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AUA Advocacy Summit Summary – February 27-March 1, 2023

The American Urological Association's (AUA) sixth Annual Advocacy Summit was held from February 27 to March 1. This year, we were back in-person for our sessions and receptions as well as our Capitol Hill visits. This year's theme was called "**Rise & Renew**" that was championed by our AUA Public Policy Council Chair, Dr. **Eugene Rhee**. I learned, networked, and advocated for our specialty and our patients in front of our California legislators along with fellow Californian urologists, Drs. **Eric Biewenga**, **Peter Bretan**, **Christi Butler**, **Junghwan Choi**, **Seth Cohen**, **Brian Grady**, **Joe Kuntze**, **Aaron Spitz**, **Yahir Santiago-Lastra** as well as physician assistant Mr. **Kevin Wayne**, medical student Ms. **Nancy Quintanilla**, and patient advocates, Mr. **Mike Crosby** from the Veterans Prostate Cancer Awareness group and Ms. **Jessie Holmes** from Health Policy and Reimbursement at NeuSpera Medical.

The summit opened up with a Welcome Address from AUA President Dr. **Edward Messing** and Dr. Rhee. Following this, Dr. Rhee interviewed Mr. James "The Ragin' Cajun" Carville who provided an insightful outlook on the current political landscape and his thoughts on health care reform and access to care. Mr. Carville recommended that when advocating about health care to legislators to come in with a solution for better outcomes, lower costs, advance science, etc.

The General Session in the afternoon were targeted towards educating the attendees on this year's four Congressional asks. The first session was titled "**The Urgent Need for Physician Payment Reform**" that featured AUA Coding and Reimbursement Committee Chair-elect, Dr. **Anurag Das**, LUGPA Board of Director, Dr. **Mara Holton**, and American Association of Clinical Urologists President, Dr. **William Reha**. Dr. Das provided context on health care spending in the United States as it compares to the rest of the world and discussed the different methods of payment for health care. He then provided a brief history on the Medicare system and how physician payment and reimbursement works, including a description of how relative value units are calculated, leading up to the 1998 Sustainable Growth Rate (SGR) to control costs and its repeal by the passage of the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) that emphasizes value-based payment models.

Methods of Payment				
Fee for service (FFS)	Predominant method of payment for specialists	Retrospective-Activity based billing	Often leads to overuse of services	Unbundled
Payment per case (DRG)	Often used for hospital inpatient and same day surgery payments	Prospective-activity based payment per patient based on diagnosis and resource use	May improve efficiency within cases but overuse of services may continue	Mostly bundled
Capitation	Per person payment method	Used in the US in the late 1980s through ~2000	Disliked by patients and physicians. Often leads to rationing of care	Mostly bundled
Global budget	Population based payment ACO Alternative payment models	Various methods to share risk	Incentives need to be well designed. Organizations can lose money.	Bundled

The issues with MACRA are that there have only been modest annual updates (increase by 0.5% 2015 to 2019, 0% 2020 through 2025), budget neutrality, and bonus for high performing providers has not worked out. Dr. Holton showed that health care costs in the United States are increasing and the obligation for payment is shifting to patients. Furthermore, that cancer care spending has more than tripled in the last two decades, and is estimated to exceed $200B this year. Urological tumors account for approximately 22% of all cancer spend. Cancer care is economically burdensome creating particular economic hardships for patients and these factors compose part of what has become known as “financial toxicity” of health care. Dr. Reha showed data from the American Medical Association (AMA) that Medicare physician payment is not keeping up with inflation and that the cost of running a medical practice has increased 39% from 2001-2020. In fact, Medicare physician pay has dropped 22% if adjusting for inflation and the cost of running a practice. Medicare payment to hospitals increased nearly 60% over the same time period and physicians are turning towards hospital-based employment as a result with 85% of all physicians under age 40 are now employees. The AUA therefore urges Congress to hold hearings, roundtables and other discussions with physician stakeholder input that would provide a structural overhaul of Medicare’s financing system – specifically the budget neutral MPFS. The AUA also urges Congress to pass legislation that would provide a fix for the steep Medicare cuts set for

implementation over the next several years due to the Centers for Medicare & Medicaid Services' (CMS) update to direct practice expense clinical labor inputs.

The second session was titled "**Not Just Phoning It In: Why Telehealth Is Vital In a Modern World**" featuring speakers, AUA Urology Telehealth Task Force Chair-elect, Dr. **Lisa Finkelstein** and Society of Women in Urology representative, Dr. **Kara Watts**. The types of telehealth include: synchronous, asynchronous (portal messages and interprofessional consultations), and remote monitoring. The number of urologists of urologist participating in telehealth has increased dramatically since 2020 coinciding with the COVID pandemic. The AUA telehealth priorities include: eliminating originating site requirement, payment parity, continued support for audio-only, role of virtual supervision, and interstate licensure. The Urology Telehealth Taskforce successfully advocated for CONNECT Act with Congress in 2021. At this juncture, the omnibus extends audio-only and patient location 2 years and the Medicare Physician Fee Schedule (MPFS) extends payment parity and virtual supervision 1 year. The public health emergency (PHE) ends May 11 so HIPAA compliance for telehealth platforms under 151 transition period and payment parity and virtual supervision end December 2023. Omnibus flexibilities end December 2024. Patients need continued telehealth access to urologists. Dr. Finkelstein shared that she flies on a propeller airplane twice a month and drives 75 miles each way to see patients in rural Wyoming. Dr. Watts shares that she has patients who take 4 buses to see her in Bronx, New York. The AUA urges House and Senate members to introduce legislation similar to the CONNECT for Health Act from last Congress to make permanent the telehealth benefits and flexibilities that were extended through 2024 as part of the Consolidated Appropriations Act of 2023. Additionally, the AUA requests payment parity for evaluation and management (E&M) services delivered via telehealth, which was not included in the end-of-year legislation.

The third session was titled "**Breaking Down Barriers to PSA Screenings**" with speakers, Dr. **Arthur Burnett II** from the CONDUC Initiative, Dr. **Adam Murphy** from the R. Frank Jones Urological Society, and Dr. **Patrick Bingham** from ZERO – The End of Prostate Cancer. The United States Preventive Services Task Force (USPSTF) prostate specific antigen (PSA) screening recommendations have long created confusion among patients and the primary care community and barriers to access for high-risk populations. In 2012, USPSTF recommended against the PSA-based screening test for prostate cancer in all men, regardless of risk. More recently, 2018, USPSTF updated their recommendation from a "D" across the board to a "C" for men aged 55-69 and a "D" rating for men over the age of 70. This is problematic because the AUA, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO), American College of Physicians-American Society of Internal Medicine, American Cancer Society, and ZERO – the End of Prostate Cancer all have encouraged yearly PSA screening for men beginning between age 40 and 55 depending on risk factors. The USPSTF recommendation does not differentiate high-risk populations – taking more of a 'one-size fits all/most' approach – which has muddled the waters when it comes to the

value/necessity of PSA screening in men. The USPSTF was created in 1984 as an independent group of experts in prevention and evidence-based medicine with the purpose of making evidence-based recommendation for clinical preventative services. The Affordable Care Act's (ACA's) Prevention Health Benefit empowered the USPSTF by requiring all private insurers and Medicare plans to cover all preventative services with an "A" or "B" rating without any cost-sharing (i.e., no out-of-pocket cost to patients). Since PSA screening do not have an "A" or "B" rating from the USPSTF, they are carved out of ACA's Preventative Health Benefit meaning patients are subject to cost-sharing/out-of-pocket costs that can be prohibitive/barriers to access. By giving PSA screenings a "C"/"D" rating, the USPSTF has diminished the well-established value/utility of PSA screenings meaning that high-risk patients are apt to think annual PSA screening may not be necessary or appropriate when it is. The AUA urges House members to cosponsor the PSA Screening for HIM Act, which is bipartisan legislation expected to be formally introduced by Congressman **Larry Buchson**. The AUA urges Senate members to introduce a companion bill in that chamber. This legislation requires private health insurance plans to cover preventive prostate cancer screenings not already covered under the recommendations of the USPSTF for men with a family history of prostate cancer, without imposing any cost-sharing requirement. Importantly, there is precedent for this as this legislation will make sure that men who are at the highest risk for developing lethal prostate cancer have the fewest barriers to access for screening. A similar approach was used by breast cancer advocates when, in 2009, the USPSTF downgraded its recommendation on mammography screening for women under 50 to a "C". The Senate added a provision to the ACA that made the USPSTF's previous recommendation (a "B") the operative rating. Furthermore, per the American Cancer Society's (ACS's) 2023 Facts & Figures report released at the beginning of the year reported that "After about 20 years of declining incidence, the first increase in prostate cancer – especially in late-stage diagnoses – likely results from changes to PSA screening guidelines." Findings from 2023 ACS report showing renewed need and urgency for The PSA Screening for HIM Act due to the incidence of prostate cancer is more than 70% higher in Black men than in White men. In addition, African-American veterans displayed a nearly 2-fold greater incidence of localized and de novo metastatic prostate cancer compared with White veterans across Veterans Affairs heath care systems nationwide.

The fourth session was titled "**Expanding the Urological Workforce in Rural America**" that was moderated by AUA Workforce Work Group Chair, Dr. **Andrew Harris** and featured speakers, Dr. **Kate Kraft** from the Society of Academic Urologists, National Rural Health Association Fellow, Dr. **Jacob Thatcher**, Senior Policy Advisor at Venable, LLP, Mr. **Jim Twaddell**, and AUA Legislative & Political Affairs Manager, Mr. **Jeremy Haines**. It is important to expand the urology workforce as 62% of all counties in the United States do not have a practicing urologist, 50% of all practicing urologists are over the age of 55, and 90% of practicing urologists have their primary practice location in metropolitan. This can mean increased costs of travel and time away from work for patients, decreased

accessibility to timely care, and delays in diagnosis and treatment. In addition, since its conception in 1987, the National Health Services Corps loan repayment program has not been expanded to include specialty physicians. The American Association of Medical Colleges (AAMC) projects a shortage of 124,000 physicians (77,000 specialists) by 2034. AAMC reports that 71% of medical school graduates will graduate with education debt and the average amount is $295,037. AAMC reports that 41% of medical students plan to enter loan forgiveness or repayment program. Urology residents report in the AUA Census that the most helpful strategy to help establish a rural practice is a loan forgiveness program for urologists to serve communities where they are most critically needed as well as exposure to these areas and types of practice during training. The AUA urges legislators to cosponsor the SPARC Act, a bipartisan bill that would encourage urologists and other specialty medicine physicians to practice in rural communities by creating a student loan forgiveness program for these essential healthcare practitioners. The bill authorizes the U.S. Department of Health and Human Services (HHS) to provide qualified specialty medicine physicians the opportunity to have a portion of their eligible student loans repaid by the federal government in exchange for practicing in a rural community experiencing a shortage of specialty medicine physicians. The loan repayment amount is up to $250,000 for six years of service.

Following these informational sessions, there were two breakout sessions: "**Trainee Advocacy Engagement: A Discussion on Getting Involved**" and "**Urologist Well-Being: How AUA Advocacy Supports Urologists**" The former breakout session was moderated by Dr. **Logan Galansky**, AUA Policy & Advocacy Resident Work Group Chair along with panelists: Dr. **Emilie Johnson**, AUA Public Policy Council North Central Section Representative, Dr. **Denise Asafu-Adjei**, AUA Gallagher Scholar, Dr. **Hiten Patel** from the North Central Section, and Dr. **Jennifer Yates**, AUA Public Policy Council New England Section Representative, and Dr. **Christine Van Horn**, AUAPAC Champion. The second breakout session on urologist well-being was moderated by Mr. Hains who was filling in for Dr. **Daniel Frendl** along with panelists: Dr. **Damara Kaplan**, AUA Board of Directors South Central Section Representative, Dr. **Grace Hyun**, New York Section, and Dr. **Seth Cohen**, Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction Representative.

The last session of the day was led by AUA Political Action Committee (PAC) Chair Dr. **Robert Bass** to discuss AUAPAC and Political Advocacy. Dr. Bass explained the role of the AUAPAC, which further raises the house of urology's profile and fosters relationships with members of Congress in Washington, DC, as well as in their home districts, thereby providing opportunities to engage lawmakers and strengthen our advocacy networks. AUAPAC strives to identify and support federal candidates – from any party – who care about the policy issues that are critical to urologic specialists and the patients they serve. Following this, we headed over to the evening Grand Reception held at the National Museum of the American Indian.

The following day prior to meeting with legislators started with talks from Dr. **Willie Underwood III**, American Medical Association Board of Trustees Chair-elect

and Northeastern Section, Dr. **Hans Arora**, AUA Lead Delegate to AMA House of Delegates, and Dr. **Ruchika Talwar**, AUA Delegate to AMA House of Delegates and AUA Holtgrewe Fellow, with a session titled "**The Role of the AMA in Physician Advocacy**". Current AMA priorities are aligned with urology with a theme titled "AMA Recovery Plan for America's Physicians":

- **Reform Medicare payments** to promote thriving practices and innovation;
- **Tackle Prior Authorization** to reduce burdens on practices and delays in care;
- **Stop Scope Creep** that threatens patient safety;
- **Reduce burnout** and address stigma around mental health; and
- **Advance Telehealth** to maintain coverage and payment

Following this session, Dr. **Larissa Bresler**, AUA Chief Diversity Officer gave a brief talk titled "**Diversity, Equity, and Inclusion in Advocacy**". Dr. Bresler's responsibilities include identifying and advising on potential solutions to meet diversity gaps, the implementation of diversity initiatives, and methods to recruit, support and retain diverse AUA leaders and volunteers. She states that it is important to promote and improve transparency around diversity, equity and inclusion (DEI) efforts in urology.

The next morning, we had the AUAPAC Breakfast with Representative **Ami Bera**, MD (**D-CA-06**) as well as speeches from Representative **Larry Bucshon**, MD (**R-IN-08**) and Representative **Jack Bergman** (**R-MI-01**) at the morning session to start the third day of the summit

The next session was moderated by Dr. **Brian Duty**, AUA State Advocacy Committee Chair-elect that was titled "**State Advocacy: Chaperone Rules and Criminalization of Physician Care**" and included speakers Dr. **Julie Riley**, AUA State Advocacy Committee Member, Dr. **Jonathan Kiechle**, AUA State Advocacy Committee Member, and Dr. **Beth Drzewiecki**, New England Section. The first topic of discussion was the Chaperone Rule, which stemmed from an email sent in 2021 by the Wisconsin Medical Board to licensed physicians regarding a new proposed rule requiring chaperones for all physical examinations because the board had seen a significant increase in complaints regarding physician behavior following Larry Nassar's trial, and the board did not have the budget to investigate all the complaints leading to the proposed new rule. Advocacy efforts led to current proposed rule: "The proposed rule expands unprofessional conduct to require that physicians either follow the policies established by their employers for the use of chaperones during physical examinations, or that physicians establish policies and follow them. Physicians will also be required to make their policy regarding the use of chaperones accessible to all patients." However, despite heavy advocacy efforts, Oregon Medical Board passed a Chaperone rule. Oregon Medical Board rule requires licensees (MD, DO, PA) to make a trained chaperone available for all: genital and rectal examinations, regardless of gender, and breast examinations for patients who

identify as female. The chaperone must hold an active Oregon license to practice as a health care professional; or complete a 2-hour course ($55) for medical chaperones reviewed by the Oregon Medical Board. Criminalization of physicians for transgender care was also discussed with several states have bills to prohibit transgender care for minors:

- 23: revocation of licensure of providers
- 16: civil damages against the facility and/or provider
- 9: criminalization of provider
    - 7 are felonies
- 2: related to child abuse
- 7: include adults (up to age 26)
- 9: related to protections of transgender care
- Statute of limitations: 2-45 years
    - Most commonly 2 years from reach majority age

The next session was titled "**Lay Down Your Burden: Prior Authorization Reforms**" with Dr. Eugene Rhee, AUA Public Policy Council Chair, Dr. Ali Kasraeian, Southeastern Section, and Dr. Josh Langston, Mid-Atlantic Section. The burden of prior authorization (PA) is significant, and is currently required by insurance companies as a cost control process, also known as utilization management. It requires physicians to qualify for payment by obtaining approval for performing services, medications, or procedures. The burden of PA on physicians and practices include cost, inefficiencies, and it is opaque. This process has led to serious and adverse events for patients and their care. The Kaiser Family Foundation found there were 35 million PA requests submitted to Medicare Advantage (MA) plans in 2021 alone and the vast majority of denials that were appealed ended up being overturned. On average, practices complete 41 Pas per physician per week. Physicians and their staff spend an average of almost two business days (13 hours) each week completing PAs. Two in five or 40% of physicians have staff who work exclusively on PA, and 88% of physicians describe the burden associated with PA as high or extremely high. The clinical and administrative burden of prior authorization (PA) can lead to abandonment of treatment as reported by 82% of physicians. PAs are not good for patients with 34% of physicians reporting it has led to a serious adverse event for a patient in their care (24% of physicians report that PA led to a patient's hospitalization, 18% of physicians report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage, and 8% of physicians report that PA has led to a patient's disability/permanent bodily damage, congenital anomaly/birth defect or death). CMS rules proposed to address PA include provisions to improve coordinated care and collaboration among patient, providers and payers: payers will be required to provide information about PA requests and decisions within a patient accessible portal and payers will be required to allow providers to initiate a request for access to patient date such as immunizations, procedures, treatment plans and other PA requests, before, during or after a patient encounter. Shorter time lines have also been proposed to reduce the wait time for decisions. Additionally, adoption of

standards for health care attachments transactions and electronic signatures, and modification to referral certification and authorization transaction standard have been proposed.

Ms. Erika Miller from CRD Associates gave a lecture titled "**Need to Know: Inflation Reduction Act of 2022 and its Impact on Urology**". The Inflation Reduction Act of 2022, signed into law by President Biden on August 16, 2022, includes several provisions to lower prescription drug costs for people with Medicare and reduce drug spending by the federal government. This legislation has taken shape amidst strong bipartisan, public support for the government to address high and rising drug prices. The Congressional Budget Office (CBO) estimates that the drug pricing provisions in the law will reduce the federal deficit by $237 billion over 10 years (2022-2031). CMS is hiring more than 200 people to implement and run the new programs authorized by the legislation.

The prescription drug provisions included in the Inflation Reduction Act will:

- Require the federal government to negotiate prices for some drugs covered under Medicare Part B and Part D with the highest total spending, beginning in 2026
- Require drug companies to pay rebates to Medicare if prices rise faster than inflation for drugs used by Medicare beneficiaries, beginning in 2023
- Cap out-of-pocket spending for Medicare Part D enrollees and make other Part D benefit design changes, beginning in 2024
- Limit monthly cost sharing for insulin to $35 for people with Medicare, beginning in 2023
- Eliminate cost sharing for adult vaccines covered under Medicare Part D and improve access to adult vaccines in Medicaid and CHIP, beginning in 2023
- Expand eligibility for full benefits under the Medicare Part D Low-Income Subsidy Program, beginning in 2024
- Further delay implementation of the Trump Administration's drug rebate rule, beginning in 2027

CMS Guidance on Drug Price Negotiation

- Agency is using guidance to implement many Inflation Reduction Act provisions as directed in the statute
- CMS encouraging public engagement throughout the implementation process
- Outlines plans for three information collection requests (ICRs)
    - Small Biotech Exception
    - Negotiation Data Elements
    - Offer and Counteroffer Exchange
- Provides timeline for 2026 – initial year of Part D negotiation

Medicare Drug Price Negotiation

- Identifying Negotiation Eligible Drugs
- Selecting Medicare Drugs for Which Prices Will Be Negotiated

- Collecting Information to Use for Negotiation
- An offer and Counteroffer Process Between Medicare and Rx Drug Companies

Selecting Negotiation-Eligible Drugs

- Drugs subject to negotiation will be selected from among the 50 drugs with the highest total Medicare Part D spending and the 50 drugs with highest total Medicare Part B spending.
- Maximum Fair Price is established and applies until the drug is no longer a selected drug, meaning it has market competition.
- List of drugs with negotiated prices will accumulated over time

Drugs Excluded From Negotiation

- There with an available generic or biosimilar
- Drugs less than 7 years (for small-molecule drugs) and 11 years (for biological products) from their FDA-approval or licensure date
- "Small biotech drugs" until 2029
- Drugs with Medicare spending less than $200 million in 2021 (increased by CPI-U for subsequent years)
- Drugs with an orphan designation as their only FDA-approved indication
- All plasma-derived products

Setting the Maximum Fair Price

- CMS will publish the list of selected drugs
- CMS and the drug manufacturers must enter into agreements detailing the negotiation process
- HHS Secretary required to consider the following when negotiation a maximum fair price:
    - The R&D costs, including the extent to which the manufacturer recouped these cost
    - Current unit costs of production and distribution
    - Federal financial support for therapeutic discovery and development for the drug
    - Data on pending and approved patent applications, exclusivities, and certain other applications and approvals
    - Market data and revenue and sales volume data in the US
    - Evidence about alternative treatments

- The ceiling is the lower of the drug's:
    - AMP (net of all price concessions) for a Part D drug or ASP for a Part B drug;
    - Percentage of the non-federal AMP based on the amount of time since FDA approval
- HHS Secretary will publish information on the maximum fair price and other factors used to determine this price

- If not subject to renegotiation, the price will increase annually by CPI-U
- Should manufacturers choose not comply with negotiation, they will face financial penalties:
    - Up to 10 times the change in price for each unit charged above the MFP
    - $1 million per day for failure to provide required information
    - An excise tax of between 65-95% of sales

What does this mean for urologists?

- Part B "buy and bill" practices will need to change
- Negotiated prices for Part B drugs will go into effect on January 1 of each year beginning in 2028
    - Drugs purchased in the previous year and administered after January 1 will be reimbursed at the new negotiated rate
    - Providers will not be made whole for the difference
- Example:
  A urologist buys 20 units of a negotiation eligible Part B drug on November 30, 2017. Fifteen of those units are administered to patients before the end of 2017. The urologists are reimbursed at the 2027 rate. The five units administered after January 1, 2028 are reimbursed at the 2028 maximum fair price.

The last session was titled "**United We Stand: Patient and Provider Takeaways from the Patient Advocacy Connections Program**" and the speakers were Dr. **Jason Jameson**, Sexual Medicine Society of North America and Dr. **Jacqueline Zarro**, AUA Patient Advocacy Liaison. The Patient Advocacy Connections Program (PACP) is joint UCF/AUA program that is held in conjunction with the AUA's Advocacy Summit and brings stakeholders together around various topics of interest to the urologic patient community. Participants include representatives from various patient, physician, and research advocacy organizations, as well as AUA members and industry partners. There were four panels of discussion.

Panel 1: Cancer Survivorship Issues

- Support groups are an avenue to reach those in need
- How to retain/prevent burnout for patient support group leaders and build the pipeline for future generations

Panel 2: Patient Engagement in Research

- Patient Advocates:
- Serve as grant reviewers to help determine what research gets funded
- Act as advisors with research teams to help guide protocols, recruitment and materials, dissemination of results
- Raise awareness and educate policymakers about the issues faced by people with or at high risk of cancer
- Advocate for research funding via NIH, NCI, DoD CDMRP

- Support state and federal policy efforts to increase access/coverage/reimbursement and reduce barriers to genetic testing, screenings, and treatment

Panel 3: Telehealth and Rural Access

- Investing in a Strong Rural Health Safety Net
- Reducing Rural Healthcare Workforce Shortages
- Addressing Rural Declining Life Expectancy and Inequality

Panel 4: Cancer Testing/Screening Landscape

- PSMA/PET imaging for prostate cancer may provide value diagnostic information
- The FIND Act addresses reimbursement issue with CMS for radiopharmaceutical agents like those necessary for PSMA/PET imaging to be introduced in Congress this week
- Pfizer is looking to serve as a partner to align organizations to assist patients with unmet needs via their Multi-Cultural Health Equity Collective

Drugs Utilized by Urologists – Part B (CY 2020 Data)

Brand Name	Generic Name	Total Spending	Total Dosage Units	Total Claims	Total Beneficiaries	Drug Use Information
Opdivo	Nivolumab	$1,586,591,103.30	62,072,115	175,292	25,352	Nivolumab is used to treat certain types of cancers (blood, skin, lung, kidney, bladder and head and neck cancer).
Avastin	Bevacizumab	$680,539,026.17	9,604,101	676,063	173,910	The medication is a man-made antibody IIgGI) used to treat kidney, cervical, ovarian, colon, and rectal cancer.
Tecentriq	Atezolizumab	$624,194,083.89	8,710,906	71,233	12,416	The medication is used to treat various cancers (such as bladder, breast, liver, lung, skin).
Imfinzl	Durvalumab	$505,845,757.78	6,817,534	76,247	9,160	Durvalumab is used to treat a certain type of bladder and urinary tract cancer. It is also used to treat lung cancer.
Yervoy	Ipilimumab	$365,961,395.02	2,611,777	17,595	6,927	Ipilimumab is used to treat melanoma (skin cancer), kidney cancer, and cancer of the large intestine (certain types of colorectal cancer).
Botox	Onabotulinumtoxina	$330,554,707.50	6,940,662	306,461	135,099	There are different types of botulinum toxin products (toxin A and B) with different uses (eye problems, muscle stiffness/spasms, migraines, cosmetic, overactive bladder). Different brands of this medication deliver different amounts of medication.

The drugs listed in this chart were in the top 30 for Medicare Part B spending in CY 2022