CITRON Roger A

From: Kresa-Reahl, Kiren <Kiren.Kresa-Reahl@providence.org>
Sent: Thursday, September 24, 2015 12:44 AM
To: CITRON Roger A
Subject: upcoming review of MS oral therapies

Hello Dr. Cintron,

I understand that you will be reviewing MS medications Thursday the 24th, and with your permission I'd like to say a few words about the usage of these drugs "in the trenches" at the Providence MS Center.

Our center cares for upwards of 3000 MS patients in the region (among 4 providers), and so due to sheer volume of patient care we have become familiar with the benefits, risks, and appropriate candidates for all of the products currently available. Since all but the interferons have unique mechanisms of Action, different relapse rate reduction, and different side effect profiles, we have found that each product clearly has its own 'niche' in our patient population. For example, there are patients who are needle phobic, have a history of significant depression, or whose disease rapidly 'breaks through" one of the traditional "platform therapies" (interferons and glatiramer acetate). In those circumstances, I believe we need to have wide availability of oral or infusible MS therapies. I would strongly urge you to not require patients to fail *two* of the platform therapies to have access to the newer products, because in my experience, if a patient fails one of the platform therapies, they are not likely to gain meaningful control over their disease by switching among the platform treatments. Since active MS lesions can cause permanent transection of up to 11,000 axons per cubic millimeter, time is of the essence to escalate treatment to maximize efficacy, even knowing that there could be additional risks.

A quick example of this is as follows: I have a 25 y.o. male patient who presented a few years ago with fulminant MS, based on his high relapse rate, poor recovery from attacks, and rapidly accumulating MRI lesion burden, cognitive dysfunction, and physical debility. He was required by his insurance to start a platform therapy, despite all the signs of having a devastating future course. I advocated for him to be placed on the highest efficacy agent available at the time, but was denied. He rapidly had a breakthrough attack despite high dose interferon therapy, and when I then requested a second generation agent, I was informed that he'd 'not yet failed Copaxone' and so would again be denied access to second generation MS treatment. During the appeal process, he had further attacks and ultimately still had to go on Copaxone (which he then also failed). He is now stabilized on a second generation MS therapy, but at a terrible cost—he now lives in an adult foster care home, demented, and wheelchair bound. He is 25 years old, and will require 24 hour care the rest of his life. I can't help but wonder if I'd had the flexibility to choose the therapy I thought he needed from the outset, whether his life would be different now.

I am well aware that the patient above is not typical, but I wrote it to emphasize the concept that having medication flexibility for the people "in the trenches" is critical.

Thanks for your time and consideration. I would certainly welcome you to contact me, should you have any questions about our therapy choice strategies—feel free to call my cell anytime at (304) 550-0598.

Sincerely,

Kiren Kresa-Reahl, M.D.
Staff Neurologist
Providence MS Center