Record of the Gastrointestinal Subcommittee of PTAC
Meeting held on 16 August 2021

Present from the Gastrointestinal Subcommittee:
Alan Fraser (PTAC member)
Murray Barclay
Michael Schultz
Jonathan Bishop

Apologies
Russel Walmsley (provided advice after the meeting)
Simon Wynn Thomas
Catherine Stedman
Sandy Dawson

1. Welcome and overview

1.1. This record is a summary of relevant discussion of the key issues and feedback relating to the proposed changes for access to adalimumab and is not to be considered an exhaustive detailed account of all discussions.

1.2. The purpose of this meeting was to discuss and provide feedback on the proposal to widen access to adalimumab and award Principal Supply Status to the citrate-free biosimilar brand of adalimumab (Amgevita), in advance of public consultation.

2. Discussion

2.1 The Gastrointestinal Subcommittee reviewed a paper from Pharmac staff regarding the proposed changes to the funding of adalimumab for patients treated for gastrointestinal indications.

2.2 The Subcommittee noted the proposed Special Authority criteria for access to the alternative brand of adalimumab (Humira) and considered these to be appropriate. The Subcommittee considered the minimum trial period of 4 weeks of treatment with Amgevita to be reasonable; however, noted that patients who experience an intolerable side effect after the first dose may not be willing to trial a second dose. The Subcommittee considered that depending on the severity of a single dose side effect, it may be reasonable to consider a waiver for these patients noting this would likely be a rare or infrequent phenomenon.

2.3 The Subcommittee noted that patients with severe Crohn's disease treated with Humira, considered at risk of severe loss of disease control, would be able to access the alternative brand without a trial of Amgevita, if considered necessary by their treating clinician.

2.4 The Subcommittee noted alternative brand access would enable access to Humira for existing patients only; all new patients would need to start on Amgevita from the list date to access funded treatment with adalimumab.

2.4.1 The Subcommittee noted that the widened access proposed would be specific to the Amgevita brand of adalimumab, with no changes in access proposed for Humira. The Subcommittee considered there may be some patients with severe Crohn's disease who do not wish to change to Amgevita treatment but may benefit from weekly dosing with adalimumab; however, would only have access to this dosing if they were to change to Amgevita. Members considered that it is likely that unstable patients are most likely to achieve the greatest benefit from weekly dosing. Patients with underlying unstable disease are likely to be considered for a change to Amgevita as they are at lower risk of further destabilisation and changing to Amgevita to access weekly dosing offers possible benefit above what is currently available. Members considered there may be some patients with severe Crohn's who do not change and could benefit from weekly dosing, and this should be considered by Pharmac.

2.5 The Subcommittees noted that increased access to adalimumab was a significant benefit of the proposed changes and would improve the access for the majority of funded indications.

2.5.1 The Subcommittee considered the proposed widening of access to Amgevita for patients with ulcerative colitis, noting this patient group would also benefit from dose escalation if required.

2.5.1.1 The Subcommittee considered the Special Authority critieria proposed for ulcerative colitis, based on the PTAC recommendation in November 2019, to be appropriate; however, recommended changes to enable use in paediatric patients. The Subcommittee noted that, whilst there is limited data on the use of adalimumab in paediatric ulcerative colitis, it has increasing use in clinical practice. Adalimumab has recently been FDA approved for use in paediatric moderate to severe colitis based on the ENVISION I study, with Amgevita Medsafe approved for use in paediatric patients 5 years or older.

2.5.1.1.1 The Subcommittee considered PUCAI (paediatric ulcerative colitis activity index) to be a straightforward clinical score with good predictive value in relation to disease activity and response to treatment. The Subcommittee noted the ENVISION I trial utilised Mayo score to document severity and disease response; however considered the Mayo score is rarely used in paediatric clinical practise and inclusion of the PUCAI scoring criteria would be the most appropriate option. Members noted there are limitations to score-based criteria when requiring prior steroid therapy and in the desire to avoid steroid dependence in children.

2.5.1.1.2 The Subcommittee considered there is a contradiction in the proposed paediatric Crohn's disease criteria noting that it restricts access to paediatric patients with severe, active Crohn's disease; however, requires PCDAI (paediatric Crohn's disease activity index) scores of ≥30 which is indicative of moderate disease activity and therefore allows a lower threshold of access. The Subcommittee considered scoring across both ulcerative colitis and Crohn's disease should be amended to PUCAI ≥35 to clinically define severe disease activity.

2.5.1.1.3 The Subcommittee considered the criteria for adult access to ulcerative colitis is based on SSCAI (simple clinical colitis activity index), for patients with severe disease as defined by a SCCAI of ≥4. Members considered there to be a well-established correlation between the full Mayo score and the SCCAI scoring system, noting both scales define moderate disease activity as ≥6; however, noted that the SCCAI does not require colonoscopy and is the established scoring tool used in New Zealand. The Subcommittee considered that, in the evidence supporting adalimumab use in ulcerative colitis, entry criteria was a Mayo score of ≥6 and therefore the SCCAI should be updated to reflect this same severity (Sandborn WJ. Gastroenterol Hepatol). The Subcommittee considered that it would be important to consider the same changes for infliximab.

2.5.1.1.4 The Subcommittee considered any changes to access criteria for ulcerative colitis and Crohn's disease should be consistently applied to access critieria to infliximab.

2.6 The Subcommittees considered the proposed changes to the Special Authority criteria for access to existing indications of adalimumab:

2.6.1 The Subcommittee considered the extension of renewal periods up to 24 months (2 years) would relieve pressure on specialists and reduce the administrative burden of reassessing stable patients every six months.

2.6.2 The Subcommittee considered the change to enable any relevant practitioner to apply for renewal Special Authorities would enable improved access to treatment for patients and improve continuity of access to treatment within the community setting.

2.6.3 The Subcommittees considered the removal of dosing restrictions and noted that for some patients, this would enable more effective disease control. The Subcommittee considered therapeutic drug monitoring be encouraged for clinicians prior to implementing increased dosing. Members noted that some patients have high neutralising antibodies to adalimumab and would not respond to increasing doses of adalimumab, presenting a fiscal risk if allowed to increase dosing without a corresponding health benefit.

2.6.4 The Subcommittee noted the severity score for access to adalimumab for patients with Crohn's disease required a CDAI (Crohn's disease activity index) score of ≥300, restricting access to severe Crohn's only. The Subcommittee considered a reduction to enable access for moderate-severe Crohn's based on a CDAI ≥220 should be evaluated as this would enable earlier access to effective biologic treatment for patients which may result in improved response and long-term outcomes. The Subcommittee considered a CDAI of ≥220 aligned with the clinical trials (CLASSIC I & II, and CHARM) supporting the efficacy of adalimumab in this patient group; however, noted this was not implemented at the time of adalimumab listing in 2009 due to the high cost of adalimumab. The Subcommittee considered there may be an increase in patient numbers of approximately 10-30% associated with this change however most patients would eventually progress to a CDAI ≥300 so the incremental increase in the patient group would be small. Members considered that any small increase in patient numbers would represent patients who unexpectedly improve without any change in treatment and therefore never progress to biologic treatment.

2.6.4.1 The Subcommittee considered that addition or replacement of CDAI with the Harvey-Bradshaw Index (HBI) scores should also be considered, noting CDAI is an impractical tool predominantly used in clinical trials whereas HBI is a widely used by clinicians and aligned with New Zealand practise.

2.6.4.2 Pharmac staff noted that whilst these changes could be considered, they may not be possible to assess as part of this proposal and evaluation could continue outside of this process.

2.6.5 The Subcommittee considered that the current Special Authority access criteria for Crohn's disease – fistulising, could be clarified to include 'complex perianal fistula's' and considered that this definition covers the existing criteria and therefore would be unlikely to result in any change in patient numbers, yet would provide a more explicit description of the patient group able to access treatment.

2.7 The Subcommittee noted the proposed listing and Principal Supply dates, with a seven-month transition for existing patients to change to Amgevita and considered these to be appropriate. The Subcommittee noted that prescribing throughout the transition period would need to be by brand, which could be a change in practise for some clinicians and would require careful communication.

2.8 The Subcommittee considered that not all patients would be reviewed by their specialist within the seven-month transition period as the duration between appointments can vary and some patients may therefore change to Amgevita in consultation with their primary health care team. The Subcommittee recommended that support and education be provided to assist with this, to provide confidence in the use of biologics and biosimilars, and specifically provide information and evidence supporting the use of Amgevita in this patient group. The Subcommittee considered communication of any change with patients was important and recommended engaging with primary care groups such as General Practitioners, nurses and pharmacists who may engage with patients managed on adalimumab, noting that a patients first interaction regarding the change is critical to ensure patients feel confident with the advice provided. The Subcommittee considered support for both patients and healthcare professionals would be valued in supporting a change and providing ongoing support for people using adalimumab. The Subcommittee noted that the supplier of Amgevita (Amgen) would provide support including education material and resources for healthcare professionals and patients, access to telephone and/or videoconferencing nurse support and general product support such as sharps bins.

2.9 The Subcommittee considered changing devices would be a significant component of any change for patients and noted that a citrate-free formulation and members feedback regarding the similarity between the Amgevita and Humira would assist in accepting a change.

2.10 The Subcommittee noted the importance of communication of any changes and engagement with relevant clinician and patient groups. The Subcommittee considered the New Zealand Society of Gastroenterology (NZSG) conference in November 2021 would be a good opportunity for Pharmac to ensure relevant stakeholders were aware of any changes.

2.11 The Subcommittee noted that public consultation on the proposed change would be released in the coming weeks and all members were able to submit individual feedback in response.