Canadian Agency for Drugs and Technologies in Health | Agence canadienne des médicaments et des technologies de la santé

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Ms. Sylvie Dupont
PMPRB, Secretary of the Board
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Dear Ms. Dupont:

I am responding on behalf of the Canadian Expert Drug Advisory Committee (CEDAC) to the recent PMPRB draft document entitled "Draft Revised Excessive Price Guidelines" that requests comments on the "Draft Revised Compendium of Policies, Guidelines and Procedures".

Comments from CEDAC relate to four main areas and are summarized below.

1. Support for the mandate of the Board

2. Methodology for the evaluation of the level of therapeutic improvement
    - Concern that hierarchy of evidence used in the assessment of therapeutic improvement is based solely on study design and does not include assessment of study outcomes.

3. Replacement of the Median International Price Comparison Test
    - The PMPRB should consider a system that reflects the therapeutic benefits (clinical value) that a new drug brings to patients.

4. Re-setting the Maximum Non-Excessive **(**MNE) price
    - Concern that there is no routine mechanism for re-visiting price based on new scientific evidence.

5. Communication between PMPRB, Health Canada and the Common Drug Review
    - Although the roles and responsibilities of each agency differ, all review data on effectiveness and safety of drugs. There may be benefits from establishing a dialogue among the agencies.

Support for the mandate of the PMPRB Board

We would first like to express our strong support for the mandate of the Board as expressed on page 2 of the "Compendium of Policies, Guidelines and Procedures" document. The mandate is stated as *"to ensure that prices charged by patentees for patented medicines sold in Canada are not excessive, pursuant to sections 83 and 85 of the Act, thereby protecting consumers and contributing to Canadian health care"*. As some publicly funded drug plans have moved towards confidential price negotiation, it is critical that PMPRB ensure that other consumers are not exposed to higher prices inadvertently, in an attempt by drug companies to protect their 'average' price.

Methodology for the evaluation of the level of therapeutic improvement

We are very concerned that sorting medications into the four therapeutic categories is based on an inadequate assessment of clinical trial evidence. Page 14 of the "Compendium of Policies, Guidelines and Procedures" indicates that the methodology used to evaluate the level of therapeutic improvement for a drug will involve an evidence-based approach *"using the hierarchy of evidence from the Oxford Centre for Evidence-Based Medicine"*. This hierarchy of evidence is based on an assessment of the quality of study design but does not incorporate an assessment of the quality and relevance of study outcomes nor does it necessarily critically appraise the quality of the individual clinical studies. Currently, it is unclear whether studies were properly conducted and adequately reported and how study outcomes would impact placement of different medications into therapeutic classes.

In addition to considering the quality of the study design, we feel that the PMPRB should consider target disease (that is, the medical conditions where there is greatest need might warrant higher prices) and that it is critical for PMPRB to consider the type of outcome measured when categorizing medications. We strongly feel that only medications which have been shown to improve clinical outcomes should be classified as "breakthrough", while medications which have information on relevant but less well defined outcomes including "clinical scales" (for example, ACR20, pain scales, etc.) could be classified as "substantial and moderate improvement". Medications which only have evidence of efficacy on surrogate endpoints (in which case the impact on overall health remains unknown) should be uniformly classified as "minimal or no improvement". Such a strategy would reward the makers of new medications that have been shown to improve "health", which is what is relevant to patients. As further clinical trial evidence becomes available, the price could be reassessed.

Replacement of the Median International Price Comparison Test

We encourage PMPRB to examine the use of the current Median International Price Comparison (MIPC) as the test for determining the Maximum Non-Excessive (MNE). We suggest that PMPRB consider a system of pricing that reflects the therapeutic benefits (clinical value) that a new drug brings to patients. For instance, price could be set at the price of the lowest equivalent comparator instead of the MIPC which is based on drug prices that are set by global manufacturers based on their costs and profits. This concept is reflected in the 2007 recommendation by the UK Office of Fair Trading *"that the current 'profit cap and price cut' scheme, where companies are free to set their own prices within very broad profit constraints, be replaced with a patient-focused value based pricing scheme, in which the prices the NHS pays for medicines reflects the therapeutic benefits they bring to patients."* (www.oft.gov.uk/news/press/2007/29-07)

Re-setting the Maximum Non-Excessive price

The following is an excerpt from page10 of the "Board Positions on Proposed Revisions to the Excessive Price Guidelines".

"In terms of scientific issues, the Board supports the identification by the HDAP of any important weaknesses or gaps in scientific evidence. However, the Board does not believe that a specific Guideline is needed, and prefers to leave the discretion to Board Staff in the application of the review process on a case-by-case basis, as appropriate."

While we agree with the importance of revisiting price based on new scientific evidence, the "Compendium of Policies, Guidelines and Procedures" does not appear to include a mechanism to ensure that this will happen routinely. We would like to propose a mechanism that uses the therapeutic categories as per our proposed definitions that are described earlier in this letter under "Methodology for the evaluation of the level of therapeutic improvement". For instance, if a new medication was categorized as having "minimal or no improvement" (that is, if it was approved by Health Canada based only on surrogate data), it could be reclassified when further clinical trial data that tested the impact of the medication on clinical outcomes became available. Assuming the results were favorable, then this could be the stimulus to reset the price. Alternatively, for medications which have already received a price based upon being categorized into the "substantial or breakthrough" categories, there should be an opportunity to lower the price, if new clinical trial data showed that the medication effect was overstated in original trials or if new lower-priced products become available.

Communication between PMPRB, Health Canada and the Common Drug Review

CEDAC believes strongly that a process to bring the three separate Canadian drug review processes of PMPRB, Health Canada and the Common Drug Review together be addressed as a priority. While recognizing there is a sequence in time of when applications are filed, the requirements for application at each of these reviews could be brought together so that applicants could anticipate subsequent requirements. Further, a collegial meeting of representatives from each of the three review organizations could facilitate discussion of the respective applications under consideration by the respective review organization. This could greatly facilitate this protracted process.

Thank you for the opportunity to comment.

Yours truly,

Dr. Braden Manns
Chair - CEDAC