

### ***Intravenous Cancer Drug Waste Issue Brief***

The National Academy of Medicine estimates that the US healthcare system wastes approximately 25% of what is spent on healthcare annually. In 2017, the Centers for Medicare and Medicaid Services (CMS) reported that spending for prescription drugs accounted for approximately 10% of the \$3.5 trillion spent on US healthcare. Looking only at the drug waste associated with intravenous (IV) cancer therapies, it's estimated that the amounts discarded or leftover after compounding costs the US healthcare system almost \$3 billion annually.<sup>1</sup> As an uncontrolled cost, drug waste is harmful to patients and health-systems' financial sustainability.

#### **Contributing Factors**

In May 2017, HOPA convened a diverse group of stakeholders to identify factors contributing to drug waste with IV cancer therapies and rationale approaches to ameliorate the issues. Centered in the discussion were the following factors that directly attribute to waste:

- 1) *Antiquated prescribing practices* – Dosing of cancer drugs is calculated based on a patient's body size and is therefore individualized and highly variable relative to medication vials sizes. As a result, the amount of leftover drug can be as high as 33%.<sup>2</sup>
- 2) *Limited variation of drug product packaging and sizes* – Many drugs are available in a limited quantity of strengths and are most often provided only as single dose vials (SDV), which restricts the ability to select products matching a patient's prescribed dose. In circumstances where it's permissible to use leftover drug, it must be used within a few hours for subsequent patients, which is not always feasible.
- 3) *Lack of drugs supplied as a multi-dose vial (MDV)* – Unlike SDVs, MDVs contain a preservative and, unless otherwise specified by the manufacturer, allow for a maximum of a 28-day expiration once the vial is punctured. Meaning, multiple patients can be dosed and waste is minimized or eliminated.
- 4) *Limited use of closed-system drug transfer devices (CSTD)* – CSTDs are proven to minimize occupational exposure to hazardous drugs. In addition, limited data demonstrates CSTDs limit the contamination of vial contents; thus, potentially allowing CSTDs to extend beyond-use dating for SDVs.<sup>6</sup>
- 5) *Lack of harmonization among regulatory policies governing sterile compounding* – Policies regulating vial contents and vial sharing between patients vary significantly between agencies [i.e., Food & Drug Administration (FDA), CMS, CDC, USP, National Institute for Occupational Safety and Health (NIOSH), etc.], creating ambiguity and confusion for practitioners and health administrators.

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<sup>1</sup> Bach PB, Conti RM, Muller RJ, et al. Overspending driven by oversized single dose vials of cancer drugs. *BMJ*. 2016; Feb 29;352:i788.

<sup>2</sup> *Id.*

## Recommendations

Drug waste generated from the preparation of IV cancer therapies is costly to the health care system, patients undergoing treatment, and society overall. Billing for waste is not the solution. This practice increases work for providers, requires insurance companies to pay for medication that has been disposed, and ultimately trickles down to patients in the form of higher out-of-pocket costs for medications and insurance premiums. Additionally, disposal of pharmaceutical waste is expensive for healthcare facilities and can pose a hazard to the environment. Lastly, given the frequency of drug shortages, disposal of unused medication is in direct conflict with the need to ensure patients have access to these life-saving therapies.

Therefore, we urge policymakers and stakeholders to consider the following mitigation strategies to reduce the generation of drug waste with IV therapies:

### *Regulatory agencies*

- Convene stakeholders to reconcile regulatory policies governing sterile compounding.

### *Pharmaceutical manufacturers*

- Determine optimal vial sizes to ensure maximal dosing flexibility and increase the availability of medications in MDV formulations.
- Manufacture drugs in vials compatible with the use of CSTDs and collaborate with CSTD manufacturers to conduct extended *stability* studies on medications compounded with CSTDs to allow for dose vial optimization (DVO).
- Develop programs to take back unused medications and reimburse for waste accordingly.

### *Clinicians and investigators*

- Examine dosing strategies in early phase investigations and work with pharmaceutical manufacturers to identify optimal vial strengths prior to commercialization.
- Develop dose-rounding, dose-capping or dose-banding and DVO protocols to align prescribed doses with available medication vial strengths.
- Implement collaborative practice agreements for advanced practice practitioners (i.e., clinical pharmacists) to ensure prescribing aligns with available medication vial strengths.

Additionally, we recognize the following secondary factors, albeit indirect, related to drug waste:

- *Billing for waste:* We recommend evaluation of policies regarding when and how billing for drug waste occurs. CMS' recommendation to strategically schedule patients to reduce waste is in conflict with its "one vial for one patient" policy as well as with other government agencies requirements that restrict this type of scheduling. For commercial payers that do allow billing and payment for drug waste, requirements are inconsistent and may or may not follow the CMS guidance for use of the JW code.
- *Automation:* Where available, HOPA encourages the use of technology to track the individual use of vials when automation is used for compounding medications within a facility or healthcare system.