# Patient Out-of-Pocket Costs for Guideline-Recommended Treatments for Erectile Dysfunction: A Medicare Cost Modeling Analysis



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## AIMS / PURPOSE

Patient out-of-pocket (OOP) cost represents a barrier to accessing treatment for erectile dysfunction (ED).

We sought to evaluate OOP costs incurred by men with ED covered by Fee-for-Service Medicare.

#### METHODS

The 2018 American Urological Association (AUA) guidelines were used to identify recommended ED treatments.

Coverage policies were obtained from the Medicare Coverage Database.

OOP costs were retrieved from the 2023 CMS Final Rule, or for treatments not covered by Medicare, OOP costs were extracted from GoodRx® or published literature and inflated to 2022 dollars.

Annual prescription costs were calculated using a published estimate of 52.2 instances of sexual intercourse per year.

The estimated number of Medicare patients with ED (n=254,650) was used to evaluate healthcare system implications.

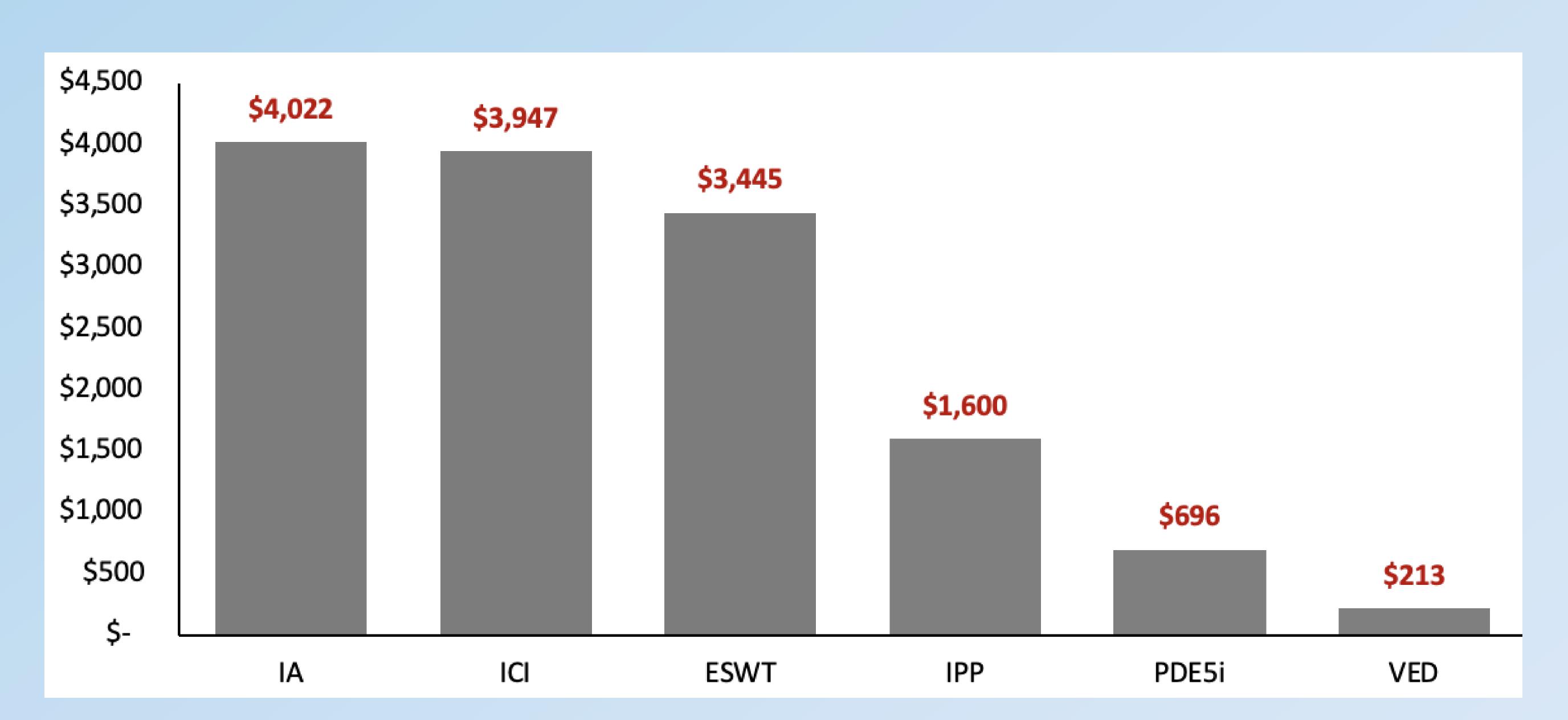
Table 1. AUA Guideline-Recommended Treatment Options for Erectile Dysfunction

Treatment Option	AUA Recommendation	Cost Analysis		
		Methodology	Unit	Cost Input Source
PDE5i	Strong	Out-of-pocket cost without coverage by Medicare Part D	Annual prescription	GoodRx® (sildenafil, Viagra, tadalafil, Cialis, vardenafil, Levitra, avanafil, Stendra)
IPP	Strong	Annual Medicare Part A outpatient copayment cap for 2023	One procedure	CMS 2023 (CPT 54405)
VED	Moderate	Out-of-pocket cost without Medicare coverage	One unit	DHHS 2013 and BLS 2023
ICI	Moderate	Out-of-pocket cost without coverage by Medicare Part D	Annual prescription	GoodRx® (Caverject and Edex)
IA	Conditional	Out-of-pocket cost without coverage by Medicare Part D	Annual prescription	GoodRx® (MUSE)
ESWT	Conditional (Investigational)	Out-of-pocket cost without Medicare coverage	One treatment course	Weinberger 2022

### RESULTS

American
Urological
Association

Figure 1. Annual Patient Out-of-Pocket Costs for Guideline-Recommended ED Treatments



ED, erectile dysfunction; ESWT, extracorporeal shock wave therapy; IA, intraurethral alprostadil; ICI, intracavernosal injection; IPP, inflatable penile prosthesis; PDE5i, phosphodiesterase type-5 inhibitor; VED, vacuum erection device.

# CONCLUSIONS

PDE5i and IPP are cost-effective options with strong guideline recommendations.

Better understanding of patient financial burden may improve shared decision making with patients who suffer from ED.

Advocating for improved coverage of treatments can help reduce the financial burden on patients and improve physician reimbursement

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