

The Managed Care Perspective

James T. Kenney, Jr., RPh, MBA

A core message often delivered to managed care pharmacy managers is “treat early and treat often,” which suggests that aggressive treatment of chronic diseases will reap benefits over the long term in the form of less morbidity and mortality. This treatment approach must be validated by controlled clinical trials with solid endpoints. In addition, comprehensive outcomes data are needed to effectively support this treatment approach.

In rheumatoid arthritis (RA), taking the opportunity to target patients at risk for disease progression would be a valuable approach to identify and treat appropriate patients. Functional decline and erosive changes may begin early in the disease and an earlier approach to treatment could offer the potential for a more durable effect over the long term.¹ Also, it is important to identify patients who would not benefit from particular therapies, as this may minimize the risk of adverse events in such patients and offer additional value to the health plans and insurers who would otherwise be charged with paying for this utilization. This could have a significant impact on pharmacy budgets and free up resources to pursue additional treatments or services.

A total of 40% to 50% of patients with undifferentiated arthritis will experience spontaneous remission, and the remaining will have active disease that will likely benefit from early treatment.^{2,3} A validated survey instrument that effectively targets appropriate patients to receive treatment could offer an important addition to the management tools used by managed care to control pharmacy drug costs.⁴ The challenge of identifying the appropriate patient is encouraged by the fact that a greater possibility of treatment success is achievable with a more targeted approach to medication selection. Ultimately, disease activity should guide the clinician on the appropriate treatment path for the patient.

Such an instrument needs to be easy to use and to incorporate into the practice by physicians. The key benefit to patients and plans is the greater probability of disease remission with earlier treatment of RA. This leads to quality-of-life improve-

ments, reduced disability, and the potential for significant cost savings. These savings include the obvious decrease in drug spending, as well as the avoidance of any costs to treat the negative side effects associated with drug treatment. A treat-to-target approach with the goal of remission supports a managed care model of disease management.

Greater improvement in clinical outcomes and greater reductions in joint damage and disability are the valuable benefits of newer complex therapies. Evidence supports the notion that remission is more likely in patients with early RA than in those with long-standing disease.⁵ The American College of Rheumatology guidelines support the managed care approach of utilizing conventional disease-modifying antirheumatic drugs (DMARDs) as first-line therapies and biologics as second-line agents.⁶

Additional studies are needed to identify the best therapeutic options based on individual patient profiles. The lack of head-to-head data makes comparisons difficult; however, current clinical studies effectively support the use of biologics in patients who fail to respond to conventional DMARDs.

The suggested improvements to make biologics cost-effective (cited in the article by Resman-Targoff and Cicero) are on target. Biologics can be cost-effective if (1) drug prices are lower; (2) the risk of death is permanently reduced with biologic therapy; (3) patients experience drug-free remission; (4) responders can be selected prior to therapy initiation; and (5) effective alternative treatments are available for patients in whom several biologic agents have failed.

The Treat-to-Target Task Force proposes the ultimate therapeutic goal of remission.⁷ Although a reduction in indirect costs has a societal benefit, direct cost reductions associated with disease remission are critical for managed care support and acceptance of early and aggressive treatment. The benefits of improved quality of life, less productivity loss, decreased physical disability, fewer hospitalizations, and a decreased need for joint replacement support the need for effective treatment of patients with RA.

Reports

Author Affiliation: Harvard Pilgrim Health Care, Wellesley, MA.

Funding Source: Supported by an educational grant from Genentech and Biogen Idec.

Author Disclosure: Mr Kenney reports no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design; analysis and interpretation of data; and drafting of the manuscript.

Address correspondence to: James T. Kenney, Jr., RPh, MBA, Harvard Pilgrim Health Care, 93 Worcester St, Wellesley, MA 02481. E-mail: jim_kenney@hphc.org.

REFERENCES

1. Puolakka K, Kautiainen H, Mottonen T, et al; FIN-RACo Trial Group. Early suppression of disease activity is essential for maintenance of work capacity in patients with recent-onset rheumatoid arthritis: five-year experience from the FIN-RACo trial. *Arthritis Rheum.* 2005;52(1):36-41.

2. van Aken J, van Dongen H, le Cessie S, Allaart CF, Breedveld FC, Huizinga TW. Comparison of long term outcome of patients with rheumatoid arthritis presenting with undifferentiated arthritis or with rheumatoid arthritis: an observational cohort study. *Ann Rheum Dis.* 2006;65(1):20-25.

3. Harrison BJ, Symmons DP, Brennan P, Barrett EM, Silman AJ. Natural remission in inflammatory polyarthritis: issues of definition and prediction. *Br J Rheumatol.* 1996;35(11):1096-1100.

4. Aletaha D, Neogi T, Silman AJ, et al. 2010 rheumatoid arthritis classification criteria: an American College of Rheumatology/ European League Against Rheumatism collaborative initiative. *Ann Rheum Dis.* 2010;69(9):1580-1588.

5. Aletaha D, Smolen J, Ward MM. Measuring function in rheumatoid arthritis: identifying reversible and irreversible components. *Arthritis Rheum.* 2006;54(9):2784-2792.

6. Saag KG, Teng GG, Patkar NM, et al. American College of Rheumatology 2008 recommendations for the use of nonbiologic and biologic disease-modifying antirheumatic drugs in rheumatoid arthritis. *Arthritis Rheum.* 2008;59(6):762-784.

7. Smolen JS, Aletaha D, Bijlsma JWJ, et al. Treating rheumatoid arthritis to target: recommendations of an international task force. *Ann Rheum Dis.* 2010;69(4):631-637.