New drugs are changing the prognosis of patients with cancers or hematologic malignancies. This is particularly true in multiple myeloma (MM) with not less than 10 new FDA-approved drugs in the past 10 years. However all new agents are usually very expensive and some of them are not affordable for patients who do not have optimal coverage or in low-income countries. Even in rich countries, the rapid increase of health care expenses raises the question of health care systems sustainability. Although the cost of new drugs represent only of part of this increase, efforts should be made to reimburse new agents at a fair price, otherwise health authorities may decide to stop coverage of effective but too expensive new agents, which was NHS decision for 17 anticancer drugs in September 2015. In MM, cost of newer agents is also an question for three reasons : more possibilities of relapse treatment increase the number of treated patients, patient are often treated for long periods of time, drug combinations are very expensive

The high prices proposed by pharmaceutical companies are usually not explained by production costs. They are mostly related to research and development(RD) costs and by health gain compared to existing therapies. However, recent examples (like sofosbuvir in VHC infection) clearly showed that benefits are rapidly beyond supposed RD costs. RD costs are generally obscure and may involve costs of previous drug development failures and of post-approval new clinical studies (in other indications)

Fair prices should be also based on a thorough assessment of the clinical benefit of a new agent compared to existing therapy. This is one of the objectives of Health Technology Assessement (HTA) agencies. However in many European countries, HTA currently includes some form of medico-economic assessment. The English NICE introduced 15 years ago the concept of incremental cost effectiveness ration (ICER) and currently uses thresholds (in £/ quality adjusted life years QALY) beyond which a new drug should not be covered. In France medico-economic assessment is used only as an argument for price negotiations

Payors should explore new modalities of payment (price-volume rebates, differential pricing, conditionnal coverage or performance-based pricing, payment for a patient pathway rather than for a drug)

Finally physicians should now pay more attention to efficiency (cost/efficacy ratio) of the therapeutic strategies they use. This implies that criteria for defining efficacy should be clearly defined (for instance PFS or overall survival for defining efficiency of SCT or of maintenance therapy)