May 31, 2021

Canadian Drug Landscape

Spring 2021

Barbara Martinez, Canada Life
Daria O’Reilly, TELUS Health
Bobby Currie, Canada Life

Your presentation team

Barbara Martinez

National Practice Leader Drug Solutions, Canada Life

- Barbara supports sales offices across Canada on prescription drug management initiatives. She provides advisors and their clients support, including designing and managing drug benefit plans.
- Barbara spent 10 years at Mercer, where she led the Canadian drug benefits consulting team before joining Canada Life in 2012. Her experience includes 13 years in the pharmaceutical industry in sales and marketing as well as government and professional affairs.
- She’s a regular speaker at industry forums and a frequent commentator on employer drug programs.

Your presentation team

Daria O'Reilly, PhD, MSc

Lead Health Economist, Pharmacy Consulting TELUS Health

- Daria holds a Master's and PhD in Clinical Epidemiology and a post-doctoral fellowship in pharmacoeconomics. Dr. O'Reilly became an Associate Professor, Department of Health Research Methods, Evidence and Impact, McMaster University in 2007 and continues to hold a part-time appointment.
- Over the past two decades, Daria has worked in the area of Health Technology Assessment for the government and the pharmaceutical industry to develop evidence to support informed healthcare policy decision making. She has authored two book chapters and more than 100 scientific papers.
- Daria joined the TELUS Health team September 2018 as Lead Health Economist. Her priority is reviewing the economic evidence of drugs submitted for formulary listing, ensuring the results are relevant to the private payer, and providing recommendations to help make evidence-informed reimbursement decisions based on cost effectiveness.

Your presentation team

Bobby Currie

Clinical Pharmacy Services and Support Leader, Canada Life

- Bobby manages a team of pharmacists that provide strategic and tactical support for Canada Life's drug programs. Bobby is an active leader in Canada Life's drug governance programs and her team directs the review and analysis of drug submissions, including health technology assessments. Bobby also has responsibilities in formulary management, client and field support, and drug policy.
- Bobby is a registered pharmacist and has held roles as a front-line community pharmacist, entrepreneur and as a specialist in pharmacy operations. She remains an active member of the pharmacy community. Bobby is an advocate of evidence-informed decision making and good governance practices.

Agenda

01 | Impact of COVID-19 on drug plans

02 | Biosimilar drugs: what, how, where

03 | Ensuring value for money and drug plan sustainability: an introduction to cost-effectiveness analysis

04 | Evidence informed decisions: applying the private payer lens

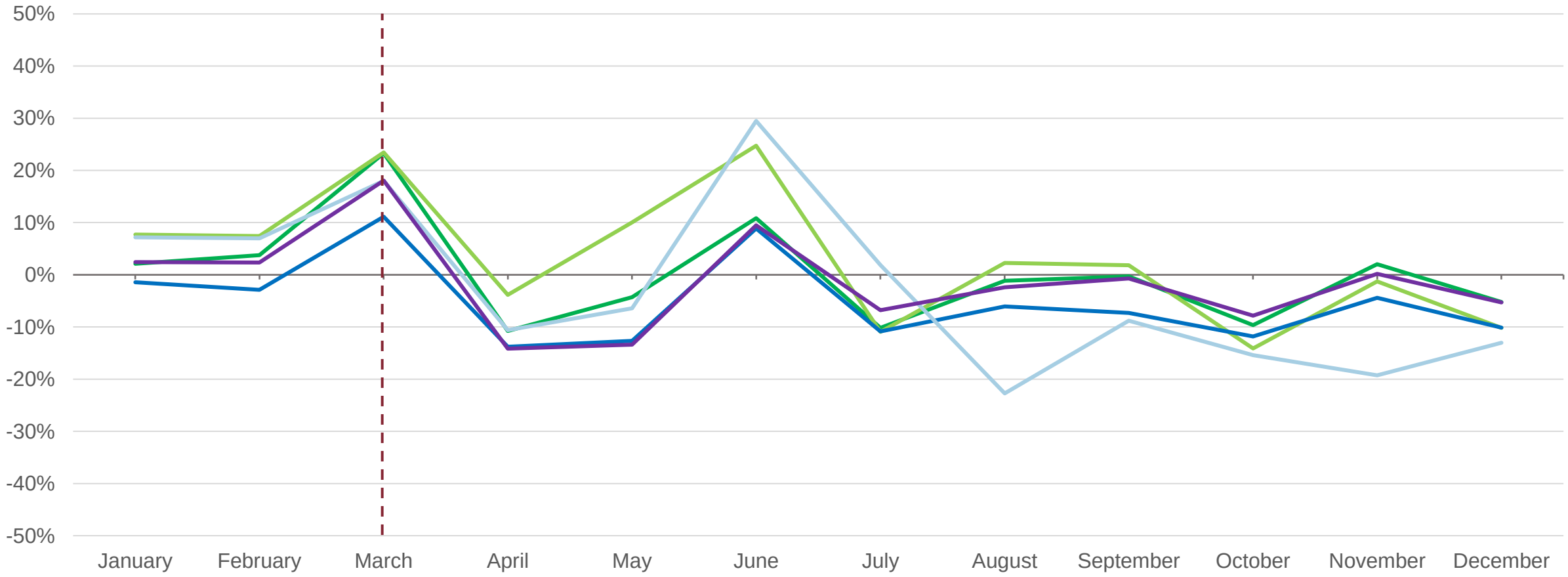
Impact of COVID-19 on drug plans

Impact of COVID-19 on Drug Plans Across Provinces

Canada Life Block

% Change in the number of claims between 2019 and 2020

British Columbia | Manitoba | Quebec | Ontario| Saskatchewan

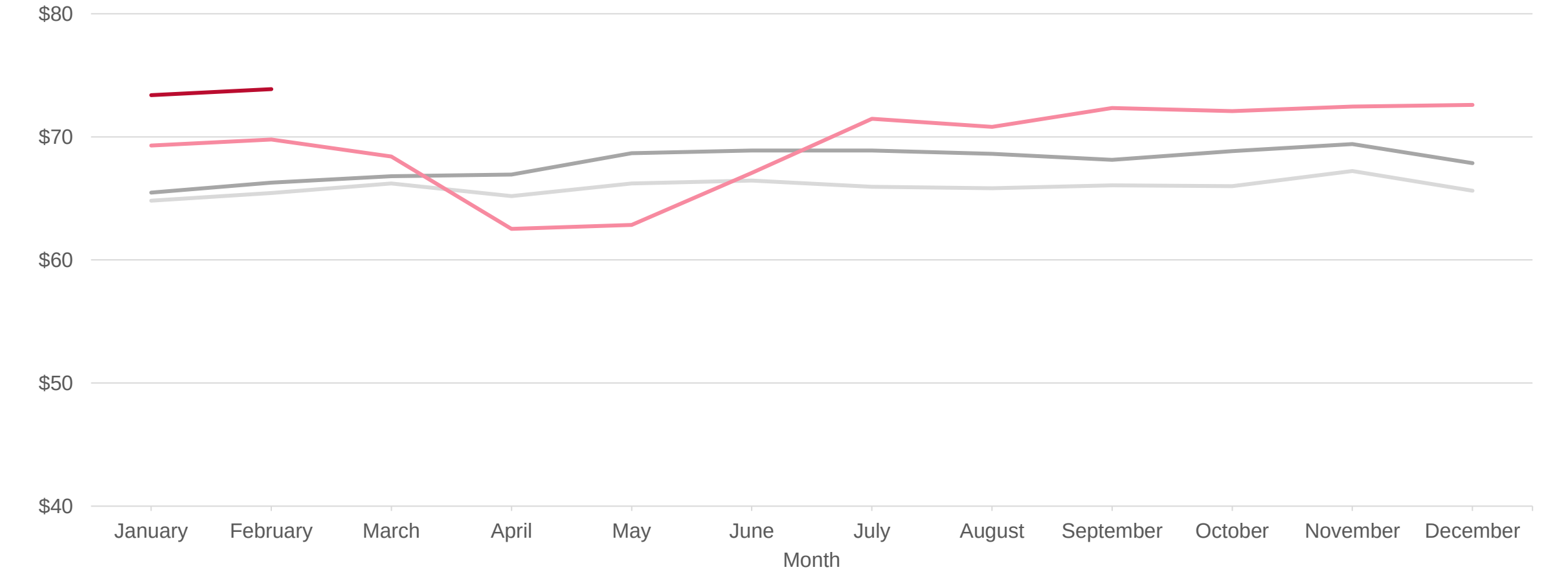


Inflation in Amount Covered per Drug Claim

Canada Life Block

Monthly average amount covered per claim

2018 | 2019 | 2020 | 2021



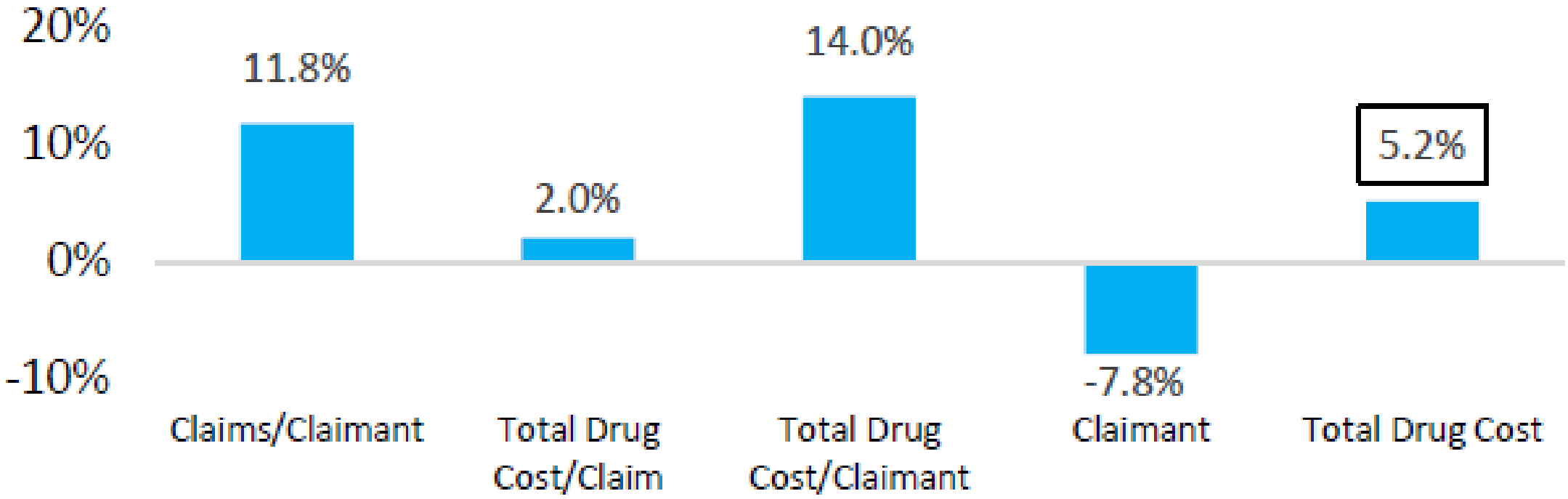
2020 VS. 2019 – Key Drug Expenditure Trends
IQVIA Private Drug Plans

- Private Drug Plans Year-Over-Year total drug cost rose by 5.2% in 2020, while the number of claimants declined by 7.8%.
- An 11.8% increase in claims per claimant was partly driven by the temporary 30-day supply limitation policy.
- Drug costs increased modestly to 4.9% with 76% of the growth attributed to specialty products, where its expenditure jumped by 12.2% in 2020 and made up 32.9% of the drug costs within the private drug plans.
- Nearly 21 out of every 100 private drug plan claimants used medications to manage their anxiety and depression symptoms during 2020 compared to 19 out of 100 from 2019.

Source: The IQVIA file March 2021

2020 Cost Driver Overview
IQVIA Private Drug Plans

Figure 1: Key Drivers, All PDP, 2020 vs. 2019



Source: IQVIA, Private Pay Direct and Reimbursement Drug Plans

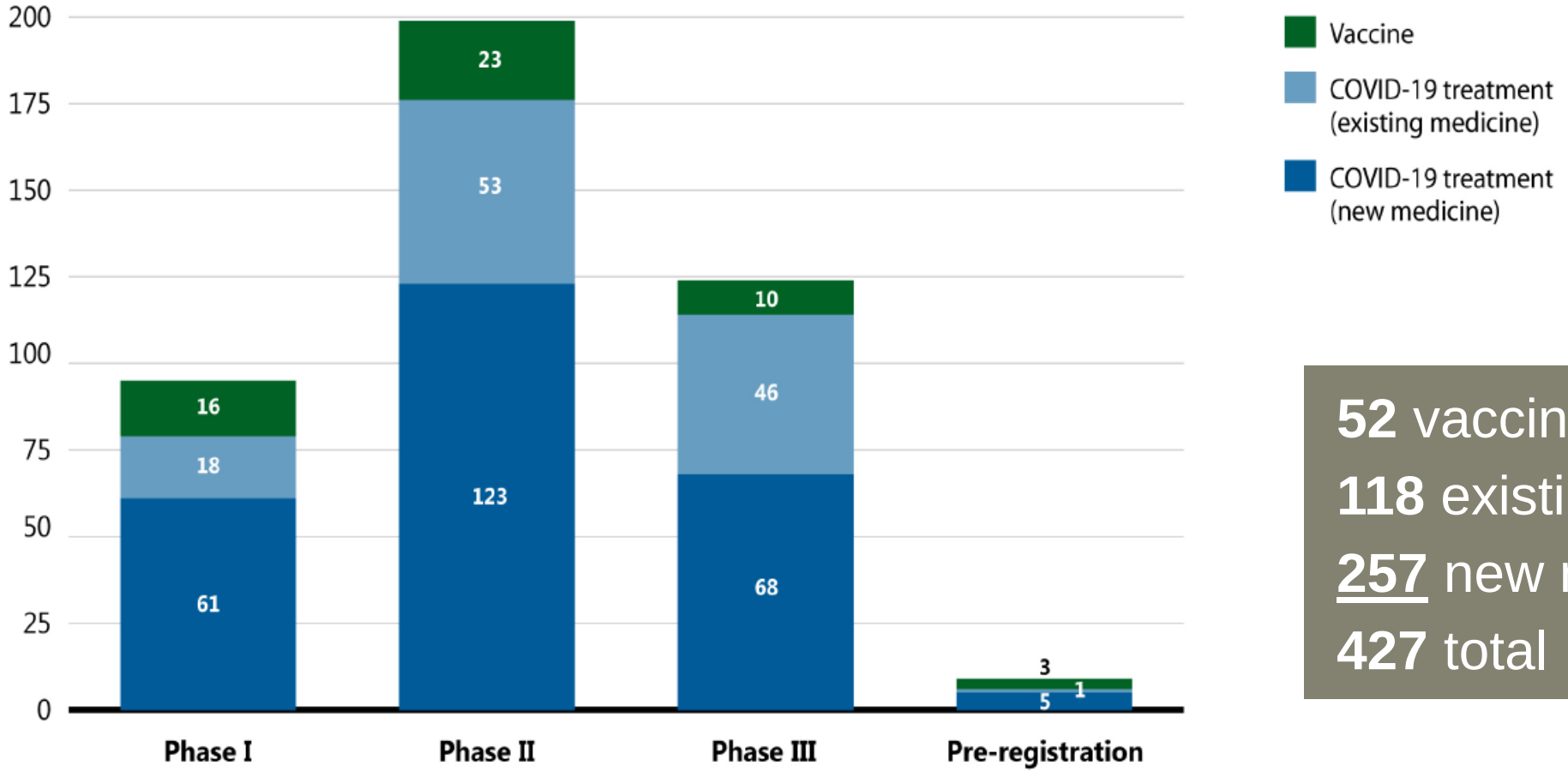
Number of COVID-19 vaccines and treatments in the pipeline

As of November 2020, there were 427 vaccines and therapies undergoing evaluation for the prevention and treatment of COVID-19 globally.

Therapies include antivirals, interferons, antimalarials, antiparasitics, monoclonal antibodies, interleukin receptor agonists, cellular therapies, convalescent plasma and cytokine adsorbers.

Number of COVID-19 vaccines and treatments in the pipeline

FIGURE 5. Number of COVID-19 vaccines and treatments in the pipeline, by phase of clinical evaluation, 2020



52 vaccines
118 existing meds
257 new meds
427 total

 Source: Meds Pipeline Monitor 2020 – Patented Medicine Prices Review Board

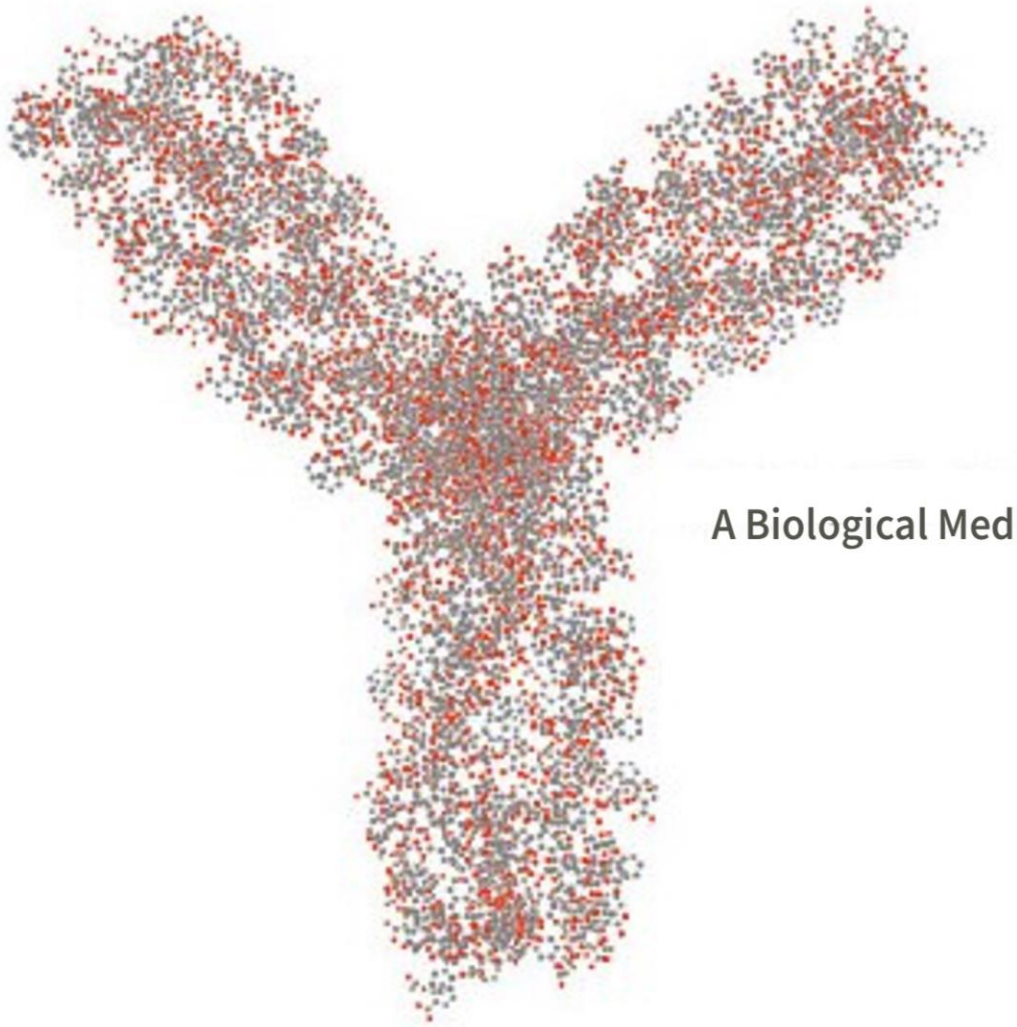
Biosimilar drugs:
what, how, where

Biosimilar drugs

- Biosimilar drugs are often confused with generic drugs because both are less expensive “copies” of brand name drugs that are available after patents expire.
- Biosimilar drugs and generic drugs are very different.
- Generic drugs are identical to the original in chemical composition, biosimilar drugs are “highly similar” to the original.

Molecular structure

Aspirin



A Biological Medicine

Why are biosimilar drugs getting so much attention?

They represent an opportunity for cost reduction in the high-priced biologic drug space.

Biologic drug category

- 29.4% of Canada Life drug spending
- Average amount covered per claim is more than 45 times that of a maintenance drug
- Average covered per claim is $2,287 vs $51 for a maintenance drug
- Since 2014 the percentage of total amount covered has increased by 32.4%

Patient types and approaches

For patients that have never been established on an originator biologic, known as “treatment naïve”, introducing them to a biosimilar is relatively simple.

For patients that are already established on an originator biologic, introducing them to a biosimilar is more complex – “switching” is required.

Examples of cost and discounts

Biologic Originator Drug Name	Biosimilar Ingredient Name	Disease Category	Originator Estimated Annual Cost*	Discount of Biosimilar as of July 2020
Remicade	Infliximab	Immunomodulator	$30,000	50%
Humira	Adalimumab	Immunomodulator	$22,000	43%
Enbrel	Etanercept	Immunomodulator	$22,000	40%
Lantus	Insulin Glargine	Diabetes	$450	23%
Neulasta	Pegfilrastim	Blood formation	$45,000	46%
Humalog	Insulin Lispro	Diabetes	$750	11%
Neupogen	Filgrastim	Blood formation	$30,000	18%
Rituxan	Rituximab	Cancer	$30,000	37%
Avastin	Bevacizumab	Cancer	$120,000	25%
Herceptin	Trastuzamab	Cancer	$60,000	28%

*Very high level estimates. Actual cost can vary significantly by patient

Provincial price negotiation

pan-Canadian Pharmaceutical Alliance (pCPA)

- The pCPA has negotiated discounts on biologics.
- This price is transparent and applied to all payers whether public or private.
- Both the public and private sectors in Canada need to work together and to leverage our common buying power to help bring down drug prices for the benefit of all Canadians.

Some provincial reimbursement initiatives

British Columbia

Switch policy implemented

75% of B.C. patients successfully transitioned during phase 1 and phase 2 of the initiative

$127 million savings as of August 2020

Savings redirected to support additional drug listings (Jardiance and Taltz) and improvements in patient care.

Alberta

Switch policy implemented

6.5 month transition period extended to 13 months early in pandemic.

Ontario

Preferential listing for biosimilars for new patients

LU code vs Exceptional Access Program

Upcoming transition policy?

Quebec

Switch policy announced May 2021

Preferential listing for biosimilars for new patients

 Source: Biosimilars Update 2020 - Apotex Webinar Series | Data provided by Apotex

British Columbia: no differences in…

- Emergency Department Visits or hospitalization
- Average number of days on oral steroids
- NSAID prescriptions
- Antibiotic use
- Pulse steroids

* Adapted from BC presentation from 2020 Market Access Summit

 Source: Biosimilars Update 2020 - Apotex Webinar Series | Data provided by Apotex

Switching studies

Jørgensen KK, Olsen IC, Goll GL, et al; NOR-SWITCH study group. Switching from originator infliximab to biosimilar CT-P13 compared with maintained treatment with originator infliximab (NOR-SWITCH): a 52-week, randomised, double-blind, non-inferiority trial. ***Lancet* 2017**; 389: 2304–2316

Razanskaite V, Bettey M, Downey L, et al. Biosimilar infliximab in inflammatory bowel disease: outcomes of a managed switching programme. ***J Crohns Colitis*** 2017; 11: 690–696.

Bergqvist V, Kadivar M, Molin D, et al. Switching from originator infliximab to the biosimilar CT-P13 in 313 patients with inflammatory bowel disease. ***Therap Adv Gastroenterol* 2018**; 11: 1–13.

Plevris N, Jones GR, Jenkinson PW, et al. Implementation of CT-P13 via a managed switch programme in Crohn's disease: 12-month real-world outcomes. ***Dig Dis Sci* 2019**; 64: 1660–1667.

Chaparro M, Garre A, Guerra Veloz MF, et al. Effectiveness and safety of the switch from Remicade® to CT-P13 in patients with inflammatory bowel disease. ***J Crohns Colitis* 2019**; 13: 1380–1386.

Craig Haifer, Ashish Srinivasan, Yoon-Kyo An, Sherman Picardo, Daniel Langenberg, Shankar Menon, Jakob Begun, Simon Ghaly and Lena Thin Med J Aust || doi: 10.5694/mja2.50824
Published online: **9 November 2020**

Private payer options

Choice

Savings

Do nothing	Leave formularies open
Member Education	Targeted education to members on originator drugs
PLA with Originator	Enter into a listing agreement with the manufacturer of the originator biologic to attain a lower price
LCA	Limit reimbursement of originator to that of the biosimilar
Prefer Biosimilar	Preferential placement of biosimilars on formularies and exclude reimbursement for originator biologics
PLA with Biosimilar	Enter into a listing agreement with the manufacturer of the biosimilar to attain a lower price
Mandatory Switching	Mandatory switching from originator to biosimilar for all patients

Barriers and challenges

- Lack of interchangeability
- Perception – patient, physician, plan sponsor and payor
- Relationships – pharma and physician, members and PAP
- Canadian regulatory framework still evolving
- Clear communication and provincial support for members and prescribers
- Pharma marketing programs

What's the answer?

A Biosimilar policy

What we need to consider?

- We need to provide a supportive environment for biosimilars so that more are developed and available in Canada
- Balance with plan sponsor and plan member philosophy and ability to choose plan design
- Ensure sustainability of drug plans

What should we do?

We need an approach that balances short term financial with longer term sustainability and provides options for plan sponsors

Conclusion

- Biosimilars represent opportunity for cost reduction in high-priced biologic space.
- Uptake has been slow but is growing.
- Need a collaborative approach between public and private payers to help drug sustainability.
- Carriers will evolve their biosimilar policies as evidence and comfort with various approaches grows.

TELUS Health

Ensuring value for money and drug plan sustainability: An introduction to cost-effectiveness analysis

Daria O'Reilly, PhD

Lead Health Economist, TELUS Health

True or false?

The goal of cost-effectiveness analysis is to find the cheapest alternative.

Learning objectives

At the conclusion of this presentation, participants will:

1. Have an appreciation of an enhanced drug review process in drug listing decision-making;
2. Have a basic understanding of what the estimated cost-effectiveness of a drug means;
3. Understand the difference between cost-effective and cost

Innovation often comes at a high price

CANADA

Health Canada approves $2.8M treatment for spinal muscular atrophy

By **Morgan Black** · **Global News**

Posted December 16, 2020 3:47 pm · Updated December 17, 2020 1:38 pm

Zolgensma, one-time gene therapy.

https://globalnews.ca/news/7526002/zolgensma-spinal-muscular-atrophy-health-canada-approval/

TELUS Enhanced Drug Review Process

New drug submitted to pharmacy team

Clinical assessment (efficacy, side effects, etc.)

Financial Impact (How much will it cost from PP perspective?

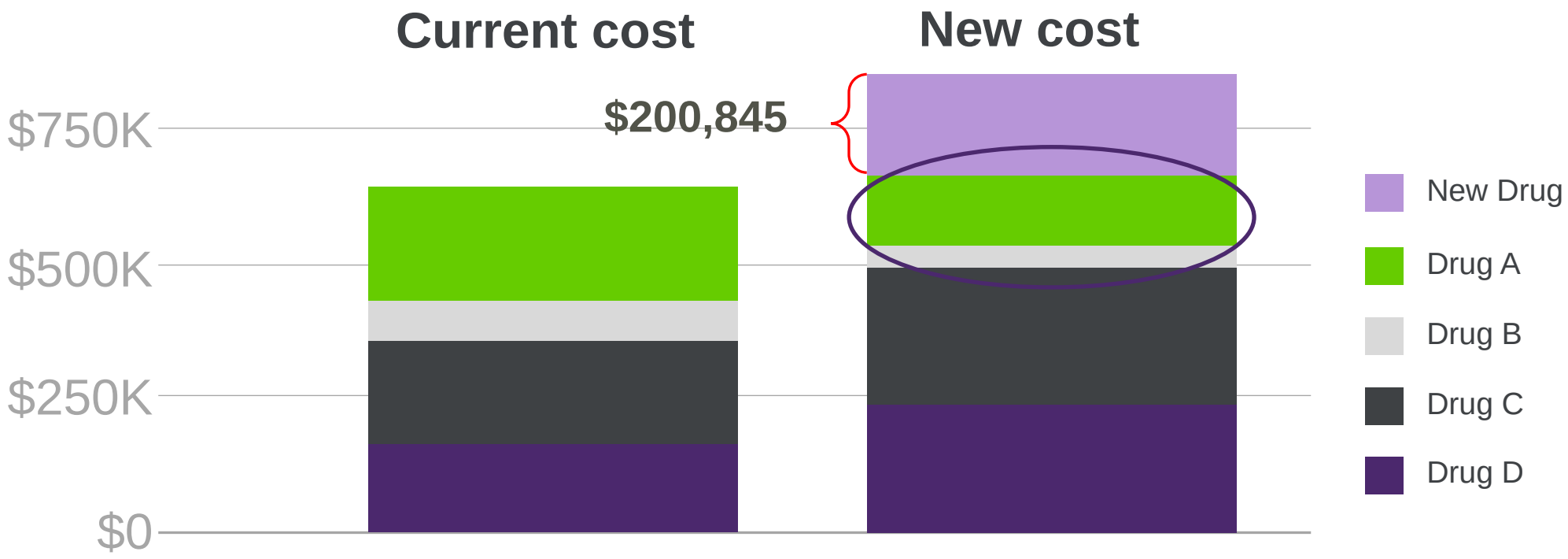
Cost-effectiveness/value for money from PP perspective

Formulary listing decisions/recommendations (listed, do not list, or list with conditions)

6-9 months

*Includes: Product and clinical trial information, Pharmacoeconomic & Budget Impact Analysis (BIA)
**Includes: Provincial Formulary / CADTH Recommendations, existing clinical guidelines (eg. Is this drug considered as part of rst line treatment)

Sample financial impact analysis



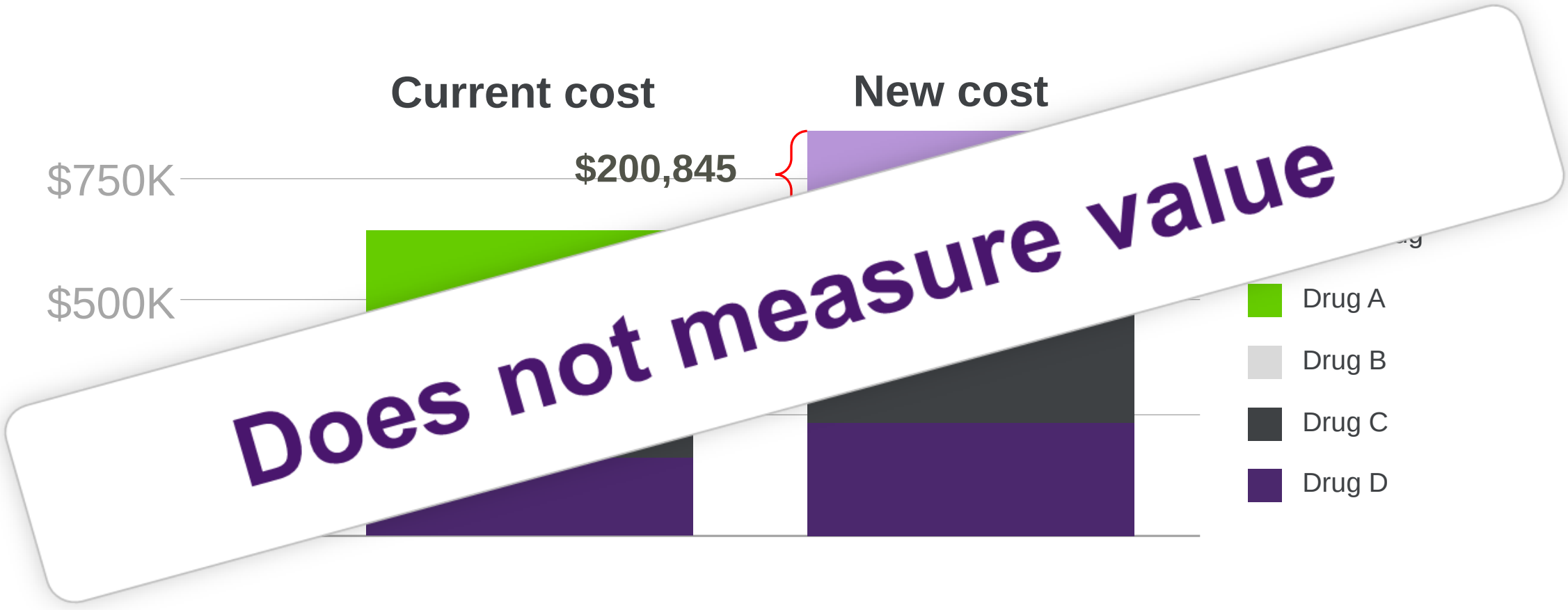
The increase in the total drug expenditure after the introduction of the new drug is $200,845.

Costly but cost-effective?

A new drug may not seem affordable, but is it cost-effective?

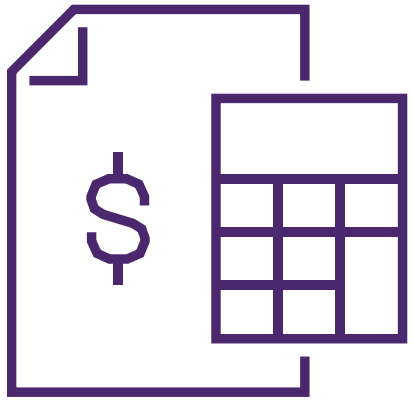
Will it increase survival, quality of life and plan member productivity?

Sample financial impact analysis



The increase in the total drug expenditure after the introduction of the new drug is $200,845.

Cost-effectiveness analysis



Compares both costs ***and*** benefits of >=2 therapies

Which alternative produces the best outcomes for investment?

Are the benefits of new drugs worth the increased costs?

- **Not the same as, “this drug delivers no benefit”**

Weighing costs and benefits

Which drug would you choose?

Drug A
Survival:1 year

Drug B
Survival: 1.5 years

Weighing costs and benefits

Drug A
Survival:1 year
Cost: $60K

Drug B
Survival: 1.5 years
Cost: $180K

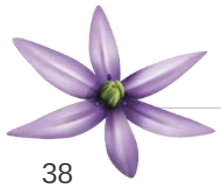
Cost-effectiveness

Result is an **incremental cost effectiveness ratio (ICER):**

$$ICER = \frac{\Delta Cost}{\Delta Effects}$$

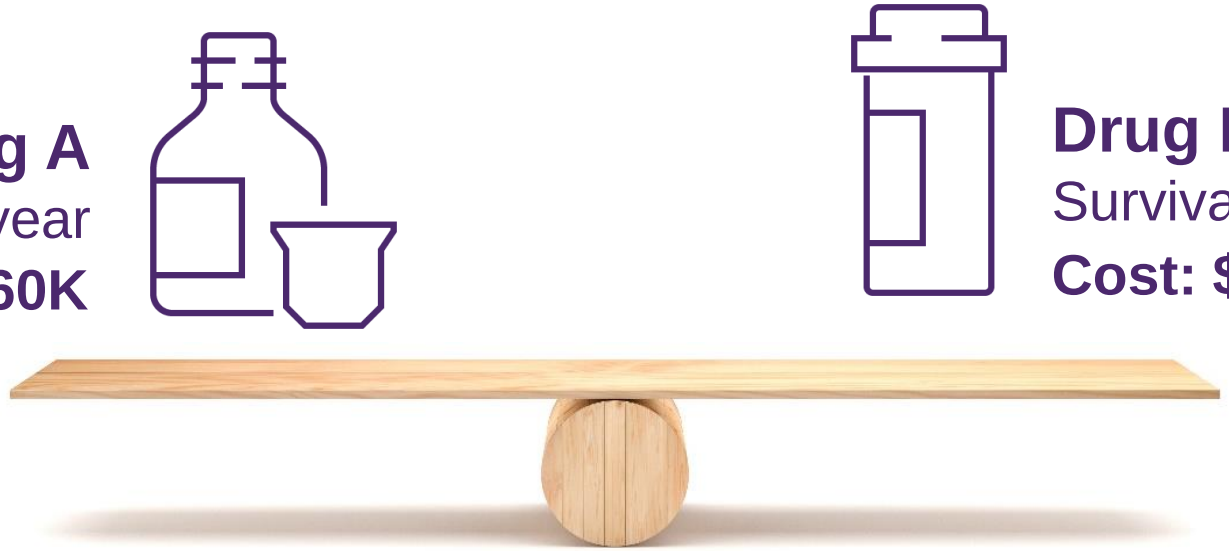
Costs include drugs ***and*** associated costs.

Effects can be life years gained, quality-adjusted life year (QALY).



Weighing costs and benefits

Drug A
Survival:1 year
Cost: $60K



Drug B
Survival: 1.5 years
Cost: $180K

ICER = ($180,000 - $60,000)/(1.5 LY- 1 LY)
= $120,000/0.5
= $240,000/LY gained

Daria’s broken washing machine

$

VS.

$$

Calculating the costs

Front-load washer $1,200 vs. top-load $600

- Uses 50% less water = lower water bills (reduced absenteeism)
- Less water, less energy to heat water = reduce hydro bill (reduce disability)
- Spins faster, clothes are drier so less heat required = save MORE on hydro bill
- Uses less detergent = buy less soap (improve productivity)
- No agitator to move clothes around inside the drum = clothes last longer, reduce clothing expenses (reduce extended health expenditures)

Measure of effectiveness/benefit

- Looks great
- Do fewer loads of laundry since we can stuff the machine with more clothes to reduce the number of times we need to do it

Cost-effective but costly?

Instances where a drug is deemed cost-effective, but due to high utilization, the financial impact would be substantial.

Summary

Financial impact

how many dollars need to be spent, so ***affordability*** can be determined or whether money would have to be taken from something else.

Cost-effectiveness

estimates predict the clinical benefit for each dollar spent—***value for money*****.**

Conclusions

Unprecedented innovation but challenges of financial impact for plan sponsors and thus ability to provide comprehensive plan.

EDR process, incorporating CE from a private payer perspective, is gaining in popularity as it helps make evidence-informed decision-making ensuring value for money.

True or false?

The goal of cost-effectiveness analysis is to find the cheapest alternative.

Evidence Informed Decisions:
applying the private payer lens

Learning objectives

At the conclusion of this presentation, you will be able to:

- Effectively evaluate managed drug plan options
- Summarize the features of today's drug landscape that make active drug plan management important for sustainability
- Compare the values and philosophies of plan sponsors to managed drug plan options
- Identify plan sponsors that are a good fit for active drug plan management
- Describe the way clinical and economic evidence is reviewed during private payer formulary management decisions
- Explain the types of expertise needed to make robust private drug plan management decisions

Drive for change

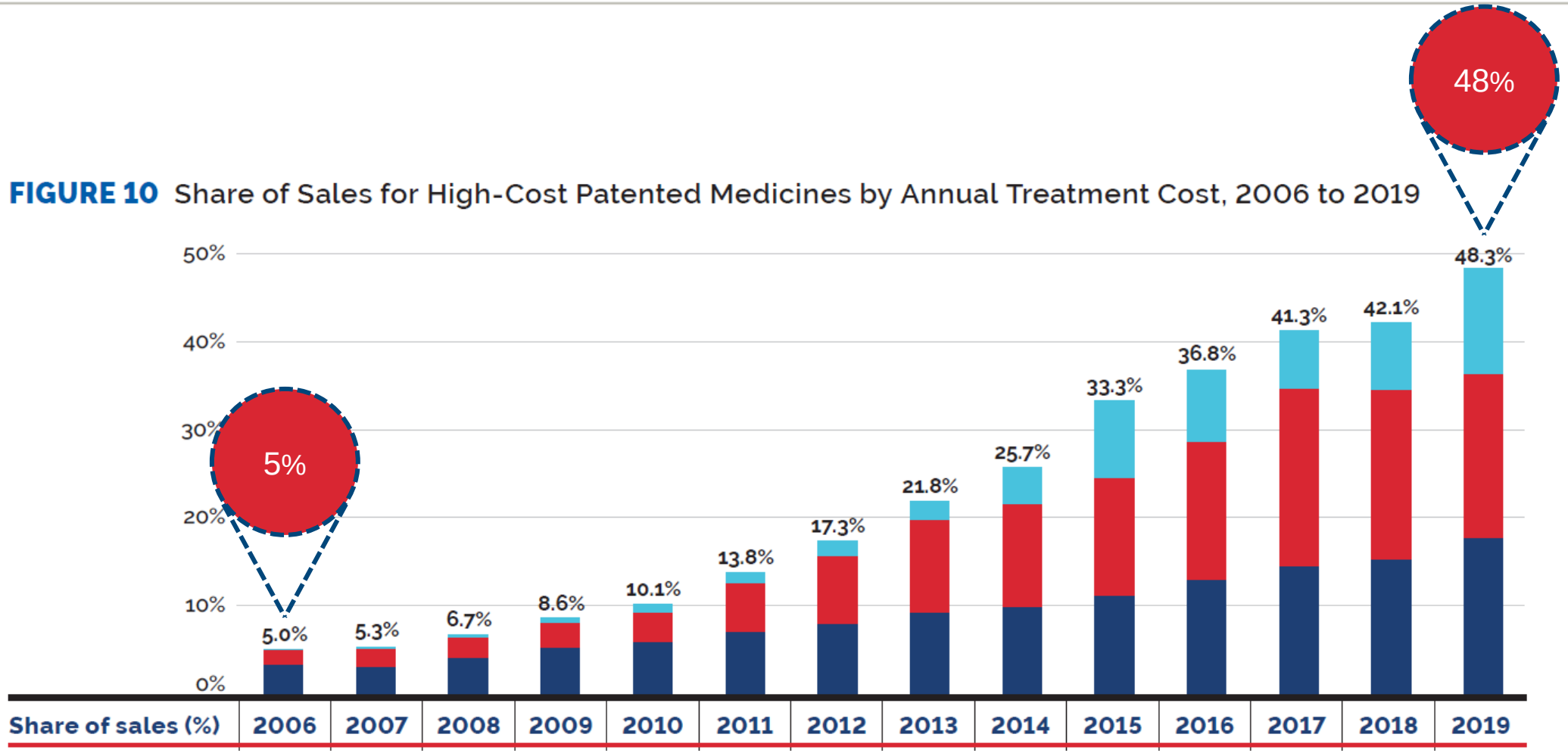
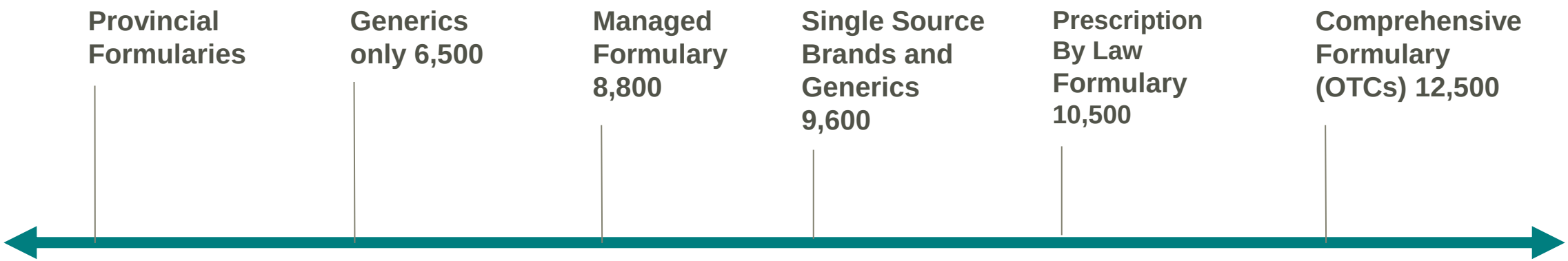


Figure source. PMPRB Annual Report 2019
Data source. PMPRB; IQVIA Private Pay Direct Drug Plan database, 2006-2019

Drug formulary positioning - by number of drugs covered

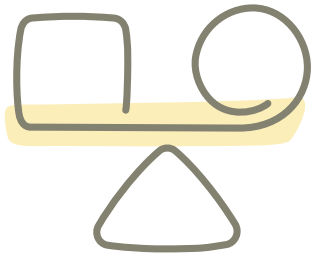


Less coverage

Very comprehensive coverage

Active management

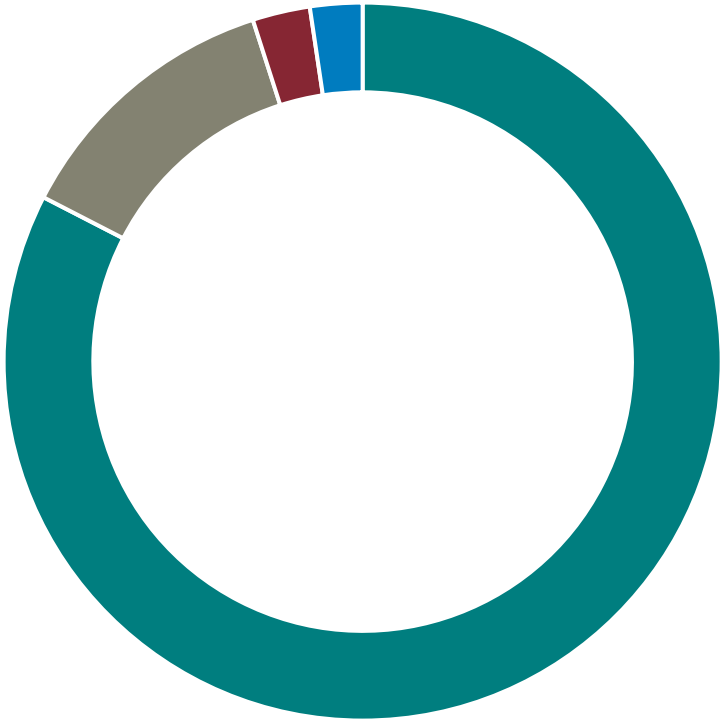
Financial
Risk Reduction



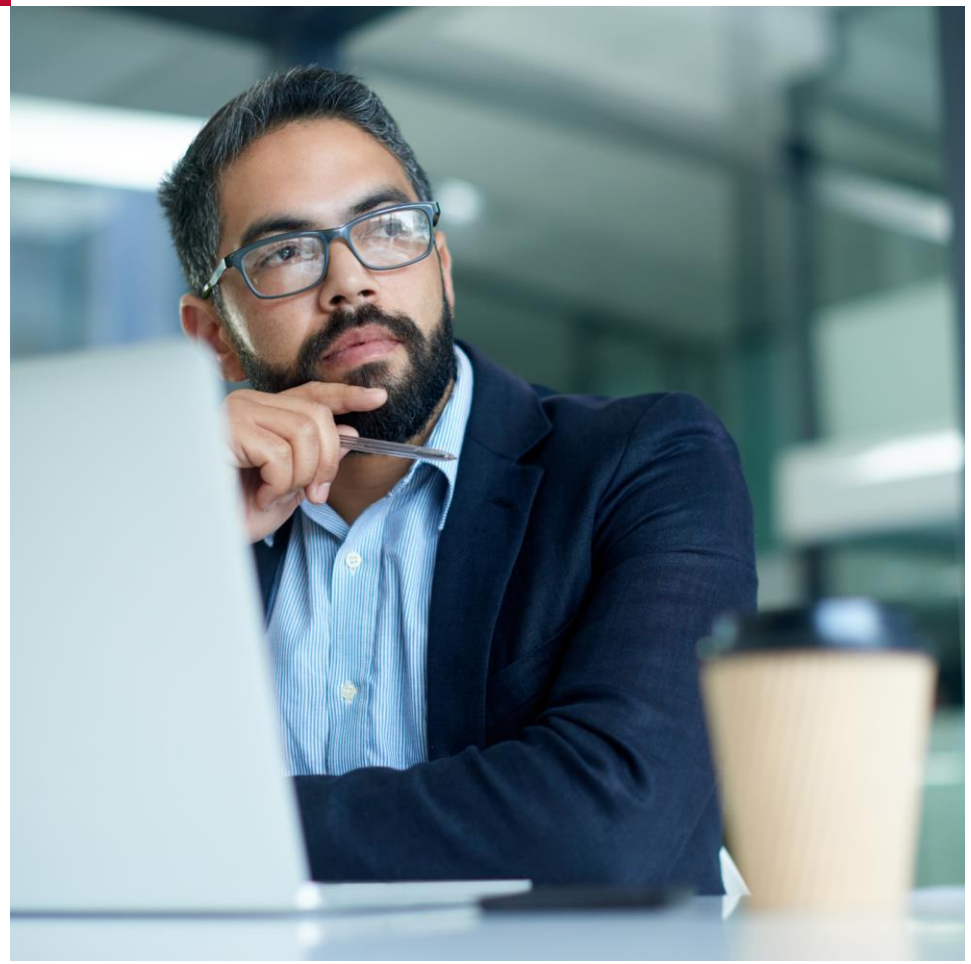
Very
Comprehensive
Coverage

What is value?

New medicines 2010-2019



Slight / No Improvement Moderate Improvement Substantial Improvement Breakthrough



Defining values

How would your client rank the following priorities?

- ❑ Competitive offering
- ❑ Containing costs
- ❑ Workplace wellness
- ❑ Plan member engagement

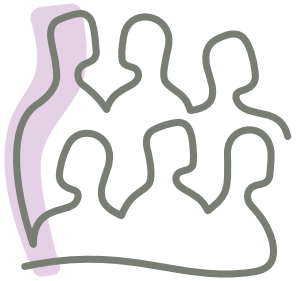
The Private Payer Lens

Critical appraisal mindset

- How does this information **apply** to private payers?
- How **reliable** is this information?
- How **impactful** is this information?

Alternative facts

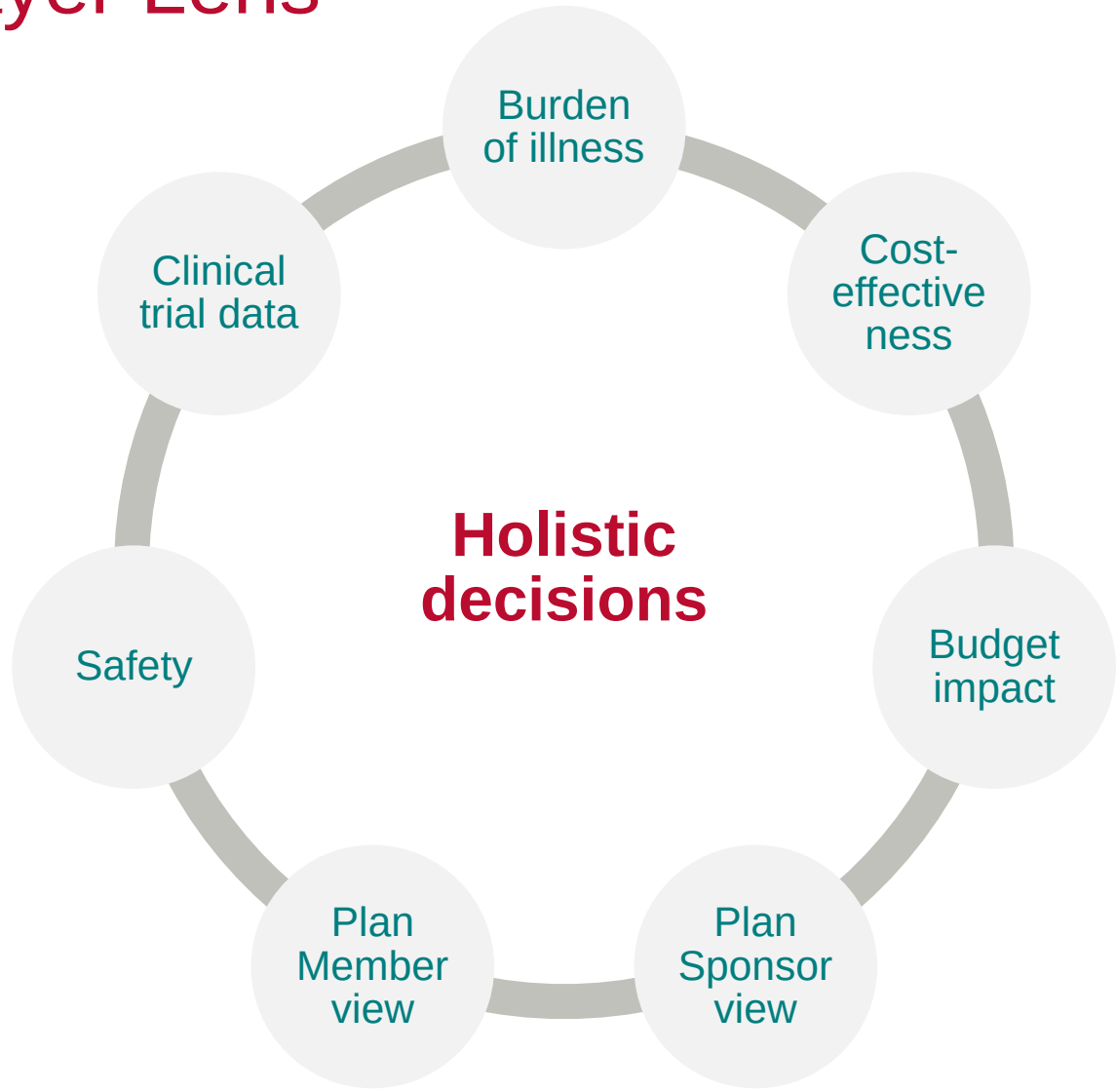
Price



Population

Clinical Trials

The Private Payer Lens

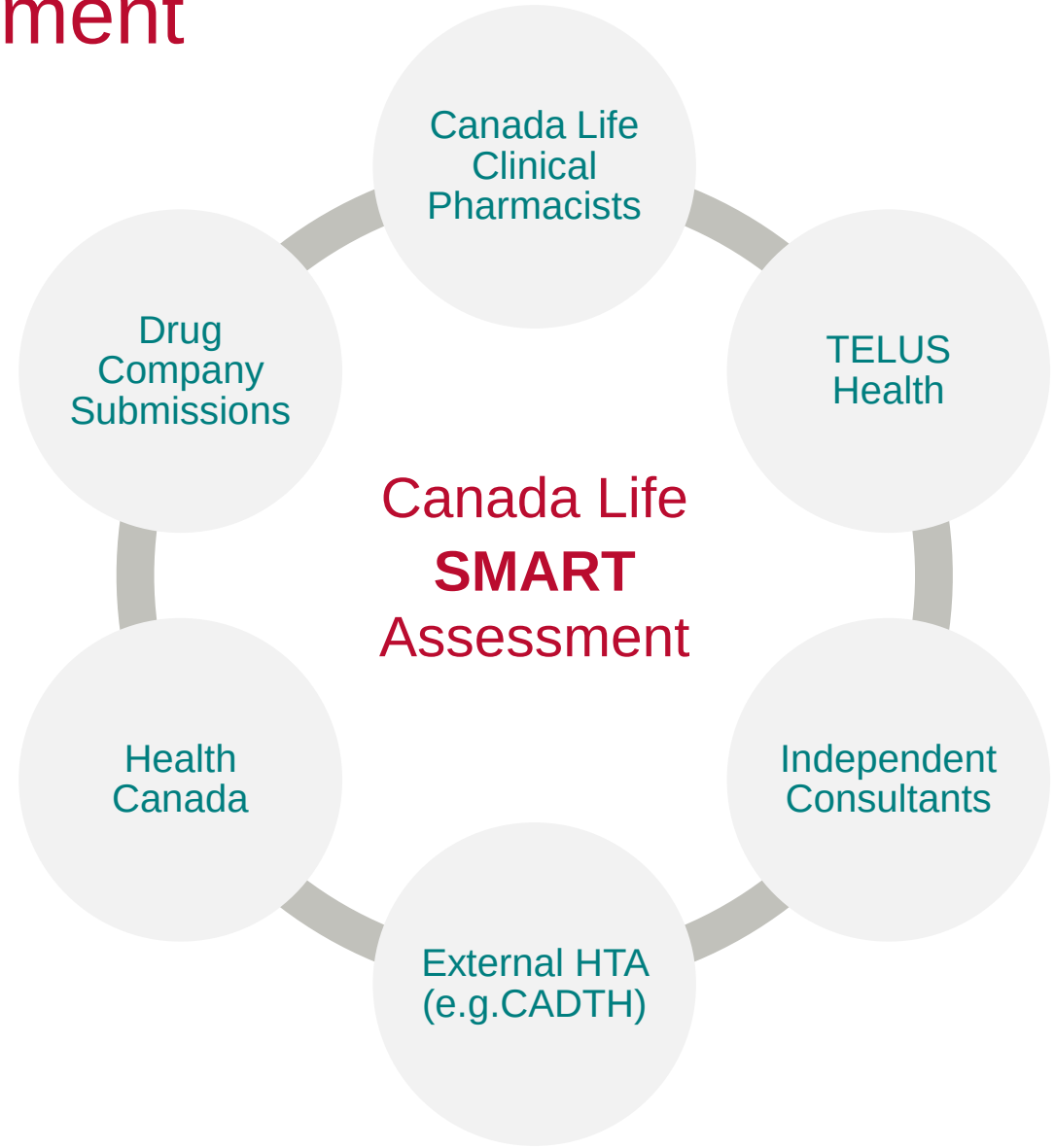


Data doesn’t make decisions. People do.

Our experts

- Pharmacists, nurses and physicians
- Health economists
- Actuaries
- Operational experts
- Business consultants

SMART Assessment



The SMART Approach

Clinical

- Needs
- Benefits
- Harm

Economic

- Budget impacts
- Cost-effectiveness
- Value for money

Perspectives

- Environmental scans
- Values
- Patient preferences
- Disability impacts

The bottom line…

Drug plans need to demand more value.

Value is informed by values.

Data doesn't make decisions. People do.

"It's not hard to make decisions, once you know what your values are."

Questions?