Patient/carer organisation statement template

Thank you for agreeing to give us your views on the technology and the way it should be used in the NHS.

Patients and patient advocates can provide a unique perspective on the technology, which is not typically available from the published literature.

To help you give your views, we have provided a template. The questions are there as prompts to guide you. You do not have to answer every question. Please do not exceed the 8-page limit.

About you

Your name: [redacted]

Name of your organisation: Myeloma UK

Are you (tick all that apply):

- a patient with the condition for which NICE is considering this technology?
- a carer of a patient with the condition for which NICE is considering this technology?
- an employee of a patient organisation that represents patients with the condition for which NICE is considering the technology? If so, give your position in the organisation where appropriate (e.g. policy officer, trustee, member, etc) ✓
- other? (please specify)

What do patients and/or carers consider to be the advantages and disadvantages of the technology for the condition?

1. **Advantages**

(a) Please list the specific aspect(s) of the condition that you expect the technology to help with. For each aspect you list please describe, if possible, what difference you expect the technology to make.

1) Tolerability / side-effects

To date, the mainstay of myeloma management has been balancing the toxicity of existing treatments against their potential benefit.

Lenalidomide is the first myeloma treatment to be developed where the balance between efficacy and side-effects is excellent, so much so that patients can remain on it longer term. Myeloma UK is in contact with patients who have been on the treatment in excess of 3 years.

Lenalidomide can be dose adjusted for the side-effects it *can* cause and, importantly, can also be taken by renal-impaired patients. It can be used in patients with pre-existing peripheral neuropathy and in contrast to thalidomide and bortezomib the rates of peripheral motor, sensory or autonomic neuropathy are very low.

Lenalidomide will prove particularly useful for patients where side-effects with other regimens are a significant issue.

2) Relapsing / refractory nature of the disease

All patients with myeloma inevitably relapse from any remission afforded by previous treatment. Also patients can be / become refractory (resistant) to treatment. Due to the clinical variability of both the cancer itself and of response rates and side-effects encountered, doctors require a number of evidence-based alternative treatments for patients when they relapse.

It is notable that patients in the pivotal licensing trials MM-009 / MM-010 that were refractory to standard treatments had a median time to progression of more than 10 months, and a prolongation of overall survival. These are significant outcomes in myeloma which historically has a very poor prognosis.

Further, good response rates with lenalidomide are still seen in patients who are refractory to thalidomide suggesting that cross-resistance is limited and positive response rates can be expected.

3) Quality of life

Lenalidomide is a convenient treatment for patient and their families.

For patients, oral dosing does not require the resource and time-intensive visits to the hospital that is required for the administration of intravenous treatments – patients can self-medicate at home or at work. Myeloma is predominantly a disease of older people so not having to make such regular visits to hospital can be extremely

beneficial to their general quality of life. By creating a semblance of normality in an otherwise dramatically changed life, the fact that lenalidomide is orally administered and can be taken easily at home is important to the majority of patients.

There is also the wider impact to patients being able to take their treatment at home. Patients often travel to hospital with a family member of friend; oral dosing allows for supportive care to take place at home and reduces the burden on family members.

(b) Please list any short-term and/or long-term benefits that patients expect to gain from using the technology. These might include the effect of the technology on:

- the course and/or outcome of the condition
- physical symptoms
- pain
- level of disability
- mental health
- quality of life (lifestyle, work, social functioning etc.)
- other quality of life issues not listed above
- other people (for example family, friends, employers)
- other issues not listed above.

The shorter-term benefits that patients may expect to gain from using lenalidomide are covered in our answer to (a) and include fewer side-effects and an improved quality of life due to the convenience of oral dosing and less time spent travelling to / in hospital.

For a disease as historically intrusive as myeloma, these benefits are hugely valuable.

Longer-term benefits include extended remission rates and survival gains for patients who have a disease associated with a poor prognosis. Together with other developments lenalidomide is ensuring that myeloma patients have treatment options even when they are refractory to other therapies, and will help them live longer to benefit from future developments.

The goal is for myeloma to become a disease that patients live with rather than die from.

What do patients and/or carers consider to be the advantages and disadvantages of the technology for the condition? (continued)

2. **Disadvantages**

Please list any problems with or concerns you have about the technology. Disadvantages might include:

- aspects of the condition that the technology cannot help with or might make worse.
- difficulties in taking or using the technology
- side effects (please describe which side effects patients might be willing to

accept or tolerate and which would be difficult to accept or tolerate)
- impact on others (for example family, friends, employers)
- financial impact on the patient and/or their family (for example cost of travel needed to access the technology, or the cost of paying a carer).

The major drawback of lenalidomide is that ultimately patients do and will relapse after taking it.

From our communication with patients we have heard of no difficulties in taking or using this technology other than intolerance to / side-effects attributable to dexamethasone.

Lenalidomide has a tolerable side-effect profile with the most commonly reported side-effects to our Infoline being neutropenia and increased infection, which are in line with the reported side-effects in the licensing trials.

It has been communicated to us that with lenalidomide, both the impact on others and the financial impact are diminished compared to most other treatments due to the reduced need to travel to hospital and ability to self-medicate.

3. Are there differences in opinion between patients about the usefulness or otherwise of this technology? If so, please describe them.

The feedback we get from patients about this technology is resoundingly consistent and favourable.

4. Are there any groups of patients who might benefit **more** from the technology than others? Are there any groups of patients who might benefit **less** from the technology than others?

The patients who might benefit more from lenalidomide include those that have pre-existing peripheral neuropathy from previous treatment with bortezomib or thalidomide; those that have an aversion to intravenous therapy and those patients who live far away from hospital who thus would benefit from oral therapy in the home environment.

Those who could potentially benefit less are those with a history of thromboembolic events, although this risk can be managed with prophylactic administration of anti-coagulants.

Comparing the technology with alternative available treatments or technologies

NICE is interested in your views on how the technology compares with existing treatments for this condition in the UK.

(i) Please list any current standard practice (alternatives if any) used in the UK.

High-dose dexamethasone (HDD)
Bortezomib monotherapy and bortezomib in combination with HDD
Thalidomide-containing regimens
Repeat initial chemotherapy with regimens based around melphalan, vincristine, cyclophosphamide and doxorubicin.

(ii) If you think that the new technology has any **advantages** for patients over other current standard practice, please describe them. Advantages might include:

- improvement in the condition overall
- improvement in certain aspects of the condition
- ease of use (for example tablets rather than injection)
- where the technology has to be used (for example at home rather than in hospital)
- side effects (please describe nature and number of problems, frequency, duration, severity etc.)

The choice of treatment is dictated by patient response to last treatment, co-morbidities (renal failure, neuropathy), patient specific factors, patient preference and access. Each of the current therapies is associated with particular disadvantages / advantages. For example, thalidomide and bortezomib can both cause peripheral neuropathy but thalidomide is orally administered rather than intravenous. Bortezomib does not cause the somnolence that thalidomide does, and is associated with a lower frequency of constipation.

Lenalidomide offers patients an oral, easy-to-use, tolerable treatment that can be taken at home and reduces the resource / time constraints of hospital-based therapy.

The combination of lenalidomide and dexamethasone has been shown to be effective in increasing response rates, time to progression and overall survival in relapsed patients and also those who are refractory to conventional treatment.

The technology will be a significant advance in the treatment of this patient group, and has the potential to change the outlook for many patients with relapsed / refractory myeloma.

(iii) If you think that the new technology has any **disadvantages** for patients compared with current standard practice, please describe them. Disadvantages might include:

- worsening of the condition overall
- worsening of specific aspects of the condition
- difficulty in use (for example injection rather than tablets)
- where the technology has to be used (for example in hospital rather than at home)
- side effects (for example nature or number of problems, how often, for how long, how severe).

From our experience there are no disadvantages of the technology when compared with the current available treatments. The most common side-effects that we hear of

are low blood counts which can be managed with dose adjustments. The feedback has in fact been unquestionably positive.

Research evidence on patient or carer views of the technology

If you are familiar with the evidence base for the technology, please comment on whether patients' experience of using the technology as part of their routine NHS care reflects that observed under clinical trial conditions.

We are in contact with patients that have been treated with lenalidomide who fall into two groups: 1) those that have received NHS funding for it or are receiving it privately or 2) those that had the opportunity to use the technology under an Expanded Access trial.

From speaking with the first group of patients, both the clinical response and the toxicity profile have been confirmed to reflect that observed in the MM-009 / MM-010 trials, except that the dexamethasone dose is sometimes reduced in practice due to patient intolerance and side-effects.

Patients who received lenalidomide through the Expanded Access scheme were given up to 6 courses of the treatment through a trial organised by the manufacturer to bridge the inevitable gap in patient access between licensing and NICE guidance. Some on the scheme have gone on to be funded by the NHS after the 6 courses and continue to do well. However the majority of patients who responded well to the treatment have had their requests to remain on lenalidomide turned down by Trusts.

The feedback we are getting is that a substantial proportion of these patients have relapsed quite quickly i.e. their time to progression has been affected by the break in active treatment.

This suggests that, if not used in line with the trial protocol, the clinical reality can be at odds with outcomes seen in MM-009 / MM-010, substantiating the need to use the treatment in line with its licensed indication i.e. treat until disease progression.

Are there any adverse effects that were not apparent in the clinical trials but have come to light since, during routine NHS care?

None to our knowledge. All adverse events that we have heard of are in line with those reported in the trials.

Are you aware of any research carried out on patient or carer views of the condition or existing treatments that is relevant to an appraisal of this technology? If yes, please provide references to the relevant studies.

Recent studies[1-3] have shown that in the past decade the overall survival of myeloma patients has improved. The studies demonstrate the real impact that improved and novel treatments (such as high-dose chemotherapy and stem cell transplant, thalidomide, bortezomib and lenalidomide) have had on survival in the past decade.

In the past decade the overall survival of myeloma patients has increased from around 29% to almost 35% at 5 years, and from 11% to 17% at 10 years[1].

The introduction of novel treatments, alongside advances in supportive care, gives myeloma patients the stepping stones to reach the next development in the pipeline by improving their prognosis. Not all treatments for relapsing patients are suitable for everyone so it is important to expand the toolbox of the doctor so that decisions in the best interests of the patient can be made.

Newer treatments such as lenalidomide can provide substantial benefit to patients in increasing the number of therapeutic options they have available to get back into remission, improving their overall survival and helping them lead an increasingly independent life.

1. Shaji K Kumar *et al*. (2007) Improved survival in multiple myeloma and the impact of novel therapies *Blood* doi:10.1182/blood-2007-10-116129

2. Hermann Brenner *et al*. (2007) Recent major improvement in long-term survival of younger patients with multiple myeloma Blood doi:10.1182/blood-2007-08-104984

3. Bjorkholm *et al*. (2007) Patterns of survival in multiple myeloma: a population-based study of patients diagnosed in Sweden from 1973 to 2003. *Journal of Clinical Oncology* 25:1993-1999

Availability of this technology to patients in the NHS

What key differences, if any, would it make to patients and/or carers if this technology was made available on the NHS?

The effectiveness and side-effect profile of lenalidomide indicates that it is a significant development for the majority of patients, both younger and older, following relapse from a number of clinical scenarios.

Other than the excellent response rates and survival benefits this technology can offer patients, the key difference that access to lenalidomide would make to patients, their families and carers is hope for the future.

For patients to know that there is a licensed, clinically effective treatment out there but that they cannot have it is one cross they should not have to bear.

What implications would it have for patients and/or carers if the technology was **not** made available to patients on the NHS?

If this technology was **not** made available, it would be denying patients access to a treatment with a substantiated efficacy that is easy to use, does not give them awful side-effects and lets them get on with their lives with minimal disruption.

The bottom line is that without lenalidomide UK patients may have reduced survival at a time when survival rates in cancer are rising in other European countries.

Are there groups of patients that have difficulties using the technology?

As previously stated, those patients that have a history of thromboembolic events will require prophylaxis with an anti-coagulant but this should not preclude them from receiving treatment with the technology.

Other Issues

Please include here any other issues you would like the Appraisal Committee to consider when appraising this technology.

Lenalidomide clearly ticks most of the boxes. It has strong data from two RCTs to substantiate its clinical effectiveness; it has a tolerable side-effect profile; the feedback from patients is that they find it convenient and easy to use.

Although the data is strong, our experience from the bortezomib appraisal is that the cross-over that occurred during the trials will cause uncertainty in the considerations. We hope that all necessary action is taken to ensure that this unavoidable turn of events does not affect the likelihood of this technology being approved.

We also know that the list price of this technology is expensive which we fear will impact negatively on this appraisal. Given the nature of the disease and the importance of the technology we urge NICE, the Department of Health and the manufacturer to discuss ways in which the price can be reduced which is acceptable to the NHS and in the best interests of patients.