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FOLLOW THE SCRIPT®

SPRING 2018

Behind the scenes at Green Shield Canada's preferred pharmacy network

Remember the preferred pharmacy network (PPN)? Let's refresh your memory: Green Shield Canada (GSC) introduced the PPN for specialty drugs back in the July 2015 issue of *The Advantage*® and launched the program in fall 2015. It's been working quietly in the background helping your plan members with their specialty drug prescriptions ever since.

All drugs available through the PPN require prior authorization from GSC – these drugs usually treat serious medical conditions and are often very expensive. The PPN is designed to ensure these drugs are accessible for plan members and affordable for drug plans. The pharmacies in the PPN have agreed to provide these drugs at a reduced markup to GSC plan members.

GSC's partner in delivering the PPN is HealthForward™, a subsidiary of AmerisourceBergen Canada. HealthForward is an industry leader with extensive specialty medication experience including administering patient support programs and preferred pharmacy networks.

The PPN also offers invaluable support services to plan members provided by a dedicated care coordinator. Specialty drug regimens can be very complex, and many people find it a challenge to adhere to them. Therefore, although the PPN adherence support program is voluntary, we strongly recommend that plan members take advantage of the services.

How the PPN works

Prescriptions for the PPN drugs must be filled at a network pharmacy in order to be reimbursed by the plan member's drug plan. Network pharmacies are located across Canada and include some popular retail chains, independent pharmacies, and regional cancer centres. Home delivery is available for plan members who find that option more convenient.

Once plan members are approved for a drug included on the PPN, they are automatically enrolled in the program and contacted by a care coordinator from HealthForward. Care coordinators are responsible for working with the plan member, physician, and network pharmacy to coordinate drug access and the plan member's treatment schedule. They help plan members find an approved network pharmacy and ensure plan members receive the treatment support they need when taking these drugs. This includes coaching, resources, and ongoing support – with a focus on adherence.

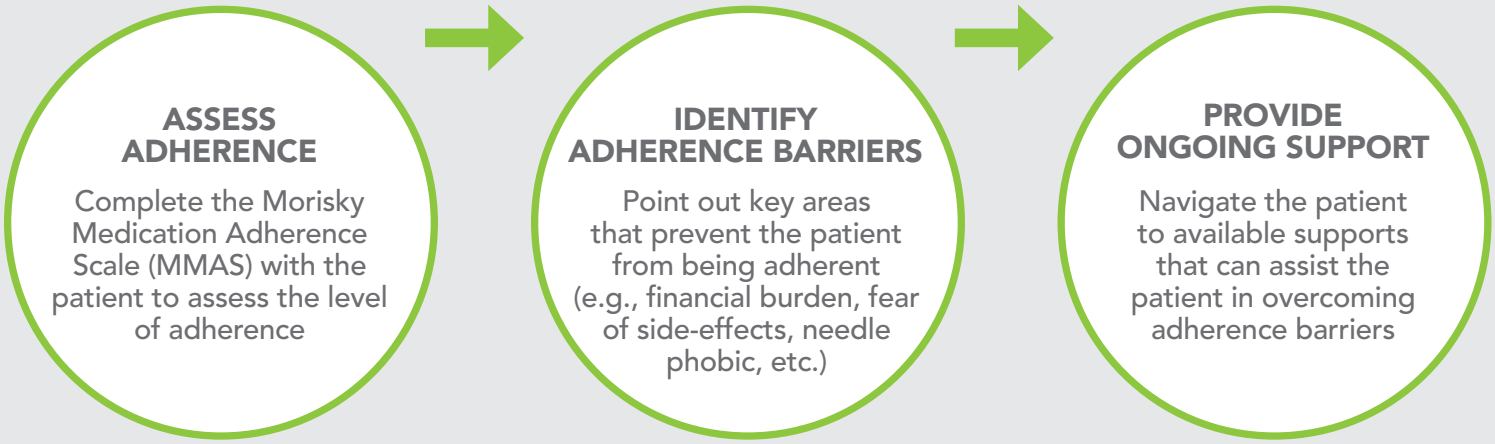
Here's what patients said to HealthForward…

"Thank you for the support. I hope this program helps many other people like it did for me and my family."

"[The care coordinator] patiently and pleasantly explained the situation with understanding and sympathy, and then went through the process with me. Employees like this are what keeps people happy."

"I'm so thankful and grateful for all your help and assistance and being so kind and approachable to talk to."

ADHERENCE SUPPORT PROGRAM



Quick facts

It's now been just over two years since the launch of the specialty drug PPN, and overall, it's meeting our expectations. Here's a snapshot:

- → Number of patients enrolled from February 2017 to January 2018 – over 1,440.
- → Most patients are in Ontario, but otherwise participation is almost evenly spread out over the country (except in Quebec and Alberta where the program is not available due to regulatory constraints).
- → Despite having a network of over 2,100 pharmacies across Canada, only 46 per cent of the pharmacies are currently being utilized by PPN patients.
- → A broad range of medical conditions is represented, including rheumatoid arthritis, hepatitis C, Crohn's disease and colitis, and many forms of cancer.
- → The top ten medications account for 68 per cent of all the drugs included in the PPN.

THESE TOP 10 MEDICATIONS ACCOUNT FOR 68% OF THE TOTAL PROGRAM. We've also shown the medical conditions typically treated by each drug.

33%	**Humira**	Rheumatoid arthritis, juvenile arthritis, psoriatic arthritis, ankylosing spondylitis, plaque psoriasis, Crohn's disease, ulcerative colitis, uveitis, and hidradenitis suppurativa
16%	**Enbrel***	Plaque psoriasis and psoriatic arthritis
12%	**Xolair**	Allergic asthma and chronic idiopathic urticaria
8%	**Stelara**	Crohn's disease, plaque psoriasis, and psoriatic arthritis
8%	**Simponi**	Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, non-radiographic axial spondyloarthritis, and ulcerative colitis
6%	**Entyvio**	Ulcerative colitis and Crohn's disease
5%	**Otezla**	Psoriatic arthritis and plaque psoriasis
5%	**Tecfidera**	Multiple sclerosis
4%	**Actemra**	Rheumatoid arthritis, juvenile arthritis, and giant cell arteritis
3%	**Orencia**	Rheumatoid arthritis and juvenile arthritis

* Please note, under GSC policies, Enbrel is currently only considered for rheumatoid arthritis, ankylosing spondylitis, and juvenile arthritis under exceptional circumstances.

Improving medication adherence

Since one of the main objectives of the PPN's services is to help plan members be more adherent to their specialty medications, we recently conducted an analysis of the PPN's adherence support program. This study compared the adherence levels of plan members who opted for the adherence support program to plan members who declined the program.

The analysis showed that participants in the program have a five per cent higher adherence rate to the medications compared to non-participants. Studies have shown that medication adherence can be very difficult to improve, but even slight increases in adherence can have significant impacts on health outcomes. Research has also shown that medication adherence is associated with improved plan member health that positively impacts productivity and reduces absenteeism.

About HealthForward's adherence support program

Plan members enrolled with the PPN are offered an adherence support program, which includes personalized coaching, resources, and ongoing monitoring during treatment. The key goals of the program are to:

- → Identify plan members who are not compliant with their medication
- → Optimize plan member adherence
- → Support plan members in recognizing and overcoming potential adherence barriers

The program's support services are provided by care coordinators and include:

- → Assessing the plan member's level of adherence
- → Providing reminders to take medications as prescribed
- → Encouraging adherence with prescribing information
- → Working with the physician if side-effects occur
- → Providing navigation to available community support programs and resources

What's next?

The PPN is a key part of GSC's drug management initiatives and, as it continues to grow, we want to ensure it meets patient needs. Our next step will be undertaking a plan member experience survey which will determine whether plan members are finding the PPN and the support services valuable and ways in which we can improve. Look out for those results later in 2018.

BEHIND THE COUNTER

In 2017 GSC reviewed our Narcotic Pain Medication Policy and announced some updates to it to improve plan member safety as the opioid crisis continues to be an issue across Canada. In this issue of *Follow the Script*, we talk to GSC pharmacist Chris Leung about the most recent change to the policy.

Follow the Script: Hello, Chris! About a year ago we spoke to you about opioids and how they're being prescribed and used. Let's call this discussion a continuation of that topic.

Chris: Always happy to talk to you. The recent change to the Narcotic Pain Medication Policy was a really positive update for everyone.

FtS: Before we talk about that – as a subject matter expert, as a pharmacist – is the whole opioids crisis getting better or is it going to get worse before it gets better?

Chris: It's probably going to get better. Governments, medical practitioners, and regulatory agencies have now all recognized this as an issue.

FtS: So we've reached the tipping point?

Chris: We've reached the tipping point. Finally we have guidelines that say maybe opioids shouldn't be used like they were back in the '80s and '90s, when they were seen as the panacea for pain control. Back then the medical thinking was, "You got pain, take this, it will work." And patients were using really high doses of opioids – the idea was that they shouldn't feel any pain at all.

FtS: And now… ?

Chris: Now we know it's best for the few patients who really need opioids to use the lowest amount that they can. And even before using any drugs at all, they should start off with other kinds of treatment – things like exercise, yoga, mindfulness, physiotherapy, psychotherapy, and cognitive behavioural therapy. If necessary, non-opioid therapy can be added – like anti-inflammatories – things that are less addictive or less likely to be abused. If those things aren't working, then that's when a patient might also start using an opioid. The major goal of treatment for pain relief is that the person can function so that they're able to be good for society, good for their family, and good for everybody around them.

FtS: OK, about GCS's Narcotic Pain Medication Policy… what was our thinking when we developed the original policy?

Chris: Before the update, the limitations for narcotic pain medications were based on dollars and cents. We knew that more expensive opioids were the ones more likely to be abused or diverted because some people think that they can sell them on the street. Also, because doctors tend to write prescriptions for things that they've seen promoted by drug manufacturers, we were seeing claims for expensive brand-name products. That's why we used dollar limits – and, at the time, we had no other way of doing it.

FtS: How did we arrive at the specific dollar amount?

Chris: Knowing the specific product that was most problematic made it easy to translate dosages into dollars. We looked at the maximum daily dosage of OxyContin, which was a specific number of tablets per day. Then we calculated how much that number of tablets would be in dollars. We didn't have the technology to apply limitations according to morphine equivalents.

FtS: Ah, yes, "morphine equivalents." This is a technical term that seems very complicated. Can you explain it in a simpler way?

Chris: Morphine is the granddaddy of all the opioids – these are drugs derived from the opium poppy. Comparing the potency of each opioid drug to the potency of morphine results in a standardized measure called a morphine equivalent. Measuring in a standard way helps us determine whether an individual is taking too much, too little, or is at the right level of opioid for their pain control according to the guidelines.

Now we've developed the technology to compare all the opioids that a plan member is using and total it up to an amount that's equivalent to morphine. This means we can compare apples to apples. It's a better way of comparing.

FtS: So all opioid drugs have been evaluated and given a morphine equivalent value?

Chris: Yes, there's a conversion factor to it. Through tests and studies, experts have determined what the formula is for each opioid. For example, for the morphine equivalence of OxyContin, you multiply the total dosage per day by 1.5 to get a morphine equivalent per day.

Here at GSC, we have access to a database that tells us what the equivalence is for all opioids. So technology has changed and the information available has changed – this enabled us to make our Narcotic Pain Medication Policy safer for patients. We invested in this technology to help protect individuals from harm.

FtS: Are plan members understanding it? Is it a major change for them?

Chris: It's mainly seamless for plan members. After all, we're not cutting them off their narcotic pain medication; we're asking for a reason why they're on high doses for these drugs. Some of these people may have been on the opioids for a very long time. When new standards come out, we can't suddenly ask them to cut the dosage or they will have withdrawal symptoms. It's not good for the patient and it could cause even more or worse problems, such as mental health issues or additional physical issues.

Although now, with the change, we're mailing out more letters to plan members requesting additional information about their opioid use, and we're seeing that most of them are on the drugs for the right reasons. So the change is positive for them. And if we see there's a plan for opioid reduction or that the person has tried to reduce the amount of opioid they're taking, but it didn't work out, that's OK. That's good for us, we're doing our job. We know the person is on the drug for the right purpose and is being properly managed by their doctor who is ensuring their patient is getting a benefit from the drug that outweighs the risks.

FtS: To ease the opioid crisis, many different players need to be involved. Is anything being done on the prescribing side?

Chris: A lot of provinces are developing tools to look at prescribing. The Ontario government has a Narcotics Monitoring System registry that looks at all the narcotics and controlled drugs prescribed by all the doctors in Ontario by patient. There's a formula they use to flag doctors that might be prescribing too many narcotics and that information is sent to the College of Physicians and Surgeons for investigation. At GSC, we look at this as well. If we notice something unusual in our data, we're going to do the same thing – we'll report our concern to the College of Physicians and Surgeons and suggest that they may want to investigate it.

FTS: Are doctors on board with the change to morphine equivalents?

Chris: Yes, I think doctors are pretty much on board. Doctors don't like other people telling them what to do, so there might be some that think that it shouldn't be the insurance company questioning them. But because of the opioid crisis, the many news stories, and the increased scrutiny of regulators across Canada, I think that doctors and patients get it.

FtS: Does GSC have any more changes coming to help with the opioids crisis?

Chris: We'll continue to monitor the situation and update the Narcotic Pain Medication Policy as needed. We're here to ensure the plan member gets the right drug at the right time for the right reason. We want people to get the most out of their therapy. We're not seeing fewer claims for opioids, but the dosages are coming down, so that's a good sign.

FtS: Will opioids ever go away – maybe be replaced by something else?

Chris: I don't think there's going to be a time when no one uses opioids – they're always going to be around. They have a role in managing some kinds of pain, like after surgery or if a person has cancer or a severe injury. But in the future we're going to use them more sparingly and more appropriately for chronic pain. It's not going to be a free-for-all like it was. There's no magic pill that's going to work for everyone's pain. That's what OxyContin was promoted as being when it first came out, so it was prescribed and used a lot, and people got hooked. That's how we ended up with a crisis.

Doctors now understand that there are cases when a patient needs opioids and cases where they don't. Pain doesn't always have to be treated with opioids. There are nerve blocks and other types of medications such as anti-inflammatories, gabapentinoids, and antidepressants used for pain control. As I already mentioned, there are many non-drug treatments that can be effective for pain control. There's nerve stimulation. There's always new investigations and something else coming up for controlling pain. Increasingly we're going to see multi-modal ways of treating pain being adopted. That's our future.

FtS: Thanks Chris, I'm sure we'll speak to you again on this topic.

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]
CANCER				
Traditional; High-cost; Specialty (Tier 5)	Rydapt™ (midostaurin)	Leukemia occurs when there is an overproduction of abnormal blood cells in the bone marrow (also known as stem cells). While there are many different types of leukemia, it is classified by the originating type of blood stem cell (myeloid or lymphoid) and how quickly it develops and grows. Under normal processes, myeloid stem cells can develop into red blood cells, certain white blood cells, or platelets. In acute myelogenous leukemia (AML), there is usually a sudden overproduction of abnormal myeloid stem cells (developing within days or weeks). AML is the most common type of leukemia in adults and in 2013, an estimated 1,315 Canadians were diagnosed with it.[5] Additionally, in some people diagnosed with AML, certain chromosome (genetic) changes may be present that can provide insight into prognosis. Approximately 30 per cent of those diagnosed with AML present with a mutation in the FMS-like tyrosine kinase 3 (FLT3) gene which is associated with a poor prognosis.[5] Current standard of care involves treatment with chemotherapy and is generally made up of two phases – initially to kill the cancer cells and secondly to stop it from coming back (referred to as induction and consolidation respectively). Prior to the availability of Rydapt, treatment options were limited, particularly for those who did not respond to chemotherapy or experienced relapse. Rydapt, an oral FLT3-inhibitor addresses an unmet need and is the first targeted therapy to be approved by Health Canada for use in combination with standard induction and standard consolidation chemotherapy for the treatment of adult patients with newly diagnosed FLT3-mutated AML. It is administered orally twice daily on days eight to 21 of each induction cycle with cytarabine and daunorubicin and on days eight to 21 of each cycle of consolidation with cytarabine (for a maximum of six cycles).	**$$$** Per cycle	→ Specialty drug PPN → Requires prior approval

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]Acute Myelogenous Leukemia, Canadian Cancer Society, http://www.cancer.ca/en/cancer-information/cancer-type/leukemia-acute-myelogenous-aml/acute-myelogenous-leukemia/?region=on.