White Paper

Access Challenges in the Cancer Patient Journey

How barriers to oral oncology affect patient initiation and persistency

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Introduction

Oncology is one of the fastest-growing markets in the U.S., with total medicine spending increasing $10 billion to $91 billion from 2022 to 2023.[1] As developments in cancer treatment advance, we are now at a point with many tumor types at which multiple options for effective therapy have emerged, and extended survival is leading to increased utilization of those therapies. Market competition and higher volume prompt payers to increase control and raise hurdles to access. The ability for patients to initiate and maintain therapy is crucial for successful treatment and disease management, but we have identified barriers that undercut favorable outcomes.

Every day, millions of cancer patients rely on their medications to improve their well-being and survival. Obtaining that therapy is a necessary first step, yet access controls in oncology are expanding, constricting patients' abilities to start and stay on therapy.

Since 2021, IQVIA has been tracking the use of formulary exclusions in oncology medicines affecting both provider- and self-administered treatments.[2,3] These controls are on the rise and are growing more impactful as the use of oral oncology products continues to grow, and as payers shift infused oncology products away from the buy-and-bill model into integrated benefit models and favor specialty pharmacies ("white- bagging") via the pharmacy benefit.[4]

Within the pharmacy benefit, patient access can be impacted by several factors beyond formulary exclusions. A more well-known barrier to access is affordability. As drug prices become a focus of public and political attention, the role that financial support plays in therapy acquisition becomes increasingly pertinent in the discussion of oncology access.

Another example is the accessibility of dispensing sites. Optionality and patient choices have become more limited with the use of payer networks that often require or incentivize patients to fill prescriptions via specific pharmacies. These networks are often integrated with the payer and impact specialty medicines more than others.

The start of 2024 saw the first wave of changes to the Medicare Part D Benefit design stipulated by the Inflation Reduction Act (IRA). This included the elimination of the 5% patient coinsurance in the Catastrophic phase, which could improve affordability for many patients. However, it is expected shifting costs and liabilities from the IRA will also lead to greater payer restrictions and "skinny" formularies. Even in protected classes such as oncology, where restrictions are already increasing, the risk of even greater control is a threat to many.

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Overview

Expanding formulary controls

Payer formularies may outright exclude therapies from coverage or first require patients to fulfill prior authorization, step therapy, and specific pharmacy fulfillment requirements. These utilization management techniques, though largely limited to the pharmacy benefit, have increased across both self - and physician-administered oncology medicines.

- There were 134 formulary exclusions of 186 products across five payers in 2024, up from 37 exclusions in 2020.
- Prior authorization and step therapy requirements were the most common rejection type across payer channels.
- When patients worked through restrictions, it took them up to twice as long to initiate therapy as those without restrictions.

Dispensing site effects

Generally, patients have options for where they would like to fill their prescriptions: medically integrated, specialty/mail, and retail pharmacies. Each type offers different levels of accessibility and convenience for patients, but because payer restrictions often include limited pharmacy networks, patients might encounter rejections related to their dispensing site. Patients filling prescriptions through medically integrated and specialty/mail pharmacies are more successful at overcoming access challenges such as costs and payer restrictions relative to retail pharmacies.

- Medicare patients that overcome rejections do so most quickly at medically integrated sites.
- Specialty/mail and medically integrated pharmacies had lower rates of abandonment relative to retail pharmacies.

Financial support in oncology

Cancer patients can face costs as high as $500 or more per prescription. To facilitate affordability, copay support programs take a number of forms but are most often manufacturer-sponsored copay cards used among privately insured patients and charitable gifts from foundations used by Medicare patients. These programs play a crucial role in treatment compliance but are a limited resource that could face more disruption as the IRA impacts funding.

- In 2023, 76% of Medicare patients without support faced prescription costs above $500 versus 13% of those with support.
- Medicare patients who utilized support were ~20% more likely to continue therapy than those without.

Expanding formulary controls

As the oral oncology market grows and white-bagging for medical products becomes increasingly prevalent, payers utilize a number of controls to manage access.

Formulary exclusions have increased, particularly for products with generic alternatives. Though market expansion in the form of new launches currently outpaces the increasing formulary exclusions, such exclusions can prevent timely access to these life-saving medicines.

"Coverage" is a blunt measure of product access. For medicines on formulary, payers can utilize other forms of control to manage utilization, also delaying treatment or halting therapy altogether. As more vertical integration between payers and specialty/mail pharmacies develop, payers increasingly mandate where and how patients can receive their medications.

The overwhelming majority of patients face barriers to access, and only roughly half of those patients ever fill the treatment they were prescribed within one year. For 20% of those that do, it takes at least four weeks for their prescription to be approved.

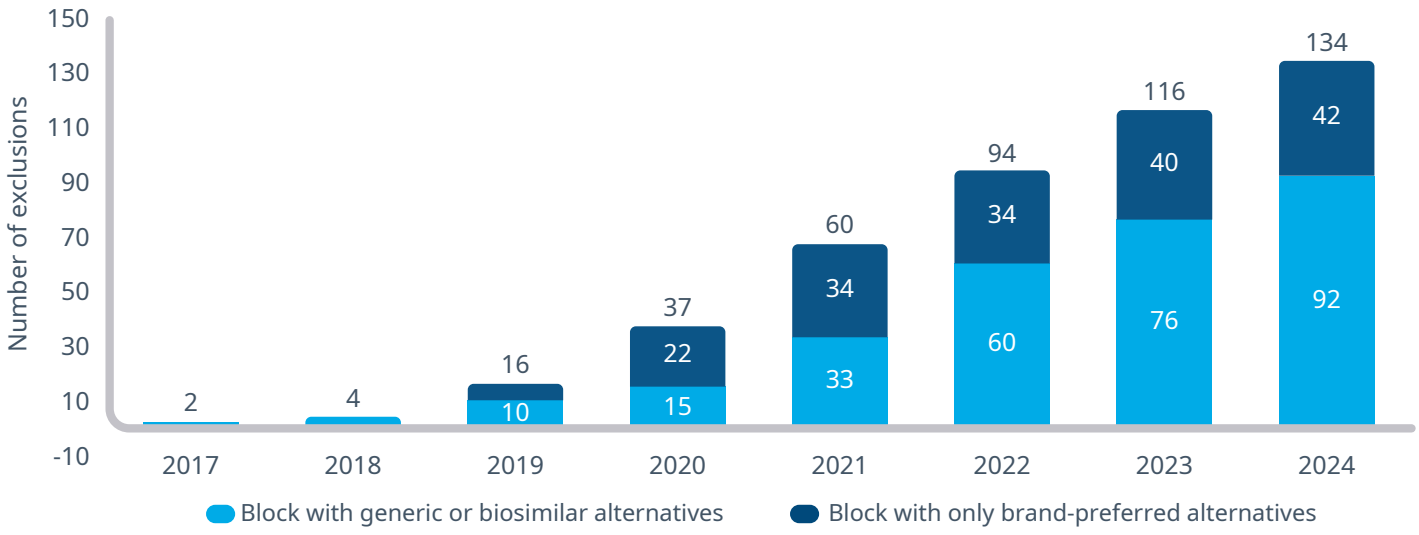
Every access barrier is a threat to the initiation of a therapy prescribed by a patient's physician. For cancer patients, getting on these treatments in a timely manner can be crucial for their well-being and survival.

KEY TAKEAWAYS:

- Following a Payer rejection, our analysis indicates that 43% of Commercial and 53% of Medicare patients never initiate therapy.
- Only 10% of Commercial and 23% of Medicare patients received payer approval on the first day their prescription was submitted.
- Since 2020, the number of oncology product formulary exclusions among top national payers grew from 37 to 134, mainly for products with generic or biosimilar alternatives.
- Formulary exclusions were applicable across a range of tumor types and modes of administration.
- Though oral products have the greatest number of formulary exclusions, products administered intravenously, subcutaneously, and intramuscularly are impacted as well.
- Among those that were approved, 20% of patients had to wait over four weeks for initial therapy.

Formulary exclusions for oncology medications continue to expand in competitive brand and low-cost alternative scenarios

Exhibit 1: Number of national formulary exclusions by year, top national payers, oncology products, Commercial



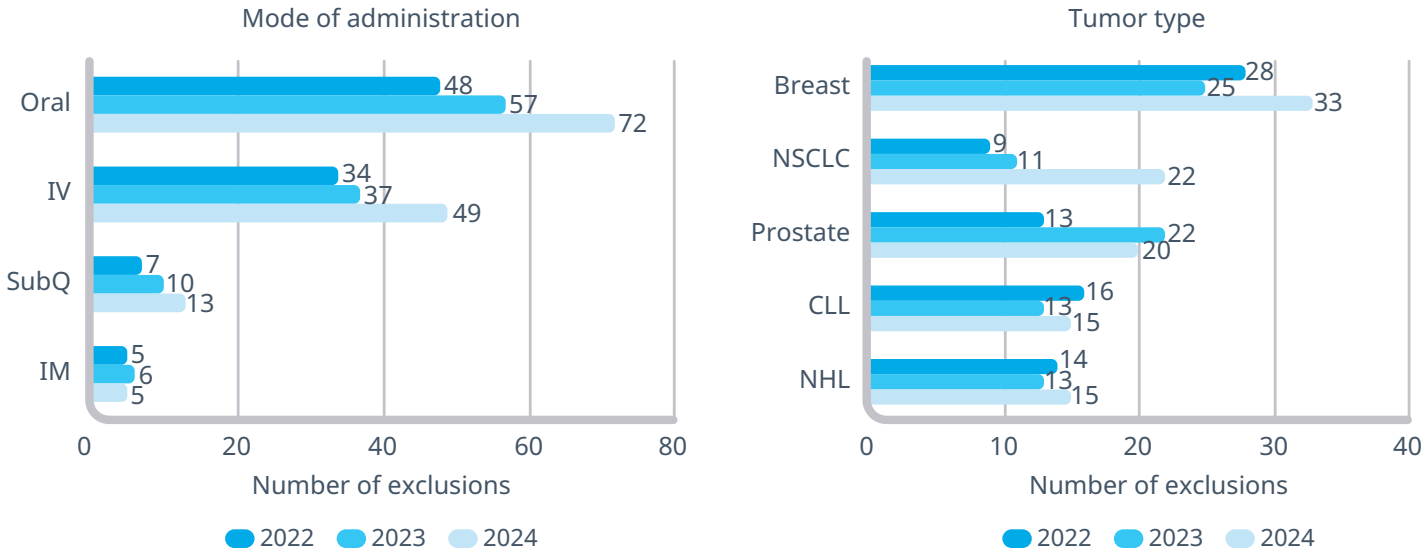
Source: Published national Commercial formularies; IQVIA U.S. Market Access Strategy Consulting analysis

- As more oncology products are developed and brought to market, competition for favorable formulary placement increases between products.
- Across top national Commercial formularies, there were 134 formulary decisions to exclude oncology products in 2024.
- 42 of the exclusions in 2024 occurred where the preferred alternatives were brands only.
- The remaining 92 excluded products were in favor of lower list price generic or biosimilar alternatives.
- Formulary exclusions are just one strategy payers can use to control access; types of restrictions could be prior authorization, step therapy, or other formulary requirements.
- In addition to rejections, payers affect access through patient cost-sharing (deductibles, copay tiers, coinsurance).

Notes: Exclusions are counted as payer-product combinations.
A product is considered excluded if the formulary explicitly states so; products left off formulary are not counted

Formulary exclusions are not limited to certain modes of administration or tumor types

Exhibit 2: National formulary exclusions, top national payers, oncology products, Commercial



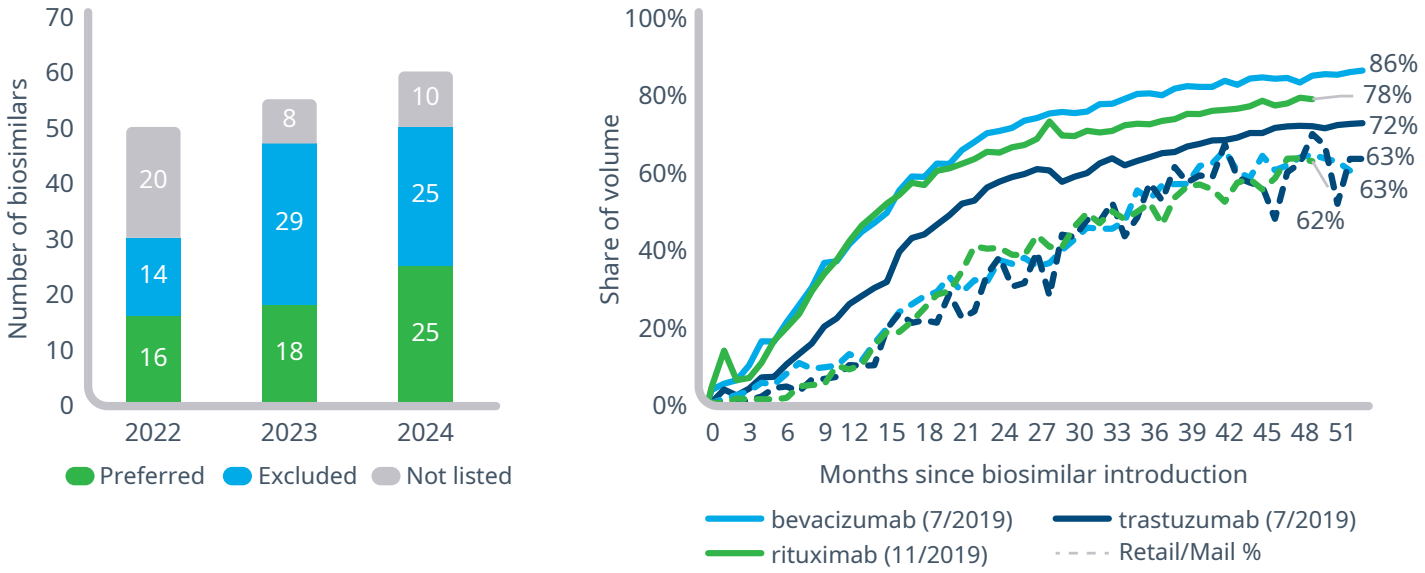
Source: Published national Commercial formularies; IQVIA U.S. Market Access Strategy Consulting analysis

- Formulary exclusions are not limited to oral products alone. Therapies administered intravenously, subcutaneously, and intramuscularly are impacted, as well.
- Stated exclusions of oral cancer medicines grew over time, reaching 72 exclusions in 2024.
- The number of exclusions for IV products grew by 48% from 2023 to 2024, reaching 49 exclusions.
- The exclusion of physician-administered products on formularies suggests that payers are controlling products that are regularly white-bagged.
- Exclusion prevalence spans across a number of tumor types.
- The greatest number of exclusions have been placed on breast cancer products, with a total of 33 in 2024.
- Non-small cell lung cancer products had the greatest increase in exclusions among tumor types in 2024, doubling from the year before.
- Increased formulary exclusions in breast and lung cancer are partly the result of an increase in the number of approved treatment alternatives and increased market competition.[5]

Notes: Exclusions are counted as payer-product combinations.
A product is considered excluded if the formulary explicitly states so; products left off formulary are not counted.
Tumor types chosen based on the greatest number of exclusions in 2024.
Some products have multiple modes of administrations and/or are indicated for multiple tumor types.
IV — Intravenous; SubQ = Subcutaneous; IM = Intramuscular; NSCLC = Non-small cell lung cancer; CLL = Chronic lymphocytic leukemia; NHL = non-Hodgkin's lymphoma

After 4+ years, coverage is expanding for biosimilars with share reaching above 70% across therapies

Exhibit 3: Formulary status and market share uptake of biosimilars, oncology products, all payer channels



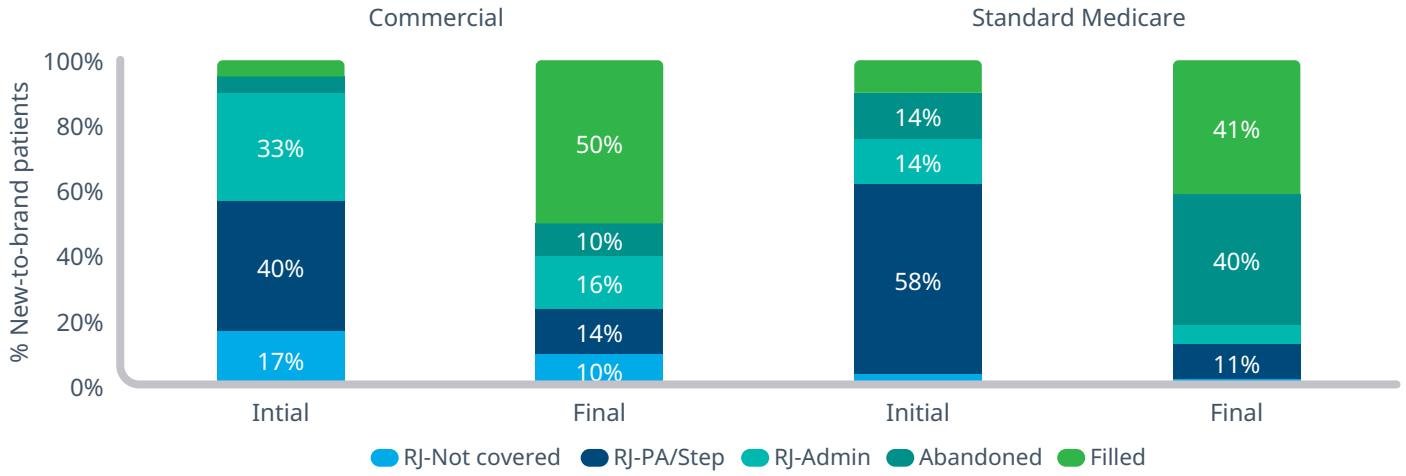
Source: Published national Commercial formularies; IQVIA National Sales Perspective; U.S. Market Access Strategy Consulting analysis

- There are currently three cancer-treating therapies that have biosimilars on the market: bevacizumab, rituximab, and trastuzumab.
- In 2022, there were a total of 10 launched oncology biosimilar drugs; 11 more launched in 2023; 12 more in 2024.
- Across all five national, Commercial formularies, at least one biosimilar was preferred over an innovator.
- Even when products are included on formulary, patients may face other utilization management tools such as prior authorizations or step therapy requirements which can impede patient access.
- In 2024, biosimilars were covered 42% of the time on national formularies, an increase from 32% in both 2022 and 2023.
- 98.5% of medical oncology products flowed through the buy-and-bill system, while some patients received their medication via white-bagging (dotted line) in the retail/mail acquisition channel.
- In buy-and-bill, bevacizumab and rituximab biosimilars reached 50% of share 15 months post-launch; trastuzumab biosimilars did not reach 50% until 21 months after introduction.
- Unlike white-bagged claims, buy-and-bill prescriptions are affected by physician/practice economics that favor discounts.

Notes: Exclusions are counted as payer-product combinations.
Currently, biosimilars are only available for medical oncology products.
While biosimilars exist for filgrastim, pegfilgrastim, and epoetin, these therapies are considered supportive care as opposed to oncology treatments. Volume determined by eaches, defined as the number of single items (vials, syringes, bottles, etc.) contained in a unit or shipping package.

Over 75% of cancer patients must overcome an initial rejection for their medication, regardless of payer channel

Exhibit 4: Initial and final 30-day claim status by payer channel, branded oral oncology therapy, 2020-2023



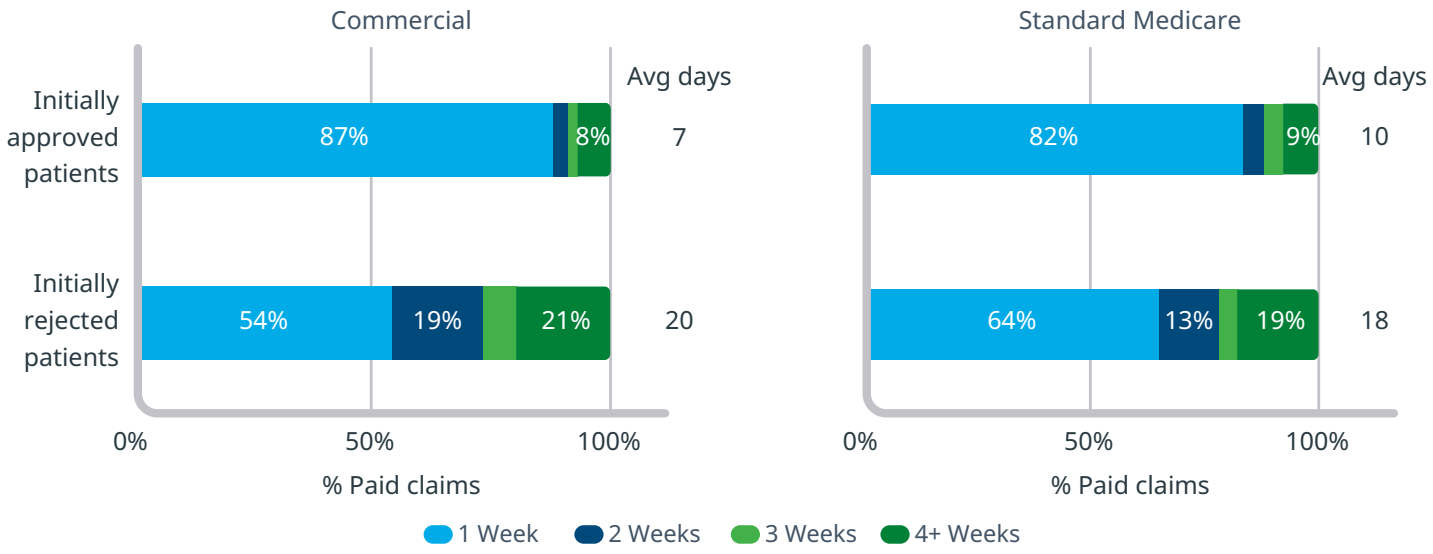
Source: IQVIA LAAD Pharmacy Claims data; U.S. Market Access Strategy Consulting analysis

- Patients can face one of three types of rejections: a rejection that the product is not covered on formulary; a rejection specifying that prior authorization (PA) or step therapy is needed; or an administrative rejection (e.g. a patient is filling a product too soon or quantity limit).
- Only 10% of Commercial and 23% of Medicare patients are approved on their first attempt to fill a branded oral oncology therapy.
- The most common rejection type for all patients was a PA or step requirement, necessitating additional provider input for approval and burdening providers with paperwork/tests.
- For Commercial patients, half of all administrative rejections were due to requirements that patients fill through specified, specialty pharmacies.
- The increasing integration of payers and pharmacies lends itself to narrower networks for patients.
- Despite 81% approval, only half of new Medicare patients ultimately filled their oral oncology medication within 30 days of an initial attempt.
- The high abandonment in Medicare was most likely due to the especially high costs patients face.
- Having already eliminated Catastrophic coinsurance in 2024, the IRA will also lower the out-of-pocket cap in 2025.
- However, industry stakeholders expect controls to grow even more strict in Medicare Parts D and B as IRA increases payer liabilities.

Notes: Brands include treatments against breast, lymphoma, leukemia, prostate, and non-small cell lung cancer;
An Initial claim status is defined as a patient's first attempt to fill a prescription; final status is the ultimate outcome of the claim 30 days after the initial attempt.

Payer rejections delay Commercial and Medicare patients from initiating therapy by an average of three weeks

Exhibit 5: Time to treatment by initial claim status, branded oral oncology therapy, 2020-2023



Source: IQVIA LAAD Pharmacy Claims data; U.S. Market Access Strategy Consulting analysis

- Payer rejections can often place multiple, time-consuming requirements on patients and providers before approval, such as authorization forms, additional tests, changes in distribution site, etc.
- Administrative or physical delays may make it so that patients do not always fill or receive therapy on the same day payers approve their prescriptions.
- Of the patients who were initially rejected, only 57% of Commercial and 47% of Standard Medicare ultimately filled their therapy within 365 days.
- For Commercial and Medicare patients who were approved on their first attempt, 87% and 82% of them, respectively, filled therapy within one week of the initial attempt, compared to 54% and 64% of patients who were initially rejected.
- Around 20% of initially-rejected patients had at least a 4-week delay in initiating therapy.
- It took nearly three times as long for Commercial patients who were initially rejected to initiate therapy (20 days) versus those who were initially approved (7 days); for Medicare patients it took 1.5 times as long (10 days vs 18).
- Rejections may be intended to manage utilization of costly therapy, but they can cause delays for patients starting clinically necessary treatment.

Notes: Brands include treatments against breast, lymphoma, leukemia, prostate, and non-small cell lung cancer; Any fill within 365 days of initial attempt is included.

Dispensing site effects

Patients can acquire their medications from a number of different dispensing sites and points-of-sale. For oncology patients, these include medically integrated on-site practice pharmacies, specialty/mail pharmacies, and retail pharmacies, each offering unique advantages.

Medically integrated pharmacies have the benefit of bringing patients, providers, and pharmacists together in one place, facilitating their ability to work through obstacles live and in-person. Similarly, specialty/mail pharmacies are skilled in the swift distribution and support of specialty medications, such as oral oncology medicines. Retail pharmacies (from local independents or large retail supermarkets) can be places patients frequent in their daily routines and may prefer to use due to their familiarity and accessibility.

Pharmacy networks have become the norm in oncology, and they can be leveraged as yet another form of payer control and utilization management. Between mandated specialty/mail and medically integrated pharmacies, our analysis indicates both are lower risk for prescription abandonment.

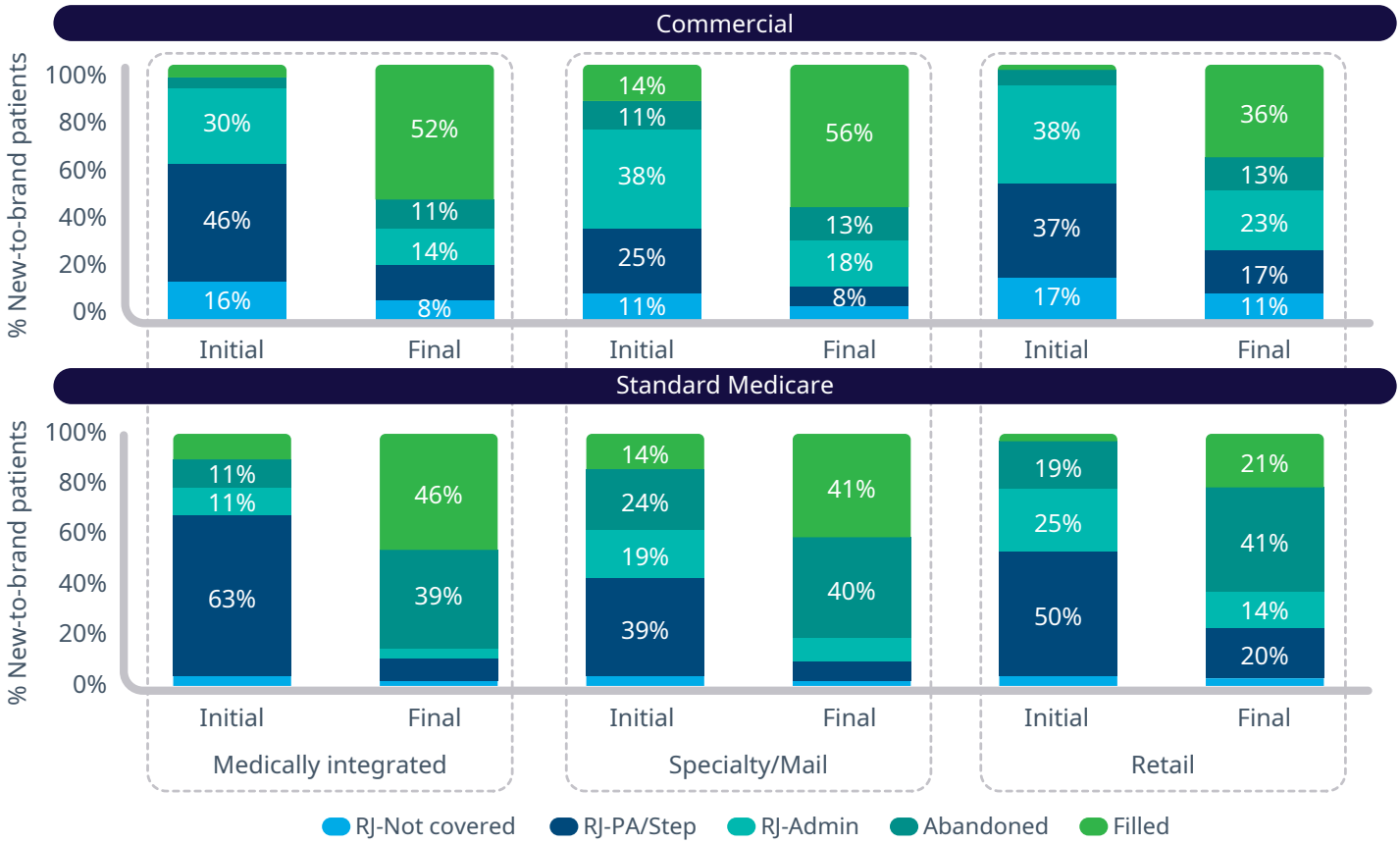
As the dispensing landscape evolves, understanding how different settings impact patient access will help to inform future conversations around the optimal way patients can and should obtain their therapy.

KEY TAKEAWAYS:

- Patients at retail pharmacies faced the greatest proportion of and most durable rejections across pharmacy sites.
- Specialty/mail pharmacies had the greatest initial approval rates for all new patients.
- Despite not having the highest rate of initial approval, medically integrated pharmacies were just as efficient as specialty/mail pharmacies in helping patients overcome rejections.
- Patients who overcome access hurdles at retail pharmacies are at a greater risk of waiting over two months to initiate therapy than those at specialty/mail or medically integrated pharmacies.
- Patients were twice as likely to abandon therapy at retail sites (31% Commercial, 64% Medicare), while medically integrated and specialty/mail pharmacies had similar fill rates (18% Commercial, 37% Medicare).
- In both Commercial and Medicare, retail pharmacies had the greatest proportion of costs above $250 (22% and 70%, respectively) compared to specialty/mail (15%, 63%) and medically integrated pharmacies (15%, 58%).

Patients face heavy initial restrictions, but most medically integrated and specialty/mail rejections are ultimately approved

Exhibit 6: Initial and final 30-day claim status, branded oral oncology therapy, 2020-2023



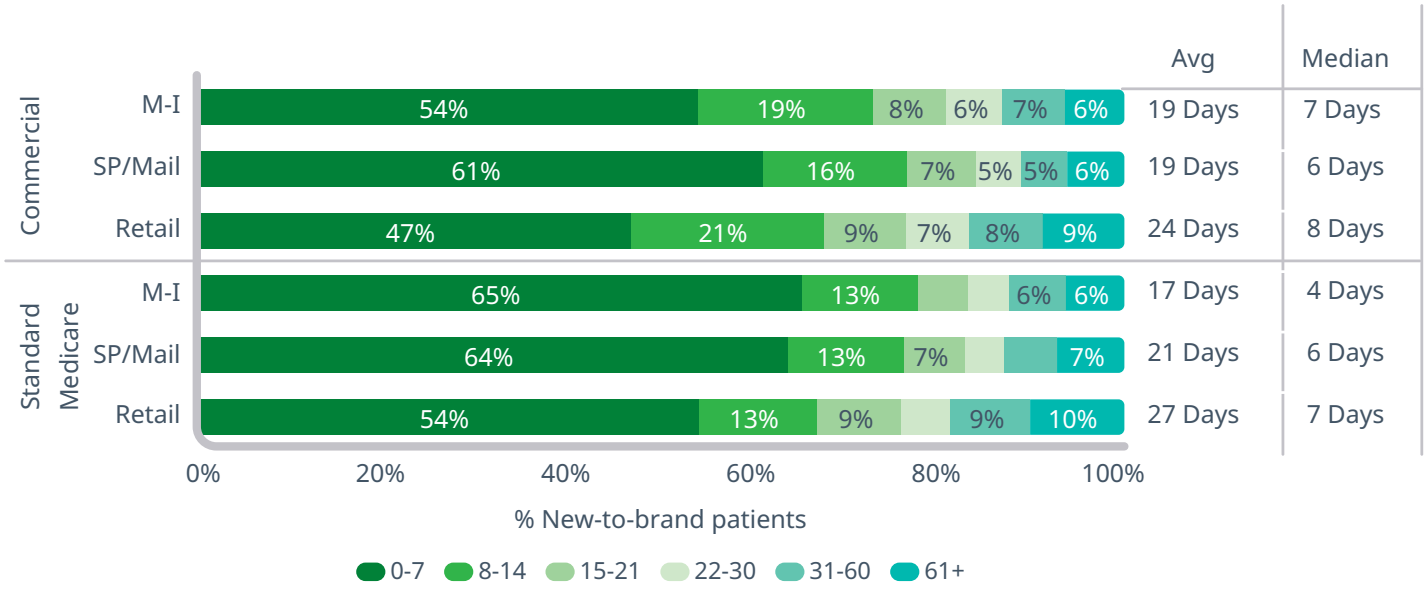
Source: IQVIA LAAD Pharmacy Claims data, IQVIA Market Access Strategy Consulting analysis

- With fewer PA/Step rejections, specialty/mail pharmacies had the greatest initial approval rates for new Commercial and Medicare patients.
- Commercial patients faced high administrative rejections across sites, while control for Medicare patients took the form of PA/Step rejections.
- Regardless of site, administrative rejections in Commercial were mainly made up by requirements for patients to fill at specified pharmacies.
- Patients at retail pharmacies had the hardest time overcoming their initial rejections.
- Retail pharmacies had both the lowest rates of initial and final approvals, with only 36% of Commercial and 21% of Medicare patients filling their scripts.
- Overall, medically integrated pharmacies and specialty/mail pharmacies had similar patterns of therapy initiation.

Notes: Initial claim status is defined as a patient's first attempt to fill a prescription; final claim status is the ultimat e outcome of the claim 30 days after the initial attempt.
Brands include treatments against breast, lymphoma, leukemia, prostate, and non-small cell lung cancer

Medicare patients are quickest to overcome rejections at medically integrated sites, which took 2.5 weeks on average

Exhibit 7: Time in days from initial rejection to fill within 1 year, branded oral oncology therapy, 2020-2023



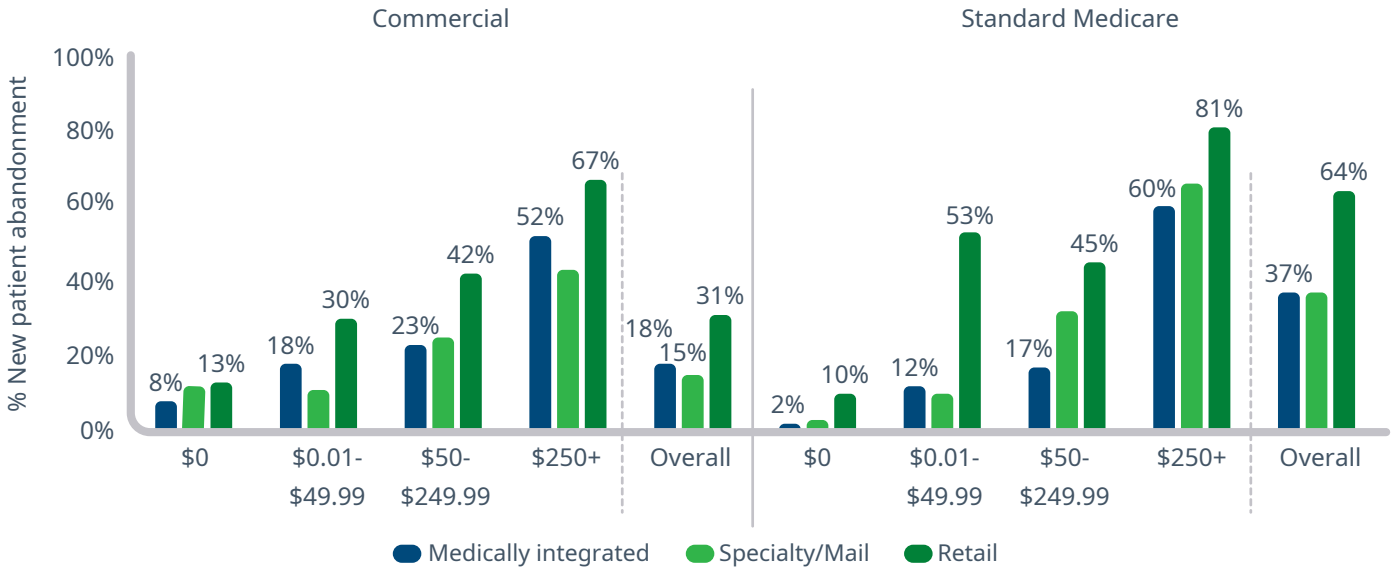
Source: IQVIA LAAD Pharmacy Claims data; U.S. Market Access Strategy Consulting analysis

- Payer rejections cause quantifiable delays in treatment starts and can vary across pharmacy type.
- For Commercial patients, 46% at retail sites filled their prescriptions within one year after an initial rejection; 58% at specialty/mail filled; and 60% at medically integrated sites filled.
- Some patients work through access challenges at the same pharmacy location, while others may switch to a new pharmacy and/or pharmacy type.
- For Medicare patients, 29% at retail sites filled their prescriptions within one year after an initial rejection; 44% at specialty/mail filled; and 53% at medically integrated sites filled.
- Most patients overcame rejections within a week of an initial attempt, but on average, patients were not able to initiate therapy for at least 2.5 weeks.
- Medicare patients in medically integrated pharmacies overcame rejections in the least amount of time.
- Across payer channels, those who faced initial rejections at retail pharmacies took the longest time to initiate therapy while overcoming those barriers.
- Unlike medically integrated and specialty/mail pharmacies, retail pharmacies are less automated and have a limited infrastructure when handling restrictions on patients' medications.
- Medically integrated pharmacies especially benefit from having providers on-site, facilitating quicker success through rejections requiring provider input.

Notes: Brands include treatments against breast, lymphoma, leukemia, prostate, and non-small cell lung cancer; Any fill within 365 days of initial attempt is included.

Patients abandon at different rates by pharmacy type and can reach 67%-81% when costs exceed $250

Exhibit 8: New patient abandonment, branded oral oncology therapy, 2020-2023



Source: IQVIA LAAD Pharmacy Claims data; U.S. Market Access Strategy Consulting analysis

- Patients are considered to have abandoned their prescriptions if they have not filled their therapy within 90 days of gaining payer approval.
- Retail pharmacies had the highest abandonment rate regardless of cost.
- 31% of approved Commercial patients at retail pharmacies did not fill their treatment, while 64% of Medicare patients abandoned theirs.
- Increased abandonment at retail pharmacies may be due to unique hurdles characteristic of retail locations that could include transportation, mobility, and time.
- Additionally, retail sites may not have the resources — or inventory — to support patients on specialty medications.
- Across all dispensing sites, increased patient cost exposure led to increased abandonment, with over 50% of patients not filling prescriptions over $250.
- Over 75% of all Commercial patients faced costs below $50, while 60% of all Medicare new-to-brand prescriptions had costs above $250.
- Overall, patients who attempted to fill at either a medically integrated or SP/mail pharmacy site had similar abandonment rates.

Notes: Brands include treatments against breast, lymphoma, leukemia, prostate, and non-small cell lung cancer.

Financial support in oncology

Due to specialty tiering and price-based coinsurance, cancer patients may face hundreds of dollars in costs per prescription. Financial support in the form of manufacturer-sponsored copay cards in Commercial and charitable foundations in Medicare play a necessary role in offsetting patient out-of-pocket costs, and thus, facilitate treatment initiation.

Without such assistance, patients abandon their prescriptions at a greater rate and do not initiate treatment for the medicines they were prescribed. For both Commercial and Medicare patients, financial support can be crucial to therapy initiation and maintenance. Patients with financial support are also more likely to stay on therapy over the course of a year than those without.

Standard Medicare patients are especially prone to high costs during the gap phase of coverage — a phase the IRA will sunset in 2025 along with adding a $2,000 cap on total patient spending. On the cusp of major changes to the standard Part D benefit, optimists would believe that affordability has been solved for Medicare patients, but foundations will still be necessary for many.

Foundations, already strained and dependent on manufacturers for funding, may find that resources are threatened as the IRA affects manufacturer budgets.

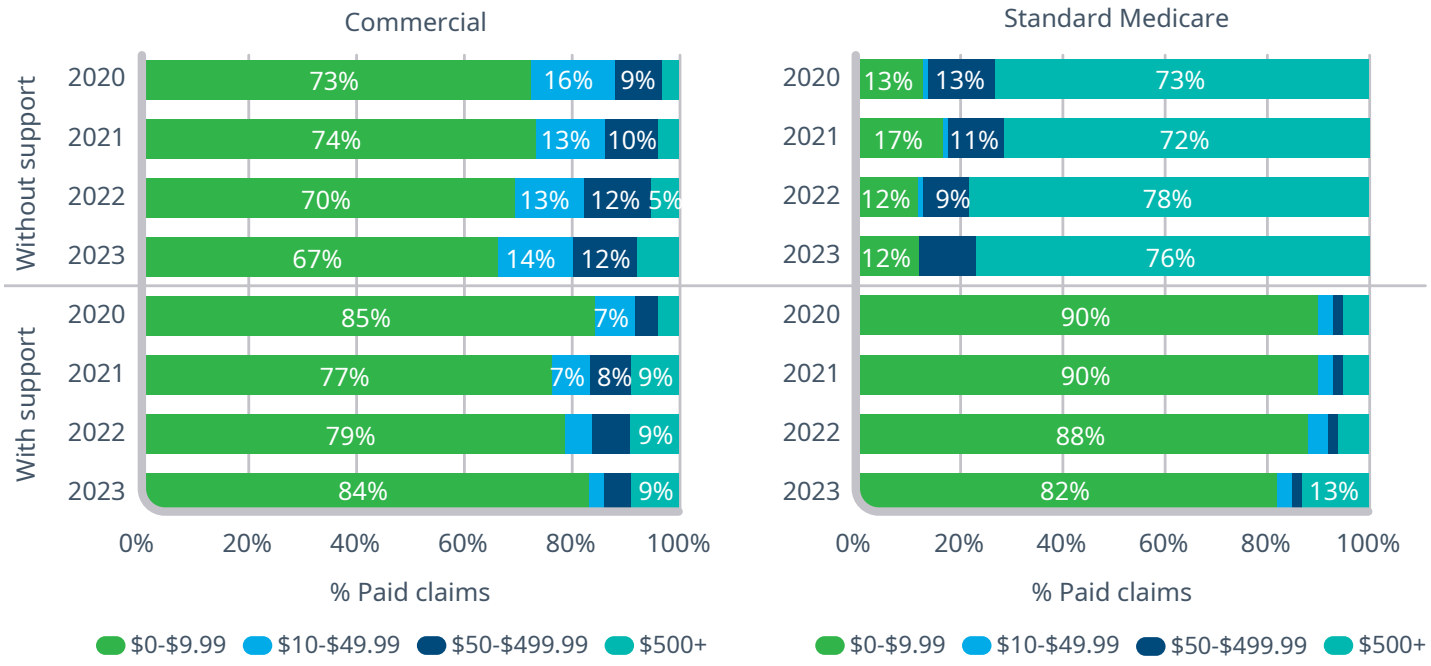
KEY TAKEAWAYS:

- For 2023, 68% of Commercial patients utilized copay support, while 43% of patients utilized foundations in Medicare.
- With no support, 76% of Medicare patients faced prescription costs above $500 compared to 13% with copay support.
- Commercial patients did not face prescription costs as high as Medicare patients, however, 84% of Commercial patients utilizing support paid less than $10 per prescription versus 67% without support.

- Commercial patients with no financial support were three times more likely to abandon their new-to-brand prescriptions (22%) than those with support (7%); Medicare patients were 10 times more likely (49% vs 5%) to abandon without support.
- Medicare patients who utilized support were about 20% more likely to maintain therapy one year post-initiation than those without financial support.
- Twelve months after a Commercial patient's first fill, 30% of non-support patients were still filling their medication, compared to 34% who had used support.
- Since the implementation of the IRA's Part D redesign, third-party support spend dropped by 22%.

Patients who fill with copay support face lower costs than those without it, though Medicare patients have the greatest need for them

Exhibit 9: Normalized adjudicated claim distribution, branded oral oncology therapy, paid claims



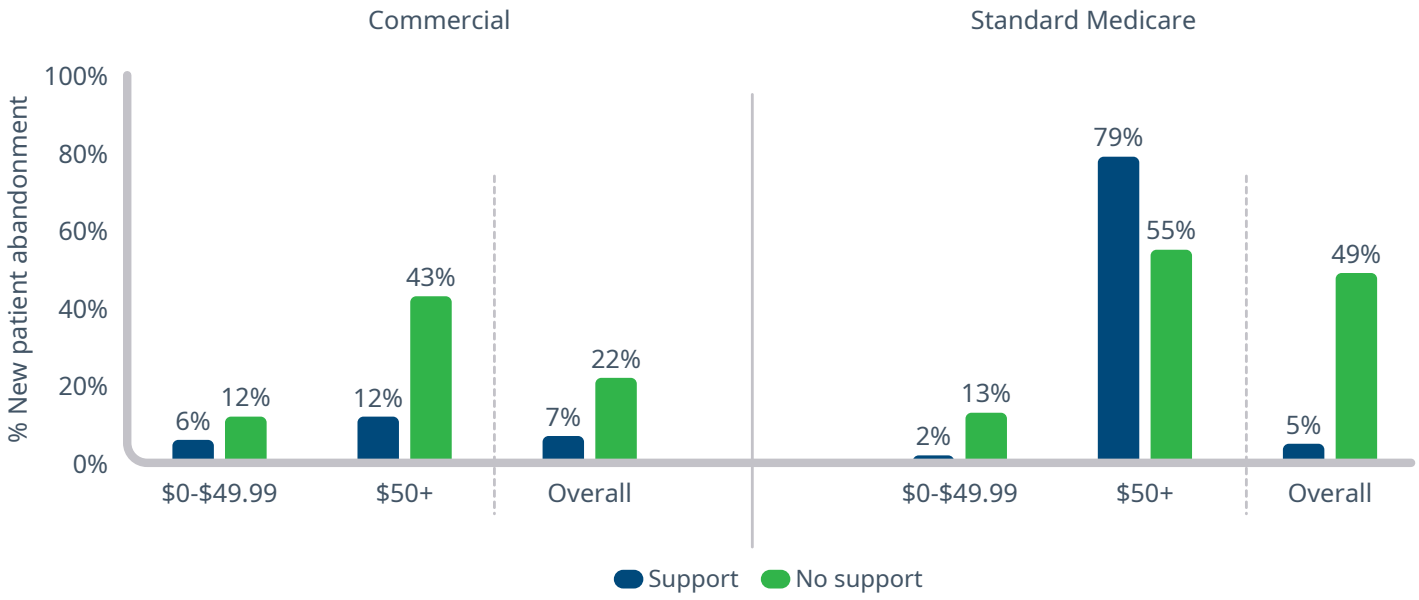
Source: IQVIA LAAD Pharmacy Claims data; U.S. Market Access Strategy Consulting analysis

- Nearly three-quarters of Commercial patients use some form of copay support, whereas in Medicare, half of patients seek support mainly from charitable foundations.
- Commercial claims with copay support have lower costs than those without it; however, Commercial patients generally don't face costs as high as Standard Eligible patients.
- Over 70% of Medicare claims that did not utilize copay support had costs greater than $500; in the same time periods, between 82% and 90% of Medicare claims utilizing copay support cost under $10.
- As IRA changes to the Part D Benefit design take effect in 2024 and 2025, cost exposures will change for Medicare patients, most likely reducing out-of-pocket (OOP) costs as patients progress through phases of coverage.
- In addition, foundations may struggle to adapt to the Medicare Prescription Payment Plan, in which patients can pay medication costs in monthly installments over the course of the year.

Notes: Brands include treatments against breast, lymphoma, leukemia, prostate, and non-small cell lung cancer;
Patient support classification is defined as having at least one paid claim with primary or secondary support for each patient-product combination. All paid claims normalized to a 30-day supply.

Medicare patients without financial support abandon their oncology prescriptions 49% of the time due to high costs

Exhibit 10: Abandonment by support use, branded oral oncology therapy, 2020-2023



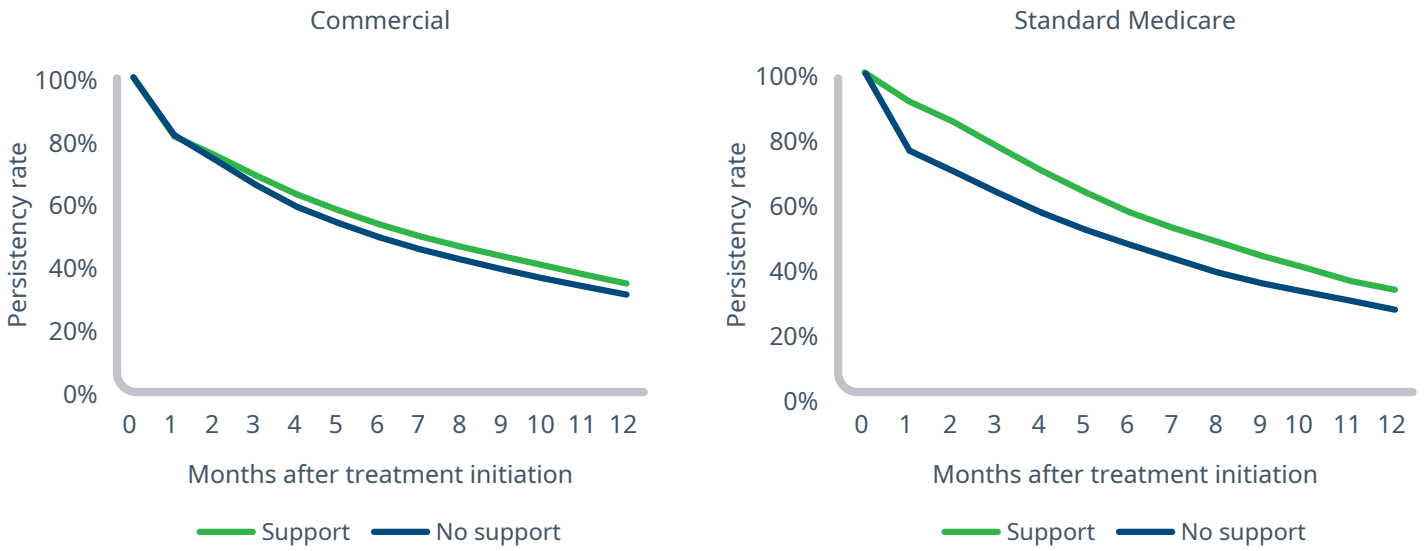
Source: IQVIA LAAD Pharmacy Claims data; U.S. Market Access Strategy Consulting analysis

- Without copay support, patients are three to ten times more likely to abandon their new-to-brand prescriptions.
- 22% of new-to-brand Commercial patients abandon their prescriptions when they do not have copay support, compared to only 7% of patients that do have copay support.
- On average, Medicare patients with copay support were asked to pay $78 for their first oral oncology prescription, while those with no financial aid faced an average cost of $1,783.
- With patients facing high costs, it is no surprise that almost half, 49%, of Medicare patients who did not have financial aid chose not to fill their oral oncology medication.
- Though a relatively small number of patients, Medicare patients who utilized copay support but still faced high costs, tended to abandon more often than no-support patients.
- As Standard Medicare patients tend to be older, retired, and on fixed-incomes, they are particularly sensitive to high costs.

Notes: Brands include treatments against breast, lymphoma, leukemia, prostate, and non-small cell lung cancer
Patient support classification is defined as having primary or secondary support for a patient's first approved claim for an individual product. .

Medicare patients who utilize copay support are about 20% more likely to continue therapy than those without

Exhibit 11: New patient persistency by month after treatment initiation, branded oral oncology therapy, 2020-2023



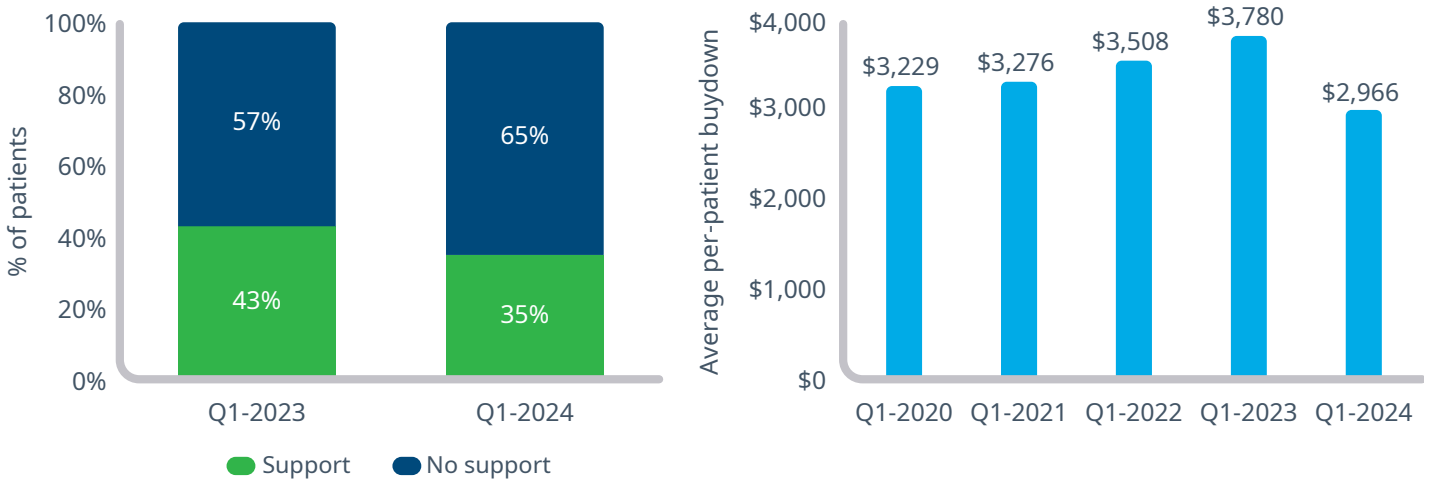
Source: IQVIA LAAD Pharmacy Claims data; U.S. Market Access Strategy Consulting analysis

- Persistency is measured by the proportion of patients, relative to the start of therapy, who continue filling their prescriptions in the months following initiation.
- Commercial patients tended to drop off therapy at similar rates regardless of copay support.
- Twelve months after a Commercial patient's first fill, 30% of non-support patients were still filling their medication, compared to 34% who had used support.
- The greater separation in persistency between Medicare patients who did and did not use copay support aligns with their differences in costs.
- Overall, persistency among patients with support was about 20% greater than those without.
- Twelve months after a Medicare patient's first fill, 27% of patients with no copay support were still filling their treatments, compared to 33% who had copay support.
- The IRA's 2025 cumulative OOP cap will most likely lead to overall lower patient costs, possibly improving future patterns of patient behavior as financial burden declines.

Notes: Brands include treatments against breast, lymphoma, leukemia, prostate, and non-small cell lung cancer;
Patient support classification is defined as having at least one paid claim with primary or secondary support for each patient-product combination. Analysis includes "one-and-done" patients who leverage a support program for their first and only adjudicated claim.

Support need and spend dropped with 2024 IRA changes, an early sign of what's to come with the 2025 IRA out-of-pocket cap

Exhibit 12: Financial support prevalence and average per-patient third-party support spend, branded oral oncology therapy, Standard Eligible Medicare, paid claims



Source: IQVIA LAAD Pharmacy Claims data; U.S. Market Access Strategy Consulting analysis

- In 2024, the IRA eliminated 5% patient coinsurance in the Catastrophic phase of coverage, having effectively implemented an approximately $3,300 OOP cap for Standard Eligible patients.
- In response to these changes, the Patient Action Network (PAN) Foundation reduced their annual oncology benefit from $7,000 to $3,250 for the year 2024.[6]
- Compared to last year, Standard Eligible patients utilized foundation support for pharmacy claims less frequently in Q1-2024, with 43% of patients utilizing it in Q1-2023 vs 35% in Q1-2024.
- Lower total patient spend in 2024 contributes to the lower need by patients for financial support for pharmacy claims.
- Per-patient spend by third-party support programs dropped by 22% for Q1-2024 as compared to the first quarter of 2023.
- Lower spend per-patient could be due to a reduction in patient need and/or to the reduction in PAN or other foundation per-patient benefits.

Notes: Brands include treatments against breast, lymphoma, leukemia, prostate, and non-small cell lung cancer;
Patient support classification is defined as having at least one paid claim with primary or secondary support for each patient-product combination.

The past, present, and future of control in oncology

New oncology innovations increase the number and variety of available cancer treatments. Yet, with more medicines comes more payer control, partially due to ongoing efforts to manage payer-leveraged market competition and partly the result of ongoing efforts to manage overall drug utilization and costs. The unfortunate side effect of managed oncology medicines is the likely delay or disruption of cancer therapy.

When payer coverage is available, patients may still face obstacles in the form of cost-sharing as well as limited pharmacy networks that channel prescriptions through specific dispensing sites. Specialty/mail pharmacies may provide delivery convenience for some, but for patients opting to use medically integrated and retail pharmacies, payer restrictions and other site- related challenges can further put off treatment.

The Inflation Reduction Act is expected to accelerate the trends that have already been observed. The IRA stands to reduce total patient costs and minimize CMS liabilities through price negotiation and Part D redesign. Yet the system will absorb these shifting costs elsewhere such that manufacturer and payer liabilities are likely to increase. Not only could this bring even greater stress to the controls already in-place for the Medicare benefit, but it could also strain the budgets available for patient support programs. It is believed that the effects of the IRA on Medicare will spill over into Commercial insurance as well.

Though time alone can tell what will come from the IRA and any second-order effects, historical evidence provides a discouraging baseline for oncologics despite having been labeled as a protected class, and patients struggled for access despite clinical necessity. Thus, manufacturers of in-market and pipeline medicines alike should expect to face an even more dynamic and potentially challenging landscape in the years to come.

Ultimately the patient is affected by these challenges, and it will be up to stakeholders across the industry to protect and support patient access.

Notes on sources

IQVIA Longitudinal Access and Adjudication Data is made up of nearly 4 billion U.S. prescription claims per year, with history from January 2006 with coverage over 90% for the retail channel, 60-85% for mail service, and 75-80% for long-term care. Longitudinal data derives from electronic data received from pharmacies, payers, software providers, and transactional clearinghouses.

This information represents activities that take place during the prescription transaction and contains information regarding the product, provider, payer, and geography. Rx data is longitudinally linked back to an anonymous patient token and is linkable to events within the data set itself and across other patient data assets.

IQVIA National Sales Perspectives measures revenue within the U.S. pharmaceutical market by pharmacies, clinics, hospitals, and other healthcare providers. NSP reports 100% coverage of the retail and non-retail channels for national pharmaceutical sales at actual transaction prices. The prices do not reflect off- invoice price concessions that reduce the net amount received by manufacturers.

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About IQVIA's Market Access Center of Excellence

With a passion for innovation, quality, and customer service, IQVIA's Market Access COE is at the forefront of industry trends in biopharma and therapy access. The COE's portfolio of services includes patient engagement and commercial solutions that continue to advance a long-standing mission to the enhancement of patient access and health outcomes while delivering an unyielding focus on driving client satisfaction. Market Access is committed to driving real change for its clients and patients by way of newly combined offerings, expertise, and talent from the diverse organizations of 1,000+ dedicated individuals within it.

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