Special Assessment of Outpatient Treatments for COVID-19: Final Policy Recommendations

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Policy Recommendations

Following its deliberation on the evidence, the Midwest CEPAC engaged in a moderated discussion with a policy roundtable about how best to apply the evidence on the use of outpatient treatments for COVID-19. The policy roundtable members included one patient advocate, two clinical experts, two payer representatives, and three representatives from the drug companies. The discussion reflected multiple perspectives and opinions, and therefore, none of the statements below should be taken as a consensus view held by all participants. The top-line policy implications are presented below.

Federal Government

Federal policymakers should view the advance market commitment strategy followed with outpatient COVID-19 treatments as a success that should be built upon.

The federal government's advance market commitment mechanism was effective in reducing the financial uncertainty that could deter manufacturers from bringing a drug to market. These financial risks are due to uncertainty regarding the expected market size and duration because of difficulty in predicting to FDA indication, uptake by providers, and evolving variants with different treatment susceptibility and virulence. The federal government's advance market commitment approach substantially reduced manufacturer risk and resulted in multiple drugs becoming available in a relatively short time at prices that were aligned with clinical benefit.

The framework for drug price negotiation between the government and drug makers during a pandemic should be made more transparent so that the public is aware of the parameters that the federal government considers in pricing negotiations.

There is a lack of clarity regarding the parameters that the federal government uses to negotiate drug prices and the justification for the amount of treatment purchased for different therapies. Such frameworks for pricing and volume should be determined prior to the pandemic.

The federal government should continue to include pricing protection clauses in future pricing negotiations in order to be good stewards of tax-funded budgets.

The contract terms between the federal government and Pfizer for Paxlovid were made public through a FOIA request.[1] The contract terms included a buyback clause in which Pfizer would buy back the US government's Paxlovid supply if its EUA were withdrawn. The contract also contained a most-favored nation clause, which guarantees that if one of six other high-income countries gets a lower price, the US would automatically get the same lower price. Such provisions provide assurance that tax-funded budgets are being used to purchase treatments that are aligned with clinical benefit.

The FDA needs to establish a clear and effective pathway for supporting evaluation of repurposed drugs.

Since manufacturers do not have a direct financial incentive to pursue FDA authorization to repurpose off-patent drugs for the treatment of COVID-19, the FDA needs to establish a proactive pathway to identify potential drugs where the data suggests that a review is warranted. For instance, this may include proactive outreach to study investigators to invite applications and providing technical assistance during application development as well as internal application initiation and development by the FDA.

The federal government needs to work with stakeholders to develop more robust data infrastructure and standardized treatment allocation approaches to achieve more efficient and equitable distribution of treatment supplies during a pandemic.

A recent study of Medicare beneficiaries reported that from November 2020 to August 2021 only 7.2% of outpatients with a new COVID-19 diagnosis received monoclonal antibody treatment.[2] A large proportion of these patients are likely eligible for treatment since older age and many chronic conditions common among the elderly are risk factors for severe COVID-19. The study also found that some of the highest risk patients were the least likely to receive treatment and that there was also substantial variation in the percent of patients treated across states with Rhode Island (21%) and Washington state (1%) having the highest and lowest percentages, respectively.

Greater investment in data infrastructure is needed to prioritize the communities where treatments are most needed. Often, these are communities in which there are many people of color or other communities in which access to care is inadequate. The federal government also needs to develop a standardized approach to allocating treatments to states and for states to collaborate with private distributors systems in a manner that ensures equitable and efficient distribution. Without appropriate data infrastructure and standardized approaches to distribution of supplies from the federal government to states and private entities, the distribution of new treatments for COVID-19 will continue to be ad hoc and likely to exacerbate inequities.

The federal government should work with states and other policymakers to adopt policy changes needed to improve the effectiveness of its "test-to-treat" program.

As of April 2022, there is a paucity of sites nationwide that provide point-of-care testing and treatment in a single visit.[3] While limited in number, CVS Health's "MinuteClinics" are an emerging example of how such a test and treat strategy can be implemented. These clinics have co-located services for testing, prescribing, and pharmacy supply where patients may access all three services in a single visit. Test-to-treat sites like these are greatly needed to more immediately link diagnosis with treatment.

One barrier to implementing test-to-treat is the FDA's restrictions on who may prescribe COVID-19 outpatient treatments.[4,5] Given the need for rapid and broad distribution of treatment during a pandemic, the federal government should consider working with states and professional stakeholders to broaden the functional scope of practitioners who can prescribe COVID-19 treatments. It may be possible to use telemedicine or other means to accomplish this goal, but allowing pharmacists to prescribe under certain circumstances should also be considered. Beyond prescribing, strategies should also be developed to increase the options for testing and for delivering medications to patients, including mobile units, kiosks, and even drones. This kind of infrastructure should be considered a long-term strategic priority for the federal government as it assesses preparedness for future pandemics.

The federal government needs to ensure that test-to-treat sites are equitably located.

COVID-19 has had a higher prevalence and greater severity within communities of color in the US. Non-White COVID-19 patients and patients living in rural areas appear to be less likely to receive neutralizing antibody treatment for COVID-19.[2,6,7] Further, test-to-treat sites, which offer the convenience of co-located services, may differentially benefit individuals with low incomes since these individuals may have lower means to make multiple visits to access testing and treatment. Therefore, the location of test-to-treat sites should address such access disparities.

Guideline Developers

Guideline developers (including clinical societies[8] and the National Institutes of Health[9]) should adopt certain best practices in guideline development. These include:

- Involving patients from diverse communities in guideline development to make sure that patient preferences are reflected in guidelines.
- Defining the target audience of their guideline, whether it is individual primary care providers or specialists, health system leaders, payers, or policymakers.
- Tailoring guidelines to the target audience such that the guidelines can serve as useful decision aids rather than just data summaries.
- To the extent possible, different guideline development groups should coordinate and communicate so that recommendations are consistent across groups.

Manufacturers

Manufacturers should anticipate from the earliest possible stage how they will share COVID-19 treatment intellectual property with low-income countries and, if possible, provide technical assistance with scaling of the manufacturing process.

Given the large global health burden of COVID-19, and the inability to contain spread of SARS-CoV2 across borders, it is imperative that we manage the pandemic from a global perspective.

Manufacturers should consider development of additional treatment options for immunocompromised patients.

There are seven million immunocompromised adults in the US. These individuals have among the highest risks for severe COVID-19.[10] Further, immunocompromised patients may remain infectious for a longer period of time than non-immunocompromised patients. Yet for immunocompromised patients, vaccines have lower efficacy in preventing severe COVID-19. Further, some patients on immunosuppressants may not be able to use Paxlovid due to drug interactions.[11] Molnupiravir may have relatively lower efficacy and has not specifically been tested in this population. Therefore, manufacturers should consider developing treatment options to address this unmet need.

Payers and Manufacturers

When COVID-19 drug pricing and payment moves from federal contracts into private markets, manufacturers and payers should work together to explore innovative approaches for coverage and pricing that minimize the use of restrictive coverage access as a means of cost control.

<u>Recommendations for Manufacturers</u>

- Manufacturers should price treatments so they are affordable to private insurance systems and patients. Aligning the price with the relative benefit to patients, as measured in cost-effectiveness analysis, is a good starting point, but other factors should be weighed as well. The scale and immediacy of the need for treatments can create an affordability challenge even with value-based pricing. Similarly, lower pricing or some form of installment payment over a longer time period may be warranted when there has been federal investment in the early science or later development of a drug.
- For uninsured and underinsured patients, manufacturers should collaborate with governmental policymakers to ensure that patients have access to treatments independent of their ability to pay out of pocket.
- Manufacturers should consider collaborating with private payers on innovative reimbursement approaches. For example, these approaches may include subscription-based models in which manufacturers provide as much supply of drugs as needed for a flat recurring fee.[12] Alternately, manufacturers and payers should consider volume-based

purchasing models similar to current federal contracts where a pre-specified volume of drugs are supplied at an agreed upon price.

Recommendations for Payers

- Given the need to treat COVID-19 rapidly upon symptom onset, payers should ensure that any prior authorization process leads to immediate coverage for an available and appropriate treatment and does not risk having patients not fill their prescriptions.
- The treatments available currently through EUA are so different in their effectiveness and their risk and side effect profiles that any form of step therapy would not be clinically appropriate. In the future, if there are multiple therapeutically equivalent oral outpatient treatment options for COVID-19, payers may consider formulary negotiation approaches that include the possibility of step therapy as long as those coverage policies follow criteria established to protect patients.

Researchers

Future research is needed to understand the epidemiology of long COVID and the impact of different prevention and treatment strategies on this condition.

Current estimates of the number of Americans with long COVID are imprecise, but may be as high as eight to 23 million.[13] Common symptoms include fatigue, shortness of breath, and cognitive dysfunction typically one to three months after initial infection.[14,15] Given the potentially large population and non-specific symptoms, more research is needed to understand the incidence, prevalence, risk factors, and symptoms of long COVID as well as ways to prevent and treat this condition. Among the treatments of interest in our review, we identified only one study that evaluated the impact of treatment on long COVID,[16] although we identified other treatments in earlier stages of development focusing specifically on treatment of individuals with long COVID.[17-20] We recommend that the clinical research community work with patients in the design and conduct studies of long COVID and that the federal government fund these studies.

Future research is needed to define and measure the effects of treatments on a more inclusive set of patient-centered and societal outcomes.

The key trials in our review primarily measured efficacy in clinical terms including viral load, hospitalization, and death. In these trials, there was a lack of inclusion of patient-reported outcomes and a lack of uniformity in those outcomes when they were reported. The key trial for Paxlovid did not measure patient-reported outcomes.[21] The key fluvoxamine trial[22] measured the patient-reported outcomes measurement information (PROMIS) Global Health Scale while the key molnupiravir trial[23] measured specific patient-reported COVID-19 symptoms. Researchers should work to define patient-important outcomes and clinical trialists should apply them uniformly across trials. For instance, patient-important outcomes in COVID-19 could include time to recovery and

restoration of activities of daily living. Further, the impacts of improving ICU capacity, caregiver burden, and broader impacts on the opening of education and businesses are important societal outcomes that require better measurement.

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