CADTH

CADTH REIMBURSEMENT REVIEW

Stakeholder Feedback on Draft Recommendation

ETRASIMOD (Velsipity)

(Pfizer Canada ULC)

Indication: For the treatment of adults with moderately to severely active ulcerative colitis (UC) who have had an inadequate response, lost response, or were intolerant to either conventional therapy or an advanced treatment.

August 1, 2024

CADTH

CADTH Reimbursement Review
Feedback on Draft Recommendation

Stakeholder information	
CADTH project number	SR0795-000
Brand name (generic)	Velsipity® (etrasimod)
Indication(s)	ulcerative colitis
Organization	Gastrointestinal Society
Contact information[a]	Jaymee Maaghop

Stakeholder agreement with the draft recommendation		
1. Does the stakeholder agree with the committee's recommendation.	Yes	☒
	No	☐

We agree with the recommendation overall but find the language on pricing and negotiation confusing.

Specifically, there is a discrepancy between the summary on page 3 and the details on pages 4-5. On page 3, under the Rationale for the Recommendation, it states that "total drug cost of etrasimod should not exceed the total drug cost of the least costly advanced therapy reimbursed". However, pages 4-5 claims that etrasimod "does not exceed the drug program cost of treatment with the least costly **relevant advanced therapy** reimbursed". From public drug plan feedback and implementation questions, it appears that the "relevant advanced therapy" is ozanimod (Zeposia®). Public drug plans also see ozanimod as the appropriate comparator for etrasimod in the decision-making process (page 8), further highlighting that "there would be no concern if criteria and pricing is in line with recently negotiated ozanimod… etrasimod would need confidential pricing equal to ozanimod as they are both in the same class of drugs S1P modulators" (page 11). To ensure consistency and clarity in reimbursement condition, all language related to pricing negotiations should explicitly include "relevant advanced therapy comparators."

However, we do support several aspects of this recommendation, including:

- leaving determinations on clinical response and remission up to the treating physician, recognizing that there are ongoing challenges with accessing endoscopies in a timely manner and their associated healthcare costs to the system
- allowing physicians experienced in the treatment and management of ulcerative colitis to prescribe etrasimod
- the acknowledgment of ulcerative proctitis, a subgroup representing up to 30% of all patients living with ulcerative colitis in Canada, despite the manufacturer not applying for this indication. We value the inclusion of this disease by the CDA based on the Clinician Group input that they received.
- the use of appropriate comparators for cost and cost-effectiveness on page 19, since it focused on advanced therapies such as biologics and small molecules, and did not include conventional therapies. This approach differs from previous recommendations, such as the one for ozanimod, where conventional therapies were included.

Thank you, CDA, for recognizing the importance of having a variety of treatments available for ulcerative colitis, especially oral medications such as etrasimod! In our 2024 survey report on the Unmet Needs in IBD,[1] 82% of 651 respondents said they are at least somewhat concerned about running out of options and 30% indicated having difficulty with obtaining coverage for their

medications. This positive recommendation supports patients who will potentially be able to receive public coverage of a critical medication for their chronic condition.

Expert committee consideration of the stakeholder input

2. Does the recommendation demonstrate that the committee has considered the stakeholder input that your organization provided to CADTH?	Yes	☒
	No	☐

Yes, and we are grateful that CDA provided more information about the disease in the Background section. This includes information on the rate of relapse among patients, the prevalence of those experiencing an aggressive course of the disease, especially estimates on how many live with moderate and severe disease, and the increased risk of other complications that can make life more challenging for patients living with ulcerative colitis.

As a patient organization, this portrays to us that CDA sees the complexities of a disease such as ulcerative colitis, and the diverse challenges that patients experience, including how these factors underscore the need for varied and nuanced treatment strategies.

Clarity of the draft recommendation

3. Are the reasons for the recommendation clearly stated?	Yes	☒
	No	☐

4. Have the implementation issues been clearly articulated and adequately addressed in the recommendation?	Yes	☒
	No	☐

We want to acknowledge several notable improvements in transparency reflected in this draft recommendation. The increased detail on the views of public drug plans provides us with a clearer understanding of the factors influencing decision-making processes in CDA and within public drug plans, which we greatly appreciate as patients and patient representatives. This includes the recognition by drug plans on the advantages of etrasimod, such as the absence of induction dosing and the lack of handling precautions required. The recommendation also called out the inherent limitation with calculating the medication's budget impact given the reality that public drug plans engage in confidential pricing negotiations.

However, we encourage CDA to conduct research, such as horizon scans, on predictors of disease response to advanced therapy since this is an ongoing gap in ulcerative colitis. CDA already did some work in this in a 2023 horizon scan,[2] but more needs to be done focusing on treatment sequencing in ulcerative colitis.

This is a significant need and we do not support the requirement for patients to fail conventional therapies in order to receive coverage for advanced treatments. We believe that patients and their treating physicians should have access to all the tools in the toolbox to treat their disease, and there is increasing evidence supporting the early use of advanced therapies for better patient outcomes. We have been calling for this in many of our feedback documents to CDR recommendations. The clinical expert also highlighted this, and the importance of avoiding additional costs to the healthcare system and patients when managing the side effects of corticosteroids. Public drug plans *know* that this is incurring costs, as it states on page 9 that 20-40% of patients on conventional therapy do not respond to treatment. This is a significant number of patients that should not have to endure unnecessary suffering based on outdated practices!

5. If applicable, are the reimbursement conditions clearly stated and the rationale for the conditions provided in the recommendation?	Yes	☐
	No	☒

Please see responses to Questions 1 and 4.

[a] CADTH may contact this person if comments require clarification.

Appendix 1. Conflict of Interest Declarations for Patient Groups

- To maintain the objectivity and credibility of the CADTH drug review programs, all participants in the drug review processes must disclose any real, potential, or perceived conflicts of interest.
- This conflict of interest declaration is required for participation. Declarations made do not negate or preclude the use of the feedback from patient groups and clinician groups.
- CADTH may contact your group with further questions, as needed.
- Please see the *Procedures for CADTH Drug Reimbursement Reviews* for further details.

A. Patient Group Information	
Name	*Jaymee Maaghop*
Position	*Health Policy & Outreach Manager*
Date	*31-07-2024*
☒	I hereby certify that I have the authority to disclose all relevant information with respect to any matter involving this patient group with a company, organization, or entity that may place this patient group in a real, potential, or perceived conflict of interest situation.

B. Assistance with Providing Feedback		
1. Did you receive help from outside your patient group to complete your feedback?	No	☒
	Yes	☐
2. Did you receive help from outside your patient group to collect or analyze any information used in your feedback?	No	☒
	Yes	☐

C. Previously Disclosed Conflict of Interest		
1. Were conflict of interest declarations provided in patient group input that was submitted at the outset of the CADTH review and have those declarations remained unchanged? If no, please complete section D below.	No	☐
	Yes	☒

D. New or Updated Conflict of Interest Declaration

3. List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.

Company	**Check Appropriate Dollar Range**			
	$0 to 5,000	**$5,001 to 10,000**	**$10,001 to 50,000**	**In Excess of $50,000**
Add company name	☐	☐	☐	☐
Add company name	☐	☐	☐	☐
Add or remove rows as required	☐	☐	☐	☐

[1] Gastrointestinal Society. Unmet Needs in IBD Survey Report. Available at: https://badgut.org/2024-ibd-survey-results/.
[2] Mendell A *et al.* An Overview of Emerging Trends and Technologies in Ulcerative Colitis: CADTH Horizon Scan. *Canadian Journal of Health Technologies.* 2023;3(7). https://www.cadth.ca/overview-emerging-trends-and-technologies-ulcerative-colitis.

CADTH

CADTH Reimbursement Review
Feedback on Draft Recommendation

Stakeholder information	
CADTH project number	SR0795-000
Brand name (generic)	Velsipity
Indication(s)	etrasimod
Organization	Crohn's and Colitis Canada
Contact information[a]	Name: Patrick Tohill

Stakeholder agreement with the draft recommendation

1. Does the stakeholder agree with the committee's recommendation.	Yes	☐
	No	☒

Please explain why the stakeholder agrees or disagrees with the draft recommendation. Whenever possible, please identify the specific text from the recommendation and rationale.

We believe that the committee has ignored etrasimod's value as a first line therapy, as well as its benefit as an oral therapy. The requirement that patients must first *try and fail* on other conventional or advanced therapies first flies in the face of the advice given by the clinician group that "as a first-line advanced therapy and could also be used as a second- or third-line agent in selected cases for UC treatment" as well as the advice of the expert clinician who recommended "etrasimod should be considered and administered to patients with UC earlier in their disease course".

The clinician group further emphasized that etrasimod has several advantages over other advanced therapies including: "(1) oral delivery, (2) a once-daily dosing regimen, (3) efficacy in all patient subgroups including those with limited proctitis (the clinician group noted that the UC patients with ulcerative proctitis have been excluded from previous clinical trials but they represents up to 30% of the overall UC population), and (4) a favourable long-term safety compared to existing oral alternatives including ozanimod, upadacitinb and tofacitinb."

The recommendation report further states in table 2 column 2 on page 9 that "The clinical expert noted the evidence suggests the efficacy of etrasimod diminishes with more drug failures. Therefore, to optimize the efficacy, the clinical expert suggested that etrasimod should be considered and administered to patients with UC earlier in their disease course (i.e., trial of conventional therapy prior to initiation of moderate to severe UC would not be required)". It is disappointing and certainly not in the best interest of patients that this feedback is ignored in favour of a requirement that patients must first try and fail other therapies before being prescribed etrasimod when there is seemingly clinical consensus that it is useful as first line option and indeed there is some risk when it is not introduced early enough in the course of disease progression.

Our submission likewise spoke both to etrasimod's value in helping patients move away from corticosteroid use and its value as an oral therapy but our feedback was scarcely acknowledged in the report and like that of the other patient group, the clinician group and the expert clinician, has been ignored.

Expert committee consideration of the stakeholder input

2. Does the recommendation demonstrate that the committee has considered the stakeholder input that your organization provided to CADTH?	Yes	☐
	No	☒

If not, what aspects are missing from the draft recommendation?

The committee has failed to take into account the patient feedback we submitted that makes clear that patients would like to avoid steroid use if at all possible. For example, we stated that “Almost all patients surveyed agree that they only take systemic steroids if absolutely necessary (93%) with four in five in agreement that they wish they could eliminate systemic steroids from the list of medications they use. Half of respondents say that systemic steroids is/was a burden in their UC management.” As noted in our submission this is especially true for those with moderate to severe forms of UC. Some 71% of respondents in the survey we cited in our submission and 90% of those with a severe state of UC indicated that they have experienced adverse side effects from systemic steroid use. This is particularly the case for women who we noted “are more likely than men to find it important to ensure they have enough treatment options, understand the side effects of long-term use, and minimize the use of steroids.”

The draft recommendation once again gives short shrift to patient feedback reducing our feedback and that of the other patient group who provided input to a mere five lines in the report. We are particularly nonplussed to see that the input we gave on etrasimod’s value as an oral medication was not acknowledged so we will repeat it here: “Patients noted the convenience of pill-based administration, not needing to worry about refrigerating the medication and not having to travel to a clinic for infusions. One patient described the switch to an oral therapy as having been “amazing” in terms of its impact on quality of life, adding: ‘Being hooked up to an IV for six hours, no thank you. Injecting yourself with biologics, no thank you.’.”

Clarity of the draft recommendation		
3. Are the reasons for the recommendation clearly stated?	Yes	☒
	No	☐
If not, please provide details regarding the information that requires clarification.		
4. Have the implementation issues been clearly articulated and adequately addressed in the recommendation?	Yes	☐
	No	☐
If not, please provide details regarding the information that requires clarification. Declined to answer this question.		
5. If applicable, are the reimbursement conditions clearly stated and the rationale for the conditions provided in the recommendation?	Yes	☐
	No	☐
If not, please provide details regarding the information that requires clarification. Declined to answer this question.		

[a] CADTH may contact this person if comments require clarification.

Appendix 1. Conflict of Interest Declarations for Patient Groups

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- CADTH may contact your group with further questions, as needed.
- Please see the *Procedures for CADTH Drug Reimbursement Reviews* for further details.

A. Patient Group Information	
Name	*Patrick Tohill*
Position	*Director, Advocacy and Government Affairs*
Date	*26-07-2024*
☒	I hereby certify that I have the authority to disclose all relevant information with respect to any matter involving this patient group with a company, organization, or entity that may place this patient group in a real, potential, or perceived conflict of interest situation.

B. Assistance with Providing Feedback		
1. Did you receive help from outside your patient group to complete your feedback?	No	☒
	Yes	☐
If yes, please detail the help and who provided it.		
2. Did you receive help from outside your patient group to collect or analyze any information used in your feedback?	No	☐
	Yes	☒
If yes, please detail the help and who provided it. Yes. The initial analysis of the data in the first survey cited in our feeback was conducted by Leger.		

C. Previously Disclosed Conflict of Interest		
1. Were conflict of interest declarations provided in patient group input that was submitted at the outset of the CADTH review and have those declarations remained unchanged? If no, please complete section D below.	No	☐
	Yes	☒

D. New or Updated Conflict of Interest Declaration

3. List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.

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	$0 to 5,000	**$5,001 to 10,000**	**$10,001 to 50,000**	**In Excess of $50,000**
Add company name	☐	☐	☐	☐
Add company name	☐	☐	☐	☐
Add or remove rows as required	☐	☐	☐	☐

Canada's Drug and Health Technology Agency

CADTH Reimbursement Review

Feedback on Draft Recommendation

Stakeholder information	
CADTH project number	SR0795
Name of the drug and Indication(s)	Etrasimod (Velsipity) for the treatment of adults with moderately to severely active ulcerative colitis (UC) who have had an inadequate response, lost response, or were intolerant to either conventional therapy or an advanced treatment
Organization Providing Feedback	FWG

1. Recommendation revisions Please indicate if the stakeholder requires the expert review committee to reconsider or clarify its recommendation.		
Request for Reconsideration	**Major revisions:** A change in recommendation **category** or patient **population** is requested	☐
	Minor revisions: A change in reimbursement **conditions** is requested	☐
No Request for Reconsideration	**Editorial revisions:** Clarifications in recommendation **text** are requested	☐
	No requested revisions	X

2. Change in recommendation category or conditions Complete this section if major or minor revisions are requested
Please identify the specific text from the recommendation and provide a rationale for requesting a change in recommendation.

3. Clarity of the recommendation Complete this section if editorial revisions are requested for the following elements
a) Recommendation rationale
Please provide details regarding the information that requires clarification.
b) Reimbursement conditions and related reasons
Please provide details regarding the information that requires clarification. Page 8, Table 1, number 4: Etrasimod should only be prescribed by a physician experienced in the diagnosis and management of UC.

Please provide clarity regarding whether the prescribing is restricted to gastroenterologists.
c) Implementation guidance
Please provide high-level details regarding the information that requires clarification. You can provide specific comments in the draft recommendation found in the next section. Additional implementation questions can be raised here.

Outstanding Implementation Issues

In the event of a positive draft recommendation, drug programs can request further implementation support from CADTH on topics that cannot be addressed in the reimbursement review (e.g., concerning other drugs, without sufficient evidence to support a recommendation, etc.). Note that outstanding implementation questions can also be posed to the expert committee in Feedback section 4c.

Algorithm and implementation questions
1. Please specify sequencing questions or issues that should be addressed by CADTH (oncology only)
1. 2.
2. Please specify other implementation questions or issues that should be addressed by CADTH
1. 2.
Support strategy
3. Do you have any preferences or suggestions on how CADTH should address these issues?
May include implementation advice panel, evidence review, provisional algorithm (oncology), etc.