pan-Canadian Oncology Drug Review

Patient Advocacy Group Feedback on a pCODR Expert Review Committee Initial Recommendation

Alectinib (Alecensaro) for Non-small Cell Lung Cancer

Lung Cancer Canada

May 4, 2017

1 Feedback on pERC Initial Recommendation

Name of the drug indication(s):	Alecensaro (alectinib)
Name of registered patient advocacy group:	Lung Cancer Canada

**pCODR may contact this person if comments require clarification. Contact information will not be included in any public posting of this document by pCODR.*

1.1 Comments on the Initial Recommendation

a) Please indicate if the patient advocacy group agrees or disagrees with the initial recommendation:

____ agrees ____ agrees in part __X__ disagree

Please explain why the patient advocacy group agrees, agrees in part or disagrees with the initial recommendation. Please see blow.

b) Notwithstanding the feedback provided in part a) above, please indicate if the patient advocacy group would support this initial recommendation proceeding to final pERC recommendation ("early conversion"), which would occur within 2(two) business days of the end of the consultation period.

____ Support conversion to final recommendation. Recommendation does not require reconsideration by pERC.	__X__ Do not support conversion to final recommendation. Recommendation should be reconsidered by pERC.

c) Please provide feedback on the initial recommendation. Is the initial recommendation or are the components of the recommendation (e.g., clinical and economic evidence) clearly worded? Is the intent clear? Are the reasons clear?

Page Number	Section Title	Paragraph, Line Number	Comments and Suggested Changes to Improve Clarity
Pg. 6	**Overall Clinical Benefit**	**Studies Included**	The highlighted phrase is the key and Lung Cancer Canada reminds the committee of the reason for this submission and the

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		…evaluating the safety and efficacy of alectinib in patients with ALK positive NSCLC who progressed on or were intolerant to treatment with crizotinib.	chance that alectinib offers for patients that have progressed beyond crizotinib. "There is no comparison, (alectinib) has allowed me to live." – CZ, patient "I want to get on (alectinib) as soon as possible…the suffering has been out of the stratosphere." – S, patient. Excerpted from pg. 13 of original submission. We feel that the committee has not adequately weighted the voices of patients like CZ or S and our response brings us back to the reason and need for alectinib.
Pg. 3	**Summary of pERC Deliberations**	Para 3: pERC noted that tere appears to be anti-tumour activity with alectinib and was confident that there was tumour response with alectinib; however, the magnitude of effect compared with available treatments is unknown, given the lack of comparative data…	To recognize that ceritinib has anti-tumour activity but then to conclude that there is not enough evidence does not recognize both the uniqueness of targeted therapy and the high unmet need. In this case waiting for phase 3 denies life to those that are in need of it now. On Dec. 11, 2015 the FDA and in Oct 2016 Health Canada, both granted alectinib breakthrough therapy designation based on preliminary evidence of clinical activity in patients with metastatic ALK-positive NSCLC previously treated with crizotinib. The approval of alectinib was based on the results of two, single-arm clinical trial, the same two that pCODR used for its consideration. The FDA and Health Canada approvals stand in stark contrast to the arguments used by pERC vis a vis safety, strength of evidence and the need for randomized trials In fact, Phase 3 data may not be required in this case. As argued by Stewart and Kurzrock, and more particularly Stewart and Batist: "Common cancers may arise from several different mutations, and each causative mutation may require different treatment approaches. There are also several mechanisms by which malignancies may become resistant to therapy, and each mechanism will also require a different

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			therapeutic strategy. Hence, the paradigm of devising therapies based on tumor type is suboptimal. Each common malignancy may now be regarded as a collection of morphologically similar but molecularly distinct orphan diseases, each requiring unique approaches. Current strategies that employ randomized clinical trials (RCTs) in unselected patients carry a high risk of misleading results. Available data suggest that it is reasonable to grant marketing approval for new anticancer agents based solely on high single-agent response rates in small phase I-II studies involving molecularly-defined patient groups where benefit from other therapies is unlikely."
Pg. 8	**Need:** pERC agreed with the CGP…there is a significant need for effective treatments…with CNS metastases.		Alectinib has demonstrated efficacy in patients with brain metastases. This is a highly significant finding that the committee has not given enough consideration to. Studies suggest that lung cancer has a higher incidence of brain metastases as compared to other cancers and those with brain metastases have a outlook on lower survival [A Ali et al., Survival of patients with non-small cell lung cancer after a diagnosis of brain metastases. Curr Oncol. 2013 Aug; 20(4): e300–e306] "I was so weak I could barely get out of bed. 16 weeks later, my CT scans were summarized as: 'No CT evidence of residual or recurrent disease.' A complete response!" – patient This is highly meaningful and data suggests that she is more typical. This meets a huge unmet need in lung cancer. To the patient, brain metastases represents despair and a loss of function. Patients on alectinib remain highly functional. If the high unmet need is recognized, why then have two ALK+ therapies for NSCLC been rejected?
Pg. 1	**pERC Recommendation**	Unable to determine how alectinib compares to	This statement ignores two of the key elements presented in the patient group

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		other treatments including best supportive care, radiation and chemotherapy.	submission: Time and quality of life filled with hope.
Pgs 6/7	**Overall Clinical Benefit**	Key Efficacy Results: Because a percentage of patients in each trial – 21% (n=18) in trial NP28761 and 12% (n=16) in trial NP26673 – were deemed not to have measurable disease…	Chemotherapy does not have the same response rates.

1.2 Comments Related to Patient Advocacy Group Input

Please provide feedback on any issues not adequately addressed in the initial recommendation based on patient advocacy group input provided at the outset of the review on outcomes or issues important to patients that were identified in the submitted patient input. Please note that new evidence will be not considered during this part of the review process, however, it may be eligible for a Resubmission. If you are unclear as to whether the information you are providing is eligible for a Resubmission, please contact the pCODR Secretariat.

Examples of issues to consider include: what are the impacts of the condition on patients' daily living? Are the needs of patients being met by existing therapies? Are there unmet needs? Will the agents included in this recommendation affect the lives of patients? Do they have any disadvantages? Stakeholders may also consider other factors not listed here.

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			ALK+ patients in Canada currently have one line of publically funded targeted therapy. People living with other cancers for example breast, have more than one line of publically funded targeted therapy. The FDA has awarded alectinib breakthrough status – recognizing its efficacy. Health Canada has also provided approval. Lung

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			cancer already falls behind other cancers in terms of other cancers. We ask the pCODR panel to give lung cancer patients a chance… a chance to have standards of care similar to other cancers - life-extending therapies that will help increase the four month median survival for stage 4 lung cancer patients. In this case, the data sufficiently demonstrates efficacy. The patients that need alectinib now cannot wait until 2018. Help bring efficacious choice to lung cancer patients, similar to other cancers and other countries. Please reconsider the funding decision. Do not take away the "real hope" that alectinib represents for these patients.

About Completing This Template

pCODR invites those registered patient advocacy groups that provided input on the drug under review **prior** to deliberation by the pCODR Expert Review Committee (pERC), to also provide feedback and comments on the initial recommendation made by pERC. (See www.cadth.ca/pcodr for information regarding review status and feedback deadlines.)

As part of the pCODR review process, the pCODR Expert Review Committee makes an initial recommendation based on its review of the clinical, economic and patient evidence for a drug. (See www.cadth.ca/pcodr for a description of the pCODR process.) The initial recommendation is then posted for feedback and comments from various stakeholders. The pCODR Expert Review Committee welcomes comments and feedback that will help the members understand why the patient advocacy groups agree or disagree with the initial recommendation. In addition, the members of pERC would like to know if there is any lack of clarity in the document and if so, what could be done to improve the clarity of the information in the initial recommendation. Other comments are welcome as well.

All stakeholders have 10 (ten) business days within which to provide their feedback on the initial recommendation and rationale. If all invited stakeholders, including registered patient advocacy groups, agree with the recommended clinical population described in the initial recommendation, it will proceed to a final pERC recommendation by 2 (two) business days after the end of the consultation (feedback) period. This is called an "early conversion" of an initial recommendation to a final recommendation.

If any one of the invited stakeholders does not support the initial recommendation proceeding to final pERC recommendation, pERC will review all feedback and comments received at the next possible pERC meeting. Based on the feedback received, pERC will consider revising the recommendation document as appropriate. It should be noted that the initial recommendation and rationale for it may or may not change following consultation with stakeholders.

The final pERC recommendation will be made available to the participating provincial and territorial ministries of health and cancer agencies for their use in guiding their funding decisions and will also be made publicly available once it has been finalized.

Instructions for Providing Feedback

a) Only registered patient advocacy groups that provided input at the beginning of the review of the drug can provide feedback on the initial recommendation.

- Please note that only one submission per patient advocacy group is permitted. This applies to those groups with both national and provincial / territorial offices; only one submission for the entire patient advocacy group will be accepted. If more than one submission is made, only the first submission will be considered.
- Individual patients should contact a patient advocacy group that is representative of their condition to have their input added to that of the group. If there is no patient advocacy group for the particular tumour, patients should contact pCODR for direction at www.cadth.ca/pcodr.

b) Feedback or comments must be based on the evidence that was considered by pERC in making the initial recommendation. No new evidence will be considered during this part of the review process; however, it may be eligible for a Resubmission.

c) The template for providing *pCODR Patient Advocacy Group Feedback on a pERC Initial Recommendation* can be downloaded from the pCODR website. (See www.cadth.ca/pcodr for a description of the pCODR process and supporting materials and templates.)

d) At this time, the template must be completed in English. Patient advocacy groups should complete those sections of the template where they have substantive comments and should not feel obligated to complete every section, if that section does not apply to their group. Similarly, groups should not feel restricted by the space allotted on the form and can expand the tables in the template as required.

e) Feedback on the initial pERC recommendations **should not exceed three (3) pages in length,** using a minimum 11 point font on 8 ½″ by 11″ paper. If comments submitted exceed three pages, only the first three pages of feedback will be forwarded to the pERC.

f) Feedback should be presented clearly and succinctly in point form, whenever possible. The issue(s) should be clearly stated and specific reference must be made to the section of the recommendation document under discussion (i.e., page number, section title, and paragraph). Opinions from experts and testimonials should not be provided. Comments should be restricted to the content of the initial recommendation.

g) References to support comments may be provided separately; however, these cannot be new references. New evidence is not considered during this part of the review process, however, it may be eligible for a Resubmission. If you are unclear as to whether the information you are considering to provide is eligible for a Resubmission, please contact the pCODR Secretariat.

h) The comments must be submitted via a Microsoft Word (not PDF) document by logging into www.cadth.ca/pcodr and selecting "Submit Feedback" by the posted deadline date.

i) Patient advocacy group feedback must be submitted to pCODR by **5 P.M. Eastern Time** on the day of the posted deadline.

j) If you have any questions about the feedback process, please e-mail pcodrinfo@cadth.ca. For more information regarding patient input into the pCODR drug review process, see the *pCODR Patient Engagement Guide*. Should you have any questions about completing this form, please email pcodrinfo@cadth.ca

Note: Submitted feedback is publicly posted and also may be used in other documents available to the public. The confidentiality of any submitted information at this stage of the review cannot be guaranteed.