

**May 2004 meeting of the Pharmacology and Therapeutics Advisory Committee**

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“**Minute**” means that part of the record of a PTAC or Sub-committee meeting (including meetings by teleconference and recommendations made by other means of communication) that contains a recommendation to accept or decline an application for a new investment or a clinical proposal to widen access and related discussion.”

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### **Exemestane (Aromasin) for second-line treatment of advanced breast cancer in postmenopausal women**

The Committee noted that CaTSOP had previously considered this application from Pfizer for the listing of its aromatase inhibitor, exemestane (Aromasin). Members noted that exemestane is an irreversible inhibitor of aromatase, and that Pfizer were applying for the same access criteria that are currently in place for anastrozole.

The Committee noted that the papers provided by Pfizer were predominantly comparisons of exemestane with megestrol. Members considered that the data demonstrated that exemestane has a slightly better response rate than megestrol, and that time to progression was also slightly longer with exemestane. They considered that, although there were no studies directly comparing exemestane with other aromatase inhibitors, the effects of exemestane were likely to be similar to letrozole and anastrozole, and that its effects should be considered as an aromatase class effect unless data became available that demonstrated otherwise.

The Committee considered that exemestane should be listed on the Pharmaceutical Schedule with the same access criteria as anastrozole, for "treatment of advanced breast cancer refractory to tamoxifen". Members gave a low priority to this recommendation. However, the Committee noted that if a suitable commercial proposal were reached, its priority recommendation would change to high, as indicated by CaTSOP. The decision criteria most relevant to this recommendation are as follows: *(iv) the clinical benefits and risks of pharmaceuticals*; the irreversible nature of the inhibition by exemestane may translate into clinical benefits over existing therapy although this still needs to be confirmed in clinical studies

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### Escitalopram (Lexapro)

The Committee considered an application for the listing of escitalopram (Lexapro) 10 mg and 20 mg tablets on the Pharmaceutical Schedule. Members noted that the supplier had applied for the listing of escitalopram for treatment-resistant depression under the same Special Authority criteria that are currently in place for venlafaxine.

In addition to the studies and meta-analysis included in the application, the Committee considered an article by Saxby et al: "Medication options in the treatment of treatment-resistant depression" (from the Australian and New Zealand Journal of Psychiatry 2004; 38:219-225). The Committee considered 'treatment resistant depression' to be a major depressive episode that had failed to respond to two courses of different antidepressants at their maximum tolerated doses. Each course should have been for at least four weeks.

The Committee considered that escitalopram was another selective serotonin re-uptake inhibitor (SSRI) and was a different agent to the dual action serotonin and noradrenaline re-uptake inhibitor (SNRI) venlafaxine. Members considered that escitalopram was useful in major depressive disorder, being marginally superior to citalopram and broadly equivalent to venlafaxine but better tolerated. They noted, however, that there was no evidence provided in the application on the effectiveness of escitalopram compared with these agents in 'treatment-resistant depression'. They also noted that the submission did not provide any data comparing escitalopram with either fluoxetine or paroxetine. However, given that the efficacy of citalopram was similar to the efficacy of fluoxetine and paroxetine, they considered that it could be argued that escitalopram might be more effective than these two agents in major depressive disorder. However, without confirming data this argument cannot be accepted.

The Committee considered that the argument that escitalopram was more effective than citalopram in major depressive disorder did not justify its use in 'treatment-resistant depression'. The Committee considered that, given its slightly superior potency compared with citalopram, escitalopram could perhaps be used in patients who require high doses (e.g. 60 mg) of citalopram.

The Committee noted that generic citalopram was significantly less expensive than escitalopram. The Committee considered that the evidence presented in the submission did not support the indication for which the supplier had applied for listing. The Committee recommended that the application be declined.

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### **Oxycodone hydrochloride (OxyContin) controlled-release formula**

The Committee noted that the Analgesic Sub-committee of PTAC had considered that there was a clinical need not being met by the products currently listed in the Analgesic therapeutic group of the Pharmaceutical Schedule and had recommended that PHARMAC staff explore the possibility of listing oxycodone. Members noted that the submission from Mundipharma was in response to PHARMAC staff requesting it.

The Committee considered that the evidence supplied by Mundipharma was adequate, but contained no clinical data comparing oxycodone with other strong opioids. However, it did note that oxycodone appeared to have similar analgesic efficacy to morphine sulphate, and was on the WHO Pain Ladder at Step 3. The Committee asked that more comparative data against other step 3 opioids be supplied by Mundipharma and that other formulations of oxycodone also be included in the application (short acting, liquids and injection).

The Committee considered that oxycodone would replace morphine in times of opioid switching and/or rotation. It considered that morphine sulphate would continue to be used as first-line treatment for palliative care. However, there are approximately 18% of patients currently being treated with morphine who, due to lack of analgesic effect or intolerable adverse effects, may benefit if oxycodone were available.

They noted that oxycodone was more expensive than morphine sulphate in both the UK and in Australia, and that the supplier had not submitted pricing in its application.

The Committee recommended that long-acting oxycodone should be listed on the Pharmaceutical Schedule, and gave this a medium priority. The relevant decision criteria for this recommendation were (i) The health needs of all eligible people within New Zealand; as there are some patients currently being treated with morphine who due to lack of analgesic effect or intolerable adverse effects, may benefit if oxycodone were available; and (iii) The availability and suitability of existing medicines, therapeutic medical devices and related products and related things; there are some patients for whom there are no suitable alternatives.

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### Etanercept (Enbrel) – widening access for adult rheumatoid arthritis

The Committee considered an application from Wyeth New Zealand for the widening of access to etanercept (Enbrel) injection (1 x 25 mg) on the Pharmaceutical Schedule to include adults. Members noted that they had considered etanercept previously and they had considered that, although it was an effective drug, it was very expensive and listing had been recommended only for juveniles. They also noted that the application from Wyeth was in response to PTAC's concerns and included proposed targeting criteria for adult rheumatoid arthritis, to contain cost.

The Committee considered that there was no way of validating the data presented by Wyeth, as it had been pulled from clinical trial data on file and not from any clinical trial report or published paper. Members considered, however, that the Australian criteria for etanercept were potentially more restrictive than the criteria listed in the application to PTAC, as the Australian criteria specify the protocol of a DMARD regime before funding for etanercept is made available. They noted the low uptake of etanercept prescribing in relation to budget projections in Australia; however, they noted that prescribing in Australia was still in the early stages. Members recommended caution in interpretation of this data about patient numbers from Australia. Members noted that some modelling using the New Zealand situation could be helpful, and that if listed in the future, a national database should be put in place to monitor adverse effects to etanercept.

Overall the Committee reconfirmed the moderate priority it had previously given to listing etanercept for use in adults.