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Pharmaceutical Management Agency

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Dear all

Final Version 2 of the Prescription for Pharmacoeconomic Analysis (PFPA)

Thank you to those who responded to consultation on the draft version 2 of the Prescription for Pharmacoeconomic Analysis (PFPA). PHARMAC staff discussed the consultation responses in detail and also obtained further expert advice on a number of issues raised in consultation. As a result of the review of the PFPA and the issues raised in consultation, a number of amendments have been made to PHARMAC's recommended methodology for cost-utility analysis (CUA). These amendments were approved by the PHARMAC Board in April 2007.

The final version 2 of the PFPA is now available to download from the PHARMAC website: http://www.pharmac.govt.nz/pharmo_economic.asp. The key amendments to the PFPA are outlined below.

1. Discount rate
It is recommended that all costs and benefits in CUAs be discounted based on the five-year average real risk-free long-term government bond rate (3.5%). Rates of 0%, 5%, 10% will be included (without exception) in sensitivity analyses. Consultation responses on the proposed reduction to the discount rate indicated that there was wide support for the use of a lower discount rate.

It is not recommended that the discount rate for budget-impact analysis (BIA) be adjusted – this should continue to be based on the rate of 8%.

2. Estimating costs – inclusion of generic pharmaceutical prices
It is recommended that CUAs include the lower prices that PHARMAC is able to receive when generic pharmaceuticals are introduced in order to represent the true cost of the pharmaceutical.

3. Costs included in CUAs – direct patient healthcare costs
Direct patient healthcare costs should be included in CUAs as these are one of PHARMAC's decision criteria. However, these costs should be restricted to healthcare costs that government partially subsidises, and should be based on the cost to government plus the additional cost to the patient. These costs include General Practitioner visits, pharmaceutical co-payments and continuing care.

4. Review of clinical evidence
Clinical trials should be critically appraised using the Graphic Appraisal Tool for Epidemiology (GATE). The use of this tool should improve the consistency between evaluations of the clinical evidence and also ensure that all key issues are considered in a systematic manner when critiquing a clinical trial.

Details on the GATE framework, including critical appraisal spreadsheets, are available at: www.epiq.co.nz and http://ebm.bmj.com/cgi/content/full/11/2/35.

5. Inclusion/exclusion of statistically significant clinical events

It is recommended that all statistically significant clinical events be included in base-case analyses. For clinical events with a *p* value close to 0.05, consideration should be given to whether the results are likely to be clinically significant; the magnitude of the effect; the relevance and validity of composite measures; and also whether statistical significance has been demonstrated in an independent study.

6. Recommended treatment comparator

The definition of the comparator in the PFPA has been amended to the 'treatment that most prescribers would replace in practice at the time of pharmaceutical funding AND treatment prescribed to the largest number of patients (if this differs from the treatment most prescribers would replace)'. The PFPA also notes that is important to consider likely future practice (i.e. treatment regimens at the time the pharmaceutical is likely to be funded). This allows for any changes that may occur in treatment regimens over time.

PHARMAC will continue to update the PFPA. We welcome any further feedback.

Yours sincerely

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