# Impact of Quick Start and Bridge Programs on Rare Disease Therapy Initiation and Preventing Gaps in Therapy

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## Background

Patients with rare diseases often face high-cost therapies and significant hurdles related to insurance benefit design and coverage delays. The high cost of medication negatively impacts therapy initiation and increases abandonment, as one study found specialty drug abandonment rates of 32% to 75% when patient cost sharing is over $100. Without timely and affordable access to therapy, patients may experience delayed therapy initiation and decreased adherence, leading to poorer health outcomes.

Manufacturers offer support such as Quick Start (QS) and Bridge programs to provide temporary access to medications for eligible patients experiencing coverage delays. QS provides a patient's first fill during coverage delays, while Bridge provides continuity of therapy during temporary coverage gaps caused by insurance changes or reauthorization delays. This study aims to analyze the usage and impact of QS and Bridge programs. While patient support programs are accepted strategies for preventing gaps in therapy, published data that measures the impact of these programs in the rare disease space is limited.

## Objective

Assess the impact of QS programs on the initiation of therapy and quantify medication taking behaviors in terms of adherence among patients utilizing Bridge programs.

## Methods

This retrospective analysis evaluated patients who received QS or Bridge shipments between January 1, 2025 and January 31, 2026 using a national rare pharmacy database. The investigators conducted two separate analyses. The first analysis included five oral rare disease therapies initially launched with both QS and Bridge programs. The second analysis included an injectable therapy launched without a QS or Bridge program that later implemented a Bridge program.

The primary outcome of interest was medication adherence among patients on Bridge, measured by Proportion of Days Covered (PDC). All PDC analyses used 180-day observation windows. In the first analysis, PDC was calculated for all commercial insurance and Bridge patients across the five oral therapies. Then PDC was calculated only including the patients across the five oral therapies that received Bridge. Finally, this PDC was recalculated treating Bridge usage as gap days to assess the impact of Bridge program support on patient adherence. In the second analysis the same three PDC calculations were conducted looking at an injectable therapy, where the first PDC calculation included all commercial insurance and Bridge patients receiving the injectable therapy, the second PDC calculation only included patients on Bridge, and the third PDC calculation treated Bridge shipments as gap days. This second analysis of patients on the injectable therapy included an additional PDC measure, assessing PDC prior to Bridge program implementation from January 1, 2023 to January 31, 2024.

Secondary outcomes were assessed for the five oral therapies, and included QS and Bridge utilization patterns, average time to clean claim (TTCC), time saved to therapy initiation with QS (measured as days to first payable claim minus days to first QS shipment), and reasons for program ineligibility and therapy discontinuation.

## Results

### Adherence

**Figure 1: Oral Therapy PDC**

| Group | Number of Patients* | PDC |
|---|---|---|
| Oral Therapy Commercial Insurance and Bridge Patients | 1,857 | 86.7% |
| Oral Therapy Patients on Bridge | 268 | 92.8% |
| Oral Therapy Adjusted to Gap Days for Patients on Bridge | 268 | 78.0% |

*Total population counts are lower compared to other measures, as not all patients were on therapy long enough to calculate PDC
**Study timeframe: January 1, 2025 – January 31, 2026 unless otherwise noted

**Figure 2: Injectable Therapy PDC**

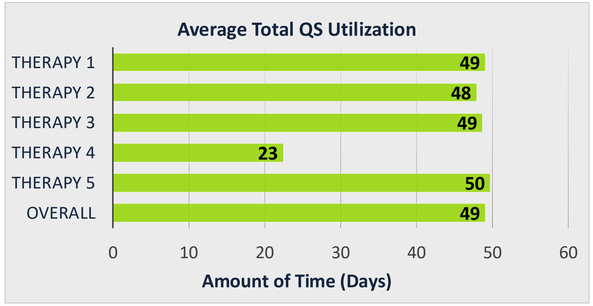
| Group** | Number of Patients | PDC |
|---|---|---|
| Injectable Therapy Pre-Bridge Implementation (January 1, 2023 – January 31, 2024) | 1,081 | 74.2% |
| Injectable Therapy Commercial Insurance and Bridge Patients Post-Bridge Implementation | 1,583 | 75.0% |
| Injectable Therapy Patients on Bridge | 26 | 82.8% |
| Injectable Therapy Adjusted to Gap Days for Patients on Bridge | 26 | 64.0% |

### Utilization

**Figure 3: QS and Bridge Utilization**

| Group | Count | Percentage of Patients that Utilized QS/Bridge > 1 Time |
|---|---|---|
| QS Shipments | 1,416 | |
| Bridge Shipments | 833 | |
| Distinct Patients that Utilized QS | 754 | 46% |
| Distinct Patients that Utilized Bridge | 454 | 33% |

**Figure 4: Average Total QS Utilization by Therapy**




### Quick Start Impact on Therapy Initiation

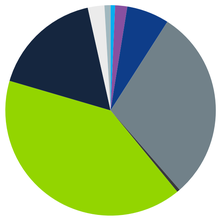
**Figure 5: QS Impact on Days Saved to Therapy Initiation**

| Therapy | Total Number of Patients | Average (Range) Days Saved to Therapy Initiation with QS | Number of Patients (Excluding Outliers)** | Average (Range) Days Saved with Outliers Removed |
|---|---|---|---|---|
| Overall | 749* | 38 (0 – 384) | 719 | 28 (0 – 178) |
| 1 | 571 | 33 (0 – 375) | 550 | 22 (0 – 121) |
| 2 | 42 | 47 (0 – 384) | 40 | 24 (0 – 178) |
| 3 | 8 | 16 (0 – 49) | 7 | 11 (0 – 37) |
| 4 | 2 | 9 (0 – 18) | 1 | 0 (N/A) |
| 5 | 126 | 60 (0 – 204 ) | 121 | 53 (0 – 171) |

*5 patients are missing from this count as compared to overall utilization counts due to not having received QS as their first shipment in the study timeframe
** The top 5% of values for each therapy were classified as outliers due to unique cases with prolonged prior authorization, appeals, or insurance changes

### Therapy Discontinuations

**Figure 6: Discontinuation Reasons**



| Discontinuation Reason | Number of Patients |
|---|---|
| Insurance-Related | 3 |
| Patient Deceased | 8 |
| Patient Unreachable | 28 |
| Unknown/Other | 127 |
| Transfer to Other SP/HUB | 2 |

| Discontinuation Reason | Number of Patients |
|---|---|
| Adverse Event (AE) | 174 |
| Patient or Prescriber Declined/Stopped Therapy (Unrelated to Cost or AEs) | 73 |
| Patient Receiving Alternate Therapy | 11 |
| Therapy Complete | 4 |

## Discussion

Two separate analyses were conducted to evaluate how Bridge use impacts medication adherence. The first included 268 patients on Bridge across five oral therapies, where Bridge was available at launch. Among oral therapy patients on Bridge, the average PDC was 92.8%, which decreased to 78.0% when Bridge usage was treated as gap days (statistically significant, $p < 0.001$). The second analysis included 26 patients on Bridge receiving the injectable therapy, where Bridge was added post-drug launch. A similar pattern to the oral therapy Bridge population was observed with the injectable therapy patients on Bridge, where average PDC was 82.8%, which decreased to 64.0% when Bridge usage was treated as gap days. The difference between the Bridge PDC and Bridge PDC adjusted to gap days was not statistically significant, primarily due to lack of a sufficient sample size. Since the Bridge program was added to the injectable therapy after launch, PDC was assessed before and after Bridge implementation (74.2% vs 75.0%, not statistically significant $p = 0.95$). These findings suggest that Bridge programs have a strong impact on PDC at the patient level but a minimal effect at the population level.

The secondary outcomes further evaluated the patient level impact of QS and Bridge. Between January 1, 2025 to January 31, 2026, 1,416 QS shipments (754 patients) and 833 Bridge shipments (454 patients) were dispensed. Nearly half of patients on QS (46%) and one-third of patients on Bridge (33%) used the program more than once. Average QS duration was 49 days. Due to variation in days' supply that may be dispensed through QS and Bridge, direct comparison across products is limited. To evaluate the benefit of QS programs on time to therapy initiation, time to clean claim (TTCC) was analyzed. When QS was used for the first shipment, the average TTCC was 54 days compared to 15 days when QS was not utilized for the first shipment (statistically significant, $p < 0.001$). Some patients who received a QS shipment did not subsequently obtain a clean claim from their insurance and were therefore excluded from this portion of the study.

Average time saved to therapy initiation was calculated for oral therapies by analyzing TTCC with QS use. Extreme outliers defined as the top 5% of values were excluded from the analysis. These outliers were primarily associated with prolonged prior authorization, appeals, or when patients had changes in insurance coverage. A total of 30 patients were excluded. After exclusion of outliers, the average time saved to therapy initiation with QS was 28 days compared to 38 days when outliers were included. Study limitations include patients who utilized QS due to high out-of-pocket costs despite having received a clean claim. In these instances, patients received QS after a clean claim, creating a negative value. For the purpose of this analysis, this value was set to zero, which may have resulted in an underestimation of the true impact of QS on time to therapy initiation.

Program ineligibility and discontinuation reasons showed no notable trends. The most common ineligibility reasons for both QS and Bridge were approval of prior authorization or claim resolution. The most common discontinuation reason was adverse events.

## Conclusion

This retrospective analysis demonstrated that QS and Bridge programs support timely access and medication adherence. Calculating the theoretical PDC with Bridge adjusted to gap days illustrated the dose disruption that would occur without Bridge support. Similarly, since patients must wait for a clean claim before they can receive their first commercial shipment, this data showed how much longer patients would have to wait to initiate therapy in the absence of QS. These findings illustrated the vital role of access programs in reducing medication delays and preventing treatment gaps in patients with rare disease.

## References

Ismail WW, Witry MJ, Urmie JM. The association between cost sharing, prior authorization, and specialty drug utilization: A systematic review. *J Manag Care Spec Pharm*. 2023;29(5):449-463.