The availability of novel disease-modifying therapies (DMTs)—Copaxone 40 mg three times weekly (3TW), Plegridy, Lemtrada, oral DMTs—has complicated clinical decision-making and treatment choice in the management of multiple sclerosis (MS) in Europe. The syndicated ChartTrends: Multiple Sclerosis (EU) audit database and report allows clients to better understand the actual treatment of MS with DMTs through comparison of what physicians self-report about disease management with what actually occurs at the patient level in the clinical setting. Through an in-depth review of 1,006 charts from patients currently treated with Aubagio, Avonex, Betaferon, Copaxone (20 mg and 40 mg 3TW), Gilenya, Lemtrada, Plegridy, Rebif, Tecfidera, and Tysabri, details such as product initiation, switching, monitoring, anti-John Cunningham Virus (JCV) antibody assay testing, and a host of patient demographic variables, as well as reasons for initiation and discontinuation, help define patient types and identify drivers of therapy choice. The report also evaluates physician receptivity to late-phase emerging therapies for the treatment of MS and the potential introduction of generic glatiramer acetate 20 mg, and identifies potential characteristics of patient candidates for each therapy.

Questions Answered in This Report:

- Interferons and platform injectables continue to be the dominant first-line options, while high-potency DMTs Gilenya, Lemtrada, and Tysabri are usually reserved for second-line or later use owing to their high-risk, high-reward clinical profiles. What anticipated product qualities drive the decision to prescribe injectable therapies (i.e., interferon-betas and Copaxone), oral DMTs, and high-potency therapy options? Where do oral DMTs fit into the treatment algorithm? What role does induction therapy play in first-line prescribing practices? Under which circumstances do neurologists choose to switch patients from one DMT to another? How are newly approved DMTs differentiating themselves against products with longer tenure on the market? How does market access affect prescribing patterns in the individual EU5 countries?

- Continuing to drive decisions related to Tysabri candidacy, the anti-JCV antibody test has been increasingly incorporated into the MS treatment algorithm with significantly more patients having been tested with the assay than in previous EU5 audits. How often do audit patients test positive for anti-JCV antibodies, and how does this compare with rates seen in clinical studies? Which DMTs are patients most likely to be treated with or considered candidates for at the time of testing? What role does serostatus play in prescribing decisions for DMT-naive and switch candidates, especially in relation to the high-potency DMTs?

- Identification of potential candidates for emerging DMTs is largely based on mechanism of action and/or mode of administration of the emerging products. What role will emerging
therapies play in the evolving MS market landscape in the EU5 countries? Which DMTs are at the highest risk of replacement by one or more emerging products? Which emerging therapies have the greatest market potential? How do candidates for each emerging therapy differ from non-candidates? How do neurologists plan to incorporate generic glatiramer acetate into their practice, and is switching to the generic anticipated to be voluntary or forced?

Scope:
Markets covered: EU5 (France, Germany, Italy, Spain, UK).
Primary research: 229 neurologists (1,006 patient charts audits).
Indication coverage: Clinically isolated syndrome (CIS), relapsing-remitting MS, secondary-progressive MS (progressive-relapsing MS, primary-progressive MS).
Emerging therapies: Phase III: 4 drugs.

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