

## **Modulator Treatments for Cystic Fibrosis: Effectiveness and Value**

*Revised Background and Scope*

**October 29, 2019**

Cystic fibrosis (CF) is an autosomal recessive condition caused by mutations in the cystic fibrosis transmembrane conductance regulator (*CFTR*) gene. Children born with CF inherit two pathogenic mutations, one from each parent. It is a relatively rare condition, occurring in approximately one in 2,500 to 3,000 live births, but it is the most common lethal genetic disease in Caucasian populations.<sup>1-4</sup> CF is a progressive disease that affects many organ systems, but most of its morbidity and mortality are associated with its impact on the respiratory system.

The life expectancy of patients with CF has increased substantially over the past 20 years, due in part to successes in the coordinated delivery of care and advances in CF management.<sup>5</sup> Until recently, treatment for CF focused on reducing symptoms and managing complications. New therapies target the abnormal proteins made by the mutated *CFTR* gene. More than 2,000 *CFTR* mutations have been identified that have different effects on the quantity and function of the *CFTR* protein.<sup>6</sup> Mutations to the *CFTR* gene can affect the amount of *CFTR* protein that is produced, the amount of protein integrated into the cell membrane, or the *CFTR* protein's ability to regulate ion and water flow.<sup>5</sup> This leads to thick secretions that can block passages in the lungs, pancreas, and reproductive organs, which may result in frequent lung infections and reduced lung function, poor weight gain (due to gastrointestinal dysfunction), diabetes (due to pancreatic damage), and fertility problems.<sup>7</sup>

The focus of this review is on triple therapy that adds the novel agent elexacaftor to the combination of tezacaftor and ivacaftor (Trikafta™, Vertex Pharmaceuticals, Inc.), which was approved by the United States Food and Drug Administration (FDA) on October 21, 2019.<sup>8</sup> Elexacaftor is another corrector therapy like lumacaftor and tezacaftor. It helps to correct folding of the *CFTR* protein and its trafficking to the cell surface. In addition, we will update our prior review of ivacaftor (Kalydeco®, Vertex Pharmaceuticals, Inc.) and the combinations lumacaftor/ivacaftor (Orkambi®, Vertex Pharmaceuticals, Inc.) and tezacaftor/ivacaftor (Symdeko®, Vertex Pharmaceuticals, Inc.).

The use of these agents has generated tremendous interest and hope on the part of clinicians, patients, and their families. The new triple therapy has the potential to improve the lives of patients with CF with mutations that are not effectively treated by the current generation of

modulator therapies (patients who are heterozygous for the F508del mutation and a minimal function mutation). In addition, there may be new data with longer follow-up for patients treated with currently-available therapies. All stakeholders will benefit from a comprehensive, updated review of the clinical evidence and potential economic impact of modulator treatments.

## Stakeholder Input

This scoping document was developed based on input from a group of stakeholders comprised of patients and their families, clinicians, researchers, and representatives from patient organizations in preparation for this new review; additional input had been gathered during ICER's previous review of modulator therapies for CF.

Several themes arose from the discussions with patients, their caregivers, and organizations supporting patients. The first theme was hope: "We have been waiting for a miracle and the triple combo is the closest thing ..."; "Our hope is that it will make her close to normal, if not normal, while taking the triple combo."

The second theme reflected the daily burden required to manage CF. Airway clearance activities and taking dozens of pills and inhaled therapies consumes several hours of every day for patients. This is exhausting and takes away time that would normally be spent on social activities, school, and family. It also contributes to the stigma associated with the disease. In addition, there is a substantial time burden from hospitalization for pulmonary exacerbations and the need for long-term IV antibiotic therapy. Again, patients expressed hope that the new triple therapy would alleviate some of this daily load.

A third theme was the psychosocial burden associated with living with a chronic, life-shortening illness. Depression and anxiety disorders contribute significantly to the overall burden of disease and are often insufficiently captured in measures of disease burden and quality of life.

A fourth theme was the financial burden imposed by the disease. Many of the therapies are not completely covered by insurance, requiring substantial financial contributions by patients and their families. Patients miss school and work due to routine follow-up, disease exacerbations, and eventually the disability imposed by progressive disease. In addition, caregivers often forego job opportunities, switch from full- to part-time employment, or stop working all together in order to care for their loved one who has CF. Some patients also stated that they were "deeply concerned about the staggering price of drugs."

Finally, patients highlighted the heterogeneity of the disease. Patients with different combinations of *CFTR* mutations have variable disease courses and even patients with the same mutation type have different lived experiences with CF. There is no "typical" patient living with CF – the patients are unique individuals.

In response to comments that we received on the draft scope, we expanded our list of outcomes and adverse events. We also removed the combination therapy lumacaftor/ivacaftor from consideration for the population of patients who are heterozygous for the F508del mutation and a residual function mutation because it does not have an FDA indication in that population. Although we received some suggestions that we focus only on triple therapy, we have elected to update our prior review of the three older drugs to incorporate new real-world data and to help provide context for the additional benefits of triple therapy. We have retained FEV<sub>1</sub> as an intermediate outcome despite it being a primary outcome in many of the trials because the key outcomes that matter to patients are their quality of life and functional improvements that flow from the improvement in FEV<sub>1</sub> as well as the longer-term reductions in pulmonary exacerbations, hospitalizations, transplants, and mortality. Finally, we greatly appreciated the suggestions about low value care, but those received reflected potential benefits from the disease-modifying drugs and not current approaches to care or treatments that represent low value.

## Report Aim

This project will evaluate the health and economic outcomes of the new triple therapy CFTR modulator treatment and update our prior review of modulator therapies. The ICER value framework includes both quantitative and qualitative comparisons across treatments to ensure that the full range of benefits and harms – including those not typically captured in the clinical evidence such as innovation, public health effects, reduction in disparities, and unmet medical needs – are considered in the judgments about the clinical and economic value of the interventions.

We propose to assess some of the CFTR modulator treatments (ivacaftor, lumacaftor/ivacaftor, and tezacaftor/ivacaftor) under an adaptation of the ICER value framework for treatments of serious, ultra-rare conditions because we believe they meet the following criteria:

- The eligible patient populations for the treatment indication(s) included in the scope of the ICER review is estimated at fewer than approximately 10,000 individuals.
- There are no ongoing or planned clinical trials of the treatment for a patient population greater than approximately 10,000 individuals.

The candidate population for treatment with modulators may be as small as 1,200 individuals (for ivacaftor monotherapy) and is anticipated to involve 10,000 individuals or less in each genetically-specified population.

The use of triple therapy with elexacaftor may not qualify for ultra-rare designation as early reports suggest that it has the potential for use in 90% of patients with CF, which would likely cross the 10,000-patient threshold. We will assess the size of the population potentially eligible for triple therapy and will apply the appropriate framework for that population.

## Scope of Clinical Evidence Review

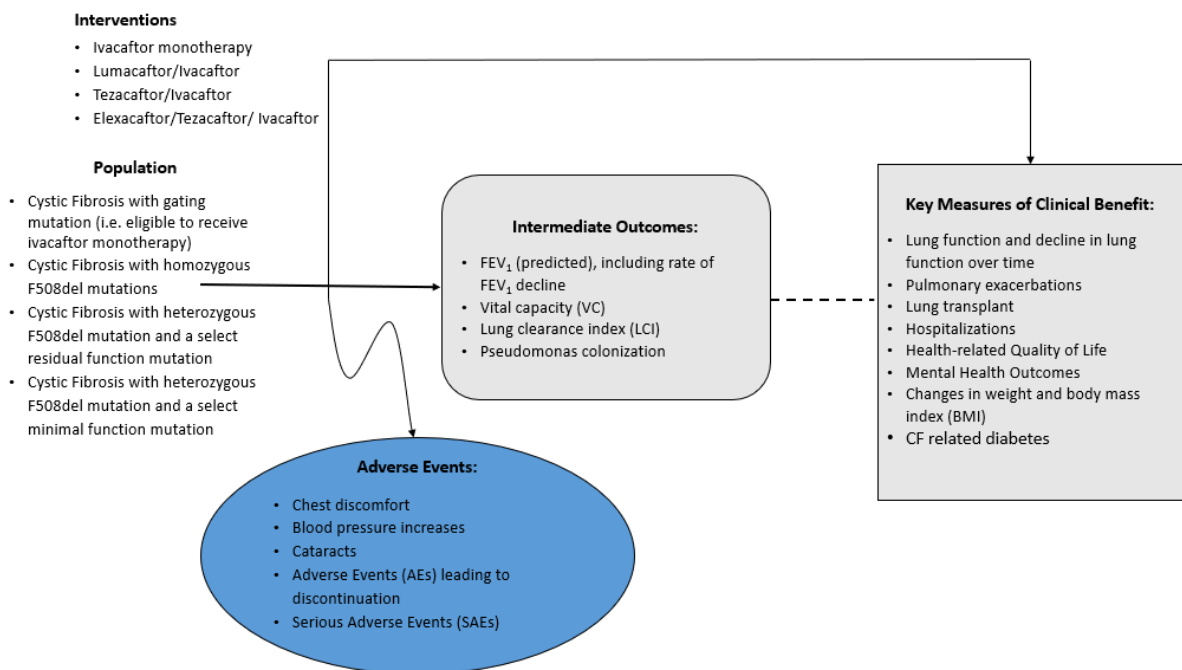
The proposed scope for this assessment is described on the following pages using the PICOTS (Population, Intervention, Comparators, Outcomes, Timing, and Settings) framework. Evidence will be abstracted from randomized controlled trials as well as high-quality systematic reviews; high-quality comparative cohort studies will be considered, particularly for long-term outcomes and uncommon adverse events. Our evidence review will include input from patients and patient advocacy organizations, data from regulatory documents, information submitted by manufacturers, and other grey literature when the evidence meets ICER standards (for more information, see <https://icer-review.org/methodology/icers-methods/icer-value-assessment-framework/grey-literature-policy/>).

All relevant evidence will be synthesized qualitatively or quantitatively. Wherever possible, we will seek out head-to-head studies of the interventions and comparators of interest. Data permitting, we will also consider combined use of direct and indirect evidence in network meta-analyses of selected outcomes. Randomized trial evidence is preferred, but observational data will also be considered to assess long-term outcomes that are beyond the scope of the clinical trials. The assessment of the quality of the evidence will address potential confounding in observational studies (for example, confounding by indication). Full details regarding the literature search, screening strategy, data extraction, and evidence synthesis will be provided after the finalized scope in a research protocol published on the Open Science Framework website (<https://osf.io/7awvd/>).

## Analytic Framework

The general analytic framework for assessment of therapies for CF is depicted in Figure 1 on the following page.

**Figure 1. Analytic Framework: Modulator Therapies for Cystic Fibrosis**



The diagram begins with the population of interest on the left. Actions, such as treatment, are depicted with solid arrows which link the population to outcomes. For example, a treatment may be associated with specific health outcomes. Outcomes are listed in the shaded boxes; those within the rounded boxes are intermediate outcomes (e.g., FEV<sub>1</sub>), and those within the squared-off boxes are key measures of benefit (e.g., hospitalization). The key measures of benefit are linked to intermediate outcomes via a dashed line, as the relationship between these two types of outcomes may not always be validated. Curved arrows lead to the adverse events of treatment which are listed within the blue ellipse.<sup>9</sup>

### **Populations**

We will review CFTR modulator therapies in four distinct populations across all ages based on current FDA labeling and the clinical trial populations.

1. Individuals with CF who carry mutations included in the FDA-approved indications for ivacaftor.
2. Individuals with CF who are homozygous for the F508del mutation.
3. Individuals with CF who are heterozygous for the F508del mutation with a residual function mutation.

4. Individuals with CF who are heterozygous for the F508del mutation with a minimal function mutation.

Within these populations, subgroups of interest are defined according to presence of advanced nonreversible lung disease (e.g., patients with or without bronchiectasis; who have predicted FEV<sub>1</sub> below 40%, 40-70%, 70-90%, or above 90%) and age (groups as defined in each study). Predicted FEV<sub>1</sub> is a measure of lung function defined as forced expiratory volume during the first second of expiration, adjusted for age, height, sex, and race. Other subgroups of interest are people with advanced non-pulmonary disease, such as recurrent pancreatitis, liver transplantation, poor growth, and infertility.

We will include studies of individuals of any age, regardless of their past medical history, comorbidities, or the severity of their CF.

### ***Interventions***

#### **Population 1**

- Ivacaftor plus best supportive care

#### **Population 2: Homozygous for F508del**

- Lumacaftor/ivacaftor plus best supportive care
- Tezacaftor/ivacaftor plus best supportive care
- Elexacaftor/tezacaftor/ivacaftor plus best supportive care

#### **Population 3: Heterozygous F508del and a residual function mutation**

- Ivacaftor plus best supportive care
- Tezacaftor/ivacaftor plus best supportive care
- Elexacaftor/tezacaftor/ivacaftor plus best supportive care

#### **Population 4: Heterozygous F508del and a minimal function mutation**

- Elexacaftor/tezacaftor/ivacaftor plus best supportive care

### ***Comparators***

The comparator for each population will be best supportive care and, where applicable, the other Interventions for that population.

## **Outcomes**

### Key Outcomes

- Lung function and decline in lung function over time
- Pulmonary exacerbations
- Lung transplant
- Hospitalizations
- Mortality
- Health-related quality of life
- Mental health including depression and anxiety
- Weight, body mass index (BMI), and growth
- CF-related diabetes

### Other Outcomes

- Time lost from school or work
- Pill burden and correlation to adherence with medication regimen
- Worry, stress, and anxiety about the disease or its financial impact
- Ability to participate in athletic activity and social functions
- Financial insecurity
- Caregiver burden
- Acute pancreatitis
- Fertility
- Liver transplant
- Hemoptysis
- Pneumothorax
- Gall stones
- Kidney stones
- Sinus / nasal polyp surgeries
- Fertility in women

### Intermediate Outcomes

- FEV<sub>1</sub> (predicted), including rate of FEV<sub>1</sub> decline
- Sweat chloride
- Vital capacity
- Lung clearance index
- Pseudomonas colonization
- Fasting glucose and related measures of glucose control

### Adverse Events

- Chest discomfort
- Increased blood pressure
- Liver function / injury
- Cataracts
- Adverse events (AEs) leading to treatment discontinuation
- Serious adverse events (SAEs)

### ***Timing***

Studies of all follow-up durations are eligible. Our focus will be on studies in which patients are prescribed a course of treatment.

### ***Settings***

All settings will be considered. Studies conducted in any country will be considered. However, the primary interest is in outpatient settings in the United States.

### **Potential Other Benefits and Contextual Considerations**

Our reviews seek to provide information on potential other benefits offered by the intervention to the individual patient, caregivers, the delivery system, other patients, or the public that would not have been considered as part of the evidence on comparative clinical effectiveness. These elements are listed in the table below.



**Table 1. Potential Other Benefits and Contextual Considerations**

<b>Potential Other Benefits</b>
This intervention offers reduced complexity that will significantly improve patient outcomes.
This intervention will reduce important health disparities across racial, ethnic, gender, socio-economic, or regional categories.
This intervention will significantly reduce caregiver or broader family burden.
This intervention offers a novel mechanism of action or approach that will allow successful treatment of many patients for whom other available treatments have failed.
This intervention will have a significant impact on improving return to work and/or overall productivity.
This intervention will have a significant positive impact outside the family, including communities.
This intervention will have a significant impact on the entire “infrastructure” of care, including effects on screening for affected patients, on the sensitization of clinicians, and on the dissemination of understanding about the condition, that may revolutionize how patients are cared for in many ways that extend beyond the treatment itself.
Other important benefits or disadvantages that should have an important role in judgments of the value of this intervention.
<b>Potential Other Contextual Considerations</b>
This intervention is intended for the care of individuals with a condition of particularly high severity in terms of impact on length of life and/or quality of life.
This intervention is intended for the care of individuals with a condition that represents a particularly high lifetime burden of illness.
This intervention is the first to offer any improvement for patients with this condition.
Compared to “the comparator,” there is significant uncertainty about the long-term risk of serious side effects of this intervention.
Compared to “the comparator,” there is significant uncertainty about the magnitude or durability of the long-term benefits of this intervention.
There are additional contextual considerations that should have an important role in judgments of the value of this intervention.

ICER encourages stakeholders to provide input on these elements in their public comment submissions.

## **Scope of Comparative Value Analyses**

As a complement to the evidence review, we will modify and update existing decision-analytic models to assess the lifetime cost-effectiveness of the various CFTR modulator therapies plus best supportive care relative to best supportive care alone.<sup>10</sup> We will update our prior analyses conducted for the previous ICER review to incorporate new evidence as well as evaluate elxacaftor/tezacaftor/ivacaftor as a new therapy for certain populations. Hence, we will evaluate four possible therapeutic options for four CF populations as follows.

1. For patients who are candidates for ivacaftor monotherapy based on the current indications, we will compare ivacaftor plus best supportive care to best supportive care alone (updated analysis).
2. For patients who are homozygous for the F508del mutation, we will compare tezacaftor/ivacaftor plus best supportive care, lumacaftor/ivacaftor plus best supportive care, elexacaftor/tezacaftor/ivacaftor plus best supportive care and best supportive care alone as competing alternatives (updated and new analyses).
3. For patients who are heterozygous for the F508del mutation and a residual function mutation, we will compare tezacaftor/ivacaftor plus best supportive care, ivacaftor plus best supportive care, elexacaftor/tezacaftor/ivacaftor plus best supportive care, and best supportive care alone (updated and new analyses).
4. For patients who are heterozygous for the F508del mutation and a minimal function mutation, we will compare elexacaftor/tezacaftor/ivacaftor plus best supportive care and best supportive care alone (new analysis).

Because the recommended start age varies by drug, we will model sequential drugs in relevant populations. For example, for patients who are homozygous for the F508del mutation we will assume that all patients on a CFTR modulator strategy will start with lumacaftor/ivacaftor at age 2 and then switch to tezacaftor/ivacaftor at age 6, unless they are assigned to lumacaftor/ivacaftor therapy. For those patients assigned to elexacaftor/tezacaftor/ivacaftor therapy we will allow them to switch to this therapy at age 12.

Under ICER's modifications to the value assessment framework for treatments for ultra-rare diseases, we will consider dual "base cases" that will reflect the health system and societal perspectives for all therapies which have an anticipated population of less than 10,000 individuals. A societal perspective will be included as a co-base case for ultra-rare diseases if it is anticipated that the impact of the treatment on patient and caregiver productivity, education, disability and nursing home costs are large relative to health care costs. In our last review we did not find that impact of the therapies on societal costs were large relative to the impact on health care costs; however, we will re-evaluate the balance of these costs with updated evidence. If not assessed as a dual base case, a societal perspective will be considered in a scenario analysis.

The model structures are influenced by other published models of CF treatment<sup>11-13</sup> and characterize patients by lung function (i.e., predicted FEV<sub>1</sub>) and predict the decline in lung function over time for those patients receiving best supportive care. The models also include variables that have been shown to impact survival among CF patients (e.g., weight-for-age z score, pancreatic sufficiency, diabetes mellitus, number of acute pulmonary exacerbations, lung transplantation).<sup>14</sup> The models allow us to simulate the health states of a cohort of patients over a lifetime time horizon, modeling patients from treatment initiation until death.

Key model inputs include clinical probabilities, quality of life values, measures of resource utilization (such as hospitalization for pulmonary exacerbations), and health care costs. Probabilities, costs, and other inputs will differ to reflect varying effectiveness between interventions. Treatment effectiveness will be estimated using results from relevant clinical trials, and assumptions about treatment effectiveness beyond the time horizon of trials will be varied in scenario analyses. We will incorporate the drug discontinuation rates from the trials and make reasonable assumptions about drug continuation beyond the time horizon of the trial. A 3% discount rate will be applied to both costs and outcomes.

Health outcomes will be dependent on patient health status, clinical events, and AEs. The risk of AEs may be modeled as a function of predicted FEV<sub>1</sub>, and will include both treatment-related AEs and consequences of disease progression (e.g., new-onset diabetes). Quality of life weights will be applied to each health state, including quality of life decrements for acute exacerbations and for SAEs. The health outcome of each intervention will be evaluated in terms of numbers of acute pulmonary exacerbations and hospitalizations, incidence of lung transplantation, and life-years as well as quality-adjusted life years (QALYs) gained. The model will include direct medical costs, including but not limited to costs related to drug administration, drug monitoring, condition-related care, and serious adverse events. Results will be expressed in terms of the marginal cost per QALY gained and cost per life-year gained. In addition, other cost-consequence measures will be considered, such as cost per acute pulmonary exacerbation avoided.

We will also incorporate a new effectiveness measure – the equal value life years gained (evLYG). This metric evenly measures any gains in length of life, independent of the treatment’s ability to improve patient quality of life. If treatment adds a year of life to a person with compromised health (i.e., a lower quality of life) the treatment will receive the same evLYG as a different treatment that adds a year of life for healthy members of the community.

In separate analyses, we will explore the potential health system budgetary impact of treatment over a five-year time horizon, utilizing published or otherwise publicly-available information on the potential population eligible for treatment and results from the simulation model for treatment costs and cost offsets. This potential budgetary impact analysis will indicate the relation between treatment prices and level of use for a given potential budget impact, and will allow assessment of any need for managing the cost of such interventions.

More information on ICER’s methods for estimating potential budget impact can be found at: <http://icer-review.org/wp-content/uploads/2018/05/ICER-value-framework-v1-21-18.pdf>.

### ***Identification of Low-Value Services***

ICER includes information in its reports on wasteful or lower-value services in the same clinical area that could be reduced or eliminated to create additional resources in health care budgets for

higher-value innovative services (for more information, see <https://icer-review.org/material/final-vaf-2017-2019/>). These services are ones that would not be directly affected by the treatment regimens under review (e.g., pulmonary exacerbations, hospitalizations, etc.), as these services will be captured in the economic model. Rather, we are seeking services used in the current management of CF beyond the potential offsets that arise from a new intervention. ICER encourages all stakeholders to suggest services (including treatments and mechanisms of care) that could be reduced, eliminated, or made more efficient.

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