

26 March 2009

Proposal to widen access to rituximab

PHARMAC is seeking feedback on a proposal relating to widening access to rituximab (Mabthera) from 1 July 2009. In summary, the proposal involves:

- allowing access to subsidised rituximab for the first-line treatment of indolent, low-grade non-Hodgkins lymphoma (NHL) for a maximum of 6 cycles;
- amending the restriction applying to large B-cell NHL to allow subsidised rituximab for use with non-anthracycline based multi-agent chemotherapy regimens in treatment-naïve patients where anthracyclines are contraindicated;
- amending the restriction applying to rituximab for re-treatment of relapsed low-grade lymphomas to require a treatment-free interval of at least 12 months;
- removing the discount on invoice that applies to rituximab sales to DHB hospitals; and
- adding a rebate to the sales of rituximab.

Feedback sought

PHARMAC welcomes feedback on this proposal. To provide feedback please submit it in writing by 4 pm on **Friday, 1 May 2009** to:

Jackie Evans
Therapeutic Group Manager
PHARMAC
PO Box 10 254
Wellington 6143

Email: jackie.evans@pharmac.govt.nz
Fax: 04 460 4995

All feedback received before the closing date will be considered by PHARMAC's Board (or Chief Executive acting under delegated authority) prior to making a decision on this proposal.

Details of the proposal

The Special Authority criteria applying to rituximab would be amended to read as follows from 1 July 2009:

Special Authority for Subsidy

Initial application — (Post-transplant) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 The patient has B-cell post-transplant lymphoproliferative disorder*; and
- 2 To be used for a maximum of 8 treatment cycles.

Initial application — (Low-grade lymphomas) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
 - 1.1 The patient has low grade NHL with relapsed disease following prior chemotherapy; and
 - 1.2 To be used for a maximum of 4 treatment cycles; or
- 2 Both:
 - 2.1 The patient has indolent, low grade lymphoma requiring systemic chemotherapy; and
 - 2.2 To be used for a maximum of 6 treatment cycles.

Initial application — (Large cell lymphomas) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of:

- 1 The patient has treatment-naive large B-cell NHL; and
- 2 To be used with a multi-agent chemotherapy regimen given with curative intent; and
- 3 To be used for a maximum of 8 treatment cycles.

Renewal — (Low-grade lymphomas) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

All of:

- 1 The patient has had a treatment-free interval of 12 months or more; and
- 2 Either:
 - 2.1 The patient has B-cell post-transplant lymphoproliferative disorder*; or
 - 2.2 The patient has low-grade NHL with relapsed disease following prior chemotherapy;
- 3 To be used for a maximum of 4 treatment cycles.

Indications marked with * are Unapproved Indications.

Whilst the listed price of rituximab would not change under this proposal, the discount on invoice that currently applies to sales of rituximab to DHB hospitals would no longer apply. Instead, a rebate arrangement would exist between PHARMAC and Roche Products NZ Limited.

Background

Lymphoma is a broad term encompassing a variety of cancers of the lymphatic system. About 80% of all lymphomas diagnosed are Non-Hodgkins Lymphoma (NHL). Low-grade NHL often grows very slowly, with median survival without treatment of between eight to ten

years. In asymptomatic patients, treatment may be postponed for a long time, a so-called 'watch and wait' approach, in symptomatic patients, current treatment may include radiotherapy with or without chemotherapy. Some types of low-grade NHL can be cured with treatment.

Rituximab, a monoclonal antibody, is indicated for the treatment of NHL, and is sold by Roche Products under the brand name Mabthera. Rituximab is listed in the Pharmaceutical Schedule as a Pharmaceutical Cancer Treatment (PCT), meaning that only DHB hospitals can claim for its use.

Rituximab is currently funded for the treatment of patients with relapsed low-grade NHL, patients with large B-cell NHL when given concurrently with CHOP (cyclophosphamide, vincristine, doxorubicin and prednisone) or alternative anthracycline-containing chemotherapy and patients with B-cell post transplant lymphoproliferative disorder. Rituximab re-treatment is currently funded following a treatment-free period of at least six months.

This proposal would widen funded access to rituximab for the first-line treatment of indolent, low grade NHL. Rituximab, when combined with other chemotherapy medicines, significantly increases overall survival, time to treatment failure, time to disease progression and response rate (compared with chemotherapy alone) in patients with low-grade NHL.

Following review of the evidence the Cancer Treatments Subcommittee of PTAC (CaTSoP) recommended that that rituximab be listed on the Pharmaceutical Schedule for use in combination with chemotherapy for patients with indolent low-grade NHL. CaTSoP gave this recommendation a high priority.

CaTSoP considered that the efficacy of rituximab had been demonstrated with a variety of chemotherapy regimens; therefore, there was no need to restrict a funding recommendation to one particular regimen. The Subcommittee considered that administration of rituximab would be associated with additional service costs for infusions, noting that the first infusion is to be given over six hours, whilst remaining infusions are given over 1.5 hours. CaTSoP further considered that although in some studies eight cycles of treatment were administered, in practice patients are likely to receive only six cycles.

The Subcommittee noted that although the application from Roche was for follicular NHL, there was evidence that rituximab treatment also improved outcomes in Mantle Cell Lymphoma, therefore the funding proposal is not limited to follicular NHL only.

This proposal would also extend the treatment free period required for the funding of rituximab re-treatment from 6 to 12 months or more. CaTSoP considered that the treatment free period should be extended to 12 months, since this was in line with common practice and six months was considered too early to determine true disease relapse rather than non-response to treatment.

Finally, the proposal would widen funded access to rituximab for patients with large B-cell NHL being treated with a non-anthracycline containing chemotherapy regimen given with curative intent. CaTSoP considered that the current rituximab Special Authority criteria was too strict in that it excluded some patients who would benefit from treatment but cannot tolerate, or have contraindications to, anthracyclines; such patients include those with heart conditions (e.g ischemic heart disease). CaTSoP considered that such patients would be given rituximab in combination with other multi-agent non-anthracycline containing regimen rather than CHOP. This would benefit a small number of patients who cannot tolerate, or have contraindications to, anthracyclines, for example patients with heart conditions.

It is anticipated that this proposal would result in approximately 200 additional patients accessing funded treatment annually.