

May 2005 PTAC Meeting

PTAC minutes are published in accordance with the following definitions from the PTAC Guidelines 2002:

“**Minute**” means that part of the record of a PTAC or Sub-committee meeting (including meetings by teleconference and recommendations made by other means of communication) that contains a recommendation to accept or decline an application for a new investment or a clinical proposal to widen access and related discussion.”

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Emtricitabine (Emtriva) for treatment of HIV

The Committee considered the application for listing of emtricitabine (Emtriva) on the Pharmaceutical Schedule for the treatment of HIV.

It considered the strength of the evidence in support of this application to be fair and the quality to be fair to poor. The Committee's view was that, there was minimal evidence of equivalence and no evidence of superiority over lamivudine. It considered that emtricitabine had a similar therapeutic effect and genetic resistance profile to lamivudine. The Committee commented that, if funded, emtricitabine was likely to replace lamivudine in some patients.

The Committee noted the reduced pill burden associated with emtricitabine could potentially result in increased compliance but that this was likely to be the only benefit over lamivudine. It also noted that registration of the oral liquid had been delayed and commented that this product would therefore not be suitable for children.

The Committee also considered that emtricitabine might be associated with more side effects than lamivudine.

The Committee considered that there was no unmet health need that would be met by emtricitabine, as there are adequate alternative treatments. However, it considered that, if emtricitabine was funded, it would be used by treatment naïve HIV patients, those with CD4 counts of 200-400, as well as those who are poorly compliant with lamivudine.

The Committee **recommended** that the application to list emtricitabine on the Pharmaceutical Schedule be declined. The particularly relevant decision criterion is: *the clinical benefits and risks of pharmaceuticals*.

Pegylated interferon alpha-2a for non-cirrhotic genotype 2/3 Hepatitis C (HCV) plus HIV coinfected patients

The Committee considered an application for funding of Pegylated Interferon alpha-2a (PEG-IFN) in non-cirrhotic genotype 2 and 3 HCV and HIV co-infected patients.

The Committee noted that there were two studies that provided compelling evidence that sustained biological response could be achieved with PEG-IFN and ribavirin therapy in a substantial proportion of co-infected patients. It noted there is a significantly higher rate of a sustained biological response to PEG-IFN and ribavirin among patients infected with HCV genotype 2 or 3 than among those infected with genotype 1 or 4.

The Committee noted there was insufficient evidence to suggest whether 24 or 48 weeks of therapy is appropriate in genotype 2 or 3 co-infected patients. It noted that patients who did not have a virological response after 12 weeks of treatment with PEG-IFN and ribavirin were unlikely to have a sustained virological response.

The Committee considered that widening access would include 15 to 20 new patients and that prevention of new infection and control of co-infected patients immigrating to New Zealand would limit further growth of this patient group. It noted that approximately one third of HIV patients are co-infected with HCV.

The Committee **recommended** widening access of PEG-IFN and ribavirin to non-cirrhotic genotype 2 and 3 HCV and HIV co-infected patients with a high priority. It considered that Special Authority should include discontinuation of therapy in patients who do not have a virological response by week 12. The particularly relevant decision criteria are: *(i) the health needs of all eligible people within New Zealand; (ii) the particular health needs of Maori and Pacific peoples; (iv) the clinical benefits and risks of pharmaceuticals (v) the cost-effectiveness of meeting health needs by funding pharmaceuticals rather than using other publicly funded health and disability support services (if liver transplant).*

Widening access to candesartan (Atacand)

The Committee considered an application by AstraZeneca to widen the Special Authority access criteria for candesartan (Atacand) to include dual therapy in congestive heart failure (CHF) and hypertension, and to include proteinuria as a funded indication. The Committee noted that candesartan is currently funded for CHF and hypertension when a patient cannot tolerate ACE inhibitor(s), and further in hypertension when beta blockers or diuretics are contraindicated, or not well tolerated, or insufficient to control blood pressure adequately.

The Committee noted that candesartan was not registered for the treatment of proteinuria, and therefore did not consider the application for this indication any further.

The Committee considered that the evidence for the widened access of candesartan in CHF was of a good standard. It noted that there was a small (2%) but statistically significant difference in mortality and a decrease in hospitalisations in the evidence, but that there were high discontinuation rates in the studies. The Committee noted that the hospitalisation data provided was probably over estimated, and likely savings from reduced hospitalisations for CHF would not accrue long-term. It noted that the supplier claimed the cost of candesartan was offset by decrease in hospitalisations. The Committee noted that in the CHARM Preserved study there was no difference in mortality and that the modest benefit was in those with poor left ventricular function.

The Committee considered the evidence for the widened access of candesartan in hypertension. It noted that there was some evidence to suggest dual therapy (candesartan and lisinopril) was effective. The Committee did note that the studies were open label and of short duration (8 weeks). It also noted that there were no clinical endpoints and that an optimum dose of an ACE inhibitor was not used.

The Committee **recommended** that access be widened for candesartan to include dual therapy in CHF with a low priority. The particularly relevant decision criteria are: *(i) the health needs of all eligible people within New Zealand; (iv) the clinical benefits and risks of pharmaceuticals*

The Committee **recommended** that the application to widen access to candesartan for raised blood pressure be declined. The particularly relevant decision criterion is: *(iv) the clinical benefits and risks of pharmaceuticals.*

Latanoprost/timolol maleate (Xalacom)

The Committee considered an application from Pfizer New Zealand Limited for the listing of Xalacom (latanoprost 50 mcg/mL, timolol maleate 5 mg/mL, 2.5mL eye drops) on the Pharmaceutical Schedule. The Committee noted that the individual components, latanoprost and timolol maleate are listed on the Pharmaceutical Schedule, and that there were no problems currently with access to the individual components.

The Committee considered two randomised controlled trials comparing the combination product with latanoprost and timolol maleate administered concomitantly. The Committee considered the evidence showed that latanoprost and timolol maleate administered in a combination solution is slightly inferior to the individual components administered concomitantly. The Committee noted, that in the application, the supplier claimed that Xalacom is both cheaper and superior to the individual components administered concomitantly. The Committee noted that the efficacy claim was based on an incorrect conclusion in a published drug evaluation (Feldman 2004) and was not supported by the available evidence.

The Committee considered that, if listed, Xalacom would replace the individual components. It noted that, at the price proposed, this would result in a net cost to the Pharmaceutical Schedule because generic timolol maleate was significantly less expensive than the brand to which the timolol component of Xalacom had been referenced.

The Committee noted that a combination product would reduce the co-payment payable by patients, but that this would not benefit patients who qualified for the higher prescription subsidy. It noted that there could be an advantage in the elderly and those who needed supervision with medicines to improve compliance, but that this was not shown in the evidence.

The Committee did not consider that there was any significant clinical benefit associated with the product. It considered that any advantage gained by increased compliance was likely to be cancelled out by the reduced efficacy of the combination product compared with the individual components when used concomitantly.

The Committee considered that if Xalacom is listed on the Pharmaceutical Schedule, the access criteria should be no more restrictive than those applying to the individual components. However, the Committee **recommended** that Xalacom only be listed on the Pharmaceutical Schedule if cost neutral. The particularly relevant decision criteria are: *(i) the health needs of all eligible people within New Zealand; (iii) the availability and suitability of existing medicines, therapeutic medical devices and related products and related thing.* In addition, PTAC considered that, at the proposed price, there was justification for declining the proposal under the budgetary impact criterion. However, it considered that the criterion relating to direct costs to patients favoured the application.

Widening access to tiotropium bromide (Spiriva)

The Committee considered an application by Boehringer Ingelheim (NZ) Limited to widen access to tiotropium bromide powder for inhalation (Spiriva) from patients with FEV₁ < 40% predicted to include patients with FEV₁ < 60% of predicted. It noted that Spiriva was listed on the Pharmaceutical Schedule in February 2005, following examination of data and cost-utility analysis by PTAC and the respiratory sub-committee of PTAC.

The Committee noted that the new evidence and sub-group analysis of previous evidence presented did not contribute anything to that previously accepted by PTAC. It considered that the evidence alone did not support the widening of access. The Committee noted however that there was no evidence of clinical risk associated with the use of tiotropium patients who have an FEV₁ > 40% but < 60% of predicted .

The Committee considered that, although there was little clinical evidence to support lowering the FEV₁ threshold, it noted that, as there was no associated clinical risk, there was no clinical reason not to lower the FEV₁ threshold to include patients with a FEV₁ < 60% predicted.

The Committee **recommended** that access should be widened to Spiriva only if a cost-neutral or cost-saving agreement could be reached with the supplier. The particularly relevant decision criteria are: (i) *the health needs of all eligible people within New Zealand*; (ii) *the particular health needs of Maori and Pacific peoples*; (iii) *the availability and suitability of existing medicines, therapeutic medical devices and related products and related things*; (iv) *the clinical benefits and risks of pharmaceuticals*; (v) *the budgetary impact (in terms of the pharmaceutical budget and the Government's overall health budget) of any changes to the Pharmaceutical Schedule*; The Committee noted that if a cost-neutral or cost-saving agreement could not be reached, given there was little or no evidence of clinical benefit it would not recommend widening of access to Spiriva.

Growth Hormone for adults

PTAC had considered an application from the NZ Society of Endocrinology requesting access to Growth Hormone for adult patients who had severe sequelae from their growth hormone deficiency at its meeting of February 2004. At that meeting it recommended the application for funding for adults be declined.

PTAC again considered the issue of adult access to Growth Hormone treatment at its meeting of February 2005, but noted the absence of documentation for the clinical trials supporting the NICE recommendations. PTAC requested that it view the clinical papers considered by NICE before making any further recommendations.

PTAC considered a number of studies including the 18 randomised controlled trials of Growth Hormone treatment for growth hormone deficient adults that measured changes to quality of life and other parameters, as identified by the two technical assessments considered by NICE. It noted that there were some problems with the data including the short duration of the trials, different measures of quality of life and a mixture of patients and dosages used. PTAC noted that overall the trials failed to demonstrate a significant benefit of treatment.

PTAC considered that in the clinical trials reviewed, the instruments used to determine treatment benefits may have not been robust enough and may have underestimated the benefits.

However, PTAC noted that with the most favourable cost-effectiveness estimate being £45,000 (pounds) per QALY the treatment was very expensive.

The Committee noted some of the benefits in terms of lowered cholesterol, improvements in mood and increased bone density but noted that other treatments were available at significantly lower cost that would achieve those benefits.

The Committee noted that there might be a case for using Growth Hormone to treat adult patients with growth hormone deficiency who suffered episodes of hypoglycaemia, but noted that such patients were few. The Committee noted that one adult patient with hypoglycaemia had been funded for Growth Hormone through Exceptional Circumstances and that this could be an avenue to fund a small number of appropriate patients, if required.

The Committee noted that having reviewed the clinical papers it was even less supportive of funding of Growth Hormone treatment for adults than previously and **recommended** that the requests for funding of Growth Hormone treatment for adults be declined. The particularly relevant decision criterion is: *(i) the clinical benefits and risks of pharmaceuticals.*