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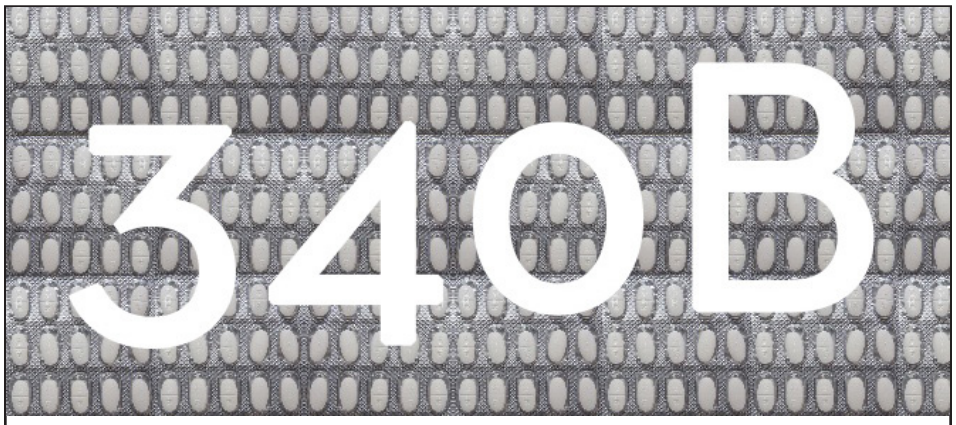


# Judge Nixes HRSA's Second Attempt To Enact Orphan Drug Discounts in 340B

*By Matthew Bin Han Ong*

A federal judge has ruled against the Health Resources and Services Administration over provider access to 340B Drug Pricing Program discounts for orphan drugs.

Judge Rudolph Contreras of the U.S. District Court for the District of Columbia vacated a HRSA "interpretive rule," in which HRSA sought to make drug companies provide discounts on some uses of orphan drugs.

Contreras determined that Congress specifically excluded all uses of orphan drugs from the 340B program.

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# 340B Guidance to Scale Back Discounts; Hospitals Will Need to Show Patient Benefit

*By Matthew Bin Han Ong*

The 340B Drug Discount Program—designed to help hospitals that serve needy patients—is on the brink of a major revamp.

The Health Resources and Services Administration issued a sweeping guidance that would provide stricter definitions for which patients and entities should be covered (The Cancer Letter, Sept. 11).

(Continued to page 4)

*In Brief*

# Hidalgo Named Director of BIDMC's Clinical Cancer Programs

**MANUEL HIDALGO** was named director of the Leon V. & Marilyn L. Rosenberg Clinical Cancer Center and Chief of the Division of Hematology-Oncology at **Beth Israel Deaconess Medical Center**. He will oversee all clinical cancer programs.

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# Judge Rules Against HRSA In 340B Orphan Drug Coverage

(Continued from page 1)

However, in a series of moves in recent years, HRSA attempted to promulgate and enforce rules that would discount the prices of orphan drugs when they are used outside their orphan indications.

For example, there is no dispute that the drug Rituxan (rituximab) should be exempt from 340B discounts when used within its orphan designations—anti-neutrophil cytoplasmic antibody-associated vasculitis, non-Hodgkin's B-cell lymphoma, and immune thrombocytopenic purpura.

However, under HRSA's now-ended rules, Rituxan would have been subjected to discounts when prescribed for non-orphan conditions, which include rheumatoid arthritis, multiple sclerosis, and autoimmune anemia.

In addition to being resistant to offering these discounts, drug companies complained that the rule created unreasonable reporting requirements. Pharmacies couldn't be expected to know whether the Rituxan they are dispensing is being used within its orphan designation or outside it, they said.

In his summary judgment Oct. 14, Contreras agreed with the plaintiff, the Pharmaceutical Research and Manufacturers of America, that the 2014 HRSA rule was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."

HRSA said it is reviewing the ruling and declined to comment. It is not publicly known whether HRSA will appeal the decision within 60 days. The ruling is available here.

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"We are very pleased with the Court's decision," PhRMA executive vice president and general counsel Mit Spears said in a statement to The Cancer Letter. "PhRMA supports the original intent of the 340B program and remains committed to working with the administration and Congress to reform the 340B program to ensure it reaches the vulnerable or uninsured patients it was intended to help.

"To achieve this important objective, it is critical the program operates in a manner consistent with the clear and unambiguous direction of Congress."

Historically, the issues Contreras addressed in his ruling have been integrally connected with another HRSA initiative, the 340B Omnibus Draft Guidance, which constitutes an effort to clarify many of the fundamental definitions in the controversial 340B Drug Discount Program. The document, published Aug. 28, is open for public comment through Oct. 27 (The Cancer Letter, Sept. 11).

Contreras's ruling means that cancer centers and rural hospitals will not be able to get 340B discounts for any orphan drug uses, said 340B Health, a Washington, D.C., trade association that represents over 1,000 340B-enrolled hospitals.

"340B Health is deeply disappointed with a federal district court ruling today that will significantly raise the cost of orphan drugs for rural and cancer hospitals and their patients," 340B Health said in a statement. "The court struck down guidance issued last year by HRSA to implement a key provision of the 340B drug discount program, finding the guidance 'contrary to the plain language of the statute.'

"The guidance allowed rural and cancer hospitals participating in 340B to purchase certain high-cost drugs that can be used to treat rare diseases at discounted prices when a hospital uses the drugs to treat common conditions instead of a rare condition.

"340B Health supported HRSA's guidance as a reasonable implementation of the 340B law's orphan drug exclusion. Many of these drugs can cost patients up to $300,000 per year or more, and without access to 340B discounts, these hospitals will struggle to meet the needs of their vulnerable patients."

**Judge: Congress Excluded Orphan Drugs**

The controversy began in 2013, when HRSA published a "final rule" that mandated discounts for the use of orphan drugs outside their orphan indications.

PhRMA sued, claiming that the HRSA rule was "based on an erroneous reading of the statutory text that HRSA is seeking to implement and is outside the scope of HHS's rulemaking power."

The PhRMA complaint, filed Sept. 27, 2013, contended that HRSA took liberties with the language of the Affordable Care Act.

The challenge may have appeared narrow, but it raised fundamental questions and therefore had broad implications.

In May 2014, Contreras declined to consider the finer points of HRSA's legislative rule. Instead, he ruled that the agency lacked authority to promulgate such rules.

This action thwarted the release of the long-awaited "mega-rule" that HRSA was expected to clarify eligibility criteria for the 340B program. (The Cancer Letter, June 13, 2014). Observers concluded that if HRSA lacked authority to enact a legislative rule on orphan drugs, it also lacked authority to enact the mega-rule.

After the 2014 ruling, HRSA turned around and downgraded both rules it had previously attempted to enact. The agency reintroduced essentially the same orphan drug proposal, calling it an interpretive rule, as opposed to a legislative rule.

The second proposal, which was once referred to as a possible mega-rule, was demoted to a mere guidance. A guidance is not held to the same legal standards as a rule, but it doesn't give the agency as much authority. Regulated entities have more leeway in challenging a guidance, which opens the door for interpretation.

In 2014, Contreras didn't consider the content of the proposed legislative rule. He threw it out, saying that the agency didn't have the authority to issue such rules.

Now, ostensibly the same document, reintroduced as an interpretive rule, prompted Contreras to conclude that HRSA was going against the congressional intent for orphan drugs in the 340B program.

PhRMA filed a complaint Oct. 9, 2014, challenging the interpretive rule under the Administrative Procedure Act.

Defending its interpretive rule, HRSA said it deems "the statutory language to exclude all indications for a drug that has an orphan drug designation would be contrary to the Congressional intent of section 340B(e) to balance the interests of orphan drug development and the expansion of the 340B Program to new entities."

In the Oct. 14 ruling, Contreras wrote: "HHS expends considerable energy arguing that the rule is not a legislative rule and, for that reason alone, is not yet subject to review under the APA."

According to Contreras, Congress unambiguously intended to exclude all drugs carrying an orphan-designation from 340B program eligibility for newly added entities.

"Because the term 'a drug designated…for a rare disease or condition' in section 340B(e), as construed with reference to related statutory provisions, the Court concludes that HHS's Interpretive Rule is contrary to the plain language of the statute," Contreras wrote.

"The Court further concedes that, 'certainly, there may be compelling policy reasons,' for excluding orphan-designated drugs from the section 340B pricing program only when they are used to treat those diseases, particularly in light of Congress's clear effort to expand the 340B Program.

"But if Congress intended that result, it did not so provide in the statute. Congress remains free to amend section 340B(e) if it determines that, in practice, the scheme it has set up is not a workable one or does not provide the hoped-for benefits to the extent envisions.

"But until Congress does so 'this court is bound by the language that Congress has so far provided.'"

Under the ACA, the indications covered by the orphan drug designation are exempt from discounts under 340B. Thus, for diseases that affect fewer than 200,000 people in the U.S. and that have been recognized as orphan indications by FDA, there would be no discounts.

The logic was straightforward: pharma companies need to be incentivized to develop drugs for smaller populations. At FDA, these drugs are exempted from the application user fee, and, when approved, receive longer exclusivity.

# 340B Guidance to Toughen Hospital Eligibility Standards

(Continued from page 1)

The draft guidance, called the 340B Program Omnibus Guidance, was issued Aug. 28. Its public comment period ends Oct. 27.

Congress established the 340B program in 1992 in response to escalation of drug prices, which limited access to treatments for low-income and uninsured patients.

Under this popular but controversial program, health care providers—including safety net hospitals and clinics that receive federal grants—get 20 to 50 percent discounted pricing on outpatient drugs. The discounts have to be provided by manufacturers participating in Medicaid or Medicare Part B programs.

To get 340B discounts, institutions usually must demonstrate that Medicaid or Medicare covers about 30 percent of their patients.

In recent years, many key players in oncology have been questioning the 340B program's expansion and the eligibility criteria it uses to enroll institutions, which are called "disproportionate share hospitals." Critics say the program is poorly defined, and is increasingly abused by entities that can fend for themselves without help from the government.

As the Oct. 27 deadline approaches, stakeholders are clamoring to influence public discourse in a heated debate over redefining eligibility criteria for 340B:

• The drug industry says the draft guidance would curb abuses and prevent unnecessary expenditure.

• The 340B-enrolled hospitals say the draft guidance would severely limit access to drug discounts for low-income patients who need them.

The new, more stringent definitions that figure in the draft guidance will reduce federal reimbursements for many institutions enrolled in the program, observers say.

"The draft guidance scales back the program to target patients and providers that were likely the intended beneficiaries," said Rena Conti, an assistant professor of health policy and economics in the Department of Pediatrics and Health studies at the University of Chicago. "By clarifying the definition eligible 'patients,' redefining the guidance, if implemented, would drastically curtail the volume of drugs eligible for the discounts.

"The guidance will reduce the amount of money eligible hospitals and affiliated outpatient providers can make off charging patients and payers higher prices for these drugs than their acquisition costs. We don't know whether this reduction in provider profit will have any measurable impact on vulnerable patients' access to care or quality of care."

As of Jan. 1 of this year, there were 11,530 registered and covered entities—at least a third of all hospitals in the U.S., according to some estimates. The Government Accountability Office places that proportion at 40 percent.

The availability of 340B dollars is a contentious issue that goes far beyond helping underserved patients at individual hospitals: the draft guidance, if enacted as-is, will benefit pharmaceutical companies and trade associations financially at the expense of patient care, 340B advocates say.

However, the 340B discounts currently apply to entire health systems, which observers say cost more than the original legislation intended.

"This guidance fundamentally curtails 340B discounts flowing to hospital outpatient departments and affiliated outpatient clinics, including those that are giving chemotherapy to patients," Conti said to The Cancer Letter. "340B eligible hospitals and clinics can use this money to fund operations, including staff salaries."

According to a study published Oct. 6 in the journal Health Affairs, hospitals that qualified for 340B discounts in 2004 or later were more likely to serve wealthier communities with higher rates of health insurance coverage (The Cancer Letter, Oct. 10, 2014).

"The 340B program is being converted from one that serves vulnerable patient populations to one that enriches hospitals and their affiliated clinics," wrote study authors Conti and Peter Bach, a pulmonologist, health systems researcher and director of the Center for Health Policy and Outcomes at Memorial Sloan Kettering Cancer Center.

The American Society of Clinical Oncology, in its most recent policy statement on the 340B program, urged policymakers to enhance transparency and accountability, and clarify definitions of relevant terms and criteria.

"ASCO recommends that policymakers place a special emphasis on understanding and responding to any adverse impacts that the 340B Drug Pricing program may have on patient access to high-quality oncology care, particularly as they relate to the recent expansion of the program," ASCO said in a statement June 2014.

**How Do, or Will, Patients Benefit?**

HRSA does not require DSH hospitals to track and report their 340B profits. This data void makes it difficult for researchers to quantify patient benefit, which in turn raises questions as to whether the program is meeting the stated intent of the program.

"The program generates profits for qualified hospitals and clinics on the backs of paying patients and their insurers, most notably those insured by fee for service Medicare. These providers don't have to share the discounts with patients and their insurers," Conti said. "If 340B hospitals and clinics cannot show how vulnerable patients or all patients are benefiting from 340B profits, they should give the money back to the people who can use it—patients and taxpayers."

A GAO investigation, published in June, found that Medicare Part B drug spending, including oncology drug spending, was substantially higher at 340B hospitals than at non-340B hospitals.

"There is a financial incentive at hospitals participating in the 340B program to prescribe more drugs or more expensive drugs to Medicare beneficiaries," GAO concludes. "HRSA and CMS have limited ability to counter this incentive, because the 340B statute does not restrict covered entities from using drugs purchased at the 340B discounted price for Medicare Part B beneficiaries and the Medicare statute does not limit CMS reimbursement for such drugs."

In an opinion piece published in JAMA Oncology Aug. 27, Hagop Kantarjian and Robert Chapman said that restricting the discounts might not be the best solution, even if recent and ongoing expansion of the 340B program is a real concern.

Kantarjian is chair of the Department of Leukemia at MD Anderson Cancer Center, and Chapman is the director of the Josephine Ford Cancer Institute at the Henry Ford Hospital.

"340B sales will continue to increase in the future. In 2013, 340B spending was about 2.3 percent of the $329 billion total U.S. drug spending," the authors wrote. "A recent analysis estimated that 340B sales could increase to $16 billion by 2019. Drug spending is expected to increase to $450 to $480 billion by 2018.

"Therefore, 340B spending (if it reaches $16 billion) would be 3.3 percent to 3.6 percent of all drug spending, a 1 percent increase."

More hospitals will treat Medicaid patients and qualify for 340B patients, because of the Medicaid expansion under the Affordable Care Act, according to the authors.

"While this would be a good measure for vulnerable patients and our health care system, it is likely that newly eligible (now insured) Medicaid patients will continue to go to the 340B hospitals they went to when they were uninsured," Kantarjian and Chapman wrote.

Restricting 340B discounts may worsen access to cancer care by forcing the shutdown of rural centers and community hospitals that rely on such programs for financial solvency, the authors said.

"Medical services and cancer care are undergoing fundamental changes that are not related to the 340B program and that would not be reversed by restricting 340B," Kantarjian and Chapman wrote.

"Clarifying the root causes of this shift in the site of cancer care from community oncology to hospital-based practices, and addressing them with solutions and incentives that stabilize or reverse this trend (if judged beneficial to cancer care in the United States), is a better approach."

**The 340B Debate**

A recent study by the Berkeley Research Group, a consulting firm, concluded that the 340B program is significantly larger than previous estimates have shown.

Commissioned by the Community Oncology Alliance, the study was funded with support through grants from Bristol-Myers Squibb and PhRMA.

"The sponsors of the study had no input into the design, research, findings, or final report," COA said to The Cancer Letter. Much of the growth in the 340B program over the past four to five years is concentrated in government reimbursements for oncology drugs, the Sept. 15 study said. When dispensed via 340B hospitals, cancer drugs cost Medicare and beneficiaries more than community oncology clinics, COA said.

COA is a non-profit that advocates for patients and their providers in the community cancer care setting. The group has a network of corporate members largely made up of pharmaceutical companies.

The study concluded that hospitals participating in the 340B program accounted for 58 percent of all Medicare Part B hospital outpatient drug reimbursements in 2013.

For oncology drugs, 340B hospitals accounted for over 60 percent of reimbursements, according to the study. Both metrics saw double-digit growth during the study period of 2010 to 2013, increasing from 43 and 47 percent respectively. This growth is poised to continue, as more hospitals become 340B eligible, COA said.

"This study adds to the findings from GAO and others that 340B has not only grown way beyond the original congressional intent but also that 340B hospitals are costing Medicare and the seniors they treat more for cancer care," COA Executive Director Ted Okon said in a statement. "With so much attention on the escalating costs of cancer drugs, Congress has to address the runaway 340B program, which has huge profit incentives for hospitals, and its role as a major driver of cancer care costs."

According to the study, the average reimbursement for Part B oncology drugs is 52 percent higher in 340B hospitals than in community cancer clinics, when compared on a per Medicare beneficiary basis. Between 2010 and 2013, 340B hospitals saw a 123 percent increase in total Part B reimbursement for oncology drugs.

"The COA study is not peer-reviewed, but it provides additional empirical evidence that the 340B program has expanded to impact the acquisition costs of drugs," Conti said. "This has been confirmed by GAO's own statistics that DSH hospitals and their clinic affiliates are heavy users of drugs that are covered under this program."

340B advocates argue that COA and the Berkeley study manipulated data and presented its findings in a way that is unfavorable to 340B hospitals.

"This drug-industry-funded presentation discusses Medicare spending on chemotherapy drugs at 340B hospitals compared to other health care providers," 340B Health, a Washington, D.C., trade association, said in a statement. "Similar comparisons have been done this year by the research firm Dobson and Davanzo and the GAO, which between them found that 340B hospitals treat significantly more low-income patients, provide more uncompensated care, are more likely to provide money-losing public health services, and have lower overall financial margins than non-340B hospitals."

Formerly called Safety Net Hospitals for Pharmaceutical Access, 340B Health represents over 1,000 340B-enrolled hospitals.

According to the group, more than half of the hospitals in the 340B program are small rural and cancer facilities that joined after 2010. These providers represent only 3 percent of 340B annual spending. Meanwhile, the number of DSH hospitals has declined 4 percent since 2012.

340B hospitals serve nearly twice as many low-income patients as non-340B hospitals—41.9 percent compared to 22.8 percent. 340B DSH hospitals account for about one third of all DSH hospitals, but provide nearly 60 percent of all uncompensated care, 340B Health said.

"Given the GAO's finding that a significant number of 340B hospitals are large teaching hospitals and therefore treat a high volume of patients, one would expect to see more Medicare Part B spending at 340B hospitals," the group said. "Drug costs are skyrocketing and the 340B program, which can only be used by hospitals that treat substantial numbers of low-income patients, plays a critical role in ensuring that these providers can give care to those who need it."

**Barrett: 340B Hospitals Charge More To Survive**

Community oncologists should not blame 340B hospitals for trying to get discounts that enable them to care for patients that private practitioners turn away, said Randy Barrett, vice president of communications for 340B Health.

"Private practitioners—private oncologists particularly—hardly see poor patients, because they really can't afford to," Barrett said to The Cancer Letter. "Their offices tend to be based in wealthy or middle-income parts of urban areas. And the poor patients they may get, they send them directly to the nearest safety net hospital because they're going to lose money treating them."

These hospitals charge more than community oncology practices because they have to make ends meet, Barrett said.

"For years, private oncologists have sent their poorest patients to the nearest safety net hospital," Barrett said. "They then turn around and blame the safety net hospitals for having charged more for care, when safety net hospitals are having to help cover and pay for thousands and thousands of patients they get who cannot pay for any care at all.

"So the 340B program helps them, but it doesn't by any means cover the whole tab. The 340B program helps the safety net hospitals through their oncology programs and other areas to help pay for all of that uncompensated care that they provide."

**Okon: That's An Excuse**

Congress never intended the 340B program to fully cover the cost of care for low-income patients, COA's Okon said.

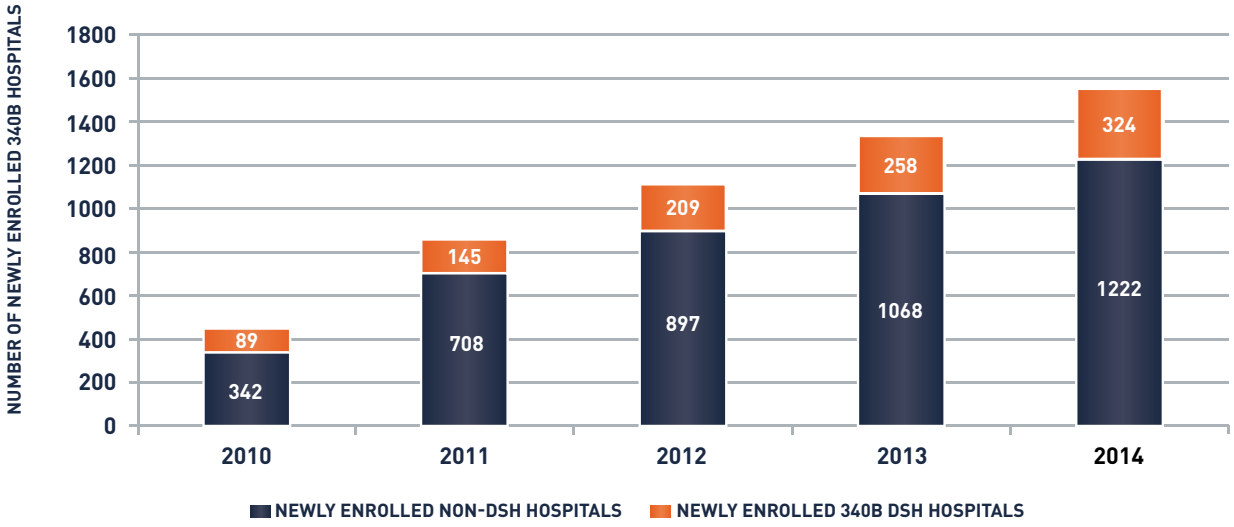
"It appears [340B Health's argument that hospitals need to make ends meet] is an excuse for why hospitals charge patients, Medicare, and private insurers more for the identical medical services," Okon said to The Cancer Letter. "The drug discount program is intended to help hospitals, and federal grantees, stretch scarce federal resources. There are numerous other mechanisms including tax breaks, DSH payments, state funding, and more that hospitals receive to cover the cost of care for low-income patients."

COA said that there are no data to support the claim that community oncologists often send low-income patients to 340B hospitals because they cannot afford to treat those patients.

"COA is aware that some practices did so after the sequester went into effect," Okon said. "It appears many of those practices did not survive and are now part of hospital systems."

FIGURE 3

CUMULATIVE COUNT OF NEWLY ENROLLED 340B HOSPITALS




Is it true that the 340B program does not completely cover the cost of care for low-income patients at 340B hospitals?

"No one knows," Okon said. "This is conjecture and the root problem with the 340B program in the hospital setting.

"DSH hospitals are not held to the same level of transparency and accountability as the grantees in the 340B program (e.g., community health centers, hemophilia clinics, Ryan White Aids clinics).

"Because of that, it is not possible to determine how much patient care the 340B program covers in safety net hospitals. It would be very informative for hospitals that participate in the 340B program to be more transparent with data that supports this statement."

**Barrett: COA Study "Cherry-picks" Data**

Barrett took issue with a graph titled "Cumulative Count of Newly Enrolled 340B Hospitals," which shows the number of hospitals enrolled in the drug discount program between 2010 and 2014.

"Figure 3 on page 5 of COA's study tells you what's going on as far as how they're manipulating data," Barrett said. "Between 2010 and 2014, 267 DSH hospitals dropped out of the 340B program, which really leaves a net gain of 57 hospitals over those four years, rather than 324.

"This report is full of cherry-picked information that is very favorable to the private oncologists. No surprise, look who paid for it—that's really the bottom line."

The study was conducted by a "prominent, independent research firm" and analyzed Medicare data, Okon said.

"The study never intended to and does not represent that there was a net gain of 324 DSH hospitals between 2010 and 2013," Okon said. "What it noted was that there have been 324 newly enrolled DSH hospitals between 2010 and 2013, which is accurate.

"The purpose was to show that these newly enrolled DSH hospitals purchase significant volumes of 340B drugs, and there will continue to be new enrollments of DSH hospitals due to Medicaid expansion.

"The net gain argument that 340B Health makes is misleading. There has been a net gain of 61 DSH hospitals between July 1, 2010 and July 1, 2015, but this is in part because 64 hospitals have changed their categorization from DSH to either SCH or RRC.

"These hospitals did not drop out of the 340B program. Rather they continue to participate in the 340B program but just not as a DSH hospital. In reality, there has been a net gain of 125 DSH hospitals.

"If anyone believes the data or study process were flawed, we welcome them to re-do the study and publish the results.

"COA undertook this study to fill in some important gaps in the data on the size of the 340B program. By analyzing actual Medicare data, this study puts the scale of the 340B program into perspective, revealing that it is much larger than thought and accounts for a significant and growing portion of Medicare Part B reimbursement.

The 340B program has grown significantly in the outpatient hospital setting since Congress changed

Medicare Part B reimbursement from AWP-based to ASP-based.

"Congress changed reimbursement to reduce the "spread" between actual drug cost and reimbursement, which oncologists stated was used to subsidize non/under-reimbursed services and bad debt.

"The 340B program in the outpatient hospital setting has reverted reimbursement to an AWP-type problem, except much larger. Hospitals say that the large margins on cancer drugs subsidize non/under-reimbursed services to patients. This is ironic and needs to be corrected.

"COA supports the 340B program as a critical safety net for patients in need. Our position is that certain parts of the program relating specifically to hospitals should be fixed."

## NCCN Unveils Evidence Blocks As Part of Oncology Guidelines

The National Comprehensive Cancer Network unveiled a new initiative—NCCN Evidence Blocks—in the new versions of the NCCN Clinical Practice Guidelines in Oncology for Chronic Myelogenous Leukemia and Multiple Myeloma.

"In cancer care, the most important value perspective is that of the individual patient," said Robert Carlson, NCCN chief executive officer. "NCCN Evidence Blocks will educate providers and patients about the efficacy, safety, and affordability of systemic therapy, serving as a starting point for shared decision-making based on the individual patient's value system."

The announcement was made at the network's 10th Annual Congress on hematologic malignancies, in San Francisco. The meeting focuses on treatment and new approaches that have been incorporated into patient management, including the use of drugs, biologics and diagnostics.

The blocks are intended as a visual representation of five key value measures that provide information about specific guideline recommendations, which include:

- Efficacy of regimens,
- Safety of regimens,
- Quality and quantity of evidence for regimens,
- Consistency of evidence for regimens, and
- Affordability of regimens.

The group published a sample as applied to the NCCN Guidelines for CML and Multiple Myeloma.

In publishing the guidelines, panel members are able to integrate new findings with existing information to determine what the evolving standard of care should be for a given disease state. Implicit in the evaluation of each treatment is the efficacy and expected associated toxicities, as well as the quality, quantity, and consistency of the evidence supporting the recommendation.

The affordability measurement represents an estimate of overall total cost of a therapy, including, but not limited to, acquisition, administration, inpatient vs. outpatient care, supportive care, infusions, toxicity monitoring, antiemetics and growth factors, and hospitalization.

"Some patients will want an emerging therapy even with limited data; others will be most concerned about the expected side effects of the treatment indicated in the safety column. Still others may be very sensitive to cost," Carlson said. "By considering the attributes of the range of possible therapies, the health care provider and the patient can discuss the benefits and drawbacks of each option and come to a decision most acceptable to the individual."

In the near term, NCCN will continue to publish two sets of guidelines—those including the evidence blocks, and those without. By the end of 2015, NCCN expects to publish evidence blocks for systemic therapies, but not surgery or radiation therapy, in the guidelines for breast, colon, non-small cell lung, and rectal cancers. Blocks for systemic therapies are expected to be contained within the complete library of NCCN Guidelines by the end of 2016.

"In an age of visual information, the NCCN Evidence Blocks are a time-saving tool for efficient scanning and interpretation of multiple therapy options in an efficient format," said Carlson. The blocks were first announced in March during the network's 20th Annual Conference: Advancing the Standard of Cancer Care.

*In Brief*

## Hidalgo Named Director Of BIDMC Cancer Center

(Continued from page 1)

Hidalgo comes to BIDMC from the Centro Nacional de Investigaciones Oncologicas (Spanish National Cancer Center) where he currently serves as director of the Clinical Research Program and vice director of translational research. He holds faculty positions at University CEU San Pablo and Johns Hopkins University.

"Dr. Hidalgo's expertise perfectly complements our work and mission," said Pier Paolo Pandolfi, director of the BIDMC Cancer Center and its Cancer Research Institute. The research platform developed by Hidalgo's team, he said, "is consistent with our approach, in which experimental drugs are tested in a 'mouse hospital setting' in parallel with human clinical trials."

Hidalgo is a founder of the Pancreatic Cancer Research Team, a private nonprofit cooperative group. In 2001, Hidalgo joined Johns Hopkins as an associate professor, and in 2003 became co-director of its newly created Gastrointestinal Cancer Program. Hidalgo joined the Spanish National Cancer Center in 2009.

"Manuel Hidalgo is a world leader in the testing and development of new agents for pancreatic and other solid tumor cancers," said Kevin Tabb, BIDMC president and CEO. "We are privileged to have him join the accomplished clinicians and physician-scientists at the BIDMC Cancer Center."

"Dr. Hidalgo's expertise perfectly complements our work and mission," said Pier Paolo Pandolfi, director of the BIDMC Cancer Center and Cancer Research Institute. "The research platform developed by his team is now used for drug screening, biomarker development and the creation of personalized therapies. It is consistent with our approach, in which experimental drugs are tested in a 'mouse hospital setting' in parallel with human clinical trials."

**ALEC KIMMELMAN** was named chair of the Department of Radiation Oncology at **NYU Langone Medical Center**, effective Feb. 1, 2016.

Kimmelman joins the Perlmutter Cancer Center following a career as associate professor in the Departments of Radiation Oncology at Harvard Medical School the Dana-Farber Cancer Institute and Brigham and Women's Hospital.

He is a practicing radiation oncologist specializing in the treatment of gastrointestinal cancers. His research has focused on RAS oncogenes. Kimmelman and his colleagues used mouse and cellular models to provide demonstrations that KRAS was required for the continued growth of pancreatic tumors through its role in rewiring cellular metabolism.

Kimmelman has received the Ruth Leff Siegel Award from Columbia University for excellence in pancreatic cancer research and was inducted into the American Society for Clinical Investigation.

**MACIEJ LESNIAK** will join the Robert H. Lurie Comprehensive Cancer Center of **Northwestern University** Nov. 1.

Lesniak has been named the Michael J. Marchese Professor and chair of the department of Neurological Surgery at the Feinberg School of Medicine and Northwestern Memorial Hospital, and will play a leadership role in the expansion of neuro-oncology related initiatives at the Lurie Cancer Center and its Brain Tumor Institute.

He joins Northwestern from the University of Chicago Pritzker School of Medicine, where he is a professor of Neurosurgery, Neurology and Cancer Biology as well as director of neurosurgical oncology and neuro-oncology research.

Lesniak's research is focused on targeted therapies for brain cancer, including gene therapy, stem cell biology, immunotherapy, and nanotechnology. He is also a recipient of the 2015 NCI Outstanding Investigator Award.

**EDWARD SCHAEFFER** will join the Robert H. Lurie Comprehensive Cancer Center of **Northwestern University** as chair of the department of Urology at the Feinberg School of Medicine and Northwestern Memorial Hospital, effective Dec. 1.

Schaeffer is currently director of the prostate cancer program, director of international urology and co-director of the Prostate Cancer Multidisciplinary Clinic at Johns Hopkins Medicine. He is also the R. Christian B. Evensen Professor of Urology, Oncology and Pathology at the Johns Hopkins School of Medicine, and founder and chief medical officer of the Prostate Cancer Foundation of Norway.

His prostate research emphasizes at-risk populations, diagnosis, treatment outcomes and the molecular biology of prostate cancer.

**ANN NATTINGER** was named senior associate dean for research at the **Medical College of Wisconsin**.

Nattinger is the Lady Riders Breast Cancer

Research Professor, a professor of medicine, chief of General Internal Medicine, and director of the Center for Patient Care and Outcomes Research.

In her new role, Nattinger lead the Office of Research infrastructure.

The Division of General Internal Medicine has expanded its research productivity, with faculty members conducting research funded by $10 million of annual NIH support as of 2014. As the founding director of the Center for Patient Care and Outcomes Research, created in 2000, Nattinger has grown the level of grant-funded research by the center's affiliated faculty to $50 million. She has also received MCW's highest faculty and staff honor, the Distinguished Service Award.

Her research focuses on evaluating the quality of surveillance care for breast cancer survivors and improving the use of mammography.

**PETER KANETSKY** was elected president for the **American Society of Preventive Oncology**. He will serve as president-elect before taking the post in March 2017.

Kanetsky is chair and program leader of Cancer Epidemiology at the Moffitt Cancer Center. Kanetsky previously served on the executive committee of ASPO.

Kanetsky's research focuses on inherited genetics and the manner in which genes and the environment interact to influence the development of melanoma and testicular germ cell tumors. He also investigates how inherited genetics relate to and inform disease progression including somatic genetics and metabolomics and longer-term survival outcomes.

**IBM** acquired **Merge Healthcare Inc**., a provider of medical image processing and clinical systems, in a $1 billion transaction.

Merge will become part of IBM's Watson Health business unit, launched earlier this year. Merge shareholders will receive $7.13 per share in cash.

The Watson Health Cloud contains over 315 billion data points, including lab results, electronic health records, genomic tests, clinical studies and other health-related data sources in a HIPAA-enabled environment.

According to Merge, clients could compare new medical images with a patient's medical history as well as populations of similar patients to detect changes and anomalies. Watson could then help healthcare providers and researchers to pursue more personalized approaches to diagnosis, treatment and monitoring.

**The American College of Gastroenterology** announced the 23 winners of the first annual **SCOPY Award**, Service Award for Colorectal Cancer Outreach, Prevention and Year-Round Excellence.

The winners will be honored at a reception at ACG Annual Scientific Meeting in Honolulu Oct. 18.

The Grand SCOPY, the highest honor among SCOPY recipients, which recognizes the most innovative and multi-faceted integrated communications program to raise colorectal cancer awareness, went to Darrell Gray II, of The Ohio State University.

The full list of winners can be found here.

**ELI LILLY AND CO**. announced plans to add 30,000 square feet and approximately 50 new jobs to its research and development presence at the Alexandria Center for Life Science in New York City.

This is Lilly's third strategic research and development expansion this year with a focus on internal and external collaborations. In May, Lilly announced it would build a delivery and device innovation center in Cambridge, Mass. In July, Lilly announced an expansion of its biotechnology center in San Diego.

Lilly initially entered the New York and New Jersey area with the acquisition of ImClone in 2008. In 2010, Lilly opened its research and development site at the Alexandria Center for Life Science, which is located near the East River. Lilly also has a manufacturing and clinical development center in Bridgewater, New Jersey.

*Drugs and Targets*

## FDA Approves Opdivo in Non-Squamous NSCLC

**FDA approved Opdivo (nivolumab) to treat patients with non-squamous, advanced non-small cell lung cancer** whose disease progressed during or after platinum-based chemotherapy.

The FDA also approved the PD-L1 IHC 28-8 pharmDx companion diagnostic to detect PD-L1 protein expression levels and help physicians determine which patients may benefit most from treatment with Opdivo.

Earlier this year, the FDA approved Opdivo to treat patients with advanced squamous NSCLC whose disease progressed during or after platinum-based chemotherapy. Opdivo targets the PD-1/PD-L1 cellular

pathway to help the immune system fight cancer cells.

The safety and effectiveness of Opdivo for this use was demonstrated in an international, open-label, randomized study of 582 participants with advanced NSCLC. Participants were treated with Opdivo or docetaxel. Those treated with Opdivo lived an average of 12.2 months compared to 9.4 months in the docetaxel arm.

Additionally, 19 percent of those treated with Opdivo experienced a complete or partial shrinkage of their tumors, an effect that lasted an average of 17 months, compared to 12 percent among those taking docetaxel, which lasted an average of 6 months.

The most common side effects of Opdivo are fatigue, musculoskeletal pain, decreased appetite, cough and constipation. Opdivo also has the potential to cause serious side effects that result from the immune system effect of Opdivo.

The FDA granted Opdivo breakthrough therapy designation for this indication. It also received priority review status—the approval of Opdivo occurred approximately three months ahead of the goal date of Jan. 2, 2016.

Opdivo is marketed by Bristol-Myers Squibb. ThePD-L1 IHC 28-8 pharmDx test is marketed by Dako North America Inc.

**FDA granted orphan drug designation to drug candidate BLU-554** for the treatment of hepatocellular carcinoma.

BLU-554, a selective inhibitor of fibroblast growth factor receptor 4, is currently being evaluated in a phase I clinical trial in patients with advanced HCC and cholangiocarcinoma.

Aberrantly activated signaling of FGFR4 may be a key driver in up to 30 percent of HCC patients, according to an analysis by Blueprint Medicines, the drug's sponsor. BLU-554 has been shown to have significant anti-tumor activity in preclinical models of HCC driven by aberrant FGFR4 signaling.

**The European Medicines Agency granted an Orphan Drug Designation to CF102**, developed by Can-Fite BioPharma Ltd., for hepatocellular carcinoma.

CF102 will benefit from protocol assistance and a 10-year market exclusivity following market authorization in the 28 European Union member states, as well as three additional European Economic Area countries.

In the U.S., CF102 has received Fast Track Designation as a second line for the treatment of HCC of patients who have previously received Nexavar (sorafenib) and Orphan Drug Designation for the treatment of HCC.

Can-Fite is conducting a phase II study with CF102 in patients with advanced HCC in the U.S., Europe and Israel. The randomized, double blind, placebo controlled study is expected to complete enrollment by the end of the first half of 2016 in 78 patients with Child-Pugh Class B cirrhosis.

**The European Medicines Agency granted an Orphan Drug Designation to ENMD-2076,** developed by CASI Pharmaceuticals Inc., for the treatment of hepatocellular carcinoma, including fibrolamellar carcinoma, a rare type of HCC.

FDA granted the drug Orphan Drug Designation for the treatment of HCC in 2014.

ENMD-2076 is an orally-active, Aurora A/ angiogenic kinase inhibitor with a unique kinase selectivity profile and multiple mechanisms of action. ENMD-2076 has been shown to inhibit a distinct profile of angiogenic tyrosine kinase targets in addition to the Aurora A kinase. Aurora kinases are key regulators of mitosis. ENMD-2076 also targets the VEGFR, Flt-3 and FGFR3 kinases.

ENMD-2076 is currently in phase II clinical trials in multiple indications, including triple-negative breast cancer, soft tissue sarcoma, ovarian clear cell carcinomas and fibrolamellar carcinoma. ENMD-2076 has received orphan drug designation from the U.S. FDA for the treatment of ovarian cancer, multiple myeloma, acute myeloid leukemia, and hepatocellular carcinoma.

**Genentech and Arvinas Inc. entered into a license agreement** for the development of new therapeutics using Arvinas' PROTAC technology. The multi-year strategic license agreement encompasses multiple disease targets.

Arvinas will receive an undisclosed upfront payment, and is eligible to receive development and commercialization milestone payments in excess of $300 million based on achievement of certain milestones. In addition, Arvinas is eligible to receive tiered-royalties on sales of products resulting from the license agreement. Full financial terms have not been disclosed.

PROTACs, or proteolysis-targeting chimeras, are bifunctional small molecules that are designed to target proteins for degradation and removal from a cell.

**The Ontario Institute for Cancer Research and Novera Therapeutics Inc. will collaborate with Janssen Biotech,** a pharmaceutical company of Johnson & Johnson, to develop small molecule drug candidates for hematological cancers.

Novera plans to discover and develop novel therapeutic compounds identified through OICR's drug discovery program in partnership with University Health Network.

Novera will receive an upfront payment and is eligible to receive various pre-clinical, clinical, regulatory and commercialization success-based milestone payments up to a total of approximately $350 million, plus tiered royalties on potential net sales of products.

Janssen has been granted an exclusive option to license, for all human uses worldwide, candidate drugs that have been identified and will be advanced through the collaboration. Janssen will assume responsibility for subsequent pre-clinical, clinical and commercial development once it exercises its option.

**Eli Lilly and Co. and Innovent Biologics Inc.** expanded their drug development collaboration to support the development and potential commercialization of up to three anti-PD-1 based bispecific antibodies for cancer treatments over the next decade, both inside and outside of China.

Under the previous agreement, Lilly will exercise its rights to develop, manufacture and commercialize these potential cancer treatments outside of China. Innovent will now have the rights to develop, manufacture and commercialize these potential cancer treatments for China, subject to a Lilly opt-in right for co-development and commercialization.

Under the terms of the expanded agreement, Innovent could receive additional milestones totaling more than $1 billion if the products reach certain development, regulatory and sales milestones, both inside and outside of China. Further financial terms were not disclosed.

**Sequenom Inc. entered into a clinical collaboration with University Medical Center Hamburg-Eppendorf** in Germany. They will collaborate to profile circulating cell-free tumor DNA in blood to monitor response to treatment in later stage colorectal cancer patients.

Sequenom is currently developing a Research Use Only assay with an initial focus on the detection and molecular profiling of late stage non-hematologic malignancies in settings where tissue biopsies are not available or are too risky to obtain. The assay will analyze over 100 cancer-related genes that are included in professional society guidelines, linked to targeted therapies currently in clinical trials, or part of well-documented cancer pathways.

**MedImmune joined the Human Vaccines Project,** a public-private partnership seeking to develop new vaccines and immunotherapies.

MedImmune will help establish the project's global consortium, launch its research program and guide its scientific plan and future direction as a participant of the consortium and member of the Industrial Advisory Committee.

*Funding Opportunity*

## Stand Up To Cancer Offering $7.5 Million in Research Funding

Stand Up To Cancer is making $7.5 million in research funding available to early-career scientists who are pursuing innovative approaches to cancer. Proposals may focus on any discipline within basic, translational, or clinical research.

A total of 10 Innovative Research Grants will be funded over three years. Previous rounds were awarded in 2009 and 2011, to a total of 26 grant recipients.

The deadline for letters of intent is Nov. 13, by noon ET. LOIs should be submitted online via proposalCENTRAL at https://proposalcentral.altum.com. Finalists will present their proposals to the committee in person in early 2016. Recipients will be announced at the American Association for Cancer Research Annual Meeting in New Orleans in April.

For more information on eligibility criteria, the application process, and the research conducted by previous IRG recipients, please visit the AACR website.

Inquiries may also be directed to AACR's Scientific Review and Grants Administration Department at 267-765-1049 or su2c@aacr.org.

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