

# US Market Access: How Does It Differ for Orphan and Rare Disease States?

*Carol Ware, CPC, Senior Research Manager; Beth A Hahn, PhD, Managing Director, Complex Access and Pricing Strategies*

According to the National Institutes of Health, there are more than 6,800 rare diseases affecting from 25 to 30 million Americans.<sup>1</sup> Increasingly, pharmaceutical and biological manufacturers are focusing on targeted therapies that treat orphan and rare disease states. For the US, the terms are virtually interchangeable; however, the FDA provides a definition for designation as a 'rare disease or condition' as any disease or condition which affects:

- Fewer than 200,000 people in the United States or, if the drug is a vaccine, diagnostic drug, or preventive drug, the persons to whom the drug will be administered in the United States are fewer than 200,000 per year, or
- 200,000 or more people, or for a vaccine, diagnostic drug, or preventive drug to be administered to 200,000 or more persons per year in the United States, with no reasonable expectation that costs of research and development of the drug for the indication can be recovered by sales of the drug in the United States.<sup>2</sup>

The development of drugs to treat rare and orphan diseases is supported by the Orphan Drug Act of 1983. The Orphan Drug Act also authorized

an FDA-administered grant program to foster the clinical development of products for use in rare diseases by:

1. Defraying the costs of qualified clinical testing expenses incurred in connection with the development of drugs for rare diseases and conditions,
2. Defraying the costs of developing medical devices for rare diseases or conditions, and
3. Defraying the costs of developing medical foods for rare diseases or conditions.<sup>3</sup>

Since the program started in 1983, it has funded over 500 studies. At any one time, there are typically 60 to 85 ongoing grant-funded projects. The Orphan Grants Program has been used to bring 45 products to marketing approval.<sup>4</sup>

Recent years have seen an increasing number of orphan drugs come to market, due to incentives from the Orphan Grants Program as well as an increased understanding of the molecular pathways responsible for many rare genetic conditions. This has had tremendous impact on patients' clinical outcomes and quality of life, but has also led to increased payer awareness of the overall budget impact of orphan drugs.

While the clinical pathway supporting orphan drugs has clarity and is distinct from traditional non-orphan programs, it is worth considering some of the similarities and differences needed for market access preparation for these therapies.

## MARKET ACCESS DIFFERENCES

### *Patients*

Due to the small number of patients, market access strategies require a greater element of individualization to address the specific needs of patients with the condition. When planning for drug development, often manufacturers know the exact numbers of the patients on therapies, when they start and stop therapy, and the specific factors that impact disease progression for that patient. This customization requires a greater understanding of the disease impact on the patient, the caregiver, and often the family, particularly for pediatric therapies. It also speaks to the importance of using technology to communicate efficiently with manufacturers, patients and providers to maintain the exchange of information.

A source that is tapped for information sharing and guidance is the patient population itself. While not an unusual



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tactic with large disease states, the importance of working closely with the population and patient advocacy groups is critical with rare/orphan diseases. There is a “two-way street” between manufacturers of drugs for rare and orphan conditions and those suffering from the conditions— both parties are on alert for the other and alliances are often strong between the two.

#### *Physicians*

In terms of treating physicians, the number is smaller compared with non-orphan conditions and may be limited to ultra-specialist physicians who are most often Key Opinion Leaders (KOLs) conducting the research and authoring manuscripts on the disease area. As a result, manufacturer sales teams are smaller and rely more on medical liaison staff to interact with these professionals. The focus, like that of the patient, becomes on a small number of physicians and/or academic centers to ensure therapy availability for the country.

Given the limited number prescribers, who likely will not be geographically dispersed, factors such as transportation, referral, and scheduling to seek treatment for patients can be complicated and require coordination between the physicians and patient advocacy groups, which may be sponsored by manufacturers.

#### *Payers*

There is an inherent understanding of the need to cover a treatment for a disease for which no other treatments exist. Coupled with this sensitivity, however, there is also an acute sensitivity to price. Although there are no price controls in the US system, payers maintain that there is a finite amount of resources available to cover healthcare services. To protect those resources, payers implement utilization management controls such as prior authorization (to confirm diagnosis), medical policy to address the inclusion and exclusion criteria related to a specific therapy, and periodic re-authorization periods to determine response and/or progression. Payers

want a justification for cost in terms of better treated patients, which may result in the reduction of overall costs despite the spike in cost of direct treatment.

#### *Manufacturers*

The need for support services such as Patient Assistance Programs (PAPs) is heightened due to the medical needs for these patients and the expense of the therapies. Although PAPs and Copay Assistance Programs are somewhat ubiquitous in the life sciences industry, these programs are even more crucially necessary when working with rare and orphan disease populations. Typically, the same patients who participate in clinical trials, at no personal cost, will be the paying patient population (insurance cost sharing) once the treatment is approved. PAPs and other support programs are helpful to patients as they transition from the clinical trial setting to the real world by ensuring minimal disruptions to treatment.

## MARKET ACCESS SIMILARITIES

There are similarities as well for market access for rare and orphan therapies compared with therapies to address large disease states. All stakeholders—patients, physicians, and payers—seek therapies that address unmet needs and that are safe and efficacious, and importantly, are disease modifying. Other standard market conditions include:

### *Competitors*

Although these conditions tend to be associated with high unmet need, in some rare diseases, there are now several competitors, including biosimilars in some cases, vying for a limited number of patients.

### *Complex Patient Populations*

The existence of the rare or orphan disease often has complications beyond the disease itself, including comorbid conditions or health limitations due to the underlying disease.

### *Impact to Payers*

Payers seek an impact on their bottom line—what is the economic impact? Even though the patient numbers are small, a payer may have one “million-dollar patient”, and they will seek to better manage that patient, reduce cost, or get more value from healthcare expenditures.

### *Research Needs*

Key questions include:

- What is the profile of the ideal patient who will benefit from this therapy?
- What is the current standard of care and how does the new treatment improve upon it?
- Are there patient sub-populations who will not respond to treatment?
- How can likely non-responders be identified—what are the exclusion criteria?


## NEXT STEPS FOR MARKET ACCESS... REALLY THE SAME STEPS WITH MORE PRECISION

Central to market access for rare and orphan conditions is an individual focus on each patient with unique needs. This requires an in-depth understanding of the patient and often the patient’s family as caregivers. It requires manufacturers to know the physicians treating them and to quickly exchange data, information, and new learning to build on the body of knowledge to advance the science. It requires payers to be open to new therapies that can support these patients, but to require appropriate use and demonstrated efficacy. Ideally, none of this should be different

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from market access for larger disease states, the only difference being the focus on the individual. The benefit of more emphasis on rare and orphan conditions by the manufacturing community may bring a sea change for all patients to be treated as unique individuals as we move toward more patient-centered therapies—regardless of the size of the patient population. 

For more information, please contact [Carol.Ware@evidera.com](mailto:Carol.Ware@evidera.com) or [Beth.Hahn@evidera.com](mailto:Beth.Hahn@evidera.com).

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