



Subsequent Entry Biologic Template for Submitting Patient Group Input to the CADTH Common Drug Review

Section 2 — How to Complete This Submission Template

2.1 General Information

2.2 Information Gathering

The information was obtained through personal experiences of the Board of The Canadian Arthritis Patient Alliance in living with inflammatory arthritis, in addition to many years of interfacing with our membership.

2.3 Providing Experiential Information

None to suggest- prompts that are in this template are very useful.

Section 3 — Information About the Submitting Patient Group

Name of the drug	Remsima (Infliximab)
Indication of interest	Psoriatic Arthritis
Name of the patient group	Canadian Arthritis Patient Alliance (CAPA)
Name of the primary contact for this submission:	Dawn Richards
Position or title with patient group	Vice President
Email	
Telephone number(s)	
Name of author (if different)	N/A
Patient group's contact information:	
Email	
Telephone	
Address	
Website	www.arthritispatient.ca
Permission is granted for CADTH to post this submission	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

3.1 Submitting Patient Group

CAPA is a grass-roots, patient-driven, independent, national education and advocacy organization with members and supporters across Canada. CAPA creates links between Canadians with arthritis, assists them to become more effective advocates and seeks to improve the quality of life of all people living with the disease. CAPA believes the first expert on arthritis is the individual who has the disease, as theirs is a unique perspective. We assist members to become advocates not only for themselves but all people with arthritis. CAPA welcomes all Canadians with arthritis and those who support CAPA's goals to become members.

3.2 Conflict of Interest Declarations

a) *We have the following declaration(s) of conflict of interest in respect of corporate members and joint working, sponsorship, or funding arrangements:*

Sources of grants and support received by CAPA in the last year include: AbbVie, Amgen Canada, Arthritis Alliance of Canada, The Arthritis Society, Canadian Rheumatology Association, Janssen, Novartis, Ontario Rheumatology Association, and UCB Pharma.

Additionally, CAPA has also received support in the past from: Canadian Institutes for Health Research, Hoffman-La Roche, Pfizer Canada, Rx&D, Schering Canada, Scleroderma Society, and STA Communications.

b) *We have the following declaration(s) of conflict of interest in respect of those playing a significant role in compiling this submission:*

None to declare.

Section 4 — Disease/Condition and Current Treatment Information

4.1 Impact of Condition on Patients

Psoriatic Arthritis (PsA) is a type of inflammatory arthritis that is a serious, debilitating auto-immune disease, affecting every aspect of a patient's day-to-day life. Patients often experience psoriasis first, and then experience the onset of PsA symptoms usually between the ages of 20-50. PsA affects men and women relatively equally and as with other forms of inflammatory arthritis, there is currently no cure for PsA – only ways to help alleviate symptoms and hopefully slow the progression of disease. PsA is a chronic illness that one lives for from the onset of symptoms until death.

The disease is characterized by inflammation in the joints that destroys the lining of the joint and ultimately the surrounding bone resulting in the need for a total joint replacement. Once damage occurs, it is not reversible and can cause significant pain and disability. There are 5 well-documented patterns of PsA as well, and it can be very different from person to person.

PsA is a challenging disease to manage and physicians and patients often have to try different drugs to find something that works well – there are currently no methods that help physicians predict which patients will respond best to which therapies. In addition, a patient's immune system can adapt to a drug making it necessary to switch to another treatment when one becomes ineffective. As a result, patients require many medication options as treatment response is not possible to predict and changes over time.

For those whose PsA is not well-controlled, day to day activities, such as participating in post-secondary education, becoming and staying employed, taking care of oneself (bathing, dressing, activities of daily living) and one's family, and other activities that the healthy general population simply take for granted, become very difficult. It is vital that inflammation be controlled early and well so that patients can continue to be productive members of society. We can imagine that the economic benefits to society of keeping people living with AS in the work force and as productive members of society are greater than those required of the healthcare system if patients do not receive treatments for their disease.

4.2 Patients' Experiences with the Current Treatment

While there are both small molecule and biologic disease-modifying anti-rheumatic drugs (DMARDs) available to treat PsA, as per the instructions above, we have focussed this section on the originator drug with the same INN as Remsima called infliximab or via the trade name of Remicade. Since the Celltrion was provided a Notice of Compliance by Health Canada for Remsima in January, 2014, people with PSA who utilize infliximab to control their disease are utilizing the Remicade brand.

Since the biology of a person's PsA response to medications is not currently well understood or able to be predicted, patients with PsA undergo trial and error in finding the most suitable treatment for their PsA. Some patients experience long periods of responding well to a drug (meaning that their symptoms are well-controlled), while others, for reasons unknown, will need to be exposed to many different drugs over their lifetime to achieve the best treatment of their PsA. The originator drug, Remicade, is no different for patients. While it works very well (efficaciously and safely) for some, for others it is not as efficacious (sometimes immediately, or sometimes over time as a patient's immune system adapts to it), and as a result, patients and their physicians will have a conversation and decide whether or not to change the patients' pharmaceutical therapy.

For Remicade (originator drug), the most common adverse reactions are infections, allergic reactions and infusion-related reactions. The Product Monograph for Remsima does not indicate the types of adverse reactions that this medication causes since Remsima is being extrapolated for use in PsA and has not undergone any clinical trials to indicate its response and effectiveness for PsA.

With the advent of biologics for the treatment of PsA, so has the need been created for either infusions or injections. Some patients have vein scarring and scar tissue from numerous infusions and injections. In the most extreme case, a patient would have been giving themselves injections or receiving infusions for over a decade (since biologics were first approved in 2000) – a reality faced by many patients living with AS. Patients may also face scheduling issues for infusions and need to take time off work or find someone to deal with family commitments (e.g. babysitting young children). However, if Remsima is utilized, this will not alleviate these requirements for patients – these will remain items that patients are required to deal with to receive treatment.

Biologics are extremely costly for patients – while some patients have extended health insurance, others do not, and either rely on their own resources or those of their provincial Ministries of Health for assistance.

Patients rely on support programs provided by the originator company to help them maintain efficient access to receiving their medication and to be informed and properly taught about a medication's administration, assistance with drug cost coverage, and for general questions about their treatment. This patient support program is an important part of a patient receiving the originator drug.

4.3 Impact on Caregivers

Depending on a person's ability to cope with activities of daily living and their ability to still be employed, caregivers of people living with PsA are relied upon in varying capacities. In some cases, caregivers are required to assist with simple tasks such as bathing, getting in and out of bed, getting dressed, even using the toilet. The emotional toll on both patients and caregivers in this type of situation cannot be underscored enough. In other situations, a caregiver's burden may not be as great,

perhaps giving the patient their injection or need to take over family responsibilities while the patient is receiving their infusion. Living with a chronic condition as potentially debilitating as PsA can affect a person profoundly psychologically – including caregivers. Additionally, when patients do not have drug coverage options, if one’s spouse is their caregiver, this adds to the burden of disease in ways nearly unimaginable.

It is important to highlight that PsA affects patients and caregivers and family members profoundly, in all aspects of their lives – and does so from before their diagnosis, throughout their lives.

Section 5 — Information About the SEB Being Reviewed

5.1 What Are Patients’ Expectations for the SEB?

Since SEBs are new in Canada, there are a number of perceptions in the patient community about these, which include:

- *Potentially being more economic than the originator drugs*
- *Potentially not having well-established patient support programs like the originator therapeutic*
- *Disadvantage of being extrapolated for PsA based on rheumatoid arthritis phase I and phase 3 studies – Remsima has not undergone a clinical trial in patients with PsA – this is an extreme concern for the patient community which sets a precedent that no other drug has been allowed. CDEC reviews on an evidence-base, and if no evidence exists for Remsima with respect to PsA, it is unclear as to how it can be approved for use in this indication.*
- *Not having a post-market surveillance program (and associated safety concerns)*
- *As to a point above, patients have the perception that those with PsA who are put on Remsima are being placed in a real-life clinical trial without the same safety monitoring that a trial has*
- *Potential confusion at the pharmacy and by healthcare providers that since the SEB has the identical INN name as the originator drug that there will be inadvertent switching at the pharmacy level, which could potentially result in serious side effects/adverse effects for patients*
- *Potential to be ‘switched’ to the SEB by one’s insurer due to potential cost, and without being able to make an informed and evidence-based choice in partnership with one’s healthcare provider.*

Overall, access to SEBs provides another potential treatment for patients with PsA, with significant concerns and perceptions (positive and negative) that are all highlighted above.

Section 6 — Key Messages

Key submission messages include:

- *PsA is a seriously debilitating chronic illness that affects all aspects of a person’s life*
- *Therapeutic options are required for patients who live with PsA – SEBs are part of that repertoire of therapies however only when they have undergone the proper clinical trials as required for all other therapies, and for which we support as a treatment for patients who are biologic-naïve or who are being switched to another biologic due to response failure after an informed discussion and decision made with their physician*

- *While SEBs are important opportunities for patients as therapies, there are several perceptions and concerns that the patient community has about them, and which we ask CDEC to seriously consider in its review*
- *This SEB molecule has the identical INN to the originator drug – there are significant issues and concerns for patients around this, including being inadvertently exposed to the wrong drug*
- *Patient support programs are an important part of biologic therapies and are an integral part of a patient’s experience with these severely immuno-suppressive medications.*

Section 7 — Additional Information

It is unclear to CAPA why CADTH has allowed SEBs to ‘jump the queue’ for review by CDEC while new innovator drugs that target new pathways for the same diseases are waiting to be reviewed, and whose review timeline appears to be impacted by this ‘queue-jumping’ phenomenon.

It would be useful for CADTH and CDEC to also consider one Patient Input Submission for all indications for which the SEB is under review. The template form can be broken down to specifically address certain conditions, and in cases where there is significant similarity/overlap between concerns/comments for the same indications, it would save significant time for patients and patient organizations that provide such submissions.

Section 8 — Comments on Potential Ways SEBs Can be Used

To re-iterate a comment before – it is simply unacceptable and unethical for CDEC to approve Remsima for the indication of PsA without this SEB having a requirement to have undergone a clinical trial for this indication. It is unacceptable to extrapolate from the indication of RA to PsA, no matter how ‘alike’ the diseases may be. This is not allowed for any other drug, and should not be allowed/acceptable for SEBs. Patients are being placed in a position of undo and unnecessary risk because of this.

Each point in the template box is addressed in the following:

- *The SEB will be used instead of the originator (reference/brand name) product with physician approval before patient receives any treatments – Unacceptable. This should be a patient/physician joint decision and discussion.*
- *The SEB would be replacing the originator product with physician approval once the patient has been on the originator product for a period of time, i.e. a one time switch – Unacceptable. There is no way to predict how a patient with PsA will respond to a new medication, whether or not it has a similar mode of action to another drug. This is putting the patient in an unnecessarily risky situation, and does not take in to account what may occur if this is done – e.g. serious adverse event, significant side effects due to a switch, unnecessary immunogenic reaction to new medication. This will only cost the patient and the healthcare system valuable time and resources that would have been prevented by not undertaking a switch in the first place if a patient is doing well on the originator medication.*
- *The SEB will be used instead of the originator product without physician approval before patient receives any treatments – Unacceptable. As per the first point, only the physician and patient together can decide the best, agreed-upon course of treatment for the patient.*

- ***The SEB would be replacing the originator product without physician approval once the patient has been on the originator product for a period of time. Unacceptable – only the physician and patient together can decide the best, agreed-upon course of treatment for the patient.***
- ***Back and forth replacement between SEB and originator product without physician consent- Unacceptable- only the physician and patient together can decide the best, agreed-upon course of treatment for the patient.***
- ***There is a real concern about switching patients back and forth from the originator drug to the SEB, as it can increase a patient's risk of immunogenicity side effects. This is a significant patient safety issue and could potentially affect patient response to even the originator drug.***
- ***CAPA supports SEBs as options for patients when the SEB has undergone rigorous clinical trials for an indication, for biologic-naïve patients, or for patients who are being put on a new biologic because of failure to respond to another. This is only after careful consideration, dialogue, and informed conversation between physician and patient and is a decision that only they should undertake, not one that should be pushed on them in response to cost, etc.***

It is unclear why an opinion is even asked on these sections. If the reader of this submission would simply put themselves in a patient's position, and if they too had lived with PsA or know someone who does, they would read the above statements and call them all unacceptable, and may even take it so far as to call them unethical. Physicians work with their patients to provide the best medications possible for the patient – it is doubtful that they would also stand for the statements above.