AMCP Dossiers: Latest Guidelines and Best Practices

The AMCP Format for Formulary Submissions
Version 4.0

A Format for Submissions of Clinical and Economic Evidence in Support of Formulary Consideration
April 2016

The power of knowledge. The value of understanding.
Agenda

• Introductions
• Version 4.0 background
• Overview of key changes in Version 4.0
• Best practices
• Q & A
About Our Presenters

Catherine Masaquel, MPH, is a Director in the Market Access and Outcomes Strategy group at RTI-HS. Ms. Masaquel has 10 years of industry experience in health economics and outcomes research, including positions at Pfizer and Amgen. She has previous experience with health care quality and medical informatics research and medical claims database analysis while working at managed care organizations. Ms. Masaquel is responsible for conducting market access and outcomes research activities, including health outcomes strategy, analyzing outcomes data, and publication development. Her areas of expertise include leading systematic and targeted literature reviews, value message positioning, and the development of global value and Academy of Managed Care Pharmacy dossiers.

Shahnaz Khan, MPH, is a Senior Director of Market Access and Outcomes Strategy. Ms. Khan is responsible for the development of pricing and reimbursement dossiers. She has more than 12 years of experience working in medical communications and has earned a certificate in medical writing from the American Medical Writers Association. Prior to joining RTI-HS, she served as a Medical Writer for a contract research organization. Her extensive clinical writing experience includes preparation of protocols, clinical study reports, and manuscripts in the areas of ophthalmology, infectious diseases, cardiovascular disease, endocrinology, urology, gynecology, oncology, hematology, and neurology. In addition to her focus on pricing and reimbursement dossiers, she has considerable experience in the production of corporate health economics and outcomes research communication materials.

Sandra Talbird, MSPH, is the Director of Health Economics at RTI HS. Her experience at RTI HS includes developing advanced economic models, such as cost-effectiveness, cost-utility, cost-benefit, and budget-impact models, using Microsoft Excel and Visual Basic for Applications. Her primary research focus has been in infectious disease, including both treatment and prevention strategies. Her experience at GlaxoSmithKline included conducting detailed literature reviews and supporting the writing and development of abstracts and manuscripts. Ms. Talbird's academic experience is grounded in finance, economics, and public health.

Melissa Juniper, MS, is a Senior Director of Market Access and Outcomes Strategy at RTI-HS. In more than 12 years with RTI-HS, Ms. Juniper has successfully led a number of large, multifaceted projects for leading pharmaceutical companies. She has focused on developing formulary submission dossiers, systematic literature reviews, and value dossiers. She offers knowledge in a variety of therapeutic areas, including cardiovascular disease, diabetes, oncology, psychiatric disorders, musculoskeletal and connective tissue disorders, and respiratory disorders.
Version 4.0 Background

• Version 3.1 was released in December 2012
• A draft Version 4.0 for public comment was released in December 2015
  – The most common comments on the draft included:
    • Suggestions around the grading of clinical studies (do not add this to guidance)
    • Clarification around placement of treatment guidelines (Section 3 or 5?)
    • Reinstatement of the recommended section lengths that were included in Version 3.1, but had been excluded from the draft Version 4.0 for public comment
• The final Version 4.0 was released on April 21, 2016
  – Evident that the Format Committee considered comments received
  – www.amcp.org/FormatV4
Key Changes in Version 4.0: General Changes

- Revised emphasis on unsolicited request process and dialogue between manufacturers and health care decision makers (HCDMs)
  - Dossier content should be kept confidential

- Preapproval dossiers
  - Bottom line: Information can be shared at the manufacturer’s discretion

- Updates to dossiers
  - Bottom line: Updates at manufacturer’s discretion based on new evidence/significant changes
  - May do amendment to dossier
  - HCDM must clearly request updates (within specified time period) during the unsolicited request
Key Changes in Version 4.0: General Changes (cont.)

• 3 addenda from Version 3.1 have been incorporated into core guidelines in Version 4.0:
  – Comparative Effectiveness Research
  – Companion Diagnostic Tests
  – Specialty Pharmaceuticals

• Guidance on biosimilars
  – Same evidentiary requirements; state source of evidence (innovator studies or new, direct evidence using biosimilar product)
  – Biosimilars generally do not require a cost-effectiveness model; a budget-impact model or cost-minimization analysis may be more relevant

• Heterogeneity of treatment effect
  – Does treatment response vary by patient?

• Page limits
  – In general, page limits have been increased
  – Format provides recommended length and maximum length guidance
  – Still need to remain focused and concise

• Media for dossier and model submissions
  – Electronic formats

Note: Draft recommendations for manufacturers to rate quality of studies was removed from final Version 4.0.
Key Changes in Version 4.0

• Section 1: Executive Summary: Clinical and Economic Value of the Product
  – Subsections (Clinical Benefits, Economic Benefits, and Conclusions) remain unchanged

  What’s New:
  – Comparative effectiveness relative to available alternative therapies added
  – Economic impact of special handling, delivery, route and site of administration, and risk evaluation and mitigation strategies
  – Recommended length of Section 1 was ~2.5 pages in Version 3.1, and is now specified as 5 pages (maximum 8 pages)
Key Changes in Version 4.0

• **Section 2: Product Information and Disease Description**
  - Section 2.1 (Product Description) is largely unchanged since Version 3.1, except as follows:

    **What’s New:**
    - Addition of a section focusing on special populations (corresponding to Section 8 in the PI)
    - Addition of a section focusing on the impact of the product on quality measures
    - Recommended length of Section 2.1 was 20 pages in Version 3.1, and is now specified as 5 pages (maximum 10 pages)
    - For the product comparison table, it is now recommended that a statement be added regarding why the comparators were selected. For example, was this decision based on meta-analyses, guidelines, a literature search?
Key Changes in Version 4.0

• **Section 2: Product Information and Disease Description (cont’d)**
  – Section 2.2 (Place of the Product in Therapy)
    • Section 2.2.1 (Disease Description) is largely unchanged
    • Section 2.2.2 (Approaches to Treatment)
      
      **What’s New:**
      – The section formerly titled “Principal Options and Practice Patterns” is now titled “Principal Therapeutic Options, Common Practice Patterns, and Standards of Care”
      – The Alternative Treatment Options section has been deleted
      – 3 new sections have been added: Appropriate Care Setting(s); Heterogeneity of Treatment Effect; and Ongoing Postapproval Monitoring of Drug Safety and Adverse Events
    
    • Old Section 2.2.3 (Relevant Treatment Guidelines and Consensus Statements from National and/or International Bodies) has been deleted here, and clinical practice guidelines should now be summarized in detail in Section 5.1.
Key Changes in Version 4.0

• Section 2: Product Information and Disease Description (cont’d)
  – Section 2.3 (Evidence for Companion Diagnostic Tests)
    • This is based on guidance that was part of an addendum in Version 3.1
    • 2.3.1 (Product Information for Companion Diagnostic Tests)
      – Recommended length is 5 pages (maximum 10 pages)
    • 2.3.2 (Place of Companion Diagnostic Test in Clinical Practice)
      – Recommended length is 10 pages (maximum 15 pages)
    • 2.3.3 (Supporting Clinical Data)
      – Recommended length of each study summary is 2 pages (maximum 5 pages)
      – Recommended length of each evidence table row < 1 page (maximum 2 pages)
Key Changes in Version 4.0

• Section 3: Clinical Evidence
  – This section was formerly titled “Supporting Clinical Evidence”

  What’s New:
  – The organization of this section has been simplified, with only 2 subsections:
    • Study Summaries
    • Evidence Tables
  – Recommended length for each study summary is 2 pages (maximum 5 pages); the recommended length was 2 pages previously
  – Recommended length of each evidence table row is < 1 page (maximum 2 pages); there was no recommended length specified previously
Key Changes in Version 4.0

- **Section 3: Clinical Evidence (cont’d)**
  - Additional guidance on evidence for biosimilars, specialty products, and companion diagnostic tests (CDTs)
  - Revised guidance on what type of studies should be included
    - Bottom line: Interested in data from any study design providing evidence on the product, including:
      - RCTs
      - Observational studies
      - Registries
      - Published and unpublished
      - US and ex-US
      - Ongoing
  - Clarification on what should be included in Section 3 vs. Section 5
Key Changes in Version 4.0

• **Section 3: Clinical Evidence (cont’d)**
  – Large amount of evidence can be handled as follows:
    • Text and evidence table summaries of large, rigorous, pivotal trials
    • Evidence table summaries only for smaller informative studies
    • Bibliography of other studies that may be of interest to HCDMs
Key Changes in Version 4.0

• **Section 4: Economic Value and Modeling Report**
  – Previously, the Modeling Approaches and Methods section focused mainly on cost-effectiveness analyses
  – Change in overall structure of Section 4.0 to clarify budget-impact models (BIMs) can be included in addition to cost-effectiveness analyses (CEAs) as a component of the overall economic evidence
Key Changes in Version 4.0

• Section 4: Economic Value and Modeling Report (cont’d)

**What’s New:**

• Modeling methods revised to refer to updated ISPOR-SMDM best practices for both CEAs and BIMs
• Modeling considerations for biosimilars and specialty pharmaceuticals were added throughout these sections

– Section 4.2 (Cost-effectiveness Analysis)
  • Removed recommendation for reporting results at multiple time frames for chronic diseases (despite this being a best practice)
  • Recognized that indirect comparisons could be considered when studies evaluating treatments directly are lacking
  • Clarified utility values derived from studies surveying the general population are ideal because CEAs are conducted at the population level, but acknowledge trial derived utilities may be used (aligned with NICE Guidance)
  • Sensitivity analysis: added a statement about using 95% confidence intervals and strongly discouraging arbitrary lower/upper values

– Section 4.3 (Budget Impact Model)

ISPOR = International Society For Pharmacoeconomics and Outcomes Research; SMDM = Society for Medical Decision Making.
Key Changes in Version 4.0

• **Section 4: Economic Value and Modeling Report (cont’d)**

  **What’s New:**
  – Section 4.4.2 (Modeling Report Format)
    • Recommended length was 20 pages in Version 3.1 and is now 12 pages (maximum 20 pages) *per model*
    • Subsections of the Economic Value and Modeling Report (Abstract, Introductions, Methods, Results, Limitations, Discussion), remain the same as well as the required tables and figures
    • Modeling report guidance now refers to newly published CHEERS reporting standards for economic evaluations
  – Section 4.4.3 (Interactive Model)
    • Manufacturers are encouraged to publish economic models in peer-reviewed literature and to update models with real-world evidence as it becomes available

CHEERS = Consolidated Health Economic Evaluation Reporting Standards.
Key Changes in Version 4.0

• **Section 5: Additional Supporting Evidence**
  – Previously titled “Other Supporting Evidence”
  – This section has been substantially reorganized
  – There are now separate subsections for each of the following:
    • Clinical Practice Guidelines
    • Health Technology Assessments and Systematic Reviews
    • Compendia approved by HHS\(^a\)
    • Other Economic or Outcomes Evidence
    • Impact on Quality
    • Other Evidence and Information
  – Recommended length for each study summarized is 2 pages (maximum 5 pages); the recommended length was 2 pages previously

\(^a\) Compendia officially recognized by the Secretary of Health and Human Services that lists the drug.
Key Changes in Version 4.0

• Section 6: Dossier Appendices
  – Previously titled “Supporting Information”
  – Previously contained only subsections for a reference list and the economic model\(^a\)
  – Now also includes the following subsections:
    • Product prescribing information (which was previously recommended to be included as a separate appendix)
    • Patient information
    • Material safety data sheet

\(^a\) Mandatory requirements on submitting a model and statements about confidentiality were removed and integrated into other sections.
Best Practices

Plan ahead.
~9-12 months prior to launch

Know health plans’ review cycles.

Establish your working group early.

Know your internal stakeholders.
Best Practices

Establish a timeline and regular communications.

Ensure that the work plan supports optimum efficiency.

Consider the eDossier platform.
Best Practices

Ensure that the writing team has all sources early.

Check for updated versions of sources periodically.

Establish editorial, content, and QC review processes.
Best Practices

- Provide consolidated comments on drafts to dossier writers.

- Develop a plan for periodically updating the dossier.
Best Practices: Economic Modeling

Ask payers what they are interested in.

Consider the model structure carefully.

Consider the relevant time horizon.

Conduct scenario analyses.
Best Practices: Economic Modeling

Coordinate with the modeling team.

Leave behind.
Generating knowledge and providing greater understanding so that you—and those who regulate, pay for, prescribe, and use your products—can make better decisions.

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