The impact of patient out-of-pocket costs and satisfaction with therapy on adherence to disease-modifying drugs in patients with multiple sclerosis

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INTRODUCTION

- Adherence to disease-modifying drugs (DMDDs) in multiple sclerosis (MS) has been associated with better health-related quality of life, fewer emergency room visits, fewer severe relapses, lower disease progression, and lower health-care costs, and increased quality of life (QoL) compared with non-adherent patients.
- A number of studies have shown that a high proportion of patients with MS may not take their medications as prescribed, with published rates of adherence to DMDDs ranging from 20% to 83%.
- Adherence to therapy is often assessed by self-report, which is often non-ambiguous, non-comprehensive, and may be subject to misunderstanding and hinder its quantification.
- Several methods in the literature and epidemiology have evaluated factors associated with OOP adherence in MS, however, literature evaluating influence of patient-related outcomes on adherence to DMDDs is sparse.

OBJECTIVE

- To evaluate the impact of patient out-of-pocket (OOP) costs and satisfaction with therapy on adherence to DMDDs in patients with MS.

METHODS

Study population

The data source for this study was the Kantar Health MS Syndicated (MHIS) 2.0, an internet-based survey of patients with MS.

- Patients with an MS diagnosis of at least 1 year (n=1112) from the US National Health and Wellness Survey or LightSpeed Research panel and its affiliates completed a 34-minute Internet survey between April and October 2015.
- This analysis only included patients who were being treated with a DMDD in the past 6 months, had relapsing-remitting MS, had stable disease activity, and were employed.
- All participants were aged ≥18 years and self-reported as ever being diagnosed with relapsing-remitting MS.

Data collection and study measures

- Questions about demographics, disease severity and symptoms, treatments, healthcare utilisation, and OOP costs were included.
- Demographic variables included age, sex, race, marital status, education, household income, employment status, and health insurance.
- Health history question topics included smoking habits, exercise behaviour, alcohol use, body mass index category, smoking status, exercise frequency, body mass index, and race.
- Disease characteristics included years of experience, symptoms, diagnoses made with MS, time on current treatments, number of relapses in the past 2 years, and other medications used to treat the symptoms related to MS.
- The Patient-Determined Disease Steps scale3 assessed MS disease status.
- The MSRS-R asks respondents to rate their level of fatigue, ability to perform typical activities, mood, role functioning, pain, and sleep quality.
- The Multiple Sclerosis Rating Scale, Revised (MSRS-R)*

RESULTS

- Of 605 surveys respondents meeting study criteria, 429 reported high adherence (MMAS-4 score > 2) and 376 reported low adherence (MMAS-4 score ≤ 2).
- A number of health outcomes (Table 1) were higher in high adherers (MMAS-4 score = 0) versus low adherers (Table 2).
- The MMAS-4 is a validated self-reported measure of medication-taking behavior.
- The TSQM asks respondents to rate the following: TSQM satisfaction score.

CONCLUSIONS

- Poor adherence to treatment is an important issue for the management of patients with MS.
- In the real-world acquisition with MS with lower OOP costs and greater treatment satisfaction had higher levels of adherence to DMDD treatment.
- Strategies such as improved patient education and support programmes on needed to help improve patient adherence to healthcare providers to overcome and monitor barriers to adherence in MS. Therefore, medication adherence remains a challenge among patients.

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DISCLOSURES

L Mayer and unaffiliated, paid consultant for EMD Serono, Inc.; S Gupta and S Phillips, unaffiliated and served as a speaker for Genentech; Steinberg SC, unaffiliated; and Teva Neuroscience, and served as a speaker for Biogen, Genentech, Novartis.

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LIMITATIONS

- All responses were self-reported via an online survey. Patients without internet or computer access were not represented in the current sample.
- Causality cannot be established with the current study design.
- Factors that were not accounted for may have contributed to the observed relationships.

REFERENCES