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Examining the Economic Impacts of Biosimilars in Oncology

Dr. Cheeley:
Welcome to *Project Oncology* on ReachMD. I'm Dr. Mary Catherine Cheeley, and joining me to discuss the use and economic impacts of biosimilars in the oncology space is Dr. Sophia Humphreys. She's the Director of System Pharmacy Formulary Management and Clinical Programs at Sutter Health, a multihospital health system in California.

Dr. Humphreys, thanks for joining me today.

Dr. Humphreys:
Thank you. I'm honored to be here.

Dr. Cheeley:
So let's kind of start at the beginning. Can you tell us about biosimilars and how they're different from what we traditionally think of as biologics?

Dr. Humphreys:
That is a great question. As you know, biologic medications are large, complicated protein molecules, and they're made in living organisms. In that sense, it is difficult to make an identical copy of a biologic medication. Therefore, there's no generic products available for biologics. In 2009, a part of the Affordable Care Act has provided an abbreviated pathway for a product called biosimilars to be developed. These are molecules that are highly similar to the reference product biologic medications in safety, purity, efficacy, potency, pharmacokinetics, pharmacodynamics, and immunogenicity. And there's no meaningful clinical differences between these biosimilar products and the reference product compounds. We have had many years of experience in the US and longer experience using these biosimilars in Europe and in Asia with very high efficacy and with great patient outcomes.

Dr. Cheeley:
Now that we have that baseline established, what biosimilars are currently approved by the FDA for the treatment of cancer?

Dr. Humphreys:
So I would separate the treatment for cancer into two categories. For curative, we have three molecules: Avastin, which is bevacizumab, Rituxan, which is rituximab, and Herceptin, which is trastuzumab. All three of them have multiple biosimilars in the US market. For supportive, we also have three: Neulasta, which is pegfilgrastim, Neupogen, which is filgrastim, and Epogen, of course, is epoetin. All three of these molecules have multiple biosimilars in the US market as well. The usage for all six molecules have been quite high in the past few years.

Dr. Cheeley:
What are the benefits for patients of switching to a biosimilar medication?

Dr. Humphreys:
So, as you know, biosimilars are highly similar to the reference product, and there's no meaningful clinical differences, which means our patient would see high efficacy, high safety, and great clinical outcome. And in addition to that, with the multiple biosimilars on the market for these six molecules, we are seeing the price of biosimilars much lower than the originator. On average, biosimilars sometimes can be less than 50 percent of the originator price. And also, with the biosimilars coming to the market, they increase competition, and they would reduce the price of the competing reference product as well. With the biosimilar usage we have seen since 2015 when the first biosimilar launched to the end of 2022, all over the US, we have seen 364,000,000 patient days, patients being treated with biosimilars. This is almost 150 million more patient days of biologic treatment compared to if we did not have biosimilars.

So in summary, biosimilars are lower-cost alternatives to expensive biologic medications in cancer treatment, and they provide high efficacy and safety as well as increased access to care for our patients.

Dr. Cheeley:
For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Mary Catherine Cheeley, and I'm speaking with Dr. Sophia Humphreys about the impacts of biosimilars in oncology.

Dr. Humphreys, let's dive right back in. I really want to talk about one benefit in particular when we're talking about biosimilars, and that is potential cost savings. How can these be maximized to benefit the patient? And then we'll turn that on its head and say how can we maximize that for the healthcare system as a whole?

Dr. Humphreys:
Let's start with patients. So on average, one in four cancer patients suffer from some level of financial toxicity, so copay assistance and reduction of copay and other financial assistance really would help our patients. Biosimilars being launched at much lower costs to our reference products will offer much lower copay for patients. In addition, biosimilars that qualify for 340B are reimbursed higher than reference products as well, so that would incentivize our health systems to use biosimilars more than their reference product, so we see a win-win situation for both healthcare systems as well as patients for financial benefit and for high quality alternatives of these high-cost biologic medications for both curative and supportive cancer care.

Dr. Cheeley:
Have you guys noticed at your institution and in your work with biosimilars any kind of delay in care because an insurance company or a benefit plan may cover one biosimilar over another or one reference product over the biosimilar? And it's different from plan to plan, so do you have a challenge in trying to figure out which one for which patient at which time is the best?

Dr. Humphreys:
In the very beginning, we struggled with PA processes. However, with the biosimilars being on the market for quite some time, we have developed a streamlined process where we have a devoted system formulary management pharmacist who actually maps our top nine payers within our footprint for our patients so that our financial investigation team knows which particular biosimilar or if the patient payer still prefers the reference product, which product they will target for the PA processes. In addition to that, because of our established multidisciplinary approach, our system P&T has established a pretty mature biosimilar utilization section in which we have deemed all biosimilars to one particular reference product.

Dr. Cheeley:
I think that's such a great process. There are so many different payers and so many different products at this point that having kind of a streamlined way or a road map of how to get patients what they need quickly is absolutely imperative, and that's where clinical pharmacists or utilization management programs really come in. So can you tell us how your biosimilar utilization management program initiatives help the patients that you serve and your healthcare system at large?

Dr. Humphreys:
I have a disclaimer to make because I do not have published data for Sutter Health. However, I do have published data for Providence Health, which I have worked with when I started on our biosimilar journey. So when we started our biosimilar journey at Providence in 2019, we started to track our savings for the system, and within the two years of 2019 and 2020, we achieved almost $27 million in savings from biologic purchase from our biosimilar program. So with that money that we saved, we can use that feedback to our system to provide more care for our patients. For example, we have pharmacists who run therapeutic clinics where the pharmacist can monitor our cancer patients' labs and then make follow-up phone calls and collect MET safety signals and other peripheral services. And, of course, as we have mentioned before, lower-cost biosimilars will translate to lower copay for our patients and reduce financial toxicity as well.

Dr. Cheeley:
I love that. That sounds like such a comprehensive program that you've built. Before we close, do you have any take-home messages for our listeners today?

Dr. Humphreys:
I actually have three bullet points for strategies to improve biosimilar adoption I would love to share with you and your audience. I call it "Ready, set, instant savings." "Ready" means we want to add all biosimilars to formulary before product launch. This way we can equip our contracting team to go out either with our GPO company's assistance or go to individual biosimilar as well as reference product manufacturers to negotiate best contracting terms for our health system and to maximize the benefit to our patients.

"Set" means we want to set up our contracting and operations team for success before product launch and during the launch processes,

which means we want our EPIC build to follow as soon as the contracting team selects the system-preferred product, and we want to make sure that we work with our 340B program to assure accumulation is accurate and other considerations for operation teams.

"Instant savings" means that once we did all the homework, once we build our EPIC this way, as soon as the product launches, as soon as they are on the shelf, we can start purchasing them. We can have everything ready for our system and for our patient to achieve the highest savings possible.

Dr. Cheeley:
I love that approach, and thank you so much for sharing that. This has been such an important discussion regarding the use of and impacts of biosimilars for our patients with cancer. I want to thank my guest, Dr. Sophia Humphreys, for joining me today and providing her amazing insights on this topic. Dr. Humphreys, it was lovely talking to you.

Dr. Humphreys:
Thank you very much.

Dr. Cheeley:
For ReachMD, I'm Dr. Mary Catherine Cheeley. To access this and other episodes in this series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.