Teclistamab for treating relapsed or refractory multiple myeloma after 3 treatments

Part 1 for public – contains redacted information

Technology appraisal committee C [3 September 2024]

Chair: Stephen O'Brien

External assessment group: Liverpool Reviews and Implementation Group (LRiG)

Technical team: George Millington, Sally Doss, Ross Dent

Company: Johnson & Johnson Innovative Medicine

Summary of ACM1 decisions

Teclistamab recommendation: Teclistamab is recommended as an option for treating relapsed and refractory multiple myeloma in adults after 3 or more treatments (including an immunomodulatory drug, a proteasome inhibitor and an anti-CD38 antibody) when the myeloma has progressed on their last treatment. It is only recommended if: pomalidomide plus dexamethasone would otherwise be offered

Elranatamab recommendation: Elranatamab is recommended with managed access as an option for treating relapsed and refractory multiple myeloma in adults after 3 or more lines of treatment (including an immunomodulatory agent, a proteasome inhibitor and an anti-CD38 antibody) when the myeloma has progressed on the last treatment. It is only recommended if: pomalidomide plus dexamethasone would otherwise be offered

14 March 2024 Elranatamab ACM1

4 June 2024 Teclistamab ACM1

11 July 2024 Elranatamab FDG withdrawn

12 July 2024 Elranatamab DG published

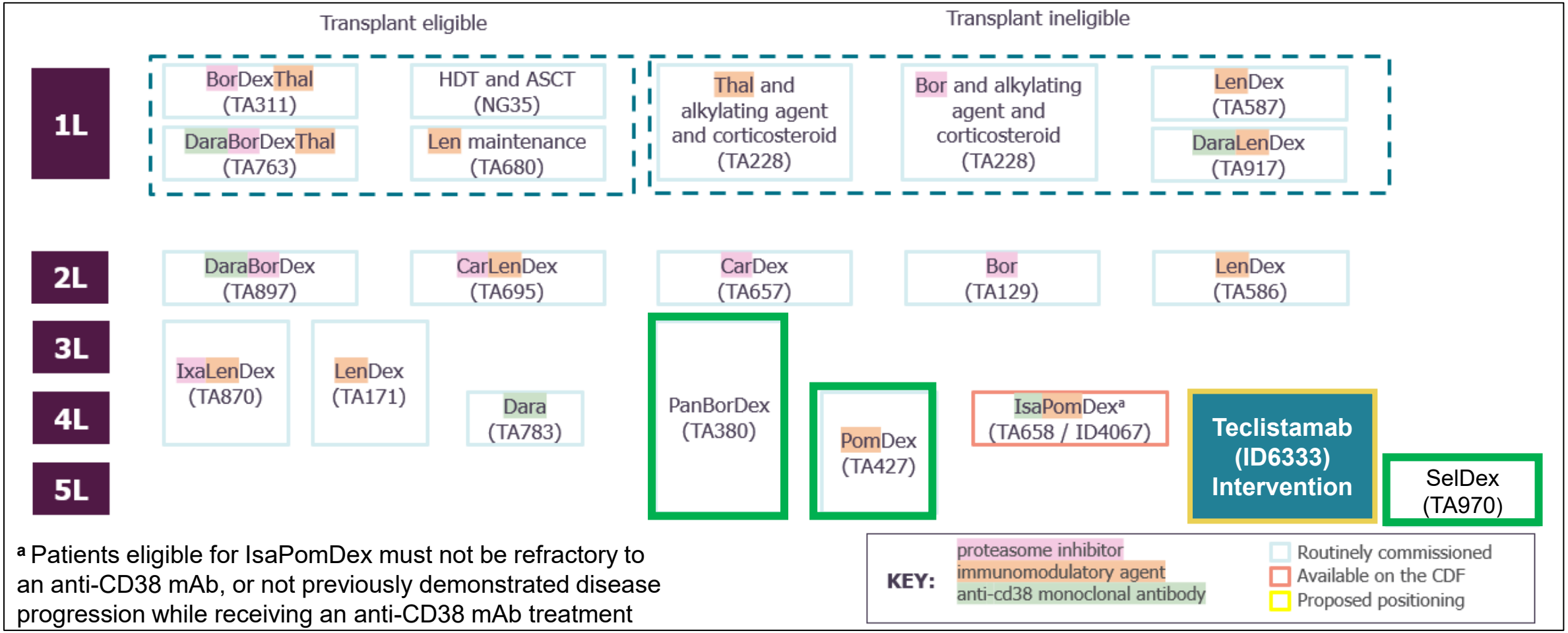
16 July 2024 Teclistamab DG published

3 Sept 2024 Teclistamab ACM2

9 Oct 2024 Elranatamab ACM2

Multiple myeloma (MM) treatment pathway and proposed positioning of teclistamab

Figure 1: The current NHS MM treatment pathway and proposed positioning of teclistamab



[a] Patients eligible for IsaPomDex must not be refractory to an anti-CD38 mAb, or not previously demonstrated disease progression while receiving an anti-CD38 mAb treatment

ASCT: Autologous stem cell transplantation; Bor: Bortezomib; Car: Carfilzomib; CDF: Cancer Drugs Fund; Dara: Daratumumab; Dex: Dexamethasone; Isa: Isatuximab; Ixa: Ixazomib; Len: Lenalidomide; PAN: Panobinostat; POM: Pomalidomide; TA: Technology appraisal; Tec: Teclistamab; Thal: Thalidomide.

Summary of responses to consultation

Submissions from Johnson and Johnson (company), Myeloma UK, and Blood Cancer UK:

- Company believes most relevant comparators are PanoBorDex (for people who are bortezomib-sensitive) and SelDex (for people who are penta-refractory)
- Company conducted unanchored MAICs against both comparators which indicated that teclistamab improves outcomes over PanoBorDex and SelDex
- Company believes there is no evidence that pomalidomide-exposed patients have substantially different outcomes to the ITT population - 84.2% of ITT population had received prior pomalidomide
- Company believes 1.7x modifier should apply to reflect the higher proportional shortfall of Pom-exposed patients (proportional QALY shortfall of [redacted]%. 1.7x severity modifier met in [redacted]% of simulations)
- Patient organisation noted during the COVID-19 pandemic, pomalidomide was approved as an interim treatment for second- and third-line myeloma to reduce the need for chemotherapy and reduce admissions and risk of neutropenia

Summary of EAG critique of company response

- Does not agree that PanoBorDex is a relevant comparator, no longer used due to ongoing toxicity concerns. Agrees that SelDex is relevant comparator for penta-refractory but BSC should also be considered a comparator
- Because SelDex was cost-effective against BSC, if teclistamab is cost-effective against Sel-Dex, it will also be cost-effective against BSC
- Considers company MAIC methods were appropriate and agrees that the teclistamab and SelDex populations were well matched after adjusting
- ITT population largely Pom-exposed, agrees that results are unlikely to be different
- Company's lognormal PFS estimate at 1 year for SelDex appears optimistic – EAG prefers Weibull distribution
- SelDex PD utility is lower than the teclistamab PD utility - reduced the teclistamab PD utility to match SelDex in base case
- Agrees with the use of the 1.7x QALY modifier for deterministic results

Cost-effectiveness results

- All ICERs are reported in PART 2 slides because they include confidential comparator PAS discounts
- When comparator PAS discounts are included, the company base case is within the range normally considered a cost-effective use of NHS resources
- The EAG base case is also within this range

ICER: Incremental cost effectiveness ratio; PAS: Patient access scheme