Developing a framework for incorporating real-world evidence into drug funding decisions:

CanREValue Collaboration Policy Working Groups Interim Report 2019

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CanREValue Collaboration

Overview of the CanREValue Collaboration

The Canadian Real-world Evidence for Value in Cancer (CanREValue) Collaboration is a pan-Canadian, multi-stakeholder initiative established in 2017 under a Canadian Institutes of Health Research Partnerships for Health System Improvement Grant. Led by Dr. Kelvin Chan, the central project is titled "Developing a framework for the incorporation of real-world evidence (RWE) into cancer drug funding decisions in Canada". The goal of the project is to develop and test a framework for the generation and use of RWE for cancer drugs to facilitate:

I. Reassessment of cancer drugs by recommendation-makers; and

II. Refinement of funding decisions, renegotiation of drug prices, or disinvestment as appropriate by decision-makers/payers across Canada.

Once developed, the framework could potentially be used to support evidence-based policy reform, pricing, and reallocation of funding from low- to high-value settings. In addition, the framework could facilitate the accountability and sustainability of the cancer system if used by the provinces and by other players in the healthcare system.

Working Groups

As part of developing the framework, five working groups (WGs) have been established to develop the framework (Figure 1). To ensure that the framework can support the needs of various stakeholders, the CanREValue Collaboration brought together a broad range of stakeholders from across different organizations and agencies (Figure 2). The WGs and their key deliverables are listed below.

- ***RWE planning and drug selection WG****:* Recommend criteria to identify and prioritize potential drug candidates for RWE studies and advise on the necessary provincial infrastructure needed for the conduct of RWE studies.
- ***RWE Data WG:*** Recommend strategies for data access and provide advice on harmonization of data elements relevant for RWE studies across provinces.
- ***RWE Methods WG:*** Recommend methods to analyze real-world data with methodological rigor.
- ***RWE Reassessment and Uptake WG:*** Develop a process to incorporate RWE for HTA reassessment and advise on strategies to incorporate RWE results into policy-making.
- ***RWE Engagement WG:*** Establish mechanisms to ensure that key stakeholders from across all relevant jurisdictions can provide feedback and input into proposed recommendations from each WGs.

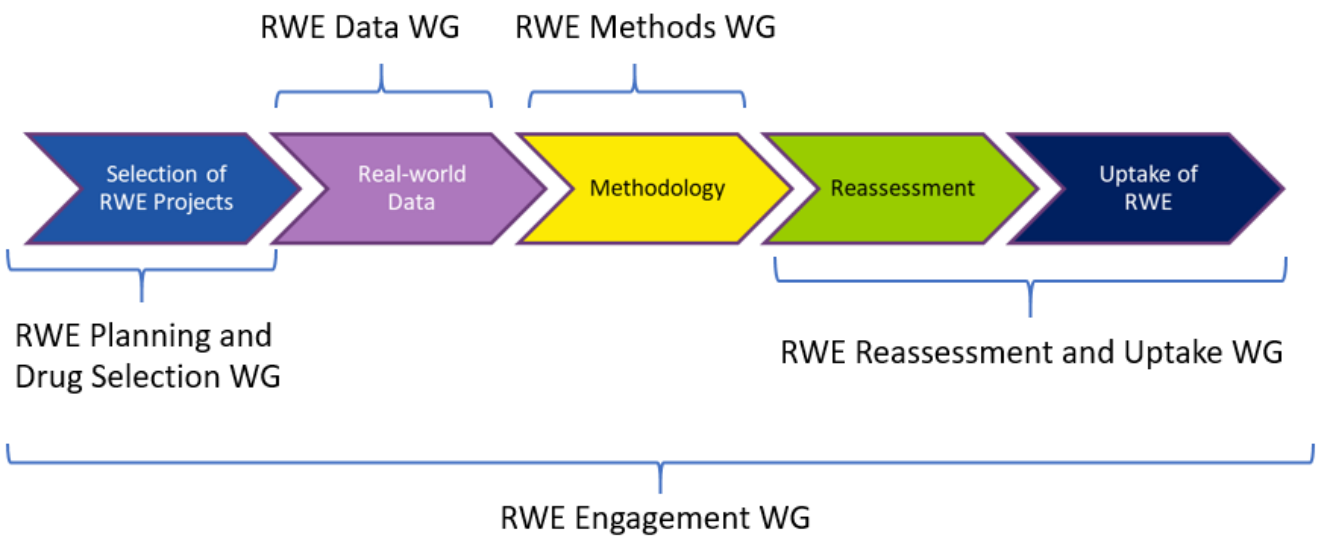

Figure 1: CanREValue Collaboration Working Group (WG) Structure

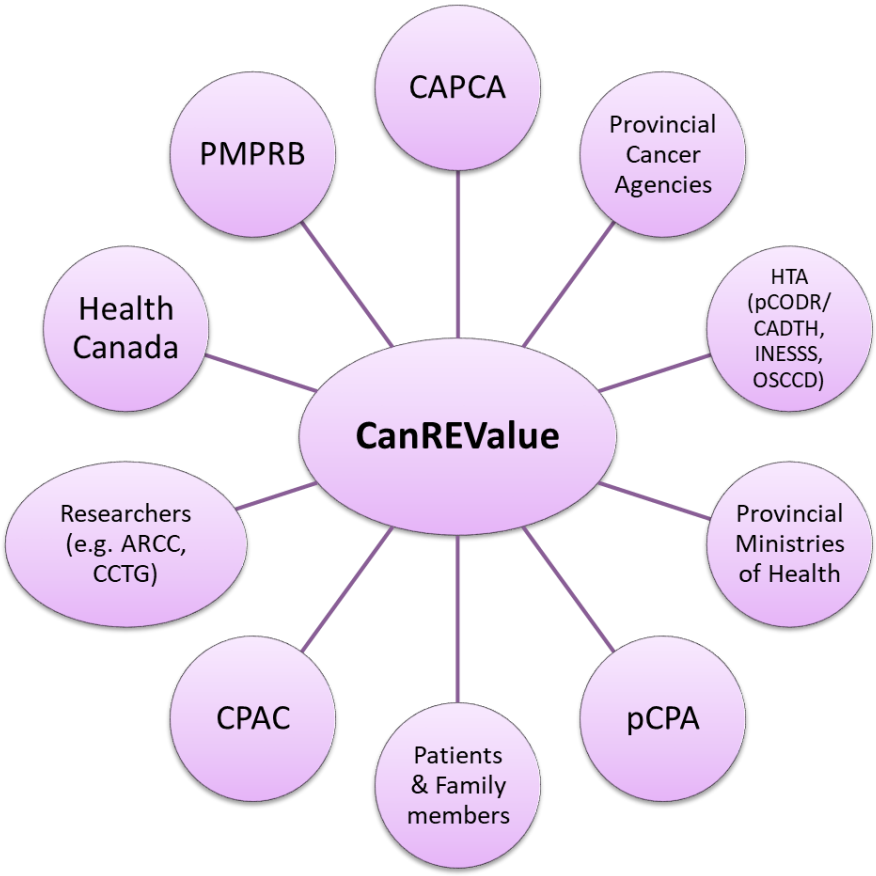

Figure 2: CanREValue Collaboration Stakeholders

CanREValue
Value-based decisions from Real World Evidence

CanREValue Collaboration: Policy Working Groups Interim Report

Developing a framework for incorporating real-world evidence into drug funding decisions:

Authors and Members of Working Groups

Kelvin Chan
Sunnybrook Research Institute
Canadian Centre for Applied Research in Cancer Control

Bill Evans
McMaster University

Wei Fang Dai
Ontario Health (Cancer Care Ontario)
Canadian Centre for Applied Research in Cancer Control

Jaclyn Beca
Ontario Health (Cancer Care Ontario)
Canadian Centre for Applied Research in Cancer Control

Rebecca Mercer
Ontario Health (Cancer Care Ontario)
Canadian Centre for Applied Research in Cancer Control

Wanrudee Isaranuwatchai
St Michael's Hospital
Canadian Centre for Applied Research in Cancer Control

Mina Tadrous
Women's College Hospital

RWE Planning and Drug Selection Working Group

Scott Gavura (Chair)
Ontario Health (Cancer Care Ontario)

Angie Wong
Ontario Ministry of Health

Helen Anderson
BC Cancer

Danica Wasney
CancerCare Manitoba

Alicia Wall
Eastern Health in Newfoundland and Labrador

Tarry Ahuja
CADTH

Maureen Trudeau
Sunnybrook Research Institute

Marianne Taylor
BC Cancer

Sang Mi Lee
Pan-Canadian Pharmaceutical Alliance

Don Husereau
University of Ottawa, School of Epidemiology and Public Health

Sylvie Bouchard
Institut national d'excellence en santé et en services sociaux

Michèle de Guise
Institut national d'excellence en santé et en services sociaux

Gunita Mitera
Canadian Association of Provincial Cancer Agencies

Nevzeta Bosnic
Patented Medicine Prices Review Board

Lisa Currie
Health Canada

Gayatri Jayaraman
Health Canada

Basanti Ghosh*
Health Canada

Anne Newman*
Patient and Family Member Representative

Elena Lungu
Patented Medicine Prices Review Board

Melissa Hunt
Health Canada

Barry Jones
Health Canada

Erika Brown*
Canadian Association of Provincial Cancer Agencies

Frances Hall*
Health Canada

RWE Reassessment and Uptake Working Group

Brent Fraser (Chair)
CADTH

Alexandra Chambers* (Chair)
CADTH

Helen Anderson
BC Cancer

Rohini Naipaul
Ontario Health (Cancer Care Ontario)

Darryl Boehm
Saskatchewan Caner Agency

Carole Chambers
Alberta Health Services

Maureen Trudeau
Sunnybrook Research Institute

Derek Finnerty
Patient and Family Member Representative

Sylvie Bouchard
Institut national d'excellence en santé et en services sociaux

Erica Craig (Chair)
New Brunswick Cancer Network

Suzanne McGurn
Ontario Ministry of Health

Jessica Arias
Ontario Health (Cancer Care Ontario)

Marc Geirnaert
CancerCare Manitoba

Patricia Caetano
Government of Manitoba

Helen Mai
CADTH

Daniel Sperber
Pan-Canadian Pharmaceutical Alliance

Bryson Brown
Patient and Family Member Representative

Michèle de Guise
Institut national d'excellence en santé et en services sociaux

Gunita Mitera
Canadian Association of Provincial Cancer Agencies

Nevzeta Bosnic
Patented Medicine Prices Review Board

Lisa Currie
Health Canada

Gayatri Jayaraman
Health Canada

Basanti Ghosh*
Health Canada

Elena Lungu
Patented Medicine Prices Review Board

Melissa Hunt
Health Canada

Barry Jones
Health Canada

Erika Brown*
Canadian Association of Provincial Cancer Agencies

Frances Hall*
Health Canada

*Former Working Group member

Executive Summary

Across provincial healthcare systems, there is consensus that there is a need for real-world evidence (RWE) in cancer care and drug funding decisions. To address this need, the Canadian Real-world Evidence for Value in Cancer (CanREValue) collaboration will develop a framework for Canadian provinces to generate and use RWE for cancer drug funding decision making in a consistent and integrated manner. Two policy working groups (WGs), the RWE Planning and Drug Selection WG and the RWE Reassessment and Uptake WG, were established and consisted of decision-makers/payers, regulatory agency representatives, health technology agency representatives, researchers, clinicians, and patient representatives. The aim of this report is to provide a high-level overview of the preliminary framework that has been developed by the two policy working groups.

In the first section of the report, we describe, in three parts, the main findings from the **RWE Planning and Drug Selection WG**. **Part one** outlines priority areas of consensus established by WG members. **Part two** outlines a preliminary model for identifying and selecting RWE projects. Finally, **part three** describes considerations regarding RWE project feasibility discussed by the WG members.

The main considerations from the RWE Planning and Drug Selection Working Group include:

- Definitions of RWD should be flexible to allow for appropriate data collection. Definitions of RWE should consider the intended use of the evidence.
- RWE can be useful to a broad range of stakeholders and the questions they are interested in can be grouped into clinically related and policy-related. The major users of RWE include decision-makers, payers and health technology assessment agencies.
- RWE is seen as complementary to randomized controlled trials (RCTs).
- RWE used to inform decision-making must be of high quality, which includes uses of high-quality RWD sources and methodologies appropriate to the study question.
- When identifying RWE projects, the Planning WG recommends that the main considerations should be residual uncertainties from the initial assessment, which would include uncertainties in the clinical evidence, its alignment with patient values, or uncertainties that factor into the value for money or feasibility of adoption into the system. Additionally, an important consideration is whether the uncertainties are expected to be addressed by future studies that are already planned or underway.
- After identifying a list of potential RWE projects, these projects must be prioritized based on feasibility, timeliness, and relevance to decision-makers.

In the second section of the report, we describe in three parts, the main findings from the **RWE Reassessment & Uptake Working Group**. **Part one** describes the main considerations needed to be taken into account when developing a reassessment process. **Part two** outlines a preliminary model of the reassessment process. **Part three** describes considerations to be taken into account when conducting a reassessment review.

The main considerations from the RWE Reassessment and Uptake Working Group are listed below:

- At the time of an initial recommendation, health technology agencies such as Canadian Agency for Drugs and Technologies in Health (CADTH) should indicate whether there is a potential need for RWE.
- The reassessment process could follow a procedure similar to the resubmission process at CADTH.
- The reassessment process should be modelled after pCODR's deliberative framework with the following 4 quadrants: clinical benefit, patient values, economic evaluation (including cost-effectiveness analysis), and implementation & sustainability.
- Three recommendation categories were proposed: status quo; revisit funding criteria or pricing; and do not continue to fund.
- The reassessment review should be prioritized to manage the volume of potential submissions.
- Stakeholders involved in the original drug review should also be involved in the reassessment review.

Introduction:

With oncology drugs becoming increasingly expensive, the concepts of sustainability and accountability in health care have become more important than ever. In the absence of RWE, drug funding decisions and clinical practice have long been informed by evidence from clinical trials and predictive economic modeling. However, there are many reasons why RWE may differ from the evidence generated in clinical trials[1,2,3,4]. As a result, policy-makers have little information on whether drug funding decisions based on clinical trials ultimately yield the outcomes and value for money that are expected[5, 6].

Interim Report:

In this interim report, we will focus on the progress of the two policy working groups:

RWE Planning and Drug Selection Working Group (Planning WG):

The goal of the Planning WG is to develop:

I. Criteria for identifying potential drug-indication candidates for real-world evaluation and;

II. Recommendations on how to establish a provincial infrastructure for RWE.

From January to December 2018, the WG convened five meetings (4 teleconferences and 1 in-person meeting) and completed three surveys (Appendix A). Throughout these iterative working sessions, the members reached a preliminary consensus on key considerations for RWE and RWD. After establishing the general context around RWD and RWE, the members worked on developing set of preliminary triggers to identify potential RWE questions. Moreover, the members drafted a preliminary process for the selection of potential RWE questions to be addressed in an RWE project. This interim report outlines the initial considerations from this working group.

RWE Uptake and Reassessment Working Group (Reassessment WG):

The goal of the Reassessment WG is:

I. To propose a high-level process on how the reassessment of currently funded drugs could work within the Canadian health system and;

II. To recommend processes and factors required to revisit negotiations and funding decisions.

From January to December 2018, the WG convened four meetings (3 teleconferences and 1 in-person meeting) and completed 3 surveys (Appendix B). During the collaborative sessions, the members discussed multiple options on how to conduct a reassessment process. Through these discussions, the WG members drafted a preliminary process for reassessment. This interim report outlines the initial considerations from this working group.

Section 1: RWE Planning and Drug Selection Working Group

Part 1: Context and priority consensus

Consideration 1: Definitions for Real-world Evidence (RWE)/Real-world Data (RWD)

The Planning and Drug Selection WG acknowledged the need to differentiate between RWE and RWD. The WG members considered RWD to be data collected from sources outside of traditional trials, commonly in an unselected population, whereas RWE was considered as evidence generated from aggregation and analysis of RWD elements.

The majority of the WG members noted that their own organizations have not yet established formal definitions for RWD and RWE, with the exception of Health Canada[7].

Health Canada uses the following definitions:

> "*Real-world data: data relating to patient health status and/or the delivery of health care routinely collected from a variety of sources.*
> *Real-world evidence: clinical evidence regarding the usage, and potential benefits or risks, of a medical product derived from the analysis of RWD.*"[7]

When considering a potential definition for RWD, the members' responses could be categorized into i) how the data are collected, and ii) what data are collected (e.g. types of outcomes) (Table 1). Moreover, the members noted that RWD are often gathered after a drug is available on the market and is funded by a drug plan (private or public) or patient support programs. When considering potential definitions for RWE and RWD, the members suggested that the definitions should consider the intended application of RWE and be broad enough to allow for flexibility. Furthermore, the members suggested that the definitions used by different organizations should be congruent with one another.

Table 1: Considerations for defining RWD

Sources of Real-world Data	Types of Outcomes
• Pragmatic trials • Prospective or retrospective observational or registry studies • Administrative and claims databases • Data from medical devices • Case reports • Electronic health records • Public health investigation or surveillance databases	• Overall survival • Drug utilization • Long-term toxicity • Health services costs

Consideration 2: Applications of RWE

The WG members acknowledged that the collection of RWD and generation of RWE could benefit a wide range of stakeholders. Some potential uses of RWE identified by the WG are listed in Table 2 by type of stakeholder. The WG members felt that the primary users of evidence derived from RWE studies were likely to be payers and regulators. HTA bodies were also considered potential primary users of RWE, given their role in advising public payers.

Table 2: Potential use of RWE for various stakeholders

Stakeholder	Uses
Payers: Provincial health ministries, cancer agencies, private payers etc.	• Assess actual uptake, effectiveness and cost-effectiveness • Re-evaluate funding decision • Re-negotiate pricing
Regulators (e.g., Health Canada)	• Safety and efficacy surveillance • Amend approved indications • Notice of compliance with conditions • Supplement RCTs
HTA Bodies	• Reconsider/reassess past recommendations • Optimal use • Inform future submissions
pCPA	• Integrate RWE studies into pricing/listing agreements
PMPRB	• Inform pricing
Healthcare Practitioners (Clinicians, Pharmacists)	• Effectiveness and safety in practice • Continuing medical education
Patients/Caregivers	• Effectiveness
Public	• Effective and efficient use of resources
Industry	• Requirements for future studies • Improve market access

Consideration 3: Potential outcomes for RWE studies

RWE studies have the potential to answer questions on outcomes that may be difficult to study using traditional clinical trials. Table 3 lists some of the common outcomes that WG members felt stakeholders may be interested in. The common outcomes of interest included comparative effectiveness, safety, cost-effectiveness, and budget impact. The WG members noted that the type of RWE needed would depend on the drug or scenario.

Table 3: Outcomes of interest for RWE studies

Clinically relevant outcomes	Policy relevant outcomes
• Long term clinical effectiveness • Comparative effectiveness • Safety monitoring • Duration of treatment • Optimal dosing • Rates of discontinuation • Patient reported outcomes • Quality of care	• Uptake of treatment • Resource utilization • Drug wastage • Treatment delivery • Budget impact • Incidence and prevalence of a disease/indication • Sequencing of different treatments in a therapeutic space

Consideration 4: Quality of RWE

The WG members highlighted the importance of using high-quality evidence to inform drug funding decisions. The sources and the quality of RWD were noted as particularly important when interpreting RWE. The process of generating RWE must be rigorous and employ methodologies appropriate to the study question. The WG members acknowledged that RWE studies lack the randomization process that is a central component of high-quality clinical trials. As such, the members view RWE studies as complementary to evidence from traditional clinical trials. Some members also suggested that the intended application of RWE should be considered.

Decisions affecting initial funding require more robust evidence in comparison to subsequent modifications to the initial funding criteria.

Consideration 5: Provincial infrastructure for RWE

In the Canadian healthcare system, most decision-making falls under the purview of provincial and territorial governments. There are variations between provinces and territories with respect to population size and characteristics, range and scope of insured services, and other considerations related to access to care. Local and provincial priorities must be considered and incorporated into the national RWE infrastructure. The WG members considered different types of models for a national RWE structure that would embrace provincial priorities. One potential model would be for provincial priorities to be fed up to a national RWE structure that would develop consensus for national priorities. The WG members acknowledged the importance of dedicated funding and resources for RWE projects. As such, they will work on recommendations for sustainable models to plan and resource RWE projects.

Consideration 6: Stakeholders involvement for planning and selection of potential RWE projects

The WG members acknowledged that different stakeholders should be included to gather a broad range of important RWE questions. In addition, the selection of an RWE project requires comprehensive collaboration from different stakeholders. For example, patients and clinicians best understand current trials and gaps in the treatment landscape. Payers and administrators understand budget constraints. Researchers and HTA agencies understand approaches to critically assess the evidence. When selecting an RWE project, a balance between value implications and pure academic interests needs to be struck due to limited resources. Moreover, priority setting from the payer perspective requires a focused assessment body with insight into the funding landscape and policy-relevant needs.

Part 2: Preliminary model for planning and selection of RWE projects

The preliminary model for planning and selection of RWE projects is outlined in Figure 4.

Step 1: Topic Identification Process

The preliminary model of the framework starts with proactive horizon scanning for new drugs that are anticipated to enter the Canadian market. Additionally, as new drugs undergo regulatory approval, health technology assessment, and pricing discussions, potential questions of interest to different stakeholders that might be addressed by RWE generation may emerge. WG members were surveyed for triggers that could be applied prospectively initiate an RWE consideration for their organization (Table 4). It was recognized that there is potential to build RWE conditions into the agreements between pCPA and manufacturers via product listing agreements.

A fourth trigger was proposed that focused on identifying RWE projects of relevance to payers as the primary focus; namely, capturing uncertainties identified in trigger 1 & 2 that cannot be managed through product listing agreements (such as clinical criteria restricting use to specific subgroups or pricing agreements that

reduce cost-effectiveness or budget impact). However, the WG members recognized that it would be challenging to operationalize the proposed trigger to identify RWE projects and thus excluded this consideration from the list of triggers. Recognizing the importance of identifying residual, policy-relevant uncertainties following the confidential listing process for new products, it was proposed that these considerations be factored into the next steps of the selection and planning process.

Table 4: Triggers for identifying potential RWE questions

Trigger 1: Uncertainties in the clinical benefit and/or alignment with patient values

• Uncertainty in the long-term comparative effectiveness, long-term comparative toxicity, or magnitude of clinical benefits
  ○ E.g.: study setting with indirect treatment comparisons, single-arm evidence, early study termination, or crossover between arms
• Uncertainty in the generalizability of the evidence
  ○ E.g.: study findings based on small trials or limited external validity
• Uncertainty in alignment with patient values and preferences
  ○ E.g.: study findings that reported minimal quality of life data or patient reported outcomes
• Uncertainty in clinical practice pattern such as optimal dosing and prescription patterns

Trigger 2: Uncertainties in value for money or feasibility of adoption of the drug

• Uncertainty in long-term cost-effectiveness
• Potential large or uncertain budget impact
  ○ Considerations include: uncertainties in cost per patient, drug delivery costs (including wastage), treatment duration, uptake and utilization
• Challenges related to adoption feasibility
  ○ Considerations include: lack of evidence for optimal sequencing, impact on treatment pathway

Trigger 3: The identified uncertainties listed in criterion 1 & 2 are not expected to be resolved by evidence from future planned studies
• No other relevant trials or studies currently underway to address the uncertainties • Absence of full regulatory approval/oversight for indication   ○ NOC/c, particularly when stated conditions may not fully resolve uncertainty for indication e.g. confirmatory study being conducted in a different setting • Absence of NOC for the stated indication (off-label use)

Step 2: Prioritization of RWE Questions

The list of RWE questions that are identified could undergo a prioritization process to determine whether an RWE project should be conducted by the CanREValue collaboration. The WG members highlighted the importance of prioritizing those questions that can be feasibly conducted in a timely manner for CanREValue projects. Moreover, it is also important to focus on projects that are of relevance to stakeholders and to payers, in particular.

Step 3: Conducting RWE studies

The CanREValue research team will undertake preparatory work for prioritized RWE projects, including obtaining research ethics approval, designing the analysis plan and consulting methodological experts. Before the analysis is conducted, the WG discussed that the framework may also include an opportunity for stakeholders to re-evaluate priorities. For example, treatment pathway changes that occur while data are collected may change the relevance and need for an RWE study prior to the conduct of the RWE analysis.

Part 3: Considerations for assessing the feasibility of a potential RWE project

One important component of the prioritization process for CanREValue projects is assessing the feasibility of conducting an RWE evaluation. In particular, determining the feasibility of translating a question or an uncertainty into an RWE project that can be conducted using population-based administrative data and in a timely manner is critical for CanREValue projects. The WG members were surveyed on elements that they would consider when conducting a feasibility assessment. The preliminary elements are listed in Table 5. In the next step of the development, the Planning WG will work closely with methodological and data experts from the CanREValue Methods and Data Working Groups to refine and develop a set of criteria to assess the feasibility of a CanREValue RWE project.

Table 5: Feasibility considerations for planning potential RWE studies

Feasibility Considerations for RWE studies
• An adequate number of patients have received the drug of interest • An appropriate comparator cohort can be identified • The outcome being studied is relevant, measureable and obtainable from existing administrative sources • There is an adequate follow-up time to ascertain the outcome of interest in the observation window • Financial support and knowledge expertise to conduct analysis in a timely manner either at the provincial or national level exists.

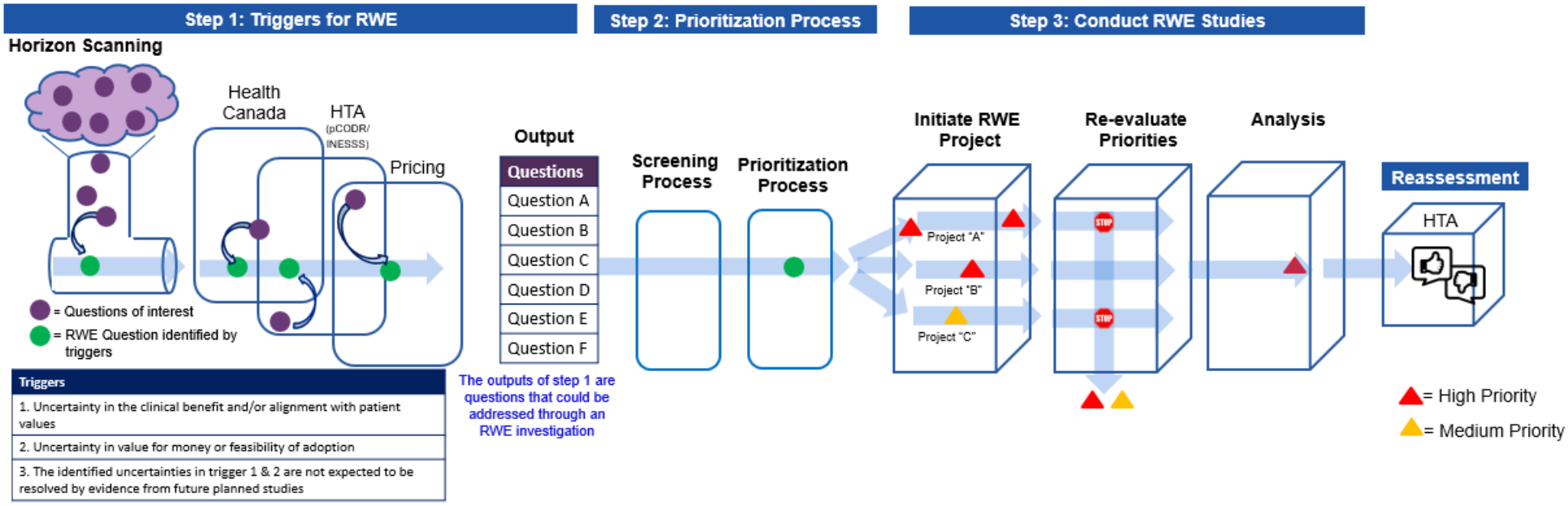

Figure 4: Preliminary CanREValue Planning and Drug Selection WG Framework

Abbreviations: RWE = real-world evidence; HTA = Health Technology Assessment; pCODR = pan-Canadian Oncology Drug Review; INESSS = Institut national d'excellence en santé et services sociaux;

Section 2: RWE Reassessment and Uptake Working Group

Part 1: Considerations for developing the Reassessment Process

Consideration 1: Definition of Reassessment

For the purpose of the CanREValue Collaboration, the definition of reassessment is as follows:

> *"A structured, evidence-based assessment of the clinical, social, ethical, and economic effects of a technology currently used in the healthcare system, to inform optimal use of that technology in comparison to its alternatives.*
>
> *The "reassessment review" refers to the subsequent review of a drug that has been previously reviewed by CADTH or INESSS. A reassessment review refers to the* ***action of critically appraising new data*** *that has been collected since the initial review and issuing a recommendation based on the critical appraisal of the new data. It does not encompass the collection of the new data."*[8] – (Soril et al, 2017)

Consideration 2: Who would initiate the reassessment process?

i. The WG members recommend that the reassessment reviews be initiated by: The federal, provincial, or territorial drug programs/jurisdictions;
ii. Cancer agencies (including tumour groups in some jurisdictions);
iii. Industry when new evidence on a funded drug becomes available

Consideration 3: Reassessment recommendation by HTA agency

The WG members discussed the particular context when HTA agencies such as CADTH pCODR Expert Review Committee, make a preliminary recommendation noting that more data needs to be collected to address uncertainties identified in the review. This additional data would then be the focus of the reassessment review. The WG members outlined the following broad needs:

i. The data needed for the reassessment review. This could include details on outcomes, such as safety, utilization, etc.
ii. The timeline for the review, based on the information made available at the time of the recommendation.
iii. A recommendation as to who should be responsible for 1) collecting the data and; 2) initiating the reassessment review (i.e. industry or jurisdictions)

The Expert Review Committee could use the following criteria to establish whether the initial recommendation should include a condition for data collection and a subsequent reassessment review:

- High unmet need (i.e. no reasonable, *publicly funded* treatment alternatives available); and
- Clear signal of benefit, but with substantial uncertainty in the magnitude of benefit compared with standard of care; and
- Feasible to gather information to address areas of uncertainty

Moreover, it was noted that at any time point between the issuance of the Expert Review Committee's final recommendation on the initial review and the initiation of a reassessment review, a jurisdictional committee (e.g. Provincial Advisory Group) could indicate that a reassessment review is no longer required. One example

as to why there may no longer be a need for a reassessment review would be that a new comparator treatment became available that is unequivocally superior to the drug under consideration. Another example could be that a change in the funding algorithm could make the use of the drug for a certain indication essentially obsolete.

Consideration 4: When to initiate a reassessment review?

As part of the proposed framework, the reassessment review could follow similar procedures to the CADTH resubmission process. The key difference between a *submission* and a *resubmission* at CADTH is that a *resubmission* must undergo an eligibility review to ensure that the new data potentially addresses the key concerns/issues from the initial recommendation. A reassessment review would likewise follow a similar eligibility review to ensure that the new data addresses the uncertainty in the initial recommendation. The timeframe between the original recommendation and the reassessment will be dependent upon the time required to obtain the data required for the reassessment.

Consideration 5: Tailored vs Comprehensive Review?

The WG members considered the advantages and disadvantages of having two reassessment review streams: a tailored review and a comprehensive review. There was substantial discussion on both possible streams and initially there was support for two distinct review streams. However, the WG finally decided that having one comprehensive reassessment review option was most appropriate at this stage. They made this decision because, without experience, it was difficult to delineate what questions would require a tailored versus a comprehensive reassessment review. The Reassessment WG suggested that a tailored review may be possible once the system has had some experience with reassessment reviews and would be better positioned to determine which questions warranted a comprehensive versus a tailored reassessment review.

Consideration 6: Incorporation of cost-effectiveness analysis

The WG members discussed that a cost-effectiveness analysis may not be needed in all reassessment reviews; however, without experience, it was difficult for the WG members to determine in which scenarios a cost-effectiveness analysis would be beneficial. The WG members felt that with experience there would likely be situations where another type of costing analysis might be sufficient to inform a recommendation on a reassessment review. Once there is more experience with reassessment reviews, the requirement to have cost-effectiveness analyses for all reassessment reviews should be reconsidered.

Consideration 7: Recommendation framework - Reassessment quadrants

There was agreement amongst the WG participants that the recommendation framework for reassessment reviews be modelled after the pCODR Expert Review Committee's (pERC) Deliberative Framework (Clinical Benefit, Patient Values, Economic Evaluation, Adoption Feasibility). All quadrants could be similar to the deliberative framework for the initial review with the exception of changing the "Adoption Feasibility" quadrant to an "Implementation and Sustainability" quadrant. This latter quadrant would consider factors such as drug utilization, budget impact analysis, and an assessment of if and how the funding algorithm has changed since the initial review.

Consideration 8: Proposed Recommendation Categories

Three recommendation categories were proposed for the draft reassessment review process:

1) Status quo
   - There are two possible scenarios:
     1. The data provided for the reassessment review confirmed the effectiveness, safety and cost-effectiveness of the initial review. There is no need to change the current reimbursement recommendation.
     2. The data provided were insufficient to address an important question of effectiveness, safety, or cost-effectiveness. Additional data and subsequent reassessment are required.
2) Revisit funding criteria or pricing
   - The reassessment committee felt that based on the new evidence reviewed, the criteria for funding need to be revised (e.g., broader or narrower indication); and/or
   - The committee felt that based on the new evidence reviewed, the cost effectiveness of the drug has changed (e.g. the drug performed better or worse than expected on one or more key outcomes of interest). Jurisdictions should evaluate whether existing pricing agreements need to be revised.
3) Do not continue funding/delist
   - The reassessment committee concluded that there was at least one other better alternative treatment available (based on patient preference, effectiveness, safety, and/or cost-effectiveness).

Consideration 9: Prioritization of drugs for data collection and reassessment reviews

There will need to be a method to prioritize which drugs require reassessment reviews, as HTA organizations have constrained budgets and could not conduct reassessment reviews for all drugs.

The WG members considered that a jurisdictional group (or groups), such as the pCODR Provincial Advisory Group (PAG), could potentially inform the (1) prioritization of which drugs should be considered for data collection and (2) subsequent reassessment reviews. Depending on the proposed framework, these two steps may be informed by two separate groups. It is important to note that the purview of the Planning and Drug Selection WG was to propose which drugs would be considered for data collection, and this was out of scope for the Reassessment and Uptake WG. It was acknowledged, however, that in order for a jurisdictional group (or groups) to inform prioritization for data collection and reassessment reviews, they would require:

- A framework or criteria to help inform how drugs are selected/prioritized for data collection (and subsequent reassessment reviews)
- A method/mechanism to receive perspectives from other key stakeholders (i.e. clinicians, patients, Health Canada, pCPA etc.)

It was the opinion of the WG members that setting an upper limit (i.e., cap) on the number of reassessment reviews was not ideal. However, this may need to be considered in order to manage the volume of potential reassessment reviews.

Consideration 10: Stakeholder involvement in the reassessment review process

It is proposed that the procedures for engagement with patients, clinicians, payers, and industry used during the original drug reviews be applied to reassessment reviews since these procedures are well established within the HTA community. However, the data requirements for reassessment reviews may vary from those for original reviews. Therefore, this will likely need further exploration to determine if the current mechanisms for original reviews are sufficient.

Part 2: Preliminary Model of the Reassessment Process

Figure 5 outlines the preliminary model of the reassessment process:

- For consistency with the initial drug review process, reassessment reviews should be conducted by CADTH and INESSS in Quebec
- An expert review committee will make the recommendations which will be used to help inform drug funding decisions, consistent with the initial review process. Evidence from the reassessment review will inform the recommendation from the expert review committee
- All types/sources of data could be considered, provided that they appropriately address issues of uncertainty
- The timeframe for conducting the reassessment review (not including data collection) should be about 6 months
- Reassessment reviews should not be conducted for all drugs.

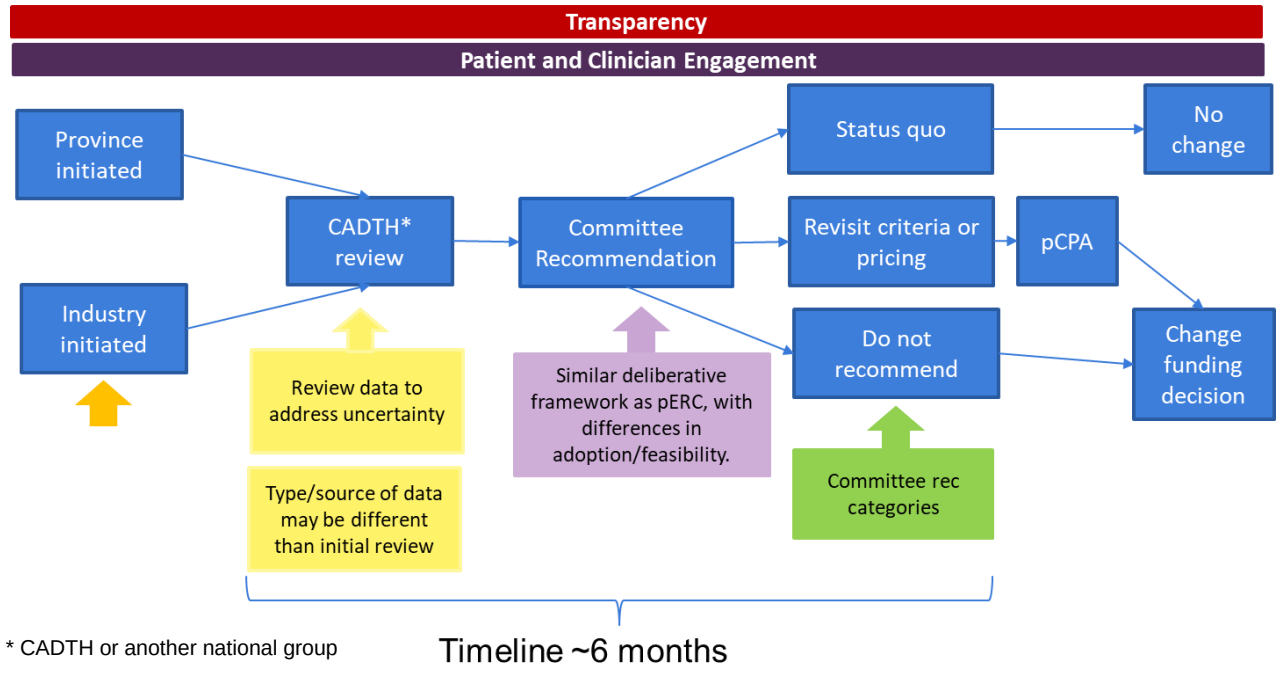

Figure 5: Preliminary CanREValue Reassessment & Uptake WG Framework

Part 3: Considerations for conducting reassessment

The WG members considered the following factors when reviewing the evidence submitted for reassessment:

1. Gaps in the evidence that informed the original drug funding recommendation
    - The new data collected for the reassessment review should address gaps or uncertainty in the evidence reviewed for the original drug review.
2. Utilization
    - Trends in utilization and whether the utilization rate was higher or lower than initially anticipated. Indication creep should also be considered (i.e., use of the drug in a broader population than what was recommended in the original review).
3. Patient experience
    - Once a drug is funded, there is increased opportunity to learn about patient experience in the real-world and compare this with the experience reported in the initial drug review.
    - A reassessment review should be considered if there is clinical relevance to the patient population.
4. Clinical outcomes
    - The important clinical outcomes (survival, safety, quality of life) identified in the initial review should be reconsidered if there was uncertainty.
5. Real-world cost-effectiveness
    - RWD could be used to update the cost-effectiveness analysis. It was recognized by the WG members that the HTA organizations will not have access to negotiated confidential drug prices, and will need to use list prices in their updated analyses for the reassessment reviews.
6. Changes in the funding algorithm & sequence of therapies
    - If new treatments have been introduced into a therapeutic space, the funding algorithm may have changed. The change in the funding algorithm may suggest the need for a reassessment review of one or more treatments in the algorithm.
7. Operational factors
    - WG members suggest that operational factors related to implementation of recommendations and sustainability be considered.

The future work of this WG will be to refine the reassessment process and identify approaches for implementing the reassessment recommendations and RWE after a reassessment review is completed by an HTA agency.

Stakeholder Consultation

Stakeholder input is essential to the development of a framework for the incorporation of real-world evidence for cancer drug decision-making. We encourage stakeholders to participate by answering the list of consultation questions provided below or to provide any other comments regarding the contents of the report.

To provide feedback and input on the interim Policy report, please use the feedback template. Please submit your completed feedback by 5:00pm EDT on January 31st, 2020 to canrevalue@cc-arcc.ca.

Note: All feedback will be collated and our subsequent responses to the feedback will be made publicly available.

Consultation Questions for consideration:

1. What barriers do you foresee in the implementation of such a framework that is proposed? What potential solutions/facilitators would ensure proper implementation.
    a. In terms of the implementation of this framework: who should participate in the reassessment of a drug that is currently publicly funded?
    b. What role should each stakeholder have in the reassessment process?
    c. In an ideal scenario, what do you foresee your role being in the process to reassessment a drug that is currently publicly funded?
    d. How should the results from a reassessment be disseminated to different stakeholders or the public?
    e. Should different criteria be used to re-assess a drug compared to when it is assessed for the first time? If so, which criteria should be different?

2. What benefit/opportunities do you anticipate for your organization or the healthcare system if there was a mechanism to re-review a drug that is currently publicly funded?

3. As we are in the planning stage of the CanREValue proposal for a reassessment process, we welcome collaboration and engagement from interested stakeholders. Please indicate how you would like to be involved in the development and implementation of this proposal.

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