Good morning. Chairman Wachtmann, Vice-chair Gonzales, Ranking Member Antonia, and members of the House Health and Aging Committee, my name is Niesha Griffith and I am the Director of Pharmacy and Infusion Services for The Ohio State University Comprehensive Cancer Center – James Cancer Hospital and Solove Research Institute.

The only free-standing cancer hospital in central Ohio and the first in the Midwest, The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (OSUCCC – James) is a national and international leader in cancer prevention, detection and treatment. OSUCCC – James physicians and scientists focus on basic, clinical and translational research to improve patients’ lives and lessen the burden of cancer around the globe.

The OSUCCC – James is a 209-bed cancer hospital and one of only 41 comprehensive cancer centers designated by the National Cancer Institute (NCI), and one of only seven institutions nationally funded by the NCI to conduct both phase I and phase II clinical trials. With research funding greater than $100 million, $48 million of that from the NCI, OSUCCC – James researchers are advancing the understanding of cancer and translating that knowledge into new treatments, moving us one step closer to achieving our mission of a cancer-free world.

I am here today in support of Senate Bill 99: a bill that would address an obstacle that many of our cancer patients must overcome in order to get their prescribed therapy.

Our goal is to eliminate the cost disparity between oral and IV chemotherapy treatments and thereby decrease the out-of-pocket expense to cancer patients receiving oral chemotherapy.

The emergence of safe, clinically effective, orally administered anti-cancer medications has significantly increased the treatment options available to cancer patients. Currently over 30 percent of drugs in development for the treatment of cancer are oral chemotherapy agents. However, many barriers impede the adoption of orally administered treatment as primary cancer therapy despite the effectiveness of oral treatment. One significant barrier is
greater out-of-pocket expense for oral therapies (covered under the pharmacy benefit) than IV therapies (covered under the medical benefit). As a result, patient access to life-saving, oral anti-cancer therapies may be restricted, despite the fact that an oral agent may be the most appropriate and effective medication for a patient’s cancer.

Unlike intravenous chemotherapy products which are routinely well covered under medical benefits, with most patients paying only a copay, newer oral chemotherapy agents are often placed on the highest tier of the pharmacy benefit plan. As a result, patients may be subject to monthly drug costs in the thousands of dollars. With such high out of pocket expenses, oral chemotherapy is simply unaffordable to many patients. To address this, we support requiring health care service plan contracts and health insurance policies to provide coverage on an equal basis, for orally and intravenously (IV) administered anti-cancer medications.

Time is of the essence for cancer patients with a life threatening illness because, due to the progressive nature of the disease, any delays in treatment may result in worsening of the patient’s condition. We should not make a distinction between different forms of life saving medications in the fight against cancer when those distinctions can lead to delayed or compromised patient care.

Parity is expected to have a negligible cost increase\(^1\). Although 27 states have passed oral parity legislation, Ohio still lags behind, despite being one of the first states to introduce the legislation.

James Cancer Hospital patients are fortunate that staff are available to assist them with accessing the medication when they are faced with financial concerns by utilizing various charitable copay foundations. But not all oncology programs have the staff to assist patients and, more importantly, the copay foundations only have limited funds. We have seen them run out of funds in the past, leaving patients in the midst of cancer treatment unable to afford their next refill.

We recently treated a patient with a diagnosis of non-Hodgkin’s Lymphoma who is receiving Revlimid\(^\text{®}\) 10mg & 25mg orally. The patient is insured through an employer group plan through Medical Mutual of Ohio. The charge for one month of Revlimid\(^\text{®}\) is $11,763 and the patient’s copay is $1,650. The patient has an income of $26,770 for a two person household and cannot afford the copay of $1,650. The patient applied for copay assistance from a non-profit organization that provides funds for patients with NHL who are underinsured. The patient was awarded grants of $8000 and $5000 to be used for her Revlimid\(^\text{®}\). Imagine the scenario if we weren’t able to assist the patient or the copay foundation ran out of money. This is the reality of cancer care today for patients taking oral chemotherapy.

\(^1\) Kathryn Fitch, RN, Med, Kosuke Iwasaki, JIAJ, MAAA, MBA, Bruce Pyenson, FSA, MAAA, “Parity for Oral and Intravenous/Injected Cancer Drugs” Milliman, Inc., NY; January 25, 2010
Payment disparity should not force our cancer patients to make life and death decisions based on their out of pocket payments.

I urge your support for Senate Bill 99. I am happy to address any questions you may have.

Below are additional patient case examples.

**Copay Assistance Patient Examples**

**Case 1:**
Patient A has diagnosis of Stage 4 breast cancer and is receiving Xeloda® 500mg orally and Zometa® intravenously. She has insurance through United Healthcare and has an out of pocket deductible of $4000 before she receives any pharmacy benefits. (i.e., she must pay all $4000 prior to any pharmacy benefit being accessed) Zometa® is an intravenous agent administered in the outpatient clinic and is covered at 100% and with a $0 copay.

The patient charge for one month of Xeloda®, the oral medication, is $3,028. The patient has an income of $35,000 for a two person household and cannot afford the $3028 copay. The patient applied for copay assistance from a non-profit organization that provides funds for patients with breast cancer who are underinsured. She was awarded a grant of $7,500 to be used for her Xeloda®.

**Case 2:**
Patient C has a diagnosis of non-Hodgkin’s Lymphoma and is receiving Revlimid® 10mg & 25mg orally. The patient is insured through an employer group plan through Medical Mutual of Ohio. The charge for one month of Revlimid® is $11,763 and the patient’s copay is of $1,650. The patient has an income of $26,770 for a two person household and cannot afford the copay of $1,650. The patient applied for copay assistance from a non-profit organization that provides funds for patients with NHL who are underinsured. The patient was awarded grants of $8000 and $5000 to be used for her Revlimid®.

**Case 3:**
Patient D has a diagnosis of Lung Cancer and is receiving Tarceva®150mg orally and Alimita® intravenously. She has insurance through Blue Cross/Blue Shield. The Tarceva® is considered a specialty drug on her prescription plan with a 50 percent copay and no out of pocket maximum. Alimita® is an intravenous agent administered in the outpatient clinic and is covered at 100% and with a $0 copay.

The patient charge for one month of Tarceva® is $4,770 and the patient’s copay is $1,914. The patient has an income of $36,000 for a household of two and cannot afford the $1,914 copay. The patient applied for copay assistance from a non-profit organization that provides funds for patients with lung cancer who are underinsured. She was awarded grants of $7,500 and $4000 to be used for her Tarceva®.

**Case 4:**
Patient E has a diagnosis of CML and is receiving Sprycel® 70mg orally every day. She has insurance through Blue Cross/ Blue Shield. The patient has an out of pocket deductible of $5000 before she receives any pharmacy benefits. The patient’s copay for a one month supply of the Sprycel® is $3,959.

The patient has an income of $55,000 for a two person household and cannot afford the $3,959 copay. The patient applied for copay assistance from a non-profit organization that provides funds
for patients with CML who are underinsured. She was awarded a grant of $5,000 to be used for her Sprycel ®.

**Case 5:**
Patient G has a diagnosis of malignant melanoma of the skin is receiving Zelboraf® 720mg orally twice a day after completing a course of intravenous Taxol®. He has insurance through Medical Mutual of Ohio and has an 80% copay charge for one month of Zelboraf® medication. Taxol® which is an intravenous agent administered in the outpatient and is covered at 100% and with a copay of $0. The patient charge for one month of Zelboraf® is $7,953.28. The patient has an income of $33,000 for a one person household and cannot afford the $7,953 copay. The patient applied for copay assistance from the pharmaceutical manufacturer who provides medication for patients with melanoma who are underinsured for Zelboraf®.

**Case 6:**
Patient H has a diagnosis of Stage 4 breast cancer and is receiving Herceptin® intravenously and has finished her therapy of Xeloda® and Tykerb®. She has insurance through Aetna. Herceptin® is an intravenous agent administered in the outpatient clinic and is covered at 100% with a $0 copay. The Xeloda® and Tykerb® have an out of pocket deductible of $2000 before she receives any pharmacy benefits. (i.e., she must pay all $2000 prior to any pharmacy benefit being accessed). The patient charge for Xeloda® and Tykerb® is $3,286. The patient has an income of $60,000 for a four person household and cannot afford the copay. The patient applied for copay assistance and was denied because the patient was over the income limits. The patient borrowed money from her parents to pay for the medication.