LSTN
Life-Saving Therapies Network
Better Therapies, Faster Access

Stakeholder Input on the Patented Medicines Prices Review Board Guidelines

Life Saving Therapies Network
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About Us

The Life-Saving Therapies Network (LSTN) – www.lifesavingtherapies.com – is a patient-led international network focused on life threatening disease therapies, including advanced cancers and other orphan diseases. The essence of our work is to reduce systemic barriers and develop efficient and equitable access to therapies for lethal diseases through the following objectives:

- ✓ Clinical research reform to permit faster, less expensive access to new therapies for lethal diseases
- ✓ Reforming regulatory frameworks for the development and approval of personalized treatment for lethal diseases
- ✓ Timely and thorough reimbursement for effective lethal disease treatments and companion diagnostics.

LSTN consists of oncologists, researchers, patients, regulators, pharmaceutical industry representatives, medical ethicists, health economists, and others from Canada, the USA and EU.

Our initiatives are based on evidence-based research, publications, and support from a cross-section of key players in the healthcare system internationally.

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International Reference Pricing

The proposed PMPRB Guidelines will rely in part on reference list prices from other jurisdictions (PMPRB12) to establish a price ceiling for a given patented medicine.

One significant change to the basket of countries currently used for international reference pricing excludes the United States. This is counterproductive for several reasons. First, the Canadian market is significantly smaller than that of the US and it faces greater competitive pressures from the American market given the United States' geographical proximity to Canada. Second, international reference pricing does not exist in a vacuum, but is subject to domestic policies of separate jurisdictions. Given that the Trump administration in the United States has indicated that they may seek to import low-cost medications from Canada, it makes sense to include the US in the basket of reference countries and avoid additional pressures on the supply of medications in the Canadian market. Third, Canadian patients are already at a disadvantage when compared to the US. According to the Canadian Organization for Rare Disorders (CORD), Canadian Patients have access to only 60% of treatments available elsewhere. Further, access to most of these treatments in Canada is delayed by up to 6 years when compared with the United States and Europe. In Canada, recent analyses indicate that there are thousands of additional life-years lost due to delays in funding of effective therapies after Health Canada approval. Anything that further delays either Health Canada approval of drugs or approval of funding will have the potential to translate into even greater avoidable suffering and loss of life.

By excluding the US from the list of reference countries and thus achieving slightly lower median drug costs, the Canadian approach would ensure that Canadian patients receive even less access to medications that are available south of the border.

Some argue that, despite all of this, Canadians have better health outcomes than Americans. However, this analysis fails to distinguish between health outcomes as a result of access to medication and health outcomes tied to a litany of other social factors that differ between the two countries, including but not limited to inadequate access to primary care for many younger Americans. Avoidable death of a young person from, for example, childbirth has a much greater impact on average life expectancy than does death of an older person from cancer. Americans have higher death rates from some things than do Canadians, but lower death rates from cancer. The comparison also does not take into account the impact on US life expectancy of the much higher rates of incarceration in the US (with its negative health consequences), and the much higher rates of deaths from firearms. Simply looking at life expectancy in the two countries as a metric for the Canadian health care system is very misleading.

For cancer, 5-year relative survival is about 68% for Americans vs 63% for Canadians, and differences have been present for a long period of time. This may not sound like much, but it translates in large numbers of premature cancer-related deaths in Canada. With an estimated 220,000 new cases of cancer in Canada annually, this 5% difference in death rate potentially

translates into more than 10,000 additional deaths in Canada that might have been avoided if Canadians had access to cancer care and therapeutics that was equivalent to the US. This difference is probably because Americans who have Medicare (65 years and older) and younger Americans with insurance can more easily obtain advanced anti-cancer drugs than for Canadians.

The current proposal risks worsening access for Canadians.

The Case Against Case-by-Case

If implemented, the PMPRB Guidelines would set a price ceiling of $60,000/QALY as determined by the PMPRB Pharmacoeconomic Assessment, with some additional expansion of the pharmaco-economic price for medicines for rare diseases. The maximum rebated price would be lowered further for every $25 million revenue increment after the first $25 million in sales.

Limiting the list price of these drugs to a maximum of $60,000/QALY (with some provision for higher pharmacoeconomic prices for treatments for rare diseases with sales up to $12.5 million) would ensure that new medications, such as targeted therapeutics and other personalized medicines for oncology and rare disorders, do not get marketed in Canada – or that they are marketed only after extensively exacerbated delays. Such an approach will have a large negative impact on the number of new, effective and innovative medications that are available to Canadian patients, and those are the medicines that extend and save lives and that relieve suffering. Canadian patients currently have less access to these medications when compared with their American neighbours. Why, and according to what moral logic, is PMPRB proposing to make it worse?

On many occasions, PMPRB has publicly said that this concern is baseless fear mongering by the pharmaceutical industry. LSTN does NOT represent the pharmaceutical industry, nor do we speak on their behalf. We are, however, deeply concerned that the PMPRB Guidelines will create a certain reduction of effective, leading-edge medications available to Canadian patients.

If medications are not going to be brought to the Canadian market, then there is no ethical or business rationale for conducting clinical trials in Canada for innovative, life saving therapies. It is morally wrong to test a pharmaceutical product in a patient population if the product is not going to be generally available to that patient population. Furthermore, pharmaceutical companies and manufacturers will have no business incentive to conduct clinical trials in Canada. The cost of conducting clinical research in Canada is higher than in many other jurisdictions, but Canadian patients are given the opportunity to participate in these clinical trials since the clinical trials foster later sales by introducing these new agents to Canadian clinicians and patients. This proposed approach will eviscerate Canada's clinical trial infrastructure, its value as an economic research generator, and, most important, the near- and long-term value to patients. Many Canadians currently access life-saving therapies through participation in a clinical trial. This will no longer be an option. Furthermore, compassionate and special access programs

will be effectively neutered since companies will have little incentive to offer compassionate access in Canada if there is little potential for them to market their agent profitably here.

The PMPRB Guidelines must provide an off-ramp to patients with lethal disorders who rely upon clinical trials and compassionate access programs to derive therapeutic benefits from experimental therapies. The notion that these patients should be treated on a case-by-case basis is untenable. They face numerous challenges and have numerous unmet needs. It is inappropriate for the PMPRB to impose another layer of bureaucratic obstacles to their individual medical circumstance, which is often time sensitive. For example, lung cancer is by far the leading cause of cancer death in Canada and is the 2nd overall leading cause of death. Every week of delay in initiating systemic therapy in patients with metastatic lung cancer another 4% of patients die and many others deteriorate to the point that they are too sick and close to death to even consider therapy. The situation is no better for other rapidly progressive malignancies like pancreatic cancer and glioblastomas. Additional bureaucratic delays during which individual patient approval is mandated will make an already difficult situation much worse. These inevitable bureaucratic delays that such a case-by-case implies would be cruel and untenable. In addition, it has to be recognized that not only do these therapies prolong highly valued life, they are also a highly effective way to alleviate suffering. Therapies that shrink a cancer even slightly can not only increase the amount of time that patients have with loved-ones but also can be a much more potent and better-tolerated analgesic than morphine.

The Guidelines must be broadly inclusive of patients in exceptional circumstances.

Reductions and delays in Canadian clinical trials for novel therapies for cancer and rare disorders will also have a negative impact on the PMPRB's own mandate as it pertains to the Guidelines. Randomized clinical trials are the only way that is even remotely reliable to define QALYs, and the RCTs have major issues. In particular, for relatively uncommon molecular subtypes it will take years to do these studies, if they can be done at all. *This will delay decisions by years, and many, many patients will die without access because of this highly flawed metric.*

Unintended Consequences

It is noble of the PMPRB to seek to make medications more affordable for Canadians. Low-income Canadians without private coverage will be able to access their medications and will not have to neglect taking the necessary medication because they can't afford it. However, price is only one aspect to access.

A drug that is not available in the Canadian market is of no benefit to Canadian patients if they cannot access it.

The PMPRB's efforts to address the issue of equality of access to therapeutics must not lead to fewer therapeutic options, especially for lethal disorders. This would unintentionally grant less

access to everyone equally. You do not chain everyone to the deck of the Titanic. LSTN feels that PMPRB may unintentionally cause this, and it may become the reality facing Canadians. The PMPRB should consider looking at these issues through the lens of improving access for all rather than selectively limiting access for some. This will not impede the PMPRB's mandate as reducing the cost of medication is an aspect of better access, but it is not the only aspect.

Recommendations

1. *Include the US in the basket of countries used for international reference pricing.*
2. *Provide more flexibility in the use of price ceilings, especially for novel and innovative therapies for lethal disorders.*
3. *Protect compassionate access and special access programs and avoid disincentives for drug makers to market and provide compassionate access to life saving drugs in Canada.*
4. *Recognize that for less common diseases it will not be feasible to do the randomized clinical trials in a timely and economic fashion that would be required to develop QALY data.*
5. *Develop an approach that is inclusive of broader needs of patients enrolled in clinical trials and maintain the sustainability of Canada's clinical trial infrastructure*
6. *Seek to avoid unintended consequences by convening a multi-stakeholder panel that will monitor discrepancies between the number of drugs approved and marketed in Canada as compared to other OECD jurisdictions.*