Lockton Pharmacy

1st QTR 2021

Newsletter

This Quarter's Articles

Common Sense Management of Narcolepsy and Cataplexy

The Mayo Clinic provides a simple definition of narcolepsy and cataplexy at their website, where they write the following:

> "Narcolepsy is a chronic sleep disorder characterized by overwhelming daytime drowsiness and sudden attacks of sleep. People with narcolepsy often find it difficult to stay awake for long periods of time, regardless of the circumstances. Narcolepsy can cause serious disruptions in your daily routine.
>
> Sometimes, narcolepsy can be accompanied by a sudden loss of muscle tone (cataplexy), which can be triggered by strong emotion. Narcolepsy that occurs with cataplexy is called type 1 narcolepsy. Narcolepsy that occurs without cataplexy is known as type 2 narcolepsy.
>
> Narcolepsy is a chronic condition for which there's no cure. However, medications and lifestyle changes can help you manage the symptoms. Support from others — family, friends, employers, teachers — can help you cope with narcolepsy."

With many plan sponsors seeing an increase in utilization and cost in this category, we want to focus on several of the medications currently approved to treat narcolepsy and cataplexy, and to suggest a rational framework for pharmacy benefit design that balances cost, safety, and quality of care.

Before we embark, we must mention and define some jargon, as these terms aren't used as often in discussing pharmacy benefits.

- **Controlled Substance Schedule:** The U.S. Drug Enforcement Administration (DEA) assigns a numeric number (for some inexplicable reason, like the Super Bowl, using Roman numerals) ranging from one to five (C-I, C-II, C-III, C-IV, & C-V) that conveys, among other things, that these drugs are deemed "controlled substances" (thus the letter "C"), that these drugs are subject to certain reporting requirements to the DEA at every stop along the distribution chain from manufacturer to patient, and the relative degree of addictive potential. In terms of relative addictive potential "directionality" of the scale, a drug designated as a C-II drug (for example morphine tablets) is understood to have more "addictive potential" than a drug designated as C-V (for example a cough syrup containing codeine. Similarly, a drug not having any Controlled Substance Schedule numeric designation is understood to have little or no addictive potential vs. a drug that does.
- **REMS program:** "REMS" is an acronym generated by the FDA. Drugs covered by mandatory REMS programs are typically required to be dispensed from a very limited number of "REMS certified" pharmacies because of safety concerns. The FDA defines a REMS program as follows:

  > "…A Risk Evaluation and Mitigation Strategy (REMS) is a drug safety program that the U.S. Food and Drug Administration (FDA) can require for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks. REMS are designed to reinforce medication use behaviors and actions that support the safe use of that medication. While all medications have labeling that informs health care stakeholders about medication risks, only a few medications require a REMS…"

Now that we understand what a Controlled Substance and a REMS program are, there are four groups of medications that are used in the treatment of narcolepsy and cataplexy that we want to focus on. The following chart compares and contrasts their key features.

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Common Sense Management of Narcolepsy and Cataplexy

A Comparison of Currently Marketed Narcolepsy and Cataplexy Treatments

	Provigil/Nuvigil	Xyrem/Xywav	Sunosi	Wakix
FDA Approval Date	1998, 2007	2002, 11/2/2020	3/29/20019	8/15/2019
Generics Currently Available?	Yes	No (generic Xyrem expected after 1/1/2023)	No	No
Controlled Substance?	C-IV	C-III	C-IV	No
Indications	Excess sleepiness due to obstructive sleep apnea, narcolepsy, or shift work disorder	Excessive daytime sleepiness from narcolepsy, cataplexy	Excessive daytime sleepiness from narcolepsy or obstructive sleep apnea	Excessive daytime sleepiness from narcolepsy, cataplexy
Approximate Annual Cost	<$500 (generics)	~$160,000 (Xyrem) ~$150,000 (Xywav)	~$12,500	$115,000
REMS Program?	No	Yes, due to risk of central nervous system depression and abuse/ misuse	No	No

Considerations for Common Sense Management of Narcolepsy & Cataplexy

1. Owing to their lowest cost via generic versions & convenient availability from a broad pharmacy network, generic versions of Provigil/Nuvigil ought to be considered the first-line treatment for narcolepsy. Neither drug (nor their respective generic versions) is indicated for the treatment of cataplexy.
2. Owing to its non-controlled substance designation, absence of a REMS program, and nominally lower cost than Xyrem/ Xywav, Wakix ought to be considered the first-line treatment for cataplexy. It also ought to be considered as a follow-on treatment, following a documented trial and failure of generic Nuvigil/Provigil, for the treatment of narcolepsy.
3. Owing to the absence of a REMS program, and significantly lower cost than either Xyrem/Xywav or Wakix, Sunosi ought to be considered as a follow-on treatment, following a documented trial and failure of generic Nuvigil/Provigil, for the treatment of narcolepsy.

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Common Sense Management of Narcolepsy and Cataplexy

4. Owing to their highest cost, highest addictive potential, and mandatory REMS program (implying a heightened safety risk and a narrow pharmacy network), Xyrem/Xywav ought to be considered treatments of last resort for patients newly diagnosed with either narcolepsy or cataplexy. Transitioning patients currently established on either Xyrem or Xywav to a suitable alternative is a decision best left to the prescribing physician and their patient.
5. Finally, in a correspondence that we recently exchanged with the Medical Information Department at Harmony Biosciences, manufacturer of Wakix, we are able to conclude that there is no published or unpublished literature, at this time, to justify the concomitant use of Wakix with any of these other medications, therefore utilization management controls ought to be implemented to preclude the opportunity for any such concomitant use.

As always, if you have any additional questions on this or any pharmacy benefits topic, please reach out to your Lockton account team and we will be happy to set up a one-on-one call.

Bob Kordella, RPh, MBA
Chief Clinical Officer

Bob has more than 35 years of diverse experience in the pharmacy industry. Over the course of his career, Bob has led clinical and PBM operations teams in successfully managing more than $4 billion in annual drug spend. This was also while limiting per-member-per-year spending growth to levels that have simultaneously drawn industry acclaim and consistently high levels of member and payer satisfaction.

Should an Employer Consider Carving Out Specialty Drug Management?

Specialty medications, which are high cost and used to treat complex conditions such as Multiple Sclerosis, Hemophilia, Rheumatoid Arthritis, etc. are one the biggest topics of conversation whenever pharmacy benefits or the pharmaceutical industry is mentioned. From a patient's perspective, these medications can have a significant positive impact on disease and overall quality of life. From a plan sponsor perspective, the budgetary impact can be difficult to comprehend as 1-2% of their population may be utilizing a specialty medication but driving upwards of 50% of the total pharmacy benefit spend. Carriers and PBMs have deployed traditional cost containment strategies including prior authorization, step therapy, formulary management and limiting dispensing to a 30-day supply from a specialty pharmacy. To bring light to the expense of the medications to patients, plan sponsors have added separate cost share structure for specialty medications. Despite all efforts, specialty utilization and costs continue to grow at a rate that outpaces that of traditional medications used to treat diseases such as diabetes and high blood pressure.

The vast majority of specialty medications are dispensed from PBM owned specialty pharmacies. According to Drug Channels Institute's estimations, the top four specialty pharmacies generated $115 billion in revenue in 2019 from dispensing specialty medications. Each of the specialty pharmacies is aligned with a major carrier or PBM and is managing the formulary and utilization management programs meant to control utilization and costs. With so much revenue being tied to specialty medications, it is fair to question whether a PBMs incentives are aligned with the plan sponsor's and whether the most stringent cost, utilization and monitoring controls are in place.

In an effort to remove any potential appearance of conflict of interest, companies focused on specialty only management have entered the complex world of pharmacy benefits. These organizations, such as Archimedes, RxResults and VIVIO, highlight potential savings achieved through carving out specialty management from the carrier or PBM. Savings is generated through a combination of tighter prior authorization criteria, length of prior authorization approval, frequency of ongoing patient monitoring, switching patient to lower cost medications and use of manufacturer copay cards tied to the specialty medication. Lockton has seen specialty carve out vendors save plan sponsors 15-25% on their specialty pharmacy spend. While this can have a significant impact on a plan sponsor's budget, there are several considerations to evaluate before carving out specialty medication management.

Partnering with a PBM that will allow specialty to be carved out is the first step. Plan sponsors who have successfully carved out specialty from major carriers and PBMs are typically larger in size or have made it a requirement of their renewal or formal RFP. There have been instances in which organizations that have previously allowed sponsors to carve out specialty are pushing back and no longer allowing new clients to do so. In these instances, a full evaluation of the market options may be necessary to ensure vendor alignment in strategy for management of both traditional and specialty medications.

Assuming carving out specialty is an option within the current contract, evaluating contractual language pertaining to discounts and rebates is required. Many contracts contain language that allows the PBM to update pricing should certain utilization metrics no longer align with the data that was initially utilized to underwrite the contract. These caveats may include group size, claim volume, drug mix or spend. While each PBM specific caveat may differ, a repricing clause could be triggered if specialty claims decrease through tighter utilization management, patients are shifted to non-specialty medications or adjudication and fulfillment no longer takes place through the PBM. These pricing changes can extend beyond discount and rebates for specialty medications and impact traditional medication as well. Any negative changes in pricing should be evaluated and applied against the savings analysis of carve out.

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Should an Employer Consider Carving Out Specialty Drug Management?

Carving out specialty is not without member impact. While it is likely only 1-2% of a plan sponsors population are at risk for being disrupted, specialty medications often treat sensitive or complex conditions and have vocal patient populations. Carving out specialty utilization management may mean tighter prior authorization criteria or step therapy programs. Patients who were approved for therapy previously may be denied coverage or asked to change medications going forward. If specialty fulfillment is also carved out, virtually all members utilizing specialty medications would be impacted by a pharmacy change.

Given the costs of specialty medications, every avenue for controlling utilization and spend should be thoroughly explored. Specialty carve out is one such strategy being discussed in the market, often claiming significant savings which grab plan sponsors attention. However, the initial savings projections shouldn't be taken at face value. In response to the specialty carveout strategy, some PBMs have developed improved management solutions employers may want to adopt. Lockton's pharmacy practice has the expertise necessary to evaluate potential savings and identify potential risks which could be associated with carving out specialty from a carrier or PBM to support our plan sponsors in making an educated and informed decision.

Jeff Eichholz, PharmD
Vice President

As vice president, Pharmacy Practice Leader for Lockton's Midwest Series, Jeff Eichholz isresponsible for providing Lockton Midwest clients with comprehensive guidance relating to pharmacy benefit strategy.

His work includes PBM procurement and renewals, benefit contract negotiation, ongoing vendor and contract management, identification of key trend drivers, as well as plan design and clinical program savings opportunities to improve health and manage total spend.

Lockton Drug Watch List

What is a "Drug Watch List" and why does Lockton use them?

We have addressed the rationale for maintaining and using a Drug Watch List in previous iterations of this newsletter. * In an effort to highlight the ongoing game of "whack-a-mole" ever present in the pharmacy benefit industry, we wanted to bring the topic back to emphasize the constant need for drug coverage and formulary management.

As a quick refresher, the Drug Watch List was created to help plan sponsors address a single question: How am I supposed to know the difference between high-value, necessary drug products and low-value drug products that require further scrutiny?

The Drug Watch List flags low-value drugs for plan sponsor's exclusion consideration; and provides examples of lower cost, therapeutically similar drugs available for their members. We can provide reporting to clients to identify utilization of these low value drugs.

How are drugs selected to include on the drug watch list?

As outlined by our Chief Clinical Officer, Robert Kordella, 7 basic categories of drugs are included on the drug watch list:

1. Products having materially higher costs relative to clinically reasonable Rx or OTC alternatives.
2. Products having materially higher costs relative to clinically reasonable alternative dosage forms.
3. Products having materially higher costs relative to clinically reasonably similar, but not identical, strengths.
4. Combination products having materially higher costs relative to their components purchased separately.
5. All products made by certain manufacturers that have developed a reputation for predatory pricing practices.
6. Formerly generic products that have been rebranded and relaunched as brand products.
7. Product types not typically covered under the pharmacy benefit such as durable medical equipment or medical supplies.

How does the Drug Watch List help plan sponsors in practice?

When our account teams present Drug Watch List exhibits to clients, the intent is always to inform and educate clients about the prevalence of these high-cost/low-value products being dispensed under their pharmacy benefit. Occasionally, a client's Pharmacy Benefit Manager (PBM) will reject a plan sponsor's ability to affect change in drug coverage as it does not align with that PBM's formulary strategy. However, through multiple discussions with a variety of PBMs, the pharmacy team has been successful on behalf of our clients in eliminating coverage for many of these products to the financial benefit of the plan sponsor.

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Lockton Drug Watch List

A few examples of drugs on the Watch List:

- Duexis, Vimovo and Treximet. All three products are high cost combination products whose individual ingredients can be found over-the-counter or as individual drugs for nominal cost.
- Venlafaxine ER Capsule vs. Venlafaxine ER Tablet. The ingredients in these products are identical, however the tablet form is 6-7 times the cost of the capsule form for the same dosage.
- Doxycycline. Doxycycline comes in a variety of formulations (capsule vs. tablet) and variety of strengths. Inexplicably, some formulation and strength combinations are many times the cost of others and can be easily replaced in therapy.

A few client-specific examples.

- For a health system, we identified the excessive utilization of Dexilant (high cost antacid medication) on the plan and recommended exclusion in favor of many generic and over-the-counter alternatives. This plan exclusion will save the health system approximately $160,000 annually.
- A large employer had significant utilization of Metformin Extended Release (ER), a drug used to treat Type-2 diabetes. Metformin ER is many times more expensive than its non-extended release alternative and provides no clinical advantage in most patients. The exclusion of Metformin ER in favor of regular Metformin saved the plan sponsor approximately $180,000 in costs annually.
- We identified significant utilization of a prescription prenatal vitamin called Trinaz in a large employer client. There are many lower cost over-the-counter prenatal vitamin alternatives available, so we recommended the client eliminate Trinaz from coverage, saving the plan over $200,000. The identification of Trinaz utilization on the benefit plan resulted in the PBM network team investigating the dispensing pharmacy and ultimately removing them from the network for fraudulent behavior.

Joe Peterson, MBA
Vice President

Joe has over a decade of experience in prescription drug benefit consulting. He has extensive experience assisting plan sponsors select, manage and audit PBM partners. Joe has overseen vendor selection, pricing evaluation, benefit design, specialty pharmacy strategy and various other client engagements supporting clients across a variety of industries.

Joe has a deep understanding of employers of all sizes; health systems; labor and trust clients; and presenting to benefits staff, clinical officers and operational decision makers. Joe has the ability to collaborate with executive level staff and business partners in order to execute pharmacy benefit strategies in coordination with both organizational goals and industry trends.

* 2019 Q1 Newsletter – please contact your Lockton account team for a copy

A Deeper Dive Into the Three COVID-19 Vaccines Authorized (or likely soon to be) in the U.S – February 26, 2021

Note: At this stage of COVID-19 vaccine rollout, patients are highly unlikely to be offered a choice of which vaccine to receive – supplies of COVID-19 are simply too scarce. The vaccine that's available at the place where you are able to be vaccinated is the one you will receive. You will be able to deduce which vaccine you receive, if you're not specifically informed, by the scheduling and timing of a second dose using the chart below.

Manufacturer(s)	Number/ Timing of Doses	Vaccine Type	Shipping/ Storage temperature requirements	Target Population	Vaccine Efficacy	Side Effects	Safety in Pregnancy & Lactation
BioNTech /Pfizer	2 (Days 0 & 21)	mRNA	-94°F in transit & storage; use within five days after thawing	16 and older	95% effective at preventing symptomatic COVID-19 beginning 7-days after receipt of two doses; equally effective across all age, racial, and ethnic groups	More common after second dose and include injection site pain, fatigue, headache, muscle & joint pain; more common in younger vs. older patients; anaphylactic reactions have occurred at a rate of 6.2 cases per million doses, primarily among people having a history of severe allergies or prior episodes of anaphylaxis	None of the vaccines have been tested in these two groups. Neither BioNTech/ Pfizer nor Moderna has seen any evidence of fetal harm in animal studies, to date. J&J intends to include pregnant women in clinical trials in the near future
Moderna	2 (Days 0 & 28)	mRNA	-4°F in transit & storage; stable at refrigerator temperature for 30 days and room temperature for 12 hours after thawing	18 and older (currently being tested in 12-to-17 group)	94% effective at preventing symptomatic COVID-19 beginning 14 days after receipt of two doses; efficacy possibly slightly lower in people 65 and older , but equally effective across racial and ethnic groups	More common after second dose and include injection site pain, fatigue, headache, muscle & joint pain; more common in younger vs. older patients; anaphylactic reactions have occurred at a rate of 2.1 cases per million doses, primarily among people having a history of severe allergies or prior episodes of anaphylaxis	

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PBM Contracts – The Devil Is In The Details

Manufacturer(s)	Number/ Timing of Doses	Vaccine Type	Shipping/ Storage temperature requirements	Target Population	Vaccine Efficacy	Side Effects	Safety in Pregnancy & Lactation
Johnson & Johnson	1 (J&J is also conducting a 30,000 person 2-dose clinical trial, but results aren't expected until May 2021)	Viral vectored	Refrigeration	18 and older	• 66% effective against moderate to severe COVID-19 infections overall beginning 28 days after injection (72% protective in U.S., 66% protective in South America, & 57% protective in South Africa) • 85% protective against severe disease across all age groups and geographic regions • 100% protective against hospitalizations and deaths across all age groups and geographic regions	Include injection site pain, fatigue, headache, muscle & joint pain; more common in younger vs. older patients; anaphylactic reactions have not been reported, to date	None of the vaccines have been tested in these two groups. Neither BioNTech/ Pfizer nor Moderna has seen any evidence of fetal harm in animal studies, to date. J&J intends to include pregnant women in clinical trials in the near future

[1] CDC recommends people should be monitored for 15 minutes following a COVID-19 vaccine injection – 30 minutes if they have a history of severe allergies.

[2] Moderna explained during their FDA Advisory Committee presentation in December 2020, that the efficacy numbers in people over age 65 could have been influenced by the relatively low number of volunteers in that age group in their clinical trial.

[3] FDA's Vaccines and Related Biological Products Advisory Committee ("VRBPAC") in progress as of 2/26/2021.