PENNSTATE HERSHEY
Cancer Institute

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Thank you, Representative DeLuca, for affording me the opportunity to make clear my support for passage of House Bill 1865, and allowing me to address the House Insurance Committee this morning. We, at the Penn State Hershey Cancer Institute, and we in the Pennsylvania oncology community eagerly await passage of this important legislation which affords the same insurance coverage benefits for chemotherapy administered orally as intravenously.

Chemotherapy is defined as chemicals administered to produce a toxic effect on cancer cells or organisms. For patients, chemotherapy means drugs being given to cure a cancer, drugs often associated with nausea and vomiting and hair loss as a side-effect. We often administer a "cocktail" of different drugs which work by different mechanisms, and have different, not additive toxicities for patients. The first such combination was developed at the National Cancer Institute in the 1960's. It was called MOPP, and cured 80% of patients with Hodgkin lymphoma. Two of the four drugs in this now 43 year-old regimen were given orally because they were either more convenient and less expensive, or the drug did not exist in intravenous form. Remember, effective combination chemotherapy, developed almost 50 years ago, half the drugs taken orally, at home.

Since then, the concept of chemotherapy has broadened to include antibody therapies, targeting specific molecules on the surface of tumor cells or to target specialized metabolic pathways that cancer cells utilize. The first and most successful drug in this class is imatinib, or Gleevec, which targets the abnormal enzyme produced by a genetic translocation (called the Philadelphia Chromosome - we should be proud) in patients with chronic myelogenous leukemia or CML. Although called a chronic disease compared to acute leukemias, this disease nevertheless was fatal to 90% of patients within 5 years. Imatinib and its successors have completely changed the future for patients with this disease: they now take a pill a day, and for most, no further therapy is needed. A pill-a-day, no injections needed. However, that pill costs $80-100 each day.

One of my patients was diagnosed with CML while pregnant. We reduced the number of leukemic cells by processing her blood during her pregnancy, we waited until she delivered a healthy baby and started imatinib. Unfortunately, 3 years out from her diagnosis, she still can't afford the drug, despite long efforts of many people and organizations. So instead of taking a pill a day, as prescribed, she takes one pill every

other day, in order to stretch out the 15 pills she can afford over a month's time. While this helps control her blood counts, half-dosing has not produced the suppression of the cancerous clone that we typically see in patients treated with this drug. Each time I see her in clinic, I am fearful that her disease will have progressed to an often fatal aggressive phase because of this inadequate treatment.

The decision of what treatment to use for a patient should be based on evidence that a drug is best for the disease judgment that it is best for a particular patient. The decision should not rest on how the drug is administered. We have almost 50 years of experience using oral chemotherapy. Patients need coverage for these drugs.