SUPPLEMENTARY MATERIALS

The evolution of payer management of oncology drugs in the United States between 2017 and 2022

Short title: The evolution of payer management of oncology drugs in the United States between 2017 and 2022
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SUPPLEMENTARY TABLE 1 Operational Definitions of Payer Management Tools

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**SUPPLEMENTARY TABLE 1 Operational Definitions of Payer Management Tools**

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<td>Quantity limits</td>
<td>Payer defines how much of a drug the patient can get during a specified time period</td>
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<td>Manage to label</td>
<td>Payer restricts use to FDA-labeled indication</td>
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<td>Split fills</td>
<td>Program where pharmacy can provide a partial fill of the member’s first prescription before filling the full specified time period of a prescription</td>
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<td>Re-authorizations</td>
<td>Re-authoriztion to continue therapy must be sought at regular intervals</td>
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<td>ST for products recommended in the same line of therapy by NCCN compendia</td>
<td>Payer requires patient to try a preferred drug before trying the product if the step edit is in line with NCCN compendia</td>
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<td>ST independent of NCCN guidelines</td>
<td>Payer requires patient to try a preferred drug before trying the product where this step edit does not follow NCCN compendia</td>
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<td>Blocking agents and having them only available by medical exception</td>
<td>Payer does not allow access to a product except through a medical exception or an appeals process by the physician; such an approach requires a significant administrative effort from the prescriber</td>
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<td>Preferred through tiering</td>
<td>Payer uses copay differentials to influence preference towards specific drugs</td>
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<td><strong>Oncology-Specific Management Tools</strong></td>
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<tr>
<td>Pathways without risk</td>
<td>Comprehensive, evidence-based treatment protocols that provide direction on how to provide cancer care; pathways without risk incentivize physicians to follow the pathway with an upside risk (e.g., positive financial incentive)</td>
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<tr>
<td>Pathways with risk</td>
<td>Comprehensive, evidence-based treatment protocols that provide direction on how to provide cancer care; pathways with risk incentivize physicians with downside and upside risk (e.g., a fee is implemented if pathway is not followed, or overall clinician reimbursement rate is dependent on the adoption of the implementation of the pathway)</td>
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<td>Buy-and-bill incentives to influence preference toward branded agents</td>
<td>Payer provides a higher reimbursement rate to clinicians for preferred branded products</td>
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<td>Buy-and-bill incentives to influence preference toward generics</td>
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<tr>
<td>Pursuing oncology specific models,</td>
<td>A payment delivery model where participating groups provide enhanced patient services, use data to drive continuous quality</td>
</tr>
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such as oncology care models

improvement, and use certified electronic health record technology. Participants in the Oncology Care Model (OCM) program receive a monthly enhanced oncology services payment of $160 per beneficiary, performance-based payment for OCM episodes, and regular fee for service payments

Shifting financial risk through payment system (e.g., bundled payments)

A cost-saving measure where reimbursement is based on expected costs of episodes of care

Restructuring provider networks based on their ability to manage oncology cost

Payers reduce the network of providers and only contract with oncology centers showing the most rational and cost-minimizing use of resources

FDA = US Food and Drug Administration; NCCN = National Comprehensive Cancer Network; ST = Step Edit
SUPPLEMENTARY APPENDIX 1 Oncology Payer Survey 2022

Thank you for agreeing to participate in this survey. Please click on the arrow below to start the survey.

Screening Questions:

S1. Please enter your first name and last name.
[First Name]
[Last Name]

S2. What organization do you currently or most recently represent? [Select one]

S3. If [Other Selected] Open Ended Text Box to Enter Organization Name

Survey Questions:

Organization Background

1. For which books(s) of business are you directly responsible for formulary decision making at your organization? [Select all that apply]
   a. Your organization’s Commercial formulary design
   b. Your organization’s Medicare Part D formulary design
   c. Your organization’s Commercial and Medicare Part D formulary design

2. How many total lives does your organization cover [open ended]

3. What is the covered lives breakdown for your organization by line of business? [The sum should total to 100]
   a. % Commercial Lives ____
   b. % Medicare Part D Lives ____
   c. % Medicaid Lives ____
   d. % Other Books of Business (e.g., HSE, ASO, please specify ____) ____

Current Management

This section will focus on the current management of drugs at your organization.

Management and Budget Impact

next set of questions will focus on the management and budget impact of drugs at your organization.

4. On a scale of 1 to 7, where 1 is low and 7 is high, how high is the level of management for the following therapeutic areas to your plan today?
   a. Diabetes
   b. Multiple Sclerosis
   c. Bleeding Disorders
   d. Oncology
   e. Rheumatoid Arthritis
   f. Psoriasis
   g. Hepatitis C

5. On a scale of 1 to 7, where 1 is low budget impact and 7 is high budget impact, how high of a budget impact are the following therapeutic areas to your plan today?
   a. Diabetes
   b. Multiple Sclerosis
   c. Bleeding Disorders
   d. Oncology
   e. Rheumatoid Arthritis
f. Psoriasis

g. Hepatitis C

6. Compared to other high-cost disease areas, what is the **current level of management** within oncology today? Please rate the response on a scale of 1 to 7, where 1 is low management and 7 is high management.
   a. Oncology in general
   b. Large solid tumors (e.g., breast, lung, colorectal)
   c. Hematological malignancies
   d. Orphan oncology

7. Compared to other high-cost disease areas, what is the **current budget impact** within oncology today? Please rate the response on a scale of 1 to 7, where 1 is low management and 7 is high management.
   a. Oncology in general
   b. Large solid tumors (e.g., breast, lung, colorectal)
   c. Hematological malignancies
   d. Orphan oncology

**Traditional Management Tools**

8. Which of the following traditional utilization management tools are you utilizing in oncology today? [Select all that apply]
   a. Manage to label
   b. Quantity limits
   c. Split fills
   d. Re-authorization
   e. Preferred through tiering
   f. Step therapy for products recommended in the same line of therapy by NCCN compendia
   g. Step therapy independent of NCCN guidelines
   h. Blocking agents and only having them available by medical exception
   i. None of these

9. [If f selected in Q8] Please provide examples of oncolytics where your organization uses step therapy for products recommended in the same line of therapy by NCCN compendia [open ended]

10. [If g selected in Q8] Please provide examples of oncolytics where your organization uses step therapy independent of NCCN guidelines.

11. [If h selected in Q8] Please provide examples of oncolytics where your organization has blocked an agent and only had it available through medical exception.

12. [If h selected in Q8] What % of the time are medical exceptions granted? [0-100%]

**Oncology-specific Management Tools**

13. Which of the following oncology-specific utilization management tools are you utilizing in oncology today? [Select all that apply]
   a. Pathways of care without risk for providers (e.g., pathways where financial risk is not shared with providers, but they are incentivized through bonuses or other upside payments)
   b. Pathways of care with risk for providers (e.g., pathways where the savings or costs are shared with providers)
   c. Buy and bill incentives to influence preference toward branded agents
d. Buy and bill incentives to influence preference toward generic agents
e. None of these

14. [If a selected in Q13] You said that you are using pathways without risk today, keeping that in mind please answer the next set of questions.

a. You said that you are using pathways without risk today, in what disease areas are pathways of care without risk used [select all that apply]
   i. Large solid tumors (e.g., breast, lung, colorectal)
   ii. Hematological malignancies
   iii. Orphan oncology
   iv. Other (please specify)

b. You said that you were using pathways without risk today, who developed these pathways? [select one]
   i. My organization – pathways closely follow NCCN guidelines
   ii. My organization – pathways are more prescriptive than NCCN guidelines
   iii. External consultants – pathways closely follow NCCN guidelines
   iv. External consultants – pathways are more prescriptive than NCCN guidelines
   v. Providers in our network

c. You said that you were using pathways without risk today, do you have pathways of care without risk that recommend a new/innovative product over older therapies (e.g., a PD-1 inhibitor vs. another for NSCLC)?
   i. Yes
   ii. No

d. You said that you have pathways of care without risk that recommend a new/innovative product over older therapies, please provide examples [open-ended]
e. You said that you do not have pathways of care without risk that recommend a new/innovative product over older therapies, why not?
f. You said that you are using pathways without risk today, do you have pathways of care without risk that recommend against combination therapies (e.g., pathways against use of YERVOY + PD-1)?
   i. Yes
   ii. No
g. You said that you have pathways of care without risk that recommend against combination therapies, please provide examples [open-ended]
h. You said that you do not have pathways of care without risk that recommend some new/innovative products over others why not [open ended]
i. You said that you are using pathways without risk today, do you have pathways of care without risk that recommend one particular brand in a class over others (e.g., one BTK-inhibitor vs. another in CLL)?
   i. Yes
   ii. No
j. You said that you have pathways of care without risk that recommend one brand over another, please provide examples [open-ended]
k. You said that you do not have pathways without risk that recommend one brand over another, why not? [open ended]
1. You said that you are using pathways without risk today, how do you ensure providers follow pathways of care when there is no risk to providers [select all that apply]
   - i. Positive financial incentives
   - ii. Positive incentives on provider ratings
   - iii. Negative incentives on provider ratings

m. You said that you are using pathways without risk today, on a scale of 1 to 7 where 1 is not successful at all and 7 is very successful, how successful has your implementation of pathways of care without risk been? [select an option 1-2-3-4-5-6-7]

n. You said that you are using pathways without risk today, on a scale of 1 to 7 where 1 is no cost savings and 7 is significant cost savings, what degree of cost savings have pathways of care without risk provided? [select an option 1-2-3-4-5-6-7]

15. [If b selected in Q13] You said that you are using pathways with risk today, keeping that in mind please answer the next set of questions.

a. You said that you are using pathways with risk today, in what disease areas are pathways of care without risk used [select all that apply]
   - i. Large solid tumors (e.g., breast, lung, colorectal)
   - ii. Hematological malignancies
   - iii. Orphan oncology
   - iv. Other (please specify)

b. You said that you were using pathways with risk today, who developed these pathways? [select one]
   - i. My organization – pathways closely follow NCCN guidelines
   - ii. My organization – pathways are more prescriptive than NCCN guidelines
   - iii. External consultants – pathways closely follow NCCN guidelines
   - iv. External consultants – pathways are more prescriptive than NCCN guidelines
   - v. Providers in our network

c. You said that you were using pathways with risk today, do you have pathways of care without risk that recommend a new/innovative product over older therapies (e.g., a PD-1 inhibitor vs. another for NSCLC)?
   - i. Yes
   - ii. No

d. You said that you have pathways of care with risk that recommend a new/innovative product over older therapies, please provide examples [open-ended]

e. You said that you do not have pathways of care with risk that recommend a new/innovative product over older therapies, why not?

f. You said that you are using pathways with risk today, do you have pathways of care without risk that recommend against combination therapies (e.g., pathways against use of YERVOY + PD-1)?
   - i. Yes
   - ii. No

g. You said that you have pathways of care with risk that recommend against combination therapies, please provide examples [open ended]
h. You said that you do not have pathways of care with risk that recommend some new/innovative products over others, why not [open ended]
i. You said that you are using pathways with risk today, do you have pathways of care without risk that recommend one particular brand in a class over others (e.g., one BTK-inhibitor vs. another in CLL)?
   i. Yes
   ii. No
j. You said that you have pathways of care with risk that recommend one brand over another, please provide examples [open ended]
k. You said that you do not have pathways with risk that recommend one brand over another, why not? [open ended]
l. You said that you are using pathways with risk today, what type of risk do you use to incentivize providers to follow these pathways of care? [select all that apply]
   i. Share financial savings from pathways
   ii. Require physicians to pay back extra costs generated by non-adherence to pathways (e.g., financial disincentives)
   iii. Face financial penalties for non-adherence to pathways
m. You said that you are using pathways with risk today, on a scale of 1 to 7 where 1 is not successful at all and 7 is very successful, how successful has your implementation of pathways of care without risk been? [select an option 1-2-3-4-5-6-7]
n. You said that you are using pathways with risk today, on a scale of 1 to 7 where 1 is no cost savings and 7 is significant cost savings, what degree of cost savings have pathways of care without risk provided? [select an option 1-2-3-4-5-6-7]
16. You said that you are using buy and bill incentives to influence preference toward branded agents, please provide examples of oncolytics where your organization uses buy and bill incentives to influence preference toward branded agents.
17. You said that you are using buy and bill incentives to influence preference toward generic agents, please provide examples of oncolytics where your organization uses buy and bill incentives to influence preference toward generic agents.

Systemic Management Tools
18. Which of the following systemic tools are you currently using to manage oncology today?
   a. Shifting financial risk to providers through a payment system (e.g., bundled payments)
   b. Pursuing oncology-specific models, such as oncology care models
   c. Restructuring provider networks based on their ability to reduce oncology cost
d. None of the above
e. Not applicable to my organization (e.g., IDN)
19. If a selected in Q18, display Q19 a-b
   a. On a scale of 1 to 5, where 1 is very uncommon and 5 is very common, how common is it to shift financial risk to providers through a payment system in oncology?
      i. 1 = Very uncommon – we only have 1 or 2 very limited pilot programs
      ii. 2 = Somewhat uncommon – we have 1 or 2 high profile pilot programs
iii. 3 = Increasingly common – we are beyond the pilot phase and trying to implement with an increasing number of providers
iv. 4 = Somewhat common – it is implemented with the majority of our providers
v. 5 = Very common – it is implemented with all of our providers

b. [If 3, 4, or 5 selected in Q19a] Please describe how your organization is shifting financial risk to providers through payment systems. [open-ended]

20. [If a selected in Q18] On a scale of 1 to 7 where 1 is not successful at all and 7 is very successful, how successful has shifting of financial risk to the provider through a payment system been? [select an option 1-2-3-4-5-6-7]

21. Are you aware of the below value frameworks?
   a. American Society of Clinical Oncology (ASCO) [Y/N]
   b. Institute of Clinical and Economic Review (ICER) [Y/N]
   c. National Comprehensive Cancer Network (NCCN) [Y/N]
   d. Memorial Sloan Kettering Cancer Center (MSKCC) Drug Abacus [Y/N]
   e. European Society for Medical Oncology (ESMO) Magnitude of Clinical Value Score [Y/N]

22. On a scale of 1 to 7, where 1 is no influence at all and 7 is significant influence, how influential are the below value frameworks to your decision making in oncology today?
   a. American Society of Clinical Oncology (ASCO) [1-2-3-4-5-6-7]
   b. Institute of Clinical and Economic Review (ICER) [1-2-3-4-5-6-7]
   c. National Comprehensive Cancer Network (NCCN) [1-2-3-4-5-6-7]
   d. Memorial Sloan Kettering Cancer Center (MSKCC) Drug Abacus [1-2-3-4-5-6-7]
   e. European Society for Medical Oncology (ESMO) Magnitude of Clinical Value Score [1-2-3-4-5-6-7]

23. Do you develop any value framework internally within your organization? [Y/N]

24. [If Y selected in Q23] Which sources do you look to for guidance? [Select all that apply]
   a. American Society of Clinical Oncology (ASCO)
   b. Institute of Clinical and Economic Review (ICER)
   c. National Comprehensive Cancer Network (NCCN)
   d. Memorial Sloan Kettering Cancer Center (MSKCC) Drug Abacus [Y/N]
   e. European Society for Medical Oncology (ESMO) Magnitude of Clinical Value Score [Y/N]
   f. None of these

Challenges in Managing the Rising Costs of Oncology Care

25. What are the top challenges to your organization in managing oncology today? [Select all that apply]
   a. Patient advocacy groups make it difficult to manage
   b. Science advances too quickly
   c. It is difficult to compare products and select a preferred one
   d. The evidence for most oncology drugs is not mature enough
   e. The patient population is too complex, clinicians need to maintain the ability to choose
   f. Other organizations do not manage this category
   g. There are limited therapeutic options in this category
   h. I will receive physician pushback if I manage this category
i. Government regulations prevent me from managing this category
j. None of these

26. On a scale of 1 to 7 where 1 is no challenge and 7 is significant challenge, what challenge do the selected factors pose to your organization’s ability to manage oncology [display each option selected in Q25 and prompt a response 1-2-3-4-5-6-7]

**Future Management (3-5 Years)**

This section will focus on the future management of drugs at your organization.

**Traditional Management Tools**

27. Which of the following traditional utilization management tools do you expect to utilize in oncology in the next 3-5 years? [Select all that apply]
   - a. Manage to label
   - b. Quantity limits
   - c. Split fills
   - d. Re-authorization
   - e. Preferred through tiering
   - f. Step therapy for products recommended in the same line of therapy by NCCN compendia
   - g. Step therapy independent of NCCN guidelines
   - h. Blocking agents and only having them available by medical exception
   - i. None of these

28. [If manage to label selected today but not in 3-5 years] You previously indicated that you are using managed to label today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.

29. [If quantity limits selected today but not in 3-5 years] You previously indicated that you are using quantity limits today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.

30. [If split fills selected today but not in 3-5 years] You previously indicated that you are using split fills today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.

31. [If re-authorizations selected today but not in 3-5 years] You previously indicated that you are using re-authorizations today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.

32. [If preferred through tiering selected today but not in 3-5 years] You previously indicated that you are using preferred through tiering today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.

33. [If step therapy for products recommended in the same line of therapy by NCCN compendia selected today but not in 3-5 years] You previously indicated that you are using step therapy for products recommended in the same line of therapy by NCCN compendia today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.

34. [If step therapy independent of NCCN guidelines selected today but not in 3-5 years] You previously indicated that you are using step therapy independent of NCCN guidelines today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.
35. [If blocking agents and only having them available by medical exception selected today but not in 3-5 years] You previously indicated that you are blocking agents and only having them available by medical exception today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.
36. [If f selected in Q27] Please provide specific examples of oncolytics where your organization expects to use step therapy for products recommended in the same line of therapy by NCCN compendia in the next 3-5 years.
37. [If g selected in Q27] Please provide examples of oncolytics where your organization expects to use step therapy independent of NCCN guidelines in the next 3-5 years.
38. [If h selected in Q27] Please provide examples of oncolytics where your organization expects to block an agent and only have it available through medical exception in the next 3-5 years.
39. [If h selected in Q27] What % of times do you expect medical exceptions to be granted [0-100%]

**Oncology Specific Management Tools**

40. Which of the following oncology-specific utilization management tools do you expect to use in oncology in the next 3-5 years? [Select all that apply]
   a. Pathways of care without risk for providers (e.g., pathways where financial risk is not shared with providers, but they are incentivized through bonuses or other upside payments)
   b. Pathways of care with risk for providers (e.g., pathways where the savings or costs are shared with providers)
   c. Buy and bill incentives to influence preference toward branded agents
   d. Buy and bill incentives to influence preference toward generic agents
   e. None of these

41. [If pathways of care without risk selected today but not in 3-5 years] You previously indicated that you are using pathways of care without risk today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.
42. [If pathways of care with risk selected today but not in 3-5 years] You previously indicated that you are using pathways of care with risk for providers today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.
43. [If buy and bill incentives to influence preference toward branded agents selected today but not in 3-5 years] You previously indicated that you are using buy and bill incentives to influence preference toward branded agents today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.
44. [If buy and bill incentives to influence preference toward generic agents selected today but not in 3-5 years] You previously indicated that you are using buy and bill incentives to influence preference toward generic agents today but do not expect to utilize it in the next 3-5 years, please explain why you anticipate not using the tool in the future.
45. [If pathways of care without risk selected today and in 3-5 years] You previously indicated that you are using pathways without risk today, do you expect implementation of pathways without risk to change in the next 3-5 years from how you are implementing them today? [Y/N]
46. How do you think the implementation for pathways without risk will change? [select all that apply]
   a. Pathways will cover more disease areas
   b. Pathways will cover fewer disease areas
   c. Pathways will become more prescriptive (recommend a product over another, such as have a preferred PD-1 for NSCLC)
   d. There will be stronger incentives for providers to follow pathways

47. [If pathways of care with risk selected today and in 3-5 years] You previously indicated that you are using pathways with risk today, do you expect implementation of pathways with risk to change in the next 3-5 years from how you are implementing them today? [Y/N]

48. How do you think the implementation for pathways with risk will change? [select all that apply]
   a. Pathways will cover more disease areas
   b. Pathways will cover fewer disease areas
   c. Pathways will become more prescriptive (recommend a product over another, such as have a preferred PD-1 for NSCLC)
   d. There will be stronger incentives for providers to follow pathways

49. [If c selected in Q40] Please provide specific examples of oncolytics where your organization expects to use buy and bill incentives to influence preference toward branded agents in the next 3-5 years.

50. If d selected in Q40] Please provide specific examples of oncolytics where your organization expects to use buy and bill incentives to influence preference toward generic agents in the next 3-5 years.

Systemic Management Tools

51. Which of the following systemic tools do you expect you will use to manage oncology in the next 3-5 years? [Select all that apply]
   a. Shifting financial risk to providers through a payment system (e.g., bundled payments)
   b. Pursuing oncology-specific models, such as oncology care models
   c. Restructuring provider networks based on their ability to reduce oncology cost
   d. None of the above
   e. Not applicable to my organization (e.g., IDN)

52. [If a selected in Q51] How do you think shifting of the financial risk will change in the next 3-5 years?
   a. It will change minimally
   b. It will become more prevalent but only a minority of providers will be under these schemes
   c. It will become the prevalent payment model

53. [If b selected in Q51] How do you think oncology care models will change in the next 3-5 years?
   a. No change at all
   b. Slight to moderate increase in importance
   c. Significant change (will become a primary tool in the management of oncology)

54. [If c selected in Q51] How do you think that the restructuring of provider networks based on their ability to reduce oncology cost will change in the next 3-5 years?
55. On a scale of 1 to 7, where 1 is no influence at all and 7 is significant influence, how influential do you expect the below value frameworks will be on your decision making in oncology in the next 3-5 years?
   a. American Society of Clinical Oncology (ASCO) [1-2-3-4-5-6-7]
   b. Institute of Clinical and Economic Review (ICER) [1-2-3-4-5-6-7]
   c. National Comprehensive Cancer Network (NCCN) [1-2-3-4-5-6-7]
   d. Memorial Sloan Kettering Cancer Center (MSKCC) Drug Abacus [1-2-3-4-5-6-7]
   e. European Society for Medical Oncology (ESMO) Magnitude of Clinical Value Score [1-2-3-4-5-6-7]

56. Do you expect to develop any value framework internally within your organization in the next 3-5 years? [Y/N]

57. [If Y selected in Q56] Which sources do you look to for guidance? [Select all that apply]
   a. American Society of Clinical Oncology (ASCO)
   b. Institute of Clinical and Economic Review (ICER)
   c. National Comprehensive Cancer Network (NCCN)
   d. Memorial Sloan Kettering Cancer Center (MSKCC) Drug Abacus [Y/N]
   e. European Society for Medical Oncology (ESMO) Magnitude of Clinical Value Score [Y/N]
   f. None of these

58. Please rate the following statement on a scale from 1 to 7 where 1 is strongly disagree and 7 is strongly agree: “Value frameworks will become an important tool to develop value-based pathways of care.” [1-2-3-4-5-6-7]

NSCLC (NON-SMALL CELL LUNG CANCER) – Current Management and Future Management

Please review the NCCN guidelines for Non-Small Cell Lung Cancer (NSCLC) below, the focus of the next section.
59. On the scale of 1 to 5 below, what level of therapeutic improvement do each of the following therapies provide in NSCLC?

a. KEYTRUDA (pembrolizumab): [1-2-3-4-5]

b. OPDIVO (nivolumab): [1-2-3-4-5]

c. CYRAMZA (ramucirumab): [1-2-3-4-5]

d. TECENTRIQ (atezolizumab): [1-2-3-4-5]

e. IMFINZI (durvalumab): [1-2-3-4-5]

f. LIBTAYO (cemiplimab-rwlc): [1-2-3-4-5]

g. OPDIVO + YERVOY (nivolumab + ipilimumab): [1-2-3-4-5]

h. TECENTRIQ + AVASTIN (atezolizumab + bevacizumab): [1-2-3-4-5]
60. On a scale of 1 to 7, where 1 is no budget impact and 7 is very high budget impact, what is the level of budget impact for the following agents used in the treatment of NSCLC today?
   A. KEYTRUDA (pembrolizumab): [1-2-3-4-5-6-7]
   B. OPDIVO (nivolumab): [1-2-3-4-5-6-7]
   C. CYRAMZA (ramucirumab): [1-2-3-4-5-6-7]
   D. TECENTRIQ (atezolizumab): [1-2-3-4-5-6-7]
   E. IMFINZI (durvalumab): [1-2-3-4-5-6-7]
   F. LIBTAYO (cemiplimab-rwlc): [1-2-3-4-5-6-7]
   G. OPDIVO + YERVOY (nivolumab + ipilimumab): [1-2-3-4-5-6-7]
   H. TECENTRIQ + AVASTIN (atezolizumab + bevacizumab): [1-2-3-4-5-6-7]

61. [If responsible for commercial lives in Q1] For commercial lives, do you manage any of the following NSCLC agents more restrictively than NCCN guidelines? [Select all that apply]
   a. KEYTRUDA (pembrolizumab)
   b. OPDIVO (nivolumab)
   c. CYRAMZA (ramucirumab)
   d. TECENTRIQ (atezolizumab)
   e. IMFINZI (durvalumab)
   f. LIBTAYO (cemiplimab-rwlc)
   g. OPDIVO + YERVOY (nivolumab + ipilimumab)
   h. TECENTRIQ + AVASTIN (atezolizumab + bevacizumab)
   i. None of these

62. [If any option a-h selected in Q61] For the NSCLC agent(s) that you are managing beyond label, what are the most common restrictions placed on the agent(s) for your commercial lives today? [Select all that apply]
   a. Manage more restrictively than label
   b. Not providing coverage for off-label use (not FDA approved) despite NCCN compendia recommendation
   c. Drive utilization through tiering differentials for like products (same line of therapy and/or MOA)
   d. Utilize management tactics such as split fills
   e. Implement steps that require the use of one product over another in the same line of therapy per guidelines
   f. Excluded an agent from formulary/coverage
   g. Utilize provider developed pathways to manage
   h. Clinical pathways for providers, without risk sharing
   i. Enter in risk sharing agreement with providers utilizing pathways (more narrow than NCCN guidelines) to manage
   j. Use of value frameworks
   k. Buy and bill incentives toward branded agents
   l. Buy and bill incentives toward generic agents
   m. None of these

63. In the past five years, there has been an increase in the number of combination therapies available to treat NSCLC. For example, OPDIVO + YERVOY and TECENTRIQ + AVASTIN are both listed as 1st line treatments in NCCN guidelines, although they are
not denoted as preferred regimens. How is your organization managing combination therapies?
   a. The combinations are managed to label, and physicians have open access to use them when they feel it is appropriate
   b. There are step edits in place that restrict the use of combination therapies
   c. Combination therapies are excluded from the formulary
   d. Other (Please specify) ______________

64. [If responsible for Medicare lives in Q1] Is your current Medicare management different than in commercial today? [Select one]
   a. Yes
   b. No
   c. I cannot speak for the Medicare book of business

65. [If yes selected in Q64] For Medicare lives, do you manage any of the following NSCLC agents more restrictively than NCCN guidelines? [Select all that apply]
   a. KEYTRUDA (pembrolizumab)
   b. OPDIVO (nivolumab)
   c. CYRAMZA (ramucirumab)
   d. TECENTRIQ (atezolizumab)
   e. IMFINZI (durvalumab)
   f. LIBATYO (cemiplimab-rwlc)
   g. OPDIVO + YERVOY (nivolumab + ipilimumab)
   h. TECENTRIQ + AVASTIN (atezolizumab + bevacizumab)
   i. None of these

66. [If any option a-h selected in Q65] For the NSCLC agent(s) that you are managing beyond label, what are the most common restrictions placed on the agent(s) for your Medicare lives today? [Select all that apply]
   a. Manage more restrictively than label
   b. Not providing coverage for off-label use (not FDA approved) despite NCCN compendia recommendation
   c. Drive utilization through tiering differentials for like products (same line of therapy and/or MOA)
   d. Utilize management tactics such as split fills
   e. Implement steps that require the use of one product over another in the same line of therapy per guidelines
   f. Excluded an agent from formulary/coverage
   g. Utilize provider developed pathways to manage
   h. Clinical pathways for providers, without risk sharing
   i. Enter in risk sharing agreement with providers utilizing pathways (more narrow than NCCN guidelines) to manage
   j. Use of value frameworks (e.g. ASCO or ICER)
   k. Buy and bill incentives toward branded agents
   l. Buy and bill incentives toward generic agents
   m. None of these

67. [If responsible for commercial lives in Q1] Do you expect commercial management to change over the next 3-5 years?
   a. Yes
b. No
c. N/A (I do not manage commercial lives)

68. [If yes selected in Q67] For **commercial** lives, do you expect to manage any of the following NSCLC agents more restrictively than NCCN guidelines in the **next 3-5 years**? [Select all that apply]
   a. KEYTRUDA (pembrolizumab)
   b. OPDIVO (nivolumab)
   c. CYRAMZA (ramucirumab)
   d. TECENTRIQ (atezolizumab)
   e. IMFINZI (durvalumab)
   f. LIBATYO (cemiplimab-rwlc)
   g. OPDIVO + YERVOY (nivolumab + ipilimumab)
   h. TECENTRIQ + AVASTIN (atezolizumab + bevacizumab)
   i. None of these

69. [If yes selected in Q67 and any option a-h selected in Q68] For the NSCLC agent(s) that you expect to manage beyond label, what do you expect will be the most common restrictions placed on the agent(s) for your **commercial** lives in the **next 3-5 years**? [Select all that apply]
   a. Manage more restrictively than label
   b. Not providing coverage for off-label use (not FDA approved) despite NCCN compendia recommendation
   c. Drive utilization through tiering differentials for like products (same line of therapy and/or MOA)
   d. Utilize management tactics such as split fills
   e. Implement steps that require the use of one product over another in the same line of therapy per guidelines
   f. Excluded an agent from formulary/coverage
   g. Utilize provider developed pathways to manage
   h. Clinical pathways for providers, without risk sharing
   i. Enter in risk sharing agreement with providers utilizing pathways (more narrow than NCCN guidelines) to manage
   j. Use of value frameworks (e.g. ASCO or ICER)
   k. Buy and bill incentives toward branded agents
   l. Buy and bill incentives toward generic agents
   m. None of these

70. [If responsible for Medicare lives in Q1] Do you expect **Medicare** management to change over the **next 3-5 years**?
   a. Yes
   b. No
   c. N/A (I do not manage Medicare lives)

71. [If yes selected in Q70] For **Medicare** lives, do you expect to manage any of the following NSCLC agents more restrictively than NCCN guidelines in the **next 3-5 years**? [Select all that apply]
   a. KEYTRUDA (pembrolizumab)
   b. OPDIVO (nivolumab)
   c. CYRAMZA (ramucirumab)
d. TECENTRIQ (atezolizumab)
e. IMFINZI (durvalumab)
f. LIBATYO (cemiplimab-rwlc)
g. OPDIVO + YERVOY (nivolumab + ipilimumab)
h. TECENTRIQ + AVASTIN (atezolizumab + bevacizumab)
i. None of these

72. [If yes selected in Q70 and any option a-h selected in Q71] For the NSCLC agent(s) that you expect to manage beyond label, what do you expect to be the most common restrictions placed on the agent(s) for your Medicare lives in the next 3-5 years? [Select all that apply]

   a. Manage more restrictively than label
   b. Not providing coverage for off-label use (not FDA approved) despite NCCN compendia recommendation
   c. Drive utilization through tiering differentials for like products (same line of therapy and/or MOA)
   d. Utilize management tactics such as split fills
   e. Implement steps that require the use of one product over another in the same line of therapy per guidelines
   f. Excluded an agent from formulary/coverage
   g. Utilize provider developed pathways to manage
   h. Clinical pathways for providers, without risk sharing
   i. Enter in risk sharing agreement with providers utilizing pathways (more narrow than NCCN guidelines) to manage
   j. Use of value frameworks (e.g. ASCO or ICER)
   k. Buy and bill incentives toward branded agents
   l. Buy and bill incentives toward generic agents
   m. None of these

**Chronic Lymphocytic Leukemia (CLL) - Current Management and Future Management**

Please review the NCCN guidelines for CLL below, the focus of the next section. Please review Exhibit 2a the NCCN guidelines for CLL without Del(17p) in patients >65 or frail patients with comorbidities below, the focus of the next section.

Please review Exhibit 2b the NCCN guidelines for CLL without Del(17p) in patients <65 below, the focus of the next section.

Please review Exhibit 2c the NCCN guidelines for CLL with Del(17p) below, the focus of the next section.
# NCCN Guidelines for the Treatment of CLL

<table>
<thead>
<tr>
<th>Del(17p)/TP53 Mutation Status</th>
<th>First Line Treatment Regimens</th>
<th>Relapsed/Refractory Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real patients with significant comorbidity OR patients aged ≥65 years and younger patients with significant comorbidities</td>
<td><strong>Acralfolibrutinib + obinutuzumab</strong>&lt;br&gt;<strong>Ibrutinib</strong>&lt;br&gt;<strong>Venetoclax + obinutuzumab</strong>&lt;br&gt;<strong>Bendamustine + anti-CD20 mAb</strong>&lt;br&gt;<strong>Chlorambucil + obinutuzumab</strong>&lt;br&gt;<strong>HDMAP + rituximab</strong>&lt;br&gt;<strong>Ibrutinib + obinutuzumab</strong>&lt;br&gt;<strong>Obinutuzumab</strong></td>
<td><strong>Acralfolibrutinib</strong>&lt;br&gt;<strong>Ibrutinib</strong>&lt;br&gt;<strong>Venetoclax + rituximab</strong>&lt;br&gt;<strong>Duvetilixib + rituximab</strong>&lt;br&gt;<strong>Alemtuzumab + rituximab</strong>&lt;br&gt;<strong>Chlorambucil + rituximab</strong>&lt;br&gt;<strong>Reduced-dose FCR</strong>&lt;br&gt;<strong>HDMAP + rituximab</strong>&lt;br&gt;<strong>Methotrexate</strong>&lt;br&gt;<strong>Lenalidomide + rituximab</strong>&lt;br&gt;<strong>Obinutuzumab</strong>&lt;br&gt;<strong>Oblinuzumab</strong>&lt;br&gt;<strong>Reduced-dose pentostatin, cyclophosphamide, rituximab</strong>&lt;br&gt;<strong>Venetoclax</strong>&lt;br&gt;<strong>Zanubrutinib</strong>&lt;br&gt;<strong>Dose-dense rituximab</strong>&lt;br&gt;<strong>Bendamustine + rituximab</strong>&lt;br&gt;<strong>Bendamustine + rituximab + ibritinib</strong></td>
</tr>
</tbody>
</table>

Note: Bold italicized text denotes preferred regimen.

*Not recommended for frail patients; **preferred for patients with IGIV-mutated CLL; †for patients with comorbidities.*

Abbreviations in notes.
73. On the scale of 1 to 5 below, what level of therapeutic improvement do each of the following therapies provide in CLL?

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. BCL-2 Inhibitor: VENCLEXTA (venetoclax)</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>b. BTK Inhibitor: IMBRUVICA (ibrutinib)</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>c. Anti-CD20 Monoclonal Antibody: ARZERRA (ofatumumab)</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>d. PI3K Inhibitor: ZYDELIG (idelalisib)</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>e. Anti-CD20 Monoclonal Antibody: GAZYVA (obinutuzumab)</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>f. BTK Inhibitor: CALQUENCE (acalabrutinib)</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>g. BTK Inhibitor: BRUKINSA (zanubrutinib)</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>h. PI3K Inhibitor: COPIKTRA (duvelisib)</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>i. Combination Therapy: VENCLEXTA + GAZYVA (venetoclax + obinutuzumab):</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>j. Combination Therapy: ZYDELIG + rituximab (idelalisib + rituximab):</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>k. Combination Therapy: CALQUENCE + GAZYVA (acalabrutinib + obinutuzumab):</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>l. RITUXAN:</td>
<td>[1-2-3-4-5]</td>
</tr>
<tr>
<td>m. RITUXAN Biosimilars:</td>
<td>[1-2-3-4-5]</td>
</tr>
</tbody>
</table>

74. On a scale of 1 to 7, where 1 is no budget impact and 7 is high budget impact, what is the level of budget impact for the following agents used in the treatment of CLL today?

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. BCL-2 Inhibitor: VENCLEXTA (venetoclax):</td>
<td>[1-2-3-4-5-6-7]</td>
</tr>
<tr>
<td>b. BTK Inhibitor: IMBRUVICA (ibrutinib):</td>
<td>[1-2-3-4-5-6-7]</td>
</tr>
<tr>
<td>c. Anti-CD20 Monoclonal Antibody: ARZERRA (ofatumumab):</td>
<td>[1-2-3-4-5-6-7]</td>
</tr>
<tr>
<td>d. PI3K Inhibitor: ZYDELIG (idelalisib):</td>
<td>[1-2-3-4-5-6-7]</td>
</tr>
<tr>
<td>e. Anti-CD20 Monoclonal Antibody: GAZYVA (obinutuzumab):</td>
<td>[1-2-3-4-5-6-7]</td>
</tr>
<tr>
<td>f. BTK Inhibitor: CALQUENCE (acalabrutinib):</td>
<td>[1-2-3-4-5-6-7]</td>
</tr>
<tr>
<td>g. BTK Inhibitor: BRUKINSA (zanubrutinib):</td>
<td>[1-2-3-4-5-6-7]</td>
</tr>
<tr>
<td>h. PI3K Inhibitor: COPIKTRA (duvelisib):</td>
<td>[1-2-3-4-5-6-7]</td>
</tr>
</tbody>
</table>
i. Combination Therapy: VENCLEXTA + GAZYVA (venetoclax + obinutuzumab): [1-2-3-4-5-6-7]

j. Combination Therapy: ZYDELIG + rituximab (idelalisib + rituximab): [1-2-3-4-5-6-7]

k. Combination Therapy: CALQUENCE + GAZYVA (acalabrutinib + obinutuzumab): [1-2-3-4-5-6-7]

l. RITUXAN: [1-2-3-4-5-6-7]

m. RITUXAN Biosimilars: [1-2-3-4-5-6-7]

75. [If responsible for commercial or commercial and Medicare Part D lives in Q1] For commercial lives, do you manage any of the following agents more strictly than to NCCN guidelines? [Select all that apply]

a. BCL-2 Inhibitor: VENCLEXTA (venetoclax)

b. BTK Inhibitor: IMBRUVICA (ibrutinib)

c. Anti-CD20 Monoclonal Antibody: ARZERRA (ofatumumab)

d. I3K Inhibitor: ZYDELIG (idelalisib)

e. Anti-CD20 Monoclonal Antibody: GAZYVA (obinutuzumab)

f. BTK Inhibitor: BRUKINSA (zanubrutinib)

g. PI3K Inhibitor: COPIKTRA (duvelisib)

h. Combination Therapy: VENCLEXTA + GAZYVA (venetoclax + obinutuzumab)

i. Combination Therapy: ZYDELIG + rituximab (idelalisib + rituximab)

j. Combination Therapy: CALQUENCE + GAZYVA (acalabrutinib + obinutuzumab)

k. RITUXAN

l. RITUXAN Biosimilars

m. None of these

76. For the agent(s) that you are managing beyond label, what are the most common restrictions placed on the agent(s) for your commercial lives today? [Select all that apply]

a. Manage more restrictively than label

b. Not providing coverage for off-label use (not FDA approved) despite NCCN compendia recommendation

c. Drive utilization through tiering differentials for like products (same line of therapy and/or MOA)

d. Utilize management tactics such as split fills

e. Implement steps that require the use of one product over another in the same line of therapy per guidelines

f. Excluded an agent from formulary/coverage

g. Utilize provider developed pathways to manage

h. Clinical pathways for providers, without risk sharing

i. Enter in risk sharing agreement with providers utilizing pathways (more narrow than NCCN guidelines) to manage

j. Use of value frameworks

k. Buy and bill incentives toward branded agents

l. Buy and bill incentives toward generic agents

m. None of these

n. N/A (I do not manage commercial lives)
77. [If responsible for Medicare Part D or commercial and Medicare Part D lives in Q1] Is your current Medicare management different than in commercial today?
   a. Yes
   b. No
   c. N/A (I do not manage Medicare lives)

78. [If yes selected for Q77] For Medicare lives, do you manage any of the following agents more strictly than NCCN guidelines today? [Select all that apply]
   a. BCL-2 Inhibitor: VENCLEXTA (venetoclax)
   b. BTK Inhibitor: IMBRUVICA (ibrutinib)
   c. Anti-CD20 Monoclonal Antibody: ARZERRA (ofatumumab)
   d. I3K Inhibitor: ZYDELIG (idelalisib)
   e. Anti-CD20 Monoclonal Antibody: GAZYVA (obinutuzumab)
   f. BTK Inhibitor: CALQUENCE (acalabrutinib)
   g. BTK Inhibitor: BRUKINSA (zanubrutinib)
   h. PI3K Inhibitor: COPIKTRA (duvelisib)
   i. Combination Therapy: VENCLEXTA + GAZYVA (venetoclax + obinutuzumab)
   j. Combination Therapy: ZYDELIG + rituximab (idelalisib + rituximab)
   k. Combination Therapy: CALQUENCE + GAZYVA (acalabrutinib + obinutuzumab)
   l. RITUXAN
   m. RITUXAN Biosimilars
   n. None of these

79. [If yes selected for Q77 and none of these selected for Q78] For the agent(s) that you are managing beyond label, what are the most common restrictions placed on the agent(s) for your Medicare lives today? [Select all that apply]
   a. Manage more restrictively than label
   b. Not providing coverage for off-label use (not FDA approved) despite NCCN compendia recommendation
   c. Drive utilization through tiering differentials for like products (same line of therapy and/or MOA)
   d. Utilize management tactics such as split fills
   e. Implement steps that require the use of one product over another in the same line of therapy per guidelines
   f. Excluded an agent from formulary/coverage
   g. Utilize provider developed pathways to manage
   h. Clinical pathways for providers, without risk sharing
   i. Enter in risk sharing agreement with providers utilizing pathways (more narrow than NCCN guidelines) to manage
   j. Use of value frameworks (e.g., ASCO or ICER)
   k. Buy and bill incentives toward branded agents
   l. Buy and bill incentives toward generic agents
   m. None of these

80. [If responsible for commercial or commercial and Medicare Part D lives in Q1] Do you expect commercial management to change over the next 3-5 years?
   a. Yes
   b. No
   c. N/A (I do not manage commercial lives)
81. [If yes selected for Q80] For your commercial lives, which agents do you anticipate will be managed more strictly than NCCN guidelines in the next 3-5 years? [Select all that apply]
   a. BCL-2 Inhibitor: VENCLEXTA (venetoclax)
   b. BTK Inhibitor: IMBRUVICA (ibrutinib)
   c. Anti-CD20 Monoclonal Antibody: ARZERRA (ofatumumab)
   d. PI3K Inhibitor: ZYDELIG (idelalisib)
   e. Anti-CD20 Monoclonal Antibody: GAZYVA (obinutuzumab)
   f. BTK Inhibitor: CALQUENCE (acalabrutinib)
   g. PI3K Inhibitor: COPIKTRA (duvelisib)
   h. Combination Therapy: VENCLEXTA + GAZYVA (venetoclax + obinutuzumab)
   i. Combination Therapy: ZYDELIG + rituximab (idelalisib + rituximab)
   j. Combination Therapy: CALQUENCE + GAZYVA (acalabrutinib + obinutuzumab)
   k. RITUXAN
   l. RITUXAN Biosimilars
   m. None of these

82. [If yes selected for Q80 and none of these selected for Q81] For the agent(s) that you expect to manage beyond label, what do you expect to be the most common restrictions placed on the agent(s) for your commercial lives in the next 3-5 years? [Select all that apply]
   a. Manage more restrictively than label
   b. Not providing coverage for off-label use (not FDA approved) despite NCCN compendia recommendation
   c. Drive utilization through tiering differentials for like products (same line of therapy and/or MOA)
   d. Utilize management tactics such as split fills
   e. Implement steps that require the use of one product over another in the same line of therapy per guidelines
   f. Excluded an agent from formulary/coverage
   g. Utilize provider developed pathways to manage
   h. Clinical pathways for providers, without risk sharing
   i. Enter in risk sharing agreement with providers utilizing pathways (more narrow than NCCN guidelines) to manage
   j. Use of value frameworks (e.g., ASCO or ICER)
   k. Buy and bill incentives toward branded agents
   l. Buy and bill incentives toward generic agents
   m. None of these

83. [If responsible for Medicare Part D or commercial and Medicare Part D lives in Q1] Do you expect Medicare management to change over the next 3-5 years?  
   a. Yes
   b. No
   c. N/A (I do not manage Medicare lives)

84. [If yes selected for Q83] For Medicare lives, do you expect to manage any of the following agents more strictly than NCCN guidelines in the next 3-5 years? [Select all that apply]
a. BCL-2 Inhibitor: VENCLEXTA (venetoclax)
b. BTK Inhibitor: IMBRUVICA (ibrutinib)
c. Anti-CD20 Monoclonal Antibody: ARZERRA (ofatumumab)
d. 13K Inhibitor: ZYDELIG (idelalisib)
e. Anti-CD20 Monoclonal Antibody: GAZYVA (obinutuzumab)
   BTK Inhibitor: CALQUENCE (acalabrutinib)
f. BTK Inhibitor: BRUKINSA (zanubrutinib)
g. PI3K Inhibitor: COPIKTRA (duvelisib)
h. Combination Therapy: VENCLEXTA + GAZYVA (venetoclax + obinutuzumab)
i. Combination Therapy: ZYDELIG + rituximab (idelalisib + rituximab)
j. Combination Therapy: CALQUENCE + GAZYVA (acalabrutinib + obinutuzumab)
k. RITUXAN
l. RITUXAN Biosimilars
m. None of these

85. [If yes selected for Q83 and none of these selected for Q84] For the agent(s) that you expect to manage beyond label, what are the most common restrictions placed on the agent(s) for your Medicare lives in the next 3-5 years? [Select all that apply]
   a. Manage more restrictively than label
   b. Not providing coverage for off-label use (not FDA approved) despite NCCN compendia recommendation
   c. Drive utilization through tiering differentials for like products (same line of therapy and/or MOA)
   d. Utilize management tactics such as split fills
   e. Implement steps that require the use of one product over another in the same line of therapy per guidelines
   f. Excluded an agent from formulary/coverage
   g. Utilize provider developed pathways to manage
   h. Clinical pathways for providers, without risk sharing
   i. Enter in risk sharing agreement with providers utilizing pathways (more narrow than NCCN guidelines) to manage
   j. Use of value frameworks (e.g., ASCO or ICER)
   k. Buy and bill incentives toward branded agents
   l. Buy and bill incentives toward generic agents
   m. None of these

Because there have been significant changes in the CLL landscape over the past 5 years, we would like to better understand the evolution of management in CLL. Specifically, we are interested in how your organization is managing costly combinations and brands which are recommended as first line treatments in NCCN guidelines. We are also interested in exploring how the entrance of biosimilars has impacted your management of Rituxan.

86. CALQUENCE + GAZYVA, IMRUVICA, and VENCLEXTA + GAZYVA are all preferred first line treatments for all mutation status and patient types in CLL. Is your organization covering all three of these options at parity status?
   a. Yes
   b. No

87. [If no is selected for Q86] Which is your preferred regimen? [Select all that apply]
   a. CALQUENCE + GAZYVA
b. IMBRUVICA
c. VENCLEXTA + GAZYVA
d. Other (Please specify)

88. [If no is selected for Q86] How are the non-preferred products managed? [Select all that apply]
   a. Non preferred products have a higher patient cost sharing responsibility
   b. Patients have to step through a preferred regimen
   c. Non preferred products are excluded from formulary
   d. Other (Please specify)

89. There are now three biosimilars for RITUXAN. How has the entrance of biosimilars impacted your management?

90. Which of the following rituximab products are preferred at your organization? [Select all that apply]
   a. RITUXAN HYCELA (rituximab)
   b. RUXIENCE (rituximab-pvvr)
   c. RIABNI (rituximab-arrx)
   d. TRUXIMA (rituximab-abbs)

91. Is the branded manufacturer continuing to offer competitive discounts, to match the net price of the biosimilars?
   a. Yes
   b. No