August 22, 2016

Steven Pearson, MD, MSc
President, Institute for Clinical and Economic Review
Boston, MA 02109 USA

RE: Disease-Modifying Anti-Rheumatic Drugs for Rheumatoid Arthritis: Effectiveness and Value ICER Draft Background and Scope

Dear Dr. Pearson,

On behalf of the more than 1.5 million adults in the United States with doctor-diagnosed rheumatoid arthritis (RA), the Arthritis Foundation appreciates the opportunity to provide comments to ICER on the *Disease-Modifying Anti-Rheumatic Drugs for Rheumatoid Arthritis: Effectiveness and Value ICER Draft Background and Scope*. First, we applaud ICER for the inclusion of initial stakeholder feedback in the draft scoping document. Highlighting the complex nature of RA is of the utmost importance moving forward in this review process. We thank ICER for making it clear that this review will be conducted on the adult population only. The Arthritis Foundation believes that a review of the efficacy and economic impact of the drugs available to treat rheumatoid arthritis should recognize that treating people with RA is very nuanced and individualized. In order for prescribers to treat people with RA, they must have timely access to a broad range of services, high-quality health care options, a strong provider-patient relationship free from undue interference, and the ability to prioritize the needs and values of these patients as shared treatment decisions are being developed. Please find our specific comments on the draft background and scope report in the subsequent sections.

Stakeholder Input. Again, RA is a complex disease that requires nuanced treatment, unique to each person who suffers from this disease. An RA diagnosis not only affects the person's quality of life, but is known to impact their entire family. Therefore, stakeholder input, including that of caregivers, is critical in order for ICER to have a comprehensive understanding of the disease. Clinical trials often lack robust patient reported outcome information. The Arthritis Foundation supports the collection of meaningful data for metrics, and we applaud ICER for the recommended use of the PROMIS toolkit. PROMIS tools measure what people are able to do and how they feel, and this information is vital to incorporate the patient voice. According to the review timeline, ICER will hold expert review panels for the draft evidence report and voting questions. We urge ICER to hold parallel patient, caregiver and provider panels that will also review the draft voting questions. The draft scoping document states ICER will seek to assess outcomes quantitatively, but some measures will be gathered by descriptive analysis, and we ask that ICER elaborate on how patients, caregivers, providers and advocacy groups will be engaged and on what qualitative methods will be utilized.

Comorbidities. Many patients with RA also suffer comorbidities such as cardiovascular disease, mental health conditions, infections and malignancies[i]. Of adults diagnosed with arthritis, 47% also have at least one of the previously listed conditions. We urge ICER to elaborate on how comorbidities will be accounted for in the economic outcome measures, including disability, quality of life, mental health and mortality.

Literature Review. Additional medical research and early and aggressive treatment is needed to reduce the incidence of and relieve the disabling symptoms of RA. Unfortunately, there are vast gaps in the literature surrounding RA medications and clinical trials. Specifically:

- There are limited long-term studies regarding the natural occurrence of RA or innovative RA medications, indicating potential underreporting of outcomes, adverse events and safety concerns[ii].
- RA medication changes are only reported administratively, therefore the reasons for prescribing patterns are largely unknown. In order to ascertain clinical intent for changes in treatment, more robust data sources are needed[iii].
- Many of the clinical trials conducted for RA are not random populations and tend to be homogenous in nature; leading to underrepresented populations[iv].
- Industry-funded studies far outnumber those conducted by the government or academic institutions, with 73.2% of studies funded by industry and only 18.9% funded by academic/government institutions. Even more concerning is the length of study: industry funded studies are 12 months on average, whereas academic studies lasted for more than 24 months[v]. Short trial durations may not capture the full range of benefits or adverse events of a medication.
- Many studies conducted on biologic or biosimilar medications were not completed in the United States.

We encourage ICER to consider that the experience of Americans with RA could differ from those in other countries. Also, it is extremely important to understand the early onset of RA, because the first two years is a critical time when the patient is most susceptible to irreversible structural damage. We urge ICER to elaborate on how these underrepresented populations will be affected by the review recommendations when decisions are made based on a scope of limited populations. We hope that ICER will take the current body of literature and research gaps into account when developing the final evidence report.

Microsimulation Model. It is encouraging to see the use of the American College of Rheumatology (ACR) response and the Health Assessment Questionnaire for Rheumatoid Arthritis Disability Index (HAQ-DI) for the microsimulation model, but best practices on measuring patient reported outcomes (PROs) have not been clearly defined and we question how the scoring will be simulated since the questionnaire is a PRO usually self-administered by the patient. Additionally, ICER states further scenario analyses will address biosimilar introduction, we seek clarification on the specific processes used to consider biosimilar introduction. Robust details explaining how the final report will be revised when biosimilar introduction occurs is needed to understand the full economic impact of RA treatment.

Limitations. We encourage the acknowledgement of ICER's study limitations, such as the use of grey literature, the homogenous nature of the clinical trial population, the imbalance of clinical trial funding and the total number of available clinical trial studies. Additionally, we continue to have concerns about the limited timeline of ICER's review. A 6-month review period - from July 2016 to January 2017 – is very short. We encourage ICER to allow ample time for full consideration of all literature and patient feedback to ensure that the report's findings are relevant and actionable for all stakeholders

Overall, the Arthritis Foundation wants to ensure people with arthritis have access to the medications they need to function in daily life. We are concerned that this clinical effectiveness and economic review of RA drugs could lead to patients' losing access to the drugs and treatments they depend on to maintain a functional quality of life. Some people spend years cycling through different treatments before they find one that works.. If a person stops treatment, it could lead to joint degeneration, organ damage and even joint death. The Arthritis Foundation cannot support any recommendations that could result in a patient on a stable drug no longer having access to that drug. To that end, we urge ICER to consider the critical need for adherence to drug regiments, and the perspective of patients, caregivers and stakeholders to ensure that the scoping document and subsequent final report has the broadest possible relevancy.

Again, thank you for the opportunity to comment on the *Disease-Modifying Anti-Rheumatic Drugs for Rheumatoid Arthritis: Effectiveness and Value ICER Draft Background and Scope.* Please contact Sandie Preiss, Arthritis Foundation National Vice President of Advocacy and Access, at 202-887-2910 or spreiss@arthritis.org with questions or for more information.

Sincerely,

Sandie G. Preiss

Sandie Preiss
Vice President, Advocacy and Access
Arthritis Foundation

[i] Centers for disease control and prevention. *Comorbidities*. CDC, 2015. Web. 1 Aug. 2016. http://www.cdc.gov/arthritis/data_statistics/comorbidities.htm.
[ii] Ryan, C., Korman, N. J., Gelfand, J. M., Lim, H. W., Elmets, C. A., Feldman, S. R., ... & Van Voorhees, A. S. (2014). Research gaps in psoriasis: opportunities for future studies. *Journal of the American Academy of Dermatology*, *70*(1), 146-167.
[iii] Yazici, Y., Shi, N., & John, A. (2008). Utilization of biologic agents in rheumatoid arthritis in the United States: analysis of prescribing patterns in 16,752 newly diagnosed patients and patients new to biologic therapy.*Bulletin of the NYU hospital for joint diseases*, *66*(2), 77-77.
[iv] Yazici, Y., Shi, N., & John, A. (2008). Utilization of biologic agents in rheumatoid arthritis in the United States: analysis of prescribing patterns in 16,752 newly diagnosed patients and patients new to biologic therapy.*Bulletin of the NYU hospital for joint diseases*, *66*(2), 77-77.
[v] Paul, J. R., & Ranganathan, P. (2012). Clinical trials in rheumatoid arthritis: a status report from the ClinicalTrials. gov website. *Rheumatology international*,*32*(6), 1831-1835