February 9, 2022

House Insurance Committee
Ohio House of Representatives
77 S High St
Columbus, OH 43215

Support for HB 451: Revise Physician Administered Drug Law

Honorable Chairman Brinkman, Vice-Chair Lampton, Ranking Member Miranda, and Members of the House Insurance Committee,

My name is Randy Drosick and I am a practicing medical oncologist and hematologist in the greater Cincinnati area. I am also the President of Oncology Hematology Care (OHC) which has multiple locations in southwest Ohio. I come to you this morning on behalf of OHC and the Ohio Hematology Oncology Society (OHOS) to speak in support of HB 451 which would revise the physician-administered drug law.

The Ohio Hematology Oncology Society represents over 150 oncologists and hematologists in Ohio who treat cancer patients in the community setting. Oncology Hematology Care is an independent, physician-led practice that delivers leading-edge technology and treatment options to cancer patients in our community and hosts multiple clinical trials which contribute to innovative cancer research. According to the American Cancer Society Cancer Action Network, more than 1.9 million new cases of cancer are expected to be diagnosed in the United States in 2022. Of those new cases, 73,700 are expected to be diagnosed in Ohio- many of whom will be treated at OHC. OHC has been fighting cancer on the front lines in Ohio for more than 35 years. We are now one of the nation's largest independent oncology practices, as well as the region's premier source of treatment for nearly every form of adult cancer and complex blood disorder.

As the President of OHC, my role is to guide practice performance through collaboration with our medical team to deliver high quality, high value cancer care within our community. As a part of that charge, I spend a significant amount of time working with our care delivery team to ensure that our patients have safe and timely access to critical infusion medications through integrated care in our convenient office setting. Recently we've seen health insurance companies across the country implement new policies where they are requiring practices to no longer procure unmixed chemotherapy directly from the manufacturer, but instead order pre-mixed doses of infusion drugs from insurer affiliated specialty pharmacies. These pre-mixed medications are then shipped to the physician's office in a process known as "white bagging".

For as long as I have been a practicing oncologist, physician-ownership of infusion drug inventory has been the standard practice for community cancer care. This is done through a closed-supply distribution system that ensures the product arrives safely and on time. Our integrated care team, under my supervision as the physician, includes oncology nurses, pharmacists, and pharmacy technicians. We

manage the drug through our on-site inventory and, when a patient arrives for treatment, bloodwork is completed and I am able to adjust their treatment for that day based on the patient's disease progression, comorbidities, or weight variation, as well as the drug's toxicity and side effects. This has become even more important as cancer treatment has become more personalized over the years.

Under the current system, we prepare these drugs on-site. I am a licensed, accredited, and certified oncologist preparing these drugs in a setting held to very high standards compliant with state and federal regulations to ensure safety for those mixing, handling, and receiving these hazardous drugs.

Because my colleagues and I are preparing these drugs on-site to the exact specifications of each individual patients' needs, we are able to immediately dispense a safe and appropriate dose to the patient as soon as the drug is mixed. Not only is this the most convenient and secure method, but it is also the most cost-effective method for the patient because treatments delivered in this way are covered under their medical benefit. The cost-sharing associated with medical benefits in the average health plan is typically significantly lower than any cost sharing associated with pharmacy benefits.

However, under these new white bagging policies, I would be required to order infusion drugs from each applicable insurer's exclusive specialty pharmacy in advance of the patient's arrival for scheduled treatment. The specialty pharmacies purchase the drug from a manufacturer, prepare the drug according to my earlier requested dose, and then ship it to my office for administration. The supply-chain is outside of my control, possibly leading to delayed, damaged, contaminated, or even counterfeit shipments. Upon arrival of the drug to my office, I would have to maintain this drug in a separate inventory from my normal drug supply, which creates added infrastructure cost and administrative burden. Beyond that, if my patient arrives for treatment and I believe her dose needs to be adjusted, I must send her home and re-order the drug from the specialty pharmacy for a different date. The unused, white-bagged drug cannot be re-dispensed or used for another patient, so it now becomes waste. Reordering the drug will lead to delays in patient care and can result in disease progression.

As an example, Mrs. Jones returns for her third round of chemotherapy in the adjuvant setting. This is given to prevent her breast cancer from recurring. We know that the optimum treatment is giving her the appropriate dose at the appropriate time. Unfortunately, Ms. Jones now has a low white blood count and we need to adjust her dose. The insurance company has sent us 100 mg of her chemotherapy. Now that her count is low, we only need 80 mg. This is a significant problem. We have a choice of overdosing her on medication or now having a treatment delay until they send the appropriate dose. Either way the patient loses. Treatment delays cost lives and are nerve-racking for the patient. They have to come back to the office the next day or whenever the medication is delivered. They have to find transportation which is usually a problem and everyone's life is disrupted. Conversely, the same thing could happen if we need a dose escalation.

In addition to white bagging being concerning and burdensome for the practice, this new policy could also be financially toxic to the patient. In plans with white bagging policies, infusion drugs would be covered under the patient's pharmacy benefit, which typically has a higher cost-sharing requirement-especially when it comes to specialty drugs like chemotherapies and immunologic drugs commonly used in cancer treatment.

Undergoing cancer treatment is already a stressful time for patients. At this time, patients should be focused on getting well while eliminating any additional complications from delayed, ineffective, or

unnecessarily costly treatment. And instead of worrying over the quality and timely arrival of pre-mixed drugs in my infusion clinic, I should be able to focus on treating my patients. For these reasons, we respectfully request support of HB 451 so that myself and other physicians providing specialized care in the State of Ohio can continue to serve our patients safely, efficiently, and effectively.

On behalf of Oncology Hematology Care as well as my fellow OHOS members from across the state, I thank you for your leadership on this issue and look forward to working with the committee throughout this process. Thank you for your time.

Sincerely,

David “Randy” Drosick, MD
President, Oncology Hematology Care
Representative of Ohio Hematology Oncology Society (OHOS)