February 25, 2009

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Office of Clinical Standards & Quality

Louis Jacques, MD
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Amy Bassano
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Center for Medicare Management

Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Dear Drs. Straube and Jacques, and Ms. Bassano,

On behalf of the physicians of the US Oncology National Policy Board[1], the physicians of the Pharmacy & Therapeutics Committee[2] of the US Oncology National Policy Board and all of the physicians in the US Oncology network, we are writing to offer our full support to the recent request of the American Society of Clinical Oncology (ASCO), in its February 9, 2009 letter (attached), that Centers for Medicare & Medicaid Services (CMS) advise National Government Services (NGS) that its recently announced policy disfavoring coverage of intravenous anti-emetics is inconsistent with national Medicare policy and must be rescinded. The US Oncology P&T Committee strongly concurs with

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[1] **The US Oncology National Policy Board (NPB)**
The US Oncology National Policy Board (the "NPB") advises US Oncology and US Oncology affiliated practices on policies and strategic initiatives that affect US Oncology's network of affiliated physician groups. The NPB's charter embraces a commitment to ensuring that neither access to, nor quality of care is compromised for cancer patients in America. The NPB is composed of the physician practice presidents of each of the US Oncology network affiliated practices. The NPB provides an essential platform for physician and management engagement within the US Oncology network and also serves as a platform for the US Oncology physician network's national government relations and public policy voice.

[2] **The US Oncology Pharmacy and Therapeutics (P&T) Committee**
The P&T Committee of the US Oncology National Policy Board is the physician body that sets quality and efficiency standards for all aspects of drug use in the offices of almost 1000 community-based oncologists in 39 states. The P&T Committee has been in place for over 10 years, providing quality of care guidance to the care of over 650,000 of the nation's cancer patients who are seen in the US Oncology network annually. Of most importance, the primary goal of the P&T Committee is to advance evidence-based pathways to assure the delivery of the highest quality care, with optimal patient outcomes, throughout the network.

ASCO in that NGS' new policy is both contrary to national Medicare policy and contrary to the interests of Medicare beneficiaries fighting cancer.

Furthermore, it is our understanding from discussion with NGS Carrier Medical Director Dr. Paul Deutsch that NGS has informed CMS of its intention to implement the provisions of its January 13 announcement[3] on March 1, 2009 if CMS does not take action to clarify the policy. CMS has both the authority and the opportunity to direct NGS to rescind its recent policy announcement and to require NGS to cover medically necessary intravenous anti-emetics without requiring a patient to have first failed on oral anti-emetics. We respectfully request that CMS take this action before March 1, 2009.

Clinical Issues Surrounding Effective Anti-emetic Therapy in Elderly Cancer Patients

The evolution of anti-emetic therapy over the last 20 years is one of the great success stories in supportive care. It has made outpatient chemotherapy tolerable and feasible. Patients have consistently reported that nausea and vomiting are top among the most distressing aspects of chemotherapy[4]. In the past patients decided to abandon therapy because of uncontrolled nausea and vomiting. Indeed, reports found that 10% to 40% of patients refused chemotherapy due to poorly controlled nausea and vomiting[5]. Serotonin antagonists given as standard prophylaxis for moderate and highly emetogenic chemotherapy changed all of that, providing complete protection from acute emesis 70% to 80% of the time[6].

We are concerned about the proposed restriction by NGS on the use of these agents in a manner consistent with current standard of care. The intravenous formulations are the standard of care for chemotherapy induced nausea and vomiting (CINV) as these were the initial formulations tested. Most of those trials were never repeated with the oral formulations even though hepatic first pass effects and genetic polymorphisms are known to influence the presence and effectiveness of active drug when drugs are taken by mouth[7].

Unlike acute nausea and vomiting, anticipatory nausea and vomiting is a syndrome known to be refractory to all known anti-emetic agents. It is believed to be a conditioned

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[3] Posted on the NGS Website January 13, 2009:
Use of Injectable Medications When an Oral Equivalent is Available
National Government Services would like to remind providers that the use of injectable medications when an oral form of the same medication is available must meet medical necessity requirement for the use of the drug, and for the route of administration. Documentation should indicate that the patient was unable to tolerate the oral preparation prior to initiation of the intravenous form of the medication. An example is a failed course of the oral anti-emetic before starting an intravenous form of the same anti-emetic. Instruction regarding this topic is from the Centers for Medicare & Medicaid Services (CMS) and is national not a local determination.

[4] Coates A et al, Ann Oncol 1990;1:213-217; Coates A et al, Eur J Cancer Clin Oncol 1983;19:203-208; Griffen AM et al, Ann Oncol 1996;7:189-195

[5] Lindley C, J Clin Oncol 1989;7:1142-1149; Wilcox PM etal, Cancer Treatment Rep 1982;66:1601-1604

[6] Gandara DR et al, Support Care Cancer 1998; 6:237-243

[7] Kaiser R, J Clin Oncol 2002;29:2805-2811; de Wit R et al, Cancer Chemo Pharmacol 2005;556:231-238

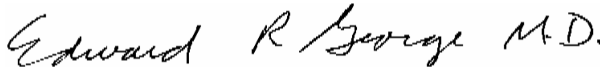
response following poorly controlled prior episodes[8]. Since IV serotonin antagonists have such high rates of complete control, this phenomenon is rarely seen in current practice. We are concerned that forcing patients to experience failure with an oral serotonin antagonist before permitting them to receive the standard of care leaves them at risk of a syndrome that cannot be adequately managed.

The policy represents a clear shift in responsibility for compliance to patients with complicated logistic demands on them. The oncology medical literature is replete with evidence that compliance with and adherence to oral anticancer therapies is remarkably low even among patients with cures at stake. Early studies in patients with hematologic malignancies where blood levels could be measured suggested that patient self reporting can overstate adherence by a factor of 2[9]. More recent data are little better with reports ranging from less than 20% to 100% depending upon the population studied and the methodology used. Patients most at risk may be those in the extremes of age[10]. Non-adherence compromises the therapeutic benefit of any drug and has been associated with early discontinuation of some therapies[11]. Non-compliance or inaccurate self reporting of compliance with oral anti-emetics prior to chemotherapy would risk a return to the problems of the past with protracted vomiting, dehydration, even refusal to continue treatment.

The nation's elderly are especially sensitive to the serious physiologic consequences of protracted nausea and vomiting. We believe that they should not be subjected to a different, largely unproven standard of care that would put them at risk. Therefore, we strongly encourage reconsideration of the policy decision to change the medical standard of care for prophylaxis of CINV.

The US Oncology P&T Committee and the physicians of the US Oncology Network request that CMS take action to avert the patient care consequences of allowing the NGS policy announcement to be implemented on March 1, 2009. We are glad to meet with you, discuss with you by phone our concerns or assist you with any further information you may need. Thank you in advance for your consideration of this request.

Sincerely,



Michael Kolodziej, MD
Chairman,
US Oncology P&T Committee

Edward R. George, MD
Chairman,
US Oncology National Policy Board

cc: Paul Deutsch, MD

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[8] Watson et al, Support Care Cancer 1993;1:171-178
[9] Levine AM et al, J Clin Oncol 1987: 1469-1476
[10] Partridge AH et al, JNCI 2002;94: 652-661
[11] Barron TI etal, Cancer 2007;109:832-839