The treatment of rheumatic diseases has changed dramatically in the last 15 years with the advent of new, effective therapies and the reassessment of older medications, leading now to the concept of treating patients to target and working to avoid disability and deformity. Along with this revolution in treatment has come a significant increase in the direct costs of therapy, especially as related to the expense of biologic medication. This reality has resulted in payers and prescribers attempting to rationalize the use of these therapies by utilizing various strategies. These have included requiring various older medications to be used first, as well as selecting only patients with certain levels of disease activity to be given access to the biologics. This had led to situations where patients with similar diseases, but different insurance companies, were not able to access the same medication. The provincial criteria for biologic access in the rheumatic diseases are also very different, so that portability of coverage across insurers and provinces is currently uneven and not particularly equitable.

To pro-actively address this situation, the Third Party Payer Committee of the Ontario Rheumatology Association (ORA), with the blessing of the Canadian Rheumatology Association (CRA), entered into discussions with the Canadian Life and Health Insurance Association (CLHIA), who were also interested in bringing more standardization to the system. For the first effort, it was decided to address biologic access for adults with Rheumatoid Arthritis (RA), as there are published treatment criteria from the CRA that had been well-accepted, and the disease is well characterized and relatively common. Given that the number of rheumatologists across the country is fairly small, it was felt that this was a reasonable first target for attempting to create pan-Canadian criteria for biologic access for private insurers.

Early on, it was decided that the actual biologic drug name was not as important as gaining access to biologics as a class. This was an important decision to allow the insurers to proceed further with the discussions. As a result, all the biologics approved for RA as of January 2014 were considered as a group, excluding Rituxan which is approved as a second-line drug after a first biologic in most cases. The criteria were derived from the evidence-based guidelines available, especially the Canadian Rheumatology Association guidelines for Rheumatoid Arthritis. CLHIA helped facilitate the discussion with its member insurance companies through meetings within industry, as well as a teleconference with the ORA/CRA committee members. The ORA/CRA team included Dr. Jane Purvis (committee lead), Dr. Art Karasik, Dr. Philip Baer, Dr Carter Thorne (ORA past president, CRA past president, CRA therapeutics committee lead), Mr. Denis Morrice, Ms. Dawn Richards (Canadian Arthritis Patient Alliance (CAPA) representative), with consultations from Dr. Cathy Flanagan and Dr. Jason Kur (British Columbia), Dr Cory Baillie (current CRA president, Manitoba), Drs. Jamie Henderson and Peter Docherty (New Brunswick), Drs. Fred Morin, Boulos Haraoui and Denis Choquette (Quebec) as well Drs. Janet Pope, Vandana Ahluwalia, Henry Averns, Nikhil Chopra, and Felix Leung (Ontario). Supportive and dissenting opinions were all carefully considered by the committee.

The final accepted criterion is as follows:

A minimum 12 week trial of Methotrexate plus one other disease modifying anti-rheumatic drug (DMARD). Where combinations of non-biologic DMARDs are impossible (a rare situation), 3 consecutive non-biologic DMARDs would be acceptable.

The agreement with the insurers is that, going forward, unless a plan sponsor instructs otherwise, private insurance plans will adhere to this standard criteria across the country. This initial step, reached with much discussion and consideration, is only our starting point on this journey, with plans to review
the functionality of the criteria after their use for a few months. Input from prescribers, insurers and patient groups will be welcomed. CLHIA along with the ORA/CRA team will meet to assess any modifications that may be required. It is hoped that this simple criterion, applied across all insurers across the country could lead to similar outcomes with provincial formularies for RA patients and we will be speaking with each province over the coming months to see if there is a willingness to move in this direction.

Respectfully,

Dr. Jane Purvis

Lead, Third Party Payer Committee

ORA/CRA