

# Endpoints in expedited regulatory approval processes

An HTA Perspective

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# HTA seeks to establish the relative effectiveness of technologies

## *Efficacy*

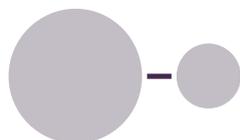
Incremental benefit of using a technology for a specific indication in ***ideal conditions*** of use, for example, in a strict protocol of a randomized controlled trial

## *(Comparative) Effectiveness*

***Comparative*** Incremental benefit of using a technology for a specific indication in ***general or routine conditions*** of use

Health technology assessment uses data submitted to the regulators on efficacy comparisons for relative effectiveness comparisons

NICE



The same evidence does not always mean the same decision

# Challenges for HTA in expedited approval processes

## Problem with clinical trial designs

- Not designed to inform clinical practice
- Adaptive designs/other master protocols difficult to interpret
- ***Surrogate endpoints have unclear relationship with OS and HRQL***

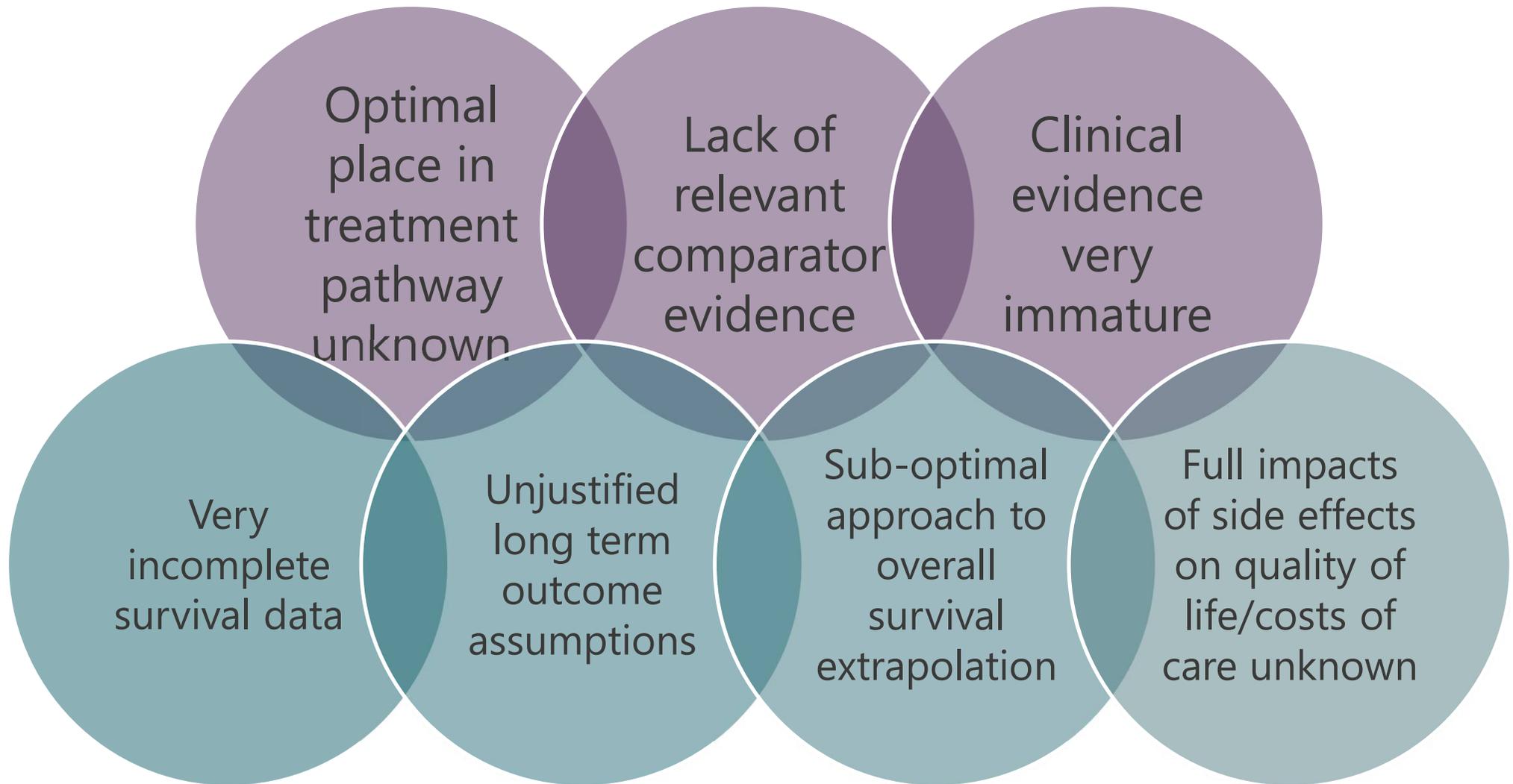
## Fewer comparative randomised clinical trials

- Increasing number of single arm trials
- Historical comparisons are not robust

## Increasing frequency of conditional approvals

- Survival outcome measurement not complete
- Ongoing data collection not 'tuned' to HTA requirements
- Increased uncertainty

# General issues in generation of clinical evidence generation for HTA



# TA517: Avelumab for Merkel cell carcinoma



- Avelumab is indicated as monotherapy for 'the treatment of adult patients with metastatic Merkel cell carcinoma.'
- Merkel cell carcinoma is a rare and aggressive cancer with limited treatment options.
- A conditional marketing authorisation was granted for first-line treatment.

# TA517: Pivotal trial evidence



JAVELIN 200 trial - a single-arm non-randomised trial:

- Part A: 88 patients with relapse after at least 1 line of chemotherapy - 2<sup>nd</sup>-line + group
- Part B: 39 patients who had not had previous systemic therapy for metastatic disease - 1<sup>st</sup>-line group

1 <sup>st</sup> -line		2 <sup>nd</sup> -line +	
ORR (3 months)	OS (median)	ORR (18 month)	OS (median)
62%	Not reached	33%	12.6 months

# TA517 Uncertainty issues - 1st-line use



## No head-to-head comparisons

- Single arm trial with small N
- Comparisons using observational study not robust
- No adjustment for prognostic factors
- Results from the indirect comparison were highly uncertain

## Immaturity of data

- N=29 with 3-month follow-up
- N=14 with 6-month follow-up

## Extrapolations

- OS and PFS derived from the second-line model by applying a HR based on assumptions, not using direct available evidence
- Committee preferred direct extrapolation from the trial
- PFS and OS estimates highly uncertain

# TA517 Uncertainty issues - 2nd-line use



## No head-to-head comparisons

- Comparisons using observational study not robust
- Results from the naive indirect comparison were highly uncertain.

## Subsequent treatments

- OS data confounded by the use of subsequent treatments
- No data on subsequent treatments were recorded

## Extrapolations

- OS and PFS were sensitive to method of extrapolation (spline-based vs Weibull approach)
- Extrapolated from 18-months data to a 40-year time horizon

# Options for bridging the evidence gap



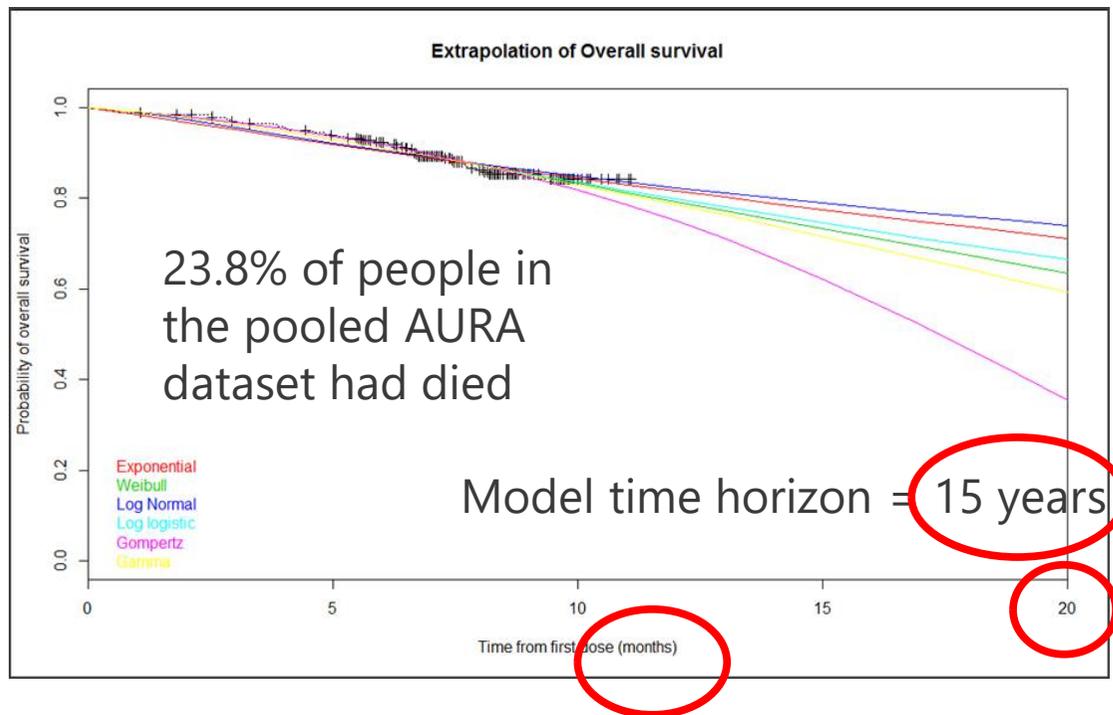
- Do nothing
- Quantitative
  - evidence synthesis, modelling
- Qualitative
  - dialogue, debate, interaction, consultation

# Uncertainty in overall survival gain is a big issue



TA416 Osimertinib - locally advanced/metastatic EGFR T790M mutation-positive NSCLC

**Immature survival data = uncertain long-term benefit = uncertainty in clinical and cost-effectiveness estimates**



## Osimertinib vs platinum-doublet therapy

Assumptions	ICER (£/QALY)
Company's	£41,705
Committee's preference (alternative extrapolation)	Between £60,663 and £70,776 <sup>a</sup>

<sup>a</sup>Dependent on utility estimates

# Bridging the evidence gap- key issues to consider as early as possible

- Optimisation of pivotal clinical trial design for HTA **and** identification of robust data to compare it with established practice
- Understanding the relationship between surrogate outcomes and mortality/health-related quality of life
- Justifying proposed extrapolation modelling approaches - based on plausibility and using data available to date - to deal with uncertainty
- Developing evidence generation plans → **increasing relevance of post-marketing authorisation studies** including clinical effectiveness

# Guidance on key aspects of NICE methods

## NICE Decision Support Unit Technical Support Documents

Welcome to a series of Technical Support Documents (TSDs) produced by the NICE Decision Support Unit.

These documents have been commissioned by NICE with the aim of providing further information about how to implement the approaches described in the current NICE Guide to the Methods of Technology Appraisal (2013).

The NICE Methods Guide does not itself provide detailed advice on how to implement and apply the methods it describes. This DSU series of Technical Support Documents is intended to help to fill that gap.

<http://nicedsu.org.uk>

**NICE**

### Flexible survival analysis approaches

#### Flexible survival methods:

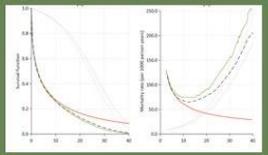
We consider a range of advanced survival techniques not covered by previous TSDs, but that have started to appear in use:

- **Flexible parametric survival methods** (splines, fractional polynomials).
- **Cure models.**
- Other **mixture modelling** approaches.
- **Piecewise models.**
- **Landmark approaches.**
- **Incorporation of external reference rates** (as a competing risks approach).

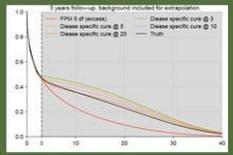
#### Be explicit:

- What is the shape of the hazard function in the short- and long-term? **Plot it.**
- What are the **assumptions** of the approach? Are they reasonable?
- Have you considered the **effect of ageing/competing mortality**?
- Plot the marginal hazard function based on reference or registry population rates. Do the extrapolated hazards look **reasonable** in contrast?
- Justify why the method being used is **appropriate** to capture the likely survival for the cohort.

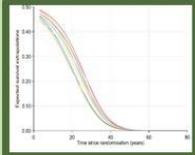
#### External data for ageing?



#### Plotting assumptions.



#### Uncertainty?



#### Short-term fit vs long-term assumptions:

- Allow sufficient flexibility of shape for hazard functions.
- May be a balance between the best method for extrapolation vs the best fit in the short-term.
- Evaluate and consider internal fit within the range of the data.
- Crucial also to consider what each approach assumes beyond the range of follow-up.
- Discuss the potential to couple complex modelling within the range of trial data with external information/data to make more plausible extrapolations.

**We simulate scenarios to stress our key points.**

#### General Recommendations:

- I. Fitted and extrapolated hazard and survival functions should always be presented.
- II. A plot of the expected (general population) survival and hazard functions should be given as context for extrapolations.
- III. Incorporation of background mortality should be strongly considered to avoid very poor extrapolations.
- IV. Consider other external information (e.g. registry data) to help model long-term survival. More research needed.
- V. Careful thought needed on how to extrapolate the effect of the intervention (long-term treatment effects).

All models make important assumptions and have limitations. Complex models do not solve all extrapolation problems, but may be useful

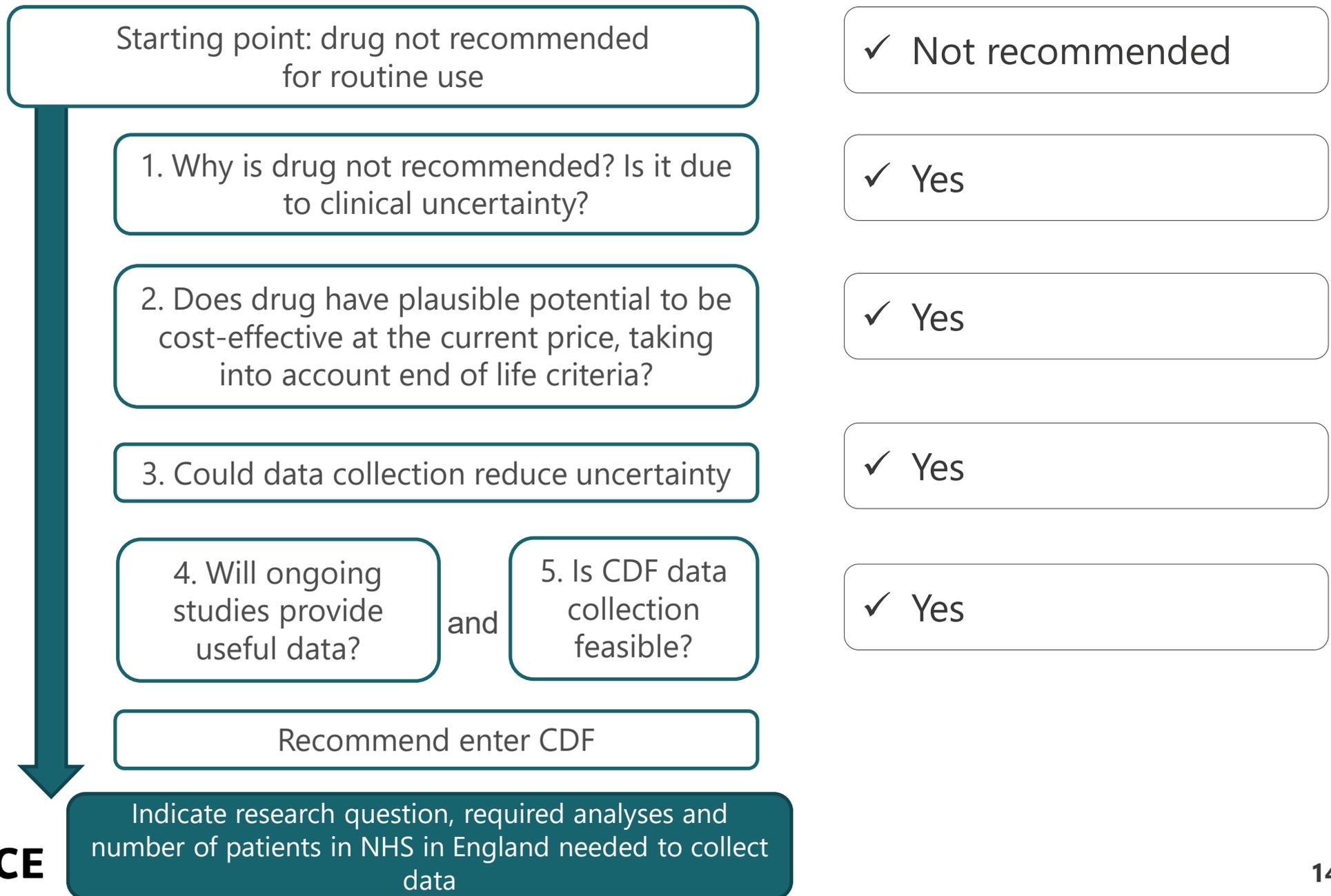
For further information: Technical Support Document 21 available from <http://nicedsu.org.uk>

# Bridging the evidence gap - the Cancer Drugs Fund and cancer drugs appraised by NICE

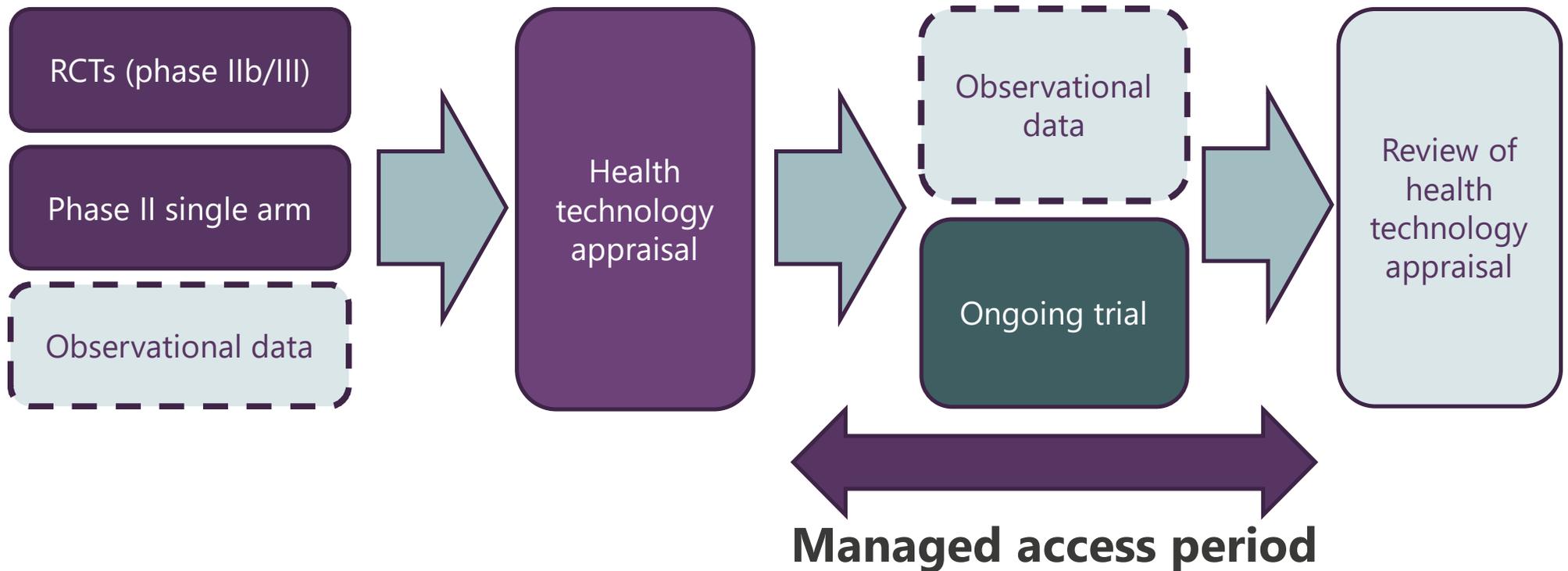
The NICE appraisal committee can make one of 3 recommendations for cancer drugs:

1. YES- recommended, the drug enters routine commissioning and will become available on the NHS
2. NO- NICE do not recommend the drug
3. Recommended for use within the CDF
  - The drug has **potential** to satisfy the criteria for routine commissioning but there is significant **clinical uncertainty** remaining which needs more investigation through real world data collection or clinical studies.

# Cancer Drugs Fund recommendation criteria



# What outcome data is collected whilst a drug is available on the CDF?



# Conclusions

- HTA bodies are most interested in 'final' end points
- It is crucial to
  - ✓ demonstrate a predictive relationship between the 'surrogate' and 'final' end point
  - ✓ anticipate what data is required to bridge from expedited regulatory processes into HTA
- Early dialogue with HTA bodies essential
  - ✓ NICE Scientific Advice and Office for Market Access
  - ✓ EUnetHTA
- Need to plan to reduce uncertainty and decision risk
  - ✓ Plans for post launch evidence generation must take account of HTA requirements
  - ✓ Pricing strategies important

# More information...

**NICE Scientific Advice:** [www.nice.org.uk/about/what-we-do/life-sciences/scientific-advice](http://www.nice.org.uk/about/what-we-do/life-sciences/scientific-advice)

**Office for Market Access:** [www.nice.org.uk/OMA](http://www.nice.org.uk/OMA)

**Technology Appraisals:** [www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance](http://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance)

**Cancer Drugs Fund:** [www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance/cancer-drugs-fund](http://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance/cancer-drugs-fund)