Outlook 2016

Pushback on Specialty Drug Prices, More Value-Based Deals Will Be Trends

In 2015, the specialty pharmacy industry hit some noteworthy milestones. The FDA approved a record number of drugs, with more than half of them considered specialty therapies. Approvals for oncology drugs continued to lead the specialty category, with the immunothersapies Yervoy (ipilimumab), Opdivo (nivolumab) and Keytruda (pembrolizumab) in particular racking up indications. The agency also approved the first biosimilar product, Zarxio (filgrastim-sndz), in a decision that most payers hope is merely the first of many to come (see story, below). But the industry also garnered its share of unfavorable press, as the number of drugs with price tags nearing — and even surpassing — $100,000 annually prompted cries for some kind of controls. SPN spoke with a variety of industry stakeholders to see what topics they think will make news in the upcoming year.

continued on p. 10

Outlook 2016

As Patents Expire, Payers Are Bullish on Price-Reducing Potential of Biosimilars

When the FDA approved the first drug to use the 351(k) approval pathway for biosimilars last March (SPN 3/15, p. 1), many industry observers thought the decision would unlock the door to approvals for many more biosimilars. Although there has been no shortage of manufacturers not only conducting clinical trials of these biologics but also submitting to the FDA abbreviated Biologics License Applications (aBLAs), Sandoz Inc.’s Zarxio (filgrastim-sndz) remains the sole FDA-approved biosimilar. But that could change in 2016, albeit at a slower pace than expected. With patent-expiration dates looming — or even passed — for some biologics, payers now are planning their management strategies for these drug, which are expected to bring some price relief to an industry under fire for steadily increasing prices.

David Lassen, Pharm.D., chief clinical officer for Prime Therapeutics LLC, points out that “There are still many unknowns with biosimilars because the issues of naming conventions and interchangeability by the FDA will have a major impact on this category.” The agency released draft guidance on the naming of biosimilars in late August in which it proposed that both reference products and biosimilars share nonproprietary names indicating the core substance, but that each product has a four-letter, FDA-designated suffix attached with a hyphen that is unique to each product but otherwise has no meaning. This would apply to biologics already on the U.S. market, as well as ones yet to launch (SPN 9/15, p. 1).

The FDA has yet to release guidance on interchangeability, which has the potential to really open up competition among biosimilars and their reference products. Asked what draft and final guidance the agency expects to issue in 2016, a spokesperson for the agency’s Center for Drug Evaluation and Research (CDER) tells SPN that “The
FDA expects to issue draft guidance on Considerations in Demonstrating Interchangeability to a Reference Product and other topics, as reflected on the CDER Guidance Agenda. However, FDA cannot otherwise comment on the time frame for issuance or finalization of guidelines.”

“The issue of interchangeability will need to be resolved in 2016,” contends Gary Rice, senior vice president, clinical, education and human resources at Diplomat Pharmacy, Inc. “The FDA wants an additional human clinical trial as part of the requirements for approval as an interchangeable biosimilar. That study is expected to be a clinical switching study involving the innovator product and the biosimilar. Although Sandoz has already completed a switching study demonstrating…interchangeability, the FDA asked Sandoz to apply just for biosimilar status because the biosimilar approval process is new, and the FDA wants to proceed prudently. Interchangeability provides additional assurances from prescribers relative to efficacy and safety ‘similarity’ and will create broader acceptability of biosimilars by prescribers.”

According to the CDER spokesperson, “as of Dec. 31, 2015, 59 programs were in the Biosimilar Product Development (BPD) Program. CDER has received meeting requests to discuss the development of biosimilar products for 18 different reference products.”

At Avalere Health, “We expect to see further applications submitted to the FDA, but also likely some consolidation in development pipelines as the significant resources needed for developing biosimilars for the U.S. market becomes more apparent to sponsors,” says Rujul Desai, a vice president at Avalere who helps lead its market access and reimbursement group. “We do not expect a ‘flood’ of biosimilars to be licensed in 2016. In order to better define the space, FDA has been issuing a series of biosimilar guidelines…that we expect to see more of in 2016.”

“There may be several biosimilar FDA approvals before year-end 2016, but when these products launch will depend on legal maneuvering of the originator and biosimilar manufacturers,” notes Elan Rubinstein, Pharm.D., principal at EB Rubinstein Associates.

In addition, biosimilars could feel the impact from reference drug manufacturers’ launching “more next-generation products” in a similar way to what Teva Pharmaceutical Industries Ltd. did with Copaxone (glatiramer acetate), says Bill Sullivan, principal consultant for Specialty Pharmacy Solutions LLC. Faced with patent expiration and the prospect of generic competition for the long-time leader within the multiple sclerosis space, Teva released a new formulation of Copaxone in early 2014 (SPN 2/14, p. 1) and has managed to transition about two-thirds of its patients to the longer-acting version (SPN 8/15, p. 5).

High-Cost Biologics’ Patent Expirations Loom

During a Jan. 6 webinar titled Navigating the Healthcare Landscape in 2016, Evercore ISI Senior Managing Director Ross Mucken noted that “over $100 billion of biologics will lose patent protection over the next five to 10 years, offering projected savings of more than $25 billion” (see table, p. 3). With all the pushback on rising specialty drug prices and considerations of ways to counter them (SPN 11/15, p. 5), “biosimilars are the way…on the specialty side to reduce uncertainty,” he maintained.

“This is what folks should support to control drug costs instead of price controls.”

“Although most do not expect biosimilars to mirror the generic market in price decrease, there is strong anticipation among payers that biosimilars will become a primary strategy to reduce specialty drug prices as ‘lower-cost’ branded options,” says Lynn Nishida, assistant vice president of pharmacy services at Solid Benefit Guidance. “Using the European market as a guide, payers are projecting pricing discounts within one to three years for biosimilar(s) and their originators of up to 20% to 30%. How large this discount turns out to be is dependent on the total market value that the biosimilar is competing in and the number of product competitors.”

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While Zarxio launched with a list price that’s 15% less than Neupogen’s, more biosimilars in a category should increase competition, pushing down prices even more. Rubinstein points out, though, that while Zarxio’s list price is known, the “net price after payer-manufacturer negotiation is not disclosed. As with Zarxio, it is reasonable to anticipate that at launch, biosimilars will carry list prices that shadow originators’ brand prices. Over time — but not in 2016 — as additional biosimilars of a given originator enter the U.S. marketplace, European experience suggests that both biosimilars and originator prices will edge downward. Overall, for 2016, it is best not to anticipate significant overall savings from biosimilars.”

“While Prime is optimistic about biosimilars coming to the market, it is not yet clear whether biosimilars will be a viable alternative because the market for biosimilar development could shrink based on economic viability,” says Lassen.

Nishida maintains that CMS’s recently finalized rule on Medicare Part B reimbursement for biosimilars stands to have an impact on the burgeoning industry (SPN 7/15, p. 8). That rule “sets a single reimbursement price for all biosimilars of a given reference product covered under Medicare Part B,” she explains. “Biosimilar manufacturers have noted that biosimilars for the same reference product may not necessarily share all indications or interchangeability status and therefore should receive unique payment rates. CMS specifically notes in the rule that it did not consider how interchangeability status will factor into its final payment policy because there are currently no interchangeable biosimilars on the market. Ultimately, if each biosimilar to a reference product is not given a different code, providers are concerned they will not receive an appropriate payment, creating issues that shortchange biosimilars.”

With Zarxio launching this past September (SPN 9/15, p. 8), “it’s really too early to draw any conclusions” about how much of an impact it’s had on formulary positioning so far, says Kate Keeping, senior director of biosimilars research at Decision Resources Group. DRG surveyed 60 oncologists in the U.S. at the one-month post-launch mark about their use of Zarxio. “Approximately one-third surveyed had used Zarxio in at least one patient,” she says, with no respondents saying they had a low opinion of the therapy (SPN 11/15, p. 1).

Reference drugs being targeted by biosimilar manufacturers are “very heavily skewed toward anti-TNFs [i.e., tumor necrosis factors] and oncology monoclonal antibodies,” she says.

So what should payers be doing now in anticipation of more biosimilar launches?

In 2016, Cigna will “continue to expand our understanding of the open questions on biosimilar approval pathway decisions,” says Thom Stambaugh, vice president of specialty pharmacy at the plan. “We are watching and planning for potential biosimilars for rituximab, bevacizumab, pegfilgrastim and epoetin alfa. With these new approvals, we will gain a better understanding of the pricing approaches taken by biosimilar manufacturers, original innovators and health plan reimbursement for biosimilars whether through the medical benefit or pharmacy benefit.”

Nishida points out that in anticipation of these therapies, “payers are meeting with external partners to discuss biosimilars and the pipeline.” Among the topics of discussion are “considerations of coverage and

### Biosimilars Could Provide an Offset to Specialty Inflation

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Note: LOE = loss of exclusivity
Source: Evercore ISI, from Jan. 6, 2015, webinar Navigating the Healthcare Landscape in 2016. Contact Senior Managing Director Ross Muken at ross.muken@evercoreisi.com.
how to manage the possible allowance of switching and interchangeability,” she says. Nishida points out that “either existing and/or evolving state laws regarding interchangeability of biosimilars that may differ from one state to the next add complexity and may limit how payers may need to handle” these therapies. According to the National Conference of State Legislatures, as of the end of 2015, 18 states and Puerto Rico have some kind of legislation addressing the dispensing of biosimilars and interchangeable biologics (SPN 12/14, p. 8).

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Does the Lack of FDA Biosimilar Approvals Hint at Bigger Problem?

After the FDA approved the first biosimilar, Sandoz Inc.’s Zarxio (filgrastim-sndz), last March, many industry experts believed the experience would help the agency work through any potential issues with approving these drugs. But even though the agency has accepted applications for other drugs seeking to come onto the U.S. market through the 351(k) pathway, it has yet to actually approve any other ones. While many payers are planning their management strategies for these drugs, one industry expert questions the FDA’s subsequent lack of action — and wonders if this is a sign that biosimilars are one and done in the United States.

When the Biologics Price Competition and Innovation Act passed as part of the Affordable Care Act in 2010, the BPCIA was fairly short on details surrounding the actual biosimilar pathway. Since that time, the FDA has issued various draft and final guidance documents on different aspects of the drugs, with the most recent guidance addressing the long-anticipated naming of biosimilars (SPN 9/15, p. 1).

Some experts have pointed to this uncertainty as a main contributor to the agency’s inaction on biosimilars. However, at a December 2014 conference, Sally Howard, deputy commissioner for policy, planning and legislation for the FDA, said that the six draft guidances the agency had released up to that point should help “the industry to understand the data they’ll need to submit to demonstrate biosimilarity.” The agency, she said, was of the opinion that “no additional guidance is needed before a product [can be] approved” (SPN 12/14, p. 1). The fact that the FDA is in discussion with multiple manufacturers about their potential biosimilars would seem to support this view (see story, p. 1).

**Cause of Delays Is Unclear**

So what’s the holdup?

Celltrion, Inc. said in August 2014 that it had completed the filing process for Remsima, a biosimilar version of Remicade (infliximab). But in February 2015, the FDA postponed a scheduled March advisory committee meeting “due to information requests” (SPN 3/15, p. 8). More than 50 countries have approved the product, with European approval coming in September 2013 (SPN 10/13, p. 5). Celltrion said it had worked with the FDA to conduct clinical trials that would determine Remsima’s bioequivalency to Remicade, including bridging studies that accounted for the almost 40 manufacturing changes that the reference product has undergone since its approval (SPN 3/15, p. 1).

And in late 2014, Hospira, Inc. submitted an application for Retacrit, a biosimilar version of epoetin alfa, which is sold in the U.S. as Epogen and Procrit. Pfizer Inc. acquired Hospira in September, and in its third-quarter 2015 earnings call on Oct. 27, Pfizer CEO and Chairman Ian Read said the FDA had issued a complete response letter on the application. “At this time we do not believe any further clinical trials are needed,” he said. “We are confident that the additional evidence we provide will support approval.”

Asked about the status of biosimilar applications that the FDA has accepted for review, including those that have passed the 10-month mark without a decision, a spokesperson for the agency’s Center for Drug Evaluation and Research says, “Federal law prohibits us from disclosing information about an existing or potential application. That information is confidential and belongs to the sponsor.”

Retacrit was approved in Europe in 2007 and has “a gazillion patient days of treatment,” points out an industry expert who declines to be identified. The fact that “the FDA doesn’t want more clinical data...is a problem.” After all, the agency has approved large molecule follow-on biologics such as Omnitrope (somatropin) and more recently Basaglar (insulin glargine) under the 505(b)(2) pathway of the Federal Food, Drug, and Cosmetic
how it would handle naming of 505 therapies when they transitioned to BPCIA oversight.

The FDA also has approved generic enoxaparin, reference drug Lovenox, through the traditional generic route of an abbreviated New Drug Application even though it’s a large-molecule biologic (SPN 1/12, p. 1).

“Enoxaparin is standing out like a flaming beacon,” maintains the source.

“Exclusivity is not the issue,” the source asserts, noting that “patents are always a bit of a morass.”

“If you look at all this, it’s a perfect storm created by the inability to answer these questions,” says the source, who wonders why the agency has not released guidance on interchangeability. “FDA’s caution is almost a move backwards.”

But with so much backlash over drug prices, which biosimilars are expected to help bring down, “this has got to come into the pricing debate at a political level,” says the source.

“We’re in for some interesting times” with the “missing and presumed dead” pathway. “At what point do we say it’s a problem?”

NEW FDA SPECIALTY APPROVALS

◆ December 11: The FDA approved Wellstat Therapeutics Corp.’s Vistogard (uridine triacetate) for the emergency treatment of people who receive an overdose of chemotherapy drugs 5-fluorouracil or capecitabine or who develop certain severe toxicities within 96 hours of receiving those treatments. Dosing should occur as soon as possible after the overdose or early onset of toxicity. The oral treatment has orphan drug designation and received priority review and fast track designation. BTG plc will market, sell and distribute the drug in the U.S. Visit www.vistogard.com.
◆ December 11: The FDA granted accelerated approval to Genentech, Inc.’s Alecensa (alectinib) to treat metastatic ALK-positive non-small cell lung cancer (NSCLC) in people whose disease has worsened after, or who cannot tolerate, treatment with Xalkori (crizotinib). The oral medication has breakthrough therapy and orphan drug designation, and the FDA gave it priority review. Dosing is 600 mg twice daily; the monthly cost is approximately $12,500. Visit www.alecensa.com.
◆ December 18: The FDA granted an additional approval to Keytruda (pembrolizumab) for the first-line treatment of unresectable or metastatic melanoma. The Merck Sharp & Dohme Corp. injectable, which is a programmed death receptor-1 (PD-1) inhibitor, gained accelerated approval as a second-line treatment for advanced melanoma last year (SPN 9/14, p. 4) and for metastatic NSCLC in October (SPN 10/15, p. 10). Dosing is 2 mg/kg every three weeks, and the average annual cost is about $150,000. Visit www.keytruda.com.
◆ December 21: The FDA approved the cobas HIV-1 viral load test for use on the cobas 6800 and 8800 systems. The Roche Molecular Systems, Inc. tests can produce up to 96 results in less than three-and-a-half hours. Over eight hours, the 6800 System can produce 384 results and the 8800 System can produce 960. Visit www.cobas68008800.com.
◆ December 22: The FDA approved Actelion Pharmaceuticals US, Inc.’s Uptravi (selexipag) to treat adults with pulmonary arterial hypertension. The agency gave the tablet, which is available in multiple dosages, orphan drug designation. The annual per-patient cost will be between $160,000 and $170,000. Visit https://uptravi.com.
UHC Fine-tunes Policy on Genetic Counseling Prior to BRCA Test

A recent policy change by UnitedHealthcare (UHC) clarifies who can provide genetic counseling before its members undergo a BRCA test. The decision prompted pushback from the American College of Obstetricians and Gynecologists and the American Congress of Obstetricians and Gynecologists, known collectively as ACOG. The objection, however, may not necessarily be warranted in UHC’s case, although it may be in the case of other insurers’ policies.

The U.S. has seen a huge explosion in the number of genetic tests on the market. But the tests have varying degrees of sensitivity and accuracy, not to mention prices, so health plans are starting to take steps to better manage this space. For some tests, this involves genetic counseling for members before they undergo testing in order to make sure they are appropriate candidates for the procedure. In these situations, there can be slight discrepancies in payers’ requirements.

Counseling Helps Prevent Inappropriate Testing

One of the more well-known genetic tests detects a person’s BRCA mutation status. Breast cancer genes 1 and 2 (BRCA1 and BRCA2) produce tumor suppressor proteins to help repair DNA, but when the genes are mutated, their ability to repair DNA is affected. Inherited mutations in the genes heighten the risk of female breast and ovarian cancers, and they also are associated with a higher risk of other kinds of cancers. Genetic tests are available to detect whether a person has BRCA1 or BRCA2 mutations, but because these mutations are not relatively common, the tests are recommended only in certain people, such as those with a family member who has a BRCA mutation or people with Ashkenazi Jewish ethnicity. Genetic counselors can help determine whether people are appropriate candidates for the test.

Results from a study of Aetna Inc. members between December 2011 and December 2012 published online Oct. 1 in JAMA Oncology revealed that genetic counseling before BRCA testing occurred only about one-third of the time (SPN 10/15, p. 1).

Among UHC members, as of Jan. 1, “genetic counselors or physicians must provide a brief counseling with the patient and certify the need for the genetic testing prior to the BRCA test being performed,” according to spokesperson Lynne High.

For several years, UHC — as well as other insurers — has required prior authorization for BRCA testing, she points out. The difference now, though, is that previously, “the laboratories administering the genetic tests have been able to provide this certification,” which will now not be permitted, High tells SPN. “It is our belief that patients deserve a more thorough evaluation from a qualified health care professional.”

In mid-December, ACOG released a position statement opposing requirements “that genetic counseling must be provided by an individual ‘certified’ in genetic counseling before genetic testing could be ordered because they impose unnecessary barriers to timely care. Moreover, ACOG opposes such attempts to restrict the scope of practice of obstetrician-gynecologists, who are fully qualified to provide pre-test counseling to their patients.”

In a press release on the statement, ACOG calls out UHC, saying it “will impose a burdensome prior authorization requirement before the insurer will cover BRCA testing.” Mark DeFrancesco, M.D., president of ACOG, says in the press release that “imposing non-medically necessary prior authorization requirements that block a woman’s trusted physician from ordering appropriate care for patients is contradictory to quality medical care, and is bad medicine.”

However, Lee Newcomer, M.D., senior vice president of oncology, genetics and women’s health for UHC, clarifies that “the intent of our genetic counseling program is to ensure that our members receive detailed and complete information about the value of the BRCA test they are seeking. UHC does not impose any additional credential requirements on providers specific to this counseling. If the physician, nurse or genetic counselor is assured that they have the training and experience to perform adequate counseling, they can attest to their competency on the prior-authorization form.”

Newcomer tells SPN that “this process requires a valid indication for the test, a three-generation pedigree, the attestation and a clinical note. These three documents should be completed by the attesting provider. UHC does not allow providers who are employed by the testing laboratory to complete the forms.”

Policy ‘Removes Potential Conflicts of Interest’

“We want to make sure UnitedHealthcare members have the best information possible about their health care options so they can make informed decisions with their care provider,” High says. “A genetic counseling visit with an independent counselor removes potential conflicts of interest that could arise if a genetic testing lab was providing the counseling on services they perform. We also encourage our members to contact InformedDNA, which maintains a database of genetic specialists who provide independent reviews.”

According to High, UHC is “reaching out to ACOG to clarify any confusion they may have regarding the policy on genetic counseling.”
Cigna, however, is one health plan that does require its members to undergo genetic counseling provided by board-certified genetic counselors before certain tests, including BRCA. Implemented in 2013, the policy specifically requires that Cigna members undergo genetic counseling — face to face, over the phone or over the Internet — with a genetic counselor within InformedDNA’s national network (SPN 8/13, p. 1).

“Genetic counseling usually involves a full hour consultation with a trained genetic counselor before testing,” says Jeffrey Hankoff, M.D., medical officer for clinical performance and quality at Cigna. “The genetic specialist takes a full family history and reviews the indications for testing. Often, there is a more appropriate test than the one the physician without training in genetics has ordered. Following testing, the genetic specialist meets again with the patient and reviews the findings and the implications, not only to the individual being tested, but also the immediate and extended family.”

According to Hankoff, “It is the unusual physician who has the time or the training to follow the standard of care and established guidelines; i.e., take a detailed three-generation history, provide guidance and post-testing counseling, and interpret the test results for both the patient and the patient’s family, all while staying current with the ever increasing number of relevant genes and genetic tests.”

Cigna May Expand Requirement

For now, Cigna’s requirement is tied to three conditions: hereditary breast/ovarian cancer, hereditary colon cancer and Long QT syndrome, a heart rhythm disorder that can cause sudden death. Hankoff tells SPN that “it’s likely that we will extend the counseling requirement to other types of genetic testing where we think it will benefit our customers. Our focus is on tests that are complex and often misunderstood or misinterpreted. Our goal is to help people get appropriate genetic testing that is clinically useful.”

Feedback that Cigna has received on its policy “indicates that providers and customers alike value the counseling because it provides individuals with information that helps them make informed health care decisions,” says Hankoff. “In our experience, the timeliness of testing has rarely been an issue. We view counseling as a bridge to appropriate testing and care, not a barrier. Our collaboration with InformedDNA expands customer access to trained, board-certified genetic counselors.”


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Outlook 2016

Broad View Clarifies Specialty Pharmacy, Infusion M&A Activity

The specialty pharmacy and infusion therapy sectors were business as usual in 2015 as far as deals go, and there’s no reason to expect that activity to change in 2016. And while a cursory glance might call into question the attractiveness of the industries to investors, a long-term evaluation of the two segments reveals that both continue to be healthy investment opportunities, says one industry expert.

Data from The Braff Group, a merger and acquisition (M&A) advisory firm focused on health care service providers, show that there were nine deals in the specialty pharmacy sector through the first three quarters of 2015 — the most recent information available — with 12 expected for the full year if the rate remains the same. That’s considerably down from the 22 transactions seen in 2014. A look at those two years alone might worry investors; however, Dexter Braff, president of The Braff Group, says that to truly understand what’s happening in the industry, one needs to look back over the last 14 years, which reveal an “up year, down year, up year, down year” pattern of M&A activity (see chart, p. 8). Looking at the data since 2001 in two-year increments reveals approximately 30 deals per period. The M&A trend within specialty pharmacy “looks like it’s all over the place, but it’s not,” says Braff. “The highs don’t vary a lot, and the lows don’t vary a lot.”

This, he tells SPN, is “fascinating to me….We’ve seen this pattern for 10 years; it happens all the time.” Still, he adds, “I would not go so far as to say this is an institutionalized pattern, where companies do a lot of transactions and then slow down.” Instead, “specialty pharmacy transactions are often so large that the amount of time a buyer is going to place between transactions is going to be larger” than that seen in other industries. So this “whip-saw effect” is “much more pronounced in specialty pharmacy than virtually all other sectors we watch,” he points out.

Private-Equity Activity Is up in Infusion Segment

Through the first three quarters of 2015, the most recent data available, there were already more deals in the infusion therapy sector than there were for all of 2014 — 11 vs. eight — and only one less than the 12 transactions in 2013. “If I have to surmise why that’s the case, we have some elevated activity from private equity,” Braff points out. “Private-equity groups are continuing to enter the space despite the fact that deal volume peaked in 2012 with 24. If we went back 10 years, we would see substantially elevated activity from 2005 to 2012, and then it

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started to slow down a bit. That was because the companies that spurred the growth of transaction volume were all private-equity sponsored regional players, [which] have been acquired themselves.” In fact, he notes, “the number of buyers in the space and the number of sellers in the space went down at the same time.” According to Braff, this “cycle of diminished activity” is “very natural” and a “function of supply and demand.” But now, after M&A activity slowed down and companies exited the segment, “players want to get back in at a relatively late stage,” he says, which means that a new batch of private-equity groups is investing in the infusion space.

And “the same holds true in specialty pharmacy,” maintains Braff. “Virtually every year there are new people trying to get in. What makes it interesting is that we don’t necessarily see these kinds of steady patterns in other health care sectors….As an indicator for the M&A health of a sector, the continued investment in a space is a good barometer of sustained, measured demand.” He points out that “when you see M&A activity, you may see that in a quick-growing market,” which isn’t the case with either the specialty pharmacy or infusion therapy sectors. “It’s a steady bunch of investors getting in, doing their thing and then getting out.”

According to Braff, “IV and specialty pharmacy are the workhorses of health care M&A activity. They continue to draw new interest and create activity” that’s “nothing at a monumentally different rate, but at a sustained rate.”

A notable occurrence impacting both industries is a “two-year trend that is continuing to play out of the on-and-off flirtation of specialty pharmacies buying more traditional infusion therapy companies. It’s sort of this consistent theme that we’ve seen over and over again,” Braff notes. “In order to punch up the margins of specialty pharmacy providers, we’re seeing select ac-

Specialty pharmacy, he maintains, is “somewhat of a strange business” in that “gross profit margins are so thin, but the opportunity is so great that people are still drawn to it like bees to honey, but they can’t turn the page on generating a lot of profit dollars.” As an example, he points to Diplomat Pharmacy, Inc.’s “$2 billion plus in [annual] revenue and an EBITDA [i.e., earnings before interest, tax, depreciation and amortization] margin that hovers around 1%.”

Specialty pharmacies are “transactional businesses; everyone has to get their medications.” Still, “the biggest question that continues to befuddle the industry” is “how to capitalize” on specialty pharmacy, contends Braff. “There is no shortage of people who are rightly chasing after a very, very predictable explosion of growth. The big question is how do you do that and get ahead of the profit curve?” Investors “like to think there are economies of scale” to be leveraged, but they are “elusive” — although it’s not due to a lack of trying.

“To some degree, it’s the nature of the business,” he explains. “You might say at this point that it is somewhat
like any low-margin business where it’s hard to push margins up.” As an example, Braff points to grocery stores, which need to “look for things on the edges,” such as coffee bars and specialty items, to be profitable. In specialty pharmacy, “all profits are on the margins.” And adding an infusion company could “add 20% to an EBITDA margin.”

So what are some potential companies that could jump into the M&A fray in 2016?

Braff points to Madison Dearborn Partners LLC, which purchased a majority stake in Walgreens Boots Alliance Inc.’s infusion unit last year (SPN 2/15, p. 1). “To the best of my knowledge, they have not seemed to do a follow-up deal yet,” he says, making it likely that such a move will occur. “We expect them to add to it, but we’re not sure how they’re planning” to do so. “With Walgreens still involved, initially they might be pursuing more organic growth plans.” Such growth can take time to develop, so companies tend to take this route initially after a deal and then “follow up with discrete acquisition activity,” he says.

OptumRx’s recent purchase of AxelaCare Holdings Inc. from private-equity group Harvest Partners, LP (SPN 12/15, p. 1) is “noteworthy from two angles: First, what else is Optum going to buy?” says Braff. In addition, the industry has seen purchases of specialty pharmacies and specialty infusion companies by PBM-like companies, “but there’s not been as much action by insurers. I would expect to see more.” Braff maintains that 2015 was “a banner year for Optum,” which also purchased Catamaran Corp. (SPN 4/15, p. 1).

An “interesting transaction” was by Epic Health Services Inc., a “largely pediatric nursing company that bought a very sizable enteral therapy company,” Option 1 Healthcare Solutions. “We have not seen a nursing provider acquire a product provider in a long time,” says Braff, who notes that Epic — which is a portfolio company of private-equity group Webster Capital — “quickly followed that up with the Medco [Medical Supply] transaction,” further expanding its growth in the enteral therapy services field. Epic is “committed to a new branch of growth” for itself. Might we see more of examples of this “multipronged generic strategy of coordinated care across the health care delivery system?” Deals where skilled nursing providers purchase home health or hospice firms are “very common,” and hospitals are working with urgent care providers, but Epic’s move is different. Braff says he wonders whether this is “a signal of first-mover development” involving purchasing and putting together ancillary services. “This is not a trend, but it happened,” he says, with the backing of a “wealthy, experienced health care investor.”

What could dampen enthusiasm for the sectors in 2016? “There’s nothing out there that I can see as being different,” says Braff. “That’s part of the reason why we see a steady level of activity.”

Still, he adds, “I suppose the Optums of the world controlling distribution could be seen as a go-forward problem. The more insurers that combine and the more they take the service elements and put them under their own umbrellas, the more extent they can use in-network and out-of-network...pricing schemes to limit competi-
tion. There may be something there — the winds are blowing. I can see where the dominos could fall if you work backwards.” Such a shift would mean that “smaller providers are squeezed in a meaningful way.” And while the industry could be “moving in that direction,” Braff says there is “no near-term concern” about it.

“It could definitely go in that direction, but nothing will happen next year.”

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Focus on Prices, Value Will Continue
continued from p. 1

Specialty Drug Prices

Rujul Desai, a vice president at Avalere Health who helps lead its market access and reimbursement group: “The level of attention from politicians and policymakers will only continue to grow in 2016, particularly now that proposals to address specialty drug prices have become central to the Democratic platform. The Obama administration will likely consider limited actions that can be taken in 2016, but any major action is unlikely until the next administration takes office in 2017.”

Elan Rubinstein, Pharm.D., principal at EB Rubinstein Associates: “High visibility of the prescription drug cost situation will continue...[and] may increase if [it becomes] a talking point in presidential candidate debates, speeches or advertisements. PBMs [such as] Express Scripts have become more aggressive in manufacturer negotiations [around] specialty drugs, so it’s reasonable to expect PBMs to continue along this direction.”

Bill Sullivan, principal consultant for Specialty Pharmacy Solutions LLC: “There will be a lot of noise and good ‘sound bites’ out of Washington, but it will take legislation or executive action to break the mold of not negotiating process for Medicare. The wall to do that is very tall and wide and is defended by legions of lobbyists.”

Value-Based Drug Pricing

Atheer Kaddis, Pharm.D., senior vice president, sales and business development, Diplomat Pharmacy, Inc.: “I do believe we may see more of this as drug prices continue to increase and payers struggle to address drug cost trend as it relates to specialty pharmaceuticals. I believe we may see some additional pay-for-performance contracts for the PCSK9 products for hypercholesterolemia, as well as some of the agents used to treat multiple sclerosis and hepatitis C, as well as some of the agents used to treat rheumatoid arthritis. The challenge to these pay-for-performance contracts is agreement on specific measures used to track effectiveness as well as lack of availability of appropriate data in general. The categories listed above lend themselves to better data availability to monitor effectiveness of the agents used to treat these conditions.”

Thom Stambaugh, vice president of specialty pharmacy at Cigna: “With all stakeholders increasingly held to the value over volume reimbursement models, we are seeing, and expect to see, more pay-for-value arrangements. Innovative pharmaceutical manufacturers are engaged in developing agreements associated with the value of their medications, in addition to the standard approach of improving affordability through a rebate. Since every medication has an expected clinical outcome, we see the value-based pricing approach as relevant to all medications and classes. Its most significant application is for drugs and conditions where the expected clinical outcome has a clinical marker associated with the outcome (like with hepatitis C) or has a clinical outcome that avoids specific short-term hospitalization and emergency room events (like multiple sclerosis or hemophilia).”

Desai: “Manufacturers have an increasing interest in pursuing pay-for-performance contracts to mitigate ongoing pricing criticisms and secure additional competitive advantage from their peers when negotiating with payers...Important to note is that new resources, business models, and data assets are coming online to bridge the gap between manufacturers and payers to facilitate these performance contracts in a compliant and transparent manner.”

Rubinstein: “New risk- and value-based pricing arrangements are likely for specialty drugs due to pushback against the high price points per dose and per course, and expectations for break-the-bank utilization of these new products (e.g., hepatitis C and hypercholesterolemia)...New risk- and value-based arrangements are likely to link net price to the treated population achievement of a metric that establishes product value for the target disease, in addition to negotiation of traditional formulary and coverage policy issues. Pharmaceutical manufacturers entering into such arrangements may offer disease management or other support to maximize the extent to which treated patients achieve the target metric — but should develop such programs jointly with (rather than for) the payer or specialty pharmacy customer. Pharmaceutical manufacturers entering into such arrangements should ensure that all stakeholders are aware of the programs, understand program value from their particular perspectives, receive periodic feedback demonstrating program success, and capture data from these programs so as to support publication...Publication is important, because manufacturers are likely to find few major payers willing to do the hard work to develop, field, educate and monitor such a program, due to limited bandwidth. In anticipation of limited upfront
participation yet wishing for broad uptake, the manufac-
turer should plan on maximizing program visibility by
publishing and [speaking about results at] different con-
ferences and [in] publications.”

Lynn Nishida, assistant vice president of pharmacy services at Solid Benefit Guidance: “The jury is still out
on payers venturing into these types of arrangements
with pharma manufacturers, as well as with their PBMs.
Challenges are settling on mutual outcomes by both par-
ties that can be easily and objectively measured.”

Sullivan: “Yes, there will be more P4P [i.e., pay for performance]. It will most certainly be for drugs that
have very high cost and are being placed on benefit tiers
that make access for many patients virtually impossible.
They will carry many qualifiers, and, as long as some
dollars are refunded, these P4P programs will grease the
skids for some products. Oncology is certainly going to
lead the pack.”

Oncology Trends

Gary Rice, senior vice president, clinical, education and human resources for Diplomat Pharmacy: “There are 771 new medicines and vaccines for cancer in clinical trials or awaiting review by the FDA. Immunotherapy, by which the capability of the immune system is used to attack cancer cells, therapies were approved in 2015 where additional approvals will occur in 2016. Addition-
ally, more cell-mediated therapies will be used to over-
come chemotherapy resistance. These proteins, which are smaller than antibodies, will bring immunotherapy to
new levels in 2016. Lastly, new drug combinations, com-
ing traditional chemotherapy with immunotherapy, may also occur in 2016. This strategic approach is already
showing promise in lung cancer, prostate cancer and melanoma.”

Stambaugh: “We expect a focus on evolving the
oncologist reimbursement model from fee-for-service to
value-based and alternative reimbursement models as-
associated with and without treatment pathways. In 2016,
we are continuing to emphasize collaboration with local,
community-based oncology practices to reward doctors
for overall improved outcomes, leveraging clinical path-
ways and working with each practice to understand its
unique approach within a specific region.”

David Lassen, Pharm.D., chief clinical officer for
Prime Therapeutics LLC: “We will continue to see new
drugs come to market in the oncology space. There are at
least three new drugs expected to be approved for non-
small cell lung cancer and three more for multiple myelo-
ma. These drugs have the potential to enter the market
with high price points, which will likely increase costs for
the treatment of these cancers. We also anticipate there
will be new indications for existing drugs in this disease
state.”

Sullivan: “Pathways may finally be embraced as
long as payers/providers don’t get greedy. Case-based
reimbursement can work in oncology as long as the
ground rules are clear and neither payer nor providers
try to game the program.”

Desai: “The core personalized medicine trends…
are strongest in the oncology market, and we expect that
market to be the vanguard for innovation in this area. For
example, we will see continued efforts in ‘profiling’ of
patients to determine how to treat cancer based on ge-
genetic, lifestyle and environmental mixes of cancer causes.
These efforts will be greatly enabled [by] mining of reg-
isters and other unique big data sources to find better
means of personalizing cancer care, including the use of
payer-driven data analysis and care coordination.”

Specialty Drug Pipeline

Kaddis: “We are expecting to see some additional
agents for treatment of hepatitis C, including grazopre-
vir/elbasvir, which will further expand options to treat
this infectious disease. We are also expecting several
more oral oncolytic agents to be approved as we experi-
enced in 2015, including ixazomib for multiple myeloma
and venetoclax for chronic lymphocytic leukemia. We
also expect some new options for multiple sclerosis, in-
cluding ocrelizumab and daclizumab. Finally, we expect
some treatment options for Duchenne muscular dystro-
phy, a rare disease, including drisapersen, eteplirsen, and
ataluren.”

Sullivan: “[Payers should watch] drugs that have al-
ready been approved for orphan indications. They come
to market at premium prices, and before you know it, the
manufacturer is back at the FDA asking for additional
indications (which are often quickly granted) with much
larger populations. A good example is the Vertex cystic
fibrosis drug Kalydeco that came out in 2012. Since then
it has obtained two expanded indications, significantly
increasing patient base opportunity. At $300,000 annu-
ally, that is a big deal.”

Personalized Medicine

Desai: “Personalized medicine is a key trend for
specialty drugs, and we expect to see more genetic tests
to determine both the propensity to develop a specific
variant of a disease and results that show a positive vs.
no reaction to specific therapy. As a natural consequence,
we also expect to see payer policies that get narrower
and have more access restrictions based on results of
those genetic tests. In addition, we will see ‘designer’
combinations of therapies made available on the same
genetic testing basis, greater patient involvement in treat-
ment decision making, and more devices and tools for
personal health management.”

Ross Muken, senior managing director at Evercore
ISI: “We think it’s a pretty big paradigm shift [that’s]
been in play for several years…Capabilities there are changing the treatment paradigm.”

**Specialty Drug Management Strategies**

**Stambaugh:** “We expect more strategies on (1) pharmaceutical manufacturer coupon transparency; (2) targeted specialty drug exclusions when strong clinical alternatives exist; (3) waste reduction initiatives, particularly at the dispensing specialty pharmacy level; and (4) greater use of outcomes incentives agreements with manufacturers as they drive better alignment of specialty drug pricing with value delivered, clinical and financial.”

**Sullivan:** “If payers are smart they will start to compensate specialty pharmacies for enhanced patient management services, especially under the medical benefit where there is virtually no oversight today.”

**Kaddis:** “As an industry, I believe we will continue to see higher copayment and coinsurance for specialty drug management. We will also see greater use of blocking co-payment cards, as well as some more aggressive formulary management, including lockouts of specific specialty drugs. Waste management programs will continue to be critical. Finally, our industry can expect growth in use of medical management strategies in 2016.”

**Nishida:** “Payers are emphasizing strategies that are designed to manage specialty medications across both pharmacy and medical benefit and integrated benefits. While some payers are very mature in understanding and quantifying their medication spend under their medical benefit, there are still plans/payers who are still taking these initial steps. Quantifying what their spend is under their medical benefit should be a strategy within itself to prioritize where payers/plans should focus on specialty medication cost. A lot of specialty spend can be hidden in the medical benefit and [can] uncover a wealth of opportunity to address additional opportunities in structuring provider reimbursement and contracts, site-of-service optimization, …[and] implementation of system edits for reasonable billing quantities, as well as automated clinical edits.”

**Lassen:** “We anticipate formulary design changes to include growth in exclusion lists. We also anticipate improvements in value based contracting with manufacturers…and the increased ability to impact specialty spend with accountable care organization and other aligned systems of care contracting.”

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**NEWS BRIEFS**

◆ *Health Care Service Corp. and Excellus BlueCross BlueShield now cover Veracyte, Inc.’s Afirma Gene Expression Classifier.* The decisions mean almost 175 million insured lives are covered for the test, which is used to help identify people with benign thyroid nodules whose fine needle aspiration biopsies are indeterminate. Veracyte also said it had entered into contracts with Blue Cross Blue Shield of Massachusetts and Blue Cross Blue Shield of North Dakota to become an in-network provider. Contact Veracyte through Pam Lord at (619) 849-6003.

◆ *Independence Blue Cross inked a deal with NantHealth that will provide coverage of whole-genome sequencing for some cancers.* Access to the testing will begin in March for the health plan’s commercial members. **Independence also joined a wide array of industry stakeholders including pharmaceutical companies, major academic centers and community oncologists in forming The National Immunotherapy Coalition (NIC).** The goal of the collaboration is “accelerating the potential of combination immunotherapies as the next generation standard of care in patients with cancer.” The NIC will design and conduct clinical trials in up to 20 tumor types involving as many as 20,000 patients by 2020. Visit http://tinyurl.com/hc6f4tz and www.cancermoonshot2020.org.

◆ *Blue Cross Blue Shield of Illinois entered into an in-network agreement with Biocept, Inc.* The deal, which is the first that the molecular diagnostics company has with a Blues plan, allows the health plan’s 8 million members access to Biocept’s liquid biopsy testing. Visit http://tinyurl.com/zc2ux34.

◆ **PEOPLE ON THE MOVE:** The Biotechnology Innovation Organization named **Dan Durham** executive vice president, effective Jan. 18; he will lead BIO’s health policy section. He previously was the executive vice president for strategic initiatives at America’s Health Insurance Plans. **Kay Holcombe,** who had been interim head of health policy, will go back to her job as senior vice president of science policy.
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