

# Weighing the Evidence: Trends in Managed Care Formulary Decision Making

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Health plans, pharmacy benefit managers, and other organizations use drug formularies to promote quality care while controlling costs. However, restrictive formularies are often viewed as constraints on physician practice and potential barriers to optimal patient care. Reluctance to add new drugs to an established formulary is rational economic behavior. Innovative compounds may have unknown properties with uncertain outcomes and therefore may impose costs in the form of risk. Products that seemingly duplicate drugs already on formulary may increase transaction costs without additional benefit. In evaluating new products, formulary managers face the task of identifying, assembling, and synthesizing a wide range of complex information. Manufacturers, who may be in the best position to supply that information, have been severely restricted by U.S. Food and Drug Administration (FDA) regulations that limited marketing communications to findings from well-controlled clinical trials. The FDA Modernization Act of 1997 eased these restrictions somewhat by acknowledging that sophisticated purchasers such as organized health plans were capable of weighing the quality and impartiality of manufacturer-supplied evidence. The Academy of Managed Care Pharmacy (AMCP) created a standardized template that formularies can use to request comprehensive information about specific drugs from manufacturers. Widespread adoption of the AMCP format by health plans and manufacturers will greatly increase access to information about new drugs, speeding the process of formulary committee deliberation, and instilling greater confidence in the outcome of those decisions. Wider access to new drugs may result.

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**M**anaged care formulary committees are inherently reluctant to add new drugs to their formularies. Cost control is the obvious rationale but a more complex explanation recognizes 2 distinct sources of potential cost increase. First, truly innovative drugs involve risk of the unknown, and second, “me too” drugs (late entrants in a class with many competing brands) may impose increased transaction costs. This article describes these sources of cost and how better access to information can potentially reduce the cost and introduces a new source for that information.

## ADDING A DRUG TO A MANAGED CARE FORMULARY

Drugs that are truly new—are the first in their class—exemplify uncertainty as a primary rationale for restrictive

formularies. Introduction of the innovative antidepressant fluoxetine, the first marketed selective serotonin reuptake inhibitor (SSRI), provides a case study. At the time of its introduction, fluoxetine appeared to offer benefits such as reduced side effects when compared with other antidepressants;<sup>1,2</sup> however, the relatively sparse evidence for fluoxetine efficacy was based on clinical trials involving carefully selected patient cohorts. Fluoxetine was much more costly relative to established antidepressants such as tricyclics (TCAs), and therefore formulary inclusion could mean increased expenditure with uncertain benefit. As a result, many health plans imposed restrictions on SSRI use, such as guidelines mandating a stepped-care approach in which the patient needed to fail TCA therapy before receiving fluoxetine, or requirements for prior authorization.

Once the SSRIs became well established and brands began to proliferate, the second type of cost associated with a new drug came into play. New drugs are usually priced at parity with their competitors; however, the actual cost of a particular drug to a managed care plan may depend on volume and the proportion of the plan’s utilization of drugs within the class (i.e., internal market share). Adding a new SSRI to the list of drugs already on formulary could reduce volume and market share among the established products, potentially increasing their acquisition costs.

Although price cutting and rebates can be used to gain formulary acceptance, the manufacturing industry prefers

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to maintain price in an attempt to differentiate the product from competitors based on a superior side effect profile, faster onset of action, or other product attributes. Evidence for these benefits may be available from clinical trials but communicating this information may be difficult. Under traditional U.S. Food and Drug Administration (FDA) marketing guidelines, the pharmaceutical manufacturer can only promote a product based on claims substantiated by the clinical trial. The pivotal clinical trials for a “me too” drug are invariably designed only to demonstrate clinical equivalence to a market leader.

### **The FDA as Gatekeeper for Drug Information**

In both examples—a truly innovative and a “me too” drug—the managed care organization must make a decision by weighing the potential benefits and costs that would result from adding a particular new drug to the formulary. Making a well-informed decision first requires assembling information. While peer-reviewed journal articles are the most credible source, published studies may be scarce for new drugs. Complex information needs to be synthesized and interpreted, and outcomes observed in a clinical trial population must be extrapolated to a more heterogeneous managed care population. In addition, data from clinical trials may only reveal efficacy and side effects, but the true cost of a drug encompasses patient functional status, productivity, and quality of life. Few managed care organizations have the resources or expertise required to adequately assemble these data.

The manufacturer of a new drug has extensive knowledge about the product, garnered through years of clinical trials and would certainly have the capability and motivation to support formulary committee deliberations. However, the manufacturer might also have an economic incentive to provide biased information that is favorable to the drug while minimizing shortcomings. Cognizant of this possibility, FDA regulatory policy has traditionally limited communication about a product to claims based on evidence from 2 well-controlled clinical trials. Such a restrictive policy was perhaps appropriate when decisions about drugs were made by individual practitioners who depended on sales representatives (detailers) for updates on pharmacotherapy. However, by the 1990s, managed care organizations (MCOs) and pharmacy benefit managers (PBMs) emerged with a strong influence on drug prescribing through their ability to establish drug formularies and manipulate consumer demand by setting copayment amounts. Congress recognized that these organizations were more capable than individual practitioners of assembling and weighing evidence about the performance of drugs. The FDA Modernization Act of 1997 (FDAMA)<sup>3</sup> expanded the range of information that manufacturers could share with sophisticated purchasers such as MCOs and PBMs. For example, data about treatment costs, impact on productivity, and absenteeism obtained in the

course of a clinical trial could be communicated. The Act preserved the mandate that, in most cases, 2 adequate and well-controlled trials demonstrating a product’s effectiveness and safety were still required.

### **Unsolicited Information Requests and the AMCP Template**

The FDAMA substantially relaxed a policy that limited marketing communication to the endpoints established in 2 well-controlled clinical trials, but it was still highly restrictive. For example, if a drug for schizophrenia was determined to achieve better compliance with fewer side effects, then a pharmaceutical company could not extrapolate from that data that fewer hospitalization events would result. However, the new law opened a door to broader information access by allowing manufacturers to respond to “unsolicited requests” from MCOs and PBMs for information that may be available. This communication can be very broad and may include information from retrospective database studies or health economic and modeling studies, and even off-label information that is not substantiated by clinical trials. The unsolicited request provision has limited the FDA’s role to ensuring that these requests are truly unsolicited.

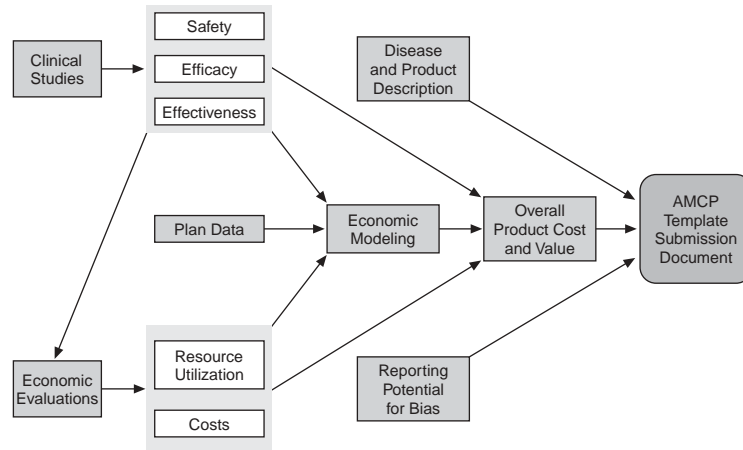
Following this change, formulary committees were faced with the challenge of knowing what information might be available, generating a specific request, and then synthesizing the resultant evidence, which was a complex and time-consuming task because different manufacturers provided data in different ways. Under the auspices of the Academy of Managed Care Pharmacy (AMCP), a working group of experts in clinical medicine, pharmacy practice, and health economics developed a standardized template (Format for Submission of Clinical and Economic Data in Support of Formulary Consideration by Managed Care Health Systems in the United States)<sup>4</sup> for use by manufacturers in responding to formulary requests for information.

### **Structure of the AMCP Template**

The AMCP working group sought to achieve 3 primary objectives in developing the template: (1) to provide a consistent and direct means for a manufacturer to supply information to a managed care organization; (2) to recognize the need for combining information regarding efficacy, safety, effectiveness, and economic evaluation in the formulary decision-making process; and (3) to emphasize that simple acquisition cost reduction is not the optimal approach to controlling overall health care expenditures (Figure 1). The template consists of 2 report components—narrative and tabular—and a budget impact model in the form of spreadsheet computer software.

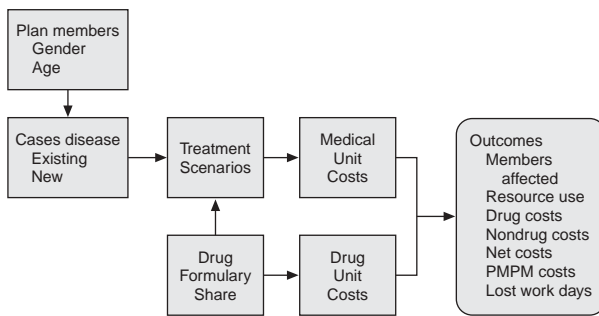
The narrative and tabular report components include a description of drug indications, mechanism of action, labeling, and a side-by-side tabular comparison with similar drugs on the market. Another section summarizes design

Figure 1. AMCP Submission Document<sup>a</sup>



<sup>a</sup>Reprinted with permission of the Academy of Managed Care Pharmacy (AMCP).<sup>4</sup>

Figure 2. Budget Impact Model<sup>a</sup>



<sup>a</sup>Reprinted with permission of the Academy of Managed Care Pharmacy (AMCP).<sup>4</sup>  
Abbreviation: PMPM = per member per month.

Model inputs include number and demographic characteristics of plan members and the epidemiology of the disease or indication(s) of interest. For example, a model for a drug to treat attention-deficit/hyperactivity disorder (ADHD) would specify the incidence of ADHD in pediatric, young adult, and older adult populations. An additional set of inputs specifies treatment patterns for various aspects of the condition in terms of average number of visits to specific types of providers, hospitalization rates, incidence of side effects, and other factors relevant to the scenario. Provision is also made for inputting the unit costs of services and supplies such as physician visits or drugs. All of these input values are readily changed to tailor the model to an individual health plan. Model outputs include impact on formulary budgets as well as total plan expenditure and patient outcomes (frequency of physician visits, hospitalization days, disability, etc.).

**BENEFITS OF USING THE AMCP TEMPLATE**

Use of the AMCP format benefits each of the 3 major parties in the marketing of new drugs: the health plan, the manufacturer, and the FDA. Health plans need not develop an exhaustive query for specific information from the manufacturer when considering a particular drug. A request for material “based on the AMCP template” saves many hours of research and ensures receipt of a comprehensive and consistently formatted document. For the drug manufacturer, the AMCP template creates a level playing field where competing drugs are presented in an identical manner. Manufacturers can afford to invest relatively substantial resources in preparing a document by adhering to AMCP guidelines because the great majority of formulary committees will accept the document without modification. This process is much more efficient than

and findings from up to 5 clinical trials. An additional section describes results of economic studies, including those based on retrospective data analysis or modeling. Finally, the report includes a concise summary of product value from the manufacturer’s perspective. Appendices include a bibliography in the expectation that most of the material presented would be based on published sources or unpublished data available from the manufacturer.

Conceptually, the budget impact model represents the most revolutionary part of the AMCP template because it enables the pharmaceutical company to mathematically synthesize information that will aid the managed care plan in projecting the impact of adopting a new drug (Figure 2). Models are designed to replicate the course and treatment of a condition based on community practice patterns rather than on a clinical trial protocol and to yield reasonable estimates of impact on per-member per-month expenditure.

generating individual responses to ad hoc requests. The FDA benefits because adherence to the AMCP template eases the task of monitoring the unsolicited request provision of the FDA Modernization Act. AMCP template documents are readily available to the FDA. Quality of the information contained therein is assured by the careful scrutiny these documents receive from a handful of very large health plans.

### CONCLUSION

The FDA originally created the FDAMA to enable pharmaceutical companies to provide managed care organizations, physicians, and other purchasers information that extended beyond evidence derived from 2 controlled efficacy trials, but the legislation failed to account for other benefits such as those pertaining to disability, survival, and quality of life. The FDAMA legislation contained a stipulation, however, known as the unsolicited request stipulation, that specifically enabled managed care formulary committees to gain access to a broader range of information including potential gains in member productivity, out-of-pocket costs to members, and budget impact. The AMCP created a submission form in response to this stipulation, to aid managed care formulary committees in assessing the estimated impact that the addition of a new drug might have on their formulary.

The implications of the AMCP model are significant for both the pharmaceutical industry and managed care organizations. The pharmaceutical industry has been granted the opportunity to convey information that reaches beyond evidence that has been substantiated by 2 adequate and well-controlled clinical trials. However, they also have a responsibility to assemble credible, cited information in

the documents they submit while reasonably considering all drug competitors and pivotal trials so the managed care committee can readily assess all pertinent data about the potential value of a new product. Managed care organizations have been granted the opportunity to evaluate the quality and content of submissions they receive which comprise a broad range of information that otherwise might be very costly and difficult to gather. Managed care formulary committees are now able to incorporate outcomes and economic evaluation data into formulary considerations, which contribute to the hope of progress.

AMCP guidelines might provide a model for Medicare benefit since current legislation provides for restrictive Medicare formularies. The AMCP guidelines offer a model not only for comprehensively open and unrestricted formularies, but also for formularies that are managed with a more reasoned approach. Although currently an enormous number of Americans belong to health plans that are covered by AMCP guidelines in some manner, it may take years for the impact of the social innovation of the AMCP guidelines to completely manifest.

*Drug name:* fluoxetine (Prozac).

### REFERENCES

1. Pande AC, Saylor ME. Adverse events and treatment discontinuations in fluoxetine clinical trials. *Int Clin Psychopharmacol* 1993;8:267-269
2. Feighner JP, Boyer WF, Meridith CH, et al. A placebo-controlled inpatient comparison of fluvoxamine maleate and imipramine in major depression. *Int Clin Psychopharmacol* 1989;4:127-134
3. U.S. Food and Drug Administration. FDA Modernization Act. Available at <http://www.fda.gov/opacom/7modact.html>. Accessed Aug 2, 2003
4. Academy of Managed Care Pharmacy. Format for Submission of Clinical and Economic Data in Support of Formulary Considerations by Managed Care Health Systems in the United States (Version 2.0) Alexandria, Va: Academy of Managed Care Pharmacy, Oct 2002. Available at <http://www.AMCP.org/>. Accessed Aug 7, 2003