PD-1 and PD-L1 checkpoint inhibitor immunotherapies: options for subsidy consideration for multiple cancer types

General/overall comments

Please note, comments that are beyond the scope of PD-1 and PD-L1 checkpoint inhibitor immunotherapies: options for subsidy consideration for multiple cancer types will not be considered

Specific responses

Please insert your comments against the consultation questions below.

Question 1

What do you/your organisation see as the potential advantages of the PBAC considering the PD-1 and PD-L1 checkpoint inhibitors for multi-tumour listings?

We see the potential to save lives by limiting the time that patients can access these drugs. Currently in some areas research is moving along faster than regulatory bodies can keep up especially in regard to genomics and molecular testing. In rare cancers such as neuroendocrine cancer where standard treatments are limited as well as Phase 1, 11 or 111 clinical trials many patients are opting for molecular testing to identify potential treatments. From studies PD – 1 and PD-L1 have been identified in the highly aggressive, poorly differentiated Neuroendocrine Carcinoma (NEC)(Roberts JA, 2017) and Merkel Cell Carcinoma (MCC) (Paul t, 2016) both these Neuroendocrine cancers have poor outcomes for patients in the absence of any accessible targeted therapy. Allowing clinicians to access PD-1 and PD-L1 checkpoint inhibitors through the PBAC for this small community without the burden of large scale clinical trials has the potential to save many lives.

Question 2

What do you/your organisation see as the potential disadvantages of the PBAC considering the PD-1 and PD-L1 checkpoint inhibitors for multi-tumour listings?

Representing a small but growing section of the community with poor outcomes we see no disadvantages to multi-tumour listings as it gives our patients access they would not usually have. If administered in a correct and safe way whilst gathering crucial data for future research, we see only advantages.

Question 3

What is urgent unmet clinical need? How should it be established? For which patient groups?

The urgent unmet clinical need is access to phase 1 and 11 trials outside of the metro hospitals, or oncologists not being aware of trials that are open. It falls to organisations like ours to educate the patient on what trials are available and where. Gov funding access for more trials through the MRFF for trials such as PD-1 for rare cancers will help but we also need to make sure patients can access them to improve recruitment numbers. More trials will help with access to first line treatments rather then ineffective treatments such as chemotherapy.

Question 4

What is the minimum level of evidence of effectiveness that you/your organisation think should be required before a PD-1 and PD-L1 checkpoint inhibitors is considered for subsidy for a particular kind of cancer? Why?

The minimum evidence we think should be required would be from phase 11, single arm, open label trials. For rare cancer patients they have usually exhausted all possible treatments and therapies so randomised trials are not an option and we do not have the patient numbers to suffice phase 111 RCT in their current state.

Question 5

Do you/your organisation think it is possible for the PBAC to be able extrapolate, or apply, the evidence of effectiveness of a checkpoint inhibitor in one kind of cancer to another kind of cancer, or from late stage cancer to early stage cancer? Why? How?

Yes, with the future of oncology going in the direction of gene speciality not location, for example PD-1/PDL-1 experts that can go across many different tumour origins, rather then a breast or bowel cancer specialist, we need to be adaptive in application also. Researcher are now looking at treatments and applications across gene mutations and building the evidence so that the PBAC can make a more informed decision if they are allowed to by their

governance.

Question 6

Do you/your organisation think it is possible for PBAC to satisfy itself that treatment with a PD-1 or PD-L1 checkpoint inhibitor is cost-effective without an economic model that is specific to that kind of cancer? How?

- Is it possible to group different cancer types together based on particular characteristics that are similar, and construct a single model for the group?
- Are other approaches to establishing cost-effectiveness across cancer types possible? What are those approaches and how would they operate?

Without understanding the health economics of this kind of modelling we may potentially see cost savings in time and effectiveness if numerous submissions do not need to be made if designing a single model for the group. Without also knowing the patient numbers it is hard to know, however, when you are looking at the rare cancer group costs for these patients to be able to access through a single model would be significantly reduced.

Question 7

What do you/your organisation think is a reasonable subsidy price for Government to pay for a PD-1 or PD-L1 medicines for cancer types where the benefit is potentially very modest?

With the absence of compassionate access that has seen its demise over the last few years, patients can be spending tens of thousands of dollars on potentially modest benefit. If these costs can be shared with government whilst appropriate data gathered to increase the potential benefit this would be advantageous to the whole community.

Question 8

Do you/your organisation think PD-1 and PD-L1 medicines should be made available to all patients whose cancers display a particular biomarker? Why? Which biomarker?

In rare cancers such as NEC and MCC, yes we do think that they should be made available especially in the absence of any other effective treatment.

Question 9

Do you/your organisation think it is appropriate for the PBAC to extrapolate the evidence from one PD-1 or PD-L1 checkpoint inhibitor to other medicines in the same class(es). This could provide patients with more choice and give Government the opportunity to negotiate better subsidy prices by utilising the competition between sponsors of medicines.

Yes we think this would be fair and advantageous. This also might encourage greater collaboration across the industry, knowledge sharing and joint clinical trials.

Question 10

Do you/your organisation think that different evidentiary requirements are appropriate for rare cancers? How do you think cost-effectiveness should be established in this case?

In rare cancers where patient numbers are lower and cannot reach the standard numbers for RCTs we think that the current requirements are unfair and unrealistic.

Question 11

Do you/your organisation think PBAC should set aside one of its meetings each year to consider only PD-1 or PD-L1 inhibitors for cancer? (This would mean no other submissions for other medicines, including other cancer medicines, or other diseases would be considered at that meeting.)

Without knowing the current demand for this I am not in a position to answer this. We may see a demand for BRAF, BRAC etc meetings at the same time also? Looking at only one type per meeting may disadvantage other patients.

Question 12

If limited evidence is available at the time of subsidy of a PD-1 or PD-L1 inhibitor for a type of cancer, what do you/your organisation think should happen afterwards?

- Should sponsors be required to collect more evidence?
- What should happen if the new evidence shows the medicine is less effective or has greater safety risks than expected?
- Should the medicine continue to be subsidised but at a price commensurate with its benefit? Should the sponsor be compelled to continue to make the medicine available even if it thinks the price is too low?

Sponsor should definitely be required to collect more evidence and with the use of innovative access models either have to reimburse the government or be paid a bonus depending on the agreed level of evidence. The medicine should be subsided but at price commensurate with its benefit. This may encourage industry to reinvest back into the medicine to make it more effective.

Question 13

(For industry/clinical groups) Clinical study information: (Please use the template provided for this information.)

- In what indications has your organisation completed clinical trials with a PD-1 and PDL1 inhibitor? Please include both positive and negative studies.
- In what indications is your organisation currently conducting or planning to conduct clinical trials with PD-1 or PD-L1 inhibitors? If usual PBAC processes were to be followed, when would you expect to make an application for subsidy for these indications?
- How does your organisation decide which indications to study and which to prioritise for registration or subsidy?

We are aware of the Avelumab study for MCC

Question 14

Are there effective international models for multi-tumour subsidy that could be applied in Australia within the current regulatory framework?

Potentially through the FDA rare access model

Question 15

(For Industry) What information can you provide regarding established international agreements for multi-tumour subsidy and how could these apply in the Australian regulatory context?

Question 16

Is there anything else you/your organisation would like to add?