National Cancer Control Programme

NCCP Technology Review Committee (TRC)

Meeting Notes

Date of Meeting:	**30th June 2025 at 4.30pm**
Venue:	**Teleconference via MS Teams**
Assessment:	Mosunetuzumab (Lunsumio®)
	Pembrolizumab (Keytruda®)

TEXT FOR REDACTION DUE TO DELIBERATIVE PROCESS HIGHLIGHTED IN YELLOW

TEXT FOR REDACTION DUE TO COMMERCIAL SENSITIVITY IS HIGHLIGHTED IN PINK

TEXT FOR REDACTION DUE TO CONFIDENTIALITY IS HIGHLIGHTED IN BLUE

Attendance:

Members present		
NCPE representative	National Centre for Pharmacoeconomics (NCPE)	By MS Teams
Dr Neil Barrett	Consultant Haematologist, Children's Health Ireland – Crumlin: IHS representative **Chair**	By MS Teams
Dr Oscar Breathnach	Medical Oncologist, Beaumont: ISMO nominee	By MS Teams
Dr Dearbhaile Collins	Medical Oncologist, Cork University Hospital: ISMO nominee	By MS Teams
Prof Janusz Krawczyk	Consultant Haematologist, Galway: IHS representative	By MS Teams
Fiona Mulligan	PCRS representative	By MS Teams
Ms Aishling McLoughlin	Chief I Pharmacist, NCCP (Deputy Chair)	By MS Teams
Dr Dearbhaile O'Donnell	Medical Oncologist, St James's Hospital: ISMO nominee	By MS Teams
Dr Derville O'Shea	Consultant Haematologist, Cork University Hospital: NCCP National Clinical Lead(s) for Haemato-oncology	By MS Teams
Dr Liam Smyth	Consultant Haematologist, St Vincent's Private Hospital: NCCP National Clinical Lead(s) for Haemato-oncology	By MS Teams
Non-member invited specialists present		
Dr Megan Greally	Medical Oncologist, Beaumont: ISMO nominee	By MS Teams
Apologies (members)		
Patrick Hayden	Consultant Haematologist, St James's Hospital: HIS representative	
Prof Maccon Keane	Medical Oncologist, Galway: NCCP National Medical Oncology Programme Clinical Advisor	
Observers present		
Ms Helena Desmond	Senior Pharmacist, NCCP	By MS Teams

Item	Discussion	Actions
1	**Introduction & reminder re. conflict of interest & confidentiality**	
	Members were reminded to raise any conflicts of interest that they had in relation to any drug for discussion prior to the commencement of the discussion of that item.	
2	**Notes of previous meeting and matters arising**	
	The following were reviewed and agreed. • The notes of the previous meeting on May 26th 2025 • The revised NCCP Technology Review Committee Terms of Reference (ToR) v8	
3	**Drugs/Technologies for consideration**	
	Mosunetuzumab Lunsumio® (Ref. TRC 176) *As monotherapy for the treatment of adult patients with relapsed or refractory follicular lymphoma (FL) who have received at least two prior systemic therapies.* The clinical aspects of this indication were discussed. The supporting evidence for this indication comes from the GO29781 study, an ongoing, phase I/II, open-label, single-arm study to evaluate mosunetuzumab in patients with relapsed or refractory (R/R) FL. Ninety patients were enrolled and received mosunetuzumab for a fixed duration of up to 17 cycles. For patients who achieved a complete response (CR), treatment was discontinued after 8 cycles, for those with a partial response or stable disease, treatment was continued for up to 17 cycles. The primary endpoint was CR, and after a follow up of 3 years (data cut February 2025), the study showed a CR rate of 60% and an overall response rate (ORR) of 77.8%. Among 54 patients who achieved CR, 49 remained in CR at the end of treatment, and the median duration of completed response (DOCR) was not reached. The median time to CD19 B-cell recovery was 18 months, and the median progression free survival (PFS) at the 3 year follow up was 24 months. Overall, the study demonstrated a clinically meaningful and sustained benefit with mosunetuzumab in this patient population. The safety profile was discussed, mosunetuzumab was well tolerated. The most common adverse events observed were cytokine release syndrome (CRS), neutropenia, pyrexia, hypophosphatemia and headache. The CRS rate was reported to be 44%, which was mostly of low grade (grade 1-2), with grade 3-4 CRS observed in 2.2% of the population. The clinical evidence for mosunetuzumab is in third line setting and beyond. As patients progress through the treatment lines with FL, the duration of each remission get shorter, representing an unmet need in this patient cohort. However, the supporting evidence shows that mosunetuzumab appears to extend the duration of remission in comparison to the relevant comparators. It was acknowledged that tisagenlecleucel, a CAR-T, was recently approved for reimbursement by the HSE for this patient cohort, and is now a relevant comparator. However, it was highlighted by the clinicians that there is currently a capacity issue with access to CAR-T in Ireland. Due to the unmet clinical need, the clinical efficacy and the ability to deliver mosunetuzumab in an outpatient setting alongside the reduced risk of CRS compared to CAR-T there is a desire among the clinicians to have mosunetuzumab available for this patient cohort. The pharmacoeconomic aspects as outlined in the HTA assessment carried out by the NCPE were discussed. The relevant comparators were outlined and the supporting evidence was discussed. The NCPE Review Group highlighted a number of limitations in the trial, such as the single arm nature of the trial, the immaturity of the data and the lack of comparative effectiveness. Due to the single arm nature of the supporting study, an indirect treatment comparison (ITC) was conducted to establish the relative effectiveness of mosunetuzumab versus the relevant comparators, it noted that there was a lot of heterogeneity across patient population, leading to	

bias and unreliability. The cost effectiveness analysis and the modelling used was outlined. In terms of cost, mosunetuzumab is administered for a fixed duration, and assuming a mean of 8.4 cycles (reflective of the supporting study), the total cost of mosunetuzumab per treatment course is €87,701 including VAT. When compared to the most relevant comparators, mosunetuzumab is the most expensive after tisagenlecleucel. In terms of the results of the cost effectiveness analysis, the NCPE made no changes to the base case ICERS, as it was considered that no adjustment could overcome the uncertainty in terms of the comparator effectiveness estimates. In the Applicant's base case, the ICER for mosunetuzumab vs a Flatiron basket treatment (considered the most relevant comparator) dominated suggesting mosunetuzumab is more costly and less effective. The ICER versus rituximab and bendamustine is [redacted], the ICER versus obinutuzumab and bendamustine is [redacted], the ICER vs Idelalisib [redacted] The ICER vs tisagenlecleucel [redacted], and the ICER vs rituximab and lenalidomide [redacted] In terms of the budget impact (BI), the Applicant estimated that 10 patients would be treated in year 1, increasing to 14 in year 5. The applicant only considered the incident patient population with R/R follicular lymphoma and excluded the prevalent population, therefore the NCPE review group considered the population estimates to be underestimated. The NCPE estimated that [redacted] The NCPE net 5-year cumulative BI is estimated to be [redacted] including VAT and [redacted] excluding VAT. The NCPE recommends that mosunetuzumab not be considered for reimbursement.

Having considered the clinical efficacy of the indication in this patient cohort the committee members agreed by majority to recommend approval of this indication to the HSE Drugs Group.

One member was absent during voting, however quorum was in place.
(Decision: TRC 176)

Pembrolizumab (Keytruda®) (Ref. TRC 177)

In combination with trastuzumab, fluoropyrimidine and platinum-containing chemotherapy, for the first-line treatment of locally advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive gastric or gastro-oesophageal junction adenocarcinoma in adults whose tumours express programmed death-ligand 1 (PD-L1) with a combined positive score (CPS) ≥ 1.

The clinical aspects of this indication were discussed, noting that the current standard of care (SOC), trastuzumab in combination with fluoropyrimidine and platinum-containing chemotherapy, has not changed since 2010 when the TOGA data showed that the addition of trastuzumab to chemotherapy extended overall survival (OS) by 2 to 3 months in the HER-2 positive population. The supporting evidence for this indication comes from the KEYNOTE 811 trial, a phase III, randomised, placebo-controlled, double-blind trial, which investigated the addition of pembrolizumab to the SOC, trastuzumab in combination with fluoropyrimidine (capecitabine, 5-fluorouracil) and platinum (cisplatin or oxaliplatin) containing chemotherapy for the first-line treatment of adult patients with HER2-positive gastric or gastro-oesophageal junction adenocarcinoma. The study demonstrated an improvement in response rates by approximately 12%, and an improvement in progression free survival (PFS) by approximately 2 months. In the PD-L1 CPS≥1 subset the OS benefit was 4.4 months which is considered to be clinical meaningful in this disease. The safety profile was discussed, and it was noted that the clinicians are familiar with the use of pembrolizumab and its toxicity profile, as it has been approved in a number of indications, and no new safety concerns were identified with pembrolizumab when added to trastuzumab plus chemotherapy in the HER-2 positive population. There is a desire among the clinicians to have an anti-HER-2 and an immunotherapy in combination with chemotherapy available for this patient cohort, as currently patients have only access to either an anti-HER-2 or an

	immunotherapy in combination chemotherapy. The pharmacoeconomic aspects as outlined in the HTA assessment carried out by the NCPE were discussed. The NCPE Review Group highlighted concerns with the patient population with regards to the geographical groups, such as the inclusion of the 'rest of the world' group, in which a greater treatment benefit was observed. The cost effectiveness analysis and the modelling used was outlined. In terms of the cost, the cost per treatment course of pembrolizumab in addition to SOC is estimated to be €140,505 including VAT while the cost of SOC alone is estimated to be [redacted] including VAT. In terms of the results of the cost effectiveness analysis, for the Applicant's base case, the ICER was estimated to be €106,066 per QALY, a number of changes were made to the NCPE adjusted base case which resulted in an ICER of €183,911 per QALY. The Review Group conducted a scenario analysis on the NCPE adjusted base case whereby time-on-treatment was assumed equivalent to PFS. In this scenario, the ICER increased to €361,099 per QALY. In order to reach cost effectiveness level a reduction of 84.5% is required. In terms of the BI, based on NCRI data, the applicant estimated that 19 patients will be treated in Year 1 increasing to 40 patients in Year 5, resulting in a 5-year net BI of €17.44 million including VAT. The NCPE recommends that pembrolizumab not be considered for reimbursement unless cost-effectiveness can be improved relative to existing treatments. Having considered the clinical efficacy of the indication, the committee members agreed unanimously to recommend approval of this indication to the HSE Drugs Group subject to an improvement in cost. One member was absent during voting however quorum was in place. *(Decision: TRC 177)*	
4	**Update on other drugs in the reimbursement process**	
	An update had been shared with the group in the documentation for the meeting	
5	**Next meeting**	
	The proposed date for the next meeting is Monday July 28th 2025	
6	**Any other business / Next meeting**	

The meeting concluded at 17.35pm.

Actions arising from meeting:

Ref.	Date of meeting	Details of action	Responsible	Update
25/06	30/06/2025	NCCP to communicate recommendations to HSE Drugs Group.	NCCP	Complete
25/06	30/05/2025	Apply for CPD	NCCP	Complete