



May 22, 2019

Submitted electronically to: publiccomments@icer-review.org

Steven D. Pearson, MD, President
Institute for Clinical and Economic Review
Two Liberty Square, Ninth Floor
Boston, MA 02109

Re: Draft Scoping Document on Oral Semaglutide for Type 2 Diabetes

Dear Dr. Pearson:

On behalf of the Institute for Patient Access, I thank you for the opportunity to provide comments regarding ICER's draft background and scope document, "Oral Semaglutide for Type 2 Diabetes: Effectiveness and Value," dated May 2, 2019.

About the Institute for Patient Access

The Institute for Patient Access (IfPA) is a physician-led policy research organization dedicated to maintaining the primacy of the physician-patient relationship in the provision of quality health care. To further that mission, IfPA produces educational materials and programming designed to promote informed discussion about patient access to approved therapies and appropriate clinical care. IfPA was established in 2012 by the leadership of the Alliance for Patient Access, a national network of more than 800 physician advocates committed to patient access. IfPA is a 501(c)(3) public charity non-profit organization.

Draft Scoping Document Comments

The Institute for Patient Access urges you to account for several important patient considerations in your analysis of oral semaglutide.

First, ICER's evaluation should explicitly account for the value created by the fact that this therapy is the first oral formulation of a GLP-1 receptor agonist. As an oral formulation, semaglutide creates convenience benefits for patients that could save time and increase their overall productivity. Specifically, oral semaglutide provides a less complex mode of administration, one that may work better for patients who dislike injections or for whom the cadence of a daily medication is more natural and simpler to maintain than the weekly injection required by the current GLP-1 formulations.

These factors may improve overall adherence rates. Of particular value, the administrative convenience of oral semaglutide may also improve accessibility for under-treated socio-

economic and geographic patient populations, increasing their adherence to treatment. The benefits from increased adherence and accessibility cannot be underestimated. They will likely improve overall health outcomes while also decreasing overall disease management costs. It is imperative that ICER fully incorporate these considerations in its analysis.

Second, when evaluating the health and economic outcomes of oral semaglutide for T2DM, it is imperative that ICER account for the high health and economic costs that Type 2 diabetes imposes on society. Diabetes was the seventh leading cause of death in the U.S. as of 2015 (the crude death rate was 24.7 per 100,000 persons).¹ As the scoping document notes, the estimated total direct and indirect costs of diabetes were \$245 billion; on a per-patient basis, there were \$7,900 in annual health expenditures directly attributable to diabetes. These cost estimates are as of 2012, however. The costs are undoubtedly higher today.

As a point of reference, the American Diabetes Association noted a 41 percent increase in the costs of diabetes between 2007, when costs totaled \$174 billion,² and 2012. While there are no estimates for costs increases over the past seven years, the growth pattern between 2007 and 2012 suggests that the direct and indirect costs of diabetes today could be more than \$345 billion. ICER should account for the likely increase in the cost that diabetes imposes on society when making its cost-effectiveness evaluations.

Third, it is imperative that ICER recognize that current treatments are not effective for all patients. In light of the high costs of diabetes, there is significant value in a medicine that can effectively treat patients for whom current therapies do not adequately control Type 2 diabetes. Global phase 3a trials have demonstrated that oral semaglutide may be more efficacious for these patients.³ It is imperative that ICER's analysis explicitly incorporate the value created when patients who did not have an efficacious medicine now do.

Fourth, patients living with diabetes have an increased risk for cardiovascular disease and stroke, which is even higher if they also struggle with obesity. Cardiovascular disease imposed over \$555 billion in costs in 2015, and it is projected to increase to \$1.1 trillion in 2035.⁴ To improve the health outcomes for patients, and lower overall health care costs, the health care system must employ a team-based, whole-patient approach to caring for people with both diabetes and cardiovascular disease. Toward this goal, medicines that can help patients control their diabetes *and* reduce their cardiovascular risks hold great promise.

It is, consequently, imperative to incorporate the long-term impact of oral semaglutide on cardiovascular disease in order to accurately assess the therapy's lifetime cost effectiveness. Based on current initial research, semaglutide may be associated with a lowered rate of adverse cardiovascular outcomes for patients with type 2 diabetes who also had high cardiovascular

¹ <https://www.cdc.gov/diabetes/data/statistics-report/deaths-cost.html>.

² <http://care.diabetesjournals.org/content/36/4/1033>.

³ <https://www.pharmacytimes.com/resource-centers/diabetes/oral-semaglutide-demonstrates-benefits-for-patients-with-type-2-diabetes>

⁴ <https://healthmetrics.heart.org/wp-content/uploads/2017/10/Cardiovascular-Disease-A-Costly-Burden.pdf>

risks.⁵ Excluding oral semaglutide’s potential cardiovascular benefits will undervalue the therapy, in turn leading to coverage and access barriers that leave patients unnecessarily at risk.

Fifth, the “Report Aim” section of the scoping document states that ICER intends to capture important “public health effects” related to oral semaglutide. However, broader, longer-term, public health effects are difficult to extrapolate from clinical trial data. Inappropriate extrapolations could lead to unwarranted conclusions.

As the aforementioned connection between diabetes and cardiovascular disease illustrates, the broader public health benefits that oral semaglutide may create can be material, even if the evidence is still preliminary or not yet available. The unavailability of the data does not justify excluding (or undervaluing) these benefits. The still developing public health effects of oral semaglutide also warrant caution regarding ICER’s intention to run a “simulation model to assess the lifetime cost-effectiveness of the treatment.” Since the public health effects cannot yet be fully understood, accurate lifetime cost-effectiveness estimates are unknowable at present. Consequently, judgements regarding the lifetime value of the treatment, given the limited nature of the clinical trial data, will simply be quantitative speculation.

Should there be insufficient evidence, particularly because only phase 3 data are available, IfPA urges caution regarding any cost-effectiveness determination. Unsupported conclusions could inappropriately jeopardize patients’ access to these medicines once a fuller understanding of the broader public health benefits is better understood.

Finally, there are always concerns when studies compare the efficacy of a treatment that has not yet been approved by the FDA to approved treatments that have been in use for years. Treatments that have not yet been approved will not have any post-marketing data (by definition). As a result, any understanding of the drug’s benefits and side-effects will be less robust than an understanding of treatments that have been available for years. Caution is warranted before any sweeping conclusions are reached regarding relative efficacy.

Conclusion

IfPA urges ICER to account for these considerations when performing its analysis, lest the clinical evidence review provide an inaccurate picture of the benefits that oral semaglutide could offer patients living with Type 2 diabetes. If IfPA can provide further detail or aid the Institute for Clinical and Economic Review in incorporating any of the above recommendations into its final draft, please contact us at 202-499-4114.

Sincerely,



Brian Kennedy
Executive Director

⁵ <https://www.nejm.org/doi/full/10.1056/NEJMoa1607141>.