Leveraging Technology to Cut Through the REMS Confusion

The Risk Evaluation and Mitigation Strategies (REMS) program has taken center stage recently as the Food and Drug Administration (FDA), pharmacies and healthcare providers seek ways to improve and streamline its administration.

Created in 2007 as part of the FDA Amendments Act, REMS was designed to ensure that the benefits of a drug or biological product outweigh its risks, as well as for post-marketing surveillance of medication safety. While providers agree with these goals, many are also concerned with issues they believe are preventing REMS from achieving its objectives.

Those concerns were made clear during a 2010 FDA meeting on REMS, where feedback indicated that program requirements are unduly burdensome to physicians, pharmacists and other healthcare providers. Other complaints included the high costs associated with carrying out REMS responsibilities, lack of compensation for the extra work required and the negative impact it can have on patient access to needed medications. Comments also conveyed concerns in the areas of standardization, implementation and assessment.

Finding a solution to the issues impacting the ability of pharmacists and physicians to carry out the program is imperative, as the list of medications with REMS is growing at a rapid pace. So too are the confusion and inefficiencies that are negatively impacting the effectiveness of the overall program.

LACK OF STANDARDIZATION COMPOUNDS COMPLEXITY

In 2009, just 60 medications required some form of REMS. By early 2011, that figure exceeded 130 medications.

Indeed, program growth has been so explosive that, according to the American Society of Health-System Pharmacists (ASHP), it has evolved into “a system that requires us to move around tens of thousands of pieces of paper between hospitals and health systems and providers in the community.”

It’s not just the number of drugs that creates challenges. It is also the lack of standardization in REMS, which are created independently by each manufacturer, as well as the lack of a centralized information resource.

“The growing number of disparate programs leads to administrative, logistical, and workflow challenges for the healthcare system,” says the American Pharmacist Association (APhA). “The inconsistency that results from such ‘silos’ programs leads to provider confusion, administrative
inefficiencies in implementation, workflow inefficiencies, and burdens on the healthcare system. This burden on the healthcare system has the potential to reduce patient access to medications because it may limit provider participation. ix

As it currently stands, the FDA may require REMS for any New Drug Application (NDA), Abbreviated New Drug Application (ANDA) or Biologics License Application (BLA) regardless of the stage in the product’s lifecycle. When it does, the manufacturer has 120 days to submit a proposed REMS for a marketed drug. For new drugs, the proposed REMS must be part of the NDA submission. ix

The elements of an individual REMS can vary significantly. While it must include a communication plan, it may also include a Medication Guide, patient package insert or other elements to assure safe use (ETASU). It may also include an implementation plan and timetable for submission of assessments.

To illustrate REMS confusion, APhA noted that just the ETASU vary widely. While all must include goals to mitigate a specific serious risk listed in the labeling of the drug, they may also require prescribers and/or pharmacies, practitioners or settings that dispense the medication to undergo specific training or certification. They may also require that the medication be dispensed only in certain healthcare settings or dispensed with evidence of safe use, such as laboratory test results.

Other safe-use requirements have included subjecting patients to monitoring, enrolling in a registry or participating in a central registry that tracks product safety. Finally, some REMS require that prescribers and/or pharmacists who dispense the medication enroll in a national registry.

Once the FDA approves a REMS, it creates enforceable obligations for manufacturers and providers – obligations that carry hefty penalties for noncompliance. Fines can go as high as $250,000 per violation, not to exceed $1 million in a single proceeding, and increase if the violation continues for more than 30 days after notification. They double for the second 30-day period and then continue to double for subsequent 30-day periods, up to $1 million per period and $10 million per proceeding. xi

CHALLENGES ACROSS CARE SETTINGS

Issues with REMS compliance are shared across the hospital and outpatient pharmacy setting. One of the most significant is ensuring patient access to needed medications while still policing the process. For example, if a physician writes a prescription but has not followed the REMS requirements, the pharmacy is prohibited from filling it. viii

Access is also impacted by REMS restrictions that limit prescribing to certain specialists or dispensing by specialty pharmacies. These restrictions make it difficult for hospitals to obtain needed medications and steer patients away from their regular pharmacies. It also increases costs. ix

Finally, there are obstacles to sharing REMS information between the in- and outpatient settings. This can be particularly problematic for outpatient pharmacies, which do not have access to information such as laboratory data or other information that may be required to verify eligibility prior to dispensing.

On the workflow front, the increased documentation and reporting requirements create additional challenges. Monitoring programs often require double and triple documentation, with redundant information added to medical charts, pharmacy records and the REMS database. Even in cases where an electronic medical record (EMR) is used, the information must still be entered separately into the REMS database. If the patient is on more than one medication with a REMS requirement, the amount of documentation increases exponentially.

Hospitals in particular also struggle with the logistics of complying with REMS that require distribution of Medication Guides. According to ASHP, the guides create “administrative burdens, workflow inefficiencies and supply challenges for pharmacists; they also generate extra costs (e.g., paper and ink for printing), lack a balance of risk and benefit information and have format inconsistencies.”

On this front, progress is being made. Draft guidance issued by the FDA in February 2011 calls for the elimination of Medication Guides from REMS in certain cases. These include times when a drug is dispensed in an inpatient setting or in an outpatient setting such as a clinic or a dialysis or infusion center. (Although these outpatient settings are still required to distribute the Medication Guide the first time the drug is dispensed.) In these cases, the assumption is that the patient will receive instructions on safe use from a healthcare professional, eliminating the need for the Medication Guide.

Under the draft guidance, Medication Guides must still be distributed at the request of the patient or when a drug
is dispensed in an outpatient setting like a retail or hospital ambulatory care pharmacy. Medication Guides must also be distributed to the patient if material changes have been made to their content.

SEEKING SOLUTIONS FROM ALL STAKEHOLDERS

In addition to proposed Medication Guide changes, the FDA has also introduced a standardized format for REMS programs. While this eliminates the variation in the way the programs are described, it does not reduce the burden of compliance. Resolving that, along with the other problems inherent in the existing REMS program, requires collaboration among all stakeholders – the FDA, pharmacists, prescribers, professional associations and vendors.

For its part, the APhA has issued a white paper outlining its recommendations on redesigning REMS in a way that would “balance the need to control medication risks against the need to maintain access and affordability.” The recommendations were culled from input provided by multiple stakeholders, including pharmacists, other provider groups, patients and health IT vendors.

In addition to introducing a tiered system based on the degree of intensity and the types of risk targeted, APhA recommends enhanced public, patient and provider education and pilot testing of all REMS programs. It also recommends that outcomes be prospectively defined and monitored for effectiveness at mitigating identified risks, as well as their impact on quality of care.

Most agree that leveraging advanced technologies is crucial for streamlining the program to reduce costs and eliminate workflow disruptions. According to the National Comprehensive Cancer Network, “In a technologically advanced society that has allowed us to pay bills and manage existing accounts online, it is hopeful that REMS processes could be similarly streamlined to minimize the inefficiencies that exist today.”

APhA calls for a “standardized, system-based process that is user-friendly, seamless and integrated into the workflow of prescribers and pharmacists.” This would ideally be encompassed in a software function that operates in the background as well as a centralized information repository.

One area where technology — specifically electronic drug information publishers — can deliver immediate relief is in the centralization of REMS information by providing a consolidated reference indexing all drugs with REMS and Medication Guides. A one-stop shop for information on the requirements of all drugs with REMS and the Medication Guides would ultimately save physicians, pharmacists and their patients a significant amount of time and headaches. By providing access to details on all active REMS programs, online references would also have a noticeable impact on clinician workflows.

For maximum value and end-user adoption, this information could be integrated with comprehensive drug information references and an array of decision support tools. When combined, the end result would be a reduction in adverse events and improved safety and care outcomes – the primary objectives of the REMS program.

CONCLUSION

Pharmacists, prescribers and other healthcare providers and the FDA agree on two things: (1) achieving the goals of the REMS program is vital, and (2) the program as it currently exists is confusing and costly and places too great a burden on those charged with carrying out its requirements.

That agreement has led to a wide-ranging conversation on possible solutions to shore up weaknesses and close the gaps that are preventing REMS from achieving its objectives. By working together and leveraging the advanced technologies that are quickly becoming ubiquitous in the daily lives of clinicians, a streamlined program that is effective and is embraced by pharmacists and prescribers can be achieved.
Facts & Comparisons®, part of Wolters Kluwer Health, provides healthcare professionals with access to the most up-to-date drug information that is tailored to their unique needs and care setting, enabling better therapeutic decisions in less time.

This includes its unique REMS information module, which provides a summary of steps required to comply with individual REMS programs. The information is divided into bullets for simple navigation, and links are provided to any required registries, certifications or education programs.

This allows the healthcare provider to reduce the amount of time required to achieve REMS compliance.

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