

**NATIONAL INSTITUTE FOR HEALTH AND CARE  
EXCELLENCE**

**Appraisal consultation document**

**Olaparib for maintenance treatment of  
relapsed, platinum-sensitive, BRCA  
mutation-positive ovarian, fallopian tube  
and peritoneal cancer following response  
to second-line or subsequent platinum-  
based chemotherapy**

The Department of Health has asked the National Institute for Health and Care Excellence (NICE) to produce guidance on using olaparib in the NHS in England. The Appraisal Committee has considered the evidence submitted by the company and the views of non-company consultees and commentators, and clinical experts and patient experts.

**This document has been prepared for consultation with the consultees.**

It summarises the evidence and views that have been considered, and sets out the draft recommendations made by the Committee. NICE invites comments from the consultees and commentators for this appraisal (see section 4) and the public. This document should be read along with the evidence base (the [Committee papers](#)).

The Appraisal Committee is interested in receiving comments on the following:

- Has all of the relevant evidence been taken into account?
- Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?
- Are the provisional recommendations sound and a suitable basis for guidance to the NHS?
- Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

**Note that this document is not NICE's final guidance on this technology. The recommendations in section 1 may change after consultation.**

After consultation:

- The Appraisal Committee will meet again to consider the evidence, this appraisal consultation document and comments from the consultees.
- At that meeting, the Committee will also consider comments made by people who are not consultees.
- After considering these comments, the Committee will prepare the final appraisal determination (FAD).
- Subject to any appeal by consultees, the FAD may be used as the basis for NICE's guidance on using olaparib in the NHS in England.

For further details, see the Guides to the technology appraisal process.

**The key dates for this appraisal are:**

Closing date for comments: 22 June 2015

Second Appraisal Committee meeting: 30 June 2015

Details of membership of the Appraisal Committee are given in section 8, and a list of the sources of evidence used in the preparation of this document is given in section 9.

Note that this document is not NICE's final guidance on this technology. The recommendations in section 1 may change after consultation.

## 1 Appraisal Committee's preliminary recommendations

- 1.1 Olaparib is not recommended, within its marketing authorisation, as maintenance treatment for adults with relapsed, platinum-sensitive ovarian, fallopian tube or peritoneal cancer who have *BRCA1* or *BRCA2* mutations and whose disease has responded to second-line or subsequent platinum-based chemotherapy.
- 1.2 People whose treatment with olaparib was started within the NHS before this guidance was published should be able to continue treatment until they and their NHS clinician consider it appropriate to stop.

## 2 The technology

- 2.1 Olaparib (Lynparza; AstraZeneca) is a poly-ADP-ribose polymerase (PARP) enzyme inhibitor that selectively kills tumour cells with an impaired homologous recombination DNA repair pathway while sparing normal cells. Olaparib has a marketing authorisation in the UK as 'monotherapy for the maintenance treatment of adult patients with platinum-sensitive relapsed BRCA-mutated (germline and/or somatic) high-grade serous epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete response or partial response) to platinum-based chemotherapy'. It is administered orally and the recommended dose is 400 mg twice daily.
- 2.2 The summary of product characteristics lists the following very common adverse reactions for olaparib: decreased appetite;

headache; dizziness; dysgeusia; nausea; vomiting; diarrhoea; dyspepsia; and fatigue. For full details of adverse reactions and contraindications, see the summary of product characteristics.

- 2.3 The list price of olaparib is £3950 per pack, with each pack containing 448 capsules of 50 mg each (equivalent to 28 days' treatment of 16 capsules per day at continuous full dose of treatment); price excludes VAT, 'British national formulary' [BNF] edition 69). The company has agreed a patient access scheme with the Department of Health. If olaparib had been recommended, this scheme would involve the NHS paying for a patient's treatment with olaparib up to a certain time, with the company providing olaparib free-of-charge beyond that point and for as long as each individual patient continues to have olaparib. The Department of Health considered that this patient access scheme would not constitute an excessive administrative burden on the NHS.

### **3 The company's submission**

The Appraisal Committee (section 8) considered evidence submitted by AstraZeneca and a review of this submission by the Evidence Review Group (ERG; section 9).

- 3.1 The key clinical evidence came from a phase II trial (Study 19) which was an international, multicentre, double-blind, randomised, placebo-controlled trial comparing olaparib with routine surveillance (a 'watch and wait' strategy) in patients with platinum-sensitive epithelial ovarian cancer (including fallopian tube and peritoneal cancer). Study 19 included 265 patients and took place at 82 study centres in 16 countries. The patients started olaparib or matching placebo within 8 weeks of their last dose of a platinum-containing regimen. Patients were included in the trial only if their disease was platinum-sensitive, which was defined as disease progression more

than 6 months after completing their penultimate platinum regimen. The mean age of the trial population was 57 years and 96% of patients were white.

- 3.2 The company's submission focused mainly on a subgroup of 136 patients with BRCA gene mutations, because this is the population covered by the marketing authorisation. In Study 19, knowledge of BRCA-mutation status was not a requirement for entry into the study. BRCA-mutation status was determined for almost all patients in the trial, but this was largely done retrospectively. In the original clinical study report the subgroup analysis by BRCA-mutation status was based on germline-BRCA status at entry to the study. In the analysis presented in the submission, and on which the licensed indication is based, patients were classified as having the BRCA mutation (referred to as BRCAm) if the mutation was identified in a sample of either their blood (germline mutation) or their tumour (somatic or tumour mutation).
- 3.3 The company explained that the demographic characteristics of the BRCAm subgroup were generally consistent with the whole trial population and the 2 groups were well balanced in terms of age and ethnicity. There were fewer people aged over 65 years in the BRCAm subgroup than the whole trial population, but the company explained that this is consistent with inherited germline BRCA mutations in relapsed, high-grade serous epithelial ovarian cancer.
- 3.4 Olaparib was associated with a statistically significant improvement in the primary outcome of progression-free survival for the whole trial population and also for the BRCAm subgroup. For the whole population, median progression-free survival was 8.4 months in the olaparib group and 4.8 months in the placebo group (hazard ratio [HR], 0.35; 95% confidence interval [CI] 0.25 to 0.49). For the BRCAm subgroup, median progression-free survival was

11.2 months in the olaparib group and 4.3 months in the placebo group (HR 0.18, 95% CI 0.10 to 0.31).

- 3.5 The company explained that Study 19 was not powered to assess overall survival and that survival data were immature. An interim analysis of overall survival was done in November 2012. Crossover to olaparib was not permitted during the treatment period of the study, but after completing the study 23% of patients in the placebo arm had a PARP inhibitor (a second PARP inhibitor was not permitted in the olaparib group). The company specified that this was likely to have a confounding effect on the overall survival results, in favour of the placebo group. Therefore, the company performed an additional post-hoc analysis of overall survival to investigate the effect of crossover to olaparib from the placebo arm. A restriction method was used that excluded data from centres in which some patients had received PARP inhibitors after disease progression. This excluded 25% (67/265) of patients in the whole trial population and 29% (39/136) of patients in the BRCAm population.
- 3.6 For the whole trial population, overall survival analysis was done when 58% of the patients had died (November 2012). Median overall survival was 29.8 months (95% CI 27.2 to 35.7) in the olaparib arm and 27.8 months (95% CI 24.4 to 34.0) in the placebo arm. A statistically significant difference in median overall survival was not identified in the whole trial population at this point (HR 0.88; 95% CI 0.64 to 1.21; p=0.44).
- 3.7 For the BRCAm subgroup, overall survival analysis was done when 52% of the patients had died. A statistically significant difference in overall survival was not identified at this point (median 34.9 months in the olaparib arm and 31.9 months in the placebo arm, HR for death 0.73; 95% CI 0.45 to 1.17; p=0.19). In the analysis that

excluded patients who had a PARP inhibitor after disease progression, the median survival was also 34.9 months in the olaparib group, but fell to 26.6 months in the placebo group. This gave a statistically significant difference in overall survival between the groups of 8.3 months (HR for death 0.52; 95% CI 0.28 to 0.97;  $p=0.039$ ).

3.8 For the whole population, there was a statistically significant improvement in the time from randomisation to treatment discontinuation or death for olaparib compared with placebo (HR 0.39; 95% CI 0.30 to 0.51). For the BRCAm subgroup, median time to treatment discontinuation or death was 11.0 months in the olaparib arm and 4.6 months in the placebo arm (HR 0.36; 95% CI 0.24 to 0.53).

3.9 There was also a statistically significant improvement in time to first subsequent therapy or death with olaparib, defined as the time from randomisation to the start of the first cancer therapy after discontinuation of olaparib or placebo, or death. In the whole population, the HR was 0.41 for olaparib compared with placebo (95% CI 0.31 to 0.54). For the BRCAm subgroup, the median time to first subsequent therapy or death was 15.6 months in the olaparib group and 6.2 months in the placebo group (HR 0.33; 95% CI 0.22 to 0.50;  $p<0.00001$ ). The difference in median time to first subsequent therapy or death between placebo and olaparib was 9.4 months, compared with a median progression-free survival difference of 6.9 months.

3.10 Olaparib was associated with a statistically significant improvement in time to second subsequent therapy or death, defined as the time from randomisation to the start of the second line of cancer therapy after discontinuing olaparib or placebo, or death. In the whole population, the HR for time to second subsequent therapy or death

for olaparib compared with placebo was 0.54 (95% CI 0.41 to 0.72). For the BRCAm subgroup, the median time to second subsequent therapy or death was 23.8 months in the olaparib group and 15.2 months in the placebo group, a difference of 8.6 months (HR 0.44; 95% CI 0.29 to 0.67;  $p=0.00013$ ).

- 3.11 Study 19 collected adverse event data from the time of consent to treatment to 30 days after the last dose of treatment. The most common adverse events in the whole trial population were nausea (71%), fatigue (52%), vomiting (34%), diarrhoea (27%) and abdominal pain (25%). The most common adverse events in the BRCAm subgroup for olaparib were nausea (73%), fatigue (54%), vomiting (36%), diarrhoea (30%) and abdominal pain (23%). The most common grade 3 or higher adverse events for olaparib in the BRCAm subgroup were fatigue (7%), anaemia (5%) and neutropenia (4%). In the olaparib treatment group, 6 people (4.4%) in the whole trial population and 5 people (6.8%) in the BRCAm subgroup stopped treatment because of adverse events.
- 3.12 Health-related quality of life was assessed in Study 19 using the Trial Outcome Index (TOI), the Functional assessment of Cancer Therapy/National Comprehensive Cancer Network Ovarian Symptom Index (FOSI), and the Functional assessment of Cancer Therapy Ovarian (FACT-O) questionnaires. There were no statistically differences in the average change in health-related quality of life for olaparib compared with placebo.

### ***Cost effectiveness***

- 3.13 The company submitted 2 economic analyses; one that excluded the cost of BRCA testing, and one that included the costs of germline BRCA testing (blood test) and the costs and benefits of expanding testing to the relatives of people identified as having

germline mutations. Neither model included the costs of testing for BRCA mutations in tumour samples.

**Company's economic model (costs of BRCA testing excluded)**

- 3.14 The company's model compared olaparib with routine surveillance in patients with BRCA mutation-positive, platinum-sensitive relapsed ovarian cancer. There were 5 states in the model: progression-free (on maintenance treatment); progression-free (discontinued maintenance treatment); first subsequent treatment; second subsequent treatment; and death. All patients entered the model in the progression-free health state. The model had a fixed treatment regimen lasting a maximum of 6 cycles and a time horizon of 15 years. A discount rate of 3.5% was applied to costs and health benefits and the analysis was done from an NHS and personal social services perspective.
- 3.15 The proportion of the hypothetical cohort in each health state in the company's model was estimated using semi-Markov-state transitions, in which time in each health state depends on the time since entry into that state. The company stated that this approach was more flexible than the partitioned survival approach, traditionally used to evaluate fixed chemotherapy regimens. It also stated that this approach was preferable when survival data were immature, and had been used in NICE's technology appraisal guidance on [bevacizumab in combination with paclitaxel and carboplatin for first-line treatment of advanced ovarian cancer](#). Transition probabilities for the BRCAm subgroup were estimated by fitting parametric survivor functions to time-to-event data from Study 19. The parametric models were adjusted for Ashkenazi Jewish ancestry (a risk factor for BRCA gene mutation) , time to progression on penultimate platinum therapy, and full compared with partial platinum therapy. The company stated that a log-normal

distribution had been used for estimating the time to first subsequent treatment or death because the goodness-of-fit Bayesian information criterion values showed this model to be the most appropriate. The company also stated that visual inspection of the cumulative survival plot for time to first subsequent treatment or death showed that the proportional hazards assumption had been met. Therefore the treatment group was included in the model.

- 3.16 In the base-case analysis, the confounding effect from patients in the placebo group having a PARP inhibitor after disease progression was adjusted for. This was done by assuming that the probability of moving from the first subsequent treatment state to the second subsequent treatment state in the placebo group was the same as in the olaparib treatment group, in which further PARP inhibitors were not allowed after treatment with olaparib was stopped. The predicted mean and median times to first subsequent treatment and time to death were based on the results of the analysis that adjusted for use of a PARP inhibitor in the routine surveillance group (see section 3.5). The predicted median overall survival in the model was 38 months for the olaparib population and 26 months for the routine surveillance population.
- 3.17 Study 19 did not include a generic measure of health-related quality of life (such as the EQ-5D), which could have been used to estimate utilities. For the progression-free health states, utilities were obtained by mapping FACT-O data from Study 19 to EQ-5D by applying a published algorithm. Utility estimates for the subsequent-therapy health states were obtained from the estimates in the EVO-301 trial of trabectedin plus pegylated liposomal doxorubicin hydrochloride (PLDH) compared with PLDH alone in patients with relapsed advanced ovarian cancer in NICE's technology appraisal guidance on [trabectedin for the treatment of](#)

[relapsed ovarian cancer](#). Health-related quality of life decrements associated with adverse events were not included in the model.

- 3.18 The company's model included costs for post-study chemotherapy, monitoring (such as CT scans), and adverse events. The monthly cost of olaparib was based on the UK list price of £3950 per pack. The mean daily dose of olaparib used in the model was based on the actual mean daily dose used in Study 19. A unit cost of £127 was applied for an outpatient visit, £3 for a blood test, and £90 for a CT scan. It was assumed that all patients with advanced ovarian cancer would have regular scheduled follow-up consultations as part of their ongoing care. Therefore no additional administration costs were applied for treatment with olaparib. The rates of treatment with subsequent chemotherapy after disease progression were based on data from Study 19. The acquisition costs of subsequent chemotherapy were obtained from the Electronic Marketing Information Tool (eMit) for generic drugs and from the British national formulary (BNF).
- 3.19 The deterministic incremental cost-effectiveness ratio (ICER) estimated by the company's model for olaparib compared with routine surveillance was £49,826 per quality adjusted life year (QALY) gained. The probabilistic ICER was £49,146 per QALY gained.
- 3.20 The company's probabilistic analysis showed that at a maximum acceptable amount for an additional QALY of £30,000, olaparib had a 2% probability of being cost effective compared with routine surveillance. If the maximum acceptable amount for an additional QALY was £50,000, then olaparib would have a 52% probability of being cost effective compared with routine surveillance.

- 3.21 The company did a series of deterministic one-way sensitivity analyses to assess the effect of varying the costs, utility estimates and clinical data in the model. The company varied the input values for key parameters by 20% of the value used in the deterministic base case. The lowest ICER reported in the company's one-way sensitivity analysis was £38,975 per QALY gained (utility for olaparib, progression-free [on maintenance therapy] state, 0.92). The highest ICER reported in the company's one-way sensitivity analysis was £69,051 per QALY gained (utility for olaparib, progression-free [on maintenance therapy] state, 0.61).
- 3.22 The company did a series of scenario analyses. A key driver of the cost-effectiveness results was the estimate of overall survival used in the model (that is, whether it was derived from the model or based on trial data) and the parametric survival curves applied to the distribution of time from first subsequent treatment or death (generalised gamma or log normal). When trial data were used, applying the generalised gamma distribution increased the base-case ICER to £80,715 per QALY gained, and applying the log-normal distribution increased the ICER to £68,812 per QALY gained. When the cost of BRCA-mutation testing was included, the cost of olaparib treatment increased by approximately £2900. This resulted in an ICER of £53,089 per QALY gained for olaparib compared with routine surveillance.

**Company's economic analyses (costs and benefits of BRCA testing included)**

- 3.23 The company did additional economic analyses comparing olaparib with routine surveillance in people with BRCAm, platinum-sensitive relapsed ovarian cancer, which included the costs and benefits of extending BRCA-mutation testing to their relatives. This analysis combined the results of the company's first cost-effectiveness

analysis with results from the cost–utility analysis of genetic testing for women with a family history of breast cancer, which was developed as part of NICE’s guideline on [familial breast cancer](#).

- 3.24 The model was a semi-Markov design with a number of health states including incidence of new cancers, survival and death. The Breast and Ovarian Analysis of Disease Incidence and Carrier Estimation Algorithm (BOADICEA) was used to analyse the pattern of inheritance of a specific genetic trait (such as the *BRCA1* or *BRCA2* mutation). This identified 5 family pedigrees, with different risk-of-disease profiles. The model had a 50-year time horizon. A discount rate of 3.5% was applied to costs and health benefits and the analysis was done from an NHS perspective.
- 3.25 The results were obtained by adding the incremental costs and QALYs from the company’s first analysis and the costs and QALYs for BRCA-mutation testing and comparing these with no testing (from the economic model used in NICE’s guideline on [familial breast cancer](#)). Across the 5 individual pedigrees, the ICER for olaparib compared with routine surveillance ranged from £33,069 per QALY gained to £41,716 per QALY gained, with an average ICER of £39,343 per QALY gained.

### ***Evidence Review Group comments***

- 3.26 The ERG was satisfied that all relevant clinical studies were included in the company’s submission. The ERG questioned the extent to which Study 19 reflected clinical practice in England, because it used blood (for inherited germline mutations) and tumour (for acquired somatic mutations) BRCA-mutation testing to select patients. It commented that these tests may not be routinely performed in England and that it is unclear if tumour testing would be possible in England on a large scale. Therefore, the ERG

considered that the population in the trial may differ from the population treated in clinical practice in England.

3.27 The ERG commented that the clinical study report for Study 19 lacked clarity as to when and under which circumstances patients had subsequent chemotherapy after disease progression. Therefore the outcomes of time to first subsequent therapy or death and time to second subsequent therapy or death may not reflect routine clinical practice in England. Clinical advisers for the ERG suggested that this would be most likely to shorten estimates and may affect comparative estimates between study groups.

3.28 The ERG considered that the clinical effectiveness evidence from Study 19 was weak and at a high risk of bias because of a number of problems:

- **Subgroup analysis:** the BRCAm subgroup was identified post hoc and had a small sample size (n=136), leading to potential bias and uncertainty as to the true size of the treatment effect in that group. An interaction test to assess whether there was evidence that the subgroup was statistically significantly different to the rest of the trial population was not presented in the company's submission, but it was included in the clinical study report; the results of this test were inconclusive.
- **Post-hoc identification of outcomes:** the outcomes of time to treatment discontinuation or death, time to first subsequent therapy or death, time to second subsequent therapy or death and long-term overall survival were all identified post hoc.
- **Continuation of study drug after progression:** some patients continued olaparib treatment after disease progression, which may not be in line with the marketing authorisation and may not reflect clinical practice. This could alter treatment effect as measured by progression-free survival, time to first subsequent

therapy or death, time to second subsequent therapy or death and overall survival because patients may have had olaparib for a different length of time than would occur in clinical practice.

- **Crossover:** crossover of patients in the placebo arm to PARP inhibitor treatment, after disease progression, may have caused confounding and bias in the overall survival results.
- **Immaturity of overall survival results:** there was a lack of mature and conclusive evidence that treatment with olaparib increases overall survival.

3.29 The ERG considered overall survival, rather than progression-free survival, to be the most clinically relevant measure to assess the effect of a treatment on survival.

3.30 The ERG commented that time to first subsequent therapy or death and time to second subsequent therapy or death could be considered more clinically relevant than progression-free survival. This is because, in England, patients with ovarian cancer often have treatment after disease progression if their symptoms cause problems. However, the ERG considered that there were issues with time to first subsequent therapy or death and time to second subsequent therapy or death in the context of Study 19, including that the analyses were post hoc.

3.31 The ERG highlighted that it had concerns about the validity of the treatment pathway in the model. It noted that all patients who survived the first subsequent therapy event and all patients who survived the second subsequent therapy event were assumed to go on to have another course of active chemotherapy. The ERG stated that it may not be realistic to assume that all patients with advanced ovarian cancer would be well enough to have active chemotherapy. The ERG added that its clinical advisers had suggested that it was more clinically realistic to assume that some

patients would opt for best supportive care. It also noted that the company's model limited the number of subsequent chemotherapy treatments to a maximum of 2, but 32% of patients in Study 19 had 3 or more subsequent chemotherapy treatments.

- 3.32 The ERG had concerns about the structure of the company's model and considered that it would have been more appropriate to use a partitioned survival model approach to estimate transition probabilities.
- 3.33 The ERG was concerned by the exclusion of progression-free survival (the primary end point in Study 19) from the model, and that overall survival data from Study 19 were not directly included. It also expressed concern that the time to first subsequent therapy or death outcome data used in the model were collected post hoc so may have been biased, and that the continued use of olaparib beyond disease progression was permitted, which may not reflect the marketing authorisation.
- 3.34 The ERG had concerns about the company's approach to modelling the time-to-event outcomes. It was unclear to the ERG why certain covariates such as Ashkenazi Jewish ancestry had been adjusted for, but others such as patients' age and performance status had not. It was also unclear how covariates had been included in the extrapolated Kaplan–Meier curves. The ERG was also concerned that the company's curve-fitting process did not appear to have included any external data, or expert subjective judgement on the plausibility of the extrapolated curves. It noted that curve fitting appeared to have been based only on visual inspection of how well the curves fit the observed data, and goodness of fit according to Akaike information criterion and Bayesian information criterion statistics. The ERG also noted that the company's submission stated that the assumption of

proportional hazards was met for the time-to-event outcomes of time to treatment discontinuation or death and for time to first subsequent therapy or death. However the ERG noted that the log-log survival plots for each of these outcomes showed that the curves for each treatment group crossed, indicating that the proportional hazards assumption may not be appropriate.

3.35 The ERG was concerned that the model overestimated the results that were seen in the trial, and that the degree of overestimation was consistently greater in the olaparib group. It considered that the median time to first subsequent therapy or death predicted in the model was upwardly biased by 4.4 months, the median time to second subsequent therapy or death was upwardly biased by 3.2 months and the median overall survival was upwardly biased by 3.1 months. The ERG noted that there was also a degree of overestimation in the routine surveillance group. The median time to first subsequent therapy or death predicted in the model was upwardly biased by 0.8 months and the median time to second subsequent therapy or death was upwardly biased by 0.7 months. By contrast, the median overall survival estimate in the model for the routine surveillance group was 5.9 months lower than the results from the trial. Therefore the ERG did not have confidence in the overall survival gains or QALY benefits predicted for olaparib in the company's model.

3.36 The ERG had concerns about the utility estimates used for the first subsequent therapy (0.72) and second subsequent therapy (0.65) health states, noting that these were derived from estimates for progression-free survival and progressed disease from the EVO-301 trial in NICE's technology appraisal guidance on [trabectedin for the treatment of relapsed ovarian cancer](#). The ERG suggested that the company's model implicitly assumed that patients in the first subsequent therapy state have a health-related quality of life

comparable to that of patients with stable disease, and that patients in the second subsequent therapy state have a health-related quality of life comparable to that of patients with progressive disease. The ERG also noted that the company's model assumed that adverse events do not have any additional effect on patients' health-related quality of life. It highlighted that the validity of these assumptions was not discussed in the company's submission.

- 3.37 The ERG did not agree with excluding the cost of BRCA-mutation testing from the company's base-case analysis. It highlighted that the NICE [guide to the methods of technology appraisal](#) states that if a diagnostic test to establish the presence or absence of a biomarker is carried out solely to support the treatment decision for the specific technology, the associated costs of the diagnostic test should be incorporated into the assessments of clinical and cost effectiveness.
- 3.38 The ERG amended the company's model by correcting 2 errors and including the cost of BRCA-mutation testing. This increased the probabilistic base-case ICER to £53,374 per QALY gained. However, the ERG did not believe that the company's model provided robust estimates of overall survival or QALY gains. Therefore it advised caution in interpreting any results produced using the model.
- 3.39 The ERG did not consider it appropriate to combine the results of the company's model with the model developed for NICE's guideline on [familial breast cancer](#). It noted that the 2 models were different in terms of the treatment pathway assumed for ovarian cancer. The ERG pointed out that the model in NICE's guideline on familial breast cancer does not include olaparib as a treatment option for ovarian cancer. Therefore the company's analysis reflected a scenario in which BRCA-mutation testing and olaparib

treatment were available for the patient but not for their relatives. The ERG suggested that the 5 family pedigrees identified may not reflect the range of possible family structures seen in the population with advanced ovarian cancer. It therefore did not consider that the ICERs from the analysis that included BRCA testing were meaningful.

3.40 The ERG did not accept that all relevant comparisons had been included in the analysis such as: no testing and no drug; testing and no drug; and testing and drug treatment for people who test positive for a BRCA mutation. The ERG commented that the analysis may therefore have led to inappropriate conclusions, because the benefit of the joint intervention was driven by the costs and benefits of BRCA testing rather than the costs and benefits of olaparib treatment.

3.41 Full details of all the evidence are in the [Committee papers](#).

## 4 Consideration of the evidence

The Appraisal Committee reviewed the data available on the clinical and cost effectiveness of olaparib, having considered evidence on the nature of recurrent ovarian cancer and the value placed on the benefits of olaparib by people with the condition, those who represent them, and clinical experts. It also took into account the effective use of NHS resources.

4.1 The Committee considered the need for treatment in people with relapsed platinum-sensitive ovarian cancer. It heard from the patient experts that a diagnosis of ovarian cancer has a devastating effect on patients and their families, and affects all aspects of their lives. People diagnosed with ovarian cancer are aware that the disease has a poor prognosis and it is of great importance to them and their families that treatments are available that maximise length

and quality of life. In addition, knowledge that they are carriers of the mutated BRCA gene is an additional burden because of the implications for relatives. The Committee also heard from the patient experts that after a first recurrence, people consider further disease recurrence inevitable, with an increasing likelihood of treatment resistance with each relapse. This has a major emotional effect. The Committee heard from the clinical expert that the only active treatment available for disease recurrence is chemotherapy, which has multiple side effects. Any treatment that extends the period between courses of chemotherapy means longer periods in which people can lead a normal life. The Committee noted written comments that stated that ovarian cancer outcomes in the UK lag behind those in some other countries. The clinical expert stated that outcome data in the UK were more complete than those from many other countries, where it may be collected in only a few specialist centres. International comparisons were therefore not necessarily reliable. The expert also confirmed that people with BRCA mutation-positive ovarian cancer generally had better outcomes for duration of response to platinum therapy than those with the non-mutated (wild type) BRCA gene. The Committee understood that olaparib is the only specific maintenance treatment for germline (inherited) and somatic (acquired) BRCA mutation-positive ovarian cancer that has a marketing authorisation for use after platinum-based chemotherapy treatments in metastatic disease. The Committee recognised that ovarian cancer is a devastating condition for patients, and that relapse after initial chemotherapy is common. It concluded that a drug treatment that improves quality of life and extends periods of remission for patients with BRCA mutation-positive ovarian cancer would be highly valued by patients and their families.

## ***Clinical effectiveness***

4.2 The Committee noted that the key clinical effectiveness evidence in the company's submission came from a phase II randomised controlled trial (Study 19) that compared olaparib with placebo in patients with relapsed platinum-sensitive ovarian cancer. It also noted that the evidence presented from Study 19 focused on a post-hoc subgroup analysis of patients with *BRCA1* or *BRCA2* gene mutations (BRCAm). The Committee was concerned that this subgroup had been identified post hoc and had a small sample size of 136 patients. It heard from the company that most of the Study 19 trial population had been tested for BRCAm retrospectively rather than before enrolment into the study, because it had not been their intention to pursue a marketing authorisation specifically for the BRCAm population. The Committee also noted that the company had specified in its submission that the demographic characteristics of the BRCAm subgroup were generally consistent with the whole trial population. The Committee noted comments from the Evidence Review Group (ERG) that interaction tests between the BRCAm subgroup and the whole population in the trial were inconclusive, so it was not possible to be certain that the treatment effect was different in the BRCAm subgroup. It heard from the clinical expert that there is a biologically plausible reason why people with BRCA mutation-positive disease would benefit more from olaparib than the whole trial population. This could be explained by the relationship between malfunctioning BRCA genes and the development of homologous recombination deficiency, and the subsequent effect on DNA repair. The Committee concluded that olaparib was clinically effective in the treatment of recurrent, platinum-sensitive ovarian cancer. It accepted the clinical expert's view that there is a biologically plausible reason olaparib is likely to be particularly effective in the BRCAm subgroup. However, taking

into account the ERG's comments on the reliability of subgroup analyses to estimate clinical effectiveness, the Committee remained uncertain about the magnitude of the benefit in the subgroup.

- 4.3 The Committee noted that olaparib was associated with a statistically significant improvement in median progression-free survival compared with placebo in the BRCAm subgroup and in the whole trial population. It also noted that olaparib was associated with statically significant gains in time to first subsequent therapy or death and time to second subsequent therapy or death in the BRCAm subgroup and in the whole trial population. The Committee considered the most appropriate outcomes for assessing clinical effectiveness in the trial. It noted that the primary outcome in Study 19 was progression-free survival, measured using Response Evaluation Criteria in Solid Tumors (RECIST) criteria for tumour growth on scans. Overall survival was a secondary outcome in the trial. Time to treatment discontinuation, time to first subsequent therapy and time to second subsequent therapy were considered to be key outcomes by the company, but had been identified post hoc in the trial. The Committee discussed how disease progression was defined in Study 19 compared with clinical practice in England. It noted that the ERG had questioned whether a rise in CA125 protein or results from scans carried out at 3-monthly intervals would be used in clinical practice to define disease progression. The Committee heard from the clinical expert that most clinicians would decide whether to treat disease progression based on recurrence of disease symptoms, but this would be informed by other information that showed the disease was progressing. The Committee questioned whether the main therapeutic benefit of olaparib is in delaying disease progression or in delaying the time to further chemotherapy, and also discussed the advantages and

disadvantages of the outcomes used in Study 19. It heard that progression-free survival is an objective measure of tumour growth but this had only been assessed at 3-monthly intervals in the trial, and therefore it was not possible to determine the exact time at which disease progression occurred. It also heard from the patient expert that the way in which progression was defined was of little relevance to patients; their main concern was extending the period in which they enjoyed good quality of life and freedom from the adverse effects of chemotherapy. The Committee noted that the need for further treatment would depend on whether patients presented with disease symptoms, and decisions on starting chemotherapy could be affected by multiple factors such as patient preference, local protocols, and variation in clinical practice. The clinical expert indicated that time to first subsequent therapy and time to second subsequent therapy were considered to be good indicators of whether treatment had a clinical effect that carried on beyond progression, and into subsequent courses of therapy. The Committee also heard from the company that the data for time to first subsequent therapy and time to second subsequent therapy had the advantage of being more complete than both the progression-free and the overall survival data. It concluded that all the measures of disease progression in the trial were relevant to assess the clinical effectiveness of olaparib, but that time to treatment discontinuation, time to first subsequent therapy and time to second subsequent therapy had been identified post hoc. Therefore they should be viewed with caution because the defined primary objective outcome of the trial was progression-free survival.

- 4.4 The Committee discussed the estimates of overall survival in Study 19. It noted that the data presented for overall survival were from an interim analysis and that the final analysis is not yet available. The Committee accepted that the overall survival data presented

by the company were immature, but it noted that no statistically significant difference in median overall survival between olaparib and placebo was identified in the whole trial population, or in the BRCAm subgroup. The Committee acknowledged that the estimates of overall survival may have been confounded because 23% of patients in the placebo group had a poly-ADP-ribose polymerase (PARP) inhibitor in subsequent rounds of treatment. It noted that the company had attempted to adjust for this in a post-hoc analysis by excluding patients in the placebo group who had a PARP inhibitor. The Committee noted that this adjustment resulted in a statistically significant gain in median overall survival of 8.3 months for olaparib compared with placebo in the BRCAm subgroup. However, it also noted that sample size for this analysis was small: only 97 patients. The Committee also heard from the clinical expert that in clinical practice there were some patients, possibly as many as 10%, who did exceptionally well on olaparib and who did not have a relapse for up to 6 years. It is not currently possible to identify these exceptional survivors, although research is being done on why olaparib appears to be particularly effective in some patients. The Committee concluded that in Study 19, olaparib increased progression-free survival and time to subsequent therapy compared with placebo, in the whole trial population and in the BRCAm subgroup. It also concluded that because of the immaturity of the data and subsequent use of a PARP inhibitor in some patients, there remained uncertainty about whether, and to what extent, olaparib increases overall survival compared with placebo.

### ***Cost effectiveness***

- 4.5 The Committee considered the company's model that compared olaparib with routine surveillance in patients with BRCA mutation-positive, platinum-sensitive relapsed ovarian cancer and excluded the cost of BRCA testing. It noted that the model was a semi-

Markov-state transition design rather than a more standard partitioned survival model. It considered that the model structure was unconventional and very different to those used in previous appraisals (see section 3.15). The Committee expressed concern that progression-free survival data from Study 19 had not been included in the model, even though this was the pre-specified primary outcome that had been used to assess clinical benefit in the trial. In addition, overall survival data from Study 19 had not been directly incorporated into the model. The Committee noted comments from the company that the time to first and second subsequent therapy from Study 19 had been used in the model, because these data were more complete compared with the overall survival data from the trial. However, the Committee was concerned that intermediate outcomes had been used to make assumptions about longer-term overall survival, and considered that it would have been more conventional to fit a curve directly to the overall survival data, with adjustment for crossover to a PARP inhibitor in the placebo arm. The Committee concluded that the company's model was a novel design that lacked external validity, and that the use of sequential intermediate outcomes to model overall survival relied on a large number of assumptions which may not all be reasonable.

- 4.6 The Committee discussed the estimates of overall survival derived from the company's model. It noted that graphical plots of survival probability derived from the model showed that the difference between the curves for olaparib and placebo increased at later time points, implying that the overall survival benefit from olaparib increases over time. The Committee noted that no data to support this had been provided. The Committee also acknowledged the clinical expert's view that greater separation of the curves over time would not be expected during treatment for cancer. The Committee

compared the median values of the various time-to-event outcomes for olaparib estimated from the company's model with the results from the trial. It was concerned that the modelled estimates for olaparib were consistently higher than the observed results in the trial, noting that the median overall survival estimate for olaparib was 3.1 months longer in the model than in the trial, time to first subsequent therapy or death was 4.4 months longer in the model and time to second subsequent therapy or death was 3.2 months longer (see section 3.35). Conversely, in the routine surveillance arm of the model, the modelled median overall survival was 5.9 months lower than the median in the trial. The Committee did however acknowledge that this discrepancy in the routine surveillance data was smaller when compared with the analysis of trial data that excluded sites where patients in the placebo group were able to crossover to a PARP inhibitor. The Committee also noted the ERG's concerns about the company's approach to modelling the time-to-event outcomes, and about the curve fitting process used in the model (see section 3.34). It accepted that the choice of appropriate parametric functions to extrapolate observed data for a small number of patients is a challenging and not totally objective process; however the substantial disagreement between the results from Study 19 and the model predictions undermined confidence in the modelling used by the company. The Committee concluded that the company's model overestimated the benefit of olaparib and therefore underestimated the incremental cost-effectiveness ratio (ICER) for olaparib compared with routine surveillance.

- 4.7 The Committee discussed the utility estimates in the model. It was disappointed that no preference-based measures of quality of life were collected in Study 19. It noted that therefore the company had estimated utility values for the progression-free health states by

mapping FACT-O data from Study 19 to EQ-5D, whereas estimates for the subsequent therapy health states were derived from estimates used in the appraisal of trabectedin and pegylated liposomal doxorubicin hydrochloride (PLDH) in NICE's technology appraisal guidance on [trabectedin for the treatment of relapsed ovarian cancer](#). The Committee noted that there was an increase in utility from 0.71 in the progression-free (discontinued maintenance therapy) health state to 0.72 in the first subsequent therapy health state and it questioned the improvement in utility between the 2 states because chemotherapy is known to have an adverse effect on a patient's quality of life. The Committee heard from the company that this increase in utility was a discrepancy in the model but not a clinically important difference in utilities, and did not affect the ICERs. The Committee also considered that it was unclear why the utility in the routine surveillance health state decreased from 0.77 for the progression-free (on maintenance therapy) health state to 0.71 in the progression-free (discontinued maintenance therapy) state, since no difference in utility would be expected for patients who were taking, or who had stopped taking, placebo. The Committee heard from the company that this decrease in utility could be explained by the fact that the same utilities for both treatment arms were used in the model for reasons of consistency, but this factor did not have a significant effect on the ICERs. The Committee concluded that some of the utility estimates lacked face validity, but accepted that utility values were not key drivers of the cost-effectiveness results.

- 4.8 The Committee considered the appropriateness of the company's exclusion of the costs of BRCA testing from its first cost-effectiveness analysis. The Committee heard from one of the patient experts that blood testing for germline mutations in people with ovarian cancer is becoming available as part of routine NHS

services in England. This follows recommendations in NICE's guideline on [familial breast cancer](#). Knowledge of blood-BRCA mutation status allows consideration of olaparib or another PARP inhibitor treatment for the patient, and also the screening of asymptomatic relatives for the genetic mutation. The Committee accepted the company's view that it was appropriate to exclude the costs of germline BRCA blood testing in the model. However, the Committee heard from the clinical and patient experts that olaparib is also indicated for patients who do not have the inherited form of the mutation, but who do have a tumour that is positive for a BRCA mutation. Both inherited and non-inherited forms can be detected by testing a sample from the tumour (although it will not distinguish between them). However, tumour testing is not widely available through the NHS. Therefore, the Committee considered that the company's model was overly simplistic because, although it was reasonable to exclude the costs of blood testing, it had not incorporated the cost of tumour testing to identify patients eligible for treatment who have the non-inherited mutation (that is, in people whose blood test was negative). The Committee considered that this would increase the costs associated with olaparib.

- 4.9 The Committee considered the company's cost-effectiveness results from its analysis that excluded the costs of testing for a BRCA mutation. It noted that the base-case probabilistic ICER estimated by the company for olaparib compared with routine surveillance was £49,146 per QALY gained. However, the Committee considered that this was likely to be an underestimate of the true ICER because it did not incorporate the cost of tumour testing to identify patients with the non-inherited mutation (see section 4.8), and it overestimated the overall survival gain associated with olaparib (see section 4.6). It also noted that that the ICER increased in all the company's scenario analyses. The

Committee therefore concluded that the most plausible ICER for olaparib compared with routine surveillance was likely to be considerably above the range normally considered to be a cost-effective use of NHS resources (that is, £20,000 to £30,000 per QALY gained).

4.10 The Committee discussed the second cost-effectiveness analysis presented by the company, which included both the costs and benefits of germline BRCA-mutation testing. The Committee noted that this combined the company's first analysis of the cost effectiveness of olaparib with results from a cost–utility study developed as part of NICE's guideline on [familial breast cancer](#). The Committee noted its previous conclusion that germline blood testing is available, or is being made available, as part of NHS services in England (see section 4.8). Furthermore, the second model did not include the cost of tumour testing to identify patients with the non-inherited mutation. The Committee agreed that neither the costs, nor the benefits to relatives of germline BRCA-mutation testing should be included in the model. It also questioned the appropriateness of combining 2 models that assumed different treatment pathways for ovarian cancer. The Committee concluded that the company's second cost-effectiveness analysis did not produce a valid estimate of the cost effectiveness of olaparib.

4.11 The Committee considered supplementary advice from NICE that should be taken into account when appraising treatments that may extend the life of patients with short life expectancy and that are licensed for indications that affect small numbers of people with incurable illnesses. For this advice to be applied, all the following criteria must be met.

- The treatment is indicated for patients with a short life expectancy, normally less than 24 months.

- There is sufficient evidence to indicate that the treatment offers an extension to life, normally of at least an additional 3 months, compared with current NHS treatment.
- The treatment is licensed or otherwise indicated for small patient populations normally not exceeding a cumulative total of 7000 for all licensed indications in England.

In addition, when taking these criteria into account, the Committee must be persuaded that the estimates of extension to life are robust, and the assumptions used in the reference case of the economic modelling are plausible, objective and robust.

4.12 The Committee discussed whether patients with relapsed BRCA mutation-positive, platinum-sensitive ovarian cancer who had previously been treated with platinum-based chemotherapy would be expected to have a mean life expectancy of less than 24 months. The Committee noted that median overall survival in the placebo arm of Study 19 was 31.9 months. When the sites that allowed crossover to a PARP inhibitor were excluded, the median overall survival in the placebo arm was 26.6 months. The overall survival associated with routine surveillance estimated by the company in its economic model was a median of 26 months and a mean of 29.8 months. The Committee heard from the clinical expert that the overall survival estimates seen in the trial may be higher than those in clinical practice in England, because less aggressive primary surgery is carried out than in some other countries that participated in the trial. However, it recalled the expert's opinion that international comparisons were not necessarily reliable, and that people with BRCA mutation-positive disease may respond better to therapy than other patients (see section 4.1). It also heard from the clinical expert that the results from the control arm of a randomised controlled trial of a different kind of drug for platinum-sensitive, relapsed ovarian cancer (the ICON-6 trial) indicated that

the median life expectancy could be as low as 20 months. The Committee noted that this did not specifically relate to people with BRCA mutation-positive ovarian cancer. The Committee also considered a retrospective review of a subgroup of an observational study from Australia that included 41 patients with BRCA mutation-positive ovarian cancer, and which showed a median survival of 21.9 months (mean not supplied). However, these results were only available as an abstract so a detailed assessment of their validity was not possible. On balance, the Committee agreed that the most robust evidence came from the trial on which the marketing authorisation for olaparib was based, which included a population corresponding directly with patients eligible for olaparib treatment. It was not persuaded that the life expectancy for people with relapsed, BRCA mutation-positive, platinum-sensitive ovarian cancer had been shown to be less than a median of 24 months without olaparib treatment, and the mean was likely to be more than the lowest (crossover-adjusted) median of 26.6 months demonstrated in the trial.

4.13 Having determined that olaparib did not meet the end-of-life criterion on life expectancy, the Committee briefly discussed the other criteria; small patient population and extension to life of more than an average of 3 months. It accepted the estimates in the company's submission that no more than 450 patients per year would be eligible for treatment with olaparib for BRCA mutation-positive platinum sensitive relapsed ovarian cancer. The Committee concluded that the eligible population for England did not exceed 7000 and that olaparib therefore met the end-of-life criterion for a small patient population.

4.14 The Committee referred to its previous conclusion (see section 4.6) that there is uncertainty about the survival benefit with olaparib. It noted that the trial data for the BRCAm subgroup showed a survival

gain of 3 months, although this was not statistically significant. It also noted that the company's analysis, which excluded sites where patients in the placebo arm had a PARP inhibitor after disease progression, resulted in a statistically significant increase in median overall survival with olaparib of 8.3 months. It was also aware that this estimate was based on a retrospective subgroup analysis that included fewer than 100 patients. The Committee concluded that the direct trial evidence was borderline for an overall survival gain of 3 months. However, because the 24-month life expectancy criterion had not been met, the Committee concluded that the end-of-life criteria did not apply to olaparib.

4.15 The Committee considered whether olaparib could be considered an innovative technology. It noted that olaparib has a different mechanism of action to other drug treatments for platinum-sensitive ovarian cancer, and therefore could be considered a significant change in the management of relapsed BRCA mutation-positive, platinum-sensitive ovarian cancer. The Committee agreed that olaparib was innovative in this respect, but it could not identify any substantial health benefits that had not been captured in the QALY estimates. The Committee therefore concluded that olaparib had not been shown to be cost effective and could not be recommended for use in the NHS.

4.1 The Appraisal Committee considered whether it should take into account the consequences of the Pharmaceutical Price Regulation Scheme (PPRS) 2014, and in particular the PPRS Payment Mechanism, when appraising olaparib. The Committee noted NICE's position statement in this regard, and accepted the conclusion 'that the 2014 PPRS Payment Mechanism should not, as a matter of course, be regarded as a relevant consideration in its assessment of the cost effectiveness of branded medicines'. The Committee heard nothing to suggest that there is any basis for

taking a different view with regard to the relevance of the PPRS to this appraisal of olaparib. It therefore concluded that the PPRS Payment Mechanism was irrelevant for the consideration of the cost effectiveness of olaparib.

**Summary of Appraisal Committee’s key conclusions**

TAXXX	Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive ovarian, fallopian tube and peritoneal cancer following response to second-line or subsequent platinum-based chemotherapy	Section
<b>Key conclusion</b>		
<p>Olaparib is not recommended, within its marketing authorisation, as a maintenance treatment for adults with relapsed, platinum-sensitive ovarian, fallopian tube or peritoneal cancer who have <i>BRCA1</i> or <i>BRCA2</i> mutations and whose disease has responded to second-line or subsequent platinum-based chemotherapy.</p>		1.1
<p>The Committee concluded that in Study 19, olaparib increased progression-free survival and time to subsequent therapy compared with placebo, in the whole trial population and in the BRCA mutation-positive (BRCAm) subgroup. It also concluded that because of the immaturity of the data and subsequent use of a PARP inhibitor in some patients, there was uncertainty about whether, and to what extent, olaparib increases overall survival compared with placebo.</p>		4.4
<p>The Committee concluded that the most plausible ICER for olaparib compared with routine surveillance was likely to be considerably above the range normally considered to be a cost-effective use of NHS resources (that is, £20,000 to £30,000 per QALY gained). It</p>		4.9

<p>noted that, in the analysis that excluded the costs of testing for a BRCA mutation, the base-case probabilistic ICER estimated by the company for olaparib compared with routine surveillance was £49,146 per QALY gained. However, the Committee considered that this was likely to be an underestimate of the true ICER because it did not incorporate the cost of tumour testing to identify patients with the non-inherited mutation (see section 4.8), and it overestimated the overall survival gain associated with olaparib (see section 4.6).</p> <p>The Committee also concluded that the company's cost-effectiveness analysis which included both the costs and benefits of germline (inherited) BRCA-mutation testing did not produce a valid estimate of the cost effectiveness of olaparib.</p> <p>The Committee concluded that the end-of-life criteria did not apply to olaparib.</p>		<p>4.10</p> <p>4.14</p>
<p><b>Current practice</b></p>		
<p>Clinical need of patients, including the availability of alternative treatments</p>	<p>The Committee recognised that ovarian cancer is a devastating condition for patients, and that relapse following initial chemotherapy is common. It concluded that a drug treatment that improves quality of life and extends periods of remission for patients with BRCA mutation-positive ovarian cancer would be highly valued by patients and their families.</p>	<p>4.1</p>
<p><b>The technology</b></p>		

<p>Proposed benefits of the technology</p> <p>How innovative is the technology in its potential to make a significant and substantial impact on health-related benefits?</p>	<p>The Committee noted that olaparib has a different mechanism of action to other drug treatments for platinum-sensitive ovarian cancer, and therefore could be considered a significant change in the management of relapsed BRCA mutation-positive, platinum-sensitive ovarian cancer. The Committee agreed that olaparib was innovative in this respect.</p>	<p>4.15</p>
<p>What is the position of the treatment in the pathway of care for the condition?</p>	<p>The Committee understood that olaparib is the only specific maintenance treatment for germline (inherited) and somatic (acquired) BRCA mutation-positive ovarian cancer that has a marketing authorisation for use after platinum-based chemotherapy treatments in metastatic disease.</p>	<p>4.1</p>
<p>Adverse reactions</p>	<p>The most common adverse events for olaparib include nausea, fatigue, vomiting, diarrhoea and abdominal pain.</p>	<p>2.2, 3.11</p>
<p><b>Evidence for clinical effectiveness</b></p>		
<p>Availability, nature and quality of evidence</p>	<p>The Committee noted that the key clinical effectiveness evidence in the company's submission came from a phase II randomised controlled trial (Study 19) that compared olaparib with placebo in patients with relapsed platinum-sensitive ovarian cancer. It also noted that the evidence presented from Study 19 focused on a post-hoc subgroup</p>	<p>4.2</p>

	analysis of patients with <i>BRCA1</i> or <i>BRCA2</i> mutations (BRCAm). The Committee was concerned that this subgroup had been identified post hoc and had a small sample size of 136 patients.	
Relevance to general clinical practice in the NHS	The Committee noted that the company had specified in its submission that the demographic characteristics of the BRCAm group were generally consistent with the whole trial population.	4.2
Uncertainties generated by the evidence	The Committee concluded that all the measures of disease progression in the trial were relevant to assess the clinical effectiveness of olaparib, but that time to treatment discontinuation, time to first subsequent therapy and time to second subsequent therapy had been identified post hoc. Therefore they should be viewed with caution because the defined primary objective outcome of the trial was progression-free survival.	4.3

<p>Are there any clinically relevant subgroups for which there is evidence of differential effectiveness?</p>	<p>The Committee accepted the clinical expert's view that there is a biologically plausible reason for olaparib being more clinically effective in the BRCAm subgroup than in the whole trial population. However, taking into account the ERG's comments on the reliability of subgroup analyses to estimate clinical effectiveness, the Committee remained uncertain about the magnitude of the benefit in the subgroup.</p>	<p>4.2</p>
<p>Estimate of the size of the clinical effectiveness including strength of supporting evidence</p>	<p>The Committee concluded that in Study 19, olaparib increased progression-free survival and time to subsequent therapy compared with placebo, in the whole trial population and in the BRCAm subgroup. It also concluded that because of the immaturity of the data and subsequent use of a PARP inhibitor in some patients, there remained uncertainty about whether, and to what extent, olaparib increases overall survival compared with placebo.</p>	<p>4.4</p>
<p><b>Evidence for cost effectiveness</b></p>		

<p>Availability and nature of evidence</p>	<p>The Committee noted that the company’s model was a semi-Markov-state transition design rather than a more standard partitioned survival model. It concluded that the model was a novel design that lacked external validity, and that the use of sequential intermediate outcomes to model overall survival relied on a large number of assumptions which may not all be reasonable.</p>	<p>4.5</p>
<p>Uncertainties around and plausibility of assumptions and inputs in the economic model</p>	<p>The Committee accepted that the choice of appropriate parametric functions to extrapolate observed data for a small number of patients is a challenging and not totally objective process; however the substantial disagreement between the results from Study 19 and the model predictions undermined confidence in the modelling used by the company. The Committee concluded that the company’s model overestimated the benefit of olaparib and therefore underestimated the incremental cost-effectiveness ratio (ICER) for olaparib compared with routine surveillance.</p>	<p>4.6</p>

<p>Incorporation of health-related quality-of-life benefits and utility values</p> <p>Have any potential significant and substantial health-related benefits been identified that were not included in the economic model, and how have they been considered?</p>	<p>The Committee concluded that some of the utility estimates lacked face validity, but accepted that utility values were not key drivers of the cost-effectiveness results.</p> <p>The Committee could not identify any substantial health benefits that had not been captured in the QALY estimates.</p>	<p>4.7</p> <p>4.15</p>
<p>Are there specific groups of people for whom the technology is particularly cost effective?</p>	<p>None were identified.</p>	
<p>What are the key drivers of cost effectiveness?</p>	<p>A key driver of the cost-effectiveness results was the estimate of overall survival used in the model (that is, whether it was derived from the model or based on trial data) and the parametric survival curves applied to the distribution of time from first subsequent treatment or death (generalised gamma or log normal).</p>	<p>3.23</p>



<p>End-of-life considerations</p>	<p>The Committee was not persuaded that the life expectancy for people with relapsed BRCA mutation-positive, platinum-sensitive ovarian cancer had been shown to be less than a median of 24 months without olaparib treatment.</p> <p>The Committee concluded that the eligible population for England did not exceed 7000 and that olaparib therefore met the end-of-life criterion for a small patient population.</p> <p>The Committee concluded that the direct trial evidence was borderline for an overall survival gain of 3 months. However, because the 24-month life expectancy criterion had not been met, the Committee concluded that the end-of-life criteria did not apply to olaparib.</p>	<p>4.12</p> <p>4.13</p> <p>4.14</p>
<p>Equalities considerations and social value judgements</p>	<p>No equalities issues were identified.</p>	

## 5 Implementation

5.1 NICE has developed tools [[link to www.nice.org.uk/guidance/TAXXX](#)] to help organisations put this guidance into practice (listed below). [NICE to amend list as needed at time of publication]

- Slides highlighting key messages for local discussion.

- Costing template and report to estimate the national and local savings and costs associated with implementation.
- Implementation advice on how to put the guidance into practice and national initiatives that support this locally.
- A costing statement explaining the resource impact of this guidance.
- Audit support for monitoring local practice.

## 6 Related NICE guidance

Details are correct at the time of consultation and will be removed when the final guidance is published. Further information is available on the [NICE website](#).

### Published

- [Bevacizumab in combination with gemcitabine and carboplatin for treating the first recurrence of platinum-sensitive advanced ovarian cancer](#). NICE technology appraisal guidance 285 (2013).
- [Trabectedin for the treatment of relapsed ovarian cancer](#). NICE technology appraisal guidance 222 (2011).
- [Topotecan, pegylated liposomal doxorubicin hydrochloride and paclitaxel for the treatment of advanced ovarian cancer](#). NICE technology appraisal guidance 91 (2005).
- [Ovarian cancer: the recognition and initial management of ovarian cancer](#). NICE clinical guideline 122 (2011).

### Under development

- [Topotecan, pegylated liposomal doxorubicin hydrochloride, paclitaxel, trabectedin and gemcitabine for advanced ovarian cancer for recurrent disease only \(Review of NICE technology appraisal guidance 91 and 222\)](#).

Date of publication to be confirmed.

## **7 Proposed date for review of guidance**

- 7.1 NICE proposes that the guidance on this technology is considered for review by the Guidance Executive 3 years after publication of the guidance. NICE welcomes comment on this proposed date. The Guidance Executive will decide whether the technology should be reviewed based on information gathered by NICE, and in consultation with consultees and commentators.

Dr Jane Adam  
Chair, Appraisal Committee  
May 2015

## **8 Appraisal Committee members and NICE project team**

### ***Appraisal Committee members***

The Appraisal Committees are standing advisory committees of NICE. Members are appointed for a 3-year term. A list of the Committee members who took part in the discussions for this appraisal appears below. There are 4 Appraisal Committees, each with a chair and vice chair. Each Appraisal Committee meets once a month, except in December when there are no meetings. Each Committee considers its own list of technologies, and ongoing topics are not moved between Committees.

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

The minutes of each Appraisal Committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

#### **Dr Jane Adam (Chair)**

Consultant Radiologist, Department of Diagnostic Radiology, St George's Hospital, London

#### **Professor Iain Squire (Vice-Chair)**

Consultant Physician, University Hospitals of Leicester

#### **Dr Graham Ash**

Consultant in General Adult Psychiatry, Lancashire Care NHS Foundation Trust

#### **Dr Gerardine Bryant**

GP, Swadlincote, Derbyshire

**Professor Aileen Clarke**

Professor of Public Health and Health Services Research, University of Warwick

**Dr Andrew England**

Senior Lecturer, Directorate of Radiography, University of Salford

**Mr Adrian Griffin**

Vice President, Health Technology Assessment and International Policy, Johnson & Johnson

**Professor John McMurray**

Professor of Medical Cardiology, University of Glasgow

**Ms Pamela Rees**

Lay Member

**Ms Ellen Rule**

Director of Transformation and Service Redesign, Gloucestershire Clinical Commissioning Group

**Mr Stephen Sharp**

Senior Statistician, University of Cambridge MRC Epidemiology Unit

**Dr Brian Shine**

Consultant Chemical Pathologist, John Radcliffe Hospital, Oxford

**Mr David Thomson**

Lay member

**Dr John Watkins**

Clinical Senior Lecturer, Cardiff University; Consultant in Public Health Medicine, National Public Health Service Wales

**Professor Olivia Wu**

Professor of Health Technology Assessment, University of Glasgow

**Dr Nerys Woolacott**

Senior Research Fellow, Centre for Health Economics, University of York

***NICE project team***

Each technology appraisal is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the appraisal), a technical adviser and a project manager.

**Helen Tucker**

Technical Lead

**Zoe Charles**

Technical Adviser

**Bijal Joshi**

Project Manager

## **9 Sources of evidence considered by the Committee**

A. The Evidence Review Group report for this appraisal was prepared by School of Health and Related Research, The University of Sheffield:

- Tappenden P, Harnan S, Ren K, et al. Olaparib for maintenance treatment of *BRCA1* or 2 mutated, relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer in people whose relapsed disease has responded to platinum-based chemotherapy: A Single Technology Appraisal, March 2015.

B. The following organisations accepted the invitation to participate in this appraisal as consultees and commentators. They were invited to comment on the draft scope, the ERG report and the appraisal consultation document (ACD). Organisations listed in I were also invited to make written submissions. Organisations listed in II and III had the opportunity to make written

submissions. Organisations listed in I, II and III also have the opportunity to appeal against the final appraisal determination.

I. Company:

- AstraZeneca (olaparib)

II. Professional/expert and patient/carer groups:

- British Gynaecological Cancer Society
- Cancer Research UK
- Ovarian Cancer Action
- Royal College of Nursing
- Royal College of Pathologists
- Royal College of Physicians
- Target Ovarian Cancer
- United Kingdom Clinical Pharmacy Association

III. Other consultees:

- Department of Health
- NHS England
- Welsh Government

IV. Commentator organisations (did not provide written evidence and without the right of appeal):

- Cochrane Gynaecological Cancer Group
- Department of Health, Social Services and Public Safety for Northern Ireland
- Health Improvement Scotland
- Institute of Cancer Research
- National Institute for Health Research Health Technology Assessment Programme

- School of Health & Related Research Sheffield (ScHARR)

C. The following individuals were selected from clinical expert and patient expert nominations from the consultees and commentators. They gave their expert personal view on olaparib by attending the initial Committee discussion and providing a written statement to the Committee. They are invited to comment on the ACD.

- Professor Jonathan A Ledermann, Professor of Medical Oncology, nominated by organisation representing British Gynaecological Cancer Society – clinical expert
- Professor Charlie Gourley, Professor of Medical Oncology, nominated by organisation representing AstraZeneca and Royal College of Physicians – clinical expert
- Dr Simon Newman, Head of Research for Target Ovarian Cancer, nominated by organisation representing Target Ovarian Cancer – patient expert
- Ms Ashley Dean, nominated by organisation representing Ovarian Cancer Action – patient expert

D. Representatives from the following company attended Committee meetings. They contributed only when asked by the Committee chair to clarify specific issues and comment on factual accuracy.

- AstraZeneca (olaparib)