AFRICA RISING
PATH TO PROFITS

BRAND STRATEGY
ID YOUR AUDIENCE

US PRICING
TIME FOR A RESET?

Pharmaceutical Executive

MAY 2014
WHERE BUSINESS MEETS POLICY
VOLUME 34, NUMBER 5
WWW.PHARMEXEC.COM

2014 BRAND of the YEAR

Built to Last

ADVANSTAR PHARMACEUTICAL

Audi
Truth in Engineering

May cause serious fleet envy.

The highly uncompromised all-new Audi A3 has all the C-suite-level innovation and design you expect from an Audi, yet is surprisingly within reach. And the high-definition retractable MMI® screen, LED daytime running lights and leather seating surfaces come standard. Now, the only difference between the C-suite and everyone else is the parking space.

Contact corporatesales@audi.com for more information.

The all-new Audi A3. Stay uncompromised.

What's Real In Deals

William Looney
Editor-in-Chief
wlooney@advanstar.com
Follow Bill on Twitter:
@BillPharmExec

THE REHABILITATION OF BIG PHARMA has entered a new phase, with three of the largest companies—Novartis, GSK and Lilly—engaging in a mutually beneficial set of asset swaps that align around a new strategic thesis: specialization and value differentiation are preferable to sheer bulk. Even what appears as a return to the old form of wholesale takeover—Pfizer's prospective $100 billion acquisition of AstraZeneca—is being sold as a safer way to get small, with the combined assets helping to fuel Pfizer's eventual breakup into two separate companies, one focused on innovative drugs and vaccines and the other on established, off-patent products. If this latter deal is consummated in a friendly manner, it will confirm a larger trend toward a step down from the bitter rivalries that once made any form of collaborative transaction unthinkable among the big Pharma players.

But the peace may be temporal, because another aspect of the current resurgence in deal making is the arrival of the hedge fund investor. These are activists who have discovered in pharmaceuticals a set of conditions that permit disruptive innovations of a purely financial nature. Their notion of partnering is stripping out the industry's high fixed costs through tax and accounting manipulations that display a fine knowledge of the ineptitude of regulators and politicians but little about the science that—in their vision—takes forever to deliver the goods. Because drugs are a "public good," some observers claim there are moral implications to the relentlessly short investment horizons of this class of financier influentials. If medical progress requires long lead times and lots of up-front money, is a hedge fund really going to wager what amounts to a non-quantifiable bet on the future?

Late last month, just as the deal maker master class struck pedal to the metal, *Pharm Exec* retreated to a race track just north of Silicon Valley to consider the state of M&A with our thought leadership partner, Campbell Alliance, and 15 business development experts from pharmaceuticals, biotech, VC and the patient community. Like everything in California, the Roundtable discussion was both insular and worldly, with a fine appreciation of how today's business performance targets keep moving. It's all about the need for speed, with faster starts, more and longer laps—and no flag at the finish line.

Here are some of the meeting's main takeaways:

Higher market valuations are shifting the traditional trajectory of deals. Smaller biotechs are more confident about commercializing their "first born" product assets themselves rather than relying on a buy-out from the deeper pockets of big Pharma. The big players still tend to be conservative on due diligence, so risk-mitigating instruments like earn outs and contingent value rights are becoming even more important as a competitive differentiator, if and when a biotech decides to move a deal forward.

Big pharma interest is moving to early-stage from mid to late-stage assets. Nevertheless, buyers want a well-established proof of concept and a distinctive compelling value proposition, along with bullet proof protection of IP rights. According to Campbell Alliance survey data, oncology remains the default therapeutic area of choice for deal makers, for the third consecutive year.

Venture capital is still wary of committing new funds to support the long lead times demanded in the pharma and biotech space. Private VCs have faster alternative ways to realize a good return, which means much of this money is not coming back. Government funding for basic research is also shrinking. New streams of money—from corporate (i.e., Google's Calico) and philanthropic foundations; high net worth individuals; crowdsourcing, through the federal JOBS Act; and professional disease associations—are unlikely to bridge the gap. It was agreed that in-house corporate VC units could do more, and should in any case raise their visibility and tolerance for risk.

Industry hasn't solved its messaging problems—few stakeholder influentials nor does the general public believe this is an industry of high costs and big risks. Strong margins for protected products and enormous cash flow must be counter-argued and measured against high development failure rates, declining periods of exclusivity and stiffer evidence-to-outcomes hurdles on pricing. Payers are beginning to coalesce around activist-style pressure campaigns designed to lower the price bar for next-in-class entry products, representing a significant threat to incremental innovation. When combined with the steep drop in financing for early stage discovery, the drag on future medical progress is clear.

Look for our take on the Roundtable in next month's *Pharm Exec*. Until then, as those deals proliferate and CEOs bask as kingmakers on the front pages of the financial press, it's best to keep your—very dry—eye on the science.

Pharmaceutical Executive

VOLUME 34, NUMBER 5

VP OF SALES & GROUP PUBLISHER	TEL [732] 346.3018
Russ Pratt	rpratt@advanstar.com
EDITOR-IN-CHIEF	TEL [212] 951.6735
William Looney	wlooney@advanstar.com
MANAGING EDITOR	TEL [732] 346.3022
Michael Christel	mchristel@advanstar.com
SENIOR EDITOR	TEL [212] 951.6738
Benjamin Comer	bcomer@advanstar.com
EUROPEAN & ONLINE EDITOR	TEL 011 44 [208] 956.2660
Julian Upton	jupton@advanstar.com
SPECIAL PROJECTS EDITOR	TEL [212] 951.6742
Marylyn Donahue	mdonahue@advanstar.com
COMMUNITY MANAGER	TEL [732] 346.3009
Hannah Becker	hbecker@advanstar.com
ART DIRECTOR	TEL [218] 740.6411
Steph Johnson-Bentz	steph.johnson@media.advanstar.com
WASHINGTON CORRESPONDENT	TEL [301] 656.4634
Jill Wechsler	jwechsler@advanstar.com
EDITORIAL OFFICES	TEL [212] 951.6600
641 Lexington Avenue, 8th floor	FAX [212] 951.6604
New York, NY 10022	www.pharmexec.com
SALES MANAGER-EAST COAST	TEL [732] 346.3054
Mike Moore	mmoore@advanstar.com
SALES MANAGER–MIDWEST, SOUTHWEST, WEST COAST	TEL [847] 283.0129
Bill Campbell	wcampbell@advanstar.com
SENIOR PRODUCTION MANAGER	TEL [218] 740.6371
Karen Lenzen	klenzen@advanstar.com
AUDIENCE DEVELOPMENT MANAGER	TEL [218] 740.7285
Kelly Kemper	kelly.kemper@advanstar.com
REPRINTS	877-652-5295 EXT. 121
	bkolb@wrightsmedia.com
	Outside US, UK, direct dial: 281-419-5725. Ext. 121
CLASSIFIED SALES & RECRUITMENT	TEL [440] 891.2793
Tod McCloskey	tmccloskey@advanstar.com
DIRECT MAIL LISTS	TEL [440] 891.2773
Tamara Phillips	tphillips@advanstar.com

POWERED BY THE POSSIBILITY.

At Covance, we understand the thrill of "what if." We share your passion for uncovering new pathways, new cures and new promises for better health. In fact, it's that passion and commitment that helped us successfully develop a third of all prescription drugs on the market today. Come discover how we deliver Solutions Made Real.™

CALL TO LEARN MORE

The Americas +1.888.COVANCE | Europe/Africa +800.2682.2682
Asia Pacific +800.6568.3000 | Or go to covance.com/powered

COVANCE is an independent, publicly held company with headquarters in Princeton, New Jersey, USA.
COVANCE is the marketing name for Covance Inc. and its subsidiaries around the world.

COVANCE®
SOLUTIONS MADE REAL™

6 Contents

2014 Brand Of The Year: Built To Last

William Looney, Editor-In-Chief, and Ben Comer, Senior Editor

Pharm Exec's Brand of the Year recipients for 2014 are Copaxone, a 17-year mainstay treatment for multiple sclerosis that was recently approved in a new formulation touting fewer injections; and KORLYM, a repurposed medicine designed to feed a future therapeutic area franchise in conditions driven by excess production of the metabolic hormone, cortisol. We profile the journey of both drugs from development to commercialization, with emphasis on their record in engaging patients through creative use of digital media.

20

On The Cover: (Left photo) Steve Lo, chief commercial officer, and Joe Belanoff, CEO, Corcept Therapeutics, which manufactures KORLYM (photo credit: Michael Sexton).
(Right photo) John Hassler, VP of marketing for neuroscience, and Mike Derkacz, VP and general manager, CNS unit, Teva, which makes Copaxone.

(Backgrounds: Getty Images/Martin Barraud/Fuse)

Emerging Markets

Lost Continent No More

By Steven Adjei, Kwaku Obeng-Appiah, and Les Funtleyder

Driven by a rising GDP and calmer political and financial waters over the past decade, Africa's nascent healthcare sector is poised for a fresh surge in growth.

42

NEWS & ANALYSIS

Washington Report

STRATEGY & TACTICS

Strategy

Digital Marketing

INSIGHTS

From the Editor

Back Page

PHARMACEUTICAL EXECUTIVE VOLUME 34, NUMBER 5 (Print ISSN 0279-6570, Digital ISSN: 2150-735X) is published monthly by Advanstar Communications Inc., 131 W. First St., Duluth, MN 55802-2065. Subscription rates: $70 (1 year), $125 (2 years) in the United States and Possessions; $90 (1 year), $145 (2 years) in Canada and Mexico; $135 (1 year), $249 (2 years) in all other countries. Price includes air-expedited service. Single copies (prepaid only): $7 in the United States, $9 in all other countries. Back issues, if available, are $20 for the United States and Possessions, $25 for all other countries. Include $6.50 per order plus $2 per additional copy for US postage and handling. If shipping outside the United States, include an additional $10 per order plus $3 per additional copy. Periodicals postage paid at Duluth, MN 55806 and additional mailing offices. POSTMASTER: Please send address changes to *PHARMACEUTICAL EXECUTIVE*, PO Box 6180, Duluth, MN 55806-6180. Canadian G.S.T. Number: r-12421 3133rt001, Publications mail agreements NO. 40612608. Return Undeliverable Canadian Addresses to: IMEX Global Solutions, P.O. Box 25542, London, ON N6C 6B2, Canada. Printed in the USA.

Not Your Traditional Call Center

customer
experience center
a trialcard company

ON A RECENTLY COMPLETED CAMPAIGN, TRIALCARD'S CUSTOMER EXPERIENCE SPECIALISTS:

REACHED THE TARGET PRESCRIBER **60% MORE** OFTEN THAN STANDARD TELE-DETAILING

COMPLETED THE CAMPAIGN AT **7% OF THE COST** FOR A TRADITIONAL SALES FORCE

The TrialCard Difference
p 1.877.343.1238
e cxcenter@trialcard.com
www.trialcard.com

#YourExperienceMatters

trialcard®

PHARM EXEC CONNECT

this month on PharmExec.com

Join The Conversation!
@PharmExecutive
Facebook.com/PharmExec
http://linkd.in/PharmExecMag

Top Stories Online

The Sovaldi Case: Is American Biotech History About to Repeat Itself?
Blog post
Tom Norton
bit.ly/1rrhKzh

Fixing Wikipedia
April issue online
Peter Houston
bit.ly/1iksaRM

Italian Ruling on Roche and Novartis Resonates Across Europe
Blog post
Reflector
bit.ly/1mH4IgS

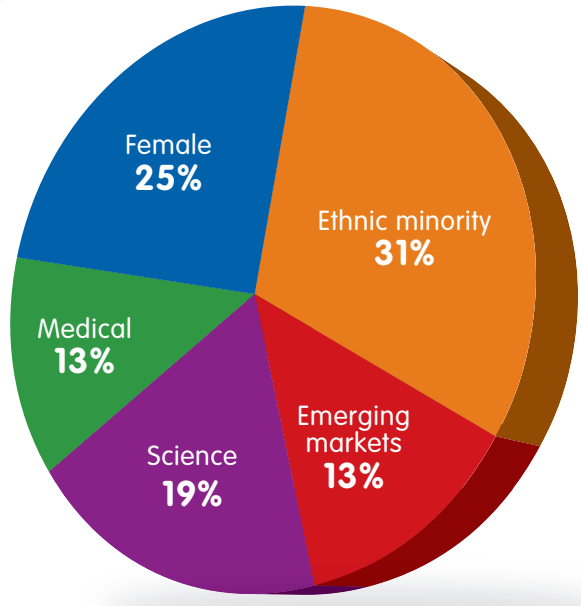
European Clinical Trials: The Die is Cast
Blog post
Reflector
bit.ly/1eEpVI9

Most-read stories online:
March 25 to April 24, 2014

Data Point

Poll data courtesy of online *Pharm Exec* readers between March 4 and March 24, 2014

Q: Which groups or areas of expertise are still missing from the biopharma industry?



Readers Weigh In

Pharma put all its pipeline eggs in the oncology and biotech basket because they believe that there is pricing power even for what might be considered me-too drugs (alternative options vs. clinical advances). The belief that this pricing power will remain in the absence of clinical advantage seems misguided.

David Melvin, 4/17/14
"The US Biotech Drug Pricing Challenge"
bit.ly/1gX83nf

According to the Bureau of Labor Statistics, the salaries of physicians are growing and will continue to grow over the next decade.

Grace Evans, 3/27/14
"Show Me the Money: Exploring Physician Incentive Compensation"
bit.ly/1ihQEKm

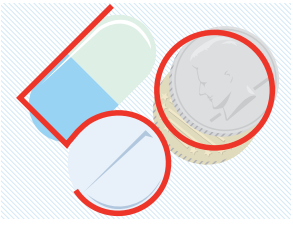
Nurses could bring the missing trust, understanding, oversight and stability to the health industry. Nurse insights emanating from the special nurse-patient bond and round-the-clock care can help innovators create great health products.

Grace DeVierno-Lipso, 3/25/14
"The Broken Clinical Research System"
bit.ly/1lObi3B

Keep in Touch!

Scan here with your smartphone to sign up for weekly newsletters

Coming soon to PharmExec.com



2014 Pharm Exec Top 50

PharmExec's annual list of the fifty largest biopharmaceutical companies in the world, and a discussion about what it takes to stay on top.

Don McCormick, *Dir. Customer Experience Management*, Mark Bouck, *President*, David Cunningham, *CEO*, and Mayor Harold Weinbrecht of Cary, NC cut the ribbon to dedicate the Customer Experience Center.

TrialCard Dedicates the Customer Experience Center

TrialCard dedicated its Customer Experience Center at a ceremony in Cary, NC. The Customer Experience Center is a rapidly growing headquarters for TrialCard's contact center services. Pharmaceutical manufacturers have turned to TrialCard to help their brands increase their share of voice through tele-detailing and tele-sampling programs, manage product safety inquiries, provide professional customer service for their customers.

"The key word in our name is Experience. By dedicating our Customer Experience Center, we are demonstrating to our customers that we are committed to enhancing their corporate reputation by creating a positive professional experience when we represent them," said Mark Bouck, President, TrialCard. "The word Experience also represents the valuable Experience that TrialCard has from the 3200 programs we have managed for our customers over the past 10 years."

The Customer Experience Center placed in the Top 10 in the Top 100 Call Center award for 2014 from BenchmarkPortal. The Top 100 competition compares the performance of contact centers throughout North America by evaluating their key metrics against industry peers.

Experience Matters. TrialCard's award-winning healthcare-focused Customer Experience Specialists provide 24/7 omni-channel customer support to increase share of voice, manage your product safety concerns, and provide a professional, positive experience for your customers. Add TrialCard's business intelligence analytics, production, graphic design, data entry, warehousing, and personalized fulfillment, and you get a turnkey solution from a single strategic partner.

customer
experience center
a trialcard company

The TrialCard Difference
p 1.877.343.1238
e cxcenter@trialcard.com
www.trialcard.com

#YourExperienceMatters

trialcard®

Front & Center

Pharma's Engagement Through New and Novel Channels

Managing disease and enhancing wellness, physicians need data to drive and reinforce behavior and digital tools to enhance patient communication

The following interview on trends and the state of pharmaceutical marketing is with Jeff Meehan, Chief Commercial Officer of MD On-Line, Inc. (MDOL), a provider of electronic healthcare solutions that leverage data to improve provider workflow and industry connectivity. But if you're expecting to read something dry and techie, forget it. The prevalent message and overriding concern of Meehan's is sensitivity—providing solutions that are responsive to both physicians' practice and patients' needs while creating value without increasing complexity. Whoever said technology didn't have a soul?—*Pharm Exec*

How do you see pharma marketing evolving in the future?

The future is now. According to a 2011 Booz report, nearly 70 percent of executives feel the current model is broken.[1] With only 55 percent of doctors accessible to reps in 2013, pharma must evolve reps' means of reaching and engaging customers.[2] Perhaps one of the most visible changes in pharma marketing is the use of technology. Pharmaceutical companies are increasingly capitalizing on innovations in targeting healthcare providers (HCPs), which is not surprising given how technology has decreased the cost of delivery. The future will center on technology in two major ways—helping engage customers to communicate core messages (content), and enhancing the ability of pharma to engage customers through new and novel channels. As use of technology increases in physicians' practices and patients' lives, the ability of pharma to access that technology while adding value and not increasing complexity will be a difficult balance to achieve.

What trends should marketers be monitoring?

Two trends have been reshaping the market landscape: regulatory changes, and the significant drop in the number of HCPs who allow sales reps to visit.

Pharmaceutical companies have been struggling with new regulations and with political efforts to decrease healthcare costs. Many have had to scale back, shrink their sales forces, do more with less, and consider nontraditional sales solutions. GSK has been leading a charge toward changing their product- and brand-centric sales and marketing efforts to efforts focused on adding value to the marketplace. In fact, GSK recently announced they will no longer have practicing physicians speak on their behalf. Will it work? Only time will tell.

Although reach and time with HCPs have declined, physicians still need and want sales information and/or drug samples. Our challenge or opportunity, then, is to continue developing new ways to capture their attention and keep them engaged—finding new ways to communicate. vRep[sm] by MDOL is just one example of a detailing solution that physicians have rapidly embraced. With vRep, reps still present product information to physicians face-to-face—they maintain that vital personal link—but without the intrusiveness that some HCPs cite as a reason for not seeing reps. vReps can get access to HCPs from Maine to California in a single day without interfering with their practices, *and* they are getting 15 to 18 minutes with each HCP. Again and again, new technologies like vRep, particularly certain mobile technologies, are proving they can fundamentally improve how effective and efficient pharmaceutical reps can be in today's environment.

How are new technologies changing the way pharma marketers approach their customers?

Marketers have resoundingly adopted technology—from iPads in the hands of the reps tracking core data on the time and quality of the rep–doctor interaction, to use of EMRs in delivering copay cards. As physicians are driven not just toward managing disease but toward enhancing wellness, they will need data to drive and reinforce their behavior. With this trend,

pharmaceutical marketers are quick to provide digital tools to help enhance doctor–patient communication. Physicians readily adopt these technologies as long as their productivity is not impaired. The challenge here is to find ways to deliver value without turning doctors off.

One innovative channel working to perfect the balance is Instinctive Data® (ID). ID is connected to the economics of physicians' practices and works by leveraging MDOL's real-time electronic-claims database to help HCPs identify patients who can benefit from testing, treatments, or procedures. Because these messages are in the doctors' nonclinical workflow and are accessed at a point when physicians can spend time understanding the data and tools offered, the success that ID is having in delivering value has been remarkable. With ID, the pharma industry and its marketers can tap into a continually growing US network, which now tops out at more than 83,000 actively engaged HCPs with more than 40 million patients.

MDOL and ID take a more targeted approach to engaging physicians, and for that reason it's a very effective marketing solution. Pharma marketers can use the system to deliver the right message to the right provider about the right patients in the doctor's workflow based on real-time patient data. An added benefit of the MDOL platform is that pharma companies are assured their messages are *viewed* by the physicians they have decided to target. Contrast that with other companies and their online endeavors—some do not even authenticate that their users are in fact doctors.

How do you see physicians' experience with pharma companies and brands changing over the next two or three years?

The integration of technology in reps' hands and physicians' practices is already changing physicians' experience with pharma. Right now, physicians are bombarded with massive amounts of information that is often not applicable to their practice, inundating them or even interfering with their ability to access *relevant* information. Through technology, providers' experience can dramatically improve. By making reps virtual and by integrating value into the providers' workflow, pharma companies can share brand information with the right HCP audiences when they want it and *how* they want it, making it relevant for their practice.

How do you think point-of-care (PoC) messaging can benefit pharma, physicians, and patients?

Proceed with caution! PoC messaging certainly has a place in healthcare marketing. However, the second that pharma interferes with a physician's focus when he or she is in the middle of treating a patient, you can be sure both pharma and the EMR companies will feel the backlash. Physician groups as well as legislators are already expressing concern—more than 11 states have proposed legislation limiting pharma's ability to message doctors at the point of care.[3]

In my experience, there is a right time and a wrong time to message physicians. It is when they want it that is when they are most responsive. For MDOL and ID, "near PoC" is when we find physicians are focusing on their business and how to maximize the value of their practice. The move to link wellness to reimbursement is where physicians are engaged in receiving messages about how to enhance their practice. We have found that physicians contacted through this window of opportunity are most likely to respond well to the messaging, and not only do they read the information that is shared at that point, but they react to it and change their behavior.

Though PoC marketing is gaining ground, the approach is thought by some to be too intrusive. Are there effective targeting alternatives that aren't disruptive, or perceived as invasive advertising?

Some marketers think the holy grail of influence is attained by targeting HCPs in the examining room, during patient visits. Although this idea is appealing, I would strongly caution marketers. Over time, we have seen that those who practice restraint and respect the sanctity of the doctor–patient relationship succeed. I might suggest that the near point-of-care approach can be not only less intrustive, but just as effective, if not more so. The communications that physicians receive through MDOL's Instinctive Data are displayed on a cloud-based dashboard that also features in-house educational material, clinical guidelines, and industry news and announcements specific to the physician. Having access to our physicians' data allows us to specify which messages are important to a particular physician. HCPs get more of what they can actually use, and none of the chaff, and in the process they save time and effort.

References

1. Booz & Company; National Analysts Worldwide. Pharmaceutical Sales and Marketing Trends 2011. Booz & Company website. www.booz.com/media/file/BoozCo-Pharmaceutical-Sales-Marketing-Trends-National-Analysts-2011.pdf. February 2012. Accessed March 31, 2014.

2. ZS Associates. Pharma rep physician access: do falling numbers point to new sales models. Access Monitor 2013 executive summary. ZS Associates website. www.zsassociates.com/publications/videos/~/media/Files/Publications/Public/ZS-Exec-Summary-Access-Monitor-2013-Final.ashx. Accessed March 31, 2014.

3. Watson AJ. Reaching doctors where they want to be engaged. Medical Marketing & Media website. www.mmm-online.com/reaching-doctors-where-they-want-to-be-engaged/article/285620. Accessed March 31, 2014.

Jeff Meehan is Chief Commercial Officer of MDOL, headquartered in Parsippany, New Jersey.

Reimbursement Limits Threaten Drug Access

High cost-sharing, narrow formularies create problems for pharma companies and patients.

More than 7 million Americans may be gaining healthcare coverage through Obamacare, but that doesn't mean they will be able to obtain needed medicines. Despite provisions in the Affordable Care Act (ACA) that require qualified health plans to cover "basic" benefits, access to prescription drugs may be limited by high out-of-pocket costs and tight pharmacy management strategies.

These developments were discussed last month at the annual meeting of the Pharmaceutical Research and Manufacturers of America (PhRMA) in Washington, D.C. The need to better communicate the value of medicines and to shift the debate from costs and prices was a major theme. Speakers were optimistic about the enormous potential for new biopharmaceutical discovery, but predicted this could be limited by curbs on research funding and on drug reimbursement.

A report for PhRMA by Battelle put coverage and payment policies at the top of the list of issues predicted to limit biopharmaceutical innovation and industry growth over the next ten years. The recent administration proposal to drop certain "protected drug classes" in Medicare Part D is a sign of the problem, noted Robert Hugin, Celgene CEO and former PhRMA chairman, at a press briefing. He observed that high cost-sharing raises questions about whether new exchange plans will provide appropriate coverage, and whether these strategies will migrate to commercial plans.

High cost-sharing benefit designs could have a ripple effect if such strategies become the norm for commercial plans.

Cost-sharing challenges

These concerns were highlighted at a panel on how health reform is reshaping pharmacy benefits, as exchange plans establish narrow formularies and specialty pharmacy tiers with steep coinsurance rates. Patient advocates cited plans that put all drugs for HIV/AIDS and hepatitis in the top specialty tier, which in some cases carry 50% coinsurance rates and excessive prior authorization requirements. And with out-of-pocket maximums exceeding $6,000 for low-cost bronze plans, many beneficiaries cannot afford needed medicines. These high cost-sharing benefit designs, moreover, could have "a ripple effect" if such strategies become "the norm" for commercial plans, noted Mark Velleca, executive VP at the Leukemia and Lymphoma Society.

Chet Burrell, CEO of CareFirst BlueCross BlueShield of Washington, D.C., Maryland, and Virginia, offered an alternative approach. He explained that insurers are looking for ways to better manage pharmacy spending, which now exceeds outlays for inpatient care for his organization with the rise in specialty medicines. Burrell explained that the ACA requiring guaranteed issue and community rating, insurers cannot offer lower rates to patients who adopt wellness programs that keep them out of hospitals.

So CareFirst is proposing to control spending on patients with multiple chronic conditions by waiving cost sharing in 2015 for those very sick beneficiaries who agree to adhere to a special care management program supervised by a physician. He acknowledged that many actuaries fear this approach will fail to achieve savings. But if it works, Burrell predicted, others may adopt it.

Another strategy is for states and regulators to set tighter limits on cost-sharing. Maryland recently enacted a $150 limit on co-pays for specialty drugs, and other states are looking at similar measures. Such a policy sets a level playing field for insurers and may prevent a "race to the bottom" in the drug coinsurance department.

Jill Wechsler is *Pharm Exec's Washington* correspondent. She can be reached at jwechsler@advanstar.com

Yet, the federal government is leery about setting limits on cost-sharing for fear that will drive up premiums, noted Jonathan Blum, principal deputy administrator of the Centers for Medicare and Medicaid Services (CMS). He acknowledged concerns about "true access" to benefits and said that CMS will be monitoring how well plans comply with policies designed to prevent discrimination against older, sicker patients. CMS issued guidance last month advising insurers that compliance reviews will scrutinize marketing practices and benefit designs that deter less healthy individuals from purchasing a plan.

Yet, that's just what occurs with plans that place whole classes of necessary medicines in the specialty tier with high coinsurance, said Carl Schmid of The AIDS Institute, who urged CMS to do more to halt such tactics. If there's no enforcement now, he queried, "who will stop the 'good' plans this year from becoming 'bad plans' next year?"

Broader changes in pharmacy benefit design are needed, observed Jim Robinson, president of Astellas US. He recalled that tiered benefit plans gained traction under Medicare Part D, along with the $600 price definition for specialty drugs. He and others want to see that threshold revised upward, and co-pays replace coinsurance for pricey therapies.

Coupons & controls

Higher cost-sharing also puts pressure on pharma companies to maintain drug co-pay assistance programs, long sponsored by marketers to help low-income and uninsured patients obtain brand medicines. While co-pay vouchers and coupons are accepted by commercial plans, they are considered "kickbacks" to prescribers under government-funded programs such as Medicare and Medicaid.

Pharma companies may channel patient support through non-profits that independently dispense the assistance to needy individuals. But uncertainty about whether CMS considers plans sold on exchanges as "federal plans" that cannot accept industry financial assistance has prompted some manufacturers to hold off on co-pay assistance for ACA beneficiaries; other firms continue to offer co-pay support pending a clear CMS ruling that this is illegal.

Meanwhile, pharmacy benefit managers (PBMs) and insurers seek new strategies for controlling outlays for specialty meds, which are expected to reach $235 billion by 2018, according to a new report by Milliman for CVS Caremark. The analysts propose that insurers shift prescription drug coverage from medical to pharmacy benefits, which can better utilize formulary tiers and utilization management to control costs. Savings close to 20% would come from revising reimbursement strategies for certain self-administered drugs obtained from pharmacies, as opposed to doctors' offices. Such a shift, though, runs counter to pharma efforts to highlight how outlays for medications can reduce overall healthcare spending—and provide value to the healthcare system. PE

What value in a $1,000 pill?

The claim that medicines offer value by preventing hospital admissions and expensive surgery applies clearly to new therapies for hepatitis C virus, a life-threatening condition that affects hundreds of millions of people around the world. Breakthrough antiviral agents that almost completely eliminate the disease, with fewer side effects and much simplified treatment, have generated loud applause.

Yet, these benefits have been offset by Gilead Science's price for Sovaldi—about $84,000 for standard 12-week treatment or $1,000 per dose. With more than 3 million Americans likely infected by Hepatitis C, the total cost of treatment will add billions to U.S. healthcare bills, and much more to treat the vast number of infected patients in other regions. The World Health Organization has called for "concerted efforts" to reduce the drug's cost to less wealthy countries, generating talk of compulsory licenses and price controls. And Express Scripts has called on PBMs and insurers to pressure Gilead to reduce Sovaldi's price.

Industry leaders continue to defend Gilead for developing a real cure that will reduce costly liver transplants and save lives. And new treatments from Merck, AbbVie, and others may drive down prices. But hepatitis C affects millions—vastly more than the small patient populations benefiting from most high-priced specialty drugs, and that has superseded any discussion of how savings on medical care will offset drug prices.

Front & Center

Taking HUB Implementation to the Next Level

Mounting cost pressures, an expanding specialty pipeline and growing demands for affordable, value-based treatment have left biopharmaceutical teams in a challenging position. At the same time, the Affordable Care Act has dramatically changed the landscape of health care. New payers entering the market are bringing new opportunities for patients, new challenges for biopharma manufacturers and new solutions that could benefit all stakeholders.

Hubs have emerged as crucial service providers that coordinate and standardize patient reimbursement and care regardless of a patient's specialty pharmacy. CBI's 2nd annual Hub Models and Program Design conference, held on February 27-28, focused on the strategic use of hub program design to propel product and brand management teams to the next level.

Heather Rose, Vice President for Brand Support Services for Omnicare Specialty Care Group, explored the lessons learned from the highly successful launch of Patient Solution Centers (hub programs) to expand patient access to specialty pharmaceuticals. The latest iteration of hub models looks beyond the pharmaceutical benefit and product launch to build patient access throughout the product life cycle. *Pharmaceutical Executive* talked with Ms. Rose after her presentation on "Next-Level Hub Implementation."

How has ACA changed the competitive environment for the biopharmaceutical world? How can biopharma professionals improve patient access under the new system?

The single biggest change is the new payers that have joined the competitive landscape. The familiar payers are still with us, the Aetnas, Anthems and Humanas, but there are many more new players that are offering new plans to individuals. As specialty service providers, we need to plug into these new payers.

Most pharmaceutical companies have access teams making sure their products are covered competitively by the larger payers. I'm more concerned about the new payers coming into the marketplace specifically for the exchanges. Manufacturers need to be sure they are positioned with the new payers, not just the ones they worked with last year.

The newer plans may not have the complete picture on a given product and could have relegated it to an inappropriate tier. It's an opportunity for the managed market team to educate new payers and help them gain the same level of knowledge more experienced payers bring to the table.

For the 2015 plan year, companies should remember to examine the medical benefit as well as the pharmaceutical benefit. Many specialty drugs are being covered on the medical side, either by assignment of benefits or buy-and-bill. A hub can help you look beyond the obvious avenues to improving access.

As the payer world shifts to expose patients to a greater share of the costs of care, how will this more consumer-like experience affect their perceptions of value? What strategies will help consumer-patients recognize the value of pharmaceutical care?

This change in emphasis is vital for consumers. We are seeing more plans with a high deductible on the pharmacy side or a per-year limit on the pharmaceutical benefit. Maybe a patient still has a $20 copay on a $1,000 drug, but if their drug benefit is limited to $10,000 annually, they won't be covered for that product for the entire year.

Biopharmaceutical companies can help with more education for consumers with respect to affordability and important ancillary services. Manufacturers should explain for example that a drug costs $1,000, but this is a critical therapy for which support is available and who is eligible and how to obtain the support. A manufacturer program could include nurse visits to avoid medical office charges or teaching visits to help learn proper self-injection technique. There may be regular calls to remind consumers to re-order or nurse hotlines. Many companies already use marketing programs like sharps kits or portable coolers. Proving that these services facilitate therapy initiation and/or maintenance are important.

Another strategy is to compare drug therapy with surgical or other alter-

natives. Sales teams already do this in physician offices, emphasizing avoided complications or fewer follow-up visits. Personalizing that same kind of information could be very effective in demonstrating value at the consumer level.

Focusing on quality of life can be helpful, but hard to demonstrate. Most consumers can understand the improved quality of life from taking a medication versus surgery or no treatment at all. It is important that patient education includes clinical information to assist with compliance since patients tend to forget how much better they feel after they have been on treatment for a while -- the new normal. One of our programs calls patients once a month to update their current symptoms on a one-to-ten scale. We can provide the results to both the patient and the physician to document their improvement on treatment.

How can a hub help manufacturers reach the entire spectrum of prescribers from primary care to specialty practices?

Prescribers typically fit into one of three categories. Our highest touch category is prescribers who want to write a script and be done. They want us to figure out how to get the patient on the product.

The opposite extreme is prescribers who are very familiar with prior authorization and the payer landscape. But they may see a need for technology to help speed approvals.

Most prescribers fall in the middle. They may have staff who can do the follow-up but need help with the benefit investigation on the front end. Or maybe they're good at the benefit investigation but don't want to remember to call the payer in three days to follow up on that prior authorization request.

When a new client or a new product presents to us, the company can help us determine where their prescribers fit along the continuum. We design a program to meet those specific needs, which depend very much on how quickly the company needs to launch. If it's a new drug, those first 60 days, first few months, first few years are going to be crucial. Manufacturers don't want prescribers to have any bad payer experiences.

Once we've had a program for a few years, it is time to take another look at the prescribers. Your prescribers' needs will change with time and experience. If you have a drug that is used only by a small group of specialists nationwide, they will very quickly gain experience and need a different mix of services.

How can a hub help manufacturers counter payer resistance and practices that switch to prescribing other products?

You start by looking at the real cause of the problem. There are payers that will not cover a specific drug, but we more often see something in the paperwork that causes it to be denied automatically. We might be hearing from prescriber offices that authorizations never go through so they switch patients to some other drug. But when we look, the payer requires a specific prior authorization form and the practice is using a form from another payer. The hub can help by completing the appropriate form and leaving the prescriber to fill in the specific diagnosis, sign it, and we take it from there.

Other payers want a letter of medical necessity submitted each time. We can create a template for the practice. All the prescriber has to do is fill in the blanks, sign and submit.

When there are payers that consistently deny a specific product, we can file an appeal on each denial. It's a tedious process, but it helps the payer recognize the large and persistent need for the drug. That can encourage a different decision for the next benefit year.

How can Omnicare SCG help biopharma manufacturers address these challenges?

Our goal is to integrate patient, prescriber, payer, specialty pharmacy and other stakeholders to speed patient conversion early in the product lifecycle and enhance adherence over the long term. Omnicare SCG teams break down the entire process from prescribing to approving to dispensing to refilling in order to maximize benefits throughout the lifecycle. Our role is to create and use different touch points to help each of the stakeholders.

The initial conversion rate is a valuable metric, but the long term need is to keep the patient on therapy. Long term adherence is a struggle for everyone, but it benefits everyone. The patient has improved outcomes, the prescriber has a healthier and happier patient, the payer avoids the costs of medical treatment, pharmacy and manufacturer have more stable revenue streams. The most thoughtful brand managers are asking for adherence data at three months, six months, a year, even longer. A growing number of sales teams are being reimbursed based on longer term adherence. Our mission is to help the patient get on, and stay on, the specific drug the prescriber writes for. Omnicare SCG is the one entity with visibility across an entire ecosystem of patients, prescribers, payers and pharmacies that can help them all maximize their unique goals.

Gravity Shift: Timely Lessons For Big Pharma

MNCs can learn a lot from generic companies in their strategic approaches to emerging markets.

The pharmaceutical industry in Asia is gearing up to be at the center of the global market—and most expect that the shift has already started. A survey by PwC shows that 55% of MNCs and 62% of domestic companies believe that the center of gravity of global pharma will be in Asia rather than the Americas or Europe. Asia could well become the biggest pharmaceutical market and will look radically different in the medium-term.

Asia has its own set of challenges and risks and demands a "whole new strategy approach" for all emerging markets to compensate for the internal factors of MNCs that can limit their success. These challenges include intellectual property rights, corruption, reputation, regulated pricing pressures, affordability, and lack of knowledge of the local business environment and culture. Generic and domestic companies, meanwhile, have been performing well in the same environment.

Role reversal

In the last three decades, MNCs have contributed greatly to the transfer of knowledge to generic companies in areas such as technology, marketing know-how, working methods, management techniques, R&D, and branding. However, now is the time that MNCs can also learn significantly from generic companies amid the changing global industry landscape. This evolution has enabled generic companies to outpace MNCs' performance in most emerging markets, including Asia.

MNCs should analyze market needs and understand the local dynamics, rather than rely on their indigenous pipeline and wait for headquarters to feed new products.

What can MNCs learn from generic companies?

There are 13 important lessons that pharma MNCs can learn from generic companies when planning and designing their strategies in emerging markets in Asia and other regions.

- **Think outward rather than inward:** MNCs should analyze the market needs and understand the local dynamics, rather than rely solely on their indigenous pipeline and wait for headquarters to feed new products.
- **Disease profile of the population:** Every market has its own set of disease burden, which may not be answered by an MNC's indigenous pipeline. The product portfolio can be designed in such a way to address the local disease profile, and MNCs may introduce off-patent products to address the unmet treatment solutions.
- **Diversified product range:** Various markets may have a different market share for each anatomical therapeutic chemical (ATC) classification, but, generally, more than 85% of market share remains within the top ten ATCs. Similar to generic companies, MNCs should have no limitation in introducing products in all ten ATCs, rather than limiting them to an inherent strong foothold of product options, which may not be significant in different markets.
- **Outsourcing R&D and manufacturing:** The majority of MNCs believe that the industry is failing to fully grasp the potential of outsourcing and, thus, are missing opportunities. According to the PwC survey, 56% of companies agree that organizations do not view outsourcing in a dynamic way. Nevertheless, today, a majority of companies are willing to outsource R&D, clinical trials, and manufacturing—with suitable controls and good partnership selection to counter the risks of outsourcing. The major benefits of outsourcing can be low-cost manufacturing and capacity optimization, allowing MNCs to

Nadeem Rehmat is Director of Business Development at PharmEvo Pvt. Ltd. He can be reached at nadeem.rehmat@pharmevo.biz.

Humans need more than instructions.

Or orders. Or rules.

That's why it's time to change the conversation.

To acknowledge human imperfection and embrace it.

And to speak a language healthcare hasn't spoken in years.

We speak that language.

Speak People

GSW

INVENTIV HEALTH

WeSpeakPeople.com

focus on branding, sales, and marketing.

- **Flexible management method and localized decision-making processes:** It's unavoidable that the bigger a company's hierarchical management in different regions, the longer it takes to get approval from headquarters on certain decisions. A delegated decision-making process (within a broader strategy frame) can help pharma MNCs expedite "speed to the market," which is paramount in emerging markets, and especially in generics.
- **Healthcare products:** Shrinking pipelines at MNCs, pricing pressure, and ever-upgrading regulatory regimes have created a space for MNCs to introduce products in areas such as healthcare, consumer, personal care, dietary supplements, and phytopharma, among others. And to do so the way domestic generic companies have successfully done in bringing alternative solutions to patients, as a clear shift is being observed from chemical products to more natural options. Today, natural products are available in standardized forms, manufactured in a pharmaceutical framework mode, and are clinically supported. Hence, the same learning curve in the pharmaceutical business can also be used for alternative medicine brands.
- **Hiring professionals from generic companies:** Generic business is largely driven by training and by mindset. Professionals at MNCs are best prepared for proprietary, innovative "new-to-market" products. Therefore, in order to excel in generics marketing, MNCs should recruit more professionals from leading generic companies in hopes of bringing in those elements best suited to the generics business.
- **Engage in portfolio marketing:** Due to limitations of proprietary products, sales and marketing teams at MNCs typically visit a large number of physicians, but often only focusing on one or two products. Thus, there is great need to engage physicians on a larger number of products, creating a deeper product portfolio in each therapeutic category. In addition, off-patent products can generate value in terms of business, physicians' trust, and in optimizing the selling cost.
- **Multi-channel engagement:** An integrated and well-executed multi-channel approach can help accelerate the effectiveness of an MNC's sales force. MNCs should consider leveraging non-traditional channels that go beyond the individual sales rep. Similarly, MNCs should create a channel to safeguard prescriptions at the pharmacy level to help their brands avoid being substituted with brands of domestic companies solely on the basis of price.
- **Unmet needs of the patient:** Stakeholders' interest will remain a prime factor in how companies form business models and strategies that deliver the best ROI. This, however, should not mean underestimating the unmet medical needs of patients in a given market condition and the existing gaps in treatment options.
- **Using country of origin effect/cue:** Studies have identified that country of origin (COO) cue can be a big competitive advantage for corporations operating on a global scale. MNCs should leverage the COO factor when introducing generic product portfolios, and ensure that the highest quality standards of their organization are applied in all business processes. There is a need for precaution as well in this approach. Due to political or other specific reasons, using COO can sometimes be counterproductive and will upset entrenched domestic competitive interests.
- **Recalibrate regulatory affairs:** The ability to accelerate a company's "go-to-market" capability can be improved if multi-channel bureaucratic hurdles can be addressed effectively and efficiently, a challenge regulatory staff must master.
- **Stand brave against domestic companies:** Without ignoring the fact that domestic companies have a unique set of capabilities in the emerging markets setting, MNCs should, nevertheless, stand brave against domestic companies, leveraging their own set of capabilities, skills, reputational assets, quality connections, and global product knowledge. It is time to "thrive" rather than just "survive."

Time to act

Branded generics in emerging markets present a viable avenue for potential growth for big Pharma companies, but MNCs must also understand the often-unique challenges they face in pursuing these opportunities. The window of opportunity may not remain open for long; therefore, MNCs should consider exploring a combination of strategies to prevail. PE

#cultofcontent

Searching for answers? Let Palio+Ignite walk your brand through a rite of passage. We're an unorthodox group, masters of the new arts needed to succeed in healthcare marketing today. Like content designed to create a more searingly intense connection to your brand. Join us and transcend the ordinary. Call Julie Priddle today at 518.226.4301. We promise it won't hurt a bit.

Art created by Taylor James.

palio + ignite

INVENTIV HEALTH

beyond experience

palioignite.com

Pharm Exec's Brand of the Year *award is itself a brand with staying power—our first recipient was Merck's Gardasil papillomavirus vaccine, which eight years later is still going strong as one of the company's 10 top-selling products. This year's winner, Teva's Copaxone, also pins the needle on the long tail, at 17 years on the market with an equally durable safety profile against its nemesis, the elusive autoimmune disease multiple sclerosis. But lest we be accused of being safely predictable, this year Pharm Exec decided to focus, too, on clinical and marketing achievement for an orphan-status rare disease drug, calling out Bay area start-up Corcept Therapeutics' initiative in repurposing an old drug, mifepristone, for a new indication as the first treatment for Cushing's syndrome, a disabling metabolic disorder that is habitually underdiagnosed. Corcept's KORLYM carries larger potential as the test launch for a new class of medicines to address how the "fight or flight" hormone, cortisol, works as a precursor to many chronic life-threatening conditions that affect millions of patients outside the rare disease space. It's literally a new way to think about disease.*

— William Looney, Editor-in-Chief

Copaxone: Built To Last

The first prescriptions for Teva's Copaxone were written in the spring of 1997, with peak sales estimated at $250 million. Seventeen years and many billions of dollars later, Teva has returned for an encore with the approval of a newly-formulated Copaxone touting fewer injections, just in time to upstage the potential entrance of generic competition this summer.

By Ben Comer

Specialty drugs for the treatment of chronic disease, along with orphan drugs for rare conditions, are the two most popular areas of biopharmaceutical R&D activity for one obvious reason—optimal return on investment. In the case of chronic diseases, companies turn patients into walking annuities toting a prescription that needs to be filled and refilled perpetually, with a caveat: it's hard to know how a drug will perform for patients 10 or 20 years later, in the

CALL, CLICK, OR VISIT TRANSFORMED SHOPPING & BANKING

Why not life sciences?

Veeva CRM

ENGAGE YOUR CUSTOMERS
ANYWHERE, ANYTIME, ANY DEVICE. SEAMLESSLY.

Integrated Multichannel CRM

BRING TOGETHER ONLINE, EMAIL, CALL CENTER, AND FACE-TO-FACE WITH VEEVA CRM TO GIVE CUSTOMERS THE INFORMATION THEY NEED.

MAKE SERVICE A COMPETITIVE ADVANTAGE.

Bring it all together at veeva.com/multichannel

Veeva

real world. Products age along with the patients who take them, sometimes with unexpected results.

Copaxone (glatiramer acetate injection), Israel-based Teva's multiple sclerosis drug and a once unlikely blockbuster, was chosen by *Pharm Exec* as one of this year's two Brand of the Year awards for its consistent success in this context. Copaxone has been on the market for 17 years, with virtually no serious side effects emerging during that time. According to John Hassler, Teva's VP of marketing for neuroscience, Copaxone is the "market leading therapy for relapsing-remitting forms of multiple sclerosis, with over 40% more total prescription volume than the next closest competitor."

In January, Teva received approval for a new 40mg version of Copaxone that reduces the number of injections from seven a week, to three. Despite the recent Supreme Court decision on Copaxone's patent—which opens the door to potential generic competition as soon as this month—Teva has already recorded strong results from the newly-formulated 40mg version. Seven weeks into the launch, Copaxone 40mg became the most prescribed treatment in terms of new prescriptions for patients with relapsing-remitting MS, the most common form of the disease, and has remained at the top since then, the company says.

Despite competing with at least a half-dozen newer disease-modifying agents for the treatment of MS, some of them oral formulations, Copaxone still managed to lead the category in 2013, with global sales topping $4.3 billion.

"When we started working with Teva, MS wasn't oncology, it wasn't being mentioned every day in the news. That's no longer the case."

—Melyssa Weible, Rx Mosaic Health

About 35% of all patients taking a drug for MS take Copaxone, or roughly 85,000 patients, adds Mike Derkacz, VP and general manager of Teva's CNS unit. Derkacz held the same title at Cephalon prior to Teva's acquisition of that company in 2011.

Teva has continued to improve the Copaxone brand experience for patients over time, from a new injection device to engaging patients online and off. The company hosted an early online MS patient community—MSWatch.com—"long before the term 'social media' was coined," says Hassler. Shared Solutions, now a part of Teva, made nurses available to patients around the clock beginning in 1997, when Copaxone launched. Shared Solutions, a gold standard in the category, is open to all MS patients, regardless of therapy.

Focus on MS patients

Multiple sclerosis, a chronic and potentially debilitating disease, affects some 450,000 people in the US, and over two million lives globally. Symptoms occur due to an autoimmune attack on nerve fibers in the brain and spinal cord, which can damage the protective myelin coating and lead to scarring and nerve damage. As with most autoimmune diseases, the causes of MS aren't well understood; an inflammatory response in the body can be as harmful as it is helpful, and no one is sure exactly what triggers an appearance of Mr. Hyde from the typically Jekyllian, and protective, human immune system.

As a result, MS can feel to otherwise young and healthy patients like it has fallen, unduly, from a clear blue sky. The effects of nerve demyelination present in many different ways, from subtle pain or blurry vision, to an inability to stand or speak, with a host of other problems in between. Symptoms—in the case of patients with relapsing-remitting MS—can suddenly dissipate into thin air as quickly as they arrived, only to reconstitute days, months, or even years later. Not knowing when or to what degree the symptoms will return can be a nightmarish predicament for MS patients, akin to cancer patients in remission long enough to almost forget they had the disease.

The unpredictable progression of MS (along with the failure of available drugs to halt it) is maybe the worst aspect of the disease. Does waking up with stiffness or numb legs indicate a new MS exacerbation, or is it simply due to an especially vigorous exercise effort the day before? When only time can tell, the clock and calendar become sinister partners in an unwelcome alliance; MS patients, a population that skews toward but isn't limited to women in the prime of their lives, can't afford to sit around and wait for what may or may not happen next.

That's why disease awareness is critical, says Melyssa Weible, president of Rx Mosaic Health, a New York-based "specialty-only" PR shop under the Omnicom umbrella. Rx Mosaic has worked on Copaxone for nine years. "When we started working with Teva, MS wasn't oncology, it wasn't being mentioned every day in the news," says Weible. "That's no longer the case."

Star power

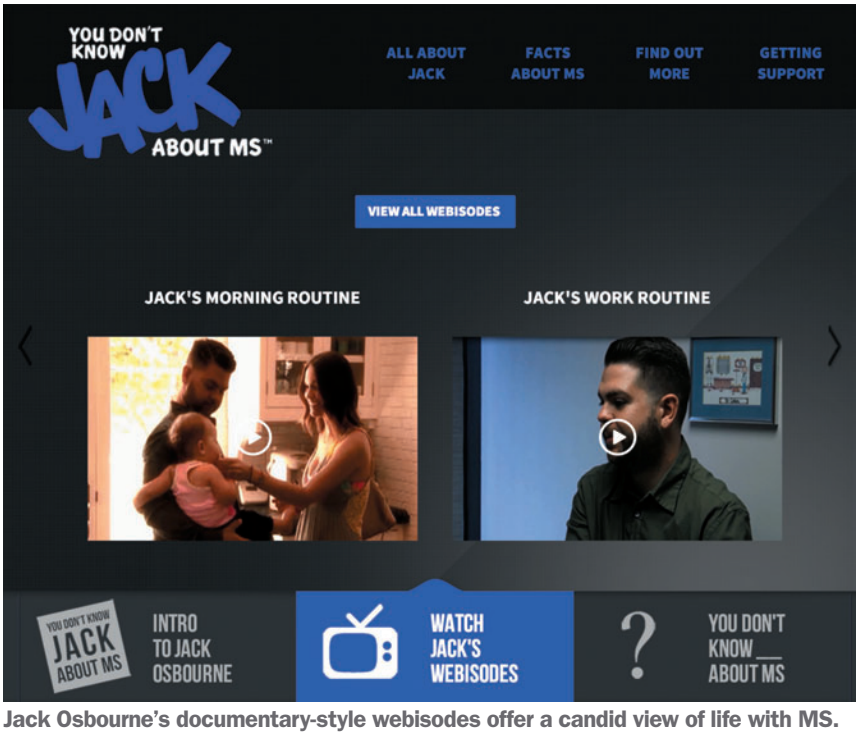
MS is at least two to three times more common in women than men, and possibly more than that, according to the National Multiple Sclerosis Society (NMSS). But Teva's celebrity faces of the disease are men: country music star Clay Walker, and Jack Osbourne, a media personality and the son of Black Sabbath front man Ozzy Osbourne.

Both men have worked with Teva on disease awareness initiatives—Clay Walker has taken Copaxone for 15 years, says Teva—and Jack Osbourne's surprise diagnosis two summers ago led to a series of candid online webisodes about living with MS, and the misconceptions people have about the disease.

"You Don't Know Jack About MS," the joint project sponsored by Teva and created by Osbourne's production company, Schweet Entertainment, debuted last December. Teva also donated $100,000 to the NMSS in recognition of Osbourne's work as an MS advocate and his participation on "Dancing with the Stars," a reality TV program. The webisodes, available at YouDontKnowJackAboutMS.com, feature Osbourne as man on the street, attending a MS patient gathering, and managing family life with a young daughter. Weible says the decision to go with documentary-style webisodes is a reflection of Osbourne's persona and interests. "We wanted to maintain the authenticity that comes with him… he's a reality TV star," says Weible.

During a webisode titled "Many Symptoms," Osbourne and five other patients recount the stories of their first symptoms and diagnosis. The individual experiences vary dramatically, reminding one of the patients of a quote from a physician: "Once you've seen one case of MS, you've seen one case of MS." Osbourne, for example, first visited the doctor due to the sudden onset of blindness in his right eye. Another patient felt an extreme numbness in his leg, and, after attempting to walk it off for 17 minutes, couldn't walk anymore. This discrepancy in the initial symptoms of MS can make an early diagnosis difficult. Osbourne was diagnosed with MS a year and half after his first symptoms emerged, he says.

Clay Walker was diagnosed in 1996, at the age of 26, after experiencing symptoms, including tingling, numbness, and facial spasms. A long-time Copaxone user, Walker has remained active in promoting disease awareness and education. Ten years ago, Walker founded a charity called Band Against MS, and has continued to speak out on behalf of MS patients, and to hold fundraising events. In March 2013, Band Against MS and Teva worked together for a public service announcement campaign intended to remind patients about the importance of adhering to their medications. Titled "Stick With It"—in reference to the daily injections most



Jack Osbourne's documentary-style webisodes offer a candid view of life with MS.

Teva's patient switch campaign, seen here in a *People* magazine cover buy, emphasizes the "freedom" of convenience.

CONGRATS TO OUR FRIENDS AT TEVA

You may have just been recognized with a prestigious award. But we've seen your dedication to the patient community since the day we opened our doors.

We're just as honored to be on your team today
as we were 15 years ago.

– Your friends at Intouch Solutions

1999

INTOUCH SOLUTIONS®

Teva joins forces with Intouch Solutions

intouchsol.com

2014

COPAXONE®
(glatiramer acetate injection)

Pharmaceutical Executive
Brand of the Year

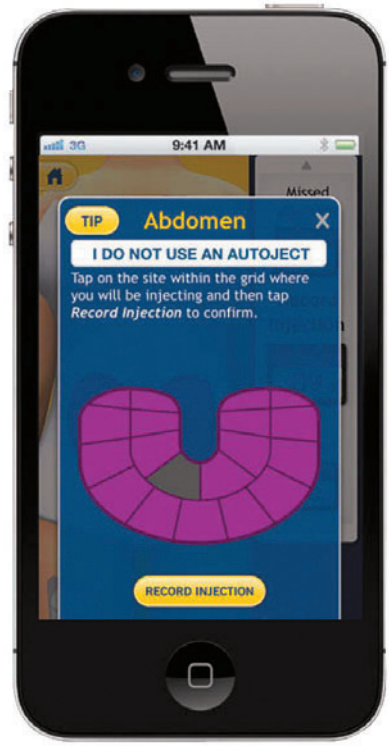
patients must give themselves—the campaign launched a Facebook page and Teva agreed to make a $1 donation for every "like," up to $25,000.

Since Copaxone is the most prescribed and best-selling MS drug on the market, it makes sense for Teva to invest in non-branded, educational campaigns. After all, if most new patients get a prescription for Copaxone, making more people aware of the symptoms, and the importance of treatment, means more prescriptions and sales. Weible says the goal of the celebrity campaigns is to "share the patient experience with newly-diagnosed patients who may feel isolated, or for patients who have MS and have been treating it for a while," she says. "Dealing with a chronic condition can be isolating and lonely, and patients want to hear from a 'patient like me,' a real-life story," she says.

Teva and Rx Mosaic assisted in hosting a Twitter conference on March 14, 2012, in partnership with the NMSS. "I think we were the first people to ever do a Twitter conference for an ethical healthcare product," says Weible. "We connected a doctor (Dr. Gabriel Pardo, @DocforMS), Clay Walker, and MS patients, and they were able to ask questions in real-time…we were thrilled with the amount of people that participated." The Twitter conference wasn't Copaxone-branded, but participants asked Dr. Pardo questions about Copaxone and several other MS products. It's hard to tell from Twitter how many people participated, and Walker (@ClayWalker) did tweet a link to Copaxone's product information at the conclusion of the one-hour event. The conference hasn't been repeated since, but it exists online as proof that pharma can engage patients using social media channels like Facebook and Twitter.

Social media before Facebook

Long before Dr. Pardo and Walker took to Twitter, Teva and InTouch Solutions, a Kansas-based digital marketing agency, launched MSWatch.com. The site functioned as a resource and community for patients living with MS. Matthew Goyer, VP of client services at InTouch, said patients signing up on MSWatch.com "not only had the ability to interact with the content provided by Teva—all the tips and suggestions and everything else to help manage their MS—but there were also methodologies where they could interact with each other through the patient forum."



The iTracker app lets patients record injection sites to aid in proper rotation.

Asked why the platform was discontinued—it lives on in Canada, in limited form, at MSWatch.ca—Teva's Hassler says the company is "proud to have been an innovator in developing this online community," but "as the social media landscape evolved, it enabled the MS community to expand the conversation beyond industry platforms."

The patient section of the Canadian site, dubbed MS Oasis, bills itself as a "safe place for the patients and caregivers in the MS community to log treatment and connect with one another." Individuals registering on the website are asked to choose a bird avatar, and then "perch in the tree where you can find resources in the birdhouses and check in on fellow Sanctuary members." There's also a rewards system where visitors "can earn badges just by keeping up with appointments and therapy."

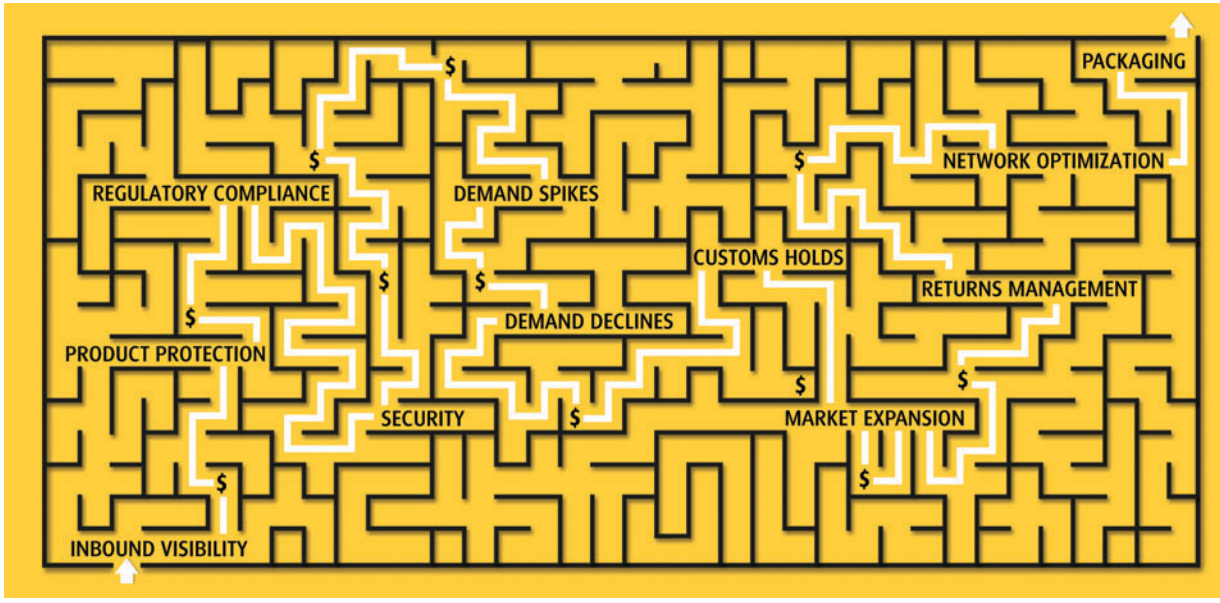
When *Pharm Exec* visited the site, seven "birds" were chirping in the sanctuary, ostensibly meaning seven people were logged in. Unless users create a therapy journal, there doesn't appear to be a way to communicate directly other than to "chirp" at someone else, similar to liking them on Facebook. Of the birds in the sanctuary when *Pharm Exec* arrived, none were reachable beyond a chirp.

Digital tools

Teva's Derkacz says Copaxone participates in all of the standard digital marketing channels, including CRM and database marketing, search optimization, display towers and banners, rich media, et cetera, but emphasizes that digital is not a silver bullet. "We're not taking a big gamble on one new innovative idea…we're making sure that we surround the patient and physician with what Copaxone is and what it can do," says Derkacz. "Let them pick the channel and the content they want to consume at the time they want to consume it."

Teva's Copaxone iTracker app, which anyone can download for free from the iTunes and Android stores, helps patients manage the injection routine—it's important to rotate the injection site—as well as set therapy reminders and receive prescription refill alerts, among other things. Derkacz says the wow factor for a prescription drug companion app is gone—"almost everyone's got an app"—but says iTracker "has been very well received by patients."

In April, Teva and Intouch launched a new "webTracker" tool which Goyer says is complimentary to iTracker, in that it allows patients who register with



HOW LOGISTICS FINDS HIDDEN VALUE IN YOUR SUPPLY CHAIN.

Knowing where to look is vital. Looking across your supply chain reinforces how enormously complex it can be to manage for greater agility, find efficiencies and identify cost savings. When you collaborate with UPS, you can tap into our expertise in healthcare logistics and utilize tools that can help better position your company for success.

ENGINEERED SUCCESS

The health of your supply chain has never been more important or strategic. The ability to quickly respond to market demands, target growth markets and ensure reliable supply is essential for success. UPS can help you rethink and redesign your supply chain to take advantage of new opportunities, investigate new channels and improve outcomes.

FINDING EFFICIENCIES

Turning supply chain inefficiencies into opportunities takes collaboration and innovation. You can reduce waste by using only the space you need when you leverage UPS's global network of healthcare distribution facilities. Coupled with our flexible transportation network, UPS can help identify cost savings throughout your supply chain.

LESS LOSS

Your products are developed for specific outcomes. If there's a compromise in quality, everyone loses. The patient's health suffers, your spoilage rates go up and your reputation can be tarnished. At UPS, our experts work with you to understand your products and offer a range of safeguard options to help shipments arrive in optimal condition, reducing product loss and improving your bottom line.

UPS has the expertise and experience to find hidden value in your supply chain. See how we did it for EndoChoice at ups.com/endochoice.

WE ♡ LOGISTICS™

Shared Solutions to login to webTracker and track "not just their injections but their overall feeling of well-being and current state of health." The webTracker tool helps patients figure out what to do if they forget a dose or use the wrong injection site, says Goyer. "We developed an algorithm, approved by Teva's regulatory staff, that automatically provides the next step for the patient," he says. "It's a tool that's a lot smarter than the tools have been in the past."

On the physician side, Intouch partnered with Harrison & Star, Teva's professional and direct-to-patient agency, for content and sales messaging materials used by sales reps in the field. Those materials are "all in a digital format and available to reps on the iPad," says Goyer. Mardene Miller, president at H&S, says the physician audience for MS—primarily neurologists—are "more the cerebral type," which seems fitting. "They're also very practical in terms of their clinical view, and they're very patient-oriented," says Miller. Teva fields a team of roughly 200 reps servicing around 7,000 neurologists in the US, says Hassler.

For the Copaxone 40mg launch, H&S developed new creative for both physicians and patients aimed at "reinforcing the overall Copaxone brand promise of trust and experience," says Kathleen Murphy, SVP, group account supervisor at H&S. "Coming soon" ads launched last October, three months prior to approval. The MS community is an active one, says Murphy, and they engage in a variety of digital channels. "But I don't want to underestimate the importance of the personal touch that Shared Solutions has with patients," she says.

Shared Solutions

Not everyone with a question about MS wants to address it to a screen or an algorithm. In preparation for the Copaxone 40mg launch in January, Teva hired an additional 100 people to work in the company's Shared Solutions group, and also added sales reps at a time when other parts of the company are shedding positions.

Shared Solutions was originally an independent third party patient services company, based in Kansas City. Teva acquired the group in 2002, and every executive interviewed for this article—internally and externally — pointed to Shared Solutions as a critical component of Copaxone's success. Anyone with MS, not just Copaxone patients, can use Shared Services free of charge.

"The key, I think, in the launch and success throughout the 17-year history of Copaxone has been Shared Solutions," says Derkacz. Shared Solutions is focused on three areas: assisting patients in getting access to therapy; providing one-to-one injection training to make sure patients have the best experience possible; and promoting adherence.

Shared Solutions has a call center component, where registered nurses answer inbound calls on a 24/7 basis, and also make outbound calls to patients who have signed up to receive them. There's also a field component, where nurses provide injection training at the doctor's office. Derkacz says physicians really appreciate this service. "They don't have the time or resources to do all of this training and hand-holding and educating that we can do for the patient [through Shared Solutions]," he says.

Patients like it, too. Derkacz and Nancy Leone, communications director at Teva, say patients form relationships with the nurses at Shared Solutions, sometimes over years on therapy. Teva has staged meetings at headquarters between patients and nurses who have bonded through Shared Solutions, to dramatic result, says Leone.

Patients are connected with Shared Solutions when they receive the first Copaxone prescription, and the group makes sure there aren't any hiccups in timely access to the drug. Shared Solutions is supporting the campaign to switch Copaxone users to the new formulation by answering questions, and placing calls, to patients who've opted in to the program, says Hassler.

Access to therapy

Copaxone enjoys "the best formulary positioning across the entire category, meaning that we have the least number of NDC blocks," says Derkacz. "You're talking 98% open access to this product." Teva offers a $0 copay option for eligible patients, as well as other kinds of qualified financial assistance. Asked about the CMS reversal and decision not to block copay assistance from drugmakers under Medicare plans, Derkacz said it was the right decision."We know that high co-pays have a negative impact on patient adherence...co-pay assistance can help achieve improved outcomes," he says.

The new Copaxone 40mg formulation is priced at 2% below the current price of Copaxone 20mg, a clear play at winning over the sympathy of payers, who may soon be forced to choose between a daily injection of generic Copaxone, or a three-times weekly version that would cost a good deal more.

On the question of whether payers might force patients onto the generic version of Copaxone 20mg (assuming a generic version is approved by FDA), rather than pay for the more convenient 40mg dose, Derkacz says that's not what Teva has been hearing from payers so far. "We're talking ethics here," says Derkacz. "How do you take a patient who has 200 fewer shots a year and then push them not only back to a once-daily formulation, but one that's unproven?" Teva has expressed doubt, in print and at just about every other opportunity, over the comparative effectiveness and safety of generic Copaxone.

Hassler says Teva expects to switch 30% to 50% of its current Copaxone 20mg patients to the 40mg version. Copaxone 40mg is the same glatiramer acetate discovered in Israel over 30 years ago, but not the same product; Hassler says the switch campaign boils down to this message: "We've taken the number

one product in the market place, and we made it better."

Copaxone through the years

After a group of scientists—Michael Sela, Ruth Arnon, and Dvora Teitelbaum—at the Weizmann Institute of Science in Rehovot, Israel, discovered copolymer 1, which would become Copaxone, they shopped it around to several large pharmaceutical companies. All of them declined; no innovative brand drug discovered and developed in Israel had ever been approved by FDA. Copaxone would become the first.

At the time, Teva produced generic medications exclusively, but Sela, from the original discovery team, was friends with Teva's founder and CEO, Eli Hurvitz. Sela and his wife Sara invited Hurvitz and his wife Dalia over to dinner. Sela arranged for a slide projector and screen, and the two couples reviewed data from the previous 17 years of copolymer 1 development. Intrigued, Hurvitz negotiated Teva's rights to the product with the Weizmann Institute, according to Teva.

Copaxone launched in the US in 1997 (and across Europe in 2001) but wasn't terribly convenient for patients. It was a frozen lyophilized product that required reconstitution before a traditional injection. The initial peak sales forecast was $250 million, according to Derkacz. In 2000, the Autoject device was introduced, making it much easier for patients to use. The same year, Copaxone jumped past Bayer's Betaseron to become the second most frequently used MS therapy. In 2002, prefilled syringes were brought to market, which again made administration easier for patients. By 2008, after Biogen Idec's Tysabri had been pulled from and then put back onto the market, Copaxone had become the market leader by prescription volume and demand.

When Novartis's Gilenya (2010), and then Biogen's Tecfidera (2013) hit the market, it was supposed to be curtains for Copaxone. "The reality is while they've gotten some traction, things haven't really changed a lot for Copaxone," says Derkacz. "We've been able to maintain prescription volumes for the most part, though 2013. And it really set the stage nicely for the launch of 40mg."

"How do you take a patient who has 200 fewer shots a year and then push them not only back to a once-daily formulation, but one that's unproven?"

—Mike Derkacz, Teva

Generics coming this month?

In January, a Teva-sponsored study published in PLOS ONE aimed to show a difference between Copaxone and a "purported generic" in development. In a release on the study, co-author Michael Hayden, president of global R&D and chief scientific officer for Teva, said the "data from this paper shows the possible significant ramifications of changes in physiochemical properties between Copaxone and a purported generic." He went on to say the study "suggests a distinct potential difference in the impact of a purported generic on the immune system of patients, with possible implications on efficacy and safety in relapse-remitting MS patients. Teva believes the only way to truly understand the impact of these differences is by conducting a full battery of clinical studies."

The active ingredient in Copaxone is a mixture of polypeptides containing a huge number of active amino acid sequences which can't be "accurately characterized using state of the art analytical techniques," says Hassler. "The only way to demonstrate efficacy, safety, and no differences in immunogenicity, is through well-controlled, comparative clinical trials."

It's unclear whether FDA will be sympathetic to this view. Craig Wheeler, CEO of Momenta, one of the lead developers of generic Copaxone, certainly is not. He says Teva is trying to "throw wrenches" into the FDA review process. Wheeler says he wouldn't give Teva his product for research, and doubts Mylan would have either, meaning the generic drug evaluated by Teva must have come from somewhere outside the US.

As for gene expression and the contents of the Teva study, Wheeler says "it's nice to put a big color graph in front of investors, but it doesn't really hold a lot of scientific water." Why not? "If you look at gene expression and how it works, it can vary animal to animal, it can vary by time of day, it can vary temporally," says Wheeler. "If you applied statistics to the data they've shown, you would have a hard time showing that there's any statistical significance in what they're saying."

Teva agrees to disagree, but the possibility of a generic 20mg Copaxone approval is one the company is nevertheless prepared for, says Hassler. "We'll continue to build brand loyalty, and at the end of this I believe most physicians and patients as well as many payers will opt for a clinically proven therapy."

The price of prevention

Copaxone is a disease-modifying therapy, but it doesn't stop the progression of MS. Patients and physicians, as evidenced by the level of utilization, are confident the drug does slow exacerbations of the disease, despite a Cochrane review that found "no beneficial effects on disease progression," and only a "slight beneficial effect in the

reduction of risk of relapses in relapse-remitting MS patients." Slight is better than nothing, and patients wouldn't keep injecting themselves everyday if they believed otherwise.

A neurologist and professor at one of America's top academic medical institutions—who asked to remain nameless for this article—said Copaxone's "importance lay in showing that an approach of this type can work, albeit modestly…that said, we have no definite idea of its mechanism of action."

To date, there haven't been any generic versions of disease-modifying MS drugs, which means that when a new product is approved, and priced, all the other products increase up to the new price level. "Pricing of MS drugs is a national scandal," said the professor, responding to a question about potential generic versions of Copaxone. "Anything that makes them more affordable is welcome."

Derkacz says Copaxone "has never been a price leader…and its pricing is largely reflective of investments made to research as the market-leading MS therapy." Derkacz also emphasizes the value and services built in to the cost; those nurses working for Shared Solutions might be free for patients to call, but they don't work for free. If a generic version does launch, how do payers put a value on injection frequency, particularly for patients who've developed injection site reactions?

It's not just MS, of course. Even products that are effectively curative, like Gilead's Sovaldi, for hepatitis C virus, are being challenged on price. For drugs targeting chronic conditions, where patients must take them indefinitely, often for the rest of their lives, pricing pressures will continue and are likely to intensify. Within the current system, the best cost solution is both the simplest and the most difficult: discover a cure, pay a premium, then develop a generic version. MS patients, their families, payers and even some taxpayers are willing to pay a little more in the short term for an assurance that the disease never comes back in the long run. PE

Ben Comer is *Pharm Exec*'s Senior Editor. He can be reached at bcomer@advanstar.com.

KORLYM: The Cortisol Connection

A repurposed drug shunned by some for ethical reasons has gained fresh momentum as the model for a new line of therapies seeking to mediate the impact of an essential human hormone—cortisol—on a wide range of life-threatening conditions, from diabetes to osteoporosis and even cancer.

By William Looney

Rare diseases are a rich and growing source of innovation in drug discovery—nine of the 27 new medicines approved by the FDA last year were for "orphan" indications affecting fewer than 200,000 people. But numbers alone don't reveal the significance the rare disease segment holds in spreading the institutional roots of innovation to new areas of unmet medical need. What really matters is how the orphan designation has helped broaden the horizons for biomedical entrepreneurs. These are individuals—scientists, academics, and clinicians, often from outside big Pharma—with the grit and vision to launch start-ups featuring medicines that extend treatments to patients underserved by the current R&D paradigm.

The science that yields these breakthroughs is often unconventional, but understanding the patient experience is an absolute pre-condition for success. Victims of rare diseases are angry, disillusioned, and often sadly uninformed: how do you cater to a customer base with a history of interactions with a health system that has very little to offer, and where the average time to an accurate diagnosis is measured in years? Patient expectations are high; researcher's reputations, as well as their wallets, are placed on the line; yet that lining is paved in silver, because ultimately everyone benefits from this expansion of the medicines frontier. Knowledge gained from the investments in rare diseases has led to the development of drugs for more common conditions like cancer, epilepsy, and dementia. The phenomenon even works in reverse, where older medicines in wide use have been repurposed as therapies for these small-population disorders.

A spiffy example is the best suit cloth for insight, so this year *Pharm Exec* decided to extend its "Brand of the Year" recognition to include an orphan drug for rare disease. We went looking for a medicine that combined three strengths:

- A novel clinical profile.
- An advance in the state of care for a difficult to treat condition, affecting a neglected cohort of patients.

INCEPTION TO LONG TERM

CHOOSE YOUR GUIDE WISELY.

AFTER ALL, THE JOURNEY TO MARKET IS OFTEN QUITE LONG.

As your new drug embarks on the long journey to market, having a dedicated partner can make all the difference. At PAREXEL we not only understand this, we pioneered strategic partnerships between biopharmaceutical companies and their service providers. From reductions in outsourcing costs to enabling access to new patients and markets, a strategic partnership with PAREXEL can help streamline processes and accelerate development cycles. The result is greater efficiencies across all phases of your product's development. Here's to a better journey.

To learn more about how we can help your journey, visit **PAREXEL.com/Partnership/PE**

PAREXEL®

YOUR JOURNEY. OUR MISSION.™

» Distinctive, multi-channel marketing geared to building community awareness around the disease, not the product.

We also considered the human element, embodied in someone who connected an untouched area of science to a new treatment opportunity—entrepreneurs, please step forward—as well as the brand's potential to seed growth in adjacent therapeutic areas, perhaps as the vanguard for an entirely new class of drugs.

KORLYM does not by itself decrease cortisol production but reduces its dangerous side-effects, especially the high blood sugar levels that usually lead to diabetes in patients with long-term exposure to excess levels of the hormone. Approved by the FDA in February 2012, the KORLYM label is a relatively narrow one, covering Cushing's syndrome patients with type 2 diabetes or glucose intolerance who are not candidates for or who have failed the most common treatment for Cushing's, which is surgery to remove the benign tumors that stimulate overproduction of cortisol.

"The potential indications around this ubiquitous and clinically underrated hormone take us beyond the rare disease state to those chronic areas where we still see large numbers of patients with unmet medical needs."

—Joe Belanoff, Corcept Therapeutics

Our choice—why?

And then we found it—in KORLYM, the first FDA-approved treatment for endogenous Cushing's syndrome, a serious, debilitating metabolic disorder caused by the overproduction of cortisol, a stress hormone, the effects of which can include hypertension, heart disease, diabetes, depression, chronic fatigue, obesity, and bone loss. An estimated 20,000 people in the US, mostly women, have Cushing's, which qualifies it for rare disease status. However, the real incidence is considered to be higher because it is frequently undiagnosed; many clinicians are unfamiliar with the disease and confuse it with other conditions that are often less lethal.

In addition, Cushing's has a strong co-morbidity profile: an estimated 3-5% of all type II diabetic patients have that condition due to the effect of uncontrolled cortisol proliferation on blood sugar levels; cortisol also erodes bone mass and is thus a contributing factor in osteoporosis.

A hormone that matters: Cortisol's big footprint

However, research indicates that KORLYM's main mechanism of action as a glucocorticoid receptor (GR-II) antagonist, which blocks cortisol from binding in the bloodstream, can improve clinical symptoms for other life-threatening conditions where excess cortisol has been identified as a causative factor. In this regard, KORLYM has potential value above and beyond its current status as one drug for a single rare disease. Could it be instead the vanguard of a much larger therapeutic franchise, one built around medicines that mediate the destructive effects of a single aberrant hormone on the nerves and tissues that keep us whole and healthy?

Corcept Therapeutics, the small, California Bay Area company that brought KORLYM to market, thinks it is. "KORLYM is the first step toward a business that we are creating around a unifying scientific theme, which is to understand how excess cortisol levels influence the incidence and progression of not just one, but potentially dozens, of different conditions," Corcept CEO Joe Belanoff told *Pharm Exec*.

From a purely medical perspective, the model makes sense: cortisol, which is found in more than 80% of all bodily tissues, is an essential regulator of system metabolism and proper organ function. A review of the clinical literature finds that, in addition to endocrine and metabolic disorders like Cushing's and diabetes, the effects of aberrant high cortisol are felt in CNS diseases, including psychotic depression, post-traumatic stress disorder, alcoholism, and early-stage Alzheimer's; ophthalmologic conditions like glaucoma and central serous retinopathy; osteoporosis; and even oncology, where research shows that cortisol can, in some cases, control the way tumors grow. Corcept is focusing its development pipeline on three main applications, covering psychiatry, metabolics. and cancer.

"The potential indications around this ubiquitous and clinically underrated hormone take us beyond the rare disease state to those chronic areas where we still see large numbers of patients with unmet medical needs," says Belanoff. The implicit message here is KORLYM exists as a prototype for something bigger—a new, multi-platform approach to identifying and treating disease.

Origins of an idea

But before the business model, there was an idea, one whose roots lay firmly in academic soil. In 1991, Alan Schatzberg, a practicing psychiatrist who trained at Harvard, joined the faculty of the Stanford Medical School as chair of its Department of Psychiatry and Behavioral Sciences, where he initiated a research project focused on the symptomatic biological origins of episodic psychotic depression, a little understood subset of

SMILEOSIS

A condition commonly caused by working with Fingerpaint. The elevated level of collaboration and energy can cause strange facial contortions in those new to partnering with a high-octane, truly integrated, independent advertising agency.

Call Ed Mitzen **518.488.8304** or visit us at **fingerpaintmarketing.com**

fingerpaint
Create
Something
Original

major depression, affecting about 15% of diagnosed patients. Schatzberg was motivated by his early interest in the biological roots of mood disorders, which ran counter to the Freudian sentiment among many in the profession that environment is determinative.

In the course of this work, Schatzberg discovered a correlation between cortisol and cognitive changes in patients with depressive psychosis, in which use of GR antagonists in test subjects led to a rapid improvement against delusional behavior. The fact that improvement occurred in a short period of time—as little as a week—is significant, as psychotic depression differs from other forms of mental illness by occurring in severe (suicide risk is high) but irregular bursts, after which there are long intervals where the patient is lacking symptoms.

Schatzberg and his colleagues at the Medical School continued to investigate the cortisol link in areas ranging from drug therapy to using imaging technology to identify stress responses in targeted areas of the brain. One volunteer was Belanoff, an undergraduate English major who at age 29 left a trading desk job on Wall Street to go to Columbia University Medical School; in 1992, he landed a residency in psychiatry at Stanford. "I was one of Schatzberg's first interviewees for a residency slot," relates Belanoff. "We hit it off after I told him I was specializing in psychiatry because we knew so little about how the brain works—and even less about the drugs the profession prescribes: why, for example, do we see the biological impact of a drug on mood or cognition in hours, while the broader clinical effects take weeks or even months? We can speculate, on an empirical basis, but precise answers to that question remain elusive."

One of Schatzberg's drug targets was mifepristone, originally identified as RU-486 by Roussel-Uclaf, the now defunct French company that developed it as a tool to induce abortions in women at risk in pregnancy. A synthetic steroid, mifepristone works as a dual action drug with properties that combine to block the female hormone progesterone and prevent the absorption of glucocorticoids in tissue and the bloodstream. The product was approved by the FDA in 2000 as an abortifacient for restricted use, under physician supervision, during the first seven weeks of pregnancy.

Although the abortion tag received top billing, there was a steady trickle of interest in mifepristone's properties as a GR antagonist, inhibiting the actions of cortisol on the brain and other major organs. Indeed, over the past 20 years, Schatzberg and his collaborators produced several dozen peer-reviewed papers analyzing how GR antagonists like mifepristone work in these areas. Given researchers' interest in the dual properties of the drug, the biological mechanisms behind mifepristone became very well known, making it a top candidate for several different clinical indications.

Corcept's anti-cortisol platform

Early on, Belanoff began to see commercial potential in the intriguing scientific knot that cortisol presented to leading academic researchers like Schatzberg. The work at Stanford in investigating links between GR antagonists and the control of episodic psychotic depression had produced a substantial library of intellectual property, much of which was sitting on the shelf. Belanoff, who by this time was looking beyond teaching at the Medical School and his private psychiatry practice, proposed to Schatzberg, among others, to put his Wall Street background to use in creating a start-up company to pursue commercialization of the cortisol research platform.

The first order was to go out and raise funds, and Belanoff developed a pitch for the Bay Area venture capital community focused on the ways mifepristone and a few other compounds might be repurposed as an indication for the symptomatic relief of psychotic depression, where there was no approved drug. Belanoff hit pay dirt with the local VC Sutter Hill Ventures—but only after 13 long interrogations led by ex-Syntex COO Jim Wilson, when the firm finally said it could no longer think of any reason NOT to invest. Corcept Therapeutics was incorporated in May 1998 with Wilson as Chairman, Belanoff as CEO and Schatzberg as a Board member (and passive shareholder). Employing a skeleton staff of 13, the company began working on two fronts: developing a proof of concept and clinical study program specifically focused on mifepristone's use in psychotic depression; and compiling an IP-protected library of selective GR antagonists—presently numbering more than 300, with mifepristone playing a central galvanizing role. Sharing this knowledge asset in collaborations with leading researchers and other external academic experts will also help Corcept improve the science and clinical understanding of how cortisol affects a wide range of diseases.

Despite this clarity of purpose, the hard reality is that Corcept spent 14 of its 16 years as a company without

Signs and symptoms of Cushing's syndrome

- Weight gain, especially in the upper body
- Rounded face and extra fat on the upper back and above the collarbones
- High blood sugar (diabetes)
- High blood pressure (hypertension)
- Thin bones (osteoporosis)
- Muscle loss and weakness
- Thin, fragile skin that bruises easily
- Purple-red stretch marks (usually over the abdomen and under the arms)
- Depression and difficulties thinking clearly
- Too much facial hair in women
- Irregular or absent menstrual periods and infertility
- Reduced sex drive
- Poor height growth and obesity in children

Source: cushingsmoxie.blogspot.com

WHY GIVE LESS THAN 100%?

You could hire a separate digital agency to build your website. Maybe another to manage your social media. But multiple agencies struggling to keep content aligned while also trying to pilfer each other's work is a recipe for inefficiency. And disaster.

Why not give 100% to an agency that's successfully incorporated digital media into its clients' branding mix for more than 15 years? One whose only agenda is delivering the right content, through the right channel, to the right audience. Who's 100% committed 100% of the time.

100% COMMITTED TO YOUR BRAND

IT'S THE WAY WE THINK

AbelsonTaylor

any marketed product. Driving forward an approved indication on psychotic depression using mifepristone has yielded some modestly encouraging trial results, but so far nothing is definitive and the trial has taken longer than expected—a pivotal Phase III trial involving 450 patients with a 1,200 mg dose of mifepristone is underway, with interim findings due at the end of the second quarter. If the trial meets its endpoint—a measurable, rapid reduction in psychosis—the company intends to proceed with a new drug application (NDA). The goal is to finally turn this indication into Corcept's second marketed product. Last December, the company also announced it was filing an investigational new drug (IND) application for a Phase I study on mifepristone as an indication for triple-negative breast cancer, its first foray into oncologics—and yet another specific condition lacking any drug treatment.

Vanguard therapy

KORLYM, however, proved to be the early bet that turned the cards in Corcept's favor, making these additional discovery investments possible. In contrast to the complexities built into a CNS indication, mifepristone's clinical potential for endogenous Cushing's syndrome was recognized as far back as 1985, with more than 50 studies subsequently corroborating its effects.

"When we analyzed the science, it became clear that the controversy around the drug's separate profile as an abortifacient was inhibiting interest in its application to Cushing's. The political baggage was very similar to thalidomide," Belanoff said. "Yet any rational analysis would have to balance that against the high level of efficacy documented in the studies as well as the sheer need—the medicines chest for Cushing's was flat empty."

In fact, the one drug that was in common use, ketoconazole, was under scrutiny for cases of liver damage after long-term exposure to patients.

Fast work from FDA

In 2007, Belanoff and his scientific team initiated a conversation with FDA staff on mifepristone as a treatment for Cushing's, receiving an unexpectedly positive reception. In rapid order, the company secured orphan-drug status for the proposed indication in treating Cushing's with type 2 diabetes—the FDA estimated the eligible population at around 5,000 patients—followed by the filing of an NDA and request for Priority Review, in April 2011.

The NDA package included the results of a 50-patient trial, in which mifepristone delivered "significant improvement" in blood sugar control along with marked reductions in insulin requirements. A REMS proposal was also included to address the dangers associated with the drug's alternative use as an abortifacient. However, when the FDA approved registration status for the drug 10 months later, it decided a full REMS was not necessary because of the small number of physician prescribers and the company's pledge to maintain tight control of distribution through a single designated specialty pharmacy, Dohmen Life Science Services. There is also a post-marketing requirement to report use data (age, sex, dose, and duration) and, of course, any side-effects.

KORLYM made its debut only two months after marketing authorization, in late April 2012. The quick start was aided by the company's advance work on a REMS package; though it turned out it was not needed for approval, the preparation forced management to focus on something that proved critical to building the brand: the patient context. It was noted early on that endocrinologists are very test-oriented in treating Cushing's.

"Because diagnosis is so difficult, repeated testing is the profession's stock in trade, because surgery is the default option once diagnosis is confirmed," Commercial Operations Director John Lyons told *Pharm Exec*. "We recognized a stronger patient voice was needed to move drug therapy forward in the treatment discussion."

"The clinical inertia around [Cushing's] is intense. We couldn't take the approach of a 30-second detail with the boilerplate message KORLYM is the right drug for your patients."

—Steve Lo, Corcept Therapeutics

A patient-centric approach also made sense from the clinical perspective. "In Cushing's, every case is unique," says Corcept Chief Commercial Officer Steve Lo. "There is the bewildering multiplicity of symptoms, which also vary by degree, as well as individual variations in relapse rates, which can be high when initial surgery fails, leading to scattershot measures involving additional surgeries, radiation, off-label use of other drugs, or outright removal of the adrenal glands—there is no standard protocol."

According to Lo, this heterogeneity required substantial investment in a different kind of sales force, one with the practice familiarity and the scientific skills to market KORLYM almost on a case-by- case basis. "The clinical inertia around this disease is intense," Lo said. "We couldn't take the approach of a 30-second detail with the boilerplate message KORLYM is the right drug for your patients."

Plan your next meeting in

THE HEART OF A RENOWNED MEDICAL COMMUNITY.

No community has more medical credentials than Baltimore. Not to mention a wide range of gourmet dining, world-class museums and boutique shopping. Hold your next medical, healthcare or pharmaceutical meeting or convention just two feet from some of the country's most advanced research and treatment facilities, with access to some of the greatest medical minds in the world.

+/- **184,000** MARYLAND HEALTHCARE PROFESSIONALS IN 2013
36,000 INCREASE IN 10 YEARS

500 CORE BIOTECH COMPANIES NEARBY

#1 NATIONWIDE IN RESEARCH & DEVELOPMENT FUNDING

+/- **27,000** BIOTECH AND DIAGNOSTIC PROFESSIONALS IN MARYLAND

Home to Johns Hopkins Medicine and the University of Maryland Medical Center

More than 24,000 physicians statewide

More than 8,500 hotel rooms and 1.2 million square feet of convention center space

Download Baltimore InSite for a virtual tour of the Convention Center, hotels, restaurants and more

For a site visit or more information, call Visit Baltimore at 800.343.3468 or go to www.baltimore.org.

Just two feet away.

MARYLAND
VisitMaryland.org

Visit Baltimore™

The Baltimore Convention Center

Launch learnings

Like many drugs today, KORLYM posted a slow start. Sales hit $2 million a year after launch but rose faster in the fourth quarter of 2013, where sales hit $4.1 million—a 58% rise over the previous quarter, lifting the full year total to $10.4 million. The company is projecting sales at more than double that for this year, in the $24 million to $28 million range. There is additional room to build; due to its orphan drug status, KORLYM has marketing exclusivity in the US until February 2019.

One key learning from the launch was the importance of defining the boundaries of the prescriber network. Early on, the assumption was that, as in most other rare diseases, the sales potential for KORLYM rested on a select few academic teaching hospitals and the specialist networks around them. Close review of claims data (Cushing's has its own ICD9 diagnosis code) indicated that this would also be the norm for KORLYM. So the focus was to create a team of "medical science liaisons" able to bridge the gap between clinical expertise and the real world of patients.

But actual experience proved otherwise, which slowed uptake in the first few months. "We noticed that, while patients did interact initially with the academic medical centers, there was a tendency for them to disperse back to caregivers at the community level—endocrinologists not affiliated with any of the large networked hospital centers," says Lo. "This was a group of prescribers we weren't covering; in fact, at the time we lacked the bandwidth to do so." Lo noted that Corcept was small enough to respond quickly, making investments in a new 20-member field force geared to this constituency. "The lesson is to subject the claims data to a 'strength test' by actually tracking the patient journey through the health system," he said.

Another lesson was finding the right message that worked with payers. Starting early, management briefed key PBMs on the disease and the drug, focusing on its narrow indication, the small target population, and the huge unmet need along with adjacent co-morbidities, where the amelioration of symptoms in chronic conditions like diabetes translates into big savings on treatment costs. At the ex-factory wholesale price of 87 cents per milligram, treatment costs per patient for KORLYMN can average a pricey $20,000 a year. Nevertheless, the impact is relatively diffuse: according to management, seven large health plans estimated their patient burden under the drug would amount to no more than 20 people.

"There is a clear unmet need for patients in whom standard treatment approaches haven't worked, so payers are recognizing this by placing few reimbursement restrictions," says Lyons.

To defer cost concerns, Corcept provides the drug to uninsured patients through a patient assistance program, SPARK (Support Program for Access and Reimbursement for KORLYM), which also funds co-pays of up to $5,000 annually per patient, based on need. Cases are referred through partnerships with patient advocates like the National Organization for Rare Diseases (NORD).

Messaging on mifepristone

Finally, management took a forthright stance to counter the stigma associated with mifepristone's dual use in terminating early-stage pregnancies. The FDA proved to be a central player in deflecting the negative connotations. It took these head on in its approval release for KORLYM by emphasizing the tight controls on distribution jointly agreed with Corcept—the company actually mimicked the approach taken when mifepristone is prescribed as an abortifacient—along with a black box warning against use of the product during pregnancy. According to Belanoff, "what we found is the FDA actually proved to be a sympathetic ally in establishing the legitimacy of this drug." Corcept is pursuing the same high engagement approach in its pending application for a marketing license for KORLYM at the European Medicines Agency (EMA).

Corcept has also had success with the argument that precedents like thalidomide offer proof that a repurposed medicine with a different indication can be administered safely while providing an option for patients without hope. "The ravage this disease imposes on patients is sufficient to make the case that KORLYM should be available, because alternatives are few and far between," said Dr. Pejman Cohan, a Los Angeles-based endocrinologist who specializes in Cushing's. He points to the difficulty in diagnosing Cushing's as a defense for the drug. "Getting to the root of this disease is a complex, sometimes contradictory task at the individual patient level," said Cohan. "Lab tests are often not definitive, with many false positives, so access to a drug treatment that is safer than invasive surgery and also reversible is a choice both I and my patients like to have."

Physician talk therapy

To reach this year's goal to double KORLYM sales, management is continuing to refine the demographics of the prescribing community while improving its understanding of the patient journey. In contrast to other rare diseases, few endocrinologists treat Cushing's exclusively, especially now that other metabolic disorders like diabetes attract more patients. On top of that, clinical protocols for Cushing's are entrenched—this is not a community of early adopters. "Our biggest hurdle in marketing is taking the physician from zero prescriptions to one, because after they see KORLYM works in that first patient the resistance to trying something new will fade," Lo told *Pharm Exec*. In other words, education is the focus: it's going to take a little extra time to show practitioners there is a new kid on the block. PE

William Looney is *Pharm Exec*'s Editor-in-Chief. He can be reached at wlooney@advanstar.com.

Plugging the Awareness Gap: Social Media Steps Up

Seeking that vital connection with patients usually requires no invitation for brands targeting a rare disease—the patient community tends to self-identify, minimizing investments in market demographics, while the level of unmet medical need fosters a more active patient engagement in building the brand's competitive profile. The rare hormonal disorder known as Cushing's syndrome may be the exception to the rule, which makes the patient outreach campaign accompanying the 2012 launch of KORLYM a landmark in using social media to overcome a central fact about this disease: most victims know they are sick, but don't know why, because the average time from symptoms to diagnosis is five to seven years.

In developing the medical history around Cushing's, Corcept managers noticed a recurrent theme of isolation among patients, whose disabling and disfiguring symptoms are often attributed by others not to the illness itself but to will power, self-control, or emotional instability issues. "The fallout from this disease is manifested not only in its life-threatening physical toll but the social consequences, particularly among women, which can range from a job loss to the breakup of marriages and battles over child custody," Katherine Waidner, Corcept's in-house Patient Advocate, told *Pharm Exec.* "Cushing's presents differently from patient to patient and the awareness among health practitioners of symptoms is limited and evolving, which results in very high levels of misdiagnosis and undertreatment. We came to the conclusion that disease awareness was so low we would have to make an investment in creating the sense of community that empowers patients to demand better care and more options toward a cure."

Corcept decided to focus its marketing efforts for KORLYM around an interactive social media platform that is disease-centric rather than product-centric. Better awareness and education of Cushing's is the goal, and to do that the company enlisted the digital media agency Heartbeat Ideas to create a program consisting of three interrelated parts:

- A web-based public forum—**Cushing's Connection**—for the exchange of ideas, information, and personal stories as well as extensive independent information on the disease. A hallmark of this digital agora is a dedicated **Facebook** page (https://www.facebook.com/cushingsconnection), whose unique feature is its allowance for open rule-based commenting—a freedom that most other company-sponsored sites forbid on grounds it could create liability for inadvertent off-label product claims. Corcept has invested in technology that pinpoints irregularities before they occur and because the site is disease-centric, there is actually very little discussion about the KORLYM brand itself, which has its own separate website.
- A user-friendly mobile app, **The Symptom Tracker**, which contains software allowing patients to identify their symptoms and evaluate whether these are receding, stable, or progressing. One tool allows the patient to anonymously compare their situation against a cohort of other patients at a similar stage of the disease. And the data can easily be downloaded and shared with his/her physician, a fact that improves the productivity of every office visit. In fact, the Tracker addresses a key feature of the practice culture around Cushing's: the endocrinologist's reliance on lab tests and other metrics to certify diagnosis as well as track the prospects for a relapse after surgical treatment—for a large minority of Cushing's patients, the benign tumors that trigger excessive cortisol production do recur. Being able to take that perception of feeling less well and turn it into a metric that the endocrinologist can respond to helps structure and record the conversation with the physician; and it is typical of Cushing's patients to see multiple physicians over the course of diagnosis and treatment.
- The third element is the Cushing's **Patient Advocate Program**, which adds a human touch to the campaign through a dedicated team of internal staff offering personal support to patients, answering questions on treatment options, obtaining medication, and providing referral options for providers and other patient advocates. Staff coordinate a modest grant project to patient organizations and works closely with the commercial and R&D teams to ensure the patient perspective is incorporated in the academic partnerships Corcept is pursuing to bolster its pipeline of GR antagonists.

Heartbeat Ideas CEO Bill Drummy says that proof of the value of Corcept's platform is found in the open embrace of the community—something that in social media can never really be anticipated until it happens. "Most pharma company sites are neither social nor media—the conversation is controlled and thus lacks immediacy and intimacy, says Drummy. "Instead, we've been stunned by the unguarded personal openness of the group conversation. It works precisely the way Facebook is supposed to work—so well, in fact, that we have seen banner ads from rival drug Signifor popping up on the Facebook page, the sincerest form of flattery. "

Drummy contends the key learning from developing the unique "Symptom Tracker" app is to plan more time to handle adaptive design implementation, where content and functionality of the app work across multiple platforms—website, mobile phone, or tablet. "There are enormous benefits to an adaptive design approach, but making everything function across multiple platforms is a challenge. You need to understand and plan for the right amount of conceptualization, development, and quality assurance."
— William Looney, Editor-In-Chief

ENTERPRISE

STRATEGY

SEO

MULTICHANNEL

MEDIA

MOBILE

CRM

CONSULTING

HCP + CONSUMER

SOCIAL

DATA & ANALYTICS

CREATIVE

IT'S IN OUR GENOME

IT'S WHAT WE WERE BORN TO DO

Redefining what marketing means to pharma.
Creating engagements with value and purpose.
Leading integrated services with our digital DNA.

When you're born to do something, *it comes naturally*.

Realize your potential with integrated services from Intouch Solutions.

INTOUCHSOL.COM/GENOME

INTOUCH SOLUTIONS®

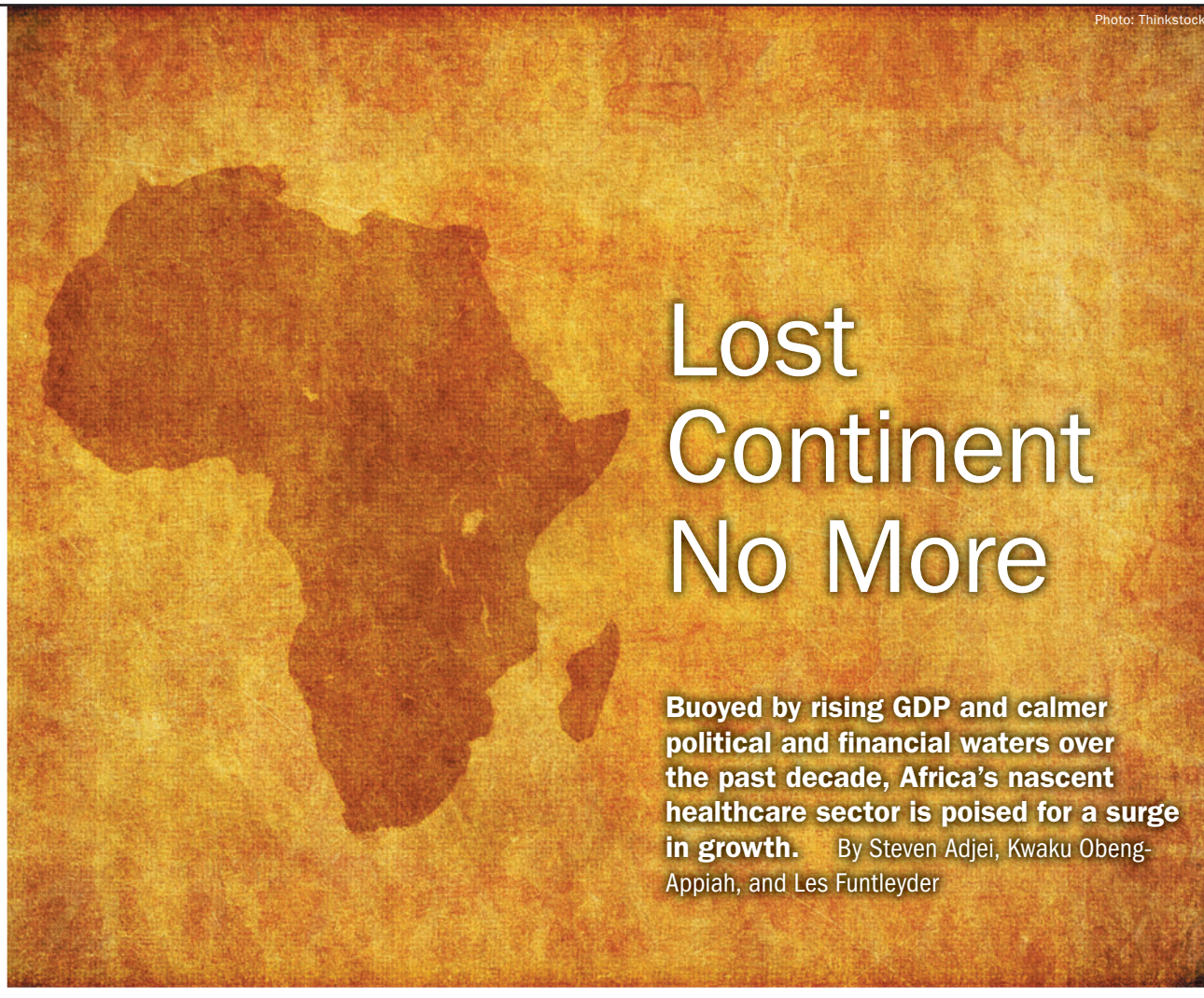


Photo: Thinkstock

Lost Continent No More

Buoyed by rising GDP and calmer political and financial waters over the past decade, Africa's nascent healthcare sector is poised for a surge in growth. By Steven Adjei, Kwaku Obeng-Appiah, and Les Funtleyder

Even though Africa boasts a fifth of the world's population, it only accounts for 3% of the world's foreign direct investment (FDI). Corrupt governments, the legacies of colonization, coup d'états, civil wars, bad governance and unfortunate natural disasters have all conspired to hinder Africa's growth, whilst the rest of the world marched on.

But in the last decade, things suddenly began to change. Improved governance, better market-friendly policies, the decline of civil wars, as well as the establishment of democracy began to yield accelerating economic stability and growth.

In telecommunications, Africa has more people connected to a mobile network than the whole of Europe; economic growth, though not quite the 7% needed to achieve the Millennium Development Goals (MDGs) set by the World Health Organization in 2000, was relatively close at 5–6% in the last decade, according to a report by the Commission for Africa in 2010.

According to the World Bank, 60 million Africans earn over $3,000 per year, a figure set to reach 100 million by 2015. The consumption of Africa's households has grown by $275 billion in the last decade, similar to Brazil, and higher than India (see Figure 1 on facing page).

The February 2013 edition of the African Business newsmagazine stated that if current growth continues, by 2050 roughly 300 million Nigerians will enjoy an average income of $10,000 with a GDP of $3 trillion, similar to Germany today.

Africa's economic output has almost tripled in the last ten years; more wealth has been created in Africa in the last decade than any other time in its history, writes Evelyn Mhango, an economist in the "Fastest Billion."

The reasons for this explosive growth are manifold:

- Improved government policies have increased the scope for the private sector to grow, and have created the low-debt, low-inflation, much improved macro-conditions that have enabled this growth.
- According to Ernst & Young's (EY) African Attractiveness Survey, the strengthening of regulatory and legal systems, privatization of public

enterprises and the opening up of economies to international trade have led to the quintupling of exports, record inflows of FDI and a doubling of per capita GDP.

- Increased democracy and the sharp decline of civil wars.
- David Mataen's book, *Africa, the Ultimate Frontier Market*, lists eight megatrends that have driven Africa's current and future economic realities: population growth and demographic shifts; cultural revolutions; rapid urbanization; commercialization of essential services such as healthcare; deregulation and liberalization; growth of credit; capital market development; and consolidation and evolution of intra-African markets.
- The recent debt relief through the IMF/World Bank Highly Indebted Poor Countries Initiative (HIPC) have enabled African countries to divert much-needed funds earmarked for debt repayments into health, education and infrastructure.

According to *TIME* magazine (December 3, 2012), business increasingly dominates foreign investment in Africa. Investment first outpaced aid in 2006, and now doubles it. This growth was, contrary to popular belief, spread across various sectors.

Healthcare problems

Healthcare outcomes in sub-Saharan Africa remain the worst in the world. Even though its population is around 11% of the world's total, it bears a quarter of the global disease burden; less than 1% of the global health expenditure is spent here, and it has just 3% of the world's health professionals.

Infectious and parasitic diseases form the bulk (42.4%) of the disease burden in Africa, but this is rapidly being compounded by the sharp rise of NCDs, particularly diabetes, chronic respiratory diseases, cancers and cardiovascular diseases.

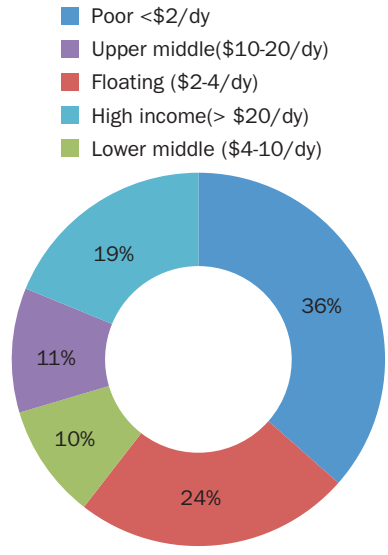


Figure 1: Distribution of the African population by income (including remittances)

A major problem is the sorry state of the majority of Africa's public health systems. Billions of aid spent on improving Africa's health systems has yielded poor results. Health systems are grossly understaffed, have crumbling and decaying infrastructure and are short on medical supplies. In addition, being built, equipped and trained to handle mainly parasitic and infectious diseases, Africa's health systems are ill-prepared for this extra epidemic of NCDs.

Mark Swai, former hospital director of the Kilimanjaro Christian Medical Centre, talking to *Pharm Exec* in 2013, said "the beds of our new HIV/AIDS were filled with HIV patients whose diseases were not under control. Since the introduction of affordable anti-retroviral drugs that decreased the disease burden, those beds are now filled with diabetes patients."

Due to these chronic problems, most Africans flock to the private sector, not through choice but because in most cases, it remains the only option.

But the private sector is also bedevilled with its own serious issues; poor managerial competency and regulatory oversight mean that prices for essential drugs cost hundreds more than the trade costs, services are poor, staff are badly trained with questionable ethics, the sector is plagued with excessive fragmentation, and medicines are either poor quality, expired or counterfeited.

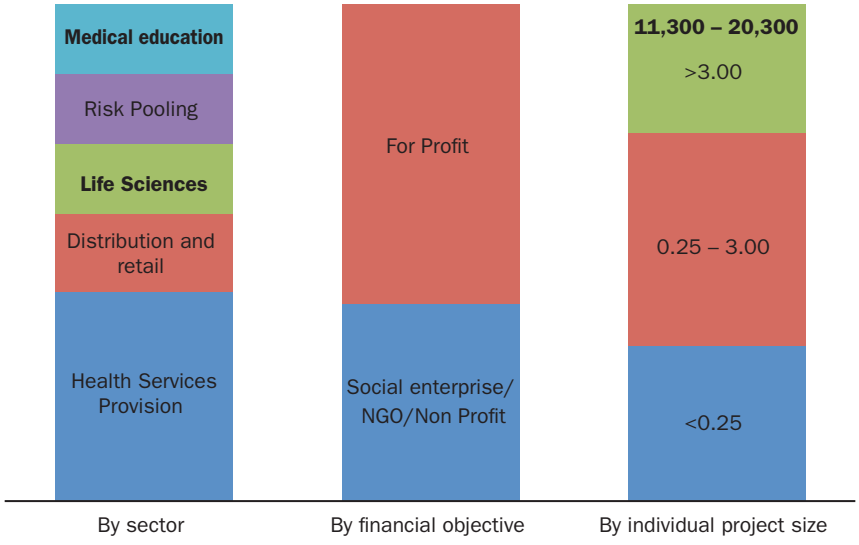
Opportunities for growth

The problems listed above, though posing huge issues, point to a low-hanging-fruit market that is ripe for innovative disruption and presents huge opportunities.

Faster economic growth signals that the healthcare market is sure to grow; the International Finance Corporation estimates that the pharmaceutical market will expand to $35 billion by 2016, and $40 billion in 2020, surpassing the UK. Spending on healthcare has increased by a compound annual growth rate of 9.6% since 2000. This demand for better healthcare presents several different bankable opportunities (see Figure 2 on next page).

The IFC estimates that $25-30 billion in new investments will be needed to meet the demand for medical care between now and 2016, of which up to 40% is expected to come from the private sector; Robertson,

Africa's economic output has almost tripled in the last ten years; more wealth has been created in this period than at any other time in its history.



Source: The Fastest Billion (2012) Mckinsey reports, Ministries of Health Files

Figure 2: Breakdown of private health investment opportunities in sub-Saharan Africa, 2007-2016
%, $ million (11,300-20,300)

writing in *The Fastest Billion*, expects a real increase of 72% in health expenditure through 2020.

Investing in healthcare also makes financial sense; in stark contrast to the 9.6% CAGR in the African healthcare sector from 2000, the healthcare, drug retailing, and pharmaceutical market growth were all in the six-worst performing sectors in the Financial Times Share Exchange (FTSE) 350 in 2012 (see Table 1 on page 46).

However, private investment into the healthcare sector in Africa has been strikingly low:

- EY's African Attractiveness survey revealed that, of the $587 billion of FDI that Africa attracted in 2011, only 1% went to healthcare projects.
- In one of McKinsey's often-quoted studies on Africa, "Lions on the Move (2010)," healthcare is not in the top 12 sectors for attracting investment.
- According to an EY study, of private equity in Africa, healthcare accounted for only 5% of exits by sector; even though 70% of FDI was in the services sector, healthcare did not even make the top ten.
- In the three best-selling books, *Africa Rising* (2008), *Africa, the Ultimate Frontier Market* (2012), and *The Fastest Billion* (2012), healthcare does not feature in the listings of the sectors most attractive for investment.

The five determinants of FDI in healthcare in sub-Saharan Africa

1. The question of affordability. According to Vijay Mahajan's *Africa Rising* (2009), the low-hanging fruit—or the elite (Africa One)—is the target of most private for-profit healthcare investments in sub-Saharan Africa. These models tend to be fragmented with minimal capitalization and are non-scalable, putting them beyond the reach of the middle class (Africa Two), where the real per capita growth is taking place (see Table 2 on page 46).

Lack of properly developed affordable health insurance schemes also compounds the affordability problem, further worsening the ability of Africans to pay for healthcare treatment.

2. The question of tangibility. The issue of tangibility as a determinant of FDI into healthcare can be divided into three areas:

- Lack of data: African healthcare data is at best fragmented, unreliable and vertical, hence, increasing risk and, therefore, unappealing to investors.
- Healthcare infrastructure and uncertainty of demand: Healthcare investing involves huge sunk costs; the issue of affordability leads to uncertainty of demand, which in turn discourages high-level investment.
- Lack of tangibility: Healthcare is an intangible asset, which cannot be measured, unlike a mobile phone or FMCGs.

3. The question of intellectual capital. The issue of "brain drain" has been one of the most problematic areas in healthcare in Africa. As a result, partly at least, sub-Saharan Africa has the lowest availability of qualified medical resources in the world.

Healthcare outcomes in sub-Saharan Africa remain the worst in the world.

4. The question of uncertainty and risk. Dr. Ernest Darkoh, founding partner of Broadreach Healthcare, an African-based healthcare consultancy, bemoans the "perception of risk putting many investors off making major investments in healthcare in Africa despite the good opportunities available."

Aside from the general perceived and actual risks in investing in Africa, political risks and instability also tend to affect the healthcare sector more disproportionately compared to other sectors due to healthcare provi-

sion being perceived as a right, not an option, by most African countries.

Linked to political risks are regulatory risks—government resistance to reforms, an inadequate and discriminatory regulatory structure, continued threats of strike action by healthcare professionals, and the reluctance to privatize public systems. The availability of cheap money in the form of aid is also a massive put off for potential for-profit investors.

5. The question of competitive strategy. Governments and host countries may need to promote and market healthcare more vigorously to attract increased FDI into the sector. However, any marketing strategy must be backed up by advantageous location-specific advantages on the ground. The most critical factors facilitating healthcare FDI in Africa are market openness, good quality government institutions, regulation harmonization and a good regulatory environment.

Many first-time investors into healthcare in Africa have had bad experiences, and, thus, have now become very tentative. To enter an African market, it is vital to choose the right country, the right risk profile, and the right model. This necessitates a lot of research work and market analysis. Alliances with domestic African healthcare businesses may increase penetration efficiency and decrease risk.

Linking the five determinants: Systems thinking and scalability

The five determinants can be represented as interdependent points on a star with strategy as the head. These determinants should be in constant alignment with each other to attract optimal FDI.

For instance, a lack of human capital in a particular FDI target instantly increases affordability (more expensive due to increased demand), increases risk (increased risk of strikes, political instability, etc.) and decreases tangibility. Hence, the determinants are to be thought of as related to each other much like an ecosystem, rather than focusing on one detail at the expense of the other—the so-called "systems thinking."

Related to this idea is the issue of scalability. Successful large-scale investments into healthcare in Africa should be affordable to the elite and the middle classes, should have an easily reproducible, standardized scalable model, should take into consideration the lack of highly skilled personnel and should tackle NCDs as at least part of its healthcare strategy. Standardization helps to ensure quality and uniformity and, hence, reduce clinical and operating risk.

Examples of successful models using those principles are the franchising model used by the Healthstore Foundation in Kenya; the organic reproducible model used by Vine Pharmaceuticals in Uganda; and World Health partners creating market efficiencies by using telemedicine to connect rural patients and semi-skilled health officials to skilled care professionals.

Healthcare investors who look for these simple principles in addition to their normal due diligence are more likely to see more large scale investments being bankable and profitable, as well as having maximum impact—what Andrew Kuper, head of Leapfrog Investments, calls "profits with purpose." PE

Steven Adjei (stevenadjei@bluecloudhealth.com), **Kwaku Obeng-Appiah** (k.obeng-appiah@bluecloudhealth.com), and **Les Funtleyder** (lesfuntleyder@bluecloudhealth.com) are consultant partners at the African healthcare investment facilitating firm, BlueCloud Healthcare (www. bluecloudhealth.com).

Table 1: FTSE sector performances, the six worst performers in 2012

Sector	Performance change in 2012 (%)
Healthcare	–6.1
Pharma and biotechnology	–6.9
Oil and gas	–11.8
Food and drug retailers	–12.0
Mobile telecoms	–12.6
Industrial metals and mining	–30.1

Financial Times Share Exchange Index adapted from September 2013 "Your guide to the FTSE 350" from the Investors Chronicle News magazine app.

Table 2: The potential of Africa's elite, middle class, and poor

Segment	% Of Market	Estimated African Population
Africa One (elite class)	5% – 15%	50–150 million
Africa Two (middle class)	35% – 50%	350–500 million
Africa Three (poor)	50% – 60%	500-600 million

Source: Mahajan (2009)

The issue of "brain drain" has been one of the most problematic areas in healthcare in Africa.

COMMAND THE WORLD'S FASTEST GROWING MARKETS

Brought to you by *Pharmaceutical Executive*: expertly maneuver your way through government policies, business regulations, and cultural nuances—to success!

- Insider details from interviews with major players
- Key drivers of rapid & sustained growth
- Perspectives from local/multinational companies, manufacturers, distributors, experts & legislators

Last to enter the financial crisis and first to emerge, the ninth-largest pharmaceutical market in the world has created a new block of middle-class "pharmerging" consumers. Includes company directory.

BRAZIL

Favorable government policies towards healthcare and innovation are driving a 20%+ compounded annual growth rate in the third-largest pharmaceutical market.

CHINA

Thanks to the ratification of more than a dozen free trade agreements, foreign direct investment has reached record highs—good news for the pharmaceutical industry as the country continues positive transformation.

COLOMBIA

In 2012, it enjoyed its biggest year for foreign direct investment in more than a decade, and its prime minister has promised he'll make it the best small country to do business in by 2016.

IRELAND

Despite its small size and lack of natural resources, it's prosperous, competitive, and in an enviable geostrategic location in Europe—holding assets for the development of a knowledge-based economy.

BELGIUM

5 ESSENTIAL PHARMA REPORTS FOR DOING BUSINESS GLOBALLY

order today at industrymatter.com/5reports

receive your reports via PDF download—instantly!

Pharmaceutical Executive | Pharmaceutical Executive Global Digest | Focus Reports Ltd | industrymatter comprehensive information for professionals

Does Your Rigor Match Your Risk?

Digital technology has changed the risk relationship between brands, HCPs, and patients—it's vital to get that technology working right the first time.

Pharmaceutical companies are undergoing radical changes—they are no longer solely in the compound development and brand marketing businesses. Today, they're moving more and more into the patient care business. Along with that, comes different responsibilities.

Back in the day, the only relationship that mattered was the one between your brand and the physician. Simply put, doctors prescribed your drugs to help patients. Today, not only can doctors prescribe your brands, they can also recommend your technology.

However, the increasing complexity of technology leads to increasing risk and greater scrutiny.

What does this mean to Senior Directors and Franchise Leaders at pharmaceutical companies? It means that there is a need for better process and quality assurance benchmarks.

Technology is a double-edged sword

Technology offers the promise of engaging patients on a level never seen before. The benefits of an engaged patient start with increased compliance—a great thing for pharmaceutical companies—and extend to a more active and empowered consumer of healthcare, and ultimately to better and more affordable outcomes.

Your marketing teams and agencies have been rightly focused on developing up-to-date, innovative digital tools in order to engage healthcare providers and patients.

However, in their rush and excitement, have they ensured the correct infrastructure and processes are in place to mitigate risk? Clearly, digital requires a new level of rigor.

Scott Hansen is VP, Executive Director, Digital Creative, AbelsonTaylor. He can be reached at Scott.Hansen@abelsontaylor.com.

Geoff Melick is EVP, Chief Innovation Officer, GA Communication Group. He can be reached at gmelick@gacommunication.com.

However, like HealthCare.gov, not enough time was put into the quality assurance process during development. Problems occur as soon as patients start using the app on their mobile phones. Quickly, it becomes clear that the app needs to be discontinued.

What was thought to be a successful launch turns into a mess when patients complain to their physicians about the poor performance of the monitoring app.

This negative feedback leads to lost revenues, damaged relationships with healthcare professionals, and increased scrutiny of your new brand—now compromised by a technological glitch.

And, unfortunately, you find yourself in ex-HHS Secretary Kathleen Sebelius's shoes.

Pharmaceutical executives need to think about evolving technology and be prepared for the impact when glitches happen. After all, the possibility exists that glitches may represent the same level of liability as a brand recall.

After all, what could go wrong?

Consider this scenario: As a Senior Director and Franchise Leader, you're responsible for the successful launch of a new drug for a chronic condition. In your tactical mix, you're including a downloadable monitoring app as part of the starter kit.

Your extended team executes what appears to be a flawless prelaunch-to-launch plan. All of the programs and tactics are successfully kicked off.

Or, so you thought.

Physicians begin writing new Rx's and handing out the starter kit. They're excited that their patients will have a digital monitoring app to go along with the new drug regimen.

Your brand Is liable

Cases like these are not atypical in today's world. Pharmaceutical executives need to think about evolving technology and be prepared for the impact when glitches happen. After all, the possibility exists that glitches may represent the same level of liability as a brand recall.

If your digital property is riddled with errors, your target is going to have a suboptimal experience. In other words, defects erode the relation-

Shift Left: QA integral across digital project continuum

Courtesy of AbelsonTaylor and GA Communication Group

ship your target has with your brand.

Finally, when problems get big enough to make it to the boardroom, it doesn't matter how small the glitch was that occurred. The outcomes can be devastating to a brand's revenue and to how both the brand and company are perceived. Senior executives need to be more cognizant of the time and costs associated with providing appropriate quality assurance scrutiny for the development of digital communications and apps that, if not done correctly, can have a major impact on your business.

Quality assurance strikes a nerve

In October 2013, GA Communication Group and AbelsonTaylor hosted the first-ever Quality Assurance Summit for Digital Healthcare Marketing in Chicago. It brought together more than 50 senior marketing directors, QA professionals, and digital directors from some of the leading healthcare companies and advertising agencies to discuss, evaluate, and scrutinize how digital quality assurance processes are being handled by the industry.

The summit was followed by a panel discussion at South by Southwest (SXSW) in March. At SXSW, it became very apparent that QA is no small issue; attendance and the level of participation indicate that it's a major concern shared by pharmaceutical executives and agencies alike.

The focus of both meetings was to identify best practices for ensuring that quality assurance is an intrinsic part of the entire process. Quality assurance has to be an attribute of the process, not an afterthought.

This is the concept of "Shift Left."

Shift Left reduces liability

The principles of Shift Left state that quality assurance must be an integral part of the digital project development life-cycle—from planning to completion—and that QA must remain present even during maintenance.

Most importantly, Shift Left states that quality assurance is the responsibility of all stakeholders: marketing, regulatory, and ad agency personnel.

The goal of Shift Left is to be more nimble, accurate and inventive when creating digital projects (see chart above). If we're looking for defects up front, we can catch them and move on. That's nimble. If we catch defects as they occur, we improve accuracy. Finally, if we're both nimble and accurate, we allow ourselves the opportunity to be more inventive—creating better communications, better interface design, and projects that benefit both our brands and our customers.

The Benefit of Shift Left

The benefit of Shift Left is that we can now set and meet expectations for successful quality assurance across every browser, every operating system, and every device. And every brand.

And we can be efficient, because doing it right, at the right time, is faster than finding and fixing the problems just days before launch—or worse yet, after your app launches.

According to the American Society for Quality, "The 'cost of quality' isn't the price of creating a quality product or service. It's the cost of not creating a quality product or service." Adopting Shift Left allows you to protect brand equity, improve customer relationships, and save money, all while limiting liability.

For more information on Shift Left and quality assurance, visit www.stateofqa.com. PE

Brands of Yesteryear

Pharm Exec's Brand of the Year selections from the last few years are still alive and kicking, although some have aged more gracefully than others. Combined, PE's picks pulled in nearly $30 billion in 2013, which complicates the oft-repeated notion that the blockbuster drug era has come to an end. Patent expiry isn't even the end for some biologics and other complicated products in the US, given the challenging regulatory environment for biosimilars. The US drug pricing wars may be coming, but these products already made their mint. We checked back in with them to see how things are going, and to look for indicators about their future prospects.

Last spring, FDA launched a review of incretin mimetic drugs, including **Januvia**, following published research suggesting the possibility of increased pancreatitis. Although FDA said patients should continue on therapy, and didn't ultimately add new safety information to Januvia's label, the publicity may have been partly responsible for the small decline in revenues. That and the launch of J&J's Invokana, the first of a new class of drugs called SGLT2s. Another SGLT2, Farxiga, went live in January.

In 2013, **Humira** brought in more sales revenue than any other brand. Abbvie, Humira's parent after the Abbott Laboratories divorce, will continue to pursue additional indications for the product; currently, Humira is being tested in a pivotal Phase 3 trial for fingernail psoriasis in patients with moderate-to-severe plaque psoriasis. In the first quarter of 2014, Humira earned $2.6 billion, more than half of that sum arriving from markets outside the US.

Gilenya's nearly $2 billion in sales last year aren't as strong as some analysts initially thought they'd be by now, due to a combination of cardio-related safety concerns and competition in the category. A patient death spooked physicians and regulators, even though FDA found nothing conclusive linking Gilenya to patient deaths. On the competitive side, Biogen Idec priced its Tecfidera product, another oral medication, just below Gilenya when it was approved last year. But Gilenya looks like it's headed in the right direction.

The release of Medicare payments made to doctors last month caused a minor imbroglio that, among other things, demonized ophthalmologists for prescribing Lucentis instead of **Avastin** for wet macular degeneration. Avastin isn't FDA approved for that use, but studies point to similar efficacy rates, and Avastin is available at a much lower cost than Lucentis. That may seem like a positive development for Avastin, but it's actually a net negative; Genentech (which markets both drugs) will face more criticism over its maneuvering with Avastin and Lucentis, a money game without much regard for patients or costs to the healthcare system.

Probably the last of the blockbuster statins, **Crestor** has had a pretty good run, considering it was late to the party. AstraZeneca was able to extend its patent on Crestor in the US, until 2016, but had less luck in other countries, where it's already available in generic form. But Crestor is hanging in there, and grew sales to $1.3 billion in the first quarter of 2014, a 2% increase from the first quarter of 2013.

CRESTOR® rosuvastatin calcium

Beleaguered smoking cessation drug **Chantix** has become something of a pop culture nightmare, due to the strange and occasionally violent behavior sometimes seen in patients who take the drug. There's now a "Chantix defense" in court, most recently deployed by Tim Danielson, who allegedly murdered his ex-wife. Pfizer said blood tests show Danielson didn't have Chantix in his system at the time of the murder, but Danielson says the drug's side effects, including depression, played a role in the crime. PE

CHANTIX (varenicline) TABLETS

Status Update: *Pharm Exec*'s Brands of the Year, 2008-2013

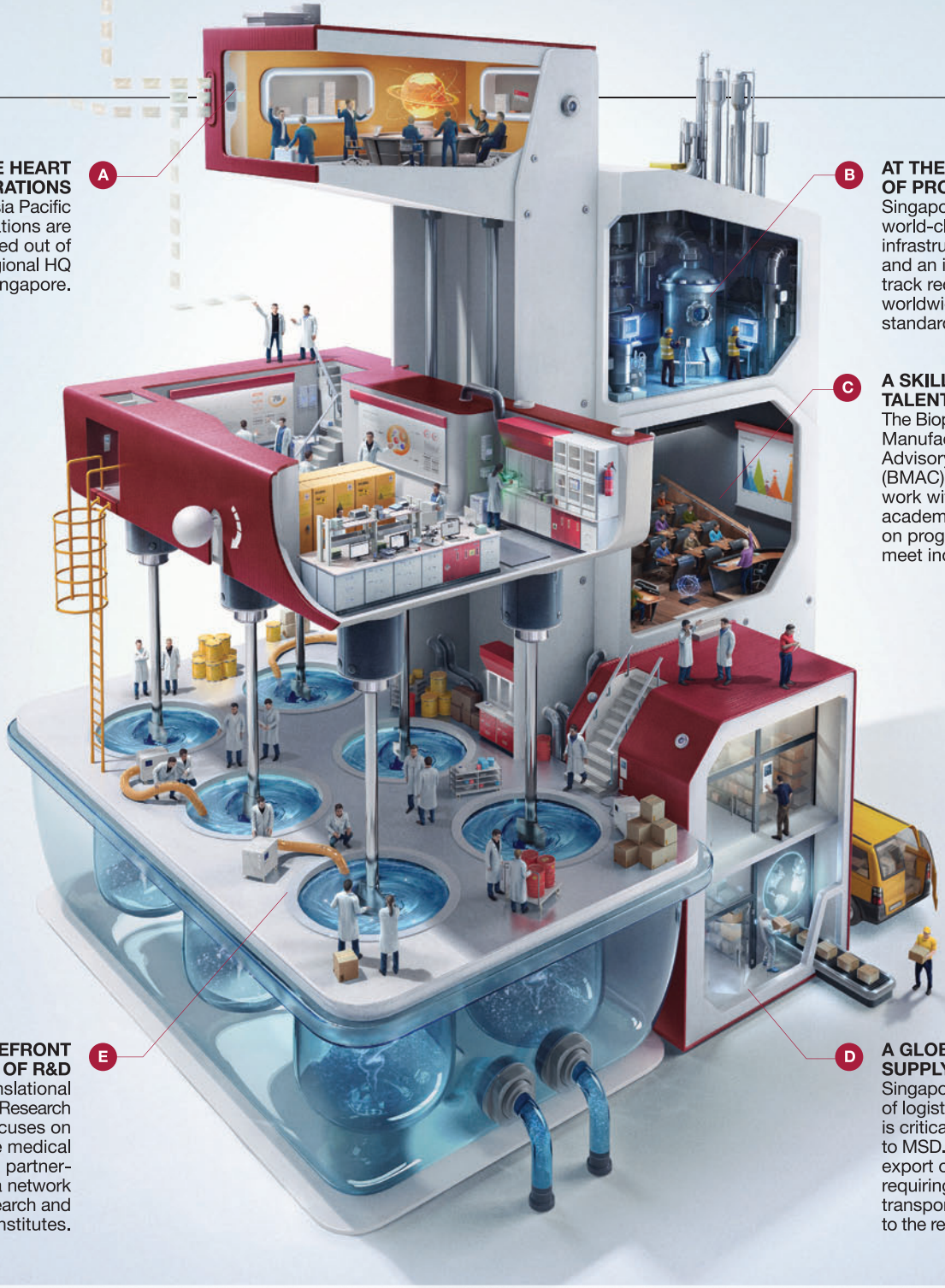
Year	Brand of the Year	2013 Sales in billions	Percent change from 2012	US Patent Expiry
2013	Januvia	$4.0	–2%	2022
2012	Humira	$10.6	+15%	2016
2011	Gilenya	$1.9	+62%	2019
2010	Avastin	$6.7	+13%	2019
2009	Crestor	$5.6	–8%	2016
2008	Chantix	$0.648	–3%	2020

Figures taken from company reports.

Ben Comer is *Pharm Exec*'s *Senior* Editor. He can be reached at bcomer@advanstar.com.

MSD WITH SINGAPORE:

Finding the right mix for success



A AT THE HEART OF OPERATIONS
MSD's Asia Pacific operations are managed out of their Regional HQ in Singapore.

B AT THE HELM OF PRODUCTION
Singapore has world-class infrastructure, and an impressive track record meeting worldwide regulatory standards.

C A SKILLED TALENT POOL
The Biopharmaceutical Manufacturers' Advisory Council (BMAC) lets MSD work with tertiary academic bodies on programs to meet industry needs.

D A GLOBAL SUPPLY CHAIN
Singapore's network of logistics partners is critically important to MSD. It enables the export of products requiring cold chain transport and storage to the rest of the world.

E AT THE FOREFRONT OF R&D
MSD's Translational Medicine Research Centre focuses on cutting-edge medical research, in partnership with a network of research and academic institutes.

Transforming Promising Ideas into Commercial Reality

At inVentiv Health there are no silos—only the seamless convergence of clinical and commercialization services delivered by 12,000 experts working together around the globe.

We're redefining services for the biopharmaceutical industry. Our clients say we solve problems no one else can, and turn to us for services entirely aligned with their needs. How can we help you?

CONVERGENCE IN ACTION:

Introducing new technology can be disruptive. But with the right communications strategy, it doesn't have to be. For a top 10 pharmaceutical client, inVentiv Health's Chandler Chicco Companies and Pharmaceutical Institute leveraged persuasive storytelling and e-learning tools to educate employees on a proprietary research methodology enabled by the new technology. The result: greater adoption, deeper insights, enhanced profitability—with minimal disruption.

inVentivHealth.com/WeCanHelp

inVentiv Health