Consultation Response on Proposed Changes to the CDA Reimbursement Review Process

February 6, 2025

Innovative Medicines Canada (IMC) and BIOTECanada are the primary associations representing the innovative medicines industry in Canada. Thank you for the opportunity to provide feedback to the current consultation regarding Canada's Drug Agency's proposed changes to the Reimbursement Review Process. We greatly appreciate the significant progress and process innovation that CDA is making in these proposals, which meaningfully reflect input provided by the medicines industry on a number of previous engagements.

In-Review Meeting Opportunities

There have been years of productive discussions on possible checkpoint meetings within the pharmaceutical review procedure. CDA has proposed a pragmatic and flexible approach to improving engagement during the review through several elective touchpoints. On this issue, we are encouraged to see our previous commentary directly reflected and would encourage open dialogue and detailed discussion of files.

To make the most of these in-review meetings it will be particularly helpful to proactively discuss issues that could subsequently arise at the expert committee, critical analytical choices such as comparator selection, and any issues regarding indirect treatment comparisons. **Discussions regarding the assumptions used by CDA to evaluate pharmacoeconomic models and evidence interpretation[1] should be considered "in scope."** Having these topics in scope would allow for a meaningful dialogue that would enhance the transparency and accountability of the review process.

We recommend for clarity that the proposed "post-submission meetings" be named "post-recommendation meetings" to better reflect when they occur in the process. For these meetings, we propose that these opportunities be granted to discuss a range of possible issues where a meeting may

[1] We encourage CDA to consider some aspects of evidence interpretation to be in scope for in-review meetings. Sponsors regularly engage in such discussions with Health Canada and find it to be of benefit to all participants. This is particularly true for novel or first-in-class treatments where a sponsor's perspective and experience in a new area could offer material insights to the CDA reviewers that would in turn support more robust expert committee deliberations. The discussion January 13, 2025 regarding the need to ensure 'scientific discourse' in relation to an 'evolving understanding of the data' to be in scope to in review meetings is critical and we suggest these meetings not need to be strictly limited to procedural matters. Parametric functions used for extrapolations should also be considered in scope.

be helpful for all parties (e.g. including cases where the recommendations involve high ICER values, which may indicate issues with comparators chosen for re-analysis).

For industry's part, given the elective nature of multiple potential touchpoints, we are committed to encouraging manufacturers to use these opportunities judiciously, when needed, to ensure efficiency of time and resources for all parties.

Thank you for confirming (January 13, 2025 working session) that manufacturers will still have an opportunity provide written comments on draft documents and that elements discussed at pre-submission meeting would be binding.[2] We encourage CDA to codify this and clarify its process documents regarding the maintenance of these existing opportunities. Thank you also for clarifying that in-review meetings can take place any time up to the draft recommendation, meaning that they could happen following manufacturer comments and CDA response.

Rolling Reviews under Target Zero

Rolling reviews for HTA submissions hold promise to accelerate those elements of the reimbursement system within CDA's direct purview.CDA and companies have collaborated to greatly improve pre-NOC submissions which now comprise 69% of reviews, reflecting significant progress under the Target Zero collaboration. However, we do not currently have published data on final outcomes of these submissions (and overall time-to-access remains a challenge in Canada at other stages of the reimbursement process). As the rolling review and related streamlining processes roll out, we look forward to being able to continue to collaborate to improve not only this proportion of submissions happening prior to NOC, but to having them happen further in advance of NOC.

IMC and BIOTECanada share CDA's objective of seeing much earlier submissions (e.g. months pre-NOC). We suggest that **improvements to the rolling review framework could be made to 1) permit rolling reviews for all pre-NOC file types;2) allow mid-review data updates/supplements for standard reviews and complex reviews; and, 3) permit greater flexibility in the rolling review process to allow clinical dossiers to be submitted and reviews initiated, while allowing economic review components to follow subsequently**.[3] As discussed on January 13, 2025, submission of provincial Budget Impact Analyses could come much later in the process and need not hold up a CDA review or impact CDA metrics. Reduced timeline for sponsor review of draft reports (to 4 days, and 8 days for the redactable information in the reviewer report) may deter some from leveraging the pathway. This could be reverted to 7 business days, with the understanding that manufacturers make efforts to submit earlier, pre-NOC.

[2] To help implement this, we suggest a procedure that identifies CDA attendance, and that discussions in these meetings be captured in minutes to be included in the confidential documentation associated with the file.

[3] CDA should consider to not requiring the "draft" economic model with placeholder values to be submitted in advance as this duplicates work and puts significant time limitations on what is practically possible by the sponsor.

As discussed January 13, 2025, industry is open to the idea of starting the 180-day target "clock" only once all documents are sent by manufacturers, or alternatively, to use the "stop clock" approach that some regulatory agencies use, where the clock would stop when the 'ball is in the manufacturer's court' (therefore not penalizing CDA when manufacturers cannot address requests/questions or provide documents in a timely manner). Our industry's overall objective is to make rolling reviews a meaningful incentive for earlier submissions. We appreciate CDA concerns regarding fees rebate issues, and we would not expect financial consideration when flexibility is provided. We also encourage CDA to permit manufacturers to provide any updated data past the draft (interim) review report—an item that CDA has noted is currently under consideration.

Separately, we would take this opportunity to encourage CDA-INESSS harmonization wherever possible, which would entail INESSS providing similar flexibilities. Without similar processes at INESSS, our members have commented that sequencing and workload timing/duplication can be an issue that could impact the realization of full benefits and thus anticipated program uptake. A shared workstream (industry-CDA-INESSS) on rolling reviews, and file acceleration more generally, would be most welcome in 2025.

Manufacturers consider the entire ecosystem holistically when planning for access in Canada. As such, we encourage CDA to lean on its role of convenorship and create a dialogue with other stakeholders (e.g. pCPA, provinces) about the potential downstream effects of any changes made at the HTA level. For instance, the spirit of Target Zero could be further realized by initiating pCPA engagement at the time of draft recommendation. This would potentially shave months in the total process and would bring the whole system closer to Target Zero.

Expansion of Time Limited Recommendations (TLR)

In previous years, there have been productive discussions with CDA on its Time Limited Recommendation (TLR) framework. We have consistently positioned around the need to expand TLR criteria to include products without pending Phase III trials, but rather that may be supported by Real-World Evidence (RWE). The slow uptake (one completed file to-date since 2023) speaks to initial restrictive criteria, but also to onerous conditions subsequently imposed by the pCPA's associated pTAP framework. See our written feedback (TLR and pTAP) for further information regarding possible avenues for TLR.

We have consistently advocated for coverage with evidence development and the TLR/pTAP is an incremental first step that can provide a platform for future advancement towards more agile payer models that will enable the entry of innovative therapies that address complex and previously untreatable illnesses emerging in the Canadian market.[4] While we appreciate CDA's intent to evolve

[4] These may present with evidence and economic uncertainties due to low disease prevalence, small evidence base, absence of comparators, lack of Phase III trial feasibility, and/or trials of short duration with outcomes that show promise of efficacy, although not confirmatory. In efforts to appraise the clinical and cost

TLR by looking at past files, **we encourage CDA and pCPA to think more boldly about how to provide faster access for patients, sustainability for health system managers, and opportunities for Canada to improve its life science performance and international launch sequencing.**

When coupled with innovative payer agreements (outcomes-based agreements, managed entry, coverage with evidence development), RWE holds considerable promise to help governments strategically manage the entry of new medicines. We understand from discussions with pCPA that it will defer to CDA regarding evidence criteria. In the course of these discussions, pCPA did not seem generally opposed to alternative scope possibilities. Therefore, we reiterate industry's position on expanded scope. If a more incremental approach is desired, CDA could also consider allowing the Phase III follow-up study to be in a different line of treatment.

Deliberative Framework

Deliberative processes are a key component of health technology assessment as they serve to combine complex sets of evidence, perspectives, and values to support open, transparent, and accountable decision making. Because of this, there is interest internationally in optimizing the effectiveness of deliberative processes in HTA. IMC and BIOTECanada recognize the innovative approach to engagement trialed through the Formulary Management Expert Committee (FMEC), and are encouraged that CDA is expanding engagement for core expert committees CDEC and pERC.

Given that changes to deliberative policy are infrequent, our core feedback to CDA is to think more boldly in this area or consider phasing in a number of innovations throughout 2025. These could include:

- ***Decision making transparency*** - Publish meeting transcript including Q&A (anonymized, not for personal attribution); highlighting areas of dissenting opinion and disclosing how the committee arrived at a final position on these elements; terms of reference for expert committee meetings and deliberations (see appendix for select international examples).
- ***Direct manufacturer engagement*** – Provide manufacturers with the **opportunity to engage directly with expert committee and clinical experts**, especially with files where there is no therapeutic area expertise on the voting committee.
- ***Publish decision tree / algorithm*** – On January 13, 2025 CDA walked through a helpful decision tree with respect to expert committee deliberations, and **we strongly encourage CDA to publish this algorithm to enhance decision making transparency** (we recommend as part of the procedures document).
- ***Persons with lived experience*** – Leading patient organizations have spent considerable time thinking about this issue. We fully support their views on needed enhancements, in particular, allowing feedback from all people with lived experience including persons *without* direct experience on drug under review (e.g. including those with experience on comparators, or

effectiveness of these therapies, and ensure timely access to patients that could benefit, an alternative approach to evaluation and reimbursement decision making is warranted.

those experiencing burden of illness). **CDA should work to engage persons with lived experience for all standard reviews as well as complex reviews and transparently communicate when this takes place.** Specific reference to how patient values were integrated into the recommendation can also add significant value.

- ***Use of societal perspectives***- The decision tree noted above may help to explain the role of societal perspectives within the decision-making process. We encourage societal perspectives to be considered eligible for any review.[5]
- ***Experts*** - Allow additional experts relevant to individual reviews, and provide transparency of those experts selected (expertise, if not names). There is often a need for more than one clinical expert, and where possible multiple experts should be consulted for all submissions, not just complex files. Manage potential bias in clinician expert input in deliberations, following an established guideline, that includes reference that an established point of contact with a manufacturer does not disqualify an expert from being considered by the CDA.
- ***Presentation of ICER estimates***– While not squarely in scope of the present consultation, IMC and BIOTECanada are greatly encouraged by the dialogues over 2024 regarding the presentation of economic information to the expert committee and within CDA review reports. We look forward to seeing the final policy from the economics team in Q1 2025 with an aim for timely implementation.

Proportionate Reviews, including Paces (formerly Fast-Pass)

IMC and BIOTECanada appreciate CDA's intent to contribute to improvements in overall time-to-patient in Canada. We are also aware of high-priority efforts by Ontario Premier Ford and the Council of the Federation to adopt a new accelerated access pathway for high priority medicines that address urgent areas of unmet patient need (see CoF December 2024 discussions and Premier Ford's announcement). This pathway could accelerate access and provide patients with immediate access to CDA-reviewed medicines in a similar manner to German and/or French accelerated access mechanisms.

While Paces could help with some CDA workload issues, and **we support the essential principle of manufacturer self-selection for Paces, we feel that more industry-CDA-pCPA-patient discussion is needed before CDA advocates to payers these particular files are prioritized over other innovative products within pCPA processes**. We have also heard some concerns from members about possible down-stream measures that may be considered by the pCPA for Paces products and would caution against the expansion of TNP-like provisions (Targeted Negotiation Process).

Regarding standard reviews as well as other project types, it remains essential that studies be accepted that address remaining gaps in evidence. There is a need for other RWE, other randomized controlled trials, or observational studies to fill the evidence base that could otherwise be critically lacking.

[5] Not including the societal perspective for Complex Review *Scenario Two* may create equity issues if the 1st in class went through *Scenario One* and had the societal perspective included. As discussed, we encourage societal perspective in *Scenario Two* as well (table 2).

Ongoing dialogue and multi-stakeholder engagement following adoption

IMC and BIOTECanada thank CDA for the opportunity to comment and have made best efforts to address key considerations on a wide-ranging suite of reforms, in a focused manner. It will be important for all stakeholders to be involved in the monitoring, assessment, discussion, and evolution of the process on an ongoing basis, particularly as it relates to deliberation and input from persons with lived experience.

Thank you again for CDA's commitment to engagement and process innovation. We are realistic that not all of our more ambitious suggestions may be implementable in a few short weeks per CDA's stated February timeline, but we do encourage CDA to consider phasing in these elements over 2025. IMC and BIOTECanada look forward to ongoing engagement on these important initiatives for Canadian patients.

Appendix: Approaches used by other HTAs that could be studied further for possible learnings

Examples provided below do not necessarily reflect specific proposals but are relevant examples for CDA to consider.

Practice	HTA Agency
Expert Committee meetings open to the public	NICE, SMC, ICER, ZIN[6]
Transparent approach to clinical expert nomination, eligibility determination and selection	NICE[7]
Transparent disclosure of clinical experts providing input to deliberations	ICER[8]
Use of language in public documents that conveys inherent uncertainty in ICERs	NICE, AWTTC
Voting by appraisal committee on the degree to which individual value considerations should affect overall judgements of long-term value for money of the intervention	ICER[9]

[6] Background paper in: 2020 HTAi Global Policy Forum. Deliberative Processes in Health Technology Assessment, Jan. 26-29, 2020.

[7] NICE health technology evaluations: the manual. Process and methods. January 2022, National Institute for Health and Care Excellence

[8] Lecanemab for Early Alzheimer's Disease, Final Evidence Report, ICER. (Institute for Clnical and Economic Review), April 17, 2023.

[9] Understanding "Contextual Considerations and Potential Other Benefits or Disadvantages", Institute for Clinical and Economic Review, located at: https://icer.org/understanding-contextual-considerations-and-potential-other-benefits-or-disadvantages/, accessed August 15, 2023.