TUAPAPA PŪKAHUKAHU
LUNG FOUNDATION
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Lung health for life

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10th March 2020

Sarah Fitt
Chief Executive
PHARMAC
Level 9 Simpl House
Wellington

By email sarah.fitt@pharmac.govt.nz

Tena koe Sarah

Thank you for your letter dated 18th February 2020 and for inviting me to meet this week.

In advance of our meeting, I thought it purposeful to provide a response to your letter and request clarification on issues which are extremely important to the wellbeing of our most vulnerable.

I hope this approach will inform our meeting.

LFNZ is extremely concerned that the ongoing delay by Pharmac to reimburse immunotherapy in first line NSCLC, is causing a (preventable) humanitarian crisis, whereby 28 patients per week are dying prematurely. These patients do not have access to Pembrolizumab (Keytruda), unless they self-fund. Financial toxicity is an added pressure and burden for those patients and families who self-fund.

You have stated Pharmac's expert clinical advisors are of the view PD- L1 immune checkpoint inhibitors for lung cancer appear to provide the same or similar effect in the treatment of advanced NSCLC. This statement suggests an "apples versus apples" situation…

LFNZ cannot agree with this statement, because clinical data (peer reviewed) demonstrates the efficacy of Pembrolizumab (Keytruda) in first-line setting, as mono-therapy and in combination therapy, is SUPERIOR to other inhibitors.

Given no other immune checkpoint inhibitors have a recommendation by PTAC for first line, we do not understand or support your stated RFP approach, which continues to delay reimbursement.

LFNZ's position remains, per our submission to Pharmac, 19th March 2019. First line is the absolute priority because the overall survival benefit for patients is significant. We too acknowledge the submission by the NZ Lung Cancer Special Interest Group, led by Dr Laird Cameron, Thoracic Oncologist (member of the LFNZ Special Advisory Committee).

Reimbursement

Pembrolizumab (Keytruda) is reimbursed in Australia for all first line lung indications (including, irrespective of PD-LI expression). In addition, more than 40 other countries funding Pembrolizumab (Keytruda) for first line lung cancer, many with much lower GDPs than NZ.

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Keytruda for patients regardless of a PD-L1 expression would benefit up to 1500 patients per year in New Zealand.

Reimbursement of Pembrolizumab (Keytruda) is central to reducing inequity in care for lung cancer and it will be a huge step forward for improving overall survival rates for the greatest number of vulnerable patients, including Maori who suffer extreme inequity.

The five year overall survival rate for lung cancer will DOUBLE for patients that have access to this treatment.

Lung Cancer Patient - Huhana Potae

Huhana Potae (67 years of age) of Tokomaru Bay (Ngati Porou) was first diagnosed with lung cancer in April 2017. She underwent a left upper lobectomy in June 2017. A little more than a year later, cancer had returned to the same lung. Last year she declined chemotherapy as a standalone treatment, because this would be too harsh for the frailty of her health. She is one of the 28 lung cancer patients every week in NZ that need access to Pembrolizumab (Keytruda) in first line to stay well for her family. This very brave mother and recently retired grandmother has been waiting for the past year in the hope that she will be able to get access to Keytruda in the public health system. Recent tests have shown Huhana has had progression with brain tumours, requiring urgent radiation treatment at Waikato Hospital.

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Post radiation treatment, Huhana's only option to extend her life is to travel to Rotorua or Tauranga to self-fund Keytruda, or leave NZ (medical refugee) to live with her eldest daughter in Australia where Keytruda is funded irrespective of PD-L1 status.

Questions:

1. What do you wish to say to Huhana and her family? They are aware of our meeting.
2. Pharmac says it looks to other international treatment guidelines and recommendations or key advice from similar countries. Q. How is their evaluation of cost effectiveness different from New Zealand?
3. How does PHARMAC measure cost effectiveness for a drug that is extending life as opposed to a treatment that is treating a chronic condition?
4. How can there be such a huge emphasis by PHARMAC on the "Factors for Consideration" which evaluates health disparity, inequity and Maori health outcomes; and yet PHARMAC has still not been proactive around investing in lung cancer treatments? These treatments have been on PHARMAC's waiting list for some years despite lung cancer being over represented in a high needs population.
5. Why hasn't Pharmac requested further budget to fund such important treatments that will transform the wellbeing and overall survival of patients with lung cancer?
6. Has Pharmac developed a strategy for introducing precision led healthcare into NZ?
7. Has Pharmac commissioned a rigorous scientific approach to measure the impact of rationing access to standard of care treatments on the wellbeing of the New Zealanders?
8. Will Pharmac acknowledge LFNZ's petition that asks the government to declare NZ's BIGGEST cancer killer, lung cancer to be a national health priority?
9. LFNZ urges the following treatments be funded in first line without further delay;

   Pembrolizumab *(Keytruda) for patients regardless of a PD-L1 expression (would benefit up to 1500 patients per year).*
   Crizotinib *(Xalkori) for patients with Ros1 - a rare form of lung cancer which makes up just 1% of non-small cell lung cancer (15 - 20 patients per year).*
   Osimertinib *(Tagrisso) for EGFR (approximately 200 patients per year).*

Naku noa na

Philip Hope (Williams-Potae)

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