

Sacubitril/valsartan reduces hospitalizations, lowers medical costs

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Nancy Albert

Patients with HF with reduced ejection fraction who were prescribed sacubitril/valsartan had fewer hospitalizations and lower medical costs than those who were prescribed an ACE inhibitor or angiotensin receptor blocker, according to findings presented at the Academy of Managed Care Pharmacy Managed Care & Specialty Pharmacy Annual Meeting.

Nancy Albert, PhD, CCNS, CHFNP, CCRN, NE-BC, FAHA, FCCM, FAAN, associate chief nursing officer, Office of Nursing Research and Innovation, and clinical nurse specialist in HF, Kaufman Center for Heart Failure, Cleveland Clinic, and colleagues compared per-patient-per-month hospitalization and health care costs in patients with HFrEF who initiated sacubitril/valsartan (Entresto, Novartis) or an ACE inhibitor or angiotensin receptor blocker between October 2015 and June 2016.

“In the PARADIGM-HF trial, which compared clinical outcomes of patients taking sacubitril/valsartan vs. enalapril, many patients were not from the United States, and due to research enrollment criteria, participants may not have matched real-world patients.” Analyses of sacubitril/valsartan in the real world are needed, Albert told *Cardiology Today*. She noted that trial populations are often younger than real-world populations, and U.S. patients with HF are more likely to have implantable cardiac devices than European patients with HF.

Propensity matching produced a cohort of 279 patients in the sacubitril/valsartan group and 279 patients in the ACE inhibitor/angiotensin receptor blocker group. All patients (mean age, 68 years; 68% men) were part of a large U.S. managed care health plan and had at least 80% of days covered for the first 3 months of treatment. Follow-up was 3 to 12 months (mean, 185 days; standard deviation, 70).

Hospitalizations and costs

Per-patient-per-month HF hospitalizations were lower in the sacubitril/valsartan group (0.01; standard deviation, 0.06) compared with the ACE inhibitor/angiotensin receptor blocker group (0.03; standard deviation, 0.1; $P = .003$), and the same was true in per-patient-per-month all-cause hospitalizations (sacubitril/valsartan group, 0.05; standard deviation, 0.11; ACE inhibitor/angiotensin receptor blocker group, 0.11; standard deviation, 0.2; $P < .001$), according to the researchers.

Per-patient-per-month all-cause total costs, defined as medical plus outpatient pharmacy costs, were lower in the sacubitril/valsartan group than the ACE inhibitor/angiotensin receptor blocker group (\$3,220 [standard deviation, 4,917] vs. \$4,495 [standard deviation, 9,911; $P = .033$), Albert and colleagues found.

Costs were lower in the sacubitril/valsartan group vs. the ACE inhibitor/angiotensin receptor blocker group for all-cause medical expenses (\$2,273 [standard deviation, 4,692] vs. \$3,980 [standard deviation, 9,838]; $P = .004$), but were higher in the sacubitril/valsartan group for all-cause outpatient pharmacy costs (\$947 [standard deviation, 1,282] vs. \$515 [standard deviation, 1,041]; $P < .001$), according to the researchers.

Making the switch

“While pharmacy costs went up because sacubitril/valsartan is a newer drug that costs more than other drugs, important clinical outcomes were better” with sacubitril/valsartan, Albert said in an interview. “Heart failure-related medical costs were lower. Heart failure-related hospitalizations were lower. Heart failure hospitalization costs were lower. Even emergency room costs for heart failure were lower. We also saw improvements in terms of mortality. We are able to keep patients alive longer and healthier if we switch them from what used to be the standard of care to this newer drug.”

Although use of sacubitril/valsartan has been increasing in the U.S., “practitioners may believe their patients are stable, and fail to switch them to sacubitril/valsartan, even when symptomatic,” Albert said. “Yet, we know that even in patients who are supposedly stable with heart failure, if they meet the criteria for receiving this drug, we do need to switch them when they are symptomatic.” – *by Erik Swain*

References:

Albert N, et al. Abstract I12. Presented at: Academy of Managed Care Pharmacy Managed Care & Specialty Pharmacy Annual Meeting; April 23-26, 2018; Boston.

Albert N, et al. *J Manag Care Spec Pharm.* 2018;doi:10.18553/jmcp.2018.24.4-a.s1.

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