LETTER FROM THE EDITOR

How many doctors does it take to shed light? The most recent estimate is 100. For those of you who read the *New York Times*, an article on the front page of the Business Day section on 26 April 2013 provided the answer. Led by Hagop Kantarjian of MD Anderson Cancer Center, 100 CML experts signed on to a Perspective in *Blood*, posted online 25 April 2013, discussing the unsustainable prices of drugs used to treat this once very deadly disease. They start by distinguishing the "fair value" of a life-saving treatment from that of a luxury item. But, the perspective differs whether you are the patient or the pharmaceutical company. Yes, there is a price associated with innovation and the failed ventures on the way to huge successes. Yet, how companies come to the price of a new drug often does not reflect those expenditures. Too often it is based on the price of the current standard drug. This practice is not new. When I began my tenure at the NCI, one of the first drugs I helped develop was pentostatin. When it was ready for commercialization, it was taken over by a no longer–existing pharmaceutical company. When I saw the price tag for a drug that the company had not spent any money on developing, I inquired as to the justification. The answer was—we based it on the price of the current standard agent, interferon. The same answer was given for the price of imatinib more than a decade later.

The target in the *Blood* article is CML, a disease once managed for a few years with hydroxyurea, or, if available, potentially cured by an allogeneic bone marrow transplant. Then along came imatinib, a drug that had to struggle to find a corporate sponsor. It was priced at around $30,000 a year in 2001 but has now ballooned to $92,000, and the other TKIs are priced up to almost 50% higher. Despite the increasing number of active, available drugs, competition has not influenced price, at least not in a positive way. The marked differences in drug prices by geography support the premise that those countries that can afford the price tag will get it shoved at them.

There is good news and bad news about the TKIs in CML, and I expect the same in the future for the kinase inhibitors in the B-cell malignancies (eg, ibrutinib, idelalisib, IPI-145). On the one hand, they have turned deadly diseases into chronic, manageable conditions. However, on the other hand, these pills need to be taken every day for life. As the authors stress, even the copayments can run $20,000–$30,000 a year. The leading cause for patient noncompliance in drug-taking is the expense. When it is a life-saving drug, that situation is unacceptable.

As we eagerly await patent expirations, entry into the marketplace of lower-priced generics may be stalled by "pay for delay" tactics in which a pharmaceutical company pays a generic company to delay market entry to the financial benefit of both parties.

This problem is clearly not restricted to CML but spills over into all new drug development for hematologic and solid tumors. Obviously, efforts are needed to lock all essential parties in a room until they come up with a solution that is equitable to all. There are many with a demonstrated interest in a sensible outcome. But, until that happens, Hagop and his 99 colleagues deserve our thanks for their courage in continuing to shine the light on this dark matter.

By the time you get around to reading this issue of *Clinical Advances in Hematology & Oncology*, ASCO will be upon us. It promises to be up to its usual caliber. But, for those of us with a lymphoma interest, the pickins will be rather slim, as the good stuff will be submitted to the International Conference on Malignant Lymphoma in Lugano, Switzerland in June. This splendid meeting is now held every other year in a beautiful setting on Lake Lugano. Registration is limited to 3,000, and it always fills quickly. Hope to see you at both of these meetings.

Until next month . . .

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