Arthritis Consumer Experts™
joint action for Canadians with arthritis

Canadian Arthritis Patient Alliance

The Arthritis Society

September 6, 2006

Office of the Premier
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VICTORIA, BC
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CANADA

sent via email to:
premier@gov.bc.ca
original mailed

Dear Premier Gordon Campbell:

We have noted with interest the leadership you have shown in challenging British Columbians to be the fittest hosts for the Olympics. Your Act Now initiative and your resent appointment of Mr. Hogg as Minister for Fitness demonstrates that you are committed to implementing programs to assist all British Columbians in achieving this goal. Unfortunately, there are many British Columbians who suffer from several different types of arthritis – like psoriatic arthritis and ankylosing spondylitis – for which the goal of fitness is unrealistic.

We are writing today to request your assistance in implementing program and policy changes that will allow these British Columbians to regain a measure of health that so many take for granted. In British Columbia today, approximately 25,000 individuals live with psoriatic arthritis and ankylosing spondylitis, and there is irrefutable evidence that these individuals could benefit from access to biologic response modifiers to help them regain their health. Much of the background information on this has been previously conveyed to Dr. Ballem and her colleagues in PharmaCare and we appreciate you passing along our previous correspondence of February 1, 2006 to Dr. Ballem.

Regards the points in Dr. Ballem's March 2006 letter, we agree and are pleased by the government's actions around a much-needed chronic disease management approach to arthritis care in the province. Indeed, we look forward with great anticipation to the implementation of a chronic disease management strategy for improving the health and well-being of 600,000 British Columbians living with arthritis.

We are also encouraged that people with arthritis have been central to the development of the chronic disease management strategy, demonstrating the positive and direct implications that our inclusion can have on the creation of effective and relevant health policy. While these represent important changes in British Columbia to the management of chronic disease, we would like to re-address your attention to the four key issues raised in our November 28, 2005 meeting with then acting Executive Director of PharmaCare, Ms. Heather Davidson.

1. **BC PharmaCare reimbursement coverage for biologic response modifiers in psoriatic arthritis and ankylosing spondylitis:**

   In Ms. Solven's April 2006 letter, she stated that an announcement of approval for coverage of etanercept (Enbrel®) for psoriatic arthritis and ankylosing spondylitis would be announced to the public in July 2006. To date, such an announcement has not been issued. We respectfully request the government follow through with their commitment and issue this announcement immediately.

   The BC PharmaCare program's Therapeutics Initiative has now taken 2 ½ years to review this breakthrough product used to treat psoriatic arthritis, and over a year to review the etanercept submission for treatment of ankylosing spondylitis.

   This performance is unacceptable to the arthritis community. This type of performance record would be considered a travesty in cancer and HIV/AIDS care. Based on what we heard you state at the Premier's Meeting on Patient Care with the Better Pharmacare Coalition on July 25, 2005, we are convinced that this cannot be acceptable to you and should not be to your government. Those needing these agents with psoriatic arthritis and ankylosing spondylitis have devastating effects from their disease.

Furthermore, there are two other biologic response modifier submissions with BC PharmaCare's Therapeutics Initiative that have been unanswered, one for over a year (infliximab or Remicade®), and one for several months (adalimumab or Humira®). These two submissions are medications used to treat psoriatic arthritis and ankylosing spondylitis, and are very much needed in the rheumatologist's armamentarium. While all three agents are directed at limiting the effects of TNF etanercept and the remaining two act through a different mechanism and in the case of psoriatic arthritis and ankylosing spondylitis some BC and Canadian experts feel that there is a therapeutic advantage to the two newer ones (both are antibodies rather than a receptor blocker). Having all available TPD approved biologic response modifiers on the BC PharmaCare drug benefit list would follow international best practice guidelines.

Be assured, our community can reasonably argue that all medications used to treat inflammatory arthritides such as rheumatoid arthritis, ankylosing spondylitis and psoriatic arthritis should be placed on the BC PharmaCare drug benefit list once Health Canada issues a Notice of Compliance. **(See attached photos illustrating the impact psoriatic arthritis and ankylosing spondylitis have on the body.)**

2. BC PharmaCare reimbursement coverage for bisphosphonates in rheumatic diseases:

As discussed in our previous meetings and letters with Ms. Heather Davidson and yourself, we request that BC PharmaCare's reimbursement coverage of all available bisphosphonates for people with inflammatory arthritis be changed to reflect the internationally accepted best practice of making them available on their drug benefit list before a person fractures a bone, not after. The BC PharmaCare policy currently requires a person to fracture before they are eligible to receive reimbursement for the bisphosphonates proved to prevent fractures. Osteoporosis specialists are using the federally approved drugs preferentially in those who can afford them. Thus, only the less fortunate who are not doing well on the BC Pharmacare approved agent remain on the agent that has never been shown to reduce fracture. Twenty percent of those who fracture their hip die and another 20% lose their independence and are placed permanently in nursing homes. These are preventable outcomes.

3. Recently revised BC PharmaCare reimbursement coverage criteria for biologic response modifiers in rheumatoid arthritis:

The current BC PharmaCare reimbursement criterion for biologic response modifiers is not entirely evidence-based and puts people with rheumatoid arthritis at risk. For example, despite no randomized controlled trials to demonstrate greater efficacy, BC PharmaCare continues to request that people with rheumatoid arthritis fail on 25 milligrams of methotrexate and try two of the following four medications; gold, sulphasalazine, leflunomide and azathioprine. In fact, in a recently published study that looked at serious side effects of medications used to treat rheumatoid arthritis, azathioprine proved to be very toxic, causing significantly increased rates of cancer in people taking this medication.

For this reason, based on current evidence we recommend the following criterion for access to reimbursement coverage for biologic response modifiers:

- A three month trial of methotrexate at 15 – 20 mgs., either oral or by subcutaneous injection, whichever is well-tolerated by the patient, and methotrexate in combination with one or both of the following medications:
    i. sulphasalazine at a dosage up to 3.0 gm/day (unless contraindicated due to sulpha allergies),
    ii. hydroxychloroquine at a dosage not to exceed 6.5 mg/kg/day lean body weight

Upon failure of the above, a person with active moderate to severe rheumatoid arthritis would be considered refractory to conventional treatment and would thus receive BC PharmaCare reimbursement coverage for a biologic response modifier.

4. Recent evidence showing that BC PharmaCare's co-pay policy increases – <u>not decreases</u> – health care costs:

There is strong evidence based on BC PharmaNet data (Anis, Canadian Medical Association Journal) showing that health outcomes are adversely affected and costs increased in rheumatoid arthritis by PharmaCare's "co-pay" policies.

We recommend that no BC PharmaCare "co-pay" policies be maintained or put into place for British Columbians with a diagnosis of inflammatory arthritis.

We have met with Minister Abbott as members of the Better Pharmacare Coalition and have appreciated the time he has taken on this file and his understanding of the importance of PharmaCare policy as a "grass roots issue". When 1 in 5 British Columbian's have or will develop arthritis, government policies that affect these 600,000 individuals is an important grass roots issue. We understand that the Minister is limited in his ability to unilaterally introduce or change PharmaCare policy which could have fiscal and other implications for other departments. Further we know the challenge that any Minister faces in trying to get an item on the Cabinet agenda given the large number of competing agenda items.

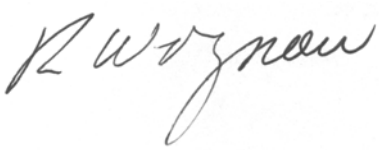
Mr. Premier, the PharmaCare policy framework introduced by the previous government continues to haunt us as it provides and institutional barrier in making the change that we have suggested above. We seek your leadership in doing two things: First, in the short-term, provide your support for the program recommendations listed above. Second, ask your Deputy Minister to coordinate the development of a new PharmaCare policy framework which is based on peer reviewed scientific evidence, includes meaningful patient participation, and is consistent with national and international best practices in the treatment of arthritis. These steps will help to ensure that PharmaCare policy is consistent with other policies and goals developed by your government.

We thank you for your consideration of our request and look forward to working with your Cabinet colleagues and Deputy Minister on this file.

Sincerely,

Cheryl Koehn
President, Arthritis Consumer Experts
Person with rheumatoid arthritis

Colleen Maloney
BC Steering Committee Representative, Canadian Arthritis Patient Alliance
Person with rheumatoid arthritis



Ron Woznow, PhD
Executive Director, The Arthritis Society, BC and Yukon Division

Encls.

C.c. Minister of Health, George Abbott

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