

Generic Prescription Utilization

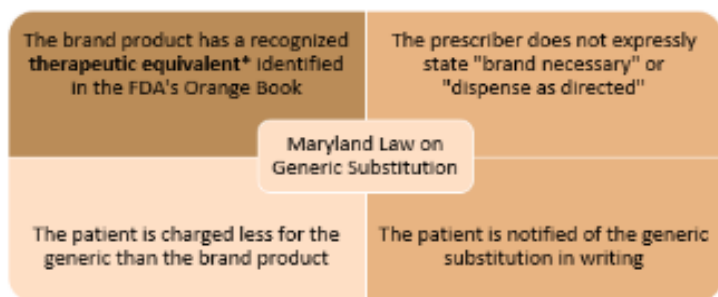
Generic Utilization:


Evaluating your generic prescribing represents an opportunity to make a significant impact on the quality and total cost of health care for your population. Consider the following statistics.

<p>Prescription drug costs make up a significant proportion of total U.S. health care costs.</p>	<ul style="list-style-type: none"> The US Department of Health and Human Services estimates that 16.8% (equating to \$457 billion) of personal health expenditures in 2018 went toward the cost of prescription drugs This is an increase compared to 2008 when, of the \$2.3 trillion spent on health care in the US, an estimated 10% (equating to \$234.2 billion) was spent on prescription drugs.
<p>Generic medication cost significantly less than brand-only products.</p>	<ul style="list-style-type: none"> Many of the most popular brand-name drugs increased at 10 times the cost of inflation from 2012 to 2017 On average, prescriptions for generic drugs cost 80-85% less than brand counterparts.
<p>Increased generic utilization results in decreased total health care costs.</p>	<ul style="list-style-type: none"> Utilization of generic drugs is estimated to have saved the US health system \$1 trillion between 1999 & 2010. It is estimated that for every 1% increase in Generic Dispensing Rate, there is an associated 1% reduction in overall drug expenditures. CMS has projected that healthcare spending will rise 5.5% annually from 2017 to 2026. It will comprise 19.7% of the U.S. economy in 2026, up from 17.9% in 2016

Generic utilization is identified as a performance metric for most insurance providers. It is measured using the **Generic Dispensing Rate (GDR)**, which is the sum of generic days supplied/ total generic + brand days supplied. Higher GDRs consistently produce lower prescription drug costs. We will soon be sending you an individual GDR/total prescription drug cost scorecard to help benchmark your prescribing habits. The best way to evaluate your personal GDR is in comparison to others in the same specialty. There may be some simple opportunities to help increase GDR and/or reduce prescription drug costs

Generic Substitution 101: Only a therapeutic equivalent can be automatically substituted for brand product in the state of Maryland. A therapeutic equivalent is required to be a pharmaceutical equivalent (meaning identical dosage form, route, active ingredient, delivering identical amounts of drug/time) with bioequivalence (rate/extent of absorption and availability at the site of action) demonstrated. Approved therapeutic equivalents are listed



in the FDA's Orange Book. It is important to understand that not all pharmaceutical equivalents are "therapeutic equivalents." Another category, **pharmaceutical alternatives**, are never therapeutic equivalents, nor qualify for automatic generic substitution. These contain the same active ingredient but may differ in salt, ester, complex, dosage form or strength. In addition to traditional generic substitution, judicious use of cost-effective pharmaceutical equivalents and alternatives may offer significant opportunity to reduce drug costs. An example of this is generic metformin ER products, for which over \$2 million could have been saved within the CCN between March of 2016 and May of 2019 by prescribing one version over the other two. 

Generic Metformin ER Products:
pharmaceutical equivalents (none are interchangeable despite all being generics)

- Metformin 500 mg ER (OSM) (generic Fortamet®) **\$656.00 for 60 tabs**
- Metformin 500 mg ER (MOD) (generic Glumetza®) **\$3,560.00 for 60 tabs**
- Metformin 500 mg ER (generic Glucophage XR®) **\$19.17 for 60 tabs** (Note: not available in 1000 mg XR dose so must order two 500 mg XR tabs to make 1000 mg dose. This achieves similar cost-savings compared to 500 mg dose examples above.)

Key Opportunities to Increase Generic Utilization and Reduce the Cost of Prescription Drugs:

1. **Simplify treatment plans by avoiding unnecessary adjuncts and deprescribing.** Classes of medications with evidence-based literature supporting deprescribing include proton pump inhibitors (PPIs), antihyperglycemics, antipsychotics, benzodiazepines, cholinesterase inhibitors, and memantine. For more information and access to guidelines, visit [deprescribing.org](https://deprescribing.org/resources/deprescribing-guidelines-algorithms/).

2. **Use time-tested generics and avoid the brand-only phase of "Me Too" drugs.** Up to 75% of new drugs on the market have no added benefit compared to existing therapies, according to a recent study. This may be attributed, in part, to industry gamesmanship that is aimed at increasing the brand-only phase of products through "evergreening," and the development of "Me Too" drugs. Although these drugs have a negative connotation, they can increase competition and have the potential to eventually drive down costs. A classic example is the development of single enantiomer products to replace a racemic mixture that has gone generic, like: escitalopram, esomeprazole, and desvenlafaxine. A recent study cites that \$17.7 billion could have been saved by Medicare between 2011 and 2017 through use of the generic, precursor racemic mixtures. Examples of these products still in brand-only phase include: Dexilant®, Brovana®, and Fetzima®. Examples of other "Me Too" drugs still in brand-only phase are Livalo®, Zytiga® 500mg film-coated tab and Sarafem®

3. **Avoid using brand-name combinations with generically-available ingredients.** A 2018 study published in JAMA looked at the annual incremental cost to Medicare related to the use of brand combination products with generic constituents. In 2016, the estimated spending for the generics would have been \$925 million less. Of the products implicated in the study, the CCN estimated total cost in 2018 is \$613,412. Examples are: Duexis® (ibuprofen & famotidine)-\$243K; Vimovo® (naproxen & esomeprazole)-\$159K; Edarbychlor® (azilsartan & chlorthalidone)-\$50K; and Treximet® (sumatriptan & naproxen)-\$13K. A more recent example is Namzaric® (memantine ER & donepezil).

4. **Increase awareness of cost-effective pharmaceutical equivalents:** The metformin ER example highlights the opportunity to reduce total cost without impacting therapeutic outcomes. Some ER, XR, CR products are shockingly expensive compared to their immediate release counterparts, even when they are generically available. Other examples may include paroxetine CR, carvedilol ER, and memantine ER. Consider also Epinephrine Auto-Injector products: of the 4 products on the market, none are interchangeable; 2 have generic equivalents. Generic Epi-pen®/ Jr (\$300/2pens) is the most cost-effective generic, but supplies have been strained. In order to avoid a phone call, consider adding a note to the pharmacy, such as: "may substitute generic AdrenaClick Auto-injector" (\$395/2 pens). Note that brand Auvi-Q costs \$4,900 and has no generic.

Sometimes drug plans prefer certain brand medications.

This occurs because pharmacy benefits managers (PBMs) may negotiate prices and receive rebates (estimated at 40% of WAC) from brand manufacturers. Federal law prohibits Medicare from negotiating prices.

whenever possible. A great example is topical acne treatments and thyroid medications, for which therapy has not significantly changed recently. From the LABA/ICS class, Fluticasone/Salmeterol inh. Powder (Advair Diskus®)-\$122/unit, is now available in generic form. Consider starting with this as an alternative to brand-only products like Symbicort®, Dulera®, Advair HFA®, and Breo Ellipta® (all ranging \$350-500/unit). **Look for updates on new generics in the CCN Newsletter.**

5. **Start new prescriptions with generics or suggest trials of generic alternatives from the same class.** A recent systematic review cites that patient acceptance of generics goes up when they have used a generic in the past. Consider generics first

6. **Talk to your patients about the cost of their medications.** There is little transparency related to true drug costs in the U.S., and a significant disconnect between the patient, prescriber, pharmacy, PBMs and drug manufacturers. Increasing your knowledge of medication costs and how this impacts your patients may ultimately impact medication nonadherence, which has an annual estimated cost between \$100-\$289 billion. Ask patients if they are having any problems "taking or paying for your meds." Patients may feel uncomfortable telling you this. Consider having your assistant ask or lead with, "Medications can be really expensive. Are you having any problems paying for them?" For more resources, visit <https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/cost-of-care-conversations>

Abiraterone (Zytiga®) 250 mg tab & 500 mg film-coated tab: pharmaceutical alternatives with generic in one strength, not in another

- Within CCN, medication with 4th highest total cost between Jan-May 2019
- Generic abiraterone 250 mg tab (4 tabs/day = 1000 mg dose) **\$385 / patient day**
- Brand Zytiga® (film-coated) 500 mg tab (2 tabs/day = 1000 mg) **\$436 / patient day** (no generic in this strength)
- Use of generic 250 mg tab to make the exact same dose **saves \$51 / per patient-day**

Where can you find drug cost information?

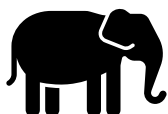
<https://www.healthcarebluebook.com/ui/consumerfront>

<https://www.goodrx.com>

<https://blinkhealth.com>

<https://werx.org>

- 7. Don't waste too much time on convincing patients that request brand only.** Have a prepared statement, such as "99.9% of the time, we use generic and never see any clinically significant difference." If the answer is still no, move on. And yes, some narrow therapeutic index medications have been debated in the literature, like seizure medications. This may not be the "lowest hanging fruit," so focus on the other simple recommendations to increase GDR and reduce the total cost of medications. Above all, do what is right for your patient
- 8. Consider that manufacturer coupons and rebates may actually increase total costs.** While a patient may have a reduced out-of-pocket cost temporarily, the use of brand medications in lieu of time-tested generics will ultimately increase the total cost of prescription drugs and cost of care. Additionally, patients with state or federal prescription insurance plans are usually precluded from using these programs



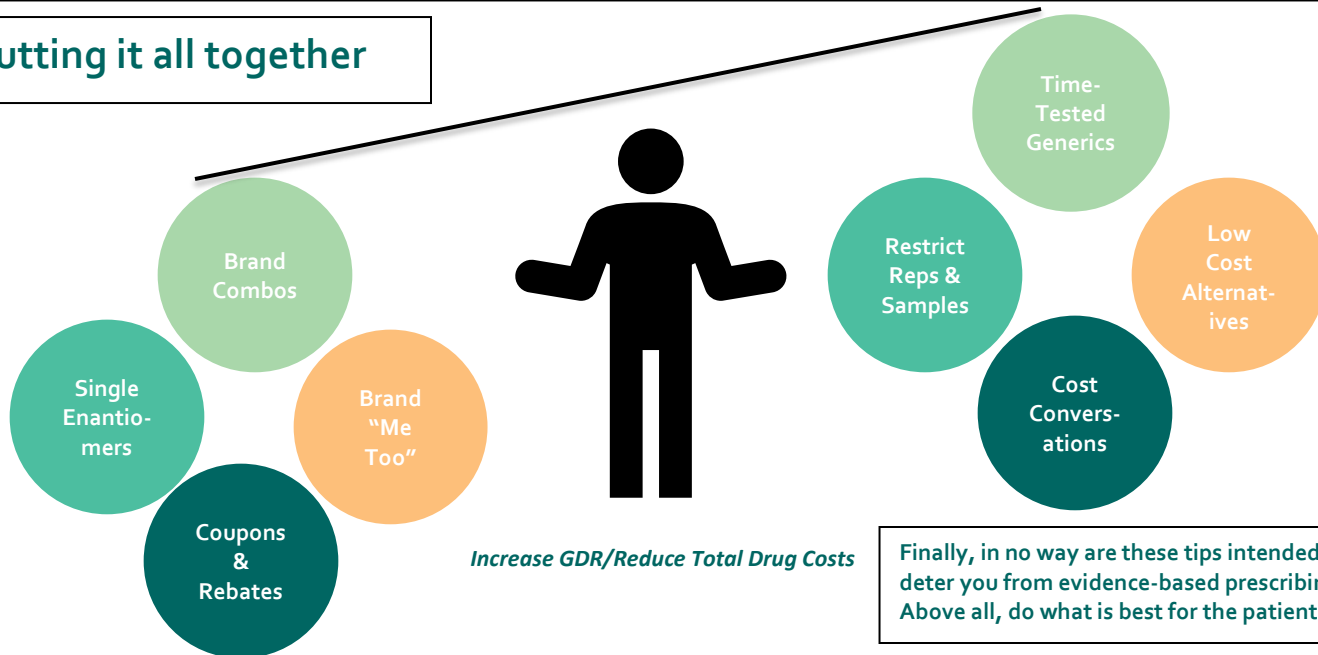
The Elephant in Your Office: There's a Reason Sales Reps Buy You Lunch and Give You Samples

Studies show that offices with increased brand name samples and more interaction (including meals) between pharmaceutical companies and prescribers have higher numbers of prescription claims, higher costs per claim, and more brand prescriptions (7.8% more in one study). Pharmaceutical companies actually buy physician prescribing profiles from data analytics companies, and with marketing strategies tailored to you, can increase acceptance of new drugs by up to 30%. We encourage you to critically assess brand drug marketing and to adopt these measures:

- Prohibit or restrict brand samples in your office to what you deem necessary.
- Prohibit or restrict pharmaceutical sponsored lunches or detailing

The American Medical Association (AMA) provides a Code of Medical Ethics Opinion 9.6.2 related to pharmaceutical industry marketing to physicians. Additionally, money paid to you by pharmaceutical reps (including for lunch/dinner) is publicly available. Check out your public information here: <https://openpaymentsdata.cms.gov>

Putting it all together



What if patients ask if generics are safe? Yes, makers of generic medicines must follow the same FDA rules about strength, quality, and purity as makers of brand-name medicines. Just like with brand products, if a generic product is recalled, pharmacies are obligated to contact patients that have received these products and replace them. Assure patients that just because one manufacturer has issued a recall, not all manufacturers or batches may be affected. Direct them to call their pharmacy. A list of FDA recalls is available at <https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts>

What's new in Maryland related to prescription drug costs? Maryland passed a new law in effect July 1, 2019, establishing a prescription drug affordability board. The law, that applies only to state government, county and city health plans, requires manufacturers to justify price hikes of brand and generic medications that exceed a certain threshold. The board can reject the explanation and set a lower price with approval of the state legislature.

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