Step Therapy Undermines Physician Choice of AMD Treatment

Some insurance companies mandate use of less-expensive off-label therapies before approved treatments.

BY TAREK S. HASSAN, MD

Pharmacologic freedom of choice for physicians means the ability to prescribe all legally available, safe, efficacious drugs and treatments for appropriate patients. Such freedom is determined by the needs of the individual patient in consultation with his or her physician and is applied without mandate by, or involvement of, any outside party dictating a specific treatment regimen. Freedom of choice applies whether the drug in question is used for an indication approved by the US Food and Drug Administration (FDA) or for an “off-label” indication.

In recent years, as pharmacologic agents to treat age-related macular degeneration (AMD) have become available, there have been threats to ophthalmologists’ pharmacologic freedom of choice from a number of quarters. Several years ago there was the potential that the manufacturer might limit access to bevacizumab (Avastin, Genentech) for ophthalmic use, although in the end this did not come to pass.

Bevacizumab for off-label ophthalmic use remains available through well-regulated compounding pharmacies. Some state pharmacy boards, however, have generated regulations designed to permit compounding only per specific patient prescriptions, therefore potentially limiting same-day access to treatment with bevacizumab. To date, this type of regulation is not widespread, and so far the battle by organized retina and organized ophthalmology to resist this trend on behalf of patient care has been effective.

STEP THERAPY

Recently, another issue regarding freedom of treatment choice for AMD has come to the fore: some payers have instituted policies, implicit or explicit, to limit or manipulate reimbursement for FDA-approved drugs. That is, some payers are trying to avoid paying for the
more expensive, approved AMD therapies ranibizumab (Lucentis, Genentech) and aflibercept (Eylea, Regeneron), either by simply not covering the cost or by instituting a requirement (overt or covert) for “step therapy.”

Step therapy, the aim of which is to help minimize the rising costs of health care, is known by other names, including “failed first protocol,” “tiered therapy,” and “graduated therapy.” In this type of arrangement, a payer mandates that more cost-effective therapies be used before more expensive alternatives in a stepwise approach. Failure of the less expensive drug is required before the patient can be switched to a costlier alternative.

This strategy is used when there are multiple safe and effective options available for treatment. The appropriate “steps” are decided upon by panels of physicians, pharmacists, and administrators, and exceptions generally are allowed on a case-by-case basis.

In many instances, the use of a generic drug is the first step in step therapy, but in the case of wet AMD it is the off-label use of bevacizumab instead of approved anti-VEGF treatments.

THE NEGATIVES
Although the cost-saving goal of step therapy is laudable, there are numerous drawbacks to the use of this strategy.

• It can be time-consuming for the patient and physician, with numerous visits required before the failure of the first “step” can be confirmed;
• It potentially involves more expensive out-of-pocket costs for the patient;
• It creates barriers that may make patients forgo or delay needed treatments;
• It may lead to a worsening medical condition and more expensive and expensive future care;
• It can increase patient frustration and depression;
• It increases the risk of noncompliance and self-medication;
• Generally there are no time limits or restrictions; the time to determination of “failure” can be indefinite;
• Ultimately, physician and patient treatment decisions are undermined, potentially to a harmful level.

A policy of step therapy may not be overtly stated: ie, the payer may require prior authorization for approval of coverage for ranibizumab or aflibercept as first-line therapy for wet AMD—but such prior authorization is almost impossible to obtain.

IDEALS VS REALITIES OF PRACTICE
There are numerous management options for wet AMD, including thermal laser photocoagulation, photodynamic therapy, and pharmacologic treatments including pegaptanib (Macugen, eyetech), ranibizumab, bevacizumab, and aflibercept. As physicians, our ideal situation is to be able to match the most appropriate of these treatments to each individual patient with AMD, and even each eye of each patient.

In my own personal experience, however, this is not always the case. There are payers with which my practice has contracts that have coverage policies that require prior authorization for the use of ranibizumab and aflibercept, only to be given after the patient has failed a prior documented trial with bevacizumab. Some policies explicitly state that there must have been “treatment with bevacizumab that has been ineffective, not tolerated or contra-indicated” before approval for the use of FDA-approved anti-VEGF therapy can be given. Yet another requires that “when an intravitreal angiogenesis inhibitor is indicated, Avastin shall be first line therapy. In the event of a non-response to Avastin …, the ophthalmologist may choose to continue Avastin or switch to either Lucentis or Eylea.”

The large-scale, randomized CATT and IVAN studies showed that ranibizumab and bevacizumab have similar efficacy and safety. Nonetheless, surveys show that some retina specialists have predilections regarding their choices of these agents. According to the 2012 American Society of Retina Specialists (ASRS) Preferences and Trends survey, 18% of respondents believe ranibizumab is more efficacious than bevacizumab; almost no respondents said the reverse. Despite several large scale trials, no one truly knows which patient will respond more favorably to which drug, so some ophthalmologists prefer to prescribe the FDA-approved drugs as first-line therapy for most patients.

Some believe that ranibizumab is safer than bevacizumab, particularly in patients with a history of cerebrovascular or cardiovascular disease. Some are concerned about the safety of compounding pharmacy preparation of bevacizumab—with the possibility of contamination, inconsistent dosing, or large particle size—and related medicolegal concerns. In the same ASRS survey, 22% said they felt ranibizumab is safer than bevacizumab, and almost no one responded the other way.

In short, most retina specialists recognize that each drug may lead to unique anatomic responses, and they are not entirely interchangeable.

ORGANIZED RETINA STEPS UP
In recent years, the ASRS and the American Academy of Ophthalmology have strongly supported freedom of choice for ophthalmologists, particularly regarding the intravitreal agent, used to treat wet AMD.

The fight is being fought on 2 fronts: for access, to ensure the availability of bevacizumab and the right to use it; and against mandate, to allow the doctor-patient relationship to determine the treatment regimen, rather
than others forcing practitioners to use the less expensive, off-label therapy prior to FDA-approved drugs.

ASRS members have reported increasing instances of step-therapy programs that mandate the use of bevacizumab, whether overtly in stated policies or covertly through the near-certain denial of authorization to use other agents. In February, ASRS surveyed its membership to determine the prevalence and nature of these step-therapy policies. With more than 450 responses received, 45% of respondents said they have contracts with third-party payers that impose some restriction on anti-VEGF medication choices, and 65% said they have contracts that impose step-therapy policies. In the great majority of cases, bevacizumab is always or sometimes required as the first line in these tiered policies.

Survey respondents identified a total of 32 insurers that they believed to employ step-therapy guidelines. In response to these findings, on August 15 the ASRS leadership sent a letter to all payers identified in the survey as using step therapy policies. The letter stated the organization’s position that it is inappropriate for an insurer to require tiered anti-VEGF therapy, advocated for the ability to individualize treatment, and urged the payer to “allow retina specialists and their patients to make wise and judicious choices based on the patients’ unique risk factors, clinical appearance, availability of compounded drugs, and economic requirements.”

ASRS has received a range of responses from payers. Some thanked ASRS for the information and said they will “reconsider” their stated policies. A small number said they have reversed their policies so that step therapy is no longer overtly mandated. Others have said, in effect, “thanks, but no thanks,” and plan to continue current policies.

**CAMPAIGN FOR PHYSICIAN CHOICE**

Organized ophthalmology is not alone in its opposition to step therapy policies. The Global Healthy Living Foundation, a nonprofit advocacy organization based in New York, has initiated a project called Fail First Hurts (failfirsthurts.org) to bring attention to the use of step therapy by health insurers. The project’s web site is a good place for interested parties to follow news about step therapy, track legislation state by state (Figure 1), and become part of a large 50-state network to coordinate lobbying efforts.

As the campaign for physician choice continues, input is needed from ASRS members and other members of the retina community. Individuals must continue to identify payers that use step therapy plans and loudly voice their opposition through letters and otherwise. (ASRS can help with letters.)

For its part, ASRS plans to list insurers that employ step-therapy policies on the public portion of its web site to draw the attention of patients and physicians. ASRS wants to increase the visibility of this issue, to inform members and the public and get them involved, and to broadcast this message through the media—whether traditional media outlets or newer social media. It is important that patients and retina specialists understand what is allowable regarding step therapy policies under current law and what is not.

It should be noted that Medicare Advantage plans are prohibited by the Centers for Medicare and Medicaid Services from employing step therapy requirements. Recently, however, CareMore, a Medicare Advantage plan in California, was identified as using a step therapy protocol mandating use of bevacizumab prior to ranibizumab or aflibercept. Members should let ASRS know if they are aware of other Medicare Advantage plans using such policies.

The ASRS leadership urges its members and others to become involved in the campaign for physician choice. Please note that this is not a campaign against bevacizumab, which is and will remain an important treatment option for many of our patients. It is a campaign to protect the sanctity of the physician-patient relationship, to protect the public from “medical” decisions made by insurance companies rather than physicians, and to preserve the importance of level 1 evidence and the FDA approval process in patient management decisions.

We find it fundamentally wrong that a payer is allowed to mandate an off-label (ie, non-FDA-approved) drug over a drug specifically approved for a given indication. How is it that a pharmaceutical company can be fined millions of dollars for discussing an off-label drug use, while an insurance company can save millions of dollars with a policy mandating that very same off-label use? Retina specialists need to be aware of this issue and join the fight for physician freedom of choice.

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