Specialty Tiers:

Benefit Design Considerations for Commercial Payors

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Executive Summary

Today's specialty drugs include the products of recent scientific achievements and are used by thousands of patients. However, the costs of these therapies can range from several hundreds to thousands of dollars. For people with health insurance, this high cost is typically split between the patient and the patient's prescription drug coverage or medical coverage (depending upon delivery channel).

This paper considers the following questions:

- How much do specialty drugs add to prescription drug costs for commercial plan payors, including insurers and employers?
- How will individuals' out-of-pocket costs vary with benefit design?
- How can payors (insurers and employers) reduce prescription drug costs without using specialty tiers?

Benefit designs that utilize specialty tiers with coinsurance are not typical in commercial plans but they dominate Medicare Part D coverage for specialty drugs. However, there is a trend among commercial payors toward introducing a specialty tier as a way of managing prescription drug expenditures. Adding the specialty tier shifts more costs to specialty-drug patients through higher cost sharing, which can create an affordability issue for some plan members.

This study is intended to convey information about the relationship between benefit designs, cost to payors, and member's out-of-pocket costs for specialty drugs. We demonstrate that there are alternatives for reducing plan costs without overly burdening patients requiring specialty therapies, including redesigning benefit structures to reduce the impact on specialty-drug users' out-of-pocket expenses through increases in cost sharing for other drugs.

In this report, we analyzed a hypothetical employer that is looking for alternatives to reduce drug costs and is confronted with two "actuarially equivalent" options – that is, we assumed both options are expected to achieve the same savings for the plan. The two options are:

1. Increase the copayments on the existing three-tier copayment benefit design
2. Place specialty therapies in a fourth tier subject to coinsurance, which may result in higher out-of-pocket costs to patients requiring these therapies

We modeled typical prescription drug plans with a three-tier copayment structure for generic, preferred brand and non-preferred brand drugs, and compared the resulting actuarial equivalent benefit designs for each option. We found that the impact on out-of-pocket costs for patients that need specialty drugs is significantly different depending on the option the employer chooses to reduce plan drug costs. For example, a patient who requires a prescription medicine that costs $3,000 a month and who pays a 5% specialty tier coinsurance would pay $1,800 out-of-pocket, compared to $540 if the drug were on Tier 3 or $300 on Tier 2 of a typical three-tier plan with brand drug copayments of $45 for Tier 3 and $25 for Tier 2 respectively.

As with other segments of the economy, it is impossible to precisely predict the longer-term impact of specialty medicines on healthcare costs for a particular program. The reader should consider that the figures in this report are based on assumptions and cannot capture impacts such as changes in the regulatory environment or scientific developments. These figures should be reviewed carefully for their applicability for any particular purpose. We note that in a market where some plans have specialty tier benefits and others do not, the plans without the specialty tier can be subject to adverse selection that disrupts the stability of insurance pools and can lead to unsustainable cost increases for some payors.

The figures presented in this report are national averages developed from historical databases. Actual results will likely differ for many reasons including statistical fluctuations. Two of the authors, Gabriela Dieguez and Bruce Pyenson, are members of the American Academy of Actuaries and meet its qualification standards to issue this report.

This report was funded by Pfizer Inc. It should not be interpreted as an endorsement of any particular legislation by Milliman. The report reflects the authors' findings and opinions. Because extracts of this report taken in isolation can be misleading, we ask that this report be distributed only in its entirety.

Background on Specialty Tier Therapies in Commercial Insurance

Today's specialty drugs include the products of recent scientific achievements and are used by thousands of patients. But the term "specialty drug" is not consistently defined. These drugs often comprise complex molecules and may include bioengineered proteins and blood derivatives. Many specialty drugs are administered to the patient by injection or infusion in the physician's office or are self-injected; however, they can also be orally administered. They may require special handling such as refrigeration or radiation shielding. *Because of the lack of a consistent definition of specialty drugs among commercial payors, our report uses a cross-section of prescription drugs that many payors designate to a specialty tier.*

Prescription drug tiers are used in insurance benefit designs to apply different cost-sharing levels to different categories of drugs. Typical drug benefit designs have fixed copayments for drugs using the standard three tiers (generics, preferred brands, and non-preferred brands). Some payors in the commercial market are introducing a specialty tier to their plans, which means for drugs placed on this tier, patients may be required to pay a percentage of the cost of the drug (coinsurance), rather than a flat copayment.

Although not as widespread as in the Medicare Part D program (see companion paper, "Specialty Tiers: Benefit Design Considerations for Medicare Part D"), the use of a specialty tier among commercial plans is increasing. According to one source, 23% of workers have benefits with four or more tiers for prescription drugs, up from 7% in 2008[1]. Of those, 48% use coinsurance on the fourth tier, with significant variation between types of benefits. Another source reports that the use of a specialty tier with coinsurance by employers and health plans is as high as 44% and 50%, respectively[2].

Why are specialty tiers an issue?

Payors create specialty tiers to help manage the cost of certain drugs. Drug benefit formulary tiers are designed to encourage patients to use less costly alternatives. However, in the case of specialty tier drugs, there may be few, if any, less costly alternatives.

In general, as cost sharing increases, utilization decreases. Studies have linked high patient out-of-pocket costs to decreasing use of or adherence to medications. These studies, which focused on specific disease populations, suggest that prescription abandonment rates increase with patient cost-sharing amounts above $100.[3],[4] The higher cost-sharing of the specialty tier could discourage some patients from initiating or adhering to a specialty drug course of treatment.

How much do specialty-tier drugs contribute to health plan costs?

In commercial plans, specialty drug prescriptions represent less than 0.4% of total scripts, but the expenses associated with them account for about 12% of gross pharmacy spending (before cost sharing)[5]. In 2012, we estimate that specialty drug costs were about $9.44 per member per month (PMPM) for the commercial population, which is usually associated with employer-based health

[1] The Kaiser Family Foundation and Health Research & Educational Trust (August 20, 2013). *2013 Employer Health Benefits* [Survey]. Retrieved September 10, 2013 from http://ehbs.kff.org/pdf/2012/8345.pdf.

[2] Pharmacy Benefit Management Institute (2013). *2012-2013 Drug Benefit Design* [Report]. Retrieved, September 10, 2013, from http://www.pbmi.com/benefitdesign.asp.

[3] Blesser Streeter, S., Schwartzberg, L., Husain, N., & Johnsrud, M. (May 2011). Patient and plan characteristics affecting abandonment of oral oncolytic prescriptions. *American Journal of Managed Care,* 17.

[4] Gleason, P., Starner, C., Gunderson, B., Schafer, J., & Sarran, H. (2009). Association of prescription abandonment with cost share for high-cost specialty pharmacy medications. *Journal of Managed Care Pharmacy*, *15*(8), 648-658.

[5] 2012 Milliman Health Cost Guidelines™.

insurance. To help put these figures in perspective, we provide nationwide average PMPM costs (combining the plan- and member-paid portions) for several health benefits in the chart in Figure 1.

Figure 1: Specialty-Tier Drug Spending Compared to Other Categories of Healthcare Spending, 2012 (commercial population)

Service Category	Estimated 2012 PMPM Gross Spending
DRUG SPENDING:	
• Non-specialty drugs	$67.11
• **Specialty drugs covered under pharmacy benefit**	**9.44**
• Specialty drugs covered under medical benefit	10.96
OTHER SPENDING:	
• Hospital inpatient	$136.00
• Hospital outpatient	77.00
• Physician	138.00
• Other	17.00

Source: *2012 Milliman Health Cost Guidelines™ and 2012 Milliman Medical Index™. The above figures do not include plan administrative costs and are before member cost-sharing.*

There is broad concern that expensive biotechnology products may consume an increasing portion of future healthcare spending. Whether this increase affects the outpatient prescription drug benefit design elements, such as the specialty tier, depends on whether these drugs will be paid through the medical or prescription drug benefit. To shed light on this issue, the authors examined investment analysts' forecasts for the products we consider specialty-tier drugs.

Forecasts for new specialty drugs come with uncertainty. Any such forecast must balance many factors, including the likelihood of new drug approvals, patent expirations, and the introduction of biosimilars, future prices, and, of course, the use of these drugs. Our examination, which is not reported further in this document, does not clearly indicate that the portion of healthcare spending on specialty-tier prescription drugs will increase rapidly.

Modeling Progressive Alternatives to the Specialty Tier

Borrowing from descriptions of tax policy, we term “regressive” benefit designs as requiring patients who need more expensive care to bear higher out-of-pocket costs. By contrast, most employers seek to maintain “progressive” benefit designs that insulate very sick employees or their dependents from high costs. The high cost of healthcare benefits has led to increases in cost sharing, but this can be done in a regressive or progressive way.

Specialty drugs are often used to treat people with serious conditions, so providing benefit designs that protect the individual from high costs poses a challenge to underwriters, consultants, actuaries, and human resource experts. We modeled actuarially equivalent plan designs with the goal of identifying progressive alternatives to introducing a fourth drug tier for specialty drug products.

This report presents actuarially equivalent benefit designs that commercial payors can use to mitigate drug cost trends and still provide specialty drug coverage under the traditional three-tier prescription drug benefit structure.

What is actuarial equivalence?

Two different benefit designs are “actuarially equivalent” if they provide, on average, the same expected value. Actuarial equivalence is determined for a population based on the population’s average cost. The concept of actuarially equivalent benefit designs is widely used in the insurance industry and is used by Medicare to regulate Part D benefit designs, where “actuarial equivalence” relates to permissible variations on the defined standard Part D benefit.

Because equivalence is determined across a population of members (e.g., the “average” member), members with higher- or lower-than-average claim costs may not experience the same out-of-pocket costs under two equivalent plan designs. Benefit differences between actuarially equivalent plans can have a significant impact on out-of-pocket costs for members whose drug expenditures are much higher than the average population drug expenditures. This is the case for beneficiaries requiring specialty-tier drugs, because coinsurance for these drugs results in large out-of-pocket expenses.

Results: Benefit Design Alternatives and Considerations

We modeled two typical commercial prescription drug plans – one with lower and one with higher cost-sharing, both with three-tier structures for generic, preferred brand and non-preferred brand drugs. We assumed that an employer is looking for ways to reduce their drug spend (for either plan) and is offered two (actuarially equivalent) options:

1. Increase the copayments on the existing three-tier benefit design
2. Place specialty therapies in a fourth tier subject to coinsurance, which may result in large out-of-pocket costs to patients requiring these therapies

We produced actuarial equivalent benefit designs that yielded the desired spending reduction. Note that both options assume no increase in premiums or in employee contributions towards their drug coverage.

Benefit design alternatives to the specialty tier

We modeled a "lower" and a "higher" copayment plan, each representative of typical three-tier benefit structures. We assumed the plan sponsor wants to achieve some level of reduction in their drug spend – in this case, we modeled the benefit adjustments that achieve 3% to 6% reductions in prescription drug costs. We illustrate these plans next to equivalent four-tier structures that use a specialty tier. We also show the patient cost under each design for a sample patient using a specialty drug that costs $3,000 per month (or $36,000 per year).

As discussed earlier, the specialty tier creates a regressive structure because of the large out-of-pocket expense for affected patients. For example, a 5% coinsurance for a specialty drug in the fourth tier, having an average cost of $3,000, results in $150 of member out-of-pocket expense per script. This is significantly greater than the typical copayment of a three-tier prescription drug benefit. And while out-of-pocket maximums can limit the cost burden for these patients, research has shown that high cost-sharing is likely to discourage patients from initiating treatment.[6],[7]

We present our results under the following three scenarios. The first scenario represents our estimates assuming current specialty drug utilization levels. Scenarios 2 and 3 provide sensitivity testing of our results. These scenarios could occur as a result of adverse selection in a plan choice environment where most plans offered by the employer have a specialty tier and only a few do not. The scenario descriptions are as follows:

- **Scenario 1:** Assumes current specialty drug spending (2012 levels). In this scenario, we consider only a single-option plan – where an employer offers either the lower or higher cost-sharing design, but not both
- **Scenario 2:** Assumes that adverse selection would cause a twofold increase in specialty drug spending. This could happen, for example, if an employer offered two plans of about equal enrollment, one with and one without a specialty tier, and all the specialty-tier users selected the latter
- **Scenario 3:** Assumes that adverse selection would cause a fourfold increase in specialty drug spending. This could happen, for example, if an employer offered four plans of about equal enrollment, three with and one without a specialty tier, and all the specialty-tier users selected the latter

The examples for scenarios 2 and 3 assume "perfect" choices by covered individuals, which, of course, do not often occur. In reality, employees are likely to base their enrollment decisions on a number of factors, such as the generosity of the medical benefit and the breadth of the provider network, which make scenarios 2 and 3 unlikely. However, extreme adverse selection can occur in the individual insurance market, such as the individual exchanges.

[6] Blesser Streeter, S., Schwartzberg, L., Husain, N., & Johnsrud, M. (May 2011). Patient and plan characteristics affecting abandonment of oral oncolytic prescriptions. *American Journal of Managed Care,* 17.

[7] Gleason, P., Starner, C., Gunderson, B., Schafer, J., & Sarran, H. (2009). Association of prescription abandonment with cost share for high-cost specialty pharmacy medications. *Journal of Managed Care Pharmacy*, *15*(8), 648-658.

Because specialty pharmacy programs do not consistently use the same list of products, our modeling reflects a cross-section of specialty pharmacy products commonly considered specialty in commercial health benefits.

Managing costs associated with specialty drugs

We found that shifting the specialty drugs to a specialty tier in the low copayment scenario is equivalent to increasing the second-tier (preferred brand) and third-tier (non-preferred brand) copayments by $5. For the high copayment plan example, shifting the specialty drugs to a specialty tier would produce the same savings as increasing the second-tier and third-tier copayments by $10 (Figure 2)[8].

Figure 2: Sample Actuarially Equivalent Benefit Designs in the Context of Prescription Drug Cost Reduction

Scenario 1: Three- and Four-Tier Structures, No Adverse Selection Assumed

	Actuarial Equivalents to Current Plan		
Current Plan	**Three-Tier Benefit Structure[a]**	**Four-Tier Benefit Structure[b]**	**Plan Savings from Either Actuarial Equivalent Relative to Current Plan**
Lower Copay Plan **$8 / $20 / $40** Annual Cost to Specialty Patient[c]	**$8 / $25 / $45** $300–$540	**$8 / $20 / $40 / 5%** $1,800	**3%**
Higher Copay Plan **$12 / $30 / $50** Annual Cost to Specialty Patient[c]	**$12 / $40 / $60** $480–$720	**$12 / $30 / $50 / 10%** $3,600	**6%**

a. Generic / preferred / non-preferred
b. Generic / preferred / non-preferred / specialty (coinsurance)
a, b. Mail-order copayment twice the retail copayment
c. Annual patient cost assumes $3,000 specialty drug per month with second, third, and fourth-tier cost-sharing

The choice an employer makes can have a significant impact on out-of-pocket spending for patients who need the specialty-tier therapies. As shown in Figure 2, a patient in the "low copay" plan, which implements a specialty tier with a 5% coinsurance, would pay a total annual cost of $1,800 (or the plan's out-of-pocket maximum, if lower) for a prescription medicine that costs $3,000 a month. Comparatively, the same patient would only pay $540 annually if the drug were on Tier 3, or $300 if on Tier 2, if the same plan had opted not to implement a specialty tier. In the "high copay" plan with a specialty tier requiring a 10% coinsurance, the patient would pay an annual cost of $3,600, compared to $720 if the drug was on Tier 3 or $480 if the drug was on Tier 2 of an equivalent plan without a specialty tier.

The specialty-tier cost-sharing amounts can be unaffordable for many patients. Depending on the underlying details of a health insurance policy, members with seemingly adequate coverage can have large out-of-pocket obligations, leaving them underinsured. This situation is partially alleviated by the existence of an out-of-pocket maximum, as, for example, required by the metallic plans in the Patient Protection and Affordable Care Act (ACA)[9].

[8] Figure 2 does not account for the potential impact of adverse selection, which is discussed in the following section.

[9] Beginning in 2014, patients with low incomes (below 250% of the federal poverty level) will qualify for reduced out-of-pocket maximums that may reduce the patient out-of-pocket cost for these therapies.

Modeling adverse selection: Scenarios 2 and 3

Adverse selection occurs when individuals select from among benefit options based on their individual medical spending needs, resulting in unexpected risk concentrations in some benefit programs. For example, suppose an employer offers two benefit options at the same price, one with a high cost-sharing specialty tier but somewhat lower copayments in non-specialty drugs – and another one with slightly higher copayments but no specialty tier. People who expect to need specialty drugs will tend to choose the plan without a high cost-sharing specialty tier. Conversely, people who do not expect to use specialty drugs will tend to choose the plan with the smaller copayments, even though this plan has a specialty tier. After the individuals make their selections, the plan without the specialty tier could end up with higher-risk (and higher-cost) people than the plan without the specialty tier.

An estimated 14% of prescription drug benefits offered by employers in 2012 used a specialty tier, compared to only 7% in 2008[10]. If this trend continues, adverse selection could occur if people who anticipate using specialty therapies have the option of enrolling in traditional three-tier plans with flat copayments. This would lead to the plans without a specialty tier attracting a disproportionate share of members who use specialty drugs. Such a shift in the population insured could impact not only the plan's prescription drug benefit design but also its medical spending. We note that if no plans used specialty tiers, this source of adverse selection would not be present.

We performed sensitivity analyses to measure the impact of adverse selection in equivalent plans with and without a specialty tier. Nationally, about 0.4% of commercial prescription drug utilization was for specialty drugs in 2012. We assumed that adverse selection could increase the specialty utilization to 0.9% or even 1.7% of total utilization. Given the concerns about recent specialty-drug cost trends, these scenarios also illustrate what we view as an extreme case of specialty costs doubling or quadrupling over the next few years.

For these sensitivity analyses, we re-estimated actuarial equivalent benefit structures for our sample benefit designs. The table in Figure 3 shows the benefit design changes needed to offer specialty therapies in a three-tier copayment design if specialty-tier utilization was to increase two or four times above 2012 levels.

Figure 3 shows that a twofold increase in specialty drug utilization, from our starting assumption of 0.4% to 0.9%, would require moderate increases in copayments, including the generic copayment, to achieve actuarial equivalence. However, a very unlikely fourfold increase in specialty drug utilization to 1.7% would require increases of $1 to $3 in the generic copayments and significant increases in the brand copayments to achieve actuarial equivalence.

[10] The Kaiser Family Foundation and Health Research & Educational Trust (August 20, 2013). *2013 Employer Health Benefits* [Survey]. Retrieved September 10, 2013 from http://ehbs.kff.org/pdf/2012/8345.pdf.

Figure 3: Sample Actuarially Equivalent Benefit Designs in the Context of Cost Reduction

Scenarios 2 and 3: Three and Four-Tier Structures, Assuming 2x and 4x Specialty Drug Utilization

Current Plan	Actuarial Equivalents to Current Plan			Plan Savings from Either Actuarial Equivalent Relative to Current Plan	
	Three-Tier Benefit Structure[a]		Four-Tier Benefit Structure[b]		
	Twofold Increase	Fourfold Increase		Twofold Increase	Fourfold Increase
Lower Copay Plan $8 / $20 / $40 Annual Cost to Specialty Patient	$8 / $30 / $50 $360–$600	$9 / $30 / $55 $360–$660	$8 / $20 / $40 / 5% $1,800	**5%**	**6%**
Higher Copay Plan $12 / $30 / $50 Annual Cost to Specialty Patient	$13 / $45 / $80 $540–$960	$15 / $55 / $85 $660–$1,020	$12 / $30 / $50 / 10% $3,600	**10%**	**13%**

[a]. Generic / preferred / non-preferred.
[b]. Generic / preferred / non-preferred / specialty (coinsurance).
[a, b]. Mail-order copayment twice the retail copayment.
[c]. Annual patient cost assumes $3,000 specialty drug per month with second, third, and fourth-tier cost-sharing, respectively.

We estimate that, assuming a twofold increase in specialty-drug spending, making specialty drugs subject to 5% coinsurance in the "lower" copayment benefit design produces the same plan savings as a $10 increase in the second and third tiers (preferred/non-preferred brand) copayment, without impacting the generic tier. If we assumed a fourfold increase in specialty drug spending, the shifting is actuarially equivalent to tier copayment increases of $1, $10, and $15 for the first, second, and third tiers, respectively.

In the "higher" copayment benefit design with a 10% coinsurance on specialty drugs, shifting the specialty drugs to a specialty tier results in savings that are equivalent to a $1 increase in the first-tier (generic) copayment, a $15 increase in the second-tier copayment, and a $30 increase in the third-tier copayment. If the specialty utilization increased to four times the current level, the shifting would be equivalent to copayment increases of $3, $25, and $35, respectively.

Methodology

We analyzed prescription drug utilization and average costs for a commercial population. Because of the lack of a consistent definition of specialty drugs among commercial payors, our report uses about 200 drugs that payors commonly classify into a specialty tier, which are listed in the Appendix. We excluded from our analysis drugs typically covered through a medical benefit such as drugs administered in a hospital outpatient setting or physician's office.

To determine actuarial equivalency, we used the Prescription Drug Rating Model included in the 2012 Milliman Health Cost Guidelines (HCGs). The HCGs is a proprietary modeling tool that includes relationships between benefit design, utilization, unit price and population costs. The cost per script, discounts and utilization used in the actuarial analysis represent national averages for commercial benefits. The benefit designs shown in this report were selected from a range of possible designs. For actuarial equivalence testing, we chose prescription drug benefits that are representative of common employer-sponsored coverage.

We modeled the elasticity of demand for specialty drugs according to cost-sharing levels based on Milliman's research on patient use of cancer therapies subject to high cost-sharing[11]. We have ignored the impact of treatment shifting from retail or mail delivery channels to office-based or facility-based delivery channels as a result of higher cost-sharing under the pharmacy benefit.

[11] Fitch, K., Iwasaki, K., & Pyenson, B. (January 25, 2010). *Parity for oral and intravenous/injected cancer drugs* [Milliman Client Report]. Retrieved September 10, 2013 from http://www.milliman.com/insight/research/health/Parity-for-oral-and-intravenous/injected-cancer-drugs.

Limitations

The figures presented in this report are national averages developed from historical databases. Actual results will likely differ for many reasons, including statistical fluctuations. As with other segments of the economy, it is impossible to precisely predict the impact of specialty medicines on healthcare costs. The reader should consider that the figures in this report are based on assumptions and cannot capture impacts such as changes in the regulatory environment or scientific developments, so these figures should be reviewed carefully for their applicability for any particular purpose.

The Patient Protection and Affordable Care Act (ACA) has particular benefit design and coverage rules, such as out-of-pocket maximums, included under "Essential Health Benefits". While our findings are directionally relevant to metallic plans including exchange-sold policies, our modeling was for large employers; we did not consider important determinants of metallic plan costs, such as actuarial value requirements and risk adjustment.

This report was funded by Pfizer Inc. It should not be interpreted as an endorsement of any particular legislation by Milliman. Two of the authors, Gabriela Dieguez and Bruce Pyenson, are members of the American Academy of Actuaries and meet the qualification standards to render the opinions expressed in this report. The report reflects the authors' findings and opinions. Because extracts of this report taken in isolation can be misleading, we ask that this report be distributed only in its entirety.

Appendix

List of Specialty Products Included in the Analysis				
8-Mop	Elaprase	Isentress	Pegasys	Tacrolimus
Acthar	Eloxatin	Kaletra	Peg-Intron	Tarceva
Actimmune	Enbrel	Kineret	Prezista	Targretin
Actiq	Epogen	Kogenate	Procrit	Tasigna
Advate	Epzicom	Kuvan	Prograf	Taxotere
Afinitor	Euflexxa	Kytril	Prolastin	Temodar
Aldurazyme	Exjade	Letairis	Promacta	Tev-Tropin
Alimta	Fabrazyme	Leukine	Pulmozyme	Thalomid
Amevive	Faslodex	Levaquin	Rapamune	Theracys
Ancobon	Fentora	Lexiva	Raptiva	Thyrogen
Anzemet	Follistim	Lovenox	Rebetol	Tobi
Apokyn	Forteo	Lucentis	Rebif	Tracleer
Aralast	Fosrenol	Lupron	Reclast	Treanda
Aranesp	Fragmin	Macugen	Recombinate	Trelstar
Arcalyst	Fuzeon	Marinol	Remicade	Trizivir
Arixtra	Gammagard	Matulane	Remodulin	Truvada
Atripla	Gamunex	Menopur	Renvela	Tygacil
Avastin	Gemzar	Mepron	Repronex	Tykerb
Avonex	Genotropin	Minilink	Revatio	Tysabri
Baraclude	Gleevec	Mononine	Revlimid	Valcyte
Bebulin	Gonal-F	Mozobil	Reyataz	Vancocin
Benefix	Granisol	Mustargen	Risperdal	Ventavis
Betaseron	Hectorol	Myobloc	Rituxan	Vesanoid
Botox	Helixate	Neulasta	Saizen	Vfend
Bravelle	Hemofil	Neumega	Samsca	Viread
Buphenyl	Hepsera	Neupogen	Sandostatin	Vistide
Cafcit	Herceptin	Nexavar	Sensipar	Vivaglobin
Cellcept	Hexalen	Norditropin	Serostim	Vivitrol
Cerezyme	Humate-P	Novoseven	Simponi	Votrient
Cimzia	Humatrope	Noxafil	Somatuline	Xeloda
Cinryze	Humira	Nplate	Somavert	Xenazine
Combivir	Hyalgan	Nutropin	Sprycel	Xolair
Copaxone	Hycamtin	Octagam	Stimate	Xyrem
Copegus	Imitrex	Orencia	Sucraid	Zavesca
Creon 20	Increlex	Orfadin	Supartz	Zemaira
Cubicin	Infergen	Orthovisc	Supprelin	Zofran
Cytogam	Innohep	Oxandrin	Sutent	Zolinza
D.H.E.	Intron-A	Oxsoralen	Synagis	Zometa
Doxil	Invanz	Panretin	Synarel	Zosyn
Duragesic	Iressa	Paradigm	Synvisc	Zyvox