Qral Group

Payers Policies Allow for Reimbursement of Off-Label Therapies

In our April 6th article, "Is 200k the New Max - Payers Redefine Proven and Medically Necessary," we identified several levers that payers have been emboldened to leverage to control costs among ultraorphan therapeutics.

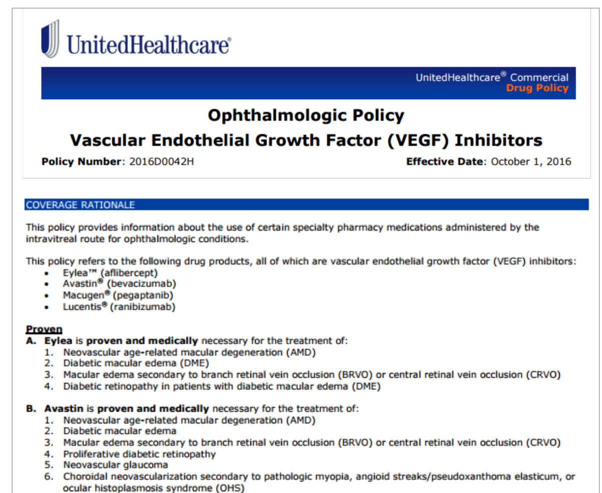
Incremental to those conclusions, we have also observed in the Specialty Ophthalmic market that payers are willing to reimburse off-label treatments given certain conditions.

Bevacizumab's (Avastin's) PI does not include any ophthalmology indications, including for Wet Age-Related Macular Degeneration (Wet AMD) and Diabetic Macular Edema (DME). But given a post-constituted price of $50 per injection, this represents a substantial cost savings vs. the approved anti-VEGFs, Lucentis and Eylea (at roughly $2,000 per injection)[1].

Case Examples

Payer Policies are NOT uniform and demonstrate that there are different tolerances for willingness to support off label reimbursement. For example:

- UHC's Ophthalmologic Policy, dated 10/1/16 states that avastin is proven and medically necessary for DME
- Aetna's policy # 0701 (anti-VEGF for Ocular Indications) as medically necessary for both Wet AMD and DME
- Cigna's 3-Tier Prescription Drug List, dated July 1, 2017, does not authorize avastin for eye conditions



UnitedHealthcare

UnitedHealthcare® Commercial
Drug Policy

Ophthalmologic Policy

Vascular Endothelial Growth Factor (VEGF) Inhibitors

Policy Number: 2016D0042H **Effective Date**: October 1, 2016

COVERAGE RATIONALE

This policy provides information about the use of certain specialty pharmacy medications administered by the intravitreal route for ophthalmologic conditions.

This policy refers to the following drug products, all of which are vascular endothelial growth factor (VEGF) inhibitors:

- Eylea™ (aflibercept)
- Avastin® (bevacizumab)
- Macugen® (pegaptanib)
- Lucentis® (ranibizumab)

Proven

A. **Eylea** is **proven and medically** necessary for the treatment of:
1. Neovascular age-related macular degeneration (AMD)
2. Diabetic macular edema (DME)
3. Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)
4. Diabetic retinopathy in patients with diabetic macular edema (DME)

B. **Avastin** is **proven and medically** necessary for the treatment of:
1. Neovascular age-related macular degeneration (AMD)
2. Diabetic macular edema
3. Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)
4. Proliferative diabetic retinopathy
5. Neovascular glaucoma
6. Choroidal neovascularization secondary to pathologic myopia, angioid streaks/pseudoxanthoma elasticum, or ocular histoplasmosis syndrome (OHS)

How Payers use these Policies to Influence Behavior

More interesting, are the potential ways that these concepts may be applied to allow or even influence behavior to increase volumes through these off-label therapies. Although not supported in fact, we can suppose that the following interventions may be occurring:

- Promotion of GPOs who offer reconstituted bevacizumab
- Data analysis to identify and then follow up with high prescribers
- Invitation-only medical events that share medical evidence of off-label treatment efficacy
- Keeping connected to the academic community to continue to study and expand the literature/compendia that review clinical benefits of off-label treatments

Qral Group conducts quarterly roundtables, please contact us to book a two hour session to focus on your questions.

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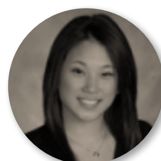

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[1] Source: Qral Group Quarterly Payer Roundtables, March 2017
Payer policies are publicly released on company websites: UHC.com, aetna.com, cigna.com

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