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POSTER ABSTRACT

Experience of a Performance-Based Risk-Sharing Arrangement for the Treatment of Rheumatoid Arthritis With Certolizumab Pegol

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Introduction

In recent years, health systems have faced the challenge of guaranteeing access to increasingly innovative, complex and high-cost treatments. Risk-sharing arrangements arise as a collaborative work tool for healthcare providers and the pharmaceutical industry that can improve the access.

The performance-based risk-sharing arrangements (PBRSAs) are results-based reimbursement agreements in which the company that markets innovation risks a percentage of its revenues, negotiated with the healthcare provider, if the expected clinical outcomes are not met.

The high prevalence of Rheumatoid Arthritis (RA), its chronicity, the availability of a reliable and simple outcome measurement and the high proportion of patients treated with biologic disease-modifying anti-rheumatic drugs (DMARDbs) led us to apply PBRSA to guarantee rational pharmacotherapy. Our objective was to describe the process and results of the implementation of a performance-based risk-sharing arrangement for the use of certolizumab pegol (Cimzia) in patients with RA, based on rational pharmacotherapy.

Methods

In 2014, the area of Drugs and Supplies Management of the health maintenance organization of the Hospital Italiano de Buenos Aires signed a performance-based risk-sharing arrangement with Montpellier Laboratory for the use of certolizumab pegol in patients with RA. The laboratory would reimburse the hospital the cost of the first 10 doses of the drug if an optimal clinical response was not achieved (difference greater than or equal to 1.2 in the Disease Activity Score 28 with erythrocyte sedimentation [ΔDAS28 ESR] measured at the beginning and at the end of the first 12 weeks of treatment), or if the patient presented with an adverse drug reaction.

Results

Forty patients with RA were included between September 2014 and January 2018. Thirty-six patients completed 12 weeks of treatment, of which 25 (69.4 %) had an optimal clinical response (ΔDAS28 ESR $\geq$ 1.2). The laboratory reimbursed the hospital 116 doses of certolizumab pegol, corresponding to 12 patients (12 of 40, 30%). Eleven of them did not reach the optimal clinical response, and 1 presented with an adverse drug reaction.

Conclusions

The performance-based risk-sharing arrangement proved to be a useful tool to optimize the resources of the healthcare payer and contributed to the collection of scientific evidence in real-life patients.

Lessons learned

The implementation of a PBRSA for certolizumab pegol contributed to an improvement in the care processes of patients with RA through monitoring and protocolization of the prescription process. It also allowed us to evaluate the use and effectiveness of certolizumab pegol in real life, as response and adverse drug reaction rates may differ from the results of clinical trials.

Limitations

A limitation of this study was that physicians were aware of the existence of the contract and the protocol, so it could eventually bias the evaluation toward a greater response.

Suggestions for future research

Compare this type of experience with other Centers that carry out PBRSA to evaluate results, applicability and impact on the sustainability of the Health System.