

34) were approved, 29% (10/34) were approved for restricted use and 14% (5/34) were not approved by the SMC. The primary reasons for the SMC to restrict or reject the use of a drug were the survival analysis and the comparator presented by companies. Of the five not approved drugs, three were rejected due to a non-submission by the company and two of the drugs were rejected due to a single-arm trial design. **Conclusion:** In conclusion, the majority of CDF-approved drugs were approved without restriction in Scotland. However, a small proportion were not approved by the SMC and a larger proportion were approved with restrictions. There may be scope for further policy changes (such as, but not limited to, an interim funding mechanism such as the CDF) to support access for these drugs.

PCN237

NATIONAL INSTITUTE OF HEALTH AND CARE EXCELLENCE HTA METHODS USED IN ASSESSING UNCERTAINTY OF ONCOLOGY DRUGS WITH CURATIVE INTENT IN ENGLAND-A TARGETED REVIEW

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Objectives: Recent scientific advances in precision and personalised medicine have shown curative potential in areas of high unmet need within oncology. The EMA has recognised this evolution by introducing adaptive licencing, however, NICE has maintained the same cost-effectiveness methods for 20 years without any significant change to valuing curative innovation. This targeted review aims to identify key areas of NICE methods that impact value assessment, uncertainty and innovation recognition in England for EMA-approved oncology treatments with curative intent. **Methods:** Targeted electronic literature search of committee papers and final appraisal documents in the online NICE guidance database.

- Search term: 'cure model'.
- Inclusion criteria: technology appraisals in oncology, January 2009-September 2019.
- Main data extraction topics: definition of cure, clinical trial design, key areas of uncertainty, end of life (EoL) criteria and recommendations for inclusion in the Cancer Drugs Fund (CDF).

Results: Data extraction was conducted on 19 technology appraisals. The definition of cure was heterogeneous across technology appraisals. In TA589 and TA541 both in acute lymphoblastic leukaemia, cure was defined by patients remaining alive at 5 and 3 years respectively. Clinical effectiveness evidence was often from single arm phase II trials (37%). The main drivers of cost-effectiveness were cure assumptions. Eighty-nine percent of the interventions identified were recommended for use in the CDF and 32% met NICE's EoL criteria. **Conclusions:** Uncertainty was a key issue for cure modelling in all appraisals, as evidenced by the high proportion of CDF recommendations. These are subjected to lower ICER thresholds in an attempt to alleviate the decision risk attributed to uncertainty. Results suggest that innovative drugs with curative intent are penalised on their evidence base, which is often from single arm trials, identify aspects of NICE methods for reform and highlight misalignment between HTA requirements and EMA adaptive licensing.

PCN239

COST-UTILITY OF THE CDK 4/6 INHIBITORS FOR POSTMENOPAUSAL WOMEN WITH HR-POSITIVE, HER2-NEGATIVE ADVANCED BREAST CANCER IN BRAZIL: A DIME PROJECT

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Objectives: Several trials have demonstrated the benefit of CDK 4/6 inhibitors for postmenopausal women with HR-positive, HER2-negative advanced breast cancer. This research aims to compare the cost-utility of the CDK 4/6 inhibitors in patients who had no prior systemic therapy in the advanced setting. **Methods:** A systematic review was carried out to extract the efficacy and safety data from the pivotal trials selected. An indirect comparison was performed to identify the Hazard Ratio for CDK inhibitors versus letrozole. ROB2 and GRADE analyses evaluated the risk of bias and the confidence in the evidence. A Markov model was constructed to estimate the incremental cost in American dollars per quality-adjusted life years (QALY) of treatments from a Brazilian public healthcare system perspective over a lifetime horizon and with a 5% annual discount rate. Deterministic and probabilistic sensitivity analyses evaluated the robustness of the results. **Results:** There is high-quality evidence that the CDK 4/6 inhibitors consistently increase close to 10 months in progression-free survival, with a tolerable safety profile. There are no head-to-head studies between the CDK 4/6 inhibitors, and the indirect comparison did not identify clinical superiority in any of them. The most cost-effective technology was ribociclib (\$64,425/QALY), followed by Abemaciclib (\$81,530/QALY) and Palbociclib (\$85,321/QALY). The univariate analysis showed that the incremental cost-effectiveness ratio (ICER) was sensitive to the parameters of utility gains and the cost of the intervention. The one thousand-probabilistic simulation showed that all ICER values were above a threshold of \$35,000/QALY. **Conclusions:** In Brazil, even though there is no established willingness-to-pay threshold, the estimated ICER for the CDK 4/6 inhibitors will represent an obstacle to their incorporation into the Brazilian healthcare system.

PCN240

SIMPLE DISCOUNTS TO SUBSCRIPTION-BASED MODELS: WHAT IS THE FUTURE OF MULTI-INDICATION ONCOLOGY PRICING AND ACCESS?

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Objectives: Oncology agents are often launched sequentially across multiple tumour types. Each additional indication is associated with a new health technology assessment, often followed by lengthy price negotiations that can delay patient access to new medicines. We aim to explore different pricing and payment models that may allow for more timely access of oncology agents undergoing indication expansion, without jeopardising the clinical assessment. **Methods:** We reviewed time to access and pricing of multi-indication oncology products and researched potential strategies to accelerate access. We used a survey to understand EU national payer perception of the issue and assess feasibility, acceptability and impact on access of select payment and access models. Survey findings were supplemented with interviews for deeper understanding of the rationale. **Results:** Of seven alternative payment models tested for feasibility and acceptability, simple discounts scored highest (5/5; 4.3/5) while subscription-based models scored lowest (2.5/5; 2/5) on both aspects. However, half of respondents considered both could have a positive impact on patient access. In contrast, although price-volume agreements and budget caps are perceived as highly feasible and acceptable (4.2-4.8/5; 4/5), payers expected they could have a negative impact on access. While payers believed more complex models could have a positive impact on access, they are associated with excessive administrative burden, limiting their feasibility. Market archetypes affected acceptability, especially in France and Germany, where pricing is heavily dependent on added clinical value ratings. In addition to payment models, payers suggested early access pathways (EAPs) to ensure access while negotiating price without compromising the rigor of the current processes. **Conclusions:** Payers preferred using pre-existing models such as simple discounts or EAPs, which are considered more manageable than complex, innovative alternatives. Such agreements could be more acceptable in the rare disease space and, once adopted into routine practice, may then be expanded into other indications, including oncology.

PCN241

COMPLEX INNOVATIVE DESIGN TRIALS: TOO COMPLEX FOR MARKET ACCESS?

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Objectives: Complex innovative design (CID) trials aim to address multiple clinical questions, including efficacy in biomarker-selected patients, specific cancer cohorts or combination regimens. While CID trials could speed up the traditional route to European Medicines Agency marketing authorisation, they can be more challenging to evaluate through Health Technology Assessments (HTA) versus conventional randomized controlled trials. This research explores whether CID oncology trials can accelerate time to regulatory approval and patient access while maintaining optimised pricing and market access outcomes. **Methods:** Thirty-minute, qualitative, in-depth interviews were conducted with payer advisors from France, Germany and the UK to understand perspectives on HTA outcomes for larotrectinib and expectations for entrectinib, histology-independent cancer drugs studied in CID trials and targeting neurotrophic tyrosine receptor kinase (NTRK) solid tumours. **Results:** In England, following the submission of a revised price, larotrectinib was recommended for inclusion in the Cancer Drugs Fund (CDF). This allows for data collection to address clinical uncertainties, stemming from the pooled analysis of single-arm trials with limited patient numbers, while providing access. In contrast, larotrectinib has broad access in Germany though its price may have been negatively impacted by its 'no additional benefit' rating based on clinical uncertainties. In France, early access to larotrectinib was provided via a cohort Temporary Use Authorisation (ATU), however payers expect less favourable HTA outcomes given uncertainties in the clinical benefit due to the trial design. Payers expect entrectinib will face similar hurdles to larotrectinib which, coupled with reduced unmet needs, will negatively impact pricing and market access opportunity. **Conclusions:** CID trials create significant uncertainty on the benefit of oncology drugs assessed using existing HTA frameworks, risking negative reimbursement outcomes. The availability of managed/early access agreements can be leveraged by manufacturers for timely access. Additionally, upcoming changes to the NICE methods review may help address uncertainties for histology-independent oncology products to optimise access.

PCN242

DIFFERENCES IN EVIDENCE REQUIREMENTS IN ONCOLOGY DRUG ASSESSMENT BETWEEN HEALTH TECHNOLOGY ASSESSMENT (HTA) BODIES AND EMA AND HTA BODIES AMONG THEMSELVES

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Objectives: Providing an initial indication of the differences in health technology assessment (HTA) evidence requirements for the assessment of oncology drugs between the European Medicines Agency (EMA) and HTA bodies and among HTA bodies themselves. **Methods:** A comparative analysis was conducted based on interviews with experts or representatives from EMA and six HTA jurisdictions