VIA SUBMISSION PORTAL AND ONLINE (www.raredisorders.ca)

June 21, 2021

Patented Medicine Prices Review Board

Standard Life Centre, Box L40

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Ottawa, ON K1P 1C1

Subject: Canadian Organization for Rare Disorders submission to PMPRB GMEP

The Canadian Organization for Rare Disorders (CORD) is Canada's national alliance of rare disease patient organizations, a registered charity, which collectively represent hundreds of thousands of individuals and families affected by rare diseases. Our mission and mandate are to:

- Improve lives of patients and families affected by rare diseases
- Represent and Advocate on behalf of rare disease patient community
- Educate and promote informed engagement of patient organizations and individuals

While CORD is taking the opportunity to respond to the consultation on the Patented Medicines Prices Review Board (PMPRB) consultation on the proposed Guideline Monitoring and Evaluation Plan (GMEP), we are contributing with limited expectation that our recommendations will make any meaningful changes to the CMEP as proposed. This opinion is based on our experiences of engagement from the very beginning when the PMPRB launched the draft regulations and asked for stakeholder input in 2016. Specifically, we note:

- There were no substantive changes to the draft regulations despite strong informed feedback from diverse stakeholders, including patient organizations, many of which challenged the PMPRB's premises and rationale for the proposed regulatory changes and the interpretation of potential impacts. Namely, the PMPRB overstated the potential "benefits" to healthcare budgets and minimized the potential fallout or negative consequences for many stakeholder but especially for patients.
- With respect to the 2019/20 feedback to the draft guidelines, there was denial of the concerns raised by CORD and other patient groups and outright rejection of recommendations as being ill-informed, biased or unnecessary. The closed-minded attitude of the PMPRB leadership to any views that were contrary to their own was apparent in the contentious discussions at the face-to-face consultations in December 2019 and subsequent communications in early 2020.
- The experience of myself as the CORD represent (and echoed by the other patient representatives) throughout the "Steering Committee" meetings from 2018 to 2019. The meetings consisted primarily of the PMPRB senior staff giving presentations on prepared guideline positions, with very limited opportunity for genuine deliberation. There was absolutely no tolerance for debate on the veracity of information presented

and no opportunity, despite repeated requests, to consider alternative approaches to the guidelines, no willingness to test their potential impact using case scenarios, and absolutely no time for deliberation on the recommendations. This lack of genuine engagement by the Steering Committee extended even to the final report, which was presented to the government without any preview, discussion, or approval of the Steering Committee (even though it was labeled as a report of the Steering Committee). There is no other way of characterizing the process except a deplorable (ab)use of power by the senior staff who were actually "steering" the process.

- On behalf of CORD but the majority of the patient community, I have been shocked by the privately and publicly expressed negative and biased comments regarding patient organizations whose views did not align with those of the PMPRB. Ironically, despite the best efforts of the PMPRB to recruit other patient groups, there have been few (no) genuine patient group representatives who actually supported the PMPRB regulatory and guidelines changes. Rather those who have appeared at public meetings or government hearings have been individual patients/families and an individual whose perspective was based on a patient group experience that took place more than 20 years ago. It has been especially discouraging to hear the PMPRB leadership privately denigrate and publicly shame" and attempt to "cancel" patient organizations, based, in part, on some of their sources of financial contribution.

CORD has been especially disheartened and indeed baffled by the continued dismissal of our opinions as biased or influenced by industry when we have hosted about a dozen public forums on PMPRB changes with a wide range of Canadian and international experts drawn from academia (e.g., University of Calgary, York University), respected research institutions (e.g., Office of Health Economics, C.D. Howe Institute), research and development consortia (e.g., Life Science Ontario, InVivo), and clinical institutions (e.g., Sick Kids Toronto, Children's Hospital of Eastern Ontario, Paediatrics and Child Health, Manitoba).

Nevertheless, we do want to provide critique and recommendations to the proposed GMEP. We will address these in the order of priority for patients, specifically from the perspective of rare disease patients and families.

Recommendation #1. Without mutual trust and agreement on the basic facts, the guidelines, however modified and implemented, will only serve as points of contention rather than tools for cooperation. In the best interests of the patient community that we are mutually committed to serve, the PMPRB and patient organizations must take necessary actions to establish a trusting and collaborative environment. This may be undertaken through mutually trusted third-party facilitators.

Access to Medicines

The proposed GMEP presents as key indicators for "access to medicines": clinical trials availability, availability of new medicines, and coordination across the activities from HTA to coverage. To those ends, they have identified the key issues as: high prices (over $100k), reduction in number of clinical trials due to unwillingness of companies to conduct CTs where there is no intention to market, and number of medicines launched in Canada relative to comparable countries. They suggest factors that speak to lack of negative impact on these outcomes as: the exemption of "high cost/small market size" therapies (rare disease drugs) from application of economic factors; trend toward fewer CTs in developed countries, and their observation of no decline in Canadian clinical trials (despite imminent implementation of new pricing guidelines).

However, given the disagreement across stakeholders including the patient community with the PMPRB's analysis of the current status of industry-engaged clinical trials and the submission of new applications to Health Canada over the past two to three years, it would be impossible to accept the PMPRB's singular monitoring of outcome measures including clinical trials availability and the number of new medicines (especially rare disease drugs) to provide an accurate reflection of the actual availability of meaningful (Phase II and III) clinical trials in Canada and the number of new medicines, including the timely submission of applications.

Recommendation #2: The analysis of CTs and new medicine submissions must be preceded with agreement among stakeholders (including patients) as to what to count and how to count. To make international comparisons, we also need to agree on the comparator jurisdictions based on various consensual factors as well as qualitative assessments as to the relevant (explanatory) factors. We also need comparable indicators of medicines available through public and private drugs plans, again with very thorough understanding as to the environments. As Canada moves into a new Rare Disease Drug Strategy, the baseline information will be very important and really require a multistakeholder ownership in the monitoring and evaluation systems, including public and private drug plans, hospitals and other clinical dispensing environments, patient organizations, patient support programs, pharmacists, and manufacturers.

In terms of systems coordination of the pathway from HTA to coverage, we respectfully suggest that these are areas where PMPRB should not be monitoring or evaluating and indeed the imposition of PMPRB into the functions and the attempt to provide any form of regulatory or quasi-judicial oversight will be a significant hindrance rather than facilitation. This is especially true with respect to the innovative complex medicines that are increasingly dominating as new drug developments. Health Canada, as regulator, is evolving new methodologies and frameworks that are premised on agile, flexibile, and adaptable processes to approve clinical trials and therapies that are increasing targeted at niche populations often with high unmet needs that challenge traditional standards for trial size and duration, clinical outcome measures, significant p-values, long-term impact and overall certainty. More than ever, the appropriate access to these therapies requires appropriate expertise, broad understanding of the patient needs, and capacity to assess health system and societal impact. Moreover, to realize the potential value of these new medicines, flexible access arrangements will need to be

put in place with ongoing monitoring and adaptation, based on real world use and outcomes. Most importantly, in order to achieve value, there must be agreement and adherence to these access arrangements by all stakeholders, and that requires mutual trust.

All of these points reinforce CORD's concerns with the imposition of PMPRB in cost-effectiveness evaluation, price negotiation between payer and manufacturer, and drug coverage by public and private payers.

Prices

There is sharp and fundamental disagreement by the patient community with the PMPRB's analysis and presentation of the current status of drug pricing; indeed, experts have challenged the data as to Canada's current drug spending. We also have clear disagreement with the projection from PMPRB as to the impact of the new regulations (and guidelines) on price reductions. Equally problematic is the unilateral application of factors, without transparency, consultation or right to redress, that will determine categorization of new drugs.

While we recognize the role of the PMPRB to set, monitor, and evaluate Maximum List Price of new medicines, we fundamentally disagree with their having any role in setting Maximum Rebated Prices. As noted in the previous section, the pathway to a reimbursement price (not necessarily rebated) is through understanding of the place in therapy for the patient, including the urgency and the unmet need, and the value to patient, healthcare system and society.

CADTH and INESSS are evolving their HTA procedures to better meet the needs of innovative medicines with high uncertainty and high cost. The international HTA community, as amply discussed by HTAi and ISPOR, is to move away from singular and ubiquitous concepts such as "cost per QUALY", that is the ICER. Rather, as debated by international HTA consortiums, such as IMPACT-HTA, the goal is to increase flexibility and agility in recommendations and to implement reassessment procedures based on real-world usage. Both CADTH and INESSS are developing capacity and processes for real-world evidence that are critical to medicines such as cell and gene-therapies.

Moreover, developed countries are also increasingly sophisticated in managed access programs that include "risk-sharing" as well as "pay for performance" agreements.

These involve negotiated risk-sharing specific to each situation (and even to each patient), and each arrangement will necessarily change over time with usage and the analysis of real-world data. The PMPRB proposition is woefully inadequate, even with the many tiers and conditions.

Moreover, it would be a total duplication (and poor one) for the PMPRB to try to put in place expertise to monitor and collect the evidence. Challenging enough for patients to share their data but to ask them to hand these over to a price regulator will be a step too far. In other words, PMPRB should stick to their knitting and leave the value-based assessments and price negotiation to those with the mandate.

Recommendation #3: The PMPRB must eliminate from its guidelines the application of economic factors and indeed remove the goal of establishing a regulated binding Maximum Rebated Price. The MRP is also the scope of the PMPRB role and mandate. The PMPRB has

already been denied any access to actual rebated (reimbursed) prices so there is no possibility of enforcing an MLP (without taking a patentee to court). And a singular MRP does not provide the flexibility, agility, and adaptability demanded by current and future innovative medicines, especially those for targeted patient populations, including rare diseases, and those with projected long-term outcomes (including cures).

Pharmaceutical Ecosystem

While the PMPRB posits the ecosystem as balance between payers' concerns about "sustainability" and industry's concerns about attractiveness of Canada for Research and Development investment, in fact, they discuss the issue only from the payers' perspective. Moreover, the PMPRB figures on drug spending, healthcare spending and "R&D to sales" have been contested by the industry and other experts who have provided other statistics and projections. Yet, the PMPRB has never reconciled their figures or even acknowledged alternative interpretations. If there is no agreement on the sources of data, the analyses, the interpretation of findings and the subsequent baseline figures, there will be no agreement on outcomes from a monitoring and evaluating of the ecosystem … if the only agent or the lead agent is the PMPRB. Garbage in, garbage out. We need trusted independent third-party assessors to collect, analyze and arbiter the baseline situation as well as conduct the monitoring and evaluation.

Recommendation #4: Establish an independent, multistakeholder, balanced, reputable, respected body to monitor and evaluate the implementation of PMPRB guideline changes … which must not include the application of economic factors nor the setting of Maximum Rebated Prices. It should differentiate spending on drugs by the public and private drug plans. However, given that direct access to negotiated drug prices is not allowed, it must be determined in advance as to the terms of reference of a monitoring body and what can be learned. Moreover, the monitoring body should be charged to carry out its mandate without the assumption, as expressed by the PMPRB, that drug pricing is excessive. Indeed, the body should develop a frame of reference that equally considers that drugs, including high-priced new medicines, can be cost-effective, affordable, and sustainable. Finally, it should also consider alternative scenarios for sustainable access, not only lowering drug prices but also increasing investment in new therapies.

Processes

It is critically important to engage with Canadians on an on-going basis to get feedback on what should be measured, how these outcomes and impacts should be measured, and who should be involved in the measuring. All stakeholders have legitimate perspectives that must be considered and legitimate outcomes that must be respected and met.

Recommendation #5: The GMEP process needs to come under the purview of a multistakeholder management group which recognizes that no one is free of vested interests

or potential conflicts. Appointment must balance perspectives and operate in a process of transparency and accountability to the public.

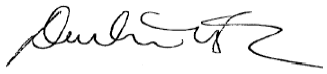
As patients who will be seriously affected by the regulations if they are implemented, it is also exceptionally important to put an immediate halt to the implementation of the new regulations, still scheduled for July 1, 2021, until there have been real consultations. Simply put, it would be UNETHICAL, UNJUSTIFIABLE, AND UNFAIR to move forward on the implementation of the PMPRB regulations given the enormous amount of remaining uncertainty associated with the new pricing system.

The regulations would also undermine ongoing federal efforts to develop a national rare disease strategy to improve access to treatments for rare disease patients. It is through initiatives like the rare disease drug strategy that the key issues can be effectively addressed, including affordability, real world evidence development, managed access and early diagnosis and treatment.

We can and we must work together to find genuine solutions that help assure medicines, including innovative new therapies, are affordable for all Canadians without endangering their access to the most appropriate treatments for their individual needs as soon as possible.

Thank you for your attention. If you require any further information on CORD's position or our efforts toward creating a national Rare Disease Drug Strategy, please do let me know.

Sincerely,



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