delivering complex pharmaceutical regimens,” Mr Zwiefenhafft said. “The evolving role of the oncology pharmacist is to be a cohort of the doctor’s office. This is done by assisting with critical clinical thinking during the regimen selection process. Perhaps most important, we also maximize the clinical yield of these expensive drugs through eliminating drug waste by compounding the patient-specific orders and then delivering them in treatment day doses.”

Kevin Askari, RPh
President and Chief Clinical Pharmacist
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For more information or to request a presentation, call OncoMed at 1-877-662-6633 or go to www.oncomed.net

**VBCC PERSPECTIVE**

By Peter G. Ellis, MD, and Kathy Lokay

As payers focus on the rising cancer care spend, they are turning to tools previously applied to other diseases. Each seems to have potential, but upon closer review, these have fundamental shortcomings when used for cancer. Disease management. Payers pay to have nurses in national call centers reach out telephonically to patients to help avoid hospitalizations. It is a labor-intensive model, often perceived by physicians as redundant at best and conflicting at worst with direct patient care. Return on investment in cancer care has proven elusive due to the high number of confounding variables. Most importantly, reductions in side effects and hospitalizations are better achieved through evidence-based treatments and supportive care combined with accountability and financial incentives to physicians. Oncologists’ therapy decisions are rarely outside national guidelines, and therefore cannot and should not be denied. Thus, UM adds a costly, cumbersome administrative process that is likely to have minimal impact on patient treatment. Moreover, UM imposes compliance costs on practices and offers physicians no incentive to narrow the variability of care or prioritize cost-effectiveness. Far greater savings could be achieved by empowering and incentivizing physicians to adopt evidence-based best practices.

"Pharmacy benefit management (PBM), including specialty pharmacy, has long been utilized to drive down pharmaceutical costs by enforcing use of generics over brands through formularies or tiered pricing along with negotiating volume discounts with pharmaceutical companies. This can dramatically increase medication cost, but upon closer review, these have fundamental shortcomings when used for cancer. Each seems to have potential, but upon closer review, these have fundamental shortcomings when used for cancer. Disease management. Payers pay to have nurses in national call centers reach out telephonically to patients to help avoid hospitalizations. It is a labor-intensive model, often perceived by physicians as redundant at best and conflicting at worst with direct patient care. Return on investment in cancer care has proven elusive due to the high number of confounding variables. Most importantly, reductions in side effects and hospitalizations are better achieved through evidence-based treatments and supportive care combined with accountability and financial incentives to physicians. Oncologists’ therapy decisions are rarely outside national guidelines, and therefore cannot and should not be denied. Thus, UM adds a costly, cumbersome administrative process that is likely to have minimal impact on patient treatment. Moreover, UM imposes compliance costs on practices and offers physicians no incentive to narrow the variability of care or prioritize cost-effectiveness. Far greater savings could be achieved by empowering and incentivizing physicians to adopt evidence-based best practices.

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**Traditional Managed Care Tools Just Don’t Work in Oncology**

Reducions in side effects and hospitalizations are better achieved through evidence-based treatments and supportive care combined with accountability and financial incentives to physicians.

—Peter G. Ellis, MD
Traditional Managed Care Tools... Continued from page 13

evaluate the value of comparable but not identical therapies. Even more difficult is the untenable choice for patients to decline treatment they cannot afford.

Manipulating drug reimbursement schedules. Payers are exploring equalizing the financial incentives to oncologists between higher cost single-source agents and lower cost multisource agents. This approach does make sense in that it removes the financial disincentive for oncologists to use an equally efficacious multisource drug where it might be appropriate. But, taken by itself, this tactic does not go far enough in defining optimal and least toxic care for patients that will drive better outcomes and present fewer complications. It will not address appropriate use of therapeutics in second-line therapy and beyond. And it will not drive the application of personalized medicine to distinguish patients who benefit from targeted therapies from those who only experience toxicities and cost.

If managed care tools are not the answer, what is the way forward? Pathways are the medically appropriate, sensible, and sustainable strategy to address the unnecessary variability and uneven quality in cancer treatment and thereby improve quality, decrease potential toxicities and side effects, and moderate costs. Pathways will actually improve the value of cancer care from the inside out.

Until the reimbursement system for oncology changes, the revenues associated with drugs are the vital financial engine to keeping community-based oncology care viable.

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unsustaintated therapies, in cancer there is often more than one treatment regimen with demonstrated anti-tumor efficacy for a given tumor type, histology, stage of disease, and treatment intent. How should we prioritize these therapies and select among them? A next challenge to achieve better care at lower cost is to define the components of value (such as potential for prolonging life or cure, side effects [both acute and long-term complications], cost, patient experience, etc) and to devise appropriate weighting of the components. With more than 750 therapeutic agents in the development pipeline for cancer alone, systems-based decision-support at the moment of clinical prescribing that aligns proper prescribing with appropriate reimbursement is now needed to assist therapeutic decision-making in community practice.

References