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Shifting Oncology Management Strategies Among Payers & Providers

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In today's rapidly evolving oncology landscape, drug utilization management (DUM) has emerged as a critical battleground where payers and providers must navigate complex treatment pathways, escalating costs, and an increasing number of therapeutic options within the same pharmacological classes. Oncology drug spending in the U.S. rose from $65 billion in 2019 to $99 billion in 2023 and is expected to grow to nearly $180 billion in 2028.[1] In 2024, the US Food and Drug Administration (FDA) approved 16 new medical entities or biologics for treatment of various types of cancer and completed 29 other approval decisions to expand the use or patient population of previously approved therapies[2]. As the pace of new drug launches accelerates, traditional approaches to oncology management that focus on access control only at the provider level are giving way to strategies that consider both payer utilization management and alignment with provider electronic health record (EHR) workflows and pharmacy-led implementation.

In this white paper, we examine the fundamental shift occurring in oncology DUM, where both payers and providers are implementing increasingly sophisticated strategies to manage costs while maintaining quality care. We also explore the parallel strategies that manufacturers must develop to address the payer and provider landscapes simultaneously, as these stakeholders operate through different mechanisms, yet both profoundly influence patient access to innovative therapies.

Escalating Cost and Competition in Oncology

US prescription medicine spending climbed 11.4% in 2024 to reach $487 billion, with oncology representing the largest therapeutic contributor at $87 billion in pharmacy benefit spending and an additional $71 billion in clinic-administered drugs.[3] Factors influencing the rising trajectory of oncology drug spending in the US include:

- **Indication proliferation.** An estimated 85-95 oncology approvals are expected each year through 2028, more than 60% of which will be line extensions or biomarker-defined subsets.[1]
- **Shifts to chronic treatment.** A growing percentage of approvals target early-stage or maintenance settings, converting what were once episodic costs into multi-year annuities.
- **Cell and gene therapies.** The median cost of CAR-T cell therapy products is $402,500, excluding hospitalization, and new entrants are expected to be just as costly.[4]

The oncology space has also become more competitive, with nine anti-PD-1/PD-L1 antibodies, three BTK inhibitors, and four CDK4/6 inhibitors now jostling for position within crowded therapeutic classes. In theory, competition should spur downward price pressure, but in practice, the impact on price has been negligible as each therapeutic secured at least one differentiated label or sequencing niche. Thus, payers have been pivoting towards preferencing rather than price wars, mandating first-line use of rebate-rich products and relegating others to use after progression.

At the same time, economic pressures on providers are increasing. Community practices, which do not benefit from the 340B Drug Pricing Program, often rely on drug margin for their revenues so their cost sensitivity may be higher than institutions. Starting in 2028, the provisions of the Inflation Reduction Act of 2022 will allow Medicare to negotiate directly with drug manufacturers for maximum fair prices (MFPs) for certain high-cost drugs and these MFPs—rather than the average sales price (ASP)—will become the basis for provider reimbursement, likely reducing add-on payments.[5]

This confluence of increasing cost, competition, and economic pressure has resulted in myriad and evolving utilization management strategies by both payers and providers to help curtail costs and to standardize treatment, where appropriate, without adversely impacting care quality and patient outcomes.

The Evolution of Drug Utilization Management in Oncology

Historically, oncology drugs enjoyed protection from the aggressive utilization management strategies common in other therapeutic areas due to three key factors:

1. **Clinical sensitivity.** Payers hesitated to restrict access to life-saving cancer treatments.
2. **Lack of alternatives.** Limited therapeutic options meant fewer opportunities for formulary management.
3. **Regulatory protections.** Medicare Part D plans are required by law to include all drugs where restricted access would have major or life threatening clinical consequences, including drugs used in the treatment of cancer.

However, this protected status is rapidly eroding, and payers are becoming an increasingly important stakeholder in determining drug choice, utilization management, access, and costs in the oncology space.

> With the surge in oncology therapies and the escalating cost of cancer care, payers are no longer passive participants—they are actively tightening utilization management in a space once considered "hands-off."

Emerging DUM Strategies

Traditional strategies used to control the cost of oncology drugs include prior authorization, step therapy, drug quantity supply limitations, member cost sharing, closed specialty pharmacy networks, formulary tiering, and adjusted drug reimbursement. The new generation of DUM strategies in oncology reflects both the complexity of modern cancer care and the sophistication of utilization management tools.

Payer-Level Strategies

Many manufacturers in oncology continue to approach access with little focus on the traditional payer, citing a belief that controls are only implemented at the provider level. However, particularly in more competitive spaces, payer cancer sophistication is increasing, and payers are implementing a variety of strategies to exert control:

- **Formulary exclusions.** While formulary exclusions were once rare among cancer medicines, they are becoming more common across tumor types and modes of administration as more oncology treatments with similar clinical profiles are now available. Between 2014 and 2020, 63 oncologic, hematologic, and antineoplastic/immunosuppressant medicines were excluded from at least one or more of the three most well-known pharmacy benefit managers (PBMs), accounting for 6.7% of all formulary exclusions. Of these 63 drugs, 38 were single-source medications with no direct alternatives. As continued development in oncology creates more treatment options and competition, the influence of exclusions on provider treatment preference, patient access, and time to initiation of therapy will continue to grow.
- **Treatment preferencing.** Payers may rely on National Comprehensive Cancer Network (NCCN) guidelines to justify preferencing, deeming regimens having the same NCCN categorization to be therapeutically equivalent.
- **Step therapy on medical benefit.** Since 2019, Medicare Advantage plans have had the option to implement step therapy for Part B drugs. More recently, cross-benefit management has enabled payers to apply formulary tools, including step therapy, to physician-administered medicines, extending their control to the medical benefit.

- **New-to-market blocks.** These blocks impose temporary coverage restrictions on newly-approved drugs pending value assessment.
- **Site of care programs.** These programs direct treatment to lower-cost settings.
- **Clinical pathways.** Oncology clinical pathways (OCPs) are evidence-based, detailed treatment protocols for specific types and stages of cancer that outline the recommended sequence of treatments or procedures a provider should follow. Payers use OCPs to influence cancer treatment decisions and encourage the adoption of value-driven choices and often incentivize providers to adhere to OCPs through mechanisms such as increased reimbursement or reduced administrative hurdles.
- **White bagging requirements.** Unlike the traditional "buy and bill" model where providers purchase and store medications and then bill payers for both the drug and its administration, "white bagging" is a drug distribution model where a specialty pharmacy ships a prescribed medication directly to the provider for administration to a specific patient. This approach seeks to control costs by directing medication sourcing to specialty pharmacies selected by the payer and billing the medication under the patient's pharmacy benefit, rather than the medical benefit.

> Reimbursement of oncology therapies is no longer an automatic—manufacturers need to ensure that their value communication to payers is as robust as their clinical data.

As payer control and oncology product exclusions become more prevalent, the impact on physician demand increases. In anticipation of control barriers, providers may reduce prescribing of excluded products while increasing prescribing of preferred brand alternatives. These behavior changes may result in a less patient-centered approach to treatment selection and a lack of willingness to adopt new therapies.

Provider-Level Strategies

In oncology, drug utilization is primarily managed at the level of providers, both large, multifaceted healthcare institutions and physician-owned community practices. To address the challenge of providing the best possible care while navigating escalations in cost—and explosions in choice—of cancer drugs, providers use treatment plans, pathways, and/or formularies to manage drug utilization (see Figure 1). According to a Precision AQ OncoGenius™ survey of leading institutional and community-based cancer care providers, compliance to formularies is high—93% at institutions and 65% in community practices—despite the majority of organizations offering the ability to prescribe outside of them.[11]

Management Tool	Institutions	Community Practices
Treatment Plans	99%	94%
Pathways	34%	65%
Formularies	93%	65%

Figure 1. Tools used by providers to manage oncology drug utilization[11]

As targeted therapies proliferate and drug choices increase, there is a need for more technology and more platforms to support decisions that weigh both clinical efficacy and cost-effectiveness. Other strategies leveraged by providers for improving patient care quality while promoting affordability and responsible resource allocation include:

- **EHR-integrated treatment plans.** One of the most significant developments in oncology DUM is the evolution of EHR systems from documentation tools to active decision support platforms. Integrating treatment plans with order sets and protocols into the EHR workflow determines what options providers see at the point of care. EHR-integrated treatment plans offer management precision based on cancer type and line of therapy but require customization to handle complex protocols and multimodal treatments. EHRs with integrated treatment plans may also include clinical decision support systems that provide evidence-based treatment recommendations, drug interaction alerts, and formulary recommendations that align with internal pharmacy and therapeutics (P&T) preferences, serving as a primary gatekeeper for treatment selection.
- **Internal pathways development:** Similar to clinical pathways, internal pathways are evidence-based treatment algorithms developed by provider organizations to drive practice efficiency and patient outcomes. Used by approximately 30% of US providers—including the US Oncology Network, one of the leading conglomerates of community-based provider networks—internal pathways typically include a hierarchy of treatment plans based on line of therapy that make the clinical decision-making process both simpler and more sophisticated. Provider practices can add weight to these pathways by incentivizing pathway adherence with predetermined goals and report card readouts. In fact, according to the OncoGenius™ survey, pathway compliance is driven more by verbal encouragement and dashboards or scorecards than by financial incentives.[11]
- **Pharmacy-led implementation.** Clinical pharmacy has emerged as a critical control point in oncology DUM. Beyond traditional dispensing, clinical pharmacists are actively and directly involved in handling manufacturer contracting and formulary decisions, serving as liaisons between IT departments and providers for EHR implementation, driving adherence to pathways and preferred regimens, and handling complex implementations for novel therapies such as CAR-T cell therapies and bispecific antibodies.
- **Preferencing.** Approximately 70% of organizations with formularies use preferencing, with a primary focus on biosimilars though this strategy is also being applied to competitive classes.[11] This strategy encourages the use of biosimilar medications over their more expensive reference biologics, often through preferred formulary placement, EHR pathway integration, and default positioning in order sets.

Other DUM Strategies

Additional DUM strategies to further curtail costs include establishment of value-based contracts that tie the cost of cancer drugs to their effectiveness and implementation of second specialty tiering in Medicare, which splits specialty drugs between nonpreferred and preferred specialty tiers, with the preferred tier carrying lower cost-sharing obligations.[8] Value-based contract models require close collaboration between payers and providers as they involve risk-sharing.

Some payers and providers are even taking their DUM strategies a step further by leveraging EHR data, advanced analytics, and artificial intelligence (AI) to determine which therapies should be on formulary and part of pathway programs, to identify variations in treatment patterns among clinicians for the same cancer type, and to generate insights into which therapies are yielding the best outcomes at the lowest cost.[8,13] For example, Meridian Health and their analytics partner COTA, in partnership with Blue Cross Blue Shield of New Jersey, created predefined treatment protocols called “lanes of care” based on a three-year review of real-world treatments and outcomes in patients with breast cancer. Implementation of these lanes of care reduced variations in breast cancer treatment, improved outcomes, and lowered overall costs.[8,14]

In the near future, we expect that integration of AI, machine learning, and predictive analytics into both payer and provider systems will enable more sophisticated, personalized approaches to utilization management.

EHR systems will also become increasingly intelligent, incorporating real-time coverage information and patient-specific factors into treatment recommendations.

Impact of DUM Strategies on Manufacturers

Payers and providers must work together to appropriately manage patient access to the oncology products they need, when and where they need them. Manufacturers can—and should—offer support to these critical decision-makers to benefit patients with cancer and to improve outcomes.

To avoid access restrictions, manufacturers must clearly and convincingly communicate the clinical and economic value of therapies. As manufacturers broaden their market access and adoption strategies to include both payers and providers, they will encounter both challenges and opportunities.

Challenges

To win in this environment, manufacturers must deliver not just clinical and economic value to both payers and providers, but also operational enablement that is tailored to each provider's infrastructure and incentives. Challenges arise if there is payer-provider misalignment, for instance if both payers and providers have pathways, but those pathways differ. Patient access can easily be blocked by a misalignment between pathway placement and coverage requirements, for example in situations where:

- A drug is covered by payers but not included in provider pathways
- Provider pathways recommend a drug that faces payer restrictions
- EHR defaults conflict with payer preferences

In addition, implementation of DUM strategies may vary by practice setting. Precision AQ's 2024 OncoGenius Landscape Report found that while economic factors are a stronger driver of utilization management decisions for community practices than institutions, community practices are significantly faster when adding new products to their treatment plans and formularies.[11] Community practices may also lack the resources for complex pathway development and integrations.

Opportunities

The shift toward outpatient administration of advanced therapies and the underutilization of oral regimen tools signal areas that are ripe for partnership and innovation. While formulary exclusions have established a degree of payer dominance in oncology DUM, recent approvals of oral drug entities are shifting a portion of that control back to the provider by restricting access from PBMs and encouraging local dispensing from medically integrated pharmacies and dispensaries.8

Currently, 30-40% of organizations do not actively manage oral therapies in their formularies or treatment plans and nearly half do not use preferencing tools.11 There also remains a gap in inclusion of oral-only regimens in the EHR, reflecting the complexity of managing therapies that cross traditional boundaries between inpatient and outpatient care, medical and pharmacy benefits, and provider and patient responsibility. Manufacturers that help organizations bridge these gaps through technology solutions, patient support tools, and care coordination tools can create sustainable competitive advantages.

Communicating Clinical and Economic Value

Manufacturers need to align their clinical and economic value propositions with the criteria of both payer and provider decision-makers such that their treatments are optimally positioned and available to be prescribed by the provider through the formulary, treatment plan, or pathway in place to manage utilization. Key questions to consider regarding treatment positioning include:[12]

- Are there unique patient populations the treatment serves due to efficacy, safety, or labeling?
- Are there economic rationales that communicate value compared to competing drugs?
- Do the decision makers have experience with the treatment, and do they adequately understand its value proposition against same-class or competing drugs?

Manufacturers can no longer rely on traditional approaches that treat payers and providers as separate stakeholders. Success requires an integrated market access strategy that addresses the unique needs and decision-making criteria of each stakeholder (see Figure 2).

Succeeding with Payers	Succeeding with Providers
Robust HEOR data	EHR integration support and resources
Value-based contracting capabilities	Clinical decision support tools
Proactive engagement with pathway vendors	Pharmacy department engagement
Understanding of local coverage determination processes	Real-world evidence generation

Figure 2. Components of an integrated market access strategy in oncology

Best Practices for Payer Engagement

Evidence assessment – Assess evidence through the lens of the payer to ensure that the evidence generated will resonate and pave the way for optimal access. Of note, over the past several years, the influence of the value assessment reports produced by the Institute for Clinical and Economic Review (ICER) on payer decision-making has increased. Consider investing in real-world evidence, as this is increasingly important for payer negotiations.

Value communication – Develop a comprehensive value narrative that moves beyond clinical efficacy to demonstrate economic impact on total cost of care, including downstream medical expenses, quality-of-life improvements, and potential cost offsets through reduced hospitalizations or complications.

Pricing and contracting strategy – Explore innovative contracting though value-based agreements or risk-sharing arrangements to overcome access barriers and avoid exclusion, particularly on the pharmacy benefit in competitive classes.

Pathway development – Engage early with major pathway vendors and payer-specific programs to ensure favorable positioning within coverage policies.

Distribution strategy – Collaborate with payers to preselect specialty pharmacies that integrate with health plan systems and provide hub services that can assist with benefit verifications, prior authorizations, and co-pays to reduce payer administrative burden. For therapies like CAR-T cell products or bispecific antibodies that require complex handling, direct distribution to certified treatment centers may help to ensure compliance with payer requirements.

Best Practices for Provider Engagement

EHR integration – Learn how EHR treatment plans and pathways are leveraged to prefer or restrict access to different products and seek opportunities for integration, keeping in mind that Epic dominates institutional settings while Flatiron and McKesson lead in community practices, so platform-specific strategies and technical capabilities will be needed. Where possible, deliver turnkey EHR build kits, including dosing calculators and safety triggers.

Pharmacy engagement – Clinical pharmacists are pivotal in contracting, procurement, and treatment plan implementation. Engage early by providing comprehensive drug information, handling requirements, and implementation guides to facilitate integration and foster strong relationships.

Community practice outreach – Target community practices for launch acceleration as these groups adopt new regimens more quickly but may need workflow support to streamline their processes for prescribing new therapies.

Operational support – Provide solutions for inventory management, prior authorization support, and financial assistance to reduce friction at the point of prescribing.

Strategies for Supporting Technology and Data Integration

As DUM strategies become increasingly sophisticated, both payers and providers will benefit from digital and data integration and interoperability. Biomarker results communication is one example of the ongoing technology integration challenges facing oncology care. The 2024 OncoGenius Landscape Report found that only 55% of organizations capture biomarker results as discrete data fields within their EHR systems, creating practical barriers to treatment optimizations.

Technology solutions that bridge payer policies and provider workflows or enable data sharing between payer and provider systems can help:

- Integrate data needed to support clinical decision-making by connecting diagnostic testing with treatment recommendations
- Identify access barriers before they impact patients
- Facilitate benefit verification at the point of prescribing
- Track actual prescribing patterns versus pathway recommendations
- Provide longitudinal outcomes data that either reinforces or refutes the value of ongoing coverage

Partnering with an Oncology Market Access Expert

At Precision AQ, our oncology expertise is grounded in deep payer, regulatory, clinical, and commercial experience. Our team includes former FDA reviewers, health economics and outcomes research (HEOR) leads, oncology brand executives, access consultants, board-certified oncology pharmacists (BCOPs), and former decision makers from national and regional payers and top US cancer centers. Together, they shape go-to-market strategies and implementation with scientific and commercial precision. We extend our expertise with OncoGenius™, a data analytics tool that leverages real-time insights from two proprietary networks that deliver real-time insights from current access decision makers at regional and national commercial and Medicare plans, as well as oncology pharmacy experts at approximately 100 leading cancer centers, bringing precise access intelligence to help manufacturers optimally position their treatments for every stakeholder—payers, providers, and patients.

250+	260+	145+
pharmaceutical clients	oncology products supported	new oncology drug launches and label expansions

Figure 3. Precision AQ experience

> You've got everyone trying to manage it, but if we don't manage it together, we're just running into each other instead of working together to benefit the patient.

Conclusion

Advances in cancer treatment have contributed to increased survival rates, decreased mortality rates, and increased costs for all stakeholders. In today's oncology landscape, access to these advances is being influenced more than ever by traditional payers, but at the same time is being increasingly defined by digital infrastructure and operational agility at the provider level.

The era of hands-off oncology management is behind us. Both payers and providers are implementing sophisticated strategies to manage utilization, driven by unsustainable cost trends and a plethora of treatment options, many with the same mechanism of action. Manufacturers who continue to approach payers and providers as separate entities risk being caught in the crossfire of conflicting DUM strategies and misaligned incentives. Instead, success in this new environment requires abandoning siloed approaches in favor of integrated strategies that address both stakeholder groups simultaneously.

The path forward demands a delicate balance: managing costs while ensuring patient access to innovative therapies. This balance can only be achieved through genuine collaboration among all stakeholders—manufacturers, payers, providers, and patients. Manufacturers who recognize this fundamental shift and adapt their strategies accordingly will be best positioned to optimize patient access to their therapies.

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