National Cancer Control Programme

# NCCP Technology Review Committee (TRC)

## Meeting Notes

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| **Date of Meeting:** | **23rd January 2023 at 4.30pm** |
| **Venue :** | **Teleconference / NCCP Offices** |
| **Assessment:** | Niraparib (Zejula®) |
| | Nivolumab (Opdivo®) |

TEXT FOR REDACTION DUE TO DELIBERATIVE PROCESS HIGHLIGHTED IN YELLOW

TEXT FOR REDACTION DUE TO COMMERCIAL SENSITIVITY IS HIGHLIGHTED IN PINK

TEXT FOR REDACTION DUE TO CONFIDENTIALITY IS HIGHLIGHTED IN BLUE

**Attendance:**

| Members present | | |
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| NCPE representative | National Centre for Pharmacoeconomics (NCPE) | By 'phone |
| Ms AnneMarie De Frein | NCCP Chief I Pharmacist – Chair | By 'phone |
| Dr Ronan Desmond | Consultant Haematologist, Tallaght University Hospital: IHS representative | By 'phone |
| Dr Michael Fay | Consultant Haematologist, Mater Hospital: IHS representative | By 'phone |
| Prof Michaela Higgins | Medical Oncologist, St. Vincent's University Hospital: ISMO nominee | |
| Ms Ellen McGrath | PCRS representative | By 'phone |
| Dr Adrian Murphy | Medical Oncologist, Beaumont: ISMO nominee | By 'phone |
| Dr Jaruskha Naidoo | Medical Oncologist, Beaumont: ISMO nominee | By 'phone |
| Dr Dearbhaile O'Donnell | Medical Oncologist, St. James's Hospital: ISMO nominee | By 'phone |
| Ms Susan Spillane | HTA Directorate: HIQA nominee | By 'phone |
| Non-member invited specialists present | | |

| Apologies (members) | |
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| Dr Oscar Breathnach | Medical Oncologist, Beaumont: ISMO nominee |
| Observers present | |
| Ms Patricia Heckmann | AND NCCP |
| Ms Helena Desmond | Senior Pharmacist, NCCP |
| Dr Derville O'Shea | Consultant Haematologist, Cork University Hospital: NCCP Clinical Lead for Haemato-Oncology |

| Item | Discussion | Actions |
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| 1 | **Introduction & reminder re. conflict of interest & confidentiality** | |
| | Members were reminded to raise any conflicts of interest that they had in relation to any drug for discussion prior to the commencement of the discussion of that item.<br><br>Member were also reminded to return conflict of interest forms, if they had not already done so. | |
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| 2 | **Notes of previous meeting and matters arising** | |
| | The notes of the previous meeting on November 28th$^{th}$ 2022 were agreed. | |
| 3 | **Drugs/Technologies for consideration** | |
| | Niraparib (Zejula®) (**Ref. TRC 126)**<br>*As monotherapy for the maintenance treatment of adult patients with advanced epithelial (FIGO Stages III and IV) high-grade ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy.*<br><br>The clinical aspects of this indication were discussed. The supporting evidence for this indication is the phase III PRIMA trial, which evaluated the safety and efficacy of niraparib versus placebo in advanced ovarian cancer, for patients in complete or partial response to first-line platinum-based chemotherapy. The primary endpoint was progression free survival (PFS); the study demonstrated that the median PFS was 13.8 months in the niraparib arm vs 8.2 months on the placebo arm, showing a PFS advantage of 5 months. However, the overall survival (OS) data were immature with only 9.9% of patients experiencing an event in the niraparib arm vs 12.6% in the placebo arm. The safety profile was discussed, noting that niraparib is reasonably toxic, however given that niraparib is already available in a later line of treatment the clinicians are familiar with its management. There is a desire among clinicians to have this treatment option available, especially for these patients without *BRCA* mutation, who represent an unmet need. It was outlined that the only current treatment option for this patient cohort is bevacizumab, which is not suitable for many patients. It was noted that there is a lot of work ongoing in this space, which may impact treatment decisions in the coming years.<br><br>The pharmacoeconomic aspects as outlined in the HTA assessment carried out by the NCPE were discussed. The supporting evidence was outlined, noting that while the evidence to support this indication was considered robust, the review group raised a number of concerns including the immaturity of the OS data and the models used. The NCPE made a number of adjustments to the applicant's base case considering these uncertainties and limitations. In terms of the cost effectiveness, the ICER was outlined based on the NCPE adjusted base case at €84,671 per QALY. The applicant . The budget impact (BI) was outlined, with an a 5 year gross BI estimated to be €7.71 million and a net 5 year BI estimated to be €5.62million based on the list price. Considering the The recommendation of the review group was to recommend reimbursement.<br><br>Having considered the clinical efficacy of the indication in this patient cohort the committee members agreed unanimously to recommend approval of this indication to the HSE Drugs Group.<br><br>*(Decision: TRC 126)* | |

Nivolumab (Opdivo®) (**Ref. TRC 127)**

*In combination with ipilimumab for the treatment of adult patients with mismatch repair deficient (dMMR) or microsatellite instability-high metastatic colorectal cancer (MSI-H mCRC) after prior fluoropyrimidine-based combination chemotherapy.*

The clinical aspects of this indication were discussed. The supporting evidence for this indication is the phase II, single arm CheckMate 142 study, which evaluated the safety and efficacy of nivolumab in combination with ipilimumab in the treatment of dMMR or MSI-H metastatic colorectal cancer in the second line setting. The study showed that nivolumab plus ipilimumab lead to an objective response rate (ORR) (the primary endpoint) of 64.7% with a comprised complete response (CR) of 13% and a partial response of 52%. The exploratory outcomes of overall survival (OS) and progression free survival (PFS) were not reached, however at the 52-month time point there was an OS of 70.5% and a PFS of 52.8%. The safety profile was discussed, noting that the toxicities experienced in the CheckMate 142 study were in line with use of this combination in the treatments of other tumour types, and the clinicians are familiar with nivolumab/ipilimumab toxicity management.

There is a strong desire among clinicians to have this treatment option available to this patient cohort. It was outlined that there is a significant unmet need for this patient cohort as they do not typically respond to fluoropyrimidine-based chemotherapy due to the biological nature of MSI-H metastatic colorectal cancer and their disease tends to progress rapidly. It was discussed, that there is another immunotherapy currently in the assessment process for the treatment of dMMR or MSI-H metastatic colorectal cancer in the earlier, first line setting. The clinicians highlighted that the number of patients eligible for treatment in this indication would be anticipated to be small, especially if the earlier line of treatment were to be approved for reimbursement in the future.

The pharmacoeconomic aspects as outlined in the HTA assessment carried out by the NCPE were discussed. The NCPE review group noted the ongoing assessment process for an immunotherapy in an earlier setting for this patient cohort. If that were to be approved patients who progress following first line immunotherapy would then not be eligible to receive nivolumab plus ipilimumab in the second line setting. The review group highlighted a number of limitations of the trial including the open label, immaturity of the exploratory outcomes, lack of indirect treatment comparisons, and the prediction models used, all of which may affect its generalisability to the Irish clinical practice. Considering cost effectiveness, nivolumab plus ipilimumab has a higher cost in comparison to the standard of care chemotherapy with the cost per patient per treatment being €165,997.93 excluding VAT, €207,384.94 including VAT. Due to concerns and uncertainties highlighted in the HTA assessment, both the applicant and the NCEP review group made a number of adjustments to the modelling and the base case. The ICERS were outlined ranging between €53,000 to €57,000 per QALY using the list price. . The budget impact (BI) was outlined, with an estimated BI over 5 years to be €33.46 million based on the adjusted NCPE base case.

Having considered the clinical efficacy of the indication in this patient cohort the committee members agreed by a majority to recommend approval

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| | of this indication to the HSE Drugs Group.<br><br>*(Decision:TRC127)* | |
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| **4** | **Update on other drugs in the reimbursement process** | |
| | An update had been shared with the group in the documentation for the meeting | |
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| **5** | **Next meeting** | |
| | The proposed date for the next meeting is February 27th 2023 | |
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| **6** | **Any other business / Next meeting** | |
| | Dr O'Shea is now the NCCP National Clinical Lead for Haemato-Oncology, in line with the NCCP TRC ToR, Dr O'Shea's membership now defaults from a voting member to observer. The NCCP will seek a nomination for a new member from the IHS. | NCCP |
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The meeting concluded at 5.30pm.

**Actions arising from meeting:**

| Ref. | Date of meeting | Details of action | Responsible | Update |
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| 23/01 | 23.01.2023 | NCCP to communicate recommendations to HSE Drugs Group. | NCCP | Complete |
| 23/01 | 23.01.2023 | Write to IHS to request a nomination for a replacement member. | NCCP | Complete |