Evaluation of access to care in patients prescribed sofosbuvir-containing regimens; data from the TRIO network

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1. BACKGROUND AND AIM

Despite the clinical success in the real-world of HCV DAA therapy approaching that seen in the clinical trials, access has been limited. Though AASLD guidelines for sofosbuvir-containing treatment have suggested that F3 and F4 fibrosis patients be prioritized, certain payers have interpreted this guidance as a restriction to deny coverage for patients with less severe disease. To establish whether this or other barriers impact access to care, we evaluated real-world patients in the Trio Health (TRIO) network who did not start prescribed sofosbuvir-based regimens.

2. METHODS

TriO Health is a disease management company that works in partnership with academic medical centers, community physicians and specialty pharmacies to optimize care for Hepatitis C. For 3,841 patients prescribed a sofosbuvir-containing regimen between Dec 2013 and Sep 2014 were obtained through the Trio Health program in partnership with a specialty pharmacy. Evaluation of these patients continued through Nov 2014, allowing a minimum of 60 days follow up to determine if initiation of therapy occurred. Approximately 80% of patients were treated by practices located in Missouri, Illinois or Texas with the remainder in 16 other states or DC.

3. TREATMENT TRENDS

No. patients intended to start sofosbuvir-containing treatment and percentage that actually started by month

4. BASELINE CHARACTERISTICS

5. REASONS FOR NON-STARTS

6. START RATES

7. MATCHED SUBGROUPS

8. SUBGROUP ODDS RATIOS

9. SUMMARY

A comparison of propensity score matched Medicaid and commercial real-world subgroups revealed that for each demographic, the commercial matched group was more likely to start therapy. The greatest disparity was observed with intended SMV + SOF +/- RBV, with an odds ratio of 15.4 in favor of commercial patients.

Only 15/315 (5%) patients did not start because they were unreachable or failed to complete required testing. 39/315 (12%) patients were following their physicians’ direction to hold treatment. Insurance-related processes and financial reasons accounted for 254 (81%) of the 315 non-starts.

The non-start rates varied by measure but were strikingly different by primary insurance coverage. The non-start rate was highest in the Medicaid population at 35% followed distantly by commercial (6%) and Medicare (2%) populations.

Baseline demographic and clinical characteristics of commercial (C) and Medicaid (M) subgroups before and after 1-1 optimal propensity score matching without replacement.

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