

» Medical marijuana – where do we go from here?

As the calendar turns over to 2018, Canada is nearing its entry into a brand-new world when it comes to marijuana. The legalization of the product on July 1 makes for a very happy Canada Day for some, but it's also a major policy shift that is provoking some concern about how opening up access to this substance will impact our society – from our homes to our workplaces – and, yes, even our benefits plans. That last consideration brings us to the topic of medical marijuana – one that is different than the decriminalization of recreational use, but is sure to get more airplay as the general public, including our plan members, inevitably combine the two into one big topic.

Although we have written a feature on this before – see *The Inside Story*® from December 2014 – we want to revisit the issue of medical marijuana and its inevitable expansion into health benefits plans in ways beyond the route it takes today – namely reimbursement under health care spending accounts (HCSAs). And we specifically want to let GSC plan sponsors know how we will let them decide on this question in 2018. But you'll have to read to the end – well, OK, if you're the impatient type, you can flip to the end of this article to see what's happening there.

Medical marijuana coverage today

For us in the health benefits world, one of the most vexing issues about medical marijuana is the fact that Health Canada has not approved the plant as medicine, nor issued a drug identification number (DIN) for it – something that every drug on our industry's formularies possesses.

But despite all that, Canadians are using medical marijuana today. And we reimburse them through HCSAs. What's the process for a patient to gain access today? First, a physician needs to complete a specific form detailing the quantity of marijuana their patient is authorized to use, the strain of the plant, and the period of use. The product is then sent to the patient by a licensed producer via mail order. There are different products for a physician to select from and different ways for a patient to ingest it (smoke, vaporize, ingest, apply topical creams, etc...). And, as a rule, it currently costs \$8–12 a gram depending on the licensed producer and the product. We reimburse claims based on these standards.

A quick re-education on medical marijuana...

- Cannabis, or its more common name, marijuana, is tobacco-like material harvested from the dried flowers, fruit tops, leaves, and stems of the plant known as *Cannabis sativa*.
- When folks refer to "medical marijuana," it means using the whole unprocessed plant and the combination of chemicals contained within it to alleviate the symptoms of certain conditions or diseases.

A brand-new world – what are plan sponsors to do...?

Well, actually, a lot... or a little... or nothing at all. There will definitely be many viewpoints on this. But here are some considerations when assessing the addition of medical marijuana to a benefits plan in a broader (than HCSA) way:

1. This is not the silver bullet for the opioid epidemic. Current treatment guidelines see the prescribing of medical marijuana as an add-on to opioid treatment, not a replacement. Further, any evidence to suggest opioid use may decrease with the usage of medical marijuana is suggestive at best.
2. With the legal use of marijuana on our horizon, the potential for diversion from medical to recreational use increases.
3. There are known health impacts with the use of marijuana – for medical **or** recreational purposes. These include a number of short-term effects (loss of balance, confusion, drowsiness, nausea, to name a few), as well as long-term psychoactive and neurocognitive impacts that are not fully known at this point.
4. This is not projected to be a low-cost benefit. If we assume an average cost of, say, \$9 per gram¹, and an average patient uses three grams per day, that plan member could approach \$10,000 in costs annually. By GSC standards, this is entering the high-cost claimant category.
5. And an always pertinent topic at GSC – the research for most of the current usage of medical marijuana is generally lacking in both quantity and quality. However, having stated that, there is more research and evidence that has emerged for some medical indications over others, specifically neuropathic pain and some side-effects related to multiple sclerosis and cancer.

These cautionary tales are not meant to suggest coverage of medical marijuana should be ruled out in benefits plans. Sufferers of the three disease states noted above (and, inevitably, other conditions), will be looking to plan sponsors for answers on the availability of medical marijuana, and we believe it is appropriate for us all – advisors, sponsors, carriers – to seriously consider how we can support these patient communities.

GSC to offer plan sponsors an option for medical marijuana reimbursement in 2018

Come early 2018, GSC will introduce a new product for our plan sponsors that will offer more options for incorporating medical marijuana into benefits plans, but with a much greater level of oversight and rigour than is currently available through HCSAs. Here are a few general specifications:

- Medical marijuana will be a benefit offered under extended health care coverage, not the drug benefit – remember there is no DIN.
- Above we noted the cost of this product; so no surprise that there will be benefit maximums put in place. They are currently under construction and the entire pricing impact of the benefit will be available for consideration in the new year.
- To receive reimbursement, claimants will have to follow a prior authorization process with criteria based on specific medical conditions.

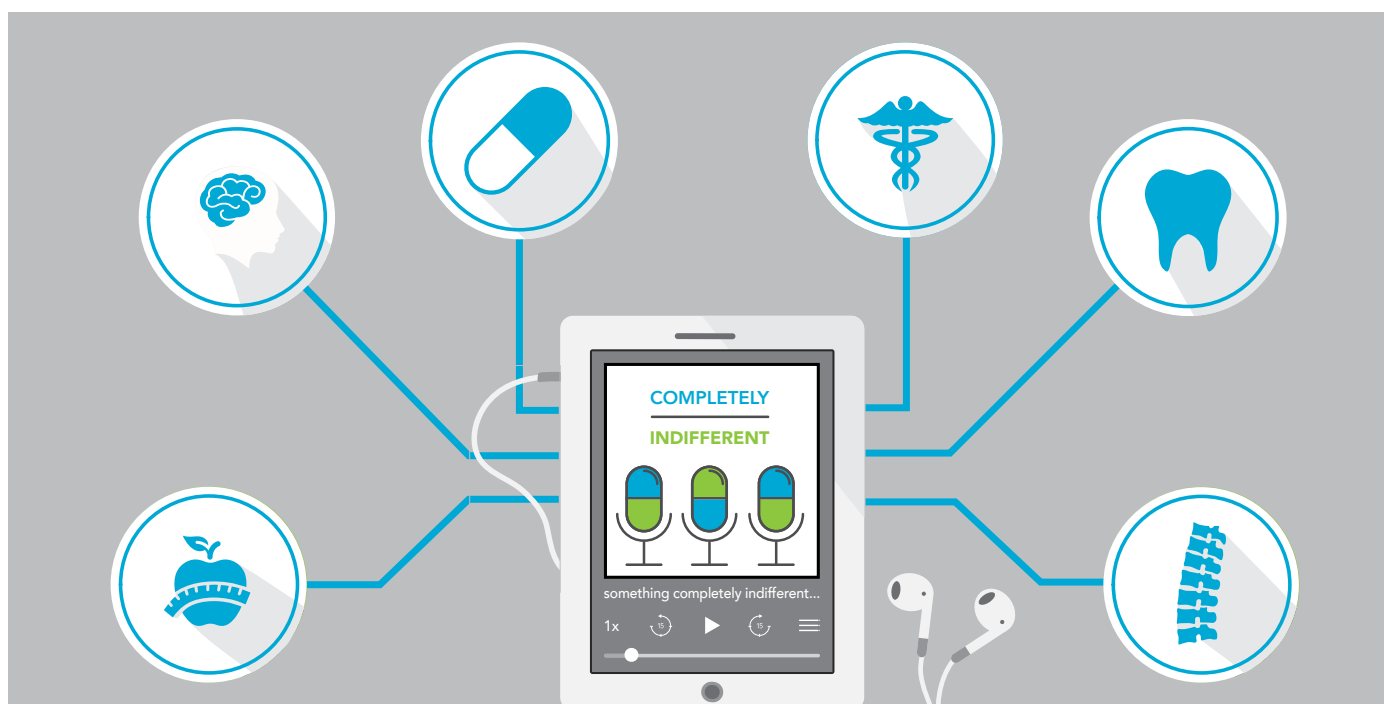
What specific medical conditions? To start, coverage will be limited to:

- Chronic neuropathic pain
- Spasticity due to multiple sclerosis
- Nausea and vomiting due to cancer chemotherapy

These were chosen based on the best available research today. The number of eligible conditions is likely to increase over time based on the emerging evidence, and will be communicated by GSC to plan sponsors when, or if, that occurs.

So, we hope you consider this issue of *Follow the Script* an end-of-year present. It's meant to provoke some serious thought, maybe even debate, over the holiday season. Perhaps those discussions will be fueled by substances fully legal – beer, wine, and other spirits – but we know our readership would NEVER test drive other products that still fall on the wrong side of the law. (July, people, it's July.)

See you in the new year!



*Check out the companion GSC podcast to this *Follow the Script**

Episode 3 of “And Now for Something Completely Indifferent...” is all about medical marijuana, and it features GSC experts and special guest Mike Sullivan of Cubic Health Inc.

CLICK HERE TO HAVE A LISTEN... and be sure to subscribe to get future episodes.

Source:

¹Solomon Israel, “How high will the price of legal pot be?”, CBC News, April 1, 2017. Retrieved: December 4, 2017.

BEHIND THE COUNTER



Expectations and responsibilities at the pharmacy counter

In each issue of *Follow the Script*[®], we interview a member of our pharmacy team about a current topic. In this issue, we talk to Leila Mandlsohn about what plan members should expect in their interactions with pharmacists when filling a prescription.

Follow the Script: Nice to talk to you again Leila. We know you've worked in a number of different settings in your career including retail pharmacies and now in the hospital. In your experience as a pharmacist, what are the major differences between those environments?

Leila: In the hospital, pharmacists develop relationships with the physicians – generally that doesn't happen at a community pharmacy. When you're working with the same team of clinicians, you establish a rapport and your credibility. They know you're a resource and they utilize you. In a community pharmacy it's a little bit different. The doctors are dealing with all the pharmacists around, you're just one of many.

Also, I have access to the patients' medical information in the hospital, so I can get a full picture of who that patient is. It allows me to have a more meaningful conversation with the patient from the beginning. In the community you have to build that picture by asking questions. It can seem a little unnatural at times to some patients, in particular when it's a new patient in your pharmacy, and often you only get a limited picture.

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FtS: What are the main things a consumer/patient going in to a retail pharmacy with a prescription has a right to expect to happen in that interaction with the pharmacist?

Leila: At the very least, they should expect the pharmacist or technician to acknowledge them as a patient and to ask the questions that are necessary to have an adequate picture of their medical history, so they can assess the appropriateness of the prescriptions. And they should be documenting this information on their file so they don't have to repeat it every time they go in.

Patients should expect a pharmacist who sees themselves as a partner with the physician, and who takes the time necessary to assess their therapy in the context of their full medical history to ensure that there are no drug therapy problems. And, if a problem is identified, the pharmacist should intervene to resolve it. A pharmacist should not see their role as someone who is just acting on the orders of the physician and simply limiting themselves to making sure there aren't any drug interactions or contraindications.

In the hospital, when a patient is admitted, I read our documentation about him or her to understand the current medical problem, and whether the patient has other conditions. I look at all the medications the patient is on – I need to make sure there's a reason for each one. If I don't see a reason, then I'm going to question it. Also I'll look to make sure that all medical conditions have an appropriate treatment in place, and where a condition is not being treated, I question it. Even in the community, the pharmacist should be working with the physician to make sure the therapy is appropriate for the medical condition. If that means calling the doctor to ask questions or to make recommendations for adding, discontinuing, or changing a therapy, your pharmacist should do that.

FtS: Would the average person understand that to be the role of the pharmacist? Wouldn't they just say: "Do what the doctor says"? Are they sophisticated enough to know that pharmacists are the experts on drugs?

Leila: Some patients get that, but not everybody. I think that's why many patients have the expectations they have when they go to the pharmacy. They ask "why does it take so long to fill my prescription, you just have to count 30 tablets." They're only thinking about the technical part of dispensing their prescription and sometimes don't understand that there's an assessment that goes along with that transactional piece. Also, while their prescription may in fact be a simple one, other people may need a more intensive level of care, and that's going to take longer. A pharmacist who is doing a proper job is taking the appropriate time with each individual patient.

FtS: What then are the responsibilities of the patient?

Leila: A responsible patient should take an interest in learning about their condition and their medications. They should also have an understanding of the level of involvement they need from their pharmacist. Some people need more involvement and attention than others. If you as a patient can look after certain things on your own – like keeping track of your refills – don't depend on the pharmacist, do it yourself because someone else may need more care.

FtS: In the context of GSC's launch of value-based pharmacy, what is the level of care we want for GSC patients?

Leila: It's exactly that. For patients with greater needs, we want pharmacies to engage with them to provide a more comprehensive level of care.

FtS: And how are we specifically going to measure that?

Leila: The asthma measures, for example. Through our claims data, we can identify for pharmacists which plan members need to be targeted to make sure their therapy is reassessed, recommendations are made to the physician, and the proper education is given to the patient to get the asthma under control. So those measures will directly help pharmacists provide targeted disease management to the right patients, those with the greatest need. Not every patient needs that same level of intervention.

Same with cardiovascular health coaching. The cardiovascular health coaching measures will identify who has two specific conditions – high blood pressure and high cholesterol – and then it's up to the pharmacist to assess whether the patient is under control, adherent to the therapy, and following good, healthy lifestyle guidelines. Maybe they don't need the pharmacist to sit down with them to provide the program. But for the ones identified as having a need, it's the pharmacist's responsibility to help them see where the problem is and what help can be provided. The issue today is that a lot of patients don't know what they need, so they don't want to take the program.

Again, all the measures should help the pharmacist identify the patients with the greatest need, so they can target those patients. While common sense tells us there are some patients who will never change their behaviour – they will never do what they need to do despite all the help they are offered – there are definitely many that will, they just need someone to reach out and provide ongoing guidance.

FtS: Thanks Leila. We look forward to speaking to you again in 2018.

DRUG REVIEW AT GSC...

To give you an idea of what drugs might impact your benefits plan next, every quarter *Follow the Script* highlights some of the drugs recently reviewed by GSC's Pharmacy and Therapeutic (P&T) Committee.

GSC CLASSIFICATION ¹	NEW DRUG ²	GENERAL INFORMATION	COST ³	COVERAGE DETAILS ⁴
INFLAMMATORY DISEASE				
<p>Biologic; High-cost; Specialty (Tier 5)</p>	<p>Actemra® (tocilizumab)</p>	<p>Giant cell arteritis (GCA) is characterized by inflammation of the blood vessels (also known as vasculitis) and typically affects the large- and medium-sized vessels in the head. The resulting reduction in blood flow can cause debilitating symptoms including headaches, jaw pain, and vision problems. If left untreated, GCA can lead to more severe complications such as stroke or blindness. ^{5,6}</p> <p>Although the exact cause is unknown, GCA is the most common systemic vasculitis, with age being the greatest risk factor. Although the overall lifetime risk of developing GCA is estimated at approximately one per cent in women and 0.5 per cent in men, the disease rarely occurs in those under 50, with the incidence steadily increasing up to a peak between the ages of 70 and 79. ⁶</p> <p>Prior to the availability of Actemra, during a GCA flare, the standard of care has been prompt treatment with high-dose corticosteroids to relieve symptoms and prevent serious complications. Although effective for inducing remission, long-term use is associated with corticosteroid-related side-effects (osteoporosis, glaucoma, diabetes, weight gain, etc.), and close to half of patients would experience disease relapse during corticosteroid reduction or discontinuation. ⁷</p> <p>Actemra addresses an unmet need and is the first biologic agent to be approved by Health Canada for the treatment of GCA in adults. Actemra is administered by injection once a week in combination with a tapering course of glucocorticoids.</p>	<p>\$\$\$\$</p> <p>Approximately \$19,000 per year</p>	<p>→ Specialty drug PPN</p> <p>→ Requires prior approval</p>

GSC CLASSIFICATION ¹	NEW DRUG ²	GENERAL INFORMATION	COST ³	COVERAGE DETAILS ⁴
CANCER				
Traditional; High-cost; Specialty (Tier 5)	Stivarga™ (regorafenib)	<p>Hepatocellular carcinoma (HCC) is an aggressive type of liver cancer and commonly occurs in those with underlying chronic liver diseases (such as hepatitis B or hepatitis C infections) or cirrhosis (liver scarring). Once diagnosed, the median survival is approximately six to 20 months.⁸ It is the third leading cause of cancer deaths worldwide and accounts for approximately 90 per cent of all liver cancers.^{9,10}</p> <p>Although surgical resection or liver transplantation are preferred, some patients are not candidates due to advanced disease or lack of access to organ transplantation. When surgical treatments are no longer appropriate, current treatment guidelines recommend systemic therapy with Nexavar® (sorafenib). Prior to the availability of Stivarga, there was no second-line treatment option approved for use for those who progress on sorafenib; these patients were limited to best supportive care or available investigational agents through clinical trials.</p> <p>Stivarga now addresses an unmet need and is the only treatment option that has been approved by Health Canada for adults with unresectable HCC who have been previously treated with sorafenib. It is administered orally (four tablets) once daily for three weeks followed by one week off therapy.</p>	<p>\$\$\$\$\$</p> <p>Approximately \$75,000 per year</p>	<p>→ Specialty drug PPN</p> <p>→ Requires prior approval</p>

Notes:

¹ Traditional generally refers to small molecule compounds derived from chemical synthesis and also includes drugs not listed in Schedule D of the Food and Drugs Act; Biologic refers to drugs produced through biotechnology and listed in Schedule D of the Food and Drugs Act; High-cost refers to drugs subject to GSC's High Cost Drug Policies; Specialty (Tier 5) refers to drugs with an expected annual treatment cost of \$10,000 or more (certain drugs approaching the threshold may also be considered if clinically warranted).

² Brand (generic)

³ Based on manufacturer list price, does not reflect pharmacy markup and dispensing fee. \$ <1,000; \$\$ 1,000–4,999; \$\$\$ 5,000–9,999; \$\$\$\$ 10,000–49,999; \$\$\$\$\$ ≥50,000.

⁴ Applicable to all formularies unless otherwise noted. PPN refers to GSC's preferred pharmacy network program.

⁵ Giant Cell Arteritis, Mayo Clinic, <https://www.mayoclinic.org/diseases-conditions/giant-cell-arteritis/basics/definition/con-20023109>.

⁶ Giant Cell (Temporal) Arteritis, UpToDate, https://www.uptodate.com/contents/clinical-manifestations-of-giant-cell-temporal-arteritis?source=search_result&search=GCA&selectedTitle=2~121.

⁷ Glucocorticoid therapy in giant cell arteritis: Duration and adverse outcomes. Arthritis Care & Research 2003; 49 (5): 703-8.

⁸ Hepatocellular carcinoma, UpToDate, https://www.uptodate.com/contents/overview-of-treatment-approaches-for-hepatocellular-carcinoma?source=search_result&search=HCC&selectedTitle=1~150.

⁹ Hepatocellular Carcinoma, Medscape, <https://emedicine.medscape.com/article/197319-overview>.

¹⁰ Hepatocellular carcinoma: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Annals of Oncology 2010; 21 (Suppl 5): v59-64.