PHARMACY VISION 2020

CSHP SEMINAR 20 • OCTOBER 21-25

Disneyland RESORT

High Cost Pharmaceuticals, Determining the Value Equation

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Scripps Mercy Hospital

Learning Objectives

At the end of this session, participants should be able to:

1. Describe which members of an organization's healthcare team need to be involved to facilitate the cost-neutral prescribing of high-cost oncology drugs (such as lutetium Lu 177 dotatate)
2. Identify components of the healthcare team required for efficient and timely formulary management
3. Explain three methods to appropriately manage high-need medications during a shortage

The presenter has no conflict of interests in regards to this presentation

GOALS FOR TODAY

- Current landscape
- Traditional Formulary Management
- System P and T, 2.5 Years Later
- Medication Shortages, a New Culture
- Site of Care Administration Tools and Case Study
- Future Direction

Hospital Locations

Four (4) hospitals on five (5) campuses

Scripps

$3.1 BILLION IN REVENUE

15,000 EMPLOYEES

3,000 PHYSICIANS

157 Medical Residents & Fellows
8 PGY1 Pharmacy Residents
2 PGY2 Pharmacy Residents
60 P4 Rotations

Not-for-profit, Integrated Health Care System in San Diego, California

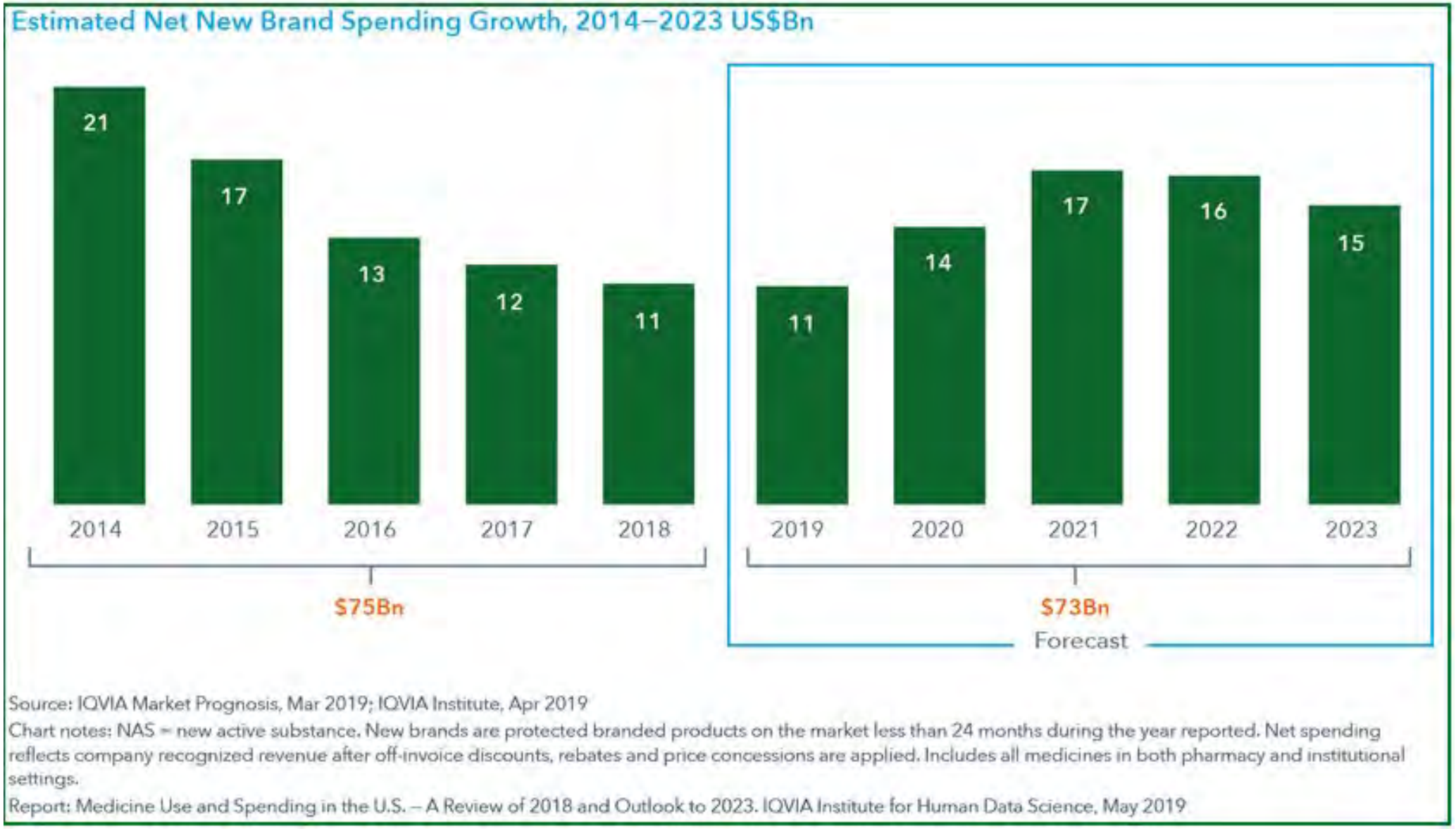
Operating Two of San Diego's Six Trauma Centers

System includes 5 Scripps Hospital campuses, Scripps Clinic, Scripps Coastal Medical Centers,

Scripps Cardiovascular Institute and Scripps Home-Based Care

HEALTHTRUST UNIVERSITY CONFERENCE

Current Landscape

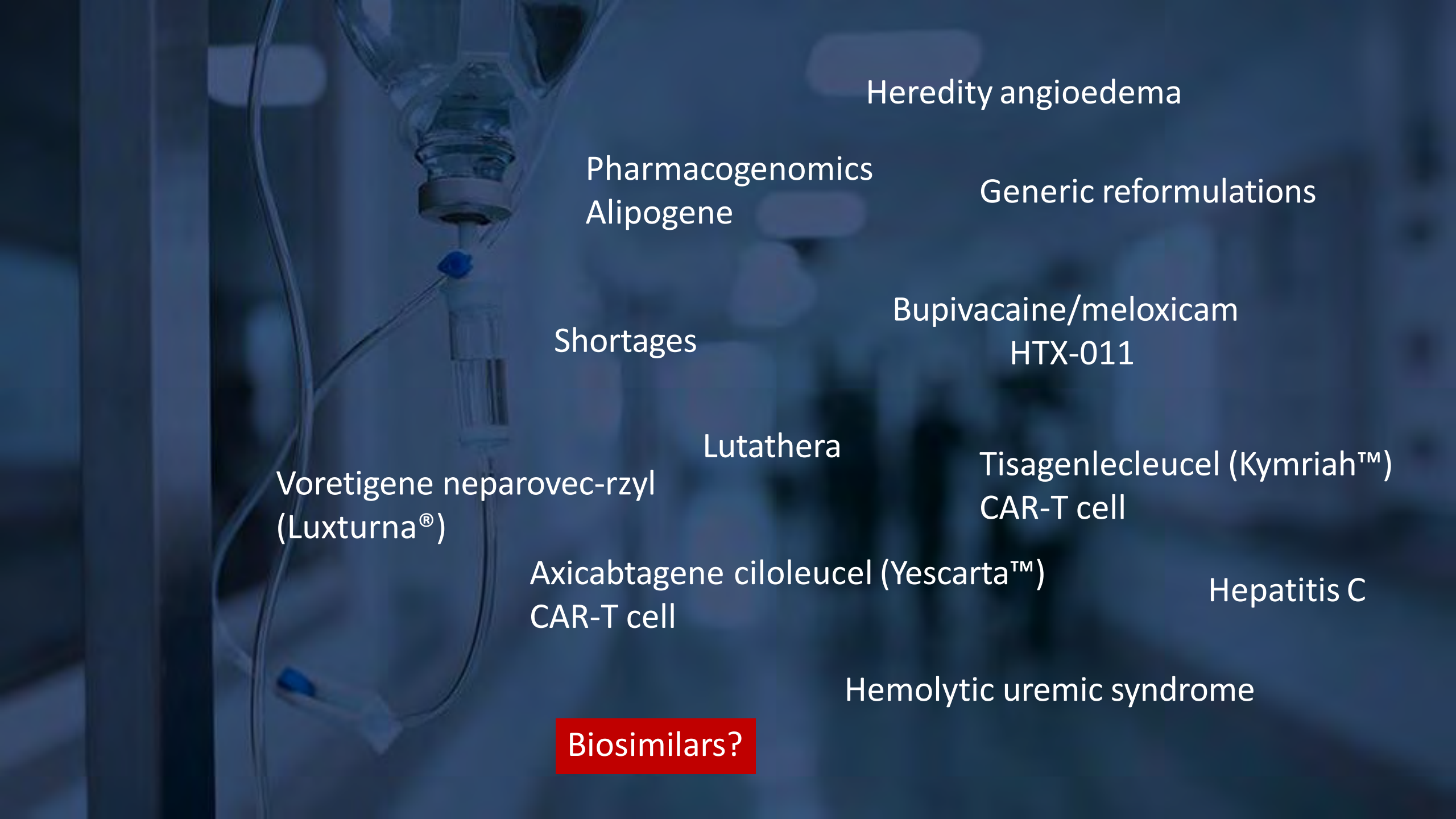


Source: IQVA Institute, Medicine Use and Spending. Published May 2019. Accessed June 2019

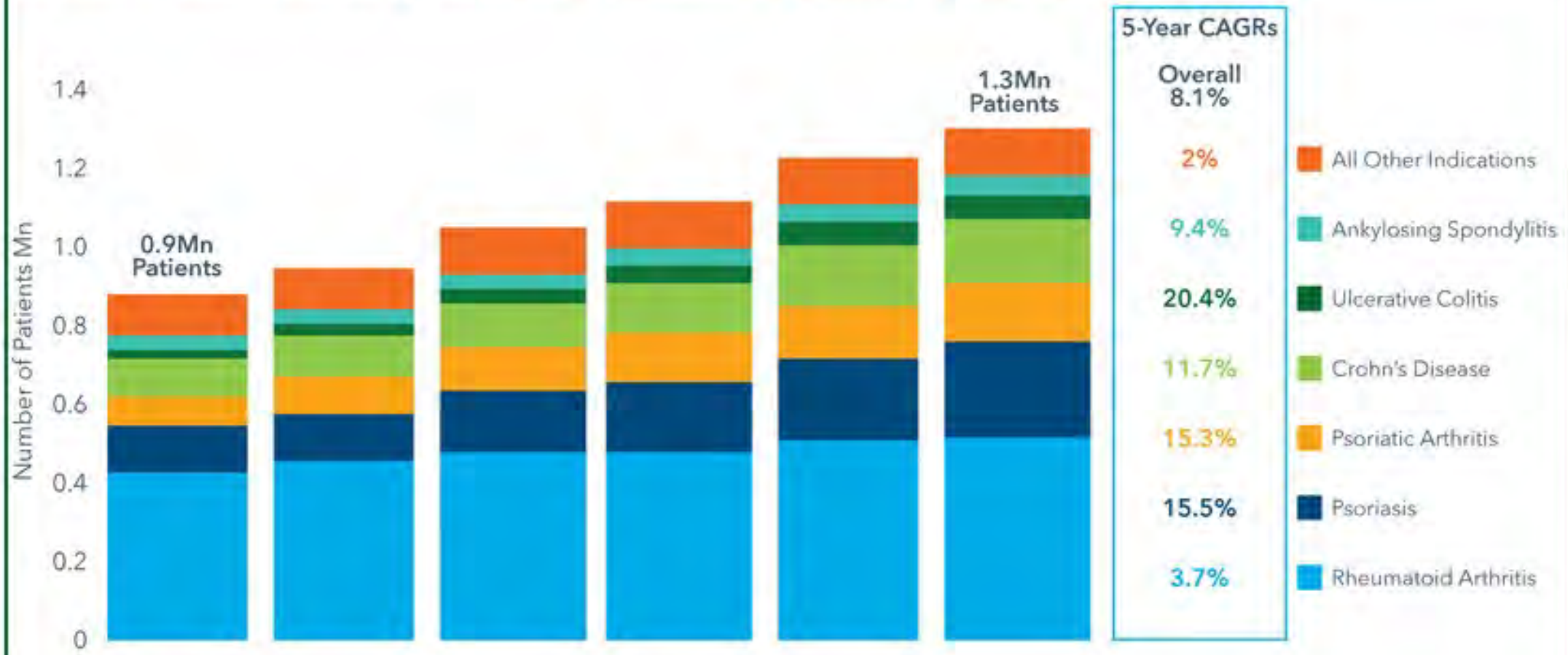
Current Pharmaceutical Landscape

- Cost of medications continues to rise at a rate of greater than 6%
- Specialty medication costs rising faster, 3 times the rate of non-specialty medications at 18–20%
- Top class of agents:
  - Antineoplastic
  - Disease-modifying
  - Immunomodulatory
- Average total drug spend/hospital admission increased 18.5% between 2015–2017

Source: AJHP 2018; 75(14):1023-1033


Heredity angioedema
Pharmacogenomics
Alipogene
Generic reformulations
Bupivacaine/meloxicam
HTX-011
Shortages
Lutathera
Tisagenlecleucel (Kymriah™)
CAR-T cell
Voretigene neparovec-rzyl
(Luxturna®)
Axicabtagene ciloleucel (Yescarta™)
CAR-T cell
Hepatitis C
Hemolytic uremic syndrome
Biosimilars?

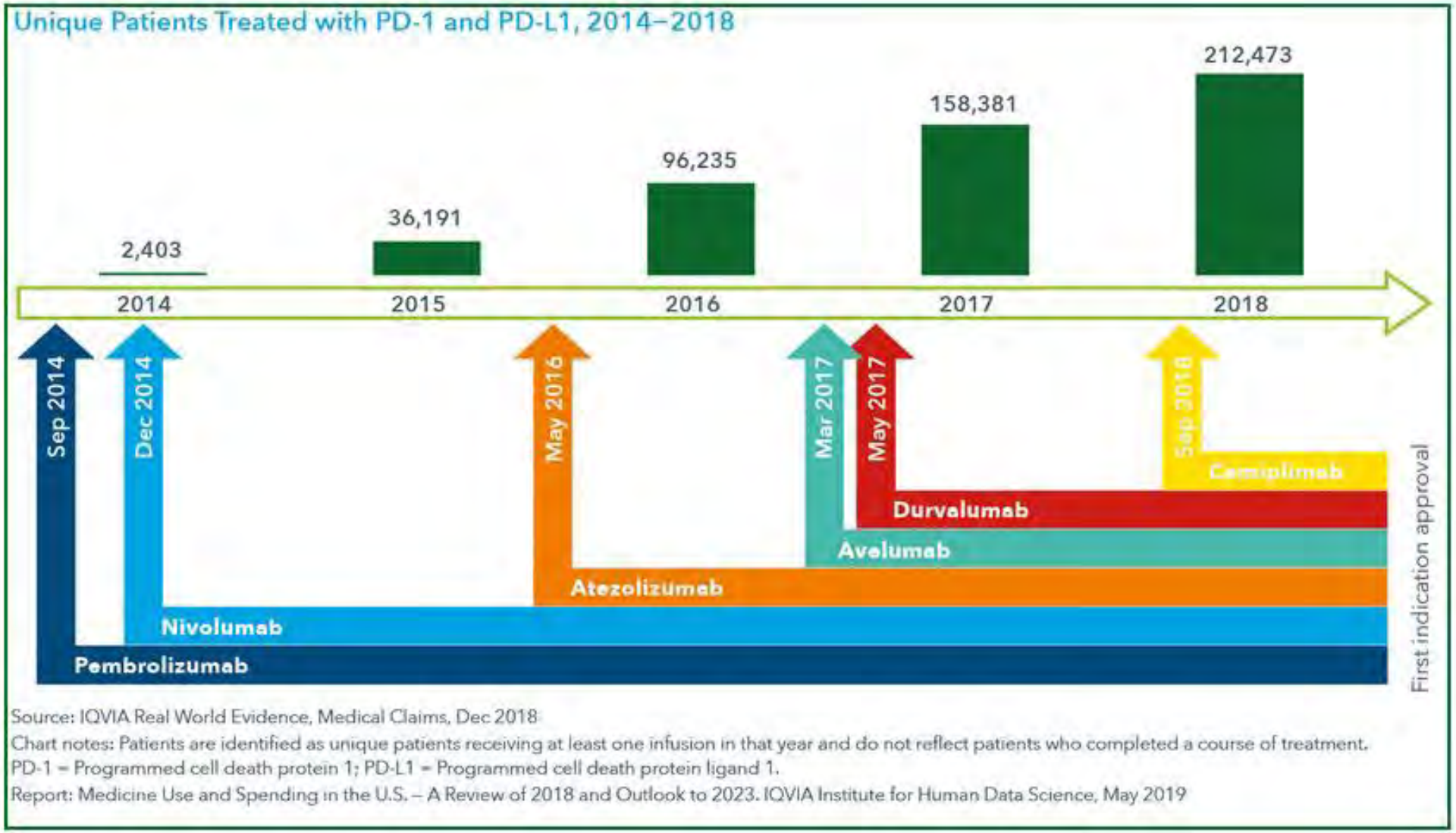
Number of Patients Receiving Treatment for Autoimmune Diseases by Indication, Millions



Source: IQVIA Real World Evidence, Longitudinal Prescription Data, Jan 2019

Chart notes: CAGR = Compound Annual Growth Rate. Anonymized patient data used to identify patients receiving at least one claim for prescription or treatment associated with relevant conditions.

Report: Medicine Use and Spending in the U.S. – A Review of 2018 and Outlook to 2023. IQVIA Institute for Human Data Science, May 2019



Source: IQVIA Real World Evidence, Medical Claims, Dec 2018

Chart notes: Patients are identified as unique patients receiving at least one infusion in that year and do not reflect patients who completed a course of treatment.
PD-1 = Programmed cell death protein 1; PD-L1 = Programmed cell death protein ligand 1.

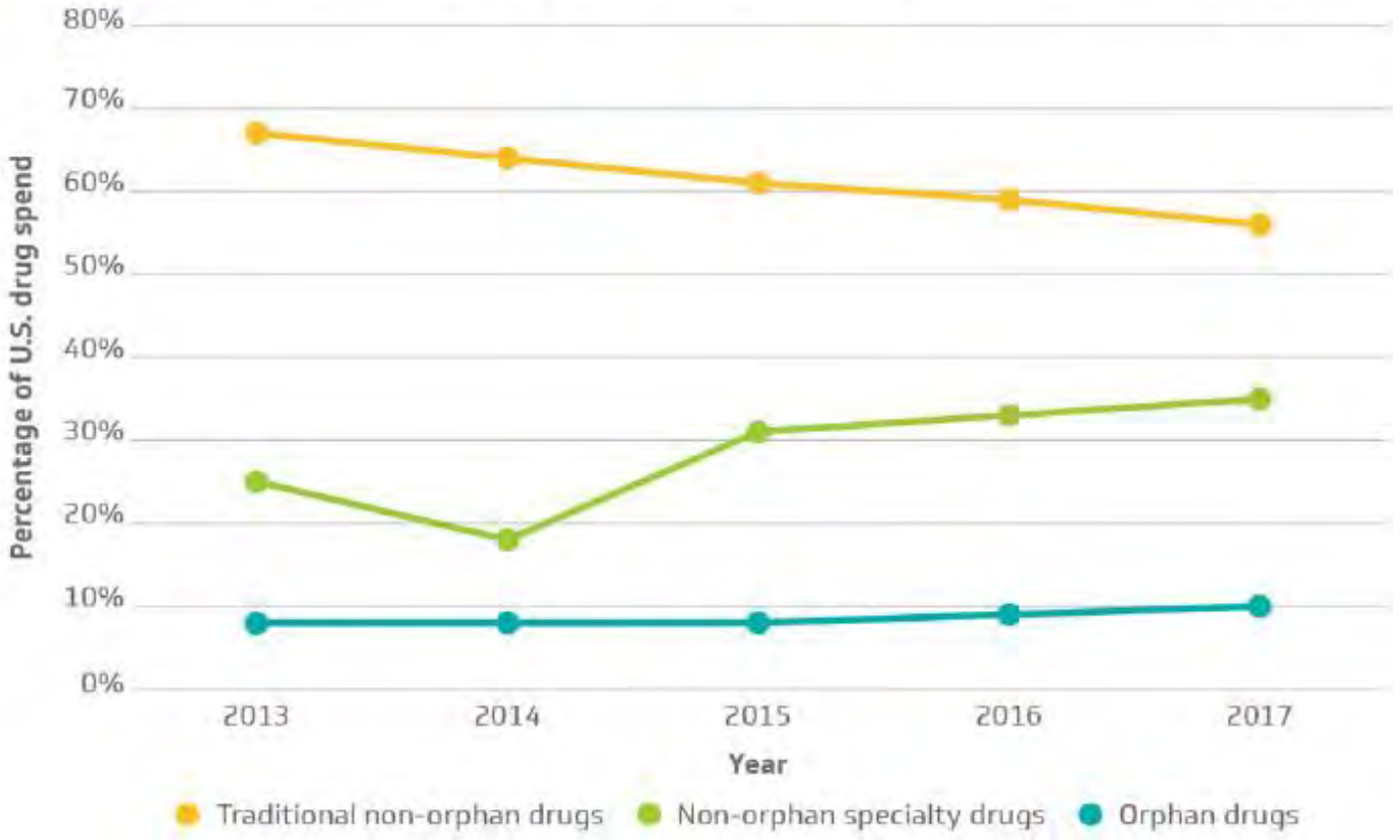
Report: Medicine Use and Spending in the U.S. – A Review of 2018 and Outlook to 2023. IQVIA Institute for Human Data Science, May 2019

Rise in Medication Spending

Etiologies

- Increased cost, not increased utilization
- Persistent shortages
- Growing specialty medications
- Medications for rare and very rare disorders

Figure 1. Annual spend by drug type as a percentage of total U.S. drug spend



Source: IQVA Institute, Medicine Use and Spending. Published May 2019. Accessed June 2019

OPPORTUNITIES

- Develop system-wide physician credentialing in hospital systems
- Address organization market positions
  - Leverage 340B programs
  - Leverage outpatient site of care
  - Home infusion
- Maximize market opportunity
  - Biosimilar

New Dynamic in Formulary Management—The Strategy

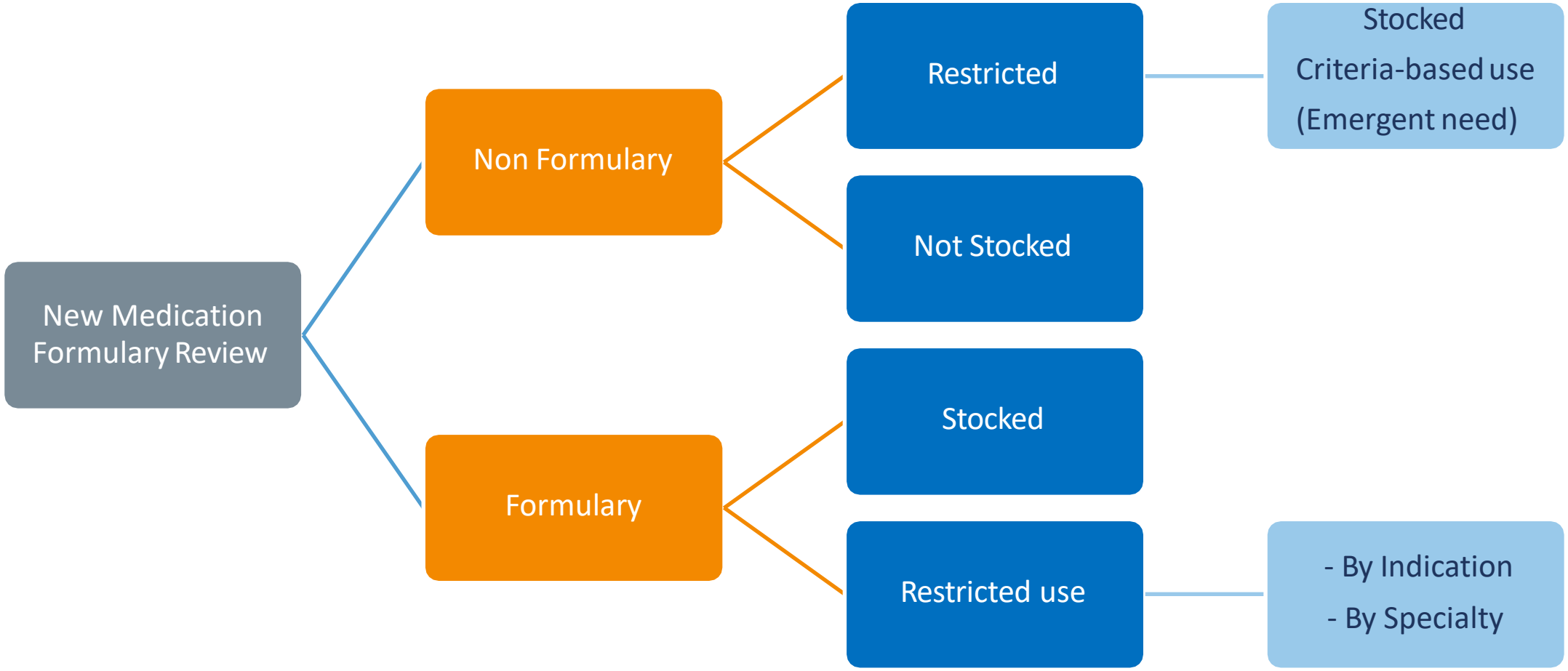
- Traditional
- Innovative
- Real time/Nimble

Strategy—Human Factor

- Credibility
- Trust
- Team

Decision Steps

TRADITIONAL—FORMULARY MANAGEMENT



Biosimilars—Time to Maximize Utilization

July 2019

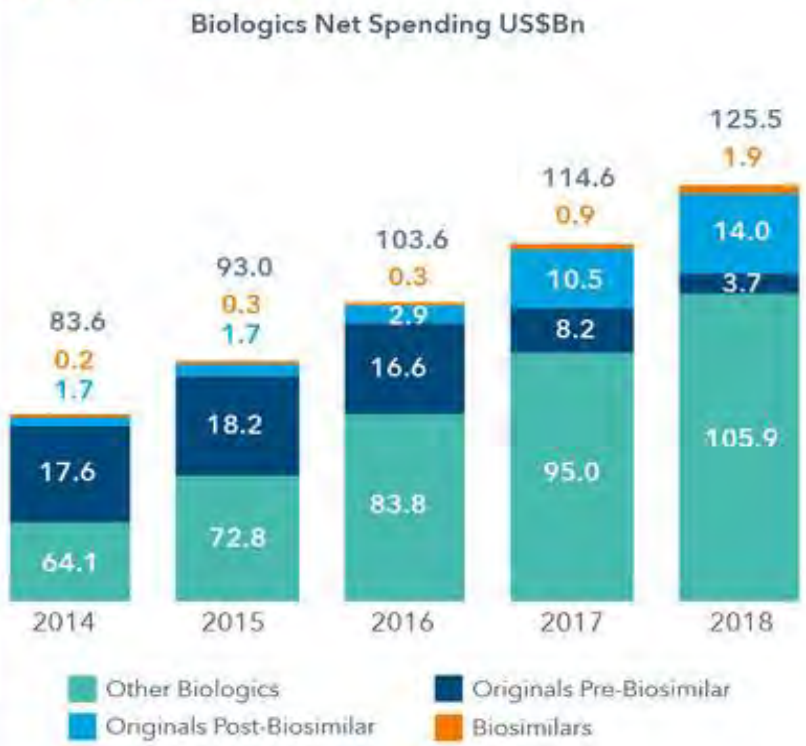
- 23 approved in US
- ~10 currently marketed
  - Patent protection/exclusivities
- CMS unique reimbursement code
  - Pass through recognition for all biosimilars

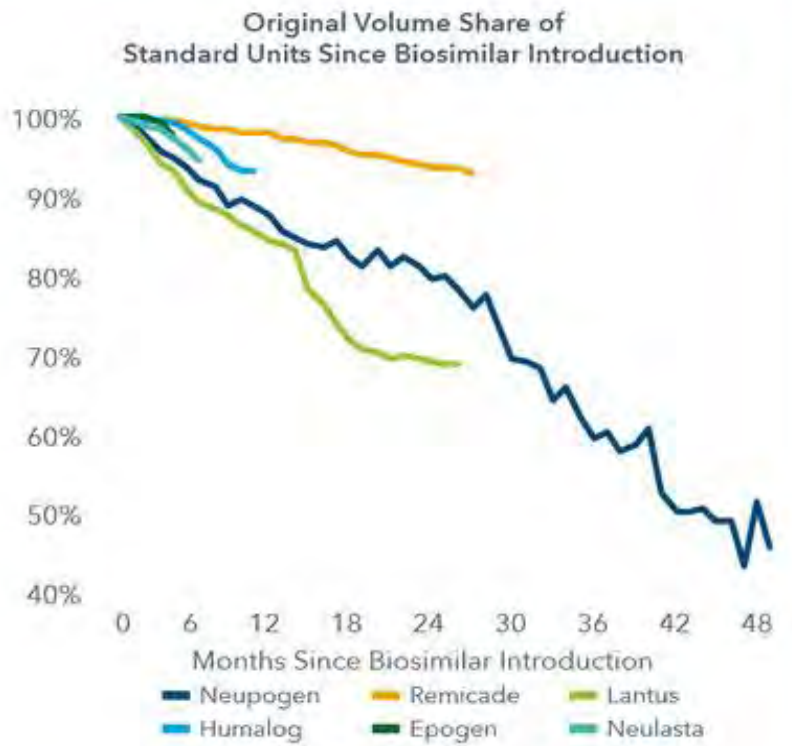
Medications

- **Pegfilgrastrim-jmdb/cbqv**
- Infliximab-dyyb/qbtx
- **Rituximab-abbs**
- **Trastuzumab-**qyyp/pkrb/dttb/dkst/ykro/anns
- **Bevacizumab**-bvzr
- **Adalimumab -** 2023
- Eternacept-szzs/ykro
- Filgrastim-sndz/aafi
- Epoetin alfa -epbx

SOURCE: *Biosimilar product information. FDA website. Accessed 7-23-19 AJHP 2018: 75(14) 1023*

Impact of Biosimilars





Source: IQVIA National Sales Perspectives, IQVIA Institute, Jan 2019

Chart notes: Biologics are defined by IQVIA as clearly identifiable molecules of biologic origin, including but not limited to products created with recombinant DNA technology and without necessarily adhering to classifications by regulatory bodies, which are sometimes inconsistent with this approach. Biosimilars are abbreviated biologic approvals made with reference to an original biologic and demonstrating similarity to the reference product. Non-original products approved outside the official biosimilar pathway have been noted as "biosimilar". Original biologics that have later faced competition have been shown separately in the chart based on whether or not they are facing competition in that period. Includes all medicines in both pharmacy and institutional settings.

Report: Medicine Use and Spending in the U.S. – A Review of 2018 and Outlook to 2023. IQVIA Institute for Human Data Science, May 2019

System Formulary Management Old & New Roles

AUDIENCE POLL QUESTION: #1

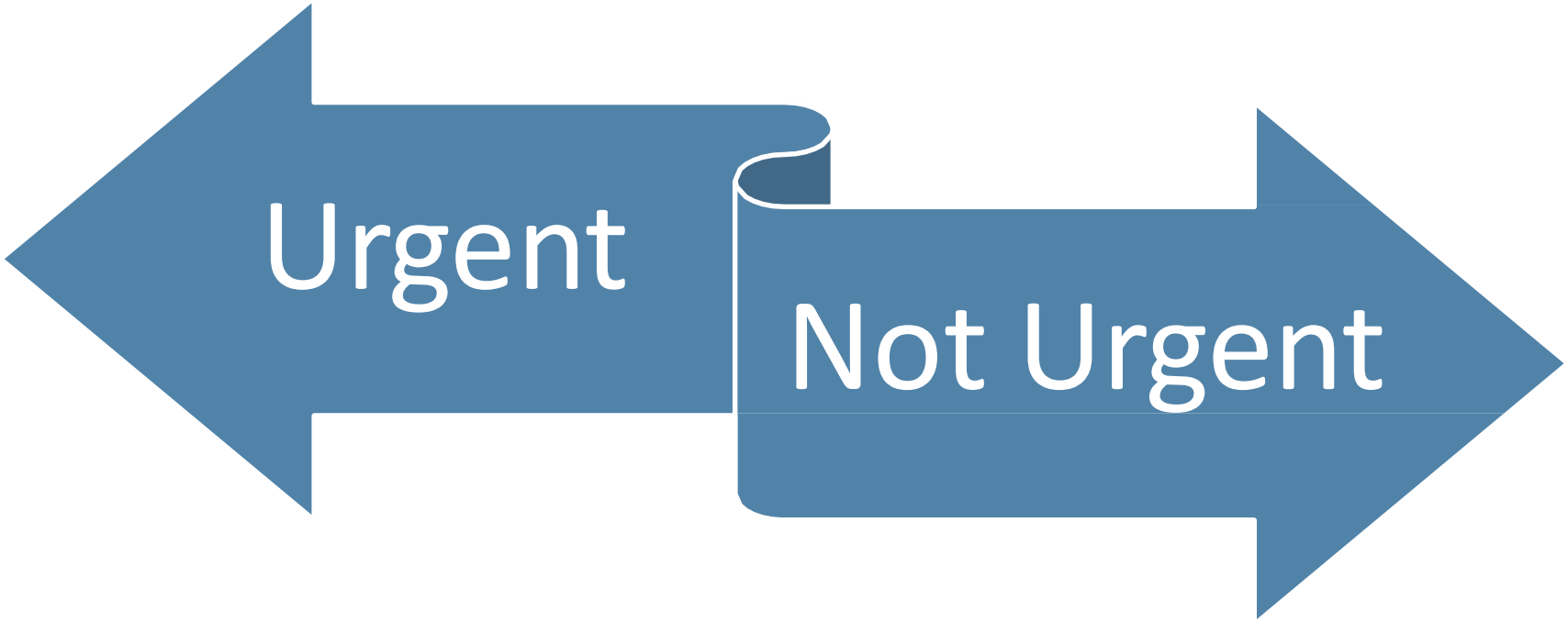
How many practice at a hospital that is part of a system that has a system level Pharmacy and Therapeutics committee making formulary decisions ?

a. YES

b. NO

System Formulary Management

Pharmacy and Therapeutics Council



Pharmacy and Therapeutics Council - Success Story

Scripps System Pharmacy and Therapeutics Council (PTC) engaged physician leaders across the enterprise in decision-making for formulary and medication management (2016)

- A system P&T was attempted at Scripps years ago, however did not survive
- PTC 2.0 – Lessons from second attempt at system P&T
- Define the scope of the problem, roles and goals
- Develop a platform that is transparent and known to all
- Involve physicians early and often
- Let physicians' lead
- Value quality over speed
- Incentivize Medical Staff
- Communicate
- Evolve practices to improve problem-solving ability of complex issues
- Re-scale efforts to remain relevant during challenging times

Actions Supporting System-Wide P&T Committee Success

Incentivize care line participation

Appoint strong physician leader to head system PTC to add legitimacy among physicians

Educate physician leadership and care line councils on cost savings and quality benefits for full system buy-in

Create budget for stipend to pay physicians for council participation

Delineate clear responsibilities for system- and site-level committees

Utilize responsibility matrix to avoid redundancies

Mandate strict time frame for approval from system to site

Create clear system governance model to monitor financial impact, utilization of the system formulary, and management of review calendar

Create clinical pharmacy support team

Provides data and gathers multidisciplinary stakeholder feedback for system-wide P&T council (PTC) decisions

Led by system clinical pharmacy leader and physician PTC chair

Established a communication cascade to provide transparency around PTC decisions and upcoming implementation

Council Composition

Disciplines Represented:

Medical Staff

- Physician Leadership Council
- Emergency Medicine
- Critical Care Medicine
- Internal Medicine
- Hospitalists
- Trauma
- General Surgery
- Anesthesia

Department of Pharmacy

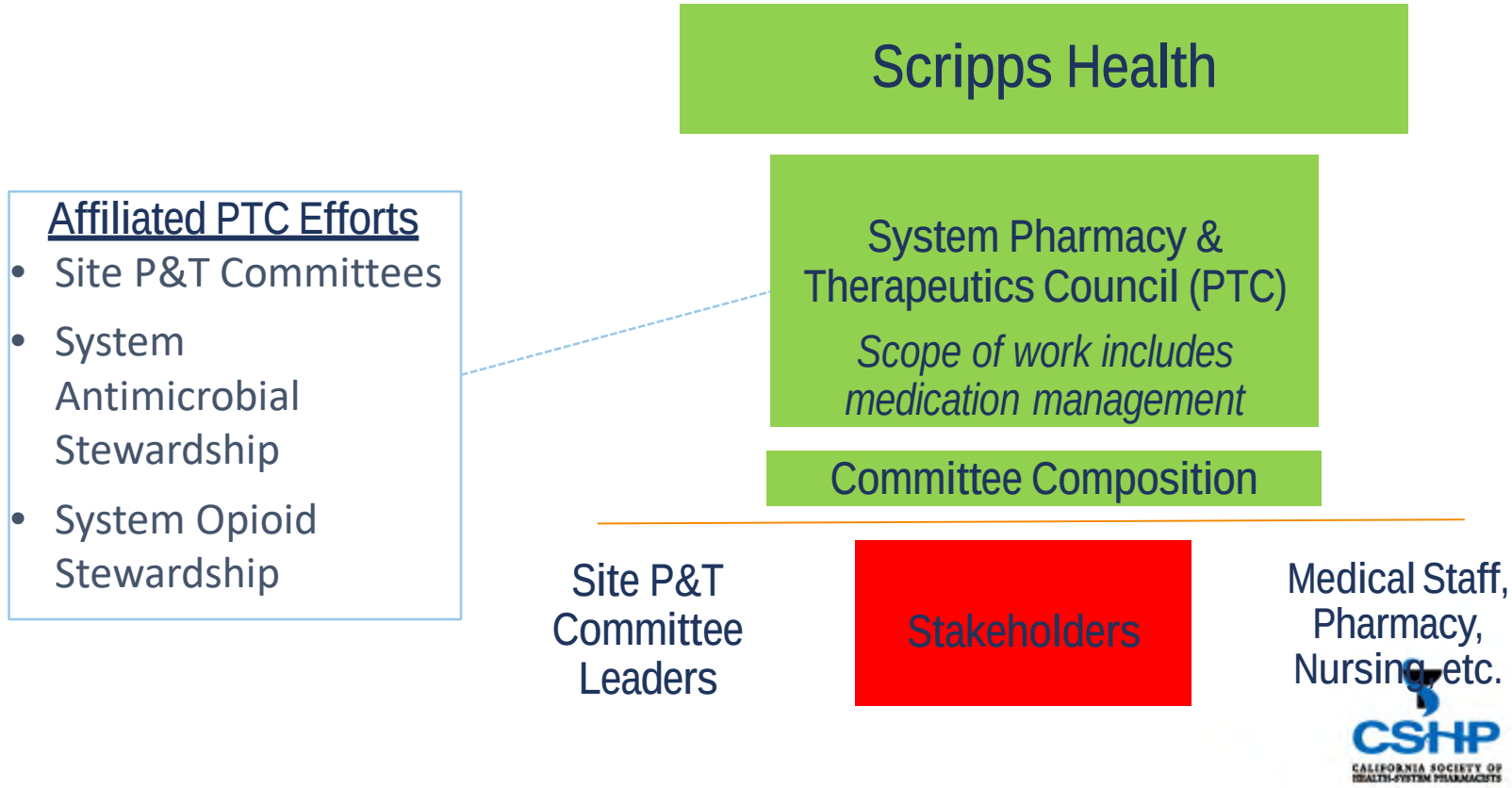
Executive Sponsorship

Nursing Leadership

Care Line Council Leadership

Clinical Support Team (CST) … the driving force of the PTC

- Site and system Clinical Pharmacy Leaders
- Financial analyst



System P and T Formulary Review Process

Scope of PTC: $20,000/treatment or $100,000/Year change

Proposed rubric for formulary decision making

IMPACT to PATIENT CARE	IMPACT on COSTS of CARE	DECISION
Strong evidence of improvement in patient outcomes – clinical and/or experiential	Significant increase per year	▪ Approve but needs authorization from finance to justify increase
	Moderate increase per year	Approve
	Minimal impact	
	Measurable savings	
Weak evidence of improvement in patient outcomes - clinical and/or experiential	Significant increase per year	Deny
	Moderate increase per year	Discuss and decide based on facts presented
	Minimal impact	
	Measurable savings	▪ Provisional approval – subject to re-review at set time, must show intended outcome achieved
No evidence of a change in patient outcomes	Significant increase per year	Deny
	Moderate increase per year	
	Minimal impact	▪ Discuss and decide based on facts presented, or Deny, or Provisional approval – subject to re-review at set time, must show intended outcome achieved
	Measurable savings	Provisional approval – subject to re-review at set time, must show intended outcome achieved
Belief that there is already a **demonstrably better alternative**	Significant increase per year	▪ Deny (regardless of impact)
	Moderate increase per year	
	Minimal impact	
	Measurable savings	

Note: *Therapies with weak evidence and significant costs should be denied per rubric*

Scripps Health System Formulary Review

Grading Quality of Evidence	
High	Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes ▪ 2 consistent, higher quality randomized controlled trials (RTCs) that yield consistent and directly applicable results, or ▪ Multiple, consistent observational studies with no significant methodological flaws showing large effects ▪ Further research is very unlikely to change our confidence in the estimate of effect
Moderate	Evidence is sufficient to determine effects on health outcomes, but the number, quality, size, or consistency of included studies limits the strength of the evidence ▪ Limitations include: biased assessment of the treatment effect, large loss to follow-up, lack of blinding, unexplained heterogeneity (even if it is generated from rigorous RCTs), indirect evidence originating from similar (but not identical) populations of interest, and RCTs with a very small number of participants or observed events ▪ Evidence from well-designed controlled trials without randomization, well-designed cohort or case– control analytic studies, and multiple time series with or without intervention also considered moderate quality ▪ Further research will have an important effect on confidence in the estimate of effect and may change the estimate
Low	Evidence is insufficient to assess effects on health outcomes because of limited number or power of studies, large and unexplained inconsistency between higher-quality studies, important flaws in study design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes ▪ Observation studies typically rated low* quality due to risk for bias ▪ Further research is very likely to have an important effect on confidence in the estimate of effect and will probably change the estimate

* Quality of evidence may be rated as moderate or even high, depending on circumstances under which evidence is obtained from observational studies. Factors that may contribute to upgrading the quality of evidence include a large magnitude of the observed effect, a dose–response association, or the presence of an observed effect when all plausible confounders would decrease the observed effect.

Success By Numbers FY2018 YTD

PTC IMPACTS TO FORMULARY

FY2017

- 42 - Formulary Reviews
  - 9 - Formulary additions
  - 9 - Formulary restrictions
  - 12 - Non-Formulary designations
  - 10 - Medication Class Reviews
- 6 - Medication Use Evaluations
- 18 - Protocols, Criteria for Use, Guidelines, Policies
- 1 - Decision Appeal
- 8 - Agenda items approved per meeting (average)

Online Requests

- 7 - Addition to Formulary Requests
- 39 - Non-Formulary Requests (Patient-Specific Use)

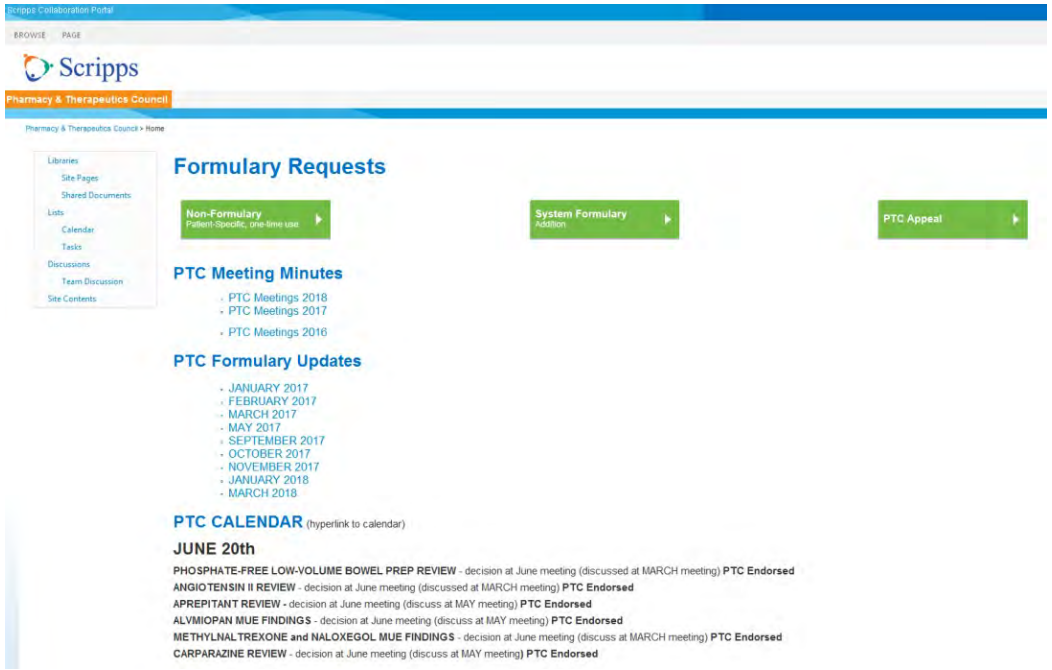
FY2018 YTD

- 16 - Formulary Reviews
  - 3 - Formulary additions
  - 3 - Formulary restrictions
  - 9 - Non-Formulary designations
  - 1 - Medication Class Reviews
- 7 - Medication Use Evaluations
- 24 - Protocols, Criteria for Use, Guidelines, Policies
- 0 - Decision Appeals
- 8 - Agenda items approved per meeting (average)

Online Requests

- 2 - Addition to Formulary Requests
- 20 - Non-Formulary Requests (Patient-Specific Use)

PTC Decisions—Transparency and Communication

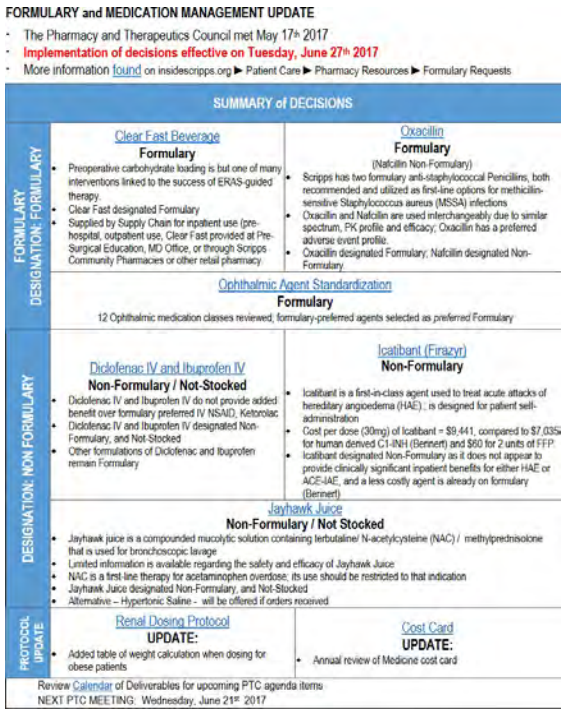


PTC information accessible for all on System website

1. Online requests
2. Calendar – agenda items scheduled months in advance
3. Meeting minutes and updates

Last step in the process is implementing the decisions

- 5 weeks following the PTC decision
- Implementation occurs at once, across all sites



Stakeholder communication reminds physicians of the PTC decision, and need-to-know details

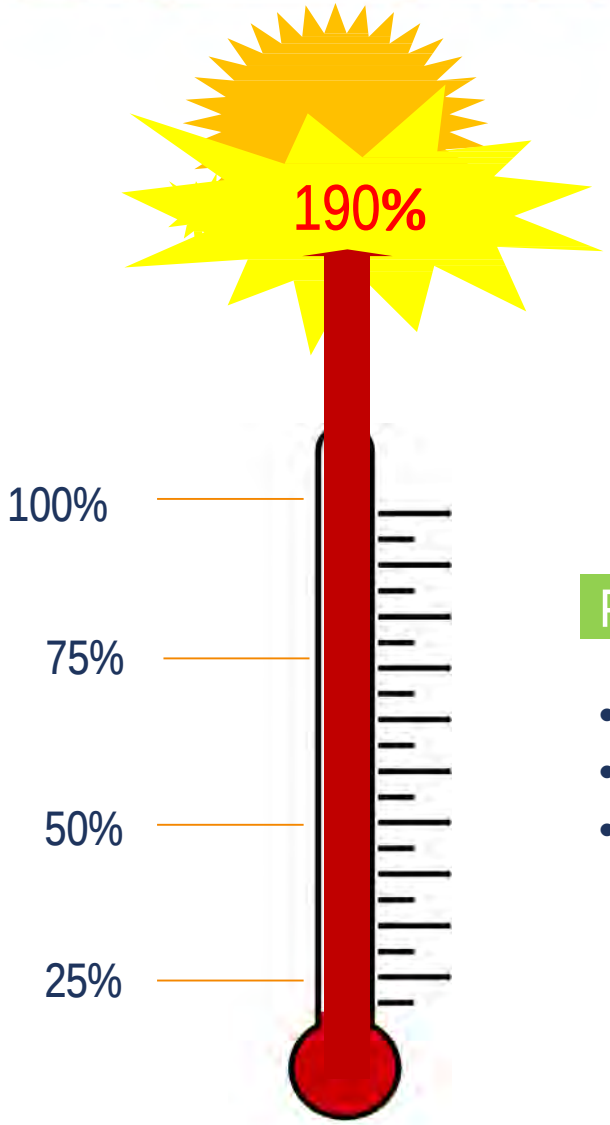
Evidence vs. Opinion

MEDICATION	CONTROVERSIES	OUTCOME
Andexanet (Andexa)	Increase in cost Evidence moderate	• Non Formulary, Not Stocked • Neurosurgery, Trauma, ED, ICU stakeholder buy in Prescriber Opinion = First NOAC reversal agent. Legal concerns Evidence: non compelling. Outcomes similar to PCC. Increased thrombotic events
Angiotensin II (Giapresa)	Increase in cost Evidence Moderate	• Non Formulary. Stocked with Orderset build. Criteria established with restricted prescribing • ICU Intensivist and Trauma buy in Prescriber Opinion: Distributive septic shock benefit. Can use as last resort. Intensivists know how to use the drug. Evidence: Clinical outcome data lacking

EVIDENCE VS. OPINION

MEDICATION	CONTROVERSIES	OUTCOME
Sugammadex (Bridion)	Increase in cost Evidence high	• Formulary (unrestricted) • Cost-Neutral • Favorable decision – anesthesia stakeholders Prescriber Opinion = inappropriate use, over spending will result if added Evidence = standard of practice
IV Acetaminophen (Ofirmev)	Increase in cost Evidence moderate	• Restricted Formulary • Lowered overall use system wide • Continuous evaluation of evidence/utilization/strategies Prescriber Opinion = miracle drug; improved pain scores, patient satisfaction, LOS Evidence = quicker onset
Bupivicaine Liposomal (Exparel)	Increase in cost Evidence low	• Non-Formulary • Continuous evaluation of literature Prescriber Opinion = improved pain control and better patient outcomes Evidence= non-compelling, when compared to standard of practice

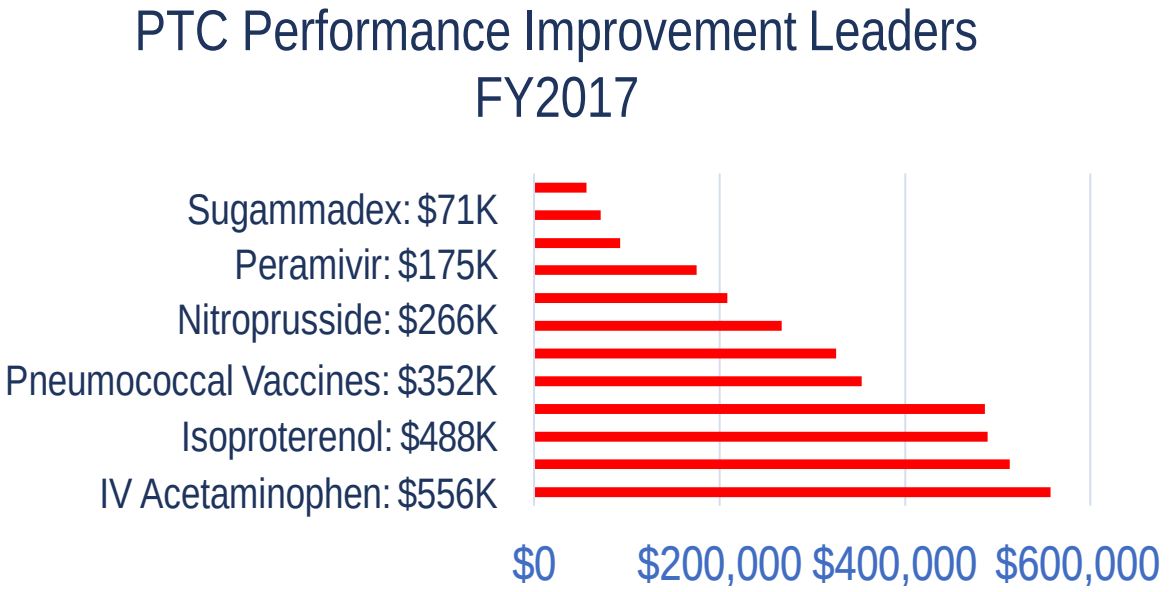
Outcome Measures Year 1



90% above target

PTC Metrics

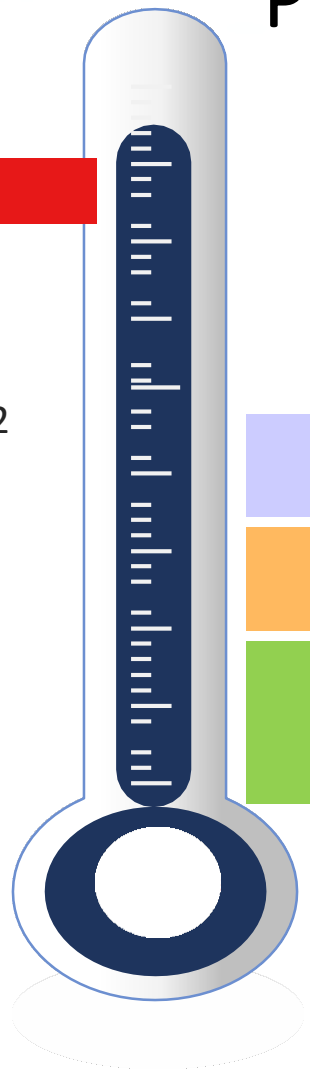
- 190% to Target
- FY17 Target: $1,848,098
- YTD Raised:$3,505,315



Pharmacy Outcome Measures Year 2
July 2018 (YTD)

All Pharmacy P.I.s

- 86.5% to Target
- 83% through Fiscal Year
- FY Target: $24,080,000
- YTD Raised:$20,840,262

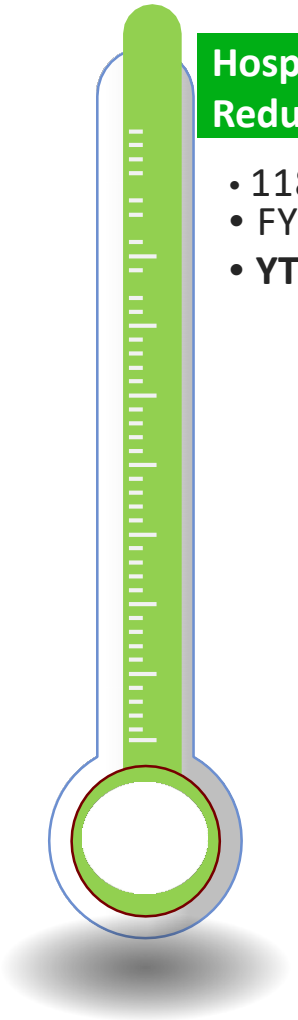


Operations $5,068,932

Retail $2,244,604

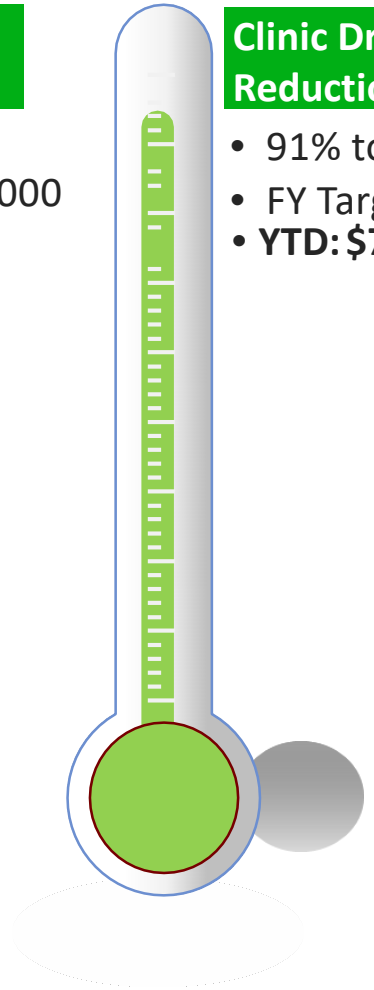
Drug Cost Reduction $12,501,865

Drug Cost Control—Utilization Outcome Measure



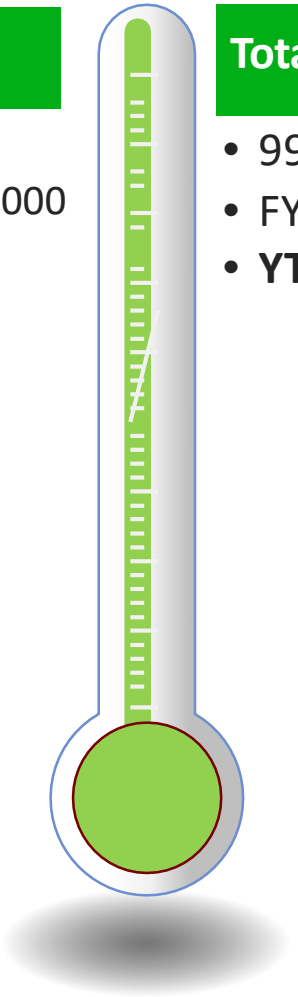
Hospital Drug Cost Reduction

- 118% to Target
- FY Target: $4,020,000
- **YTD: $4,755,587**



Clinic Drug Cost Reduction

- 91% to Target
- FY Target: $8,500,000
- **YTD: $7,746,278**



Total

- 99.8% to Target
- FY Target: $12,520,000
- **YTD Raised: $12,501,865**

PTC Continuous Improvement
Survey Results – SEPTEMBER 2016

Survey sent through same communication cascade as all other PTC information

	Efficient and Organized	Communication of Decisions	Physician Engagement	Formulary Management and Standardization	Evidence Based Decisions	Input from Multiple Stakeholders
Very Good	38	37	26	28	48	35
Good	34	26	32	43	28	28
Average	25	20	25	20	19	25
Below Average	3	12	9	8	2	8
Poor	0	5	8	1	5	4

high scoring 48% of responders stated PTC decisions were evidence based

Challenges—Specific solutions for problem medications

- **Non-Formulary designation**
  - Create toll-gates to provide evaluation of the request, when requested
- **Restricted-Formulary designation**
  - Develop Criteria of Use Guidelines with subject experts
  - Indication-specific and Specialty-specific
- **Leverage your EHR**
  - Carry over PTC decisions to order content
  - Make selections obvious and provide decision support as needed

PTC physician engagement

Speak to colleagues and medical staff at their sites regarding inappropriate use

Determine education

Routine methods or more in-depth MEMO from Chief Medical Officer, PTC Chair or Site P&T Leader

Medication Shortages

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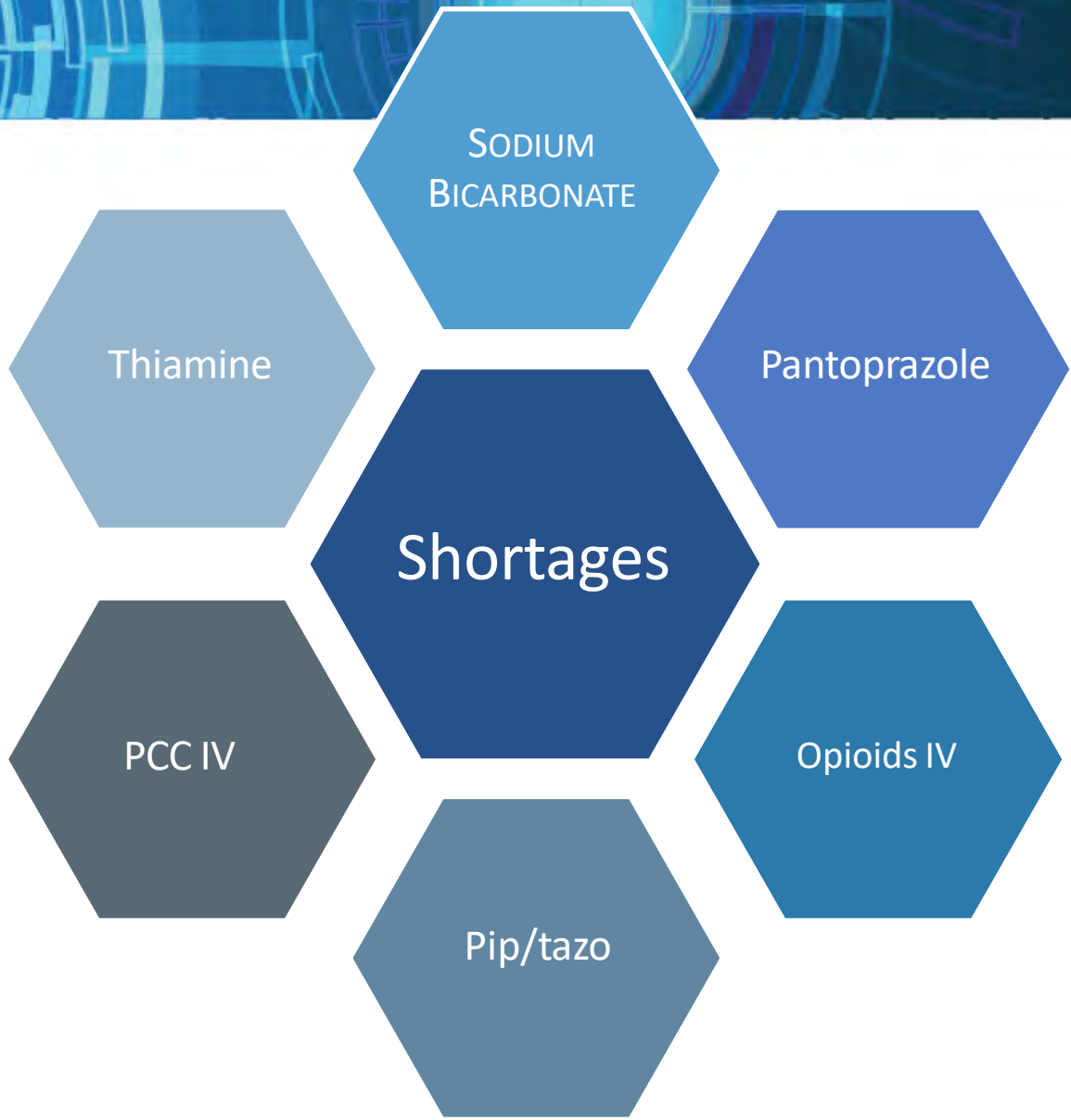

Sodium Bicarbonate
Thiamine
Pantoprazole
Shortages
PCC IV
Opioids IV
Pip/tazo

Audience Poll Question: # 2

We deal with medication shortages in one of the following ways:

a. In “real time” with automatic Pharmacist authorities to make conversions

b. Reactively after minimal supply remains

c. Limiting medication to key patient care areas

d. All of the above

Medication Shortage Management

- PIVOT and Nimble
- Collaboration with Key Opinion Leaders BEFORE they are emergent
- Scripps Intranet

Temporary Pharmacist Authorities (Drug Shortage Management)

- PHARMACIST MANAGED OPIOID IV TO PO CONVERSION
- PHARMACIST MANAGED THERAPEUTIC INTERCHANGE OF LOCALLY INJECTED LIDOCAINE
- PHARMACIST MANAGED THERAPEUTIC INTERCHANGE OF OPHTHALMIC DROPS FOR SURGICAL CASES
- PHARMACIST MANAGED THERAPEUTIC INTERCHANGE OF INJECTABLE PANTOPRAZOLE

Examples

MEDICATION SHORTAGES—PHARMACIST AUTOMATIC AUTHORITY

Pantoprazole IV

Original IV pantoprazole order received	Pharmacist will convert order to:
Pantoprazole continuous infusion ordered for patient with active upper GI bleed	Pantoprazole 40 mg IV push BID
Pantoprazole continuous infusion OR intermittent IV push ordered on non-GI bleed patient. Patient meets criteria for acid suppression (see table below)	If oral/enteral route unavailable: Famotidine 20 mg IV push BID (20 mg IV push daily if CrCl <50 mL/min) If oral/enteral route is available: Pantoprazole 40 mg PO daily OR lansoprazole 30 mg ODT per gastric tube daily
Any IV pantoprazole order on a patient that does NOT meet criteria for acid suppression	Discontinue pantoprazole order

Acid Suppression Criteria for Use

Utilize H2-receptor blockers (H2RAs – ie: Famotidine) for the following indication:

- GERD
- History of peptic ulcer disease (PUD) or duodenal/gastric ulcer disease

Limit PPI use to the following indications:

- Stress ulcer prophylaxis for **ICU patients with one of the following risk factors***
- Known or suspected upper GI hemorrhage
- Peptic ulcer/ duodenal ulcer disease for treatment
- Hypersecretory conditions (Zollinger-Ellison, major small bowel resection)

PPI use requires documented GI approval for:

- Chronic steroid use
- Erosive GERD
- Dual antiplatelet therapy

Examples

MEDICATION SHORTAGES—PHARMACIST AUTOMATIC AUTHORITY

OPIOIDS IV to PO

Inclusion

- Functioning GI Tract
- On scheduled oral medication and/or tolerating ≥ 50% of full liquids or ≥ 50% of goal for tube feeding for 24 hours with no vomiting

IV Opioid	PO Opioid
Morphine	
Morphine 1 mg	Morphine 2.5 mg
Morphine 2 mg	Morphine 5 mg
Morphine 3- 4 mg	Morphine 10 mg
Morphine 5- 6 mg	Morphine 15 mg
Morphine 7- 8 mg	Morphine 20 mg
Morphine 9- 10 mg	Morphine 30 mg
Hydromorphone	
Hydromorphone 0.2 – 0.3 mg	Hydromorphone 1 mg
Hydromorphone 0.4 – 0.7 mg	Hydromorphone 2 mg
Hydromorphone 0.8 – 1 mg	Hydromorphone 4 mg
Hydromorphone 1.1 – 1.5 mg	Hydromorphone 6 mg
Hydromorphone 1.6 mg – 2 mg	Hydromorphone 8 mg
Fentanyl	
Fentanyl 25 mcg	Morphine 7.5 mg
Fentanyl 50 mcg	Morphine 15 mg
Fentanyl 100 mcg	Morphine 30 mg

Medication Shortage Dosing Modification

Prothrombin Complex Concentrate (Kcentra)

Order of Use	Warfarin	NOAC (Rivaroxaban/Apixaban/Edoxaban)	Coagulopathy of Liver Disease Reversal in Anticipation of Surgery	Coagulopathy of Liver Disease Active Life-Threatening Bleeding
FIRST LINE	**Fixed Dose 4F PCC (KCentra)** • Vitamin K 10 mg IV x 1 ***and*** KCentra 1500 units IV x 1 • Repeat INR 15min • If INR>1.5 can give another 500 units (consider if going to surgery)	**4F PCC (KCentra)** • KCentra 25 units/kg IV x 1 • If inadequate hemostasis achieved, consider an additional 25 units/kg IV X1 • NTE 5000 units irrespective of body weight	**Fixed Dose 4F PCC (KCentra)** • Vitamin K 10 mg IV x1 ***and*** KCentra 500 units IV x1 • Consider FFP 2 units IV x 1 *Check and replete fibrinogen (> 150 mg/dL) with cryoprecipitate, platelets (>50,000mg/dL)*	**Fixed Dose 4F PCC (KCentra)** • Vitamin K 10 mg IV x1 ***and*** KCentra 1,500 units IV x1 • FFP 2 units IV x 1 *Check and replete fibrinogen (> 150 mg/dL) with cryoprecipitate, platelets (>50,000mg/dL), support with pRBC*
SECOND LINE	**3F PCC (Profilnine)** • Vitamin K 10 mg IV x 1 ***and*** • Profilnine 30 IU /kg IV x 1 • FFP 2 units IV x 1 • NTE 4000 units irrespective of body weight	**FEIBA (activated PCC)** • FEIBA 25 u/kg IV x 1 • If inadequate hemostasis achieved, consider an additional 12.5 units/kg IV X1	**3F PCC (Profilnine)** • Vitamin K 10 mg IV x1 ***and*** • Profilnine 500 units IV x 1 • Consider FFP 2 units IV x 1 *Check and replete fibrinogen (> 150 mg/dL) with cryoprecipitate, platelets (>50,000mg/dL)*	**3F PCC (Profilnine)** • Vitamin K 10 mg IV x1 ***and*** • Profilnine 1500 units IV x 1 • FFP 2 units IV x 1
For Sites without immediate access to FFP	**FEIBA (activated PCC)** • Vitamin K 10 mg IV x 1 ***and*** • INR< 5 FEIBA 500 units IV x 1[4] ***OR*** • INR≥5 FEIBA 1000 units IV x1[4]			

Audience Poll Question: #3

Is there a process to use Lutetium Lu 77 Dotatate - Lutathera® currently at your institution?

a. Yes

b. No

CASE STUDY

340B

- Therapies with marginal or negative reimbursement
- Focused services at 340b eligible site
- Develop preferred providers to funnel approval and care
- Service lines
  - Rheumatology
  - Oncology
  - Immunotherapy
- Insurances
  - Medicare
  - Capitated arrangements (IPA)
  - Managed care/HMO
  - Employee health plan

Site of Care Optimization

Case Study—Lutetium Lu 77 Dotatate - Lutathera®

U.S. Food and Drug Administration approval January 2018

Projected cost per single treatment AWP

$ 48,000

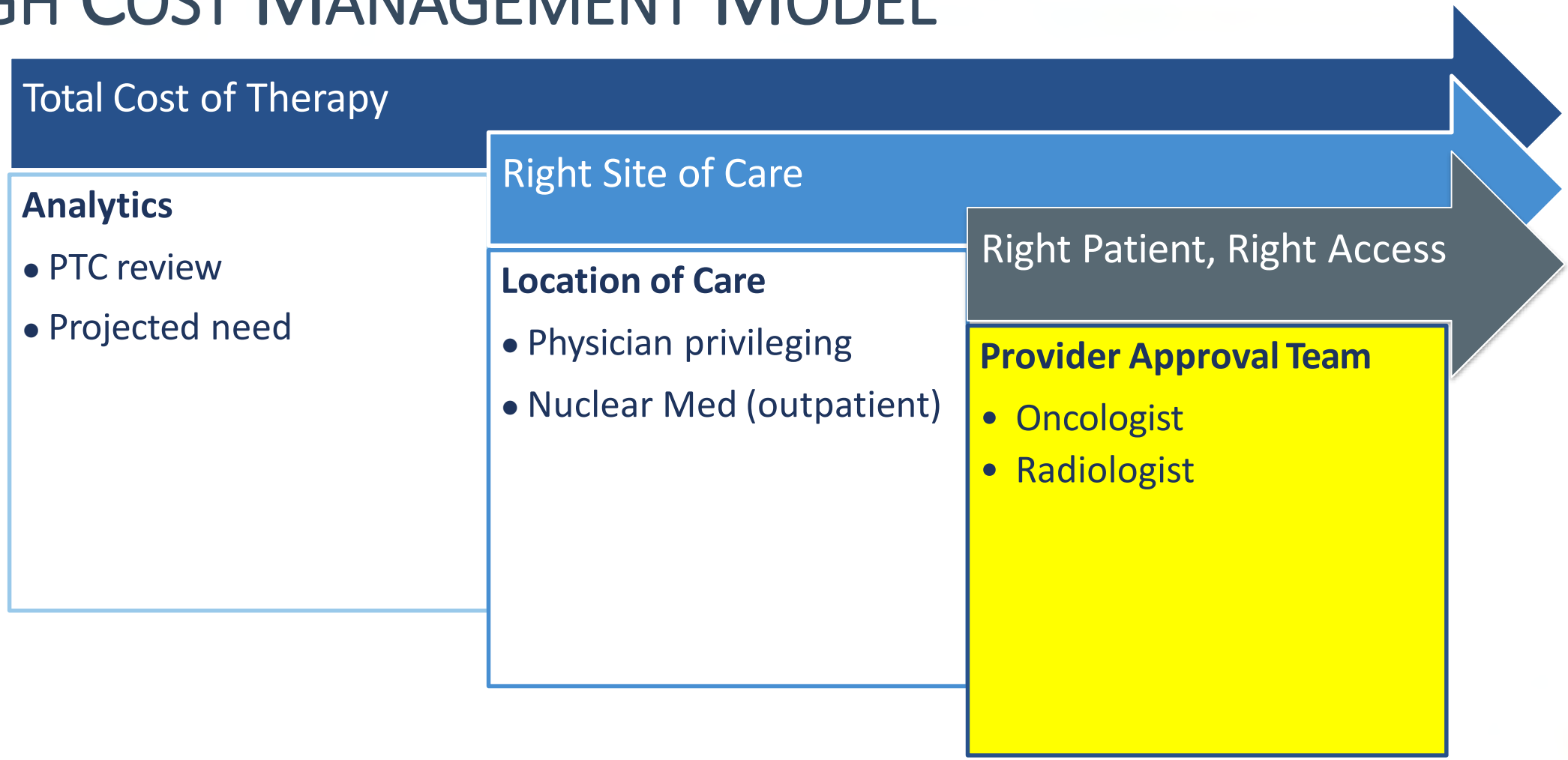
4 cycles per treatment

$ 192,000

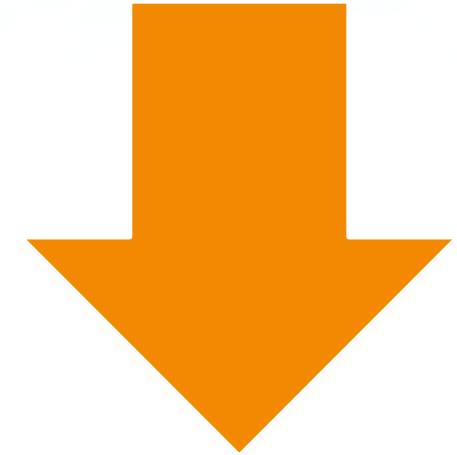
Indication:
Treatment of somatostatin receptor positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs)

Delivery: Nuclear Medicine
Prescriber Specialty: Oncology
Administration : Inpatient OR **Outpatient** Therapy

High Cost Management Model



Lutetium Lu 77 Dotatate - Lutathera®



Direct Costs

-Cost of medication
-Nurse time
-Cost of ancillary medications

Expected Reimbursement

-Medicare AWP plus 6% (includes first 6 months - pass through)
-Managed care
-Commercial insurance

Lutetium Lu 77 Dotatate - Lutathera®

Model Development—Financial Impact, First Iteration

- Initial Model Case Mix Projection (Cost of Drug Only)

	Per Treatment	Per Case
Total Direct Cost	$54,000	$ 214,000
Operating Loss	($ 14,000)	($ 56,000)

- 340B Program Projection Same Case Mix

	Per Treatment	Per Case
Total Direct Cost	$ 38,000	$ 151,000
Operating Loss	($889)	($3,600)

Total Cost of Care

- Non 340B Hospital

	Per Treatment	Per Case
Total Direct Cost	$53,494	
Weighted Average Reimbursement	$53,186	
Operating Profit/(loss)	($308)	($1,231)

- 340B Hospital

	Per Treatment	Per Case
Total Direct Cost	$37,826	
Expected Reimbursement	$62,251	
Operating Profit/ (loss)	$24,425	$97,700

LUTATHERA OUTCOMES

October 2018 – April 2019

- Goal per Model = 20 patients
- Number of Patients YTD = 15
- Insurance = 70% Medicare,30% Commercial, No Capitation

What Changed?

✓ Moved all patient care to **one** hospital

✓Prescriber privileging restricted

✓Optimized 340B reimbursement

Expected Performance $1.4 Million

TRANSITION OF CARE: ACUTE CARE TO NON-ACUTE CARE

EXAMPLES

Medication	Indication	Approximate Cost Avoidance (minus hospital stay)	Outcome
Bezlotoxumab IV x 1	Recurrent C difficile s/p 2 Fecal Microbiota Transplants	$2,000	No ED readmits
Dalbavancin IV x 1	MRSA SSTI and osteomyelitis	$9,500	No ED readmits

Performance Improvement Outcomes—Take Home Points

Through May 2019

Hospitals	
Drug Cost Savings	$397,700.00
Contribution Margin	$791,767.00
Biosimilar Conversion	$389,646.00
340B Mixed Use Increase	$379,059.00
Hospitals Total	**$ 1,958,172.20**

- **Drug Cost Savings:**
  - Lutathera (340B)
- **Drug Utilization Savings**:
  - Esmolol product switch
  - Aprepitant (Cinvanti) conversion
  - Advair interchange
  - Anavip conversion
  - Vasopressin product conversion
  - IV levothyroxine hold parameter
- **Biosimilar Conversion:**
  - Zarxio interchange
  - Inflectra/Renflexis uptake

FUTURE STEPS

Executive Value Analysis Committee (EVAC)

Purpose

The Executive Value Analysis Committee is a the group that adjudicates high cost drugs and therapies, providing financial stewardship in combination with ensuring appropriate patient care for the system. The committee will take into account organizational objectives and strategy and ensure the process is both ethical and transparent.

Trigger Points

CRITERIA FOR REVIEW BY EVAC

- Option One:
  - >$1,000,000 annually (total projected annual cost) OR
  - ≥ $20,000 per dose or device
- Option Two:
  - >$50,000 annually (total projected annual cost) per dose or device
- Option Three:
  - Supplies: >$50,000 annually (total projected annual cost)
  - Pharmaceuticals:
    - ✓ >$1,000,000 annually (total projected annual cost) OR
    - ✓ ≥ $20,000 per dose

Membership

Members:

- Physician Operating Executives
- Clinic Vice Presidents
- Chief Medical Officer – Scripps Health
- Chief Medical Officer – Scripps Health Plan
- Operational Chief Executives
- Chief Financial Officer
- Pharmacy Leadership
- Supply Chain Leadership
- Finance

CSHP
CALIFORNIA SOCIETY OF HEALTH-SYSTEM PHARMACISTS

POST TEST QUESTIONS

1. What are the top three medications classes that will account of increased pharmaceutical expenditure?
   a) Antineoplastic, asthma, infectious disease
   b) Immunomodulatory, psychiatric, infectious disease
   c) Antineoplastic, disease modifying, immunomodulatory
2. Rise in medication spending is due to increase cost and not increased utilization .

   True or False

1. Success of a system P and T relies on
   a) Strong governance
   b) Stakeholder input
   c) Evidence based rubric for formulary reviews
   d) All of the above

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Questions

THANK YOU…

Harminder Sikand

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Session Code: