

BRIEF - SUMMARY OF NEW RESEARCH ON STATINS FOR PATIENTS AT LOW CARDIOVASCULAR RISK AND SUGGESTED POLICY OPTIONS FOR FURTHER CONSIDERATION

What's the problem?

- Statins already represent a significant investment for drug formularies; recent changes in prescription patterns demonstrate considerable potential for increased use among people with low cardiovascular risk. Further increases in statin use will put further pressure on public and private insurance plans as well as out-of-pocket payers.
 - Statins have unrestricted reimbursement¹ and represent ~13% of the total expenditure by Canadian provincial formularies – increased use among people at low cardiovascular risk could lead to \$150M - \$9,000M in additional spending for these plans.
 - Recently revised Canadian practice guidelines recommend pharmacologic treatment in an increased proportion of patients at lower cardiovascular risk.
 - Even if increased use is appropriate, statins are not equally priced or utilized – brand name rosuvastatin (Crestor) is two to five times as expensive as the most popular generic statin and continues to be prescribed at an increasing rate.
 - Although a Canadian generic for rosuvastatin is expected in April 2012, this is uncertain and depends on actions taken by the manufacturer of brand-name rosuvastatin.

What does the new research tell us?

- The systematic review of 29 trials of statins in patients with low cardiovascular risk and its accompanying economic evaluation using Canadian data suggest:
 - Statins reduce lifetime risk of complications and death in patients whose 10-year risk of cardiovascular disease is <20%.
 - A difference in effectiveness between low and high potency statins could not be detected, although there was a trend in favor of high potency statins (i.e. atorvastatin and rosuvastatin) for all outcomes.
 - Statins appear cost-effective in low-risk patients assuming that their effectiveness continues for at least 10 years.
 - High potency statins might be most attractive for funding, but this conclusion depends on the results from a single, controversial, trial (JUPITER).
 - Generic atorvastatin has the potential to improve outcomes and lead to overall reductions in cost, compared to generic low potency statins.

¹ Except for low dose (5mg) rosuvastatin, which is not reimbursed in Manitoba, Nova Scotia, Newfoundland, New Brunswick and PEI

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What can we do² to address the problem?

- **Option 1** – Restrict reimbursement of high potency statins to generic atorvastatin (versus brand-name rosuvastatin) (Highest impact).
 - Reduce net expenditure growth (cost-saving).
 - This policy would be in line with best current evidence of effectiveness and cost-effectiveness.
 - May be difficult to implement for providers who insist atorvastatin was ineffective or rosuvastatin was better tolerated.

- **Option 2** – Adjust payer prices to that of generic atorvastatin or the lowest price statin (Highest impact).
 - Avoids provider backlash while saving additional costs.
 - In line with current evidence.
 - May be difficult to implement in some jurisdictions.

- **Option 3** – Adjust payer prices of rosuvastatin to a generic price in April, 2012, regardless of legal actions of AstraZeneca.
 - Fiscally responsible.
 - Sends strong signal to manufacturer regarding legal gaming at the expense of public funds and may facilitate generic entry.
 - May be difficult to implement in some jurisdictions.
 - Not entirely in line with current evidence – assumes rosuvastatin is “as good” as atorvastatin.

² The effectiveness of all of the options presented is supported by high quality systematic reviews with a sufficient number of studies to suggest that the intervention is generally effective. Options have been rated in terms of feasibility and potential impact.

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- **Option 4** - Restrict reimbursement to low potency statins (versus high potency statins) (Least feasible).
 - In line with current evidence.
 - Will be difficult to implement for providers who insist high potency statins are better.
- **Option 5** –Promote the use of lower-priced statins or generic atorvastatin through demand-side initiatives, including education, academic detailing and practice guidelines. (Least impact, most feasible).
 - In line with current evidence.
 - Infrastructure and incentives are in place.
 - May not produce the desired impact in terms of net expenditure avoidance.

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