Senator Rachel Siewert,
Chair,
Senate Community Affairs References Committee,
Therapeutic Groups Inquiry.

March 31, 2010

Dear Senator Siewert,

We are writing in our capacity as the Medical Director and Chief Executive Officer of Osteoporosis Australia, respectively, and also represent the members of the Medical and Scientific Advisory Committee of Osteoporosis Australia to comment on the proposal by the PBAC to create a new Therapeutics Group that treats all oral bisphosphonates (the most common drugs used to prevent and treat osteoporosis) as equivalent to generic alendronate and therefore interchangeable at an individual patient level.

We understand that such interchangeability would mean in practice that when a patient with osteoporosis is being considered for treatment, the attending doctor would assume there is no difference whether he/she prescribes generic alendronate once-a-week or branded Fosamax or Actonel (which may be administered either weekly or monthly). The proposal also assumes the choice of either drug will make no practical difference to the patient or to their subsequent health outcomes.

However in reality, several substantial differences exist between alendronate and risedronate from a scientific perspective, as well as emerging evidence of differences between generic alendronate, and Fosamax and Actonel. These differences can impact on patients' compliance and persistence with therapy and effectiveness on fracture reduction, as shown below:

1. Bisphosphonate drugs are not all the same.

Differences in bisphosphonate drug function exist so there is a range of potency in the inhibition of enzymes affecting the survival of the cells that break down bone (osteoclasts) and in the binding of bisposphonates to bone mineral crystals. These are likely to be reflected in differences in time of onset of anti-fracture effectiveness and in the time for effects to wear off after treatment is stopped (1-5). In this regard, risedronate is one of the fastest to achieve an onset and offset of effects on bone.

2. Adverse events and poorer compliance.

The use of generic alendronate may be associated with increased gastrointestinal side effects compared with non-generic bisphosphonates (12-16) due to its differing dissolution in the gastrointestinal tract. This increase in indigestion is likely to lead to poorer compliance with more fractures being likely as a result (12, 13).

3. Generic alendronate does not come with calcium or vitamin D supplements.

Fosamax already comes combined with Vitamin D plus optional Calcium, Actonel comes with both Vitamin D plus Calcium supplements. Generic alendronate does not come with either vitamin D or calcium. All the pivotal fracture studies with bisphosphonates were done using concomitant vitamin D and calcium supplementation, which means for most patients to achieve optimal benefits from bisphosphonates, vitamin D and calcium should be given. However, pensioners in particular, and others often cannot afford the additional expense of vitamin D and calcium, which raises issues of equity of access. The non-generic bisphosphonates currently available in Australia allow for differential supplementation with either vitamin D or calcium in combination with the bisphosphonate. This flexibility would be lost by the proposal with potential harm to our patients using generic alendronate alone.

4. Constraints on administration regimens

Better compliance and persistence with bisphosphonates is associated with reduced fractures. Better compliance and persistence is also seen with less frequent drug dosing (22, 23), e.g. weekly vs. daily; once monthly; or annual administration. There is no once monthly formulation of generic alendronate, while risedronate may be given once a month, which is very likely to result in improved compliance.

5. Prevention of Steroid Osteoporosis

Only oral risedronate and intravenous zoledronic acid are approved for prevention of corticosteroid-induced osteoporosis in Australia, while Fosamax or generic alendronate are not. It would be incorrect for a non-approved drug to be supplied by pharmacists for this indication.

In conclusion, Osteoporosis Australia believes this new proposal, although cost-effective, is not consistent with the scientific evidence regarding bisphosphonate action. A more restrictive choice is likely to lead to poorer compliance and persistence with consequent adverse fracture outcomes. These adverse outcomes will cost Australia $388 million and result in 19,417 preventable fractures between now and 2020, based on a recent Access Economics report examining the cost of osteoporosis and preventable fractures to Australia (24). We therefore strongly oppose the proposal's uptake in Australia.

Yours sincerely,

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