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What ASCO 2026 Means for Market Access

The annual meeting at ASCO sets the direction for oncology treatment. This year's data made clear how much access strategy will be required to get these therapies to patients.

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ASCO 2026 made clear that the next generation of therapies will succeed commercially if manufacturers solve the key access questions early, including biomarker readiness, evidence expectations, site-of-care friction, real-world adherence, and payer confidence. Not surprisingly, early collaboration between market access leaders and manufacturers to carefully plan access strategy will be essential in order to get the market there.

This year, ASCO's Annual Meeting (May 29-Jun 2, Chicago) drew more than 44,000 oncology professionals and delivered what some are describing as the most consequential data in years.[1] Adjuvant selpercatinib cut recurrence or death risk by 83% in resected RET fusion-positive nonsmall cell lung cancer (NSCLC), reinforcing calls for universal comprehensive biomarker testing even in early-stage disease.[1] Perioperative apalutamide paired with androgen deprivation therapy nearly tripled a near-complete pathologic response in high-risk localized prostate cancer while cutting metastasis or death risk by 20%.[1] And the phase III RASolute 302 trial delivered a rare unambiguous win in pancreatic cancer, with the investigational renin-angiotensin system (RAS) inhibitor daraxonrasib significantly extending survival in previously treated metastatic disease.[2]

Innovation is accelerating, and the standards of care built around it also need to evolve. These are precisely the types of dynamics that will raise the bar for market access.

Innovation Is Outpacing the Access Playbook

As oncology grows more specialized, the distance between FDA approval and patient access gets longer. Payers are looking beyond clinical efficacy alone; they want comparative value, real-world impact, biomarker strategy, and site-of-care implications answered before committing to coverage.

Results like LIBRETTO-432 make that dynamic concrete: A therapy tied so closely to biomarker status changes the payer's mindset. The main payer question, "Does this drug work?" changes to, "Is testing infrastructure and reimbursement in place to find the patients this drug works for?"[1] ASCO's own follow-on Breakthrough meeting in Singapore reinforced the same trajectory with sessions describing how early biomarker testing (eg, circulating tumor DNA [ctDNA] and minimal residual disease [MRD]) is moving steadily closer to directing treatment decisions in routine practice.[3] Every scientific advance is, in effect, a new access question manufacturers need to be ready for.

The Efficacy-Effectiveness Gap: A Different Kind of Access Question

RASolute 302 raises an access question beyond testing infrastructure. The headline result for daraxonrasib, a median overall survival of 13.2 months versus 6.7 months for chemotherapy, came with some meaningful toxicity. In fact, roughly one-third of patients in earlier-phase testing experienced grade 3 or higher treatment-related adverse events (TAEs),[4] and such a distinct side-effect signature functions almost like an unblinding code. This means patients and investigators alike may be able to infer the study arm from patient tolerability response. Patients randomized to chemotherapy, with no alternative available inside the trial, had every reason to stay on regimen despite adverse events. However, patients out in the wild—the real world—are not likely to share such constraint. Outside of the trial environment, patients and their providers will have alternative options, not to mention lower tolerance for staying on a regimen with difficult TAEs.

Calling this "the efficacy-effectiveness gap," we note a well-documented tendency for trial results and real-world outcomes to diverge pretty sharply. Closing that gap for RASolute 302 will depend less on the molecule and more on what gets built around it, which, of course, are (or should be) structures in the market access purview, including patient education, adherence support, and practice-level infrastructure designed to help patients stay the course. Converting a trial win to a real-world win requires a market access partner who can use data effectively to plan for persistence within the patient access journey.

Building Access Before the Launch

Who will come out ahead in access strategy? The organizations answering payer questions early and often will take the prize–meaning as early as the pipeline selection and drug development phase. It's worth repeating: This needs to be happening long before launch planning. Market access should no longer be considered a downstream commercialization activity; it belongs quite firmly at the table early enough to help shape evidence generation, value strategy, and stakeholder engagement. For a drug like selpercatinib with biomarker-driven approval, the case can be plainly made: Waiting until or after launch to align on testing pathways, site-of-care logistics, and payer evidence demands will result in the manufacturer playing catch-up for years on a strategy that should have started long before pivotal trials were designed.[1]

Turning Signals Into Strategy

At Payer Sciences, we use data, analytics, and our proprietary data-enabled platforms to begin to model the potential outcomes of policy shifts before they become an unhappy commercial reality for our clients. As providers, health systems, and payers adjust their own behaviors, our SPARK™ insights data-engine quantifies the downstream effects on access, utilization, contracting, and net revenue.

How do we turn complex market signals into strategies that support coverage, reimbursement, and provider confidence? We use our integrated analytics, AI-enabled payer intelligence, and evidence translation. Essential insights are established through our portfolio of products including PTO™, VOLT™, Gini Score, and n1Connect™, just to name a few.

The next wave of breakthroughs is already speeding through trial design. Organizations that plan access strategy in parallel with trial design will give their innovative therapies a much better chance of reaching the patients who need them most.

References:

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