NORTHERN TERRITORY GOVERNMENT | Top End HEALTH SERVICE

Medicine Management Unit (MMU)

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Dear Madam/Sir

Re: Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth) lodged by Juno Pharmaceuticals Pty Ltd, Natco Pharma Ltd, Celgene Corporation and Celgene Pty Ltd

Thank you for the invitation to provide further input regarding the application lodged by Juno Pharmaceuticals Pty Ltd (Juno), Natco Pharma Ltd (Natco), Celgene Corporation and Celgene Pty Ltd (together, Celgene) following the release of the draft determination.

Please see below NT Health's response to the questions relating to the risk management plan (RMP) that sponsors must provide to prescribers and pharmacies to supply Lenalidomide and Pomalidomide in Australia.

Please explain how Celgene's risk management plan operates and what is required to be done by prescribers / pharmacists in order to prescribe / supply lenalidomide and pomalidomide products?

Celgene's RMP – *Bristol Myers Squibb (BMS) i-access® Australia and New Zealand* - is used for its immunomodulatory agents (IMiD) Lenalidomide (Revlimid®), Pomalidomide (Pomalyst®) and Thalidomide (Thalomid®). It is designed to minimise the risk of foetal exposure as IMiDs are well known human teratogens that can cause severe congenital disabilities if exposed in utero.

The program verifies registered pharmacists and pharmacies to supply a quantity of IMiD, depending on a patient's child-bearing potential[1]. It reduces the risk of potential foetal exposure by limiting the maximum supply an enrolled patient may be supplied from a prescription as provided by a registered prescriber at a given time

The *BMS i-access* program can be explained as follows:-

- Prescribers, Pharmacists and Pharmacies are required to be registered with the program to prescribe or supply these IMiDs. This process requires the health professional to provide their profession

[1] Risk Categories are 'Male patient', 'Woman Patient of child-bearing potential and 'Woman Patient of nonchildbearing potential'. A female patient (or a female partner of a male patient) has child-bearing potential unless they meet at least one of the criteria listed in the Australian Product Information.

identification information, accept the terms and conditions of the RMP , and state they have completed mandatory training to become authorised agents.

- Patients are required to be enrolled in the program. Enrolment is completed once the Patient Consent Form is finalised and submitted to the program. The patient and the registered prescriber complete the form, typically undertaken during a consultation appointment. The completed form is submitted either fax of the hard copy, or electronically. Data collected by the program staff include the patient's name, date of birth, biological sex, address, the IMiD to be supplied, the patient's risk categorisation related to child-bearing potential, and diagnosis. Patients and prescribers must provide consent and declaration of their obligations and responsibilities with the program.
- On confirmation of patient enrolment, either via email to the prescriber or the prescriber confirming the status online, the prescriber provides the prescription to the patient. Depending on the Pharmaceutical Benefits Scheme (PBS) requirements for reimbursed indications, prescribers may be required to complete additional tasks before providing the prescription to the patient; this is independent of the program requirements.
- On receipt of the prescription, the pharmacists submit details about the prescription into the program for verification before dispensing. Data entered is patient enrolled, the registered prescriber and prescription details (IMiD prescribed, formulation strength, the prosed date it will be supplied to the patient, total daily dosage regimen prescribed, number of capsules dispensed and the institution/supplying site)
    - The program does suggest that verification be completed before placing an order for supply. Pharmacies place orders for the product through Celgene's distributor. In NT Health, a supply of commonly dispensed strengths of IMiDs is kept as stock on hand and thus is already available for supply at the point of receiving an individual patient prescription.
- Pharmacists await verification from the program following submission prior to supplying the IMiDs. The program provides verification, or rejection, dependent on the patient registration details matching the prescription, patient's child-bearing potential[2] and the cumulative supply provided to a patient thus far. Verification is provided via email to the pharmacist, or via the pharmacist check of the status online. Program support officers can be contacted via telephone should the verification process require extraditing. In the event of a discrepancy with supply, the program support officers often communicate this via phone call to the pharmacist. Verification is provided by the program based on the following criteria:-
    - For men and women not of child-bearing potential, the patient's cumulative supply must not exceed 12 weeks at any one time. If supply were to exceed 12 weeks, the pharmacy cannot supply the entire quantity prescribed and can only supply a smaller quantity to ensure cumulative supply does not exceed 12 weeks ○ For women of child-bearing potential, the patient's cumulative supply must not exceed four weeks at any one time, and they are required to provide a medically supervised, negative pregnancy test every four weeks. If supply were to exceed four weeks, the pharmacy cannot supply the entire quantity and would need to supply a smaller quantity to ensure the cumulative supply does not exceed four weeks. If a medically supervised, negative pregnancy test is not available within seven days of the new supply due

[2] A female patient, or a female partner of a male patient, is considered child-bearing potential unless she meets at least one of the criteria listed in the Australian Product Information for the applicable IMiD

date, the pharmacy cannot supply and would liaise with the prescriber to advise them of the inability to supply the medication.

- The pharmacist provides the IMiD to the patient once verification from the program has been provided and also provides appropriate patient counselling and provision of written medication information if required.

Would both the prescriber and pharmacy be required to operate the same risk management plan in order for a patient to obtain and dispense their script of the same brand of lenalidomide and pomalidomide?

The Sponsor provides the RMP per the Therapeutic Good Administration's (TGA) requirement for the supply and distribution of these agents in Australia. NT Health notes TGA correspondence to Pharmacor provided to ACCC[3] stating it would require generic sponsors to operate separate RMP and would not compel Celgene to provide access to its RMP.

The prescriber, pharmacy/pharmacist and patient all need to be enrolled/registered with the same program to provide that brand of medication. For example, a pharmacy is unable to submit verification and supply generic Lenalimid® via the generic *Cipla Lenalidomide-Pregnancy Prevention* Program (for a patient enrolled in this program) if the prescription is written by a registered *BMS i-access*® prescriber. In this instance, the pharmacist, pharmacy and patient would all need to be registered/enrolled in the *BMS i-access* program and have Revlimid® supplied, or it could be requested that the prescriber register with the *Cipla Lenalidomide-Pregnancy Prevention* program for the generic to be supplied.

Regarding other RMPs for products with multiple brands, this is in keeping with the experience of NT Health. For example, clozapine (a psychiatric medication) has two brands registered for use in Australia: Clozaril® and Clopine® with two separate RMPs that are brand specific. The mental health unit in the NT use the Clopine® brand and the corresponding *Clopine® Central* RMP. If a patient treated with the Clozaril® brand requires their medicine to be prescribed or dispensed whilst in the NT (e.g. during their holiday) the NT prescriber and pharmacist cannot supply Clozaril® under the Clopine® Central RMP. The prescriber and pharmacist are required to register with the *Clozaril® Patient Monitoring System (eCPMS)* to review the required safety checks, and continue the patient on their usual brand.

Would prescribers / pharmacies be willing to switch to, or operate, a second or subsequent generic risk management plan if generic products of lenalidomide and pomalidomide were introduced? What factors would generally be taken into account, and to what extent would additional switching costs, IT interface changes or training costs act as a barrier to prescribers/pharmacies deciding to switch

Prescribers and pharmacists operate in the frameworks required to prescribe and dispense the medications as per individual patient requirements. Should a generic Lenalidomide and Pomalidomide product provide significant cost savings, it is likely health departments would consider switching preference to the generic and use its corresponding RMP. Alternatively, health departments may give consideration to operating two RMPs, if stakeholders considered that stocking both the originator and generic was appropriate and in the best interests of patients and the health service. Either way, this would require extensive stakeholder engagement and consultation to determine the most appropriate action regarding the arrival of generics and corresponding RMPs.

This question may represent the concerns of other generic companies not part of the Juno, Natco and Celgene Agreement. TGA requirement for the Sponsor to develop and provide a new RMP, rather than utilizing existing programs, may serve as an additional barrier for generic entry, given the cost to develop, operate and maintain these programs. The 'first mover' generic Cipla and Natco would potentially have an

[3] ACC Submission (after draft decision) - Pharmacor

advantage when entering the market, with the assurance of market share, whereas other generics may not recoup expenses of establishing and operating an RMP if market share capture does not eventuate.

Although an initial switch to an originator brand and RMPs may occur, it is unlikely for health departments to undertake multiple switches in short succession due to the administration and training burden with RMPs if other brands become available unless there were compelling reasons, for example, discontinuation or short supply of the stocked brand. There are also patient safety considerations with brand switching that would need to be taken in to account. Factors that may act as barriers for prescribers/pharmacists who decide to switch include:-

- PBS listing, or confirmation of the date of PBS listing, is a significant factor for switching. It is unlikely health services would stock a generic product without confirmation of a PBS listing date.
- Confirmation of bioequivalence is a significant factor for switching, and this is likely a significant barrier for health services stocking a single generic brand if a generic is not considered bioequivalent.
- Patient confusion must be considered, particularly if brands come in different strengths/forms. Changing patients to different brands that require different number of tablets and or dosing can contribute to medication misadventure. In addition, patient convenience and support can create a barrier to adherence. Understanding consent and registration can take time and can create apprehension particularly if registration requirements are needed for multiple RMPs.
- As part of the stakeholder engagement and consultation process, health services would need to identify which policies and guidelines that would require updating concerning the brand used. Although not likely considered a significant barrier to switching but does require an increase in administration burden and time for stakeholders to update, approve, publish and communicate these updates.
- Any additional costs regarding use of a new RMP may be considered a barrier and especially if these costs differ significantly from those currently in use. Most RMPs, in their basic form are data-entry forms hosted on password-protected websites freely accessible with an internet connection; all health services should have basic IT infrastructure to access these RMPs. NT Health is currently unaware of RMPs that require significant investment by the organisation/business beyond increased time by staff to train and interact with the RMP. It would be a significant barrier to switching if a significant investment was required, such as changes to the IT infrastructure to use the RMP.
- IT interface changes and processes are generally not considered a significant barrier unless there are other factors such as patient privacy concerns with data entry requirements, a user experience considered to add significant administrative burden compared to previous RMP, or has other major IT issues.
- Training costs are generally not considered a major barrier unless there are significant training requirements—for example, a requirement to complete a paid course(s). NT Health is unaware of any RMP which currently requires significant staff investment or cost beyond time to interact in the program. It is generally expected that the Sponsor company provide appropriate training materials and resources.
- Cumbersome registration process for new practitioners can be a potential barrier for engagement, additionally, in jurisdictions with small cohort of patients receiving treatment, there is concern that practitioners keep their login/registration details current, particularly if there are multiple systems.
- It is vital to have customer support for the RMP systems, which can be an additional funding barrier for developers and industry. For facilities with 24 hour access requirements, such as hospitals, after hours support can be critical.

- If multiple generics (and originator) are available for a high risk medicines, visibility of registration as a minimum to RMPs will be essential. If a patient is unable to confirm which brand of medicine they are using, to be able to view registration (for practitioners), to inform treatment decisions maybe vital. In particular, if a health service does not have access to an RMP, but needs to view a patients history of blood results, 24 hour IT/RMP support again becomes essential.

How many separate risk management plans would prescribers / pharmacies be willing establish and operate at any given time? Please explain why.

The number of separate RMPs prescribers/pharmacies are willing to establish and operate with Lenalidomide and Pomalidomide depends on the organisation/business. There may be services where individual prescribers have a preference for a particular brand, either originator or generic (for a multitude of reasons), and the pharmacy/pharmacists cater for these preferences as needed. Generally, it is prescriber who enrols the patient in the specific RMP. In regards to public health facilities, such as NT Health hospitals, which medicines will be stocked and available is determined by a review process that involves need, efficacy, safety and cost.

From the NT Health perspective, with established relationships between prescribers and pharmacists who prescribe and dispense Lenalidomide and Pomalidomide, stakeholder consultation and engagement would need to be undertaken regarding the introduction of generics and corresponding RMPs. Whilst generally a single brand item is stocked where possible, the scenario exists where both originator and generic would be kept. Therefore, the multiple RMPs would be used with appropriate risk mitigation strategies utilised as a result, for example, education of prescribers and pharmacists to increase awareness of the different brands and the RMPs used.

Thank you again for the opportunity to provide further input. For any further information or questions, please don't hesitate to get in touch with me at [redacted].

Yours sincerely,

[redacted]

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