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A Look at the Numbers: Cost of Durable Treatments in Retinal Disease

Announcer:

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Dr. Sridhar:

Cost benefit considerations are always important for our patients who are receiving long-term therapy for macular degeneration with intravitreal treatments. So, how do newer, longer-acting therapies compare to traditional anti-VEGF therapies? This is CME on ReachMD and I'm Dr. Jay Sridhar.

Dr. Dang:

I'm Dr. Sabin Dang. Jay, you bring up a great question. We talk about healthcare economics and the cost to the healthcare system with all the treatments we provide, and I think it's an important thing for us as physicians to keep in mind just as good stewards of the healthcare economy.

One of the things that my group looked at was the economic benefit of higher-durability anti-VEGF agents in the treatment of neovascular AMD. We presented this at ASRS in Seattle this year. What we found in this analysis – we were really trying to identify what are the indirect and direct costs. So, how much cost savings did we get with faricimab versus ranibizumab for the cost of the drug – and those are the direct costs versus the indirect costs. How much time does it take for a caregiver to pick up the patient? How many of them, the caregivers and the patients, miss work? So, if we extrapolate this out and we model this out, what we find is that, hey, there's a direct cost-savings of faricimab because of its fewer injections compared to ranibizumab to the tune of about \$7,500 dollars for the first year of treatment. Now, if you add savings to the U.S. economy by all that lost economic productivity from having people out of the workforce, you're increasing that to about \$8,200 first year-savings of treatment.

Now, Jay, you know there's about 200,000 new patients with wet macular degeneration diagnosed every year. Hypothetically speaking, if we extrapolate that data out and we look at what the total U.S. economy savings was faricimab versus ranibizumab per-label dosing, we're talking about a potential economic benefit of \$1.6 billion. So, I think these are significant things, and these types of patterns have been demonstrated in other studies as well. Meer et al had identified in their population that, hey, the amount of drive time and loss of time from driving into their visits was not trivial either, and there was a significant economic savings there as well.

Dr. Sridhar:

Oh, I think it's great that your group looked at it in this way because it's so much more complex than some analyses allow, and it's a lot more work to do an analysis like you are. And for example, for the port delivery system, you know, there have been publications looking at the clinical trial data and Medicare reimbursement rates, not even capturing the burden of visits as an effect on the labor market. And even with this limited analysis, there was benefits even in the first-year cost-wise and the patient required frequent injections, 10 or more, to using the port delivery system. You already saw cost-savings in the first year. And there's definite benefits once you extrapolate that to 5 years. Of course, we're noting that off-label intravitreal bevacizumab was always the most cost-effective, but that

may not be an off-label option for much longer in the future. So, it is always important to factor in the real world.

What about DME, Sabin? We have just a couple points to make. Anything about DME versus AMD in terms of cost analysis?

Dr. Dang:

You know, DME, there's an interesting study looking at the cost savings potential of a long-acting dexamethasone implant, getting that into patient's eyes earlier. A lot of times patients have 6 or even more injections before – of anti-VEGF before they get a dexamethasone implant. And as we know, the dexamethasone implant can be an effective therapy that has high durability. And so, Ruiz-Moreno and their group had actually published studies showing that there was a benefit in terms of healthcare economics by switching earlier to those dexamethasone implants. So that's something interesting to take away, and also to keep in mind those patients of the DME population are more often a working-age population and there are significant barriers for them that – reaching and coming in for their care.

Dr. Sridhar:

Yeah, good points, and definitely a different approach for those patients than the wet AMD patients. So, again, economics important always, though we advocate for individualized treatment for the individual patient, but it is interesting to note that implication for the whole system.

Sabin, that's all the time we have today. Thanks so much for joining us today.

Dr. Dang:

Thanks for having me, Jay.

Announcer:

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