CASES AUTH/3283/11/19 and AUTH/3284/11/19

CCG SENIOR PHARMACIST v BRISTOL-MYERS SQUIBB AND PFIZER

Promotion of Eliquis

A senior pharmacist at a clinical commissioning group (CCG), complained about the conduct of a representative at a meeting which took place in a GP practice to promote Eliquis (apixaban) which was co-promoted by Bristol-Myers Squibb Pharmaceuticals Ltd and Pfizer Ltd (the Alliance). Eliquis was on the CCG formulary albeit that GPs were being asked to change eligible patients from Eliquis to Lixiana (edoxaban, Daiichi Sankyo UK Limited).

Eliquis and Lixiana were both anticoagulants indicated similarly, although not identically, for the prevention or treatment of various thromboembolic events in adults including deep vein thrombosis and pulmonary embolism.

The complainant noted that Lixiana was licensed and recommended by the National Institute for health and Care Excellence (NICE) for indications which the CCG was promoting its use. The representative asked the practice if its GPs and prescribers had 'considered plans for litigation should they switch their Eliquis patients and the patients develop a bleed'.

Following a request for more information, the complainant noted that the meeting had taken place with the dispensary finance consultant who had explained to the representative that patients were being switched to Lixiana because a manufacturer discount scheme (MDS) on Lixiana made it less expensive than Eliquis. It was explained to the representative that another practice had been switching patients for some time with no problem. Patients had been switched by a pharmacist or GP who had followed the correct criteria to make sure there were no problems. The dispensary finance consultant further explained that Lixiana would be the preferred non-vitamin K antagonist oral anticoagulant (NOAC) within the CCG, and practices were being asked to switch suitable patients to Lixiana. On numerous times when it was raised that there was a bleed risk, the dispensary finance consultant stated that only patients who were suitable would be switched and only by a pharmacist or GP following a CCG policy.

The dispensary finance consultant stated that he/she was then asked, 'Have you thought about litigation if a patient was switched and then had a bleed with the possibility of hospital admission and death?'. The dispensary finance consultant replied that he/she had not thought about it, and it did not concern him/her as the switches would be done by a pharmacist. The representative then mentioned lawsuits about which the dispensary consultant was concerned. The dispensary finance consultant stated that he/she would telephone the CCG which the representative thought was a good idea.

The detailed response from the Alliance is given below.

The Panel noted that the Constitution and Procedure stated that the complainant had the burden of proving his/her complaint on the balance of probabilities. All complaints were judged on the evidence provided by the parties.

The Panel noted that there were two representatives at the meeting, one from Pfizer and one from Bristol-Myers Squibb. The Panel considered that they were both responsible for the conversation in question as far as the Code was concerned.

The Panel noted that the Alliance colleagues attended the meeting knowing that the local CCG guidance was that in the absence of any specific clinical considerations, Lixiana should be the first-line NOAC. The meeting was with a dispensary finance consultant who appeared not to be a prescriber or a health professional. Although there was some disagreement between the parties on the exact wording used during the conversation, it was clear from the call notes that the Pfizer representative had raised the issue of litigation when switching stable patients from one medicine to another based on cost. The Panel noted the submission from the Alliance that the question had only been asked in very general terms, it was not specifically related to switching patients from Eliquis to Lixiana and that the word 'events' had been used with no specific reference to 'bleeds' or 'death'. In the Panel's view, however, in the context of a promotional meeting set up to discuss the local CCG NOAC guideline and to review the key features of Eliquis, it was inconceivable that the dispensary finance consultant would interpret the question of litigation in any other way than being related to the switching of patients from Eliquis to Lixiana and that 'events' would be interpreted to be a reference to bleeding etc. The Panel noted that in his/her summary of the call, the Bristol-Myers Squibb representative clearly stated that his/her colleague had asked 'where they would stand as health professionals, if they moved a stable patient from current direct oral anticoagulants [which would include Eliquis] to edoxaban [Lixiana] and the patient had an event (from a medical-legal viewpoint)'.

The Panel queried whether raising the issue of medico-legal consequences of any course of clinical action was an acceptable basis for promotion of medicines. It implied that the practicalities and consequences of the proposed clinical action had not been fully considered, potentially opening the door to the possibility of litigation. In that regard the Panel noted the Alliance's submission that the dispensary finance consultant had been unable to clarify the criteria being used to identify patients suitable to be switched from Eliquis to Lixiana – this was not surprising given the role of the dispensary finance consultant. The Panel considered that it was clear that the switches were done by a pharmacist or a GP and not the dispensary finance consultant. In the Panel' view, if the representatives were concerned that a broad cohort of patients in the practice might have been being considered for switch based on cost alone, and not in clear alignment with the medicines' SPCs, then they should have followed up those concerns with one of the relevant health professionals. The Panel considered that the representatives had not maintained a high standard of ethical conduct and a breach was ruled.

In the Panel's view, raising the issue of medico-legal consequences implied that patients stabilized on Eliquis would, *per se*, become unstable if they were switched to Lixiana. The Panel considered that such a position was not fair, balanced or objective and the suggestion that patients would experience 'events' if switched from Eliquis to Lixiana was disparaging. Breaches of the Code were ruled.

The Panel noted that the complaint was about what a representative had said during the course of a promotional discussion, it was not about a comparison in promotional material and in that regard the requirement for promotional material was not relevant to the matter in hand, the Panel therefore ruled no breach.

The Panel noted that the leavepiece used at the meeting did not refer to the possibility of litigation following a switch from Eliquis to any other NOAC. The Panel further noted the Alliance's submission that some health professionals had previously discussed with the Pfizer representative the issue of responsibility should events occur following switching and that this was the trigger for him/her to raise the question with the dispensary finance consultant. There was nothing before the Panel to suggest that the Alliance had encouraged or sanctioned such discussions by representatives and therefore no breach of the Code was ruled.

The Panel was extremely concerned that the issue of litigation had been used in relation to the promotion of Eliquis and it considered that the conversation, particularly with someone who appeared not to be a prescriber or a health professional, was tantamount to scaremongering. It was clear that by the end of the meeting, the dispensary finance consultant was anxious about what had been discussed. In that regard, the Panel considered that the representatives had reduced confidence in, and brought discredit upon, the industry. A breach of Clause 2 was ruled.

A senior pharmacist at a clinical commissioning group (CCG), complained about the conduct of a representative at a meeting which took place in a GP practice to promote Eliquis (apixaban) which was co-promoted by Bristol-Myers Squibb Pharmaceuticals Ltd and Pfizer Ltd (the Alliance).

Eliquis was indicated for the prevention of various thromboembolic events in adults who had undergone elective hip or knee replacement surgery. It was also indicated for the prevention of stroke and systemic embolism in adults with non-vascular atrial fibrillation with certain risk factors and also for the treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) and prevention of recurrent DVT and PE in adults. The GP practice at which the meeting was held was switching patients from Eliquis to Lixiana (edoxaban, Daiichi Sankyo UK Limited) on the grounds of cost. Lixiana was not indicated for use in elective hip or knee replacement surgery but was otherwise indicated for the same population as Eliquis.

COMPLAINT

The complainant was concerned about an incident which had been brought to his/her attention which involved a representative from Bristol-Myers Squibb-Pfizer. The representative had promoted Eliquis which was on the CCG formulary albeit that GPs were being asked to change eligible patients from Eliquis to Lixiana.

The complainant noted that Lixiana was licensed and recommended by the National Institute for health and Care Excellence (NICE) for indications which the CCG was promoting its use. The representative asked the practice if its GPs and prescribers had 'considered plans for litigation should they switch their Eliquis patients and the patients develop a bleed'.

The complainant alleged breaches of Clauses 7.2, 7.3, 8.1 and 15.2.

Following a request for more information, the complainant provided the date of the meeting at issue which was with the dispensary finance consultant who stated that no show material was provided. The dispensary finance consultant had explained to the representative that patients were being switched to Lixiana because there was a manufacturer discount scheme (MDS) on that medicine but not on Eliquis, so with the claw back, the practice lost money. No business could have a business model that lost money. It was explained to the representative that another practice had been switching patients for some time with no problem. Patients had been switched by a pharmacist or GP who had followed the correct criteria to make sure there were no problems. The dispensary finance consultant further explained that Lixiana would be the preferred non-vitamin K antagonist oral anticoagulant (NOAC) within the CCG, and practices were being asked to switch suitable patients to Lixiana. On numerous times when it was raised that there was a bleed risk, the dispensary finance consultant stated that only patients who were suitable would be switched and only by a pharmacist or GP following a CCG policy.

The dispensary finance consultant stated that he/she was then asked, 'Have you thought about litigation if a patient was switched and then had a bleed with the possibility of hospital admission and death?'. The dispensary finance consultant replied that he/she had not thought about it, and it did not concern him/her as the switches would be done by a pharmacist. The representative then mentioned lawsuits about which the dispensary consultant was concerned. The dispensary finance consultant stated that he/she would telephone the CCG which the representative thought was a good idea.

When writing to Bristol-Myers Squibb and Pfizer the Authority asked them to consider the requirements of Clauses 2 and 9.1 in addition to Clauses 7.2, 7.3, 8.1 and 15.2 as cited by the complainant.

RESPONSE

Pfizer responded on behalf of the Alliance which submitted that it had identified the call that took place between a Pfizer, a Bristol-Myers Squibb representative and a dispensary finance consultant.

The call with was arranged by the Bristol-Myers Squibb representative, who had a long-standing professional relationship with the dispensary finance consultant, to introduce the Pfizer representative who would be covering the practice for the Alliance. The call lasted approximately 20-30 minutes and included, *inter alia*, a discussion about the local CCG NOAC guideline and a review of the Eliquis key clinical features.

Before the call, the Alliance colleagues understood that the local CCG guidance was that in the absence of any other specific clinical considerations, Lixiana should be the first-line NOAC. During the call the dispensary finance consultant explained that he/she had switched the practice's dispensing patients to Lixiana due to the MDS offered with Lixiana and had now been asked to switch patients as the CCG was overspent and looking to make savings. The Pfizer representative empathised with the cost savings that the dispensary finance consultant was tasked with delivering for the CCG and agreed that switching appropriate patients was not an issue. The Alliance colleagues understood that switching between licensed medicines, where clinically appropriate and in line with the requirements of the medicines' summaries of product characteristics (SPCs), was a legitimate and appropriate activity for healthcare organisations to undertake. The Alliance colleagues denied raising any questions in relation to medico-legal

considerations or the potential for litigation in the context of switching appropriate patients in line with SPC requirements.

The Alliance colleagues asked about what specific clinical considerations were being applied to identify appropriate NOAC patients for switch. The dispensary finance consultant did not clarify the criteria and the Alliance colleagues were left with the impression that a broad cohort of patients in the practice might have been being considered for switch based on cost alone, and not in clear alignment with the medicines' SPCs. As a result of this the Pfizer representative asked a question about responsibility if events occurred when stable patients were switched from one medicine to another on cost grounds alone. The question was asked in relation to medico-legal responsibilities for events that might occur when a broad patient cohort was switched purely based on acquisition cost and not based on specific clinical criteria aligned with the medicines' SPCs. This was a concern that some health professionals had identified to the Pfizer representative as a reason not to implement cost-based switch programmes and was the trigger for asking the question. The Pfizer representative recalled asking the question in the general context of switching between any medicines and not specifically in relation to switching from Eliquis to Lixiana. The Pfizer representative did not intend to make a comparison between the NOACs by asking this question, nor did the question disparage Lixiana or any of the NOACs. This was reflected in comments recorded in the Pfizer customer relations management (CRM) system, 'Asked re litigation when switching stable patients to another drug based on cost'. This was also supported by the additional notes made by the Pfizer representative 'I asked a question regarding who was responsible if you switch a stable patient from one medication to another based on cost and then the patient has an event. No mention of any products at this point'. The Pfizer representative clearly remembered using the general term 'events' when asking the question but denied referring to specific events such as 'bleeds' or 'death'.

Pfizer submitted that its representative then went on to detail the key safety, efficacy, renal and dosing information for Eliquis using the leavepiece (copy provided). He/she reviewed the dosage guidance for each of the NOACs and focussed on renal function and requirements for dosing with food. The Pfizer representative highlighted that both low and high creatinine clearance were important considerations when selecting a NOAC and this should be a key consideration in the criteria used to identify which patients could be appropriately switched to edoxaban. He/she also summarised the gastrointestinal bleeding information for each of the NOACs. The information and comparisons described during the call were fair, accurate and balanced, were aligned with the medicines' SPCs and were not misleading. No disparaging references were made to any of the NOACs.

The Alliance colleagues recalled that the dispensary finance consultant was concerned that if the specific clinical considerations for each of the NOACs were not applied when considering a switch, this potentially placed him/herself and the pharmacist, who was also involved in switching patients, in a difficult situation. The dispensary finance consultant rang the pharmacist during the call to see whether he/she might be free to see the Alliance colleagues that day to ensure that he/she was aware of the relevant NOAC clinical considerations. However, the pharmacist was busy and not available to meet with the Alliance colleagues.

The dispensary finance consultant indicated that he/she would raise a question about the details of the clinical considerations for switching with the CCG medicines management team on a pre-planned call scheduled for later that day, which the Alliance colleagues agreed was a sensible way to gain clarity. This was reflected in the Pfizer representative's call notes 'Asked re-

litigation when switching stable patients to another drug based on cost – he/she is concerned re this and is going to raise with the CCG lead later on their telephone conversation today'.

The Pfizer representative also described the Pfizer Clinical Effectiveness Consultant (CEC) resource and offered for his/her CEC colleague to join the call by WebEx. The dispensary finance consultant did not have time for the CEC to join the call but confirmed his/her understanding of the broader cost savings to be gained from stroke prevention in non-valvular atrial fibrillation. However, he/she explained that given the CCG's financial situation, in year savings associated with lower acquisition costs had to be the priority.

The Bristol-Myers Squibb representative present in the call, also provided a summary of his/her recollection of the call.

The Alliance submitted that there appeared to be some differences in the parties' accounts and interpretation of the conversation that took place in the meeting:

- There was some confusion and inconsistency in the comments regarding which NHS roles carried out the switches. In two places the dispensary finance consultant's email account of the call, indicated that the switches were being carried out by pharmacists and GPs following the CCG policy. However, his/her email also indicated that the dispensary finance consultant him/herself was implementing the switches in his/her own right.

- The dispensary finance consultant's email suggested that the Pfizer representative asked a question about litigation in the case of patients developing a bleed when switched from Eliquis to Lixiana. The Alliance colleagues disagreed with this suggestion. They were clear that the term 'events' was used in the question and the Pfizer representative recalled that the question was asked as a general point related to switching a broad cohort of patients not based on specific clinical criteria between any medicines, and not specifically related to a switch from Eliquis to Lixiana.

- The dispensary finance consultant's account of the call suggested that the Pfizer representative referred to the scenario of a patient being switched, developing 'a bleed with possibility of hospital admission and then possible death.' The Pfizer representative clearly remembered using the general term 'events' when asking this question and denied referring to specific events such as 'bleeds' or 'death'.

- The dispensary finance consultant's account of the call also suggested that he/she would telephone the CCG specifically as a result of the conversation with the Alliance colleagues. The Alliance colleagues disagreed with this fact as they believed the dispensary finance consultant clearly stated that he/she would raise the question with the CCG on a pre-planned call later that day.

The Alliance submitted that accounts from the two Alliance colleagues were in agreement on the key topics covered during the meeting, however there were differences in the following areas:

- The Pfizer representative recalled using a specific leavepiece with the customer however Bristol-Myers Squibb believed it was his/her iPad but could not recall which content.

- The Pfizer representative's account of the meeting documented in the Pfizer CRM system two days later and his/her additional notes fifteen days later referred to the offer of a clinical effectiveness consultant to speak with the dispensary finance consultant whereas the Bristol-Myers Squibb representative did not recall this.

- The Pfizer representative recalled asking the question about responsibility if events occurred when switching a broad cohort of patients between any medicines, and not specifically related to a switch from Eliquis to Lixiana. However, in the Bristol-Myers Squibb representative's account it was described as being in relation to the NOAC class, switching any NOAC to Lixiana.

The Alliance recognised that in this case there were three slightly different accounts and it was difficult to be certain about some elements of the conversation that took place.

Relevant Alliance Briefings and Materials

The Alliance stated that it had reviewed relevant representative briefing materials. The internal briefing 'Managing the edoxaban challenge' showed that in areas where Lixiana was first-line, representatives should understand the local priorities and situation and ensure they were clear on clinical and practical differences between Eliquis and Lixiana based primarily around dosing considerations as described in the respective SPCs. With regard to any further materials available to use with customers, the slide deck 'Eliquis (apixaban): balancing [direct anti-coagulant] usage with cost constraints' (copy provided) and the accompanying briefing document for representatives (copy provided) demonstrated that the Alliance had briefed representatives in line with Department of Health guidance on strategies to achieve cost effective prescribing, with the aim to free up resources to improve patient care and treat more patients.

Clause 7.2

The Alliance submitted that the information provided to the dispensary finance consultant by the Alliance colleagues, about Eliquis and the other NOACs, was fair, accurate and balanced. All information provided was consistent with the SPCs for each of the medicines. The question asked by the Pfizer representative about responsibility if events occurred when switching patients outside of specified clinical criteria was not in reference to patients assessed as clinically appropriate for switch in line with the medicines' SPCs; it was intended as a general question asked in the context of switching between any medicines. The question was not intended to mislead the dispensary finance consultant. The Alliance denied that the conversation represented a breach of Clause 7.2.

Clause 7.3

The comparative information shared during the call was consistent with the SPCs for each of the NOACs. The question asked about responsibility if events occurred when switching patients outside of specified clinical criteria, was intended as a general question in the context of switching between any medicines. The question was not intended to make a comparison between any of the NOACs and the question did not discredit or denigrate any medicine. The Alliance denied that the conversation represented a breach of Clause 7.3.

Clause 8.1

In relation to the question asked about responsibility if events occurred when switching patients outside of specified clinical criteria, the Alliance noted its general comments above with regard to Clause 7.3 and stated that the comparisons made by the Alliance colleagues later on during the call were designed to highlight the specific clinical and dosing considerations for the NOACs based on the information contained within the SPCs for each medicine. These comparisons were accurate, fair and capable of substantiation. The Alliance denied that the conversation was in breach of Clause 8.1.

Clause 15.2

The Alliance submitted that its colleagues maintained high standards of ethical conduct during this meeting, the information provided was fair and balanced and details discussed regarding the NOACs were consistent with each product's SPC. The question asked regarding responsibility if events occurred when switching patients outside of specified clinical criteria, was intended as a general question asked in the context of switching between any medicines. The colleagues conducted the call in line with Alliance briefings. The Pfizer representative focused on highlighting clinical and practical differences between Eliquis and the other NOACs based primarily around dosing considerations as described in the respective SPCs. They also encouraged consideration of the potential system financial benefits that could be delivered through effective stroke prevention in non-valvular atrial fibrillation rather than focusing mainly on the acquisition costs of individual NOACs. The Alliance denied a breach of Clause 15.2.

Clause 9.1 and Clause 2

The Alliance submitted that high standards were maintained throughout the meeting. The question asked regarding responsibility if events occurred when switching patients outside of specified clinical criteria, was a general question asked in the context of switching between any medicines and the materials used did not bring discredit upon or reduce confidence in the industry. Additionally, the briefings to the Alliance representatives and related materials for external use were of a high standard and did not bring discredit upon, or reduce confidence in, the industry.

PANEL RULING

The Panel noted that the Constitution and Procedure stated that the complainant had the burden of proving his/her complaint on the balance of probabilities. All complaints were judged on the evidence provided by the parties.

The Panel noted that there were two representatives at the meeting, one from Pfizer and one from Bristol-Myers Squibb. The Panel considered that they were both responsible for the conversation in question as far as the Code was concerned.

The Panel noted that the Alliance colleagues attended the meeting knowing that the local CCG guidance was that in the absence of any specific clinical considerations, Lixiana should be the first-line NOAC. The meeting was with a dispensary finance consultant who appeared not to be a prescriber or a health professional. Although there was some disagreement between the parties on the exact wording used during the conversation, it was clear from the call notes that the Pfizer representative had raised the issue of litigation when switching stable patients from

one medicine to another based on cost. The Panel noted the submission from the Alliance that the question had only been asked in very general terms, it was not specifically related to switching patients from Eliquis to Lixiana and that the word 'events' had been used with no specific reference to 'bleeds' or 'death'. In the Panel's view, however, in the context of a promotional meeting set up to discuss the local CCG NOAC guideline and to review the key features of Eliquis, it was inconceivable that the dispensary finance consultant would interpret the question of litigation in any other way than being related to the switching of patients from Eliquis to Lixiana and that 'events' would be interpreted to be a reference to bleeding etc. The Panel noted that in his/her summary of the call, the Bristol-Myers Squibb representative clearly stated that his/her colleague had asked 'where they would stand as health professionals, if they moved a stable patient from current direct oral anticoagulants [which would include Eliquis] to edoxaban [Lixiana] and the patient had an event (from a medical-legal viewpoint)'.

The Panel queried whether raising the issue of medico-legal consequences of any course of clinical action was an acceptable basis for promotion of medicines. It implied that the practicalities and consequences of the proposed clinical action had not been fully considered, potentially opening the door to the possibility of litigation. In that regard, the Panel noted the Alliance's submission that the dispensary finance consultant had been unable to clarify the criteria being used to identify patients suitable to be switched from Eliquis to Lixiana – this was not surprising given the role of the dispensary finance consultant. The Panel considered that it was clear that the switches were done by a pharmacist or a GP and not the dispensary finance consultant. In the Panel's view, if the representatives were concerned that a broad cohort of patients in the practice might have been being considered for switch based on cost alone, and not in clear alignment with the medicines' SPCs, then they should have followed up those concerns with one of the relevant health professionals. The Panel considered that the representatives had not maintained a high standard of ethical conduct and a breach of Clause 15.2 was ruled.

In the Panel's view, raising the issue of medico-legal consequences implied that patients stabilized on Eliquis would, *per se*, become unstable if they were switched to Lixiana. The Panel considered that such a position was not fair, balanced or objective and a breach of Clause 7.2 was ruled. The Panel further considered that the suggestion that patients would experience 'events' if switched from Eliquis to Lixiana was disparaging. A breach of Clause 8.1 was ruled.

The Panel noted that the complainant alleged a breach of Clause 7.3 which detailed the requirements for comparisons in promotional material. The complaint, however, was about what a representative had said during the course of a promotional discussion, it was not about a comparison in promotional material. On the basis that Clause 7.3 was not relevant to the matter in hand, the Panel ruled no breach.

The Panel noted that the leavepiece used at the meeting did not refer to the possibility of litigation following a switch from Eliquis to any other NOAC. The Panel further noted the Alliance's submission that some health professionals had previously discussed with the Pfizer representative the issue of responsibility should events occur following switching and that this was the trigger for him/her to raise the question with the dispensary finance consultant. There was nothing before the Panel to suggest that the Alliance had encouraged or sanctioned such discussions by representatives and therefore no breach of Clause 9.1 was ruled.

The Panel was extremely concerned that the issue of litigation had been used in relation to the promotion of Eliquis and it considered that the conversation, particularly with someone who appeared not to be a prescriber or a health professional, was tantamount to scaremongering. It was clear that by the end of the meeting, the dispensary finance consultant was anxious about what had been discussed. In that regard, the Panel considered that the representatives had reduced confidence in, and brought discredit upon, the industry. A breach of Clause 2 was ruled.

Complaint received **13 November 2019**

Case completed **9 March 2020**