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# Multiple Sclerosis: The Evolving Competitive Landscape, the Future Challenges & the Opportunities

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**Autoimmune Centre of Excellence**

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# Multiple Sclerosis: The Evolving Competitive Landscape, the Future Challenges & the Opportunities

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Ipsos Healthcare 2016

This paper provides an overview of the current treatment approaches for Multiple Sclerosis (MS), together with an exploration of the current market dynamics and how they have evolved in recent years. It concludes with two case studies: 'Tecfidera: Still The Wonder Drug?' and 'Analysing Key Market Drivers'.

Unless stated otherwise, data and commentary are the result of analysis of Ipsos Global MS Therapy Monitor data (together with the market knowledge of Ipsos' MS experts). Running since 1997, the MS Therapy Monitor is an online multi-centre retrospective study of MS patients in the US and the EU5 (UK, France, Germany, Italy, Spain). Twice a year, 370 physicians (100 US & 270 EU5) are asked to report on 10 patients with the following quota: 7 RRMS; 2 SPMS; 1 CIS. Patient data elements collected include demographics, clinical status and diagnosis and treatment patterns. Physicians are also asked to complete a demographic form and perceptual questionnaire

## 1. The Market Context: An Evolving Treatment Algorithm

Multiple Sclerosis (MS), one of the most common neurological disorders that causes disability, is currently estimated to affect 2.5 million people worldwide<sup>1</sup>. An autoimmune disease that damages the central nervous system (CNS), it is characterised by demyelination (damage to the protective myelin sheath that surrounds neurons) which disrupts communication to and from the brain. Such lesions can impair control of bodily functions and lead to clinical disability as the disease progresses. Various types of MS have been identified – clinically isolated syndrome (CIS), relapsing remitting (RRMS), primary progressive (PPMS) and secondary progressive (SPMS) – which differ in incidence of relapses and rate of disability progression.

MS typically develops in young adults between the age of 29 and 33 years, with women more likely to suffer from MS than men. Although the etiology of MS is not fully understood, it is interesting to note that the prevalence of MS differs with geography and ethnicity. It is, for instance, more prevalent at higher latitudes (i.e. Canada has a prevalence of 291 in 100000) than in regions in the vicinity of the equator (i.e. Indonesia with a prevalence of 0.02 in 100000)<sup>2</sup>; and has been thought that individuals may be protected from MS with adequate exposure to sunlight and subsequent production of Vitamin D. MS is also more common in Caucasians of Northern European ancestry. Interestingly, however, certain ethnic groups such as the Inuits of Canada and Maoris of New Zealand have very low rates of MS, suggesting that there may be more contributing factors to the development of MS than geography and ethnicity.

At present, there is no cure for MS but the disease course can be altered by a range of disease-modifying therapies (DMTs). Such therapies have gone through some notable changes in recent years as research progresses, but with the majority of therapies only indicated for the treatment of RRMS, with the exception of some suitability for SPMS/CIS patients, there is an unmet need for PPMS patients whose disease activity is currently untreatable through licensed treatments. [Worth noting however, is the potential launch of ocrelizumab for PPMS patients in late 2016.]

<sup>1</sup> Prevalence and incidence of Multiple Sclerosis. MS Trust (Online). Available at: <https://www.ms-trust.org.uk/a-z/prevalence-and-incidence-multiple-sclerosis> (Accessed 15th June 2016)

<sup>2</sup> Incidence of Multiple Sclerosis. Multiple Sclerosis International Federation, 2013 Atlas of MS database (Online). Available at: <http://www.msif.org/about-us/advocacy/atlas/> (Accessed 15th June 2016)

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Historically, the treatment algorithms for MS have been predominantly ruled by the use of injectable drugs: the interferons and Copaxone (glatiramer acetate), which demonstrate reasonable efficacy<sup>3</sup>. In 2004 the monoclonal antibody Tysabri (natalizumab) launched into the market, offering the first alternative mode of administration and showing superior clinical benefits to the traditional DMTs<sup>3</sup>. Tysabri is an infusion therapy requiring less frequent administration than the injectables. Concerns regarding the occurrence of progressive multifocal leukoencephalopathy (PML) led to the market withdrawal of Tysabri but it later returned in 2006. In 2012, around the same time as the approval of the Stratify JCV Antibody ELISA test, Tysabri's labelling was changed to reflect that testing positive for anti-JC virus (JCV) antibodies is a proven risk factor in developing PML; hence, those considering Tysabri treatment should determine their JCV positivity.

A further gap in the market, mode of administration (MOA), was filled in 2010-11 when the first oral DMT, Gilenya (fingolimod), was launched (approved by FDA in September 2010 and by EMA in March 2011). Initially, Gilenya's growth was slow due to concerns over its safety profile; following the death of a Gilenya patient in the US in November 2011, recommended monitoring programmes were added to Gilenya's label requiring patients to be monitored for the first six hours after the initial dose. Following this label change, uptake was relatively strong, with the therapy providing a 'bridge' switch treatment between the traditional injectables and highly efficacious Tysabri. Use has gradually increased over the past 2 years; however, label restrictions, monitoring requirements and PML safety concerns continue to be strong barriers to prescribing Gilenya across both regions.

The second oral drug, Aubagio (teriflunomide), was launched in 2012-2013 and provided an alternative mode of administration for less disease-burdened patients. According to data from Ipsos Healthcare's MS Therapy monitor, the initial uptake of Aubagio was slow, particularly within certain EU5 markets. Efficacy perceptions did not resonate with HCPs and hence the drug did not positively differentiate from the 'safer' injectables. The therapy also carries a black box warning (US only) indicating the risk of hepatotoxicity and teratogenicity and, as such,

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<sup>3</sup> Multiple Sclerosis International Federation, 2011, issue 18: MS in focus (online). Available at: <http://www.msif.org/wp-content/uploads/2014/09/MS-in-focus-18-Pharmacological-treatments-English.pdf> (Accessed 15th June 2016)

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monitoring presents a substantial barrier to prescribing with the requirement for periodic blood tests and analysis of liver function. Further hindering Aubagio's initial potential was the launch of the third oral therapy, Tecfidera (dimethyl fumarate), soon after in 2013-2014; both orals were suitable for mild/moderate patients yet physicians perceived Tecfidera to have greater efficacy. Due to a large amount of noise, Tecfidera's launch was eagerly anticipated by physicians, with some appearing to warehouse patients. Accordingly, Tecfidera stormed the market upon launch and, until recently, has continued to maintain a steep growth trajectory. As a result, overall dynamic activity surged across both the EU5 and US as more patients were initiated and switched onto treatment. In October 2015, a fourth case of PML was associated with Tecfidera. Shortly after, the EMA updated Tecfidera's monitoring programme, requiring patients to undergo complete blood cell counts before starting treatment and periodically thereafter. Safety concerns surrounding the treatment have grown as a consequence.

The variety of treatment options continued to expand with the launch of Lemtrada (alemtuzumab), which was EMA approved in September 2013 and FDA approved in November 2014. Lemtrada is a monoclonal antibody infusion therapy requiring less frequent administration than Tysabri (1 per year following initial dose). Although showing encouraging clinical reduction in the accumulation of disability<sup>4</sup>, strong safety concerns, particularly amongst US physicians, have resulted in slow initial uptake of the treatment. Strict labelling in the US is the likely driver for concerns in this region; physicians, pharmacies and treatment centres must register with the REMS programme before they're able to prescribe and/or administer the therapy, whilst patients are required to have received at least 2 prior DMTs. With reduced injectable dominance for the treatment of MS and an ever-decreasing dynamic business for these platform DMTs, a 40mg formulation of Copaxone was launched in January 2014 in the EU (full EU availability was achieved in 2016). Plegridy (peginterferon beta-1a), a PEGylated version of Avonex, was also launched between 2014 and 2015. Both new injectables provide similar efficacy to their predecessors but require less frequent administration, presenting as both safe and convenient treatment options. So far, Plegridy is used similarly across the EU5 and the US but the 40mg Copaxone formulation has been particularly successful in the

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<sup>4</sup>Havrdova E et al. (Therapeutic Advances in Neurological Disorders 2015) Alemtuzumab in the treatment of multiple sclerosis: key clinical trial results and considerations for use. (Online) Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4286943/> (Accessed 15th June 2016)

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US. The approval of the 40mg dose has allowed the Copaxone brand to stay on top in this region, with share remaining relatively stable despite the pressure from Tecfidera. In June 2015 Glatopa (generic glatiramer acetate), the first generic compound for the treatment of MS, was launched in the US, providing therapeutic equivalence to Copaxone 20mg<sup>5</sup>. The success of this generic will be interesting to monitor, particularly within the US which has always been a stronger market for Copaxone and where some treatment costs fall directly onto the patient.

With the increasing diversity not only of treatment options but also modes of administration, the future of the traditional injectable therapies is already in question. The interferons (IFNs) have seen significant reductions in market share as the orals overtake across all lines of treatment. The movement of these newer therapies, albeit it with only slightly more efficacy benefits, earlier within the treatment algorithm also suggests the changing prescribing mindset of physicians. Are physicians more willing to use 'riskier' treatments despite a lack of long-term safety data? Is treating the disease more aggressively at an earlier stage now top of mind? Has the focus of the treatment benefits moved to slowing disability progression and reducing disease activity vs the reduction in the more physically obvious effect, relapses? The increased familiarity and availability of newer and/or more efficacious treatments, however, comes at a safety cost, particularly surrounding PML, now a burden for more than just Tysabri. With this said, although physicians say they are more fearful of certain treatments, their actual prescribing has shown little hesitation; Gilenya is captured as the option of choice amongst JCV positive patients by the MS Therapy Monitor, whilst Tecfidera continues to monopolise 1st line treatment initiations. Similarly, levels of satisfaction are also higher for those DMTs with greater efficacy yet greater concerns. Are patients more likely to overlook these potential safety concerns with the promise of benefits offered by these therapies? Qualitative research commissioned by Ipsos Healthcare into patient perspectives in MS has revealed that although treatment decisions are still physician-led in the main, there is a sizeable proportion of patients that exert their preferences over choice of DMT. These patients tend to be more knowledgeable and proactive in their approach to their disease and contribute to the increasing emphasis on '*convenience*' and '*lifestyle*' factors that are driving

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<sup>5</sup> Anderson J et al. (J Neurol Sci. 2015) Demonstration of equivalence of a generic glatiramer acetate (Glatopa™). (Online) Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26671082> (Accessed 15th June 2016)



prescriptions; they rank these alongside other critical factors, *efficacy* and *safety*.

The research advances in the treatment for MS have also led to the potential for therapies to conquer progressive MS types. Recently released phase III data for ocrelizumab, a monoclonal infusion therapy, boasts promising efficacy data and comparable side-effects to the IFNs alongside bi-annual administration. With approval anticipated in late 2016 for the treatment of PPMS patients and a seemingly strong efficacious and 'convenience' profile, it will be interesting to monitor the uptake of ocrelizumab as increasingly more physicians appear willing to use the therapy upon launch. However, despite this positive data, some KOLs are expressing concerns about the suitability of ocrelizumab for only a small subset of PPMS patients; will the therapy take off amongst all PPMS patients? Could there be a halo effect within the RRMS market? How will competitors fare against another eagerly anticipated therapy?

## 2. The Current Treatment Options (2016)

As MS presents with a broad range of symptoms, a team of healthcare professionals from various disciplines such as neurologists, physiotherapists and occupational therapists, may be involved in the holistic management of the disease. Whilst there is currently no cure for MS, the treatment of the disease itself is specifically managed by neurologists, who prescribe DMTs to reduce the frequency and severity of relapses experienced in MS, ultimately aiming at preventing or at least delaying the accumulation of disability. As the name suggests, DMTs modify the disease by minimising the damage to the protective myelin. There are currently twelve licensed brands across the MS market (Figure I). Additionally, there are three modes of administrations in MS; injectables (Avonex, Betaferon, Extavia, Rebif, Copaxone and Plegridy), intravenous infusions (Tysabri and Lemtrada) and oral capsules (Aubagio, Tecfidera and Gilenya). These are mainly indicated for RRMS patients.



Drug	Brands
beta interferon 1a	Avonex
	Rebif
	Plegridy
beta interferon 1b	Betaferon
	Extavia
glatiramer acetate	Copaxone
generic glatiramer acetate	Glatopa (US only)
natalizumab	Tysabri
fingolimod	Gilenya
teriflunomide	Aubagio
dimethyl fumarate	Tecfidera
alemtuzumab	Lemtrada

Figure 1: The major DMTs currently available for the treatment of MS

**beta interferons** are immunomodulatory and antiproliferative natural proteins, and switch the proinflammatory immune response to an anti-inflammatory one. Types 1a and 1b differ in the origin of synthesis. The PEGylated form (Plegridy) stays in the body longer thus allowing for less frequent administration.

**glatiramer acetate** is thought to promote an anti-inflammatory response via immunomodulation; as it is a synthetic copolymer with similarities to the myelin basic protein, it is also thought to act as a decoy to reduce the autoimmune reaction against myelin.

**natalizumab** is a monoclonal antibody raised against  $\alpha 4$ -integrin, a cellular adhesion molecule found on the surface of leukocytes. This inhibits leukocyte adhesion to endothelial cells on the blood-brain barrier and prevents migration to the CNS, thereby reducing the damage to myelin which may otherwise ensue.

**fingolimod** is a sphingosine 1-phosphate receptor modulator. It sequesters lymphocytes in the lymph nodes, thereby preventing them from infiltrating and attacking cells in the CNS.

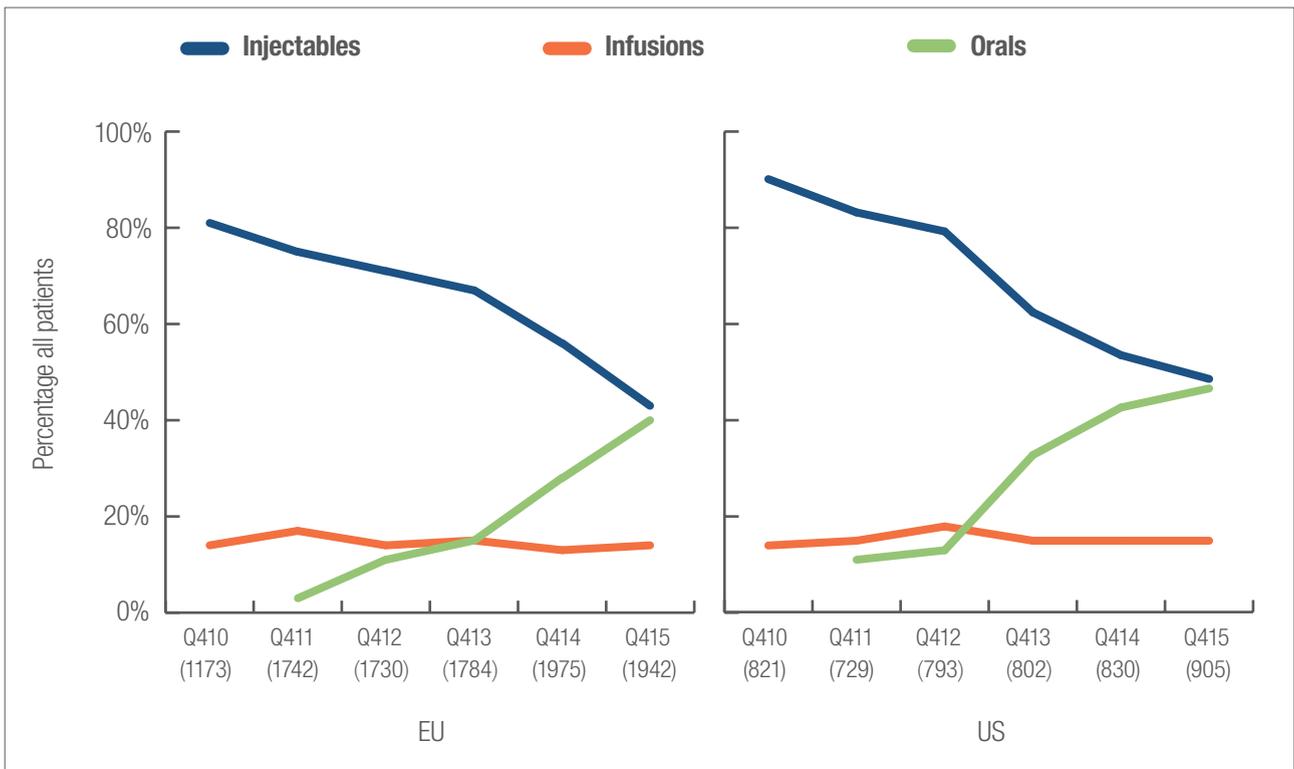
**teriflunomide** is a pyrimidine synthesis inhibitor, a small molecule that suppresses the immune system and prevents lymphocytes from dividing – thereby reducing the volumes of T and B cells circulating in the blood and attacking the CNS.

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**dimethyl fumarate**'s mechanism of action is not yet fully understood, but clinical studies suggest it has neuroprotective and anti-inflammatory effects; activating pathways that reduce oxidative stress induced neuronal death and maintain myelin integrity.

**alemtuzumab** is a monoclonal antibody and although the exact mode of action is not fully understood, studies suggest its immunomodulatory effects work through the depletion and re-population of lymphocytes.

### 3. Real World Evidence on the MS Market



**Figure II: Trend of all patient share (CIS, RRMS, SPMS) by mode of administration in Europe & the US over time**

Source – Ipsos Healthcare MS Monitor, data collected online

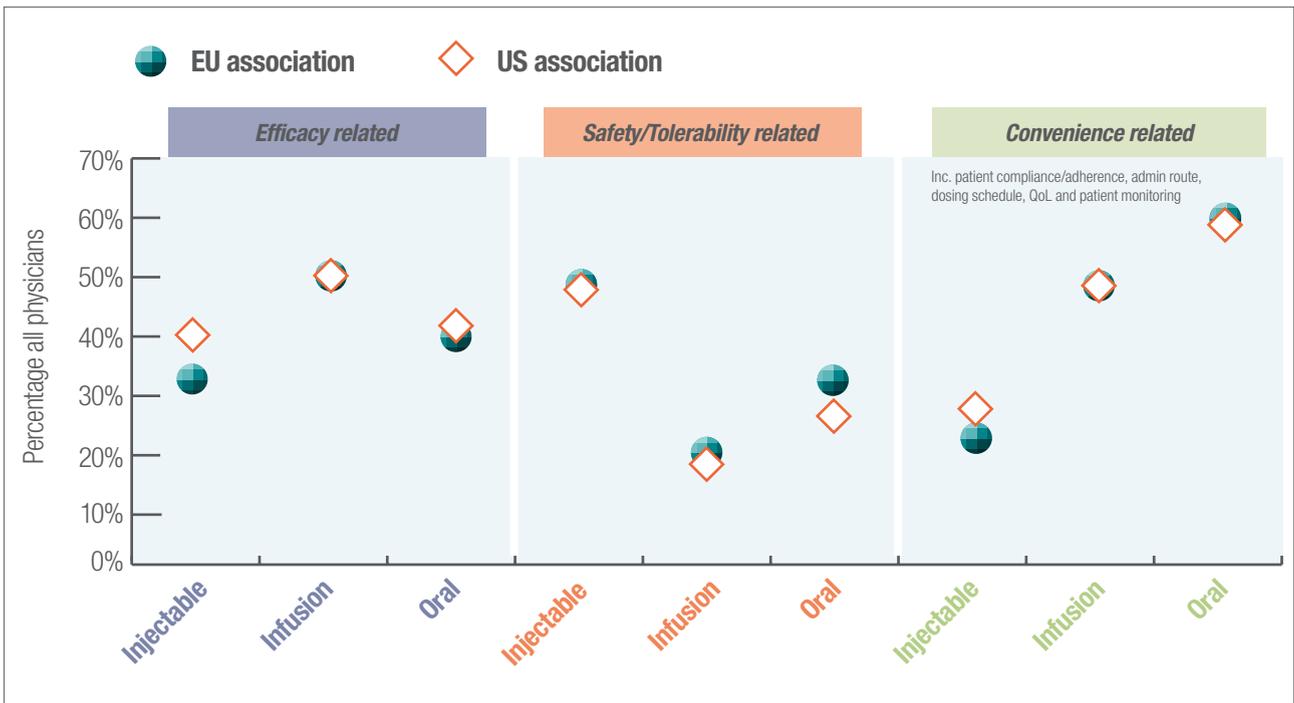
\*European countries include UK, France, Germany, Italy and Spain

With the expanding variety of treatment options in the MS market, the algorithm has shifted towards an oral preference as the traditional injectable therapies take the greatest hit. The downward trajectory of the injectable therapies began upon Gilenya’s launch in 2011 (Figure II) but the greatest impact was felt in 2013 when Tecfidera became available. Tecfidera and Aubagio present as direct competition for the injectables in the mild/moderate



patient segment – initially within the switch segment but now ever-increasingly for treatment initiations. In the EU5, oral growth mirrors injectable decline with both continuing on a steep trajectory. This continually strong momentum is likely due to staggered oral launches within the different EU5 markets. German physicians were initially fuelling this trend and although now injectable and oral share has begun to stabilise here, other EU5 markets (UK, Italy, Spain) have begun to gain confidence in the more recently launched orals; Tecfidera's growth trajectories mimic those after initial German launch. The same pattern is observed in the US but to a lesser extent, with both injectable and oral share now beginning to plateau, likely due to physician loyalty to the Copaxone brand, the high cost of oral and infusion DMTs and the initial influx of patient opportunity now subsiding. Overall Infusion share has shown little movement over the years, irrespective of new therapy launches, and remains strongest in the EU; US physicians are historically more risk averse whilst those in the EU5 appear more willing to try riskier therapies.

In line with the tendency for more reserved prescribing, US physicians generally have lower safety/ tolerability perceptions for all DMTs than their EU5 counterparts; the greatest disparity here is with oral associations (Figure III). Likely fuelling the greater persistence of injectables within the US, these physicians regard injectable efficacy more positively than EU5 HCPs, and almost in line with the oral therapies. As would be expected, associations with convenience-related attributes appear to correspond directly to both the mode and frequency of administration of a DMT. Mode of administration, however, appears to be more influential than frequency as, although only requiring either annual or bi-annual administration, the infusion therapies are perceived to be less convenient than the orals, which is likely due to the requirement for hospital-led administration.



**Figure III: Physician associations with each mode of administration**  
 Source – Ipsos Healthcare MS Monitor [EU: n= 269, US: n= 111], data collected online  
 NB: Only the US injectable grouping contains Copaxone 40mg due to only partial EU roll out in Q4 2015

With clear differences in the safety/tolerability and convenience profiles of each MOA group, a greater variety of factors are now being considered when choosing a treatment. Efficacy, particularly for relapses, has historically ruled as the top reason for choosing a DMT across all lines of treatment. This is likely due to the predominant ability for all DMTs to achieve this, albeit to a greater extent for the higher efficacy DMTs, but also partially because relapses are a more tangible measure of disease activity. This is particularly important because patients believe a therapy to be efficacious when they can physically see/feel an effect. The qualitative research led by Ipsos Healthcare into patient



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perspectives in MS has further revealed that patients' biggest concern is incapacity and being reliant on others. They measure efficacy primarily through lack of management of symptoms and relapses. Patients are perceived to be less informed about measures that are monitored through MRI rather than those where they can see/feel an immediate impact. As a result, there has always been lesser importance placed on the reduction of MRI activity, disability progression and reduction in brain atrophy. KOLs continue to discuss the importance of treating the brain, by means of targeting disease activity more aggressively earlier within a patient's treatment algorithm. The stated importance of such 'no evidence of disease activity' (NEDA) attributes has been increasing over the past two years within both regions, but to a lesser extent in the US. Therefore, it will be interesting to monitor the potential evolution of physicians' prescribing mind-set; already we see that other efficacy benefits (versus reduction in relapse rate) are being increasingly cited as the primary reason for treatment choice, with some markets indicating an increased willingness to move these higher efficacy therapies into earlier lines of therapy.

The greater number of factors for consideration when choosing a DMT has also meant that convenience implications and patient lifestyle parameters now have more of an influence than ever before. Although, 'convenient' and efficacious treatment options are now available, this increasing influence of patient lifestyle is greatest at first line, with later line patients having less influence in their treatment choice.

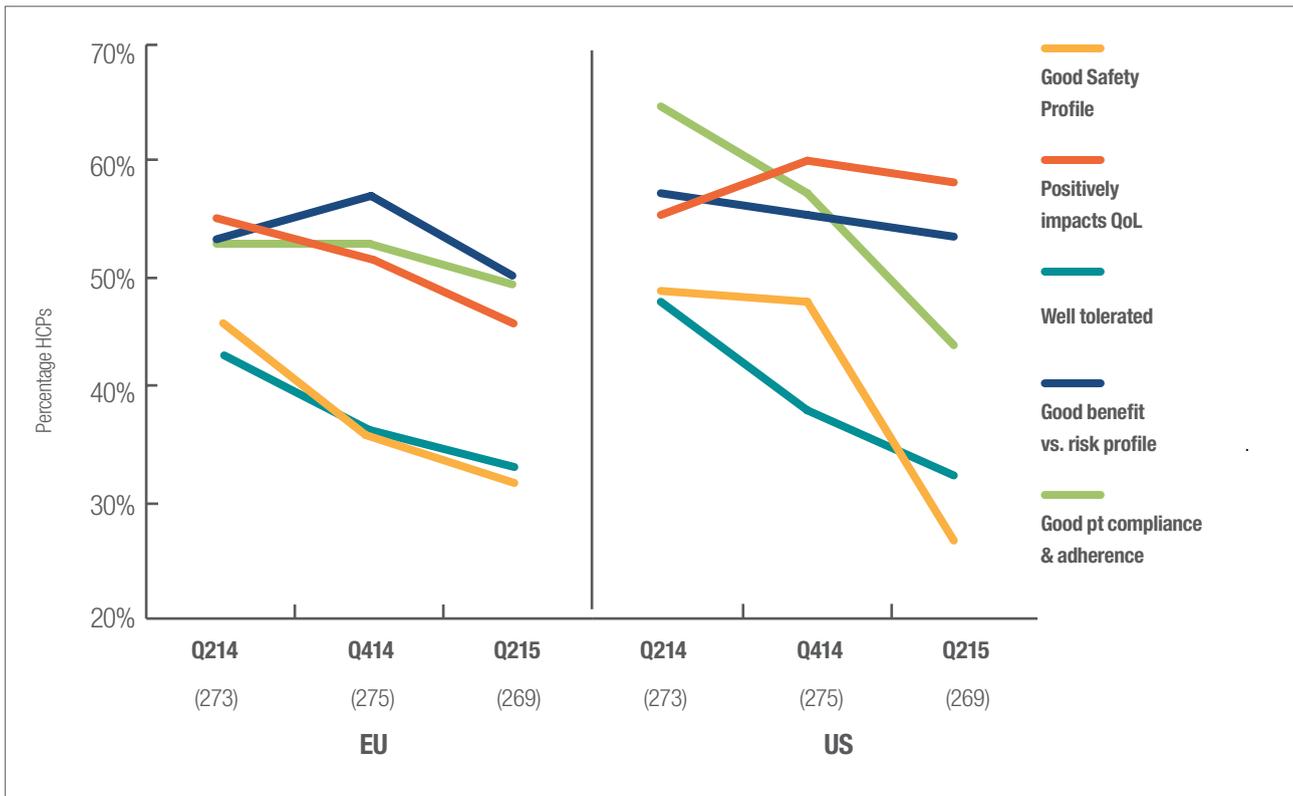
'Convenience' includes the monitoring requirements for each treatment, which although varying according to the risks, are generally strong for the more recently approved therapies. Extensive monitoring is likely impacting the uptake of some therapies, particularly so for those that are available to the less disease burdened patient. It's important to note, however, that being 'perceived' as convenient alone is not enough to drive brand prescription. Although it is to a lesser extent now than before oral launch, the majority of physicians still regard efficacy as the primary prescription driver. Will all DMTs now begin to experience increased pressure to strike the perfect balance between being efficacious and convenient in order to realise their full market potential?

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## 4. A Case Study - Tecfidera: Still The Wonder Drug?

In a market where previously only 'intrusive' therapies were available, the amount of attention received by the launch of oral therapies is unsurprising. Albeit the last oral therapy to gain approval, there was a heightened level of physician 'buzz' in anticipation of Tecfidera's launch. According to the MS Therapy Monitor (Q2 2014), only around 2/3 of physicians stated they were warehousing no RRMS patients for the therapy, meaning that a substantial number of patients were likely being lined up to begin Tecfidera. Upon launch, perceptions were strong in both the EU and the US; its efficacy was believed to be greater than Aubagio's and the injectable DMTs', with its perceived ability to reduce relapses in-line with Gilenya. Therapeutic side-effects were believed to be equally promising, with physicians generally regarding Tecfidera's non-efficacy profile more positively than that of the interferons – EU physicians particularly so for "impact on QoL", and "patient compliance", US physicians for "tolerability" and "few side-effects".

FDA approval was achieved in March 2013 and, as a result, US dynamic activity surged. Uptake was greatest in the switch segment but some first line use showed physician willingness to use ahead of the traditional platform DMTs. Following Tecfidera's EMA approval and European launch, the pattern of dynamic activity followed suit with an influx of treatment initiations and switches. Likely due to a staggered launch, initial momentum was slower in the EU and although still predominantly within the switch segment, the difference in Tecfidera's positioning was far less pronounced than in the US. Momentum continued to build with physicians in both regions driving Tecfidera earlier within the treatment algorithm, directly impacting injectable share at first line.



**Figure IV: Non-efficacy attributes associated with Tecfidera on launch vs now**

Source – Ipsos Healthcare MS Monitor, data collected online

In October 2014, however, a case of progressive multifocal leukoencephalopathy (PML) was associated with Tecfidera – the first of four cases to be associated with the treatment. Physicians’ previous confidence in the therapy has declined, with its originally strong non-efficacy profile now faltering (Figure IV) and barriers to prescribing the drug consequently increasing. Since the treatment’s launch, significantly fewer physicians



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associate Tecfidera with having a good safety and tolerability profile, with patient compliance perceptions also plummeting in the US. Fear of PML and tolerability concerns are significantly greater obstacles to prescribing than when first launched. As well as PML issues, this fall in perception could be linked to the occurrence of GI side-effects experienced during Tecfidera treatment. Although patient numbers switching from the oral are low, such effects are indicatively an overriding reason for switch/withdrawal from the therapy as well as more hesitation in starting patients on the drug.

One might have expected that, following these safety concerns, Tecfidera would face a similar fate to that of Tysabri; the impacts of PML were directly felt in patient share, with physicians actively switching patients from the treatment. So far, however, this has not been the case. The disparity between physician perceptions and actual prescribing is evident, particularly so in the overall EU market where Tecfidera has made significant gains at first line, continuing to move out of the switch segment. With their greater perceived concerns, US physicians have begun to reduce their dynamic prescribing of Tecfidera but the treatment still remains top choice for first line initiations and switches to second line. Additionally, the majority of patients currently receiving the treatment in both regions are described as having mild levels of disability and low levels of disease activity. So far, it appears that the therapeutic benefits of Tecfidera are outweighing the potential risks, but the continuation of this trend is questionable. In the markets where it was first to launch, dynamic activity (defined as treatment initiations and switches within the last 12 months) has begun to lose momentum, alongside the (albeit small) reduction in Tecfidera's dynamic business (US and Germany). Will the other EU5 markets follow this pattern? Will concerns over Tecfidera's safety grow? And if so, will physicians now begin actively switching patients from the treatment? Or is it simply the effects of warehousing whereby the pool of patients 'held' to begin the therapy has been exhausted?

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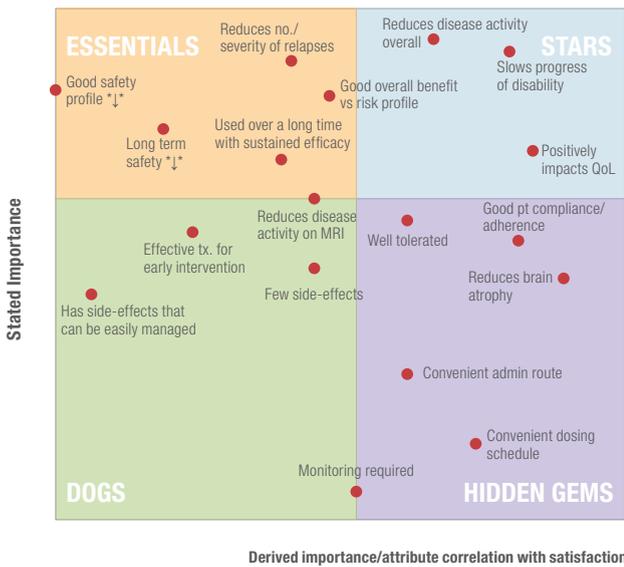
## 5. A Case Study - Analysing Key Market Drivers

Quadrant charts examine how strong the pattern is between brand performance on an attribute and whether that brand has good satisfaction ratings overall; the closer the pattern between the attribute and overall brand performance, the better the attribute is as a lever for improving brand perception. In the MS Therapy Monitor study, Ipsos asks respondents to rate the importance of attributes when selecting a DMT and to indicate which DMTs they associate with these same attributes. We also ask the same respondents to rate their satisfaction with each DMT. By doing this, we can see whether there is a relationship between overall opinion and attributes on which the brands perform well. This enables calculation of the derived importance for the attributes, measuring these qualities in a way that isn't dependent on conscious decision-making. The term "derived" is used because it is inferring the importance of the attribute based on the strength of this relationship. This may not be the same as the answers we get when we ask respondents to consciously state what is important to them.

### What does each quadrant mean?

<p><b>ESSENTIALS</b> <i>High Stated and Low Derived Importance</i></p> <p>Physicians say it's important but it has little impact on brand satisfaction, attributes expected for market access</p>	<p><b>STARS</b> <i>High Stated and High Derived Importance</i></p> <p>Physicians say it's important and it actually does impact brand satisfaction. It's worth investing resources to focus on these attributes in order to maintain positioning</p>
<p><b>DOGS</b> <i>Low Stated and Low Derived Importance</i></p> <p>Physicians say it's not important and it has little impact on brand satisfaction. Would need to relocate resources if they're focusing on these attributes</p>	<p><b>HIDDEN GEMS</b> <i>Low Stated and High Derived Importance</i></p> <p>Physicians say it's not important but it actually does impact brand satisfaction. Attributes reflect untapped opportunity to differentiate from competitors, adding value</p>

EU market drivers



US market drivers

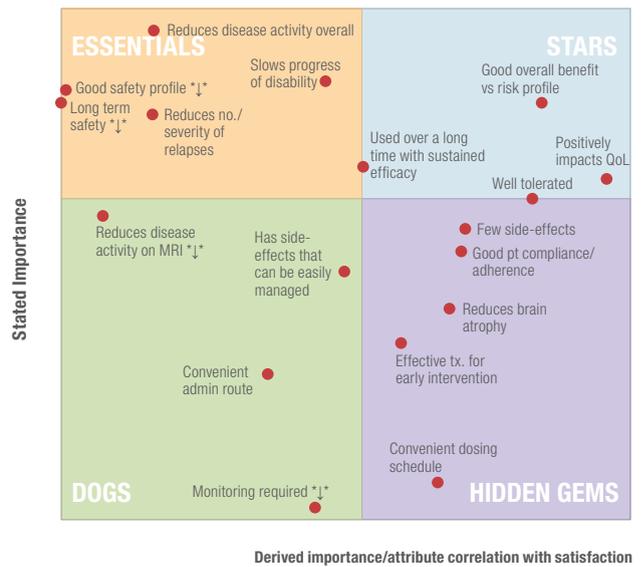


Figure V: EU5 level quadrant analysis

Source – Ipsos Healthcare MS Monitor [EU: n= 269], data collected online

NB: \*↓ in labels denotes a negative relationship between attribute performance and brand satisfaction

Figure VI: US level quadrant analysis

Source – Ipsos Healthcare MS Monitor [US: n= 111], data collected online

NB: \*↓ in labels denotes a negative relationship between attribute performance and brand satisfaction

In a shifting MS paradigm where more than just efficacy prevails, convenience factors are becoming increasingly cited as a reason for choosing a DMT. As such, the ability to reduce relapse rate is seen as an ‘essential’ attribute in the Q4 2015 MS Therapy Monitor for both EU5 and US physicians in driving brand satisfaction. This quality is expected from all DMTs, and focusing resources solely on promoting this capability will do little to strengthen brand share and satisfaction. However, patient compliance/adherence is identified as a ‘hidden gem’ attribute across both regions. The implication of this is that due to no single DMT currently differentiating itself from the rest of the field for this attribute, some untapped potential is there to be unearthed. A brand’s ability to positively impact QoL is seen as a ‘star’ attribute in the US. Promoting such related benefits will aid brands in getting ahead of competitors in the US, but less so in the EU5. Promoting efficacy benefits in

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relation to slowing disability progression – a ‘star’ attribute in the EU5 – will be the most efficient way of strengthening a therapy’s position in this market. In line with EU5 physicians’ less risk-averse nature of prescribing, there is a negative relationship here with good safety profile (an ‘essential’ attribute); although it is of high importance, it does not hinder brand prescribing and/or satisfaction amongst DMTs that are poorly associated with this attribute. This further highlights the greater willingness of EU5 physicians to use higher efficacy treatment despite associated risks and the potential to use them earlier within the treatment algorithm.

In an evolving market where a larger variety of treatment options are now available to choose from, safety and side-effects are coming under increasing scrutiny. Focusing marketing resources to more effectively message a therapy’s non-efficacy benefits, particularly building its ‘convenience’ profile, alongside a strong efficacy profile is likely to see it stand out from competitors and hence drive brand satisfaction.



## Helping Brands Stay Ahead

As the MS space continues to expand, the prescribing paradigm has shifted with an ever increasing variety of factors to consider when choosing a DMT. The emergence of digital applications and growing patient input could add another dimension to the rapid evolution of the MS market. In addition to knowing where windows of opportunity lie, understanding drivers and barriers to the prescription of each drug, the juxtaposition of these factors amongst competitors in the relevant climate and the complex processes inherent in making treatment decisions are paramount to identifying opportunities for your brand.

With a 19-year track record in MS market research, and currently available in Europe and the US (with other markets including Brazil, Canada, Australia and the Nordics run on a client need basis), the MS Therapy Monitor at Ipsos Healthcare employs a rigorous doctor perceptual and patient record methodology to help brands stay ahead of the competition. The Monitor allows subscribers to:

- **Know where competitors stand in the market**
- **Grasp the treatment climate, dynamics and patient flows**
- **Gain insight into physicians' perceptions of competing drugs and pharmaceutical companies**
- **Compare physicians' perceptions with actual prescribing behaviour**
- **Evaluate the drivers and barriers to prescription, and estimated market shares**
- **Identify threats to the brand**
- **Seek actionable opportunities for the brand, for a healthy uptake and to stay competitive**

By integrating comprehensive data on physician demographics, physician perceptions, patient demographics and treatment dynamics – and with the option of adding proprietary analytics or combining with custom research – the MS Monitor drives maximum understanding of where brand stands in the MS market.



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