Recommendation No. 22/2020

of 13 March 2020

issued by the President of the Agency for Health Technology Assessment and Tariff System

on whether Erleada (apalutamide) should be reimbursed under the following drug programme: "Treatment of castration-resistant prostate cancer (ICD-10 C61)"

The President of the Agency recommends reimbursing Erleada (apalutamide), film-coated tablets, 60 mg, 120 tablets in blister under a drug programme "Treatment of castration-resistant prostate cancer (ICD-10 C61)" **on condition that** the proposed drug programme for apalutamide is combined with the existing drug programme for enzalutamide.

Statement of reasons for the recommendation

Taking into account the position of the Transparency Council, the President of the AOTMiT believes that reimbursement of Erleada (apalutamide) in the indication in question is justified.

Results of a direct comparison with placebo + ADT are presented in the efficacy analysis of apalutamide used as adjuvant therapy used together with androgen deprivation therapy. Furthermore, results of an indirect comparison of apalutamide with enzalutamide were presented.

The results of the direct comparison (APA+ADT vs PLC+ADT) are indicative of a greater likelihood of prolonged overall survival and longer metastasis-free survival in favour of the technology in question. A cross-over analysis demonstrates that the median overall survival was not achieved in any of the compared arms and that the overall survival was statistically significantly longer in the apalutamide arm compared to the placebo arm.

However, the results of an indirect comparison (apalutamide vs. enzalutamide) do not demonstrate statistically significant differences between therapies for the analysed endpoints, including metastatic-free survival, overall survival and quality of life.

The economic analysis indicates that the technology in question is more expensive and more efficacious than placebo. In the RSS variant, the estimated incremental cost-utility ratio (ICUR) does not exceed the cost-effectiveness threshold. No calculations were made for the additional comparator (enzalutamide) as part of the economic analysis, which makes it impossible to draw conclusions in this respect.

The budget impact analysis indicates an increase in the public payer's expenditure in the event of a positive reimbursement decision of approx. *[information protected as a trade secret]*

The clinical guidelines identified in the assessed indication recommend the use of second-generation antiandrogens. Given that a drug programme for patients with castration-resistant prostate cancer already exists, it is justified to combine both programmes (the existing one and the proposed one) and to use apalutamide and enzalutamide within that programme.

Subject of the application

The order of the Minister of Health concerns assessing whether the following medicinal product should be financed from public funds: Erleada (apalutamide) film-coated tablets, 60 mg, 120 tablets in blister, EAN: 05413868117059, with the net ex-factory price: *[information protected as a trade secret]*.

The proposed patient co-payment and reimbursement availability category: a free-of-charge drug available as part of the following drug programme: "Treatment of castration-resistant prostate cancer (ICD-10 C61)", within the new limit group. The application includes a proposal of a risk-sharing scheme.

Health problem

Prostate cancer (carcinoma of the prostate gland) is a malignant neoplasm primarily originating from the peripheral zone of the prostate.

Castration-resistant prostate cancer (CRPC) is a type of prostate cancer which usually develops during the treatment of a generalised (metastatic) neoplastic disease. This cancer occurs when the castrate serum testosterone level is <50 ng/mL (or 1.7 nmol/L) with disease progression confirmed on the basis of:

- laboratory test results – three consecutive increases in PSA (prostate specific antigen) levels with a 1-week interval, whereby two increases in the PSA level by >50% over nadir (baseline), where PSA >2 ng/mL

  or
- radiographic results – the occurrence of two or more lesions in bone scintigraphy or soft tissue involvement by a change in line with RECIST (Response Evaluation Criteria In Solid Tumors) criteria.

Prostate cancer represents 13% of all malignant neoplasms in men in Poland. In 2014, the standardised incidence rate amounted to 39/100,000 (2nd place among cases of malignant neoplasms; 12,343 cases) and the mortality rate amounted to 12.63/100,000 (4,440 deaths). It is mainly diagnosed in men aged 50 and older. In Western Europe and the United States, it is the most common malignant neoplasm in men and represents 20% of all neoplasms.

Survival of patients depends on the severity of the disease and the form of treatment used. After radical treatment, 70-85% of patients survive 5 years and the percentage of 10-year survival amounts to 50-75%. In patients not eligible for radical treatment, disease progression is observed at different times from the introduction of hormone therapy, but usually after 18-36 months. Average survival of patients with a locally advanced neoplasm receiving conservative treatment is 4.5 years, and of patients with metastasis: 1-3 years.

Alternative health technologies

In the identified guidelines, using second generation antiandrogens (apalutamide, enzalutamide) and continuing androgen deprivation therapy (ADT) is recommended in patients with castration-resistant prostate cancer (with a high risk of developing metastasis).

Pursuant to the announcement of the Minister of Health of 20 December 2019 on the list of reimbursed drugs, foodstuffs for particular nutritional uses and medical devices (Official Journal of the Minister of Health, item 105), the following products are currently financed from public funds in Poland:

- reimbursement of products dispensed in pharmacies: medicinal products containing substances such as goseralin, leuprorellin, tryptorrelin and degarelix,
- B.56 "Treatment of castration-resistant prostate cancer (ICD-10 C61)" drug programme, including: abiraterone acetate, enzalutamide and radium dichloride Ra-223 (none of the indications corresponds completely to the assessed indication),
- As part of the chemotherapy catalogue (general indication – C61 Malignant neoplasm of prostate): medicinal products containing substances such as bicalutamide, carboplatin, cisplatin, cyclophosphamide, dacarbazine, docetaxel, doxorubicin, etoposide, gemcitabine, ifosfamide, vincristine and vinorelbine.

The applicant indicated chronic use of androgen deprivation therapy (ADT, pharmacological or surgical) with possible use of placebo and additionally enzalutamide (added to chronic ADT) as the alternative to Erleada. This choice is in line with the identified guidelines and should be considered as justified.

Description of the proposed intervention

Apalutamide is an orally administered, selective Androgen Receptor (AR) inhibitor which binds directly to the AR ligand-binding domain.

According to the relevant Summary of Product Characteristics (SPC), Erleada is recommended in the treatment of non-metastatic castration-resistant prostate cancer (nmCRPC) with a high risk of metastases.

The application in question concerns possible reimbursement of Erleada apalutamide) in an indication which is narrower than the indication covered by the marketing authorisation (the narrower population results from the inclusion and exclusion criteria of the proposed drug programme).

Efficacy, effectiveness and safety assessment

The assessment consists in the collection of data on health consequences (efficacy and safety) resulting from the use of a new therapy in a given health problem and other publicly financed therapies which constitute an alternative treatment option available in a given health problem. Then, the assessment requires determining the reliability of the collected data and comparing the results regarding the efficacy and safety of the new therapy with those of therapies already available in a given health problem.

Based on the above, the efficacy and safety assessment allows for obtaining information about the extent of the health effect (with regard to both efficacy and safety) to be expected in relation to the new therapy compared to the other considered therapeutic options.

The following studies have been included in the applicant's systematic review:

- SPARTAN – randomised phase III clinical trial comparing the efficacy and safety of apalutamide with placebo (in both cases, patients received additional androgen deprivation therapy) in patients with castration-resistant prostate cancer without distant metastasis and who are at a high risk of developing distant metastases. Number of patients: 1,207, Observation period: cut-off date in the first main analysis – 19.05.2017 (median observation period 20.3 months), cut-off date in the second main analysis – 17.05.2019,

- PROSPER – randomised phase III clinical trial comparing the efficacy and safety of enzalutamide with placebo (in both cases androgen deprivation therapy was administered additionally) in patients with castration-resistant prostate cancer without distant metastasis, with a high risk of developing distant metastases. Number of patients: 1,401, median observation time for the ENZ arm: 18.4 months, for the PLC arm: 11.1 months

The risk of bias in the RCTs was assessed as low in all areas.

The following parameters were used to assess efficacy:

- HR (*Hazard Ratio*) – the hazard ratio helps determine the relative likelihood of an event occurring in the experimental arm compared to the comparator arm at a given time, assuming that this event has not yet occurred.
- RR (*Relative Risk, Risk Ratio*) – the relative risk helps determine how many times the use of the assessed intervention increases the likelihood of a given event compared to the likelihood of that event occurring when the comparator is used.
- MD – mean difference Quality of life was measured using the following questionnaires:
- FACT-P: a questionnaire developed and validated in patients with prostate cancer, consisting of 39 questions broken down into 5 sub-scales (physical, social, family, emotional and functional well-being and a prostate cancer sub-scale). The possible score in the questionnaire ranges from 0 to 156 points. The higher the score, the greater the quality of life.
- EQ-5D-3: is a tool complementary to other tools used for assessment of patient-reported quality of life. This questionnaire is composed of 5 questions assessing how the patient perceives areas such as: mobility, self-care, daily activities, pain and discomfort as well as anxiety or depression. These areas are assessed using the Likert scale ranging from 1 to 3, where 1 means "no problems", 2 means "some problems" and 3 means "significant problems". On the basis of the EQ-5D-3L, the utility level is calculated, the value of which may vary from -1 to 1, where -1 means "worst imaginable health condition", 1 means "best imaginable health condition", and 0 corresponds to death.

Efficacy

<u>Direct APA+ADT vs. PLC+ADT comparison (SPARTAN study)</u>

The results of the study indicate statistically significant differences in favour of apalutamide in combination with ADT compared to the comparator for a metastasis-free survival. The median of metastasis-free survival amounted to 40.5 and 16.2 months for APA+ADT, in comparison to PLC+ADT, respectively; HR=0.28 [95%CI: 0.23; 0.35],

At the time of the first overall survival analysis, the median was not achieved in the apalutamide arm and amounted to 39 months in the placebo arm. The overall survival was longer in the apalutamide arm in comparison with the placebo arm, however the result was not statistically significant.

At the time of the second overall survival analysis, the results of which were already affected by the cross-over allowed since July 2017, the median overall survival was not achieved in any of the arms and the overall survival was statistically significantly longer in the apalutamide arm in comparison with the placebo arm; HR=0.75 [0.59; 0.96].

Furthermore, statistically significant differences in favour of the therapy in question were recorded for the following endpoints:

- increase in median time until the occurrence of metastases in total (40.5 vs. 16.6 months), HR=0.27 [95%CI: 0.22; 0.34], including both lymph node and bone metastases,

- increase in median progression-free survival (40.5 vs. 14.7 months), HR=0.29 [95%CI: 0.24; 0.36],
- prolonging time to symptomatic progression of the disease, HR=0.45 [95%CI: 0.32; 0.63],
- prolonging time to the PSA progression, HR=0.64 [95%CI: 0.052; 0.080],
- percentage of patients responding to treatment based on the PSA level, 89.7% vs. 2.2%, respectively, RR=40.09 [95%CI: 20.99; 76.58],
- percentage of patients achieving >90% decrease of PSA compared to baseline, RR=66.05 [95%CI: 24.88; 175.33],
- increase in the median of secondary progression-free survival for both cut-off dates with shorter observation periods, HR=0.49 [95%CI: 0.36; 0.66], and HR=0.50 [95%Cl: 0.39; 0.63], respectively. In the publication covering the longest observation period (cut-off date: 01.02.2019) the median of secondary progression-free survival amounted to 55.6 and 43.8 months respectively in the apalutamide and placebo arms, and the difference between the arms was statistically significant, HR=0.55 [95%CI: 0.45; 0.68]. The estimated 4-year survival without the evaluated event amounts to 64% [95%CI: 59%; 68%] in the apalutamide arm and 45% [95%CI: 38%; 52%] in the placebo arm.

In terms of quality of life, the publication authors indicated that, starting from the 11th cycle, a higher numerical deterioration was observed in the quality of life assessment (as part of the analysis of average changes in FACT-P, FACT-G scores, individual FACT-P and EQ-5D-3L subscales) in patients in the placebo arm in comparison with patients receiving apalutamide.

However, the differences observed between the arms in the 29th treatment cycle were not statistically significant in most of the evaluated parameters determining the patients' quality of life – only in the EQ-5D-3L HUI, as part of the calculations performed by the applicant, a significantly higher deterioration of this parameter was found in the placebo arm, MD=0.05 [95% CI: 0.01; 0.09].

Overall, the publication authors indicated that the FACT-P questionnaire and its subscales score, as well as the EQ-5D-3L questionnaire score, demonstrated the maintenance of quality of life of patients treated with apalutamide from the beginning of the study to the 29th cycle.

Indirect comparison: APA vs. ENZ

The results of the conducted indirect comparison did not demonstrate any statistically significant differences between APA vs. ENZ for the analysed endpoints, including metastasis-free survival, overall survival and quality of life.

Safety

Direct comparison APA+ADT vs. PLC+ADT (SPARTAN study)

No statistically significant differences in terms of deaths were observed between APA+ADT and PLC+ADT in the shortest observation period (cut-off date: 19.05.2017).

The following results were statistically significantly more reported in the APA+ADT arm in comparison to the PLC+ADT arm:

- adverse events resulting in treatment discontinuation, the risk of the event was greater by 86% in the APA+ADT arm (RR=1.86 [95%Cl: 1.26; 2.76]),
- grade 3 or 4 adverse events in total, the risk of the event was greater by 45% in the APA+ADT arm (RR=1.45 [95%Cl: 1.25; 1.67]),

- severe adverse events, the risk of the event was greater by 35% in the APA+ADT arm (RR=1.35 [95%Cl: 1.11; 1.64]),
- adverse events of any severity in total, the risk of the event was greater by 4% in the APA+ADT arm (RR=1.04 [95%Cl: 1.01; 1.07]).
- adverse events occurring in ≥15% of patients of any severity, (the risk of the event, depending on the event, was greater by 33%-430%):
    - rash (RR=4.30 (95%CI: 2.81; 6.58]),
    - body weight loss (RR=2.84 [95%CI: 1.91; 4.23]),
    - falls (RR=2.19 [95%CI: 1.57; 3.05]),
    - joint pain (RR=2.31 [95%CI: 1.62; 3.30]),
    - hot flushes (RR=1.76 [95%CI: 1.23; 2.53]),
    - fatigue (RR=1.49 [95%CI: 1.21; 1.85]),
    - diarrhoea (RR=1.45 [95%CI: 1.11; 1.88]),
    - arterial hypertension (RR=1.33 [95%CI: 1.06; 1.65])
- grade 3 or 4 adverse events of special interest:
    - rash (the risk was over twenty times greater, RR=20.82 [95%CI: 2.88; 150.70]),
    - fractures (the risk was over four times greater, RR=4.34 [95%CI: 1.55; 12.12]),
    - collapses (the risk was over three times greater, RR=3.47 [95%CI: 1.04; 11.56]),

Indirect comparison: APA vs. ENZ

The result of the indirect comparison demonstrated that there are no statistically significant differences between the arms in terms of severe adverse events and fatal adverse events.

A significantly lower risk of total adverse event was demonstrated in patients using apalutamide compared to patients using enzalutamide (RR=0.92 [95%CI: 0.87; 0.98]).

The results obtained for individual adverse events indicate that:

- the following adverse events are statistically significantly more common in apalutamide arm in comparison to the enzalutamide arm:
    - joint pain (RR=1.730 [95%CI: 1.003; 2.990]),
- the following adverse events are statistically significantly less common in apalutamide arm in comparison to the enzalutamide arm:
    - fatigue of any severity (RR=0.61 [95%CI: 0.44; 0.84]),
    - arterial hypertension of any severity (RR=0.54 [95%CI: 0.33; 0.88]),

Additional safety analysis

In line with the SPC for Erleada, very common adverse effects (≥1/10) include:

- skin and subcutaneous tissue disorders such as: rash,
- musculoskeletal and connective tissue disorders such as: fractures and joint pain,
- general disorders and administration site conditions such as: fatigue,
- deviations in additional examinations such as: body weight loss,

- injury, poisoning and procedural complications: falls.

Effectiveness

No studies on the effectiveness of the intervention in question have been identified.

Limitations of the analysis

The following aspects impact the uncertainty of results of the clinical analysis:

- No direct comparisons between apalutamide and the additional comparator – enzalutamide – have been identified, so an indirect comparison which constitutes a limited source of conclusions due to the nature of this method was carried out.
- Some of the results presented by the applicant were derived from conference abstracts.

Proposals of risk-sharing schemes

As part of the risk-sharing scheme (RSS), *[information protected as a trade secret]*

Economic analysis, including a cost-effectiveness estimation

An economic analysis consists in estimating and comparing the costs and health effects which may be associated with the use of a new therapy in an individual patient instead of therapies which are currently reimbursed.

The costs of the therapy are estimated in the Polish currency and the health effects are usually expressed using the life years gained (LYG) or the quality-adjusted life year (QALY) as a result of the therapy.

The comparison of values concerning the costs and effects related to the use of a new therapy and comparing them to the costs and effects of currently reimbursed therapies allow for obtaining an answer to the question on whether the health effect achieved as a result of the new therapy is associated with higher costs in comparison to the currently reimbursed therapies.

The achieved cost-effectiveness ratios are compared with the so-called cost-effectiveness threshold, i.e. which indicates that taking into account the means at the disposal of Poland (expressed in its GDP), the maximum cost of a new therapy necessary to obtain a unit of health effect (1 LYG or 1 QALY), compared to the currently available treatments, should not exceed three times the amount of per capita GDP.

The estimated cost-effectiveness threshold in Poland amounts to PLN 147,024 (3 x PLN 49,008). The cost-effectiveness ratio does not estimate or determine the value of life, it only allows to assess and, among other things, select a therapy associated with the potentially best use of the currently available resources.

The cost-effectiveness analysis for apalutamide + androgen deprivation therapy (ADT) was carried out in comparison to placebo + androgenic deprivation therapy (ADT), using the cost-utility method in the life-long (30 years) time horizon from the public payer's perspective (NHF) and the common perspective (patient+ payer, which is comparable to NHF's perspective). The following cost categories have been included in the applicant's economic analysis: costs of drugs, costs of administration / dispensing of drugs, costs of treatment diagnosis and monitoring, costs of adverse events, costs of disease monitoring, costs of subsequent anticancer treatment lines after the occurrence of metastases, costs of palliative care.

According to the applicant's calculations, using APA+ADT instead of PLC+ADT is more expensive and more efficacious both in the scenario with and without the RSS. In the RSS variant, the technology is cost-effective. The calculated incremental cost-utility ratio (ICUR) from the NHF's perspective was: *[information protected as a trade secret]* and PLN 288 246/QALY without the RSS.

With the ICUR value estimated in the basic analysis conducted for the comparison in question, the threshold value of the net ex-factory drug price estimated by the applicant amounts to (in the NHF's perspective) *[information protected as a trade secret]* (regardless of the RSS).

The results of the one-way sensitivity analysis demonstrated that, in each variant, adding apalutamide to ADT was a more expensive and more efficacious strategy than the comparator, *[information protected as a trade secret]*

In line with the probabilistic analysis carried out by the applicant, in the NHF's perspective and taking the RSS into account, the probability of the cost-utility of the technology in question in relation to PLC in the general population amounts to *[information protected as a trade secret]*.

Limitations of the analysis

The uncertainty of the economic analysis results is affected by the following limitations:

- There are no long-term data concerning the use of the technology in question (the median observation period in the study is 20.3 months), and therefore r the health results must be extrapolated. When analysing the impact of discount rates on health outcomes, it is possible to notice their high impact, which suggests that a significant part of the incremental health effect is generated in the period for which there are no clinical data (conclusions must be drawn based on data estimates), which limits the reliability of the obtained results.
- In HAS 2019, ENZ was included as the comparator for APA and the French agency noted that, due to the equivalence of the efficacy data of the two interventions (MFS, OS and treatment duration), they can only be differentiated by cost and tolerability profile. Therefore, for a complete view of the situation, carrying out a cost minimisation analysis for APA vs ENZ for the part of the population in question and including ENZ in the applicant's economic analysis as an additional comparator seems reasonable (as it was the case in the applicant's clinical analysis). Thus, there are some discrepancies between the analyses concerning the selection of comparators for comparison with the technology in question.

Indication whether the circumstances referred to in Article 13, paragraph 3 of the Act of 12 May 2011 on the reimbursement of drugs, foodstuffs for particular nutritional uses and medical devices apply (Journal of Laws of 2019, item 754 as amended).

In case the applicant's clinical analysis does not include randomised clinical trials which prove the superiority of the drug over the medical technologies which are currently reimbursed in the particular indication, it is the ex-factory price of the drug which must be calculated in such a way that the cost of using the drug applying for reimbursement is not higher than the cost of the health technology with the most favourable ratio of health effects to the cost of obtaining them.

The clinical analysis included a randomised trial which directly demonstrated the advantage of apalutamide over its comparator, and hence the circumstances specified in Article 13 of the Act on reimbursement do not apply.

Analysis of the effects on the healthcare system, including budget impact analyses (BIA)

The analysis of the effects on the healthcare system consists of two important parts.

Firstly, the analysis of the impact on the payer's budget allows for estimating potential expenditure related to the financing of a new therapy from public funds.

The estimated expenditure related to the new therapy (the "tomorrow" scenario) is compared with how much currently is spent on the treatment of a particular health problem (the "today" scenario). On that basis it is possible to assess whether the new therapy will require a higher level of funding for the treatment of a particular health problem or whether it will involve savings in the payer's budget.

The budget impact assessment makes it possible to determine whether the payer possesses the necessary resources to finance a particular technology.

The second part of the analysis of the effects on the healthcare system raises the question on how the decision to finance a new therapy can affect the organisation of the provision of services (especially in the context of adjustments necessary for the new therapy to be used) and the availability of other healthcare services.

The assessment of the impact on the public payer's budget was conducted from the NHF's perspective in a 5-year horizon. The estimated population size (presented as person-years) which will be using the technology in question following a positive reimbursement decision is 1 363, 391, 394, 398, 401 persons in subsequent years of financing. The following cost categories were included in the analysis: costs of drugs, costs of administration / dispensing of drugs, costs of treatment diagnosis and monitoring, costs of adverse events, costs of disease monitoring, costs of subsequent anticancer treatment lines after the occurrence of metastases, costs of palliative care.

In the event Erleada is reimbursed under the drug programme in question, the public payer's expenditure in the target population will increase in relation to the existing scenario, subsequently in five years of the analysis by:

- *[information protected as a trade secret]*

The sensitivity analysis for the variant assuming the RSS demonstrates that *[information protected as a trade secret]*

In the variant without the RSS *[information protected as a trade secret]*

In the extreme scenario (with the RSS), the anticipated public payer's expenditure in the target population will increase in relation to the existing scenario *[information protected as a trade secret]*

Limitations of the analysis

Given that, for a part of the patient population, enzalutamide is the comparator, it would be reasonable to carry out an estimate as part of the sensitivity analysis taking into account the additional comparator.

Remarks on the proposed risk-sharing scheme

[information protected as a trade secret] It should be pointed out that the guidelines also mention enzalutamide in the assessed indication, included as the comparator only in the clinical analysis. At the same time, no statistically significant differences in terms of efficacy for the APA + ADT vs ENZ + ADT comparison have been identified. This constitutes an additional condition to level the costs of these therapies, however, the economic analysis did not provide a cost-minimisation analysis for the APA vs ENZ comparison. Thus, it is not known whether even with the proposed RSS, the technology in question would not be more expensive than the comparator.

Remarks on the drug programme records

No remarks.

Review of the solutions proposed in the rationalisation analysis

The objective of the rationalisation analysis is to identify a mechanism which, if introduced, will result in a release of public funds in an amount at least corresponding to the increase in costs resulting from a positive decision to reimburse the intervention in question in the analysed indications.

A rationalisation analysis is submitted if the budget impact analysis of the public payer demonstrated that the cost of reimbursement would increase.

[information protected as a trade secret]

Implementation of the proposed rationalisation solution will allow for the release of public funds exceeding the estimated payer's expenditure in the analysed period resulting from the decision on the reimbursement of Erleada, *[information protected as a trade secret]*

Review of recommendations issued in other countries in relation to the technology in question

The following clinical guidelines from the following institutions on the assessed health technology have been identified:

- National Comprehensive Cancer Network – NCCN 2019;
- European Association of Urology – EAU 2019
- Canadian Urological Association/Canadian Uro Oncology Group – CUA/CUOG 2019
- American Urological Association – AUA 2018
- Polish Society of Urology – PTU (Polskie Towarzystwo Urologiczne) 2011;

The 2019 European EAU guidelines recommend the use of apalutamide or enzalutamide in patients with castration-resistant prostate cancer (with a high risk of developing metastasis). The same recommendation was included in the 2018 American AUA guidelines, additionally indicating that androgen deprivation therapy should be continued in these patients. In addition to the above recommendations, the 2019 Canadian CUA/CUOG guidelines also indicate a 5-year life expectancy, while the American NCCN guidelines of 2019, in addition to apalutamide and enzalutamide, indicate the possibility of using darolutamide (without indicating the preferred substance) or other second-line hormone therapy.

2 positive recommendations (Canadian Agency for Drugs and Technologies in Health 2018, Haute Autorité de Santé 2019) and 2 negative recommendations (Pharmaceutical Benefits Advisory Committee 2018 and 2019) have been identified in the search for reimbursement recommendations. Positive recommendations focus mainly on the clinical benefit of using a combination of ADT and apalutamide treatment in terms of a clinically relevant improvement in metastasis-free time, time to symptomatic progression or a satisfactory safety profile. Negative recommendations mainly point out the unclear benefits in terms of survival and the high value of the ICER ratio.

[information protected as a trade secret]

Legal basis for the recommendation

The recommendation was prepared on the basis of an order of the Minister of Health of 09.12.2019 (reference number: PLR.4600.1179.2019.18.MN), to prepare a recommendation of the AOTMiT's President on whether to reimburse Erleada, apalutamide, film-coated tablets, 60 mg, 120 tablets in blister, EAN: 05413868117059 under Article 35 sec. 1 of the Act of 12 May 2011 on the reimbursement of drugs, foodstuffs for particular nutritional uses and medical devices (Journal of Laws of 2019, item 784, as amended), after having read the Position of the Transparency Council No. 22/2020 of 09 March 2020 on the evaluation of Erleada (apalutamide) under the following drug programme: "Treatment of castration-resistant prostate cancer (ICD-10 C61)".

References

1. The Position of the Transparency Council No. 22/2020 of 09 March 2020 on the evaluation of Erleada (apalutamide) under the following drug programme: "Treatment of castration-resistant prostate cancer (ICD-10 C61)"
2. Report No. OT.4331.69.2019 "Reimbursement application for Erleada (apalutamide) to be available under the following drug programme: "Treatment of castration-resistant prostate cancer (ICD-10 C61)"". Completion date: 28 February 2020