National Cancer Control Programme

NCCP Technology Review Committee (TRC)

Meeting Notes

Date of Meeting:	**4th September 2023 at 4.30pm**
Venue :	**Teleconference**
Assessment:	Atezolizumab (Tecentriq®)
	Azacitidine (Onureg®)
	Osimertinib (Tagrisso®)

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		
NCPE representative	National Centre for Pharmacoeconomics (NCPE)	By 'phone
Dr Dearbhaile Collins	Medical Oncologist, Cork University Hospital: ISMO nominee	By 'phone
Dr Michael Fay	Consultant Haematologist, Mater Hospital: IHS representative	
Ms Patricia Heckmann	AND NCCP (Chair)	By 'phone
Ms Ellen McGrath	PCRS representative	
Dr Dearbhaile O'Donnell	Medical Oncologist, St. James's Hospital: ISMO nominee	
Non-member invited specialists present		
Dr Megan Greally	Medical Oncologist, Beaumont:	By 'phone
Apologies (members)		
Dr Oscar Breathnach	Medical Oncologist, Beaumont: ISMO nominee	
Dr Ronan Desmond	Consultant Haematologist, Tallaght University Hospital: IHS representative	
Prof Michael O'Dwyer	Consultant Haematologist, Galway: IHS representative	
Dr Susan Spillane	HTA Directorate: HIQA nominee	
Observers present		
Ms Helena Desmond	Senior Pharmacist, NCCP	By 'phone

Item	Discussion	Actions

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.	
2	**Notes of previous meeting and matters arising**	
	The notes of the previous meeting on May 22nd 2023 were agreed.	
3	**Drugs/Technologies for consideration**	
	Atezolizumab (Tecentriq®) (Ref. TRC 138) *In combination with bevacizumab for the treatment of adult patients with advanced or unresectable hepatocellular carcinoma (HCC) who have not received prior systemic therapy.* The clinical aspects of this indication were discussed, the supporting evidence for this indication is the open-label, phase III, IMbrave150 trial evaluating the safety and efficacy of atezolizumab in combination with bevacizumab (atezo-bev) versus sorafenib. The study showed a progression free survival (PFS) improvement of ~ 2.5 months with a hazard ratio (HR) for progression or death of 0.59, a 41% reduction in death. A landmark analysis at 12 months showed a 13% improvement in overall survival (OS). Response rate was 27% in the atezo-bev arm versus 11% in the sorafenib arm. Of the 27% of patients who responded, 88% of those continued to respond up to 6 months. In an updated analysis OS was 19 months in the atezo-bev arm versus 13 months in the sorafenib arm with approximately 6 months improvement in survival. The limitations of the trial were outlined, such as the open-label nature of the study which may possibly have had impacted the quality of life data and the adverse event reporting. Overall HCC is a relatively rare disease in Ireland with limited treatment options. The IMbrave150 trial showed a clinically meaningful improvement for a reasonably well tolerated and less toxic treatment. There a strong desire among clinicians to have this treatment option available for this cohort of patients. The pharmacoeconomic aspects as outlined in the HTA assessment carried out by the NCPE were discussed. The current standard of care (SOC) with tyrosine kinase inhibitors (TKIs) sorafenib and lenvatinib was outlined, noting that the Applicant considered sorafenib to the preferred treatment option, however clinician feedback to the NCPE review group indicated that lenvatinib is the preferred treatment option in the Irish clinical setting. The supporting evidence was outlined and the NCPE review group highlighted a number of limitations with the study, such as the open label nature of the study, subsequent treatments received, patient population and the confounding of OS due to lack of adjustments. The review group also raised concerns regarding the lack of direct comparator evidence against lenvatinib. The ICERS were outlined, for the comparison with sorafenib in the Applicants base case, the ICER was €154,721 per QALY, and for the comparison with lenvatinib the Applicant's base case the ICER was €97,506 per QALY. The NCPE made a number of changes, for the comparison with sorafenib the ICER was €237,984 per QALY and for the comparison with lenvatinib the ICER was €215,813 per QALY. There is a PAS included on the bases of the PAS for atezolizumab, which was incorporated, however the ICERS still remain very high for the comparison with sorafenib the ICER is [redacted] In the NCPE adjusted base case the probability of cost effectiveness is 0% at both the at both the €20,000/QALY and €45,000/QALY threshold. In terms of budget impact (BI) it is estimated that 38 patients will be treated in year 1 rising to 58 in year 5. Based on the list price for atezolizumab and maximum acceptable price for bevacizumab the 5-year cumulative gross BI is estimated to be €33.10 million including VAT, and the 5-year cumulative net BI is estimated to be 19.9 million including VAT, however when the PAS for atezolizumab and lenvatinib are considered [redacted]	

[redacted] The recommendation of the NCPE review group was that atezolizumab in combination with bevacizumab not be considered for reimbursement unless cost-effectiveness can be improved relative to existing treatments.

Having considered the clinical efficacy of the indication in this patient cohort the committee members agreed by majority to recommend approval of this indication to the HSE Drugs Group.

(Decision: TRC 138)

Oral Azacitidine (Onureg®) (Ref. TRC139)

Maintenance treatment in adult patients with acute myeloid leukaemia who achieved complete remission or complete remission with incomplete blood count recovery following induction therapy with or without consolidation treatment and who are not candidates for, including those who choose not to proceed to, haematopoietic stem cell transplantation.

The clinical aspects of this indication were discussed, this is an oral formulation of azacitidine for maintenance treatment and is not intended to replace consolidation chemotherapy. The supporting evidence for this indication is the phase III, randomised, double blind, placebo controlled trial QUAZAR AML-001 trial, which evaluated the safety and efficacy of oral azacitidine versus placebo as maintenance treatment of patients >55 years with AML who have achieved a complete response (CR) and who are not candidates for haematopoietic stem cell transplantation (HSCT). The trial showed that, at a median follow up of 41.2 months there was a significant increase in overall survival (OS) with oral azacitidine compared to placebo (24.7 months vs 14.8 months). This was reflected in the relapse free survival compared to placebo (10.2 months vs 4.8 months). The safety profile was discussed, overall the safety profile is typical of what is expected of a myelosuppressant and cytotoxic agent in terms of GI and haematological toxicity and does not represent a barrier to treatment. There is desire among clinicians to have oral azacitidine available for this cohort of patients, those with intermediate or poor cytogenetic risk disease, as currently there is no other maintenance treatment available other than best supportive care.

The pharmacoeconomic aspects as outlined in the rapid review assessment carried out by the NCPE were discussed, noting that a full HTA was recommended, but not conducted. The proposed positioning in the treatment pathway, the supporting evidence for this indication was outlined, the NCPE review group highlighted a number of limitations of the trial such as, the restrictions on age and cytogenetic profile, and the variations in the prior induction and consolidation therapies used. In terms of the cost, the cost per pack of azacitidine 300mg tablets on the High Tech arrangement is €6,516.25. Cost per treatment course, assuming 14 days treatment per 28 day cycle is €170,749.In terms of the budget impact (BI), the Applicant estimates that 12 patients will be eligible in year 1, increasing by 13 annually in year 5. The NCPE review group highlighted concerns that this is a significant underestimation of the number of eligible patients. The BI was outlined based on the list price, [redacted] Commercial negotiations with the company are ongoing.

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.

	(Decision: TRC 139) Osimertinib (Tagrisso®) **(Ref. TRC140)** *Adjuvant treatment after complete tumour resection in adult patients with stage IB-IIIA Non-Small Cell Lung Cancer (NSCLC) whose tumour has epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations.* Discussion of this item was deferred and will be added to the agenda for the next meeting.	
4	**Update on other drugs in the reimbursement process**	
	An update had been shared with the group in the documentation for the meeting	
5	**Next meeting**	
	The proposed date for the next meeting is September 25th 2023	
6	**Any other business / Next meeting**	
	New members - the Chair welcomed Ms. Aishling McLoughlin, Chief I Pharmacist NCCP to replace Ms AnneMarie Defrein.	

The meeting concluded at 5.20pm.

Actions arising from meeting:

Ref.	Date of meeting	Details of action	Responsible	Update
23/01	04/09/2023	NCCP to communicate recommendations to HSE Drugs Group.	NCCP	Complete
23/01	04/09/2023	Apply for CPD	NCCP	Complete