
CAG-00163N and 00179N

COMMENTS

of the

**WASHINGTON LEGAL FOUNDATION,
ABIGAIL ALLIANCE FOR BETTER ACCESS
TO DEVELOPMENTAL DRUGS, AND
LORENZEN CANCER FOUNDATION**

to the

**CENTERS FOR MEDICARE & MEDICAID SERVICES,
U.S. DEPT. OF HEALTH AND HUMAN SERVICES**

Concerning

**NATIONAL COVERAGE REVIEWS
OF CANCER DRUGS**

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February 10, 2004

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Dennis G. Smith
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Bldg.
200 Independence Ave., S.W.
Washington, D.C. 20201

**Re: National Coverage Reviews of Reimbursement Policy for Cancer Drugs
(Ref. Nos. CAG-00163N and 00179N)**

Dear Mr. Smith:

The Washington Legal Foundation (WLF), the Abigail Alliance for Better Access to Investigational Drugs, and the Lorenzen Cancer Foundation are submitting these comments to express our concerns regarding the two CMS national coverage reviews that are underway for important anti-cancer therapies: namely, “off-label” use of the colorectal cancer drugs Eloxatin and Camptosar and the non-Hodgkin’s lymphoma drugs Zevalin and Bexxar. As detailed below, we believe these reviews have created prolonged and unnecessary uncertainty about the status of these medicines, and that CMS lacks the authority to deny reimbursement for these medicines to Medicare patients who are fighting cancer.

I. Interests of Commenters

Commenter WLF is a nonprofit public interest law and policy center based in Washington, D.C., with supporters nationwide. Since its founding in 1977, WLF has engaged in

litigation and advocacy to defend and promote individual rights and a limited and accountable government, including in the area of patients' rights. For example, WLF successfully challenged the constitutionality of Food and Drug Administration restrictions on the ability of doctors and patients to receive truthful information about off-label uses of FDA-approved medicines. *See Washington Legal Found. v. Friedman*, 13 F. Supp. 2d 51 (D. D.C. 1998), *appeal dismissed*, 202 F.3d 331 (D.C. Cir. 2000).

Commenter Abigail Alliance is a nonprofit organization based in Arlington, Virginia, dedicated to helping terminally ill patients obtain access to the medicines they need. Abigail Alliance was founded in 2001 by Frank Burroughs, who is now its president. The group is named for Burroughs's daughter, Abigail, an honors student at the University of Virginia. Abigail died of cancer on June 9, 2001, after she was stymied in her efforts to obtain new cancer drugs that her oncologist believed could save her life, but which were still in clinical trials. Abigail Alliance has numerous members and supporters who are suffering from terminal illness or who have lost family members to terminal illness.

Commenter Lorenzen Cancer Foundation is a nonprofit organization based in Monterrey, California, providing assistance to patients fighting pancreatic cancer. The Foundation maintains a large database of clinical trials of pancreatic cancer therapies, as well as current medical news, to aid these patients and their physicians in keeping up to date on the range of available treatment options for pancreatic cancer. The chairman of the Foundation is Lee Lorenzen, who founded it in response to the diagnosis and subsequent passing of his brother Gary Lorenzen due to metastatic adenocarcinoma of the pancreas.

II. Background

After the Food and Drug Administration approves a new drug for marketing, physicians may prescribe the drug for indications other than the specific ones for which the FDA has given marketing approval. Such “off-label” prescribing allows physicians to take advantage of the most current research and experience concerning a drug’s properties for the benefit of their patients. “Off-label prescribing is common in the areas of obstetrics, oncology, pediatrics, and infectious disease (particularly with AIDS patients).” V. Henry, *Off-Label Prescribing: Legal Implications*, 20 J. Legal Med. 365, 365 (Sept. 1999).

In the late 1980’s and early 1990’s, Members of Congress learned of reports that the Medicare program, through the exercise of contractor discretion, was denying reimbursement in some instances for off-label uses of cancer medicines. A General Accounting Office survey and analysis released in 1991 confirmed that off-label prescribing is integral to oncology practice: One-third of all drug administrations to cancer patients were found to be off-label, and over half of all cancer patients were found to receive at least one off-label drug. The study also revealed that federal and private denials of reimbursement were directly affecting the quality of care. Some 62 percent of oncologists in the survey reported that they had admitted patients to hospitals within the past three months to avoid anticipated problems with reimbursement for cancer medicines. Eight to ten percent of oncologists reported altering therapies on account of expected reimbursement problems. Thus, on a broad scale, cancer patients were either being subjected to unnecessary hospital stays or being deprived of the therapy of choice for their

cancer. **Oncologists named the reimbursement policies of Medicare contractors as the number one cause of these unwanted practices.** See General Accounting Office, *Off-Label Drugs: Reimbursement Policies Constrain Physicians in Their Choice of Cancer Therapies* 3, 5 (Sept. 1991) (GAO/PEMD-91-14); General Accounting Office, *Off-Label Drugs: Initial Results of a National Survey* 21, 23-24 (Feb. 1991) (GAO/PEMD-91-12BR).

Congress properly decided to put an end to this situation in Title XIII of the Omnibus Budget Reconciliation Act of 1993. In a subsection entitled “Uniform Coverage of ‘Off-Label’ Anticancer Drugs,” Congress amended 42 U.S.C. § 1395x to require the Medicare program to reimburse for off-label uses of oncologic drugs if the use appears in any of a number of recognized medical compendia. See 103 Pub. L. 66, 107 Stat. 312 (1993), § 13553(b). (We detail the applicability of this requirement to CMS’s current coverage reviews in section III below.)

CMS appears to have largely heeded this congressional directive in the ensuing years – until the release on November 1, 2002, of its final rule on the Hospital Outpatient Prospective Payment System (HOPPS). In the preamble to the rule, CMS announced that it “may choose to perform a reasonable and necessary determination [with respect to FDA-approved medicines] in several circumstances, including, but not limited to the following: the drug or biological in question represents a novel, complex or controversial treatment, may be costly to the Medicare program, may be subject to overutilization or misuse, or received marketing approval based on the use of surrogate outcomes.” *Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports*, 67 Fed. Reg. 66718, 66756 (Nov. 1, 2002). CMS asserted

that it could undertake such reviews even with regard to indications approved by the FDA for marketing. CMS cited no legal authority for this view – with regard to either off-label *or* on-label uses – except for one of its own proposed rules that predated the 1993 legislation. *Id.*

CMS made good on its threat to cancer patients when, on July 26, 2002, it initiated a national coverage review of the non-Hodgkin's lymphoma drug ibritumomab tiuxetan (Zevalin). In the course of its review, CMS focused the review on reimbursement for off-label uses and also broadened its scope to include the non-Hodgkin's lymphoma drug tositumomab (Bexxar). *See NCA Tracking Sheet for Radioimmunotherapy for Non-Hodgkin's Lymphoma* (CAG-00163N).

CMS initiated a second national coverage review on February 12, 2003, for the cancer drug oxaliplatin (Eloxatin), which has been in use in treatment regimens for colorectal cancer and pancreatic cancer. As with the Zevalin/Bexxar review, CMS later focused on off-label uses and added a second drug, irinotecan (Camptosar). *See NCA Tracking Sheet for Oxaliplatin (Eloxatin) and Irinotecan (Camptosar) for Colorectal Cancer* (CAG-00179N).

Both reviews have continued far past their original due dates. The due date of the Zevalin/Bexxar review was initially extended to November 4, 2003, then December 31, and now is entirely open-ended. The Eloxatin/Camptosar review, likewise, was initially extended to August 14, 2003, then November 17, then December 31, then January 31, 2004. It, too, now has no announced completion date. In the meantime, Medicare contractors are apparently free in CMS's eyes to exercise discretion to deny reimbursement for off-label uses of these medicines.

III. CMS's Lack of Authority to Deny Reimbursement for the Uses At Issue

Contrary to CMS's assertion, CMS has no authority to deny reimbursement on the basis of the extra-statutory factors identified in the HOPPS announcement – namely, that a cancer drug “represents a novel, complex or controversial treatment, may be costly to the Medicare program, may be subject to overutilization or misuse, or received marketing approval based on the use of surrogate outcomes.” Any such policy would violate the direction of Congress, specifically the 1993 amendments codified at 42 U.S.C. § 1395x(t).

The statute provides as follows in pertinent part:

(1) The term “drugs” and the term “biologicals”, except for purposes of subsection (m)(5) of this section and paragraph (2), include only such drugs (including contrast agents) and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

(2)(A) For purposes of paragraph (1), the term “drugs” also includes any drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication (as described in subparagraph (B)).

(B) In subparagraph (A), **the term “medically accepted indication”, with respect to the use of a drug**, includes any use which has been approved by the Food and Drug Administration for the drug, and **includes another use of the drug if -**

(i) the drug has been approved by the Food and Drug Administration; and

(ii)(I) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia, or

(II) the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this subclause by the Secretary.

42 U.S.C. § 1395x(t) (emphasis added).

Congress has provided that CMS is to reimburse for off-label uses of FDA-approved cancer drugs. If the drug has received FDA approval, and if the use is listed in one of the references named in the statute, that is the end of the inquiry – unless the Secretary of the Department of Health and Human Services determines that the use is “not medically appropriate.” Simply put, the fact that the treatment may be “novel, complex or controversial” is neither here nor there. Costliness is also not an issue: Congress has explicitly limited CMS’s inquiry to whether the treatment is *medically* appropriate. Whether the FDA granted marketing approval “based on the use of surrogate outcomes” is also immaterial under the statute.

CMS’s pursuit of its announced policy in the face of clear statutory language seems to be based on an essentially lawless – and ghoulish – calculation that that it can simply evade legal review of that policy by virtue of the legal prerequisites to filing suit: By the time agency processes have run their course, it can be expected that an individual victim of an aggressive

cancer who has appealed for reimbursement will be dead. We believe that judicial review of denials of reimbursement is more available than this calculation would imply, given the well-established exceptions to the rules of mootness in federal courts, but the more important point is that federal agencies should not be flouting federal statutes in the first place.

IV. The Profound Effect of a Denial of Reimbursement Upon Patients and Oncologic Drug Research

CMS's policy, as announced in the HOPPS rule and as carried out in the national coverage reviews of these anti-cancer drugs, substitutes bureaucratic judgment for the judgment of experienced physicians who are familiar with the needs of an individual patient. While the national coverage decisions at issue here do not extend to FDA-approved indications, CMS has asserted the authority to second-guess even the FDA's own approvals of drugs with respect to specific indications. As the advocacy group Patients Against Lymphoma has noted, the policy "forces these patients to first use toxic therapies proven not to cure and which often compromise the cancer patient's ability to benefit from emerging therapies." Letter of Karl Schwartz, President, Patients Against Lymphoma, to Thomas Scully, Administrator, CMS, Dec. 17, 2002.

Moreover, the message to medical innovators, including sponsors of new cancer medicines, could not be more clear: Even after clearing the significant and costly hurdles associated with clinical trials and FDA approval, even after producing a medicine that is proven to extend or save the lives of cancer patients, investments of hundreds of millions of dollars may be undercut by CMS based on amorphous standards like "novel, complex or controversial." This

can only deter the drug innovation that cancer patients need today and will need in the future.

CONCLUSION

The Washington Legal Foundation respectfully requests that CMS terminate the national coverage reviews at issue and clarify that the Medicare program will reimburse for off-label uses of these cancer medicines.

Respectfully submitted,

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