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Insights from global key opinion leaders on optimizing patient care in NSCLC

Announcer:
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Dr. Gubens:
This is CME on ReachMD, and I'm Dr. Matt Gubens.

Dr. Paz-Ares:
Hello. I'm Dr. Luis Paz-Ares.

Dr. Gubens:

Management strategies for non-small cell lung cancer vary among different geographic regions due to guideline variances. Luis, what insights can you share from a European perspective? What are some of the regulatory and guidelines nuances that you use to optimize your patient care?

Dr. Paz-Ares:
Well, I think there are some, let's say, specifics in the European space in terms of guidelines, which are mainly driven by the EMA approvals, which are not always similar, which is a pity because at the end of the day we treat our patients based on evidence rather than on inferior regulatory facts. But the truth is that they somehow reshape our decisions sometimes. I'll give you some examples.

Very often we are not able to prescribe drugs that have proven a lot of efficacy based on phase 2 trials. That typically happens in some diseases with low frequency. They really ask us to have very often data from randomized trials. This is not always easy to get, and we have a number of examples like BRAF mutation, exon-14 MET mutations, and many others. Then there is an additional layer that is somehow precluding us to prescribe the right treatment, which is the reimbursement at the country level. As you know, very often a treatment and patient care in our space is based on NHS services, and there are somehow regulatory issues in pricing that allow us to use or not to use sometimes. A good example, for example, I can use chemo plus dual inhibition, CTLA-4 plus PD-1, like chemo plus IPI/NIVO, the 9LA regimen, but I cannot use IPI/NIVO. I cannot use the CheckMate 227. It's not being approved. I mean, looking at the data, I do not see big differences, but those are the rules I have to play with.

So, Matt, what about your thoughts on the US regulatory and guidelines nuances you use to optimize patient care?

Dr. Gubens:
First, the US famously doesn't have National Health Insurance; that's another policy issue. But the one good thing is that even whether you have Medicare, Medicaid, or private insurance, at least the therapies approved or shown in the NCCN Guidelines typically are approved by insurance. A couple of things that are nuances though: First of all is that increasingly there's use of pathways which might say that even if it's on NCCN, it doesn't go according to the pathway. And that's where, as your example, nivolumab and ipilimumab may not be approved in favor of a different regimen that is roughly equal, even if you might have reasons on a patient-by-patient basis

to choose.

The other big issue, of course, is especially some of these oral targeted therapies, as miraculous as they are, they're very expensive. And even if they are covered by insurance, there's often a hefty co-pay responsibility that patients have. Fortunately, there are some patchwork ways to address that. Many of the drug companies and sponsors – and there are charities as well that offer co-pay assistance. But that often requires time, filling out forms, means testing that can be very confusing and can delay therapy. And it also involves staff time as well, because our team is helping patients get that. And even in Medicare, which is for all of our seniors, even there there's a – what's called the doughnut hole, where there is a space in coverage for many patients for oral therapies where it has to be out of pocket. And that's limiting if you're of limited means.

But by large, we do get approval by insurance; it's just the nitty-gritty of getting these drugs to the patient in a timely fashion.

Dr. Paz-Ares:
So honestly, bottom line to me at least, I think those guidelines from scientific societies, such as ESMO, or from other organizations, such as NCCN, they really help us to keep on track with all the innovations that are coming and also helping us to reduce the burden of, let's say, discussion with our regulatory bodies. So they really back up our decisions, help us to really serve our patients with the best treatments.

Dr. Gubens:
I completely agree. And in the US, it's one of our best assets, when we're meeting with insurance folks to try to get approval for therapies, to have it on the NCCN Guidelines. It's a really important tool to have on that phone call.

Well, that's all the time we have for today. Thank you for a great discussion, Luis. And thanks to our audience for listening.

Announcer:
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