New oncology reimbursements in Belgium

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Overview of Belgian reimbursement news
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LIPOSOMAL IRINOTECAN (ONVYDE®)

Since the 1st of May 2019, liposomal irinotecan is reimbursed in association with 5-fluorouracil (5-FU) and leucovorin (LV) for the treatment of adults patients with metastatic pancreatic cancer who have progressed on gemcitabine-based therapy.
This reimbursement is based on the results of the phase III, randomised, open-label NAPOLI-1 trial. This study randomly assigned patients (from 76 sites in fourteen countries) with metastatic pancreatic ductal adenocarcinoma previously treated with gemcitabine-based therapy to receive either liposomal irinotecan monotherapy (120 mg/m² every three weeks, equivalent to 100 mg/m² of irinotecan base) or 5-FU/LV. A third arm consisting of liposomal irinotecan (80 mg/m², equivalent to 70 mg/m² of irinotecan base) with 5-FU/LV every two weeks was added later (1:1:1) in a protocol amendment.[1]
After 313 events, the median overall survival (OS, the primary endpoint) in patients assigned to liposomal irinotecan + 5-FU/LV (N=117) was 6.1 months as compared to 4.2 months with 5-FU/LV (N=149) in the intention-to-treat population analysis (HR[95%CI]: 0.67[0·49–0·92]; p=0.012). The median OS did not differ between patients assigned to liposomal irinotecan monotherapy and those treated with 5-FU/LV. The median progression-free survival (PFS) was 3.1 months in patients in the combination arm *vs.* 1.5 months in those allocated 5-FU/LV (unstratified HR[95%CI]: 0.56[0.41–0.75]; p=0.0001). The objective response rate with liposomal irinotecan + 5FU/LV was 16% as compared to 1% with 5-FU/LV (p<0.0001). The health related quality of life measured through the EORTC QLQ-C30 questionnaire was maintained in the patients treated ONIVYDE + 5-FU/LV over twelve weeks.[2] The most frequent grade 3/4 adverse events (AEs) among the 117 patients treated with liposomal irinotecan + 5-FU/LV were neutropenia (27%), diarrhoea (13%), vomiting (11%), and fatigue (14%).[1]
The reimbursement is to be requested through the eHealth platform and specific reimbursement criteria are, among others, patients with ECOG performance score ≤2 who have not yet been treated with irinotecan.[3]

EPOETIN ALFA (EPREX®)

Since April 1st, the reimbursement criteria for Eprex® (epoetin alfa) were extended to include the following indication: the treatment of symptomatic anaemia (haemoglobin concentration of ≤10 g/dL) in adults with IPSS risk category low- or intermediate-1-risk primary myelodysplastic syndromes (MDS) who have low serum erythropoietin (<200 mU/mL).
This new indication is based on a randomised, double-blind, placebo-controlled, multicentre study which evaluated the efficacy and safety of epoetin alfa in adult anaemic subjects with IPSS low- or intermediate-1-risk MDS.[4] Subjects were stratified by serum erythropoietin (sEPO) level and prior transfusion status at screening.[4] Erythroid response was defined according to International Working Group (IWG) 2006 criteria as a haemoglobin increase ≥ 1.5 g/dL from baseline or a reduction of RBC units transfused by an ab-

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solute number of at least four units every eight weeks compared to the eight weeks prior to baseline, and a response duration of at least eight weeks.[4]

Erythroid response during the first 24 weeks of the study was demonstrated by (31.8%) of the subjects in the epoetin alfa group compared to (4.4%) of the subjects in the placebo group (p<0.001).[4] All of the responding subjects were in the stratum with sEPO <200 mU/mL during screening.[4] In that stratum, 50% subjects without prior transfusions demonstrated erythroid response during the first 24 weeks, compared with 22.6% subjects with prior transfusions.[4] The median time from baseline to the first transfusion was significantly longer in the epoetin alfa group compared to what was seen with placebo (7.0 *vs.* 5.3 weeks; p=0.046).[4] After 4 weeks of treatment the time to first transfusion was further increased in the epoetin alfa group (20.3 *vs.* 7.1 weeks, p=0.007).[4] The percentage of subjects who were transfused in the epoetin alfa group decreased from 51.8% in the eight weeks prior to baseline to 24.7% between weeks 16 and 24, while the placebo group had an increase in transfusion rate from 48.9% to 54.1% over the same time periods.[4]

The recommended starting dose in this indication is 450 IU/kg (max. total starting dose is 40,000 IU) administered subcutaneously once every week, with a ≥5-day interval between doses.[5] Appropriate dose adjustments should be made to maintain haemoglobin concentrations within the target range of 10 to 12 g/dL (6.2 to 7.5 mmol/L).[5] It is recommended to assess the initial erythroid response eight to twelve weeks following the start of the treatment.[5] Dose increases and decreases should be done one dosing step at a time. A haemoglobin concentration of greater than 12 g/dL (7.5 mmol/L) should be avoided.[5]

Epoetin alfa needs to be prescribed by a physician specialised in haematology or oncology, or a specialist in internal medicine with a title in clinical haematology. The electronic request needs to be submitted through the eHealth platform and the prescribing physician must keep the supporting documents at the disposal of the advising physician. The maximum dosing that can be reimbursed is 1,050 IU/kg (total dose 80,000 IU) per week.

REFERENCES

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