The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Testimony of
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Before the Ohio House Health Committee
Supporting SB 252
November 18, 2020

Good afternoon Chairman Lipps, Vice Chairman Holmes, Ranking Member Boyd, and members of the House Health Committee, thank you for the opportunity to present proponent testimony in support of SB 252, introduced by Senators Hackett and Craig.

My name is David Cohn, and I am Chief Medical Officer at The Ohio State University Comprehensive Cancer Center - James Cancer Hospital and Solove Research Institute (OSUCCC-James), and a professor in the Department of Obstetrics and Gynecology, specializing in gynecologic oncology.

The only freestanding cancer hospital in central Ohio and the first in the Midwest, the OSUCCC – James is an international leader in cancer prevention, detection and treatment. Understanding that no cancer is routine because every case is biologically different, OSUCCC – James physicians and scientists focus on basic, clinical and translational research to determine the molecular origin of each person's cancer and how best to treat it, leading to better outcomes, fewer side effects and more hope. The OSUCCC – James is the only cancer program in the United States that features a National Cancer Institute (NCI)–designated comprehensive cancer center aligned with a nationally ranked academic medical center and a freestanding cancer hospital on the campus of one of the nation's largest public universities.

The OSUCCC-James strongly supports SB 252. The legislation would prohibit the use of fail first requirements, or step therapy, for patients diagnosed with stage IV cancer. At the James,

approximately 20 percent of our patients are diagnosed with stage IV disease, which means their cancer has spread from the original site of the cancer to other areas or parts of the body. This is an exciting time in cancer treatment because new, targeted therapies are, in some cases, making metastatic disease a chronic disease. However, the opportunity to achieve that state requires patients receiving the right treatment at the right time.

SB 252 would ensure that coverage of a drug to treat metastatic cancer or its associated conditions, or side effects, is not dependent on failure to successfully respond to a different (sometimes less expensive) drug. It would allow for use of a drug that is approved by the FDA for treatment of the type of cancer the patient has or a drug that is included in the National Comprehensive Cancer Network drugs and biologics compendium, which includes the medications proven to be effective for the patient's cancer. Essentially, this bill permits chemotherapy, immunotherapy or other drug use that is consistent with best practices for the treatment of the cancer, as supported by peer-reviewed medical literature, without delaying a patient's care to require them to fail a prior chemotherapy medication.

The OSUCCC – James has more than 200 oncologists, each of whom specializes in just one type of cancer. That expert sub-specialization leads to more productive integration with cancer research and, ultimately, to better outcomes. Patients are cared for by a team of experts who tailor a targeted treatment plan for each individual.

Frequently, these expert physicians have the ability to choose between treatment options within the same class of drugs. Typically there is a reason a physician chooses one treatment over another, based on that patient's unique cancer or the unique side effects of that treatment. As long as that choice is consistent with FDA approval, national guidelines, or best practices for the treatment of the cancer, insurers should not be able to override physician selection of a drug regimen.

Stage IV cancer patients have unique clinical needs that must be addressed quickly and according a treating physician's recommendation. Current law includes an expedited exemption review and appeals process in urgent cases, but patients still could lose on appeal. Stage IV cancer patients do not have the luxury of time to go through levels of appeals while waiting for drugs to be approved, or denials of clinically appropriate care.

For example, we have had challenges obtaining approval for the use of denosumab for the treatment metastatic disease to the bone. Insurers have preferred patients first try and fail two oral bisphosphonates or be refractory to other lower cost options. However, we know bisphosphonates are associated with osteonecrosis of the jaw. Patients often have to undergo

dental procedures or tooth extractions prior to beginning treatment, delaying care and causing further anxiety and discomfort to the patient.

One such patient was a 48-year-old female diagnosed with lung cancer which was metastatic to the bone in November 2014. She was a mother of 6 children and one grandchild. Three of the six are still at home. She received multiple lines of therapy over the course of her treatment. Due to her bone metastatic disease, she was prescribed denosumab, which was denied. Her oncologist completed a peer-to-peer conversation appeal and informed that the product was not a preferred agent, requiring another agent to be used. Zoledronic acid was prescribed and infused starting in December 2018. Unfortunately, the patient passed away in August 2019.

You may find it surprising to know that insurers can deny care even though a physician knows the drug mandated by the insurer will be ineffective based on the specific patient or the known side effects of the drug regimen. For example, certain chemotherapy agents have side effects of numbness or tingling of the hands or feet called neuropathy. In patients with neuropathy, treatment with chemotherapy that causes cumulative numbness would be considered ill advised. However, insurers have denied physician-prescribed chemotherapies which do not cause neuropathy until the patients first fail their recommend treatment, which will increase their side effects and could even cause patients to be unable to walk due to their numbness. Had clinical judgment and experience be permitted up front, these situations may have been avoided.

Creating barriers to immediate treatment with the preferred therapy may ultimately results in higher medical utilization costs from delayed treatment and potentially poor patient outcomes. Generalized therapy protocols do not take into account unique patient characteristics, treatment related side effects, and probable responses to treatment. Personalized cancer treatment, the presence of co-morbidities, potential drug interactions, or patient intolerances may require the selection of an alternative drug as the first course of treatment for cancer or its associated conditions. It is critically important that patients facing these life-threatening metastatic cancers receive the right treatment for them at the right time.

In enacting this legislation, Ohio would become the 13th state to enact such a law. Georgia was the first to enact a similar law in 2016 and Pennsylvania's law passed at the beginning of 2020.

Thank you for your consideration of this important measure. I urge the committee to support SB 252. I would be happy to answer any questions.