Code is assigned or, in the case of Hospital Outpatient Prospective Payment Services, a C-Code (Temporary = C9399)
- Ensure your practice has sufficient patient advocacy
    - Most practices have found that Financial Counselors/Medication Assistance Coordinators pay for themselves many times over; if you are not sure if you have enough, it's a good time to conduct an analysis

Manage Reimbursement/Finances

- Comprehensive drug recovery and copay assistance program in comprehensive community cancer center
  - Drug inventory replacement and copay assistance through pharmaceutical foundation programs or nonpharmaceutical disease foundations for patients with unaffordable coinsurance or deductible, no insurance or no drug insurance, off label denial coverage
  - Total acquisition cost is dollar value of drugs recovered based on wholesale acquisition cost for same drug at time of replacement

Fiscal year 2017		Fiscal year 2018	
Drug	Recovered cost ($)	Drug	Recovered cost ($)
Ipilimumab	1,577,741*	Ipilimumab	964,636 286,100#
Nivolumab	412,220	Nivolumab	430,164
Rituximab	300,180	Bevacizumab	283,410
Pegfilgrastim	168,631	Belinostat	245,076
Atezolizumab	163,780	Rituximab	195,982

Fiscal year	Total Acquisition Cost ($)*
2017	1,665,299
2018	2,520,002

**Note: total acquisition cost does not include adjuvant ipilimumab replacement program, which is no longer available*

**cost from adjuvant ipilimumab replacement program*

#cost without adjuvant ipilimumab replacement program

Siegel RD et al. Drug recovery and copay assistance program in a community cancer center: charity and challenges. *J Oncol Pract* 2019;15(e628-35).

Develop Approval Process

- High dollar medication approval process
  - Full benefits investigation, utilize pharma services if offered and allowed per hospital/institution policy
  - Prioritize staff resources to enroll every viable patient into a support program, regardless of on or off-label
- Robust off-label policy and procedure
  - All off-label requests require predetermination
  - Patients are made aware of risks and benefits, including financial risk
  - Patients are required to sign an advance beneficiary notice (ABN) or notice of non-coverage (NONC)
  - Peer review process for appeal if needed

Denials – Common Reasons

- Lack of pre-certification or authorization
- Does not meet medical necessity
- Considered experimental and investigational
- Requires additional information
- Non-covered service/medication on the plan benefit
- Out of network provider
- Timely filing of claims
- Multiple diagnoses coding for disease states and metastases - payer does not apply correct codes to medications
- Error in number of units billed to payer
- Insurance duplicity or delay
- Precertified at an alternate facility previously

General Rules for Denials

- Discover the root cause of the denial
  - Review payer-specific policy, local coverage determinations, national coverage determinations (LCDs & NCDs)
  - Determine if pre-certification or prior authorization was completed
  - Review documentation
    - Reimbursement is linked to the quality of the bill
    - Coders obtain information from medical record but sometimes required information is missing
- Look for denial trends with payers
  - Drugs, diagnosis, charge threshold
- Determine if dose billed for exceeds total units allowable

Handling Denials

- Work with Finance to develop a method for routing denials to appropriate personnel
  - Leverage IT to create work queue and notification process
- Consider appropriateness of resources
  - Workload (average number of denials/appeals)
  - Strict appeal timelines of many payers
- Consider training/experience of personnel
  - Ideally a nurse, pharmacist, or pharmacy technician with oncology experience
  - Ability to learn and understand financial systems and processes
  - Ability to navigate electronic medical record

Handling Denials

- Request medical peer-to-peer interaction
  - Offer additional information and rationale to discuss with clinical reviewers who made initial determination
  - Must be completed by an MD/NP/PA
- Monitor for trends
  - Increased denials for repetitive reasons may require payer, billing or provider education
- Hold payer accountable
  - Regardless of the size of the organization
    - Example: Payer not recognizing authorization because it came from a third party administrator and denying claims for reason of “lack of pre-certification”

Handling Denials

- Challenge outdated payer policies
  - Develop reconsideration packet (for both commercial payer and Medicare) with evidence to support addition of covered diagnoses and/or regimens excluded from payer policies

Billing Considerations

- Use of National Drug Code (NDC) units versus CPT/Healthcare Common Procedure Coding System (HCPCS) units creates confusion and concern for underpayment
  - J code represents the amount of drug per billing unit
    - 1 J code per medication
    - J code established by CMS
  - NDC represents the manufacturer and size of the vial
    - 1 NDC code for each vial size for each manufacturer
    - NDC code established by FDA and manufacturer
  - Monitor closely for errors in underpayment

Billing for Waste

- Billing for waste with immuno-oncology agents
  - Proper usage of the JW modifier
    - JW modifier will indicate the amount of waste volume represented
    - I-O agents that are single-use vials or single-use package for unused portion are eligible
    - Multi-dose vials are not eligible (and currently not available)
  - Not all payers will pay for waste or only pay for part
  - Some payers do not allow rounding of doses and do not pay for waste
  - Proper documentation necessary in the medical record for discarded waste
    - Mandated wastage rationale for any JW lines on Medicare claims on January 1, 2017

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Medicare

- Most Medicare Administrative Contractors (MAC) have at least one I-O agent Local Coverage Determination (LCD)
- Some MAC have separate LCD for all agents
  - Cigna Government Services (CGS) published atezolizumab LCD within the first six weeks of release of the agent
  - Updated pembrolizumab dosing (Q6W) – Medicare did not reimburse immediately after approval
- Medicare formulary updated quarterly
  - New products or indications may not be reimbursed/covered immediately
- Use of maximum dosages regardless of weight
  - Maximum allowable units per day and per date span for specialty drugs
- No successful reimbursement outside the FDA label indications

Off-label medication process: *Medicare pre-treatment*

1. Before off-label use is considered, a **risk/benefit conversation** (medical, financial risks) needs to occur with the patient
2. If patient and treating physician wish to proceed, IO point person and reimbursement specialist work together to gather **sufficient evidence** for off-label use
3. Have reimbursement specialist **reach out to manufacturer** for options
4. Medication assistance coordinator, reimbursement specialist, and clinical team **determine payment options**
   - Manufacturer assistance/replacement options
   - Medicare payment

Off-label medication process

5. Patient and the team decide **whether to proceed** with off-label use
6. After the patient receives off-label therapy, the **claim is submitted** to Medicare
7. If the claim is not immediately approved, up to **5 levels of appeals** are allowed
8. If claim is ultimately denied, financial counselors arrange for **payment** of the Medicare allowed amount

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  - On-label treatment
  - Off-label treatment
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Commercial Payers

- Policies primarily based upon published scientific evidence, Medicare reimbursement standards, and national guidelines
- Clinical policy guidelines and pathways
  - Vendor Pathways examples: Well Point, New Century Health, AIM
  - Clinical policies examples: Anthem, Aetna, UHC, Cigna, Humana
- Often the clinical policies require medication eligibility restrictions beyond the label and additional criteria to be met in order to assure reimbursement
  - Example: Anthem clinical policies for nivolumab and pembrolizumab include patient's current ECOG score must be 0-2

Commercial Payers

- Use of maximum dosages regardless of weight
  - Maximum allowable units per day and per date span for specialty drugs
- Disproportionate approvals of total billing units versus doses for a specific period of time
  - Example: Authorization for 200 mg pembrolizumab for 6 infusions but date range is for nine months
  - Make sure that the dates and authorizations match
  - Develop process for ensuring new authorization is obtained when old authorization expires

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  - On-label treatment
  - Off-label treatment
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Off-label medication process: *Commercial payers*

1. Before off-label use is considered, a **risk/benefit conversation** (medical, financial risks) needs to occur with the patient.
2. Pharmacist and reimbursement specialist work together to submit **pre-determination request** to payer.
3. If denied, an **appeal** can be filed.
4. If still denied, if there is sufficient evidence for off-label use, reimbursement specialist and medication assistance coordinator **explore payment options**, including contacting manufacturer.

Off-label medication process: *Commercial payers*

5. Patient and team decide **whether to proceed** with off-label use
6. Managed care, reimbursement specialist, and CFO determine the appropriate amount for the **patient to deposit** toward the treatment, or have patient sign **financial responsibility agreement** per institutional policies
7. Patient submits deposit/agreement and **off-label treatment is given**

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- Practical aspects of immunotherapy
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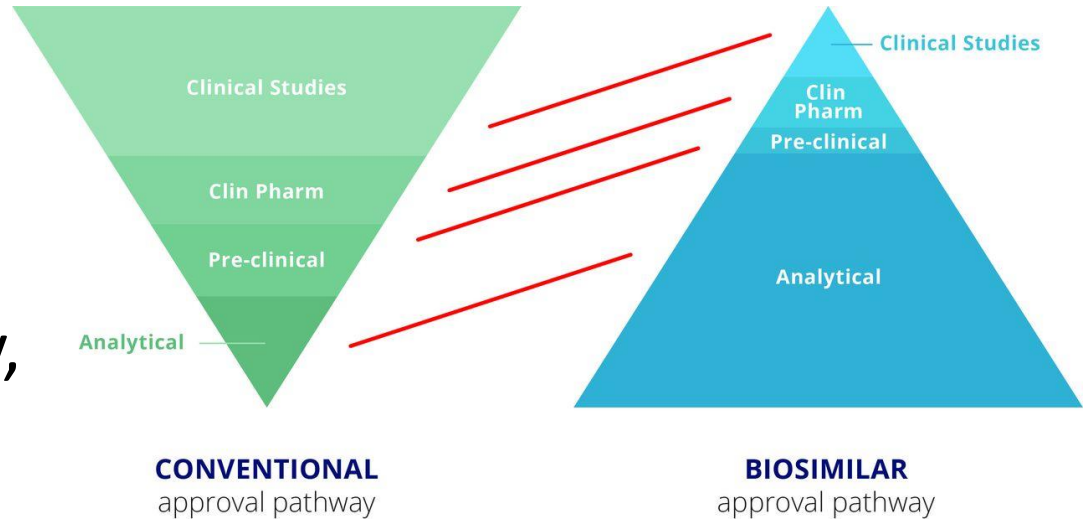
- New considerations for cancer immunotherapy
  - Biosimilars
  - Cellular therapies

Biosimilars

- FDA requires biosimilars to be highly similar, but not identical, to reference product
- Has to demonstrate no clinically meaningful differences in efficacy, safety, and potency
- Primarily tested through non-clinical pathways – examining structural and functional nature of the product



Isaacs *et al*, Consid Med 2017.

Biosimilars

- "Biosimilars" is only used to refer to biologic therapies
- Since they are not structurally identical to the reference product, they are not "generics"
- Often approved for same indications as reference product, unless manufacturer still has orphan drug exclusivity or other rights to an indication
  - Example: bevacizumab-awwb approved for CRC, NSCLC, glioblastoma, RCC, and cervical cancer, just like bevacizumab
  - Bevacizumab-awwb not approved for ovarian cancer, since manufacturer has orphan drug exclusivity until 2021

Original "reference product": **bevacizumab**

Non-proprietary drug name

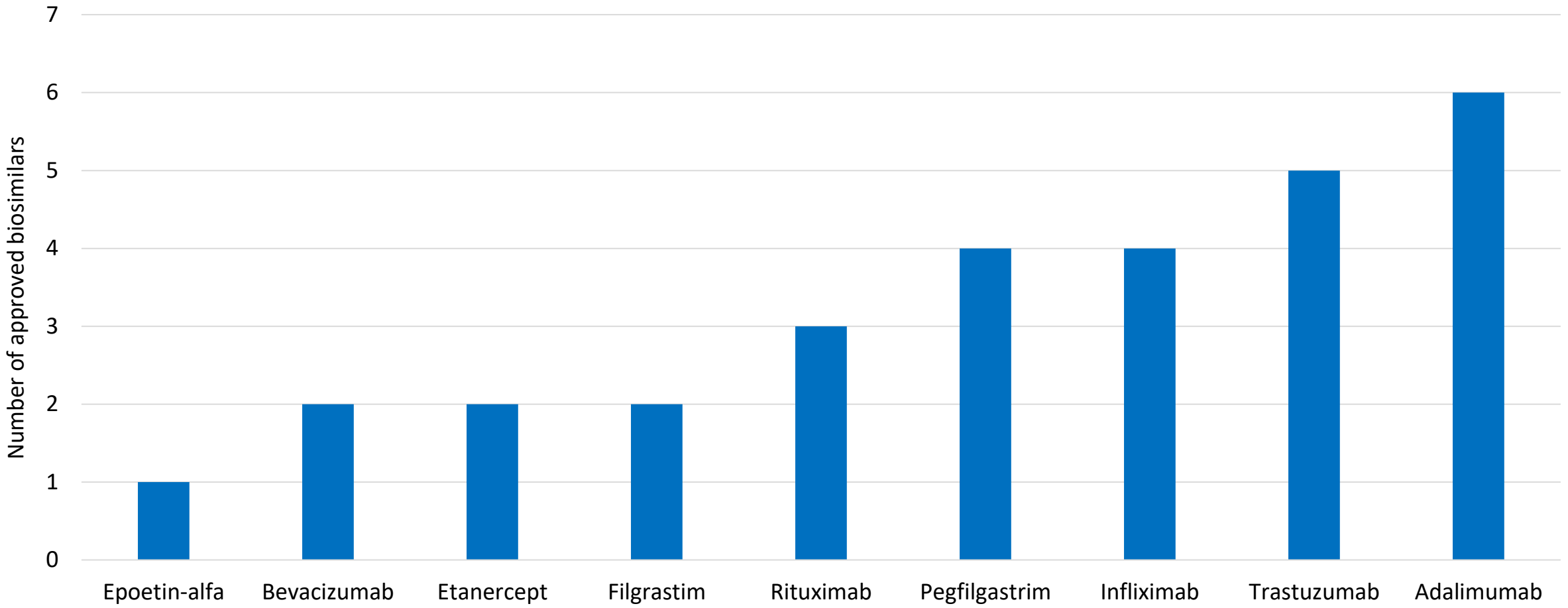
Biosimilar: **bevacizumab-awwb**

Four meaningless lowercase letters, indicating biosimilar agent

Non-proprietary drug name

Pittman, JHOP 2019

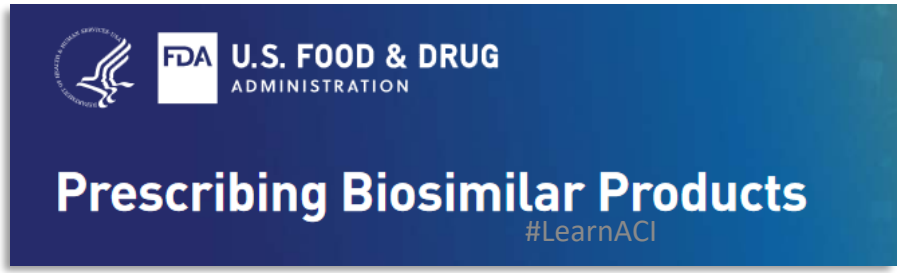
Biosimilars approved by the FDA



FDA Biosimilar Product Information

Biosimilars – practical considerations

- Healthcare providers, pharmacists, and patients are critical for biosimilar acceptance and usage
- Substitution policies vary by state – “interchangeable products” can be substituted without prescriber input
  - Vary by institutional policies (e.g. Pharmacy and Therapeutics committee may approve products to be interchanged by pharmacist without prescriber approval)
- Incentives to prescribe biosimilars from Medicare
- Formulary product (reference or biosimilar) varies by insurance company
  - Pharmacy needs to stock multiple biosimilar products
  - Preferred product may change with limited or no notice



Unique considerations for CAR T therapies

- Large up-front cost instead of smaller costs over time
- Potential side effects can lead to large costs as well
- Financial risks associated with cellular therapies may limit facilities that want to administer them
- Medicare coverage:
  - National coverage determination in August 2019
  - Will be covered by Medicare if administered in health care facilities that follow FDA REMS (risk evaluation and mitigation strategies)

CAR T reimbursement through Medicare

- New Technology Add-On payment expires in September 2020
- CMS has proposed a new DRG for CAR-T therapy for 2021
  - 2020 - DRG 016: Autologous Bone Marrow Transplant with Complications or Major Complications (CC/MCC) or T-Cell Immunotherapy
  - 2021 (proposed) – CRG 018: CAR T-cell immunotherapy

Actual cost of CAR-T administration*	Base DRG 16 payment	Maximum NTAP payment	Outlier payment and other adjustments*	Total DRG payment*	Difference from actual cost in 2020*
$403,000	$43,000	$242,450	$67,550	$353,000	-$50,000
*Average values					

Strohman, American Action Forum 2020.

“Local Practices”

Common scenarios in my clinic highlight value of early communication

- Off-Label therapy:
  - Early communication is vital for timely initiation of treatment
  - Identify patient, inform RN → Pharm → Auth Team → Payer → Pharma/Patient Assistance
- Biosimilars:
  - Pharmacy and Therapeutics committee decides when to introduce a biosimilar
  - Early discussion with Providers is key for successful introduction
  - Prescribers are informed & provided their list of patients to review
  - Patients are informed of biosimilar use
- New Therapies:
  - Identify the champion for agent/combination early to develop education, SOP, EMR plans

Future Considerations

- Payer ability to keep up with accelerating evidence-based new indications (e.g., new lines of therapy, new tumor types)
- Increasing utilization of checkpoint inhibitors in combination with a host of agents (e.g., chemo, targeted, immunotherapeutic)
- Potential for coverage policies to be biomarker driven (e.g., PD-L1 overexpression)
- Financial implications of high-dollar agents becoming first line
- Emergence of biosimilars and CAR T treatments