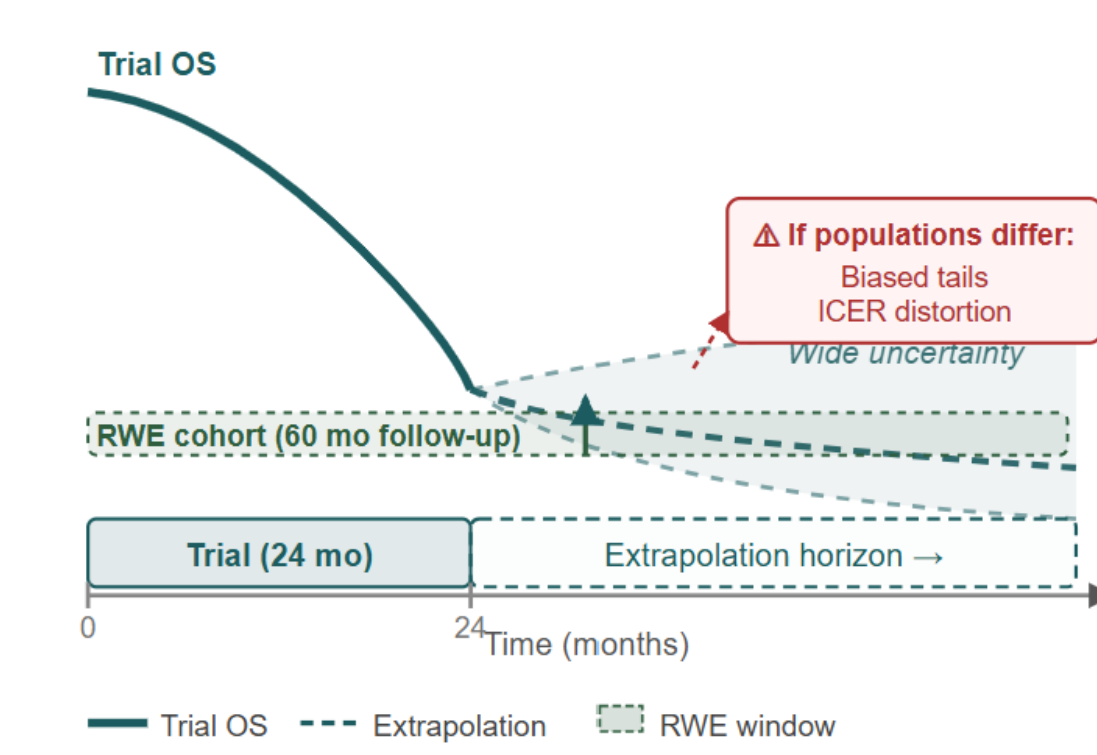


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INTRODUCTION

- Health Technology Assessment (HTA) submissions in oncology require Overall Survival (OS) extrapolation to a lifetime horizon, yet pivotal trials report median follow-up of 12-30 months leaving survival tails sparsely observed and highly uncertain at the point of decision^{1,2}
- Real-world evidence (RWE) from registries and electronic health record (EHR) cohorts can supplement trial data to improve long-term precision, but systematic population differences (prognosis, prior treatment, disease stage) risk distorting extrapolated tails through prior data conflict^{3,4}
- The comparative operating characteristics of these strategies and their downstream impact on incremental cost-effectiveness ratio (ICER) estimates have not been formally evaluated in an oncology extrapolation simulation context
- Power priors and commensurate priors provide principled Bayesian frameworks for external borrowing, but fixed-weight approaches do not self-limit under conflict motivating conflict-robust extensions (estimated weights, robust mixture priors)^{5,6}

Figure 1: The Borrowing Problem



OBJECTIVE

- To compare five Bayesian borrowing strategies fixed and estimated power priors, commensurate prior, and robust mixture commensurate prior for long-term OS extrapolation in oncology, evaluating bias, root mean square error (RMSE), and 95% coverage of five year restricted mean survival time (RMST) under concordant and conflict scenarios across 1,000 simulation replicates, and quantifying downstream ICER consequences via a partitioned survival cost-effectiveness model

METHODS

Phase 1 - Simulation Design

- A randomized trial setting was simulated (N=480; 1:1 allocation; 24-month administrative censoring) with event generation from a Weibull proportional hazards model (shape $\gamma=1.2$; baseline hazard $\lambda=0.015$; treatment log-HR $\beta=-0.35$; HR=0.70); approximately 214 deaths observed per replication (44.6% event rate)
- An external real-world control cohort (N=1,500; 60-month follow-up) was generated under two pre-specified population scenarios: Concordant ($\lambda_{ext}=0.015$ identical baseline hazard to trial controls) and Conflict ($\lambda_{ext}=0.008$ systematically lower hazard, reflecting a better prognosis registry population with less advanced disease)
- Shape parameter γ was held constant across both scenarios to isolate the effect of scale conflict on borrowing performance; 1,000 independent Monte Carlo replicates were generated per scenario
- Primary estimand: 5-year RMST for the control arm, computed analytically as $\int_0^{\infty} \exp(-\lambda t^\gamma) dt$ from true parameters to serve as the reference for bias and coverage assessment

Figure 2: Overall phases

1 Simulation Design
Weibull PH data generation for trial (N=480) and external RWE (N=1,500) under concordant and conflict scenarios

2 Borrowing Strategy Models
Fixed PP ($\alpha=0.2/0.5/1.0$), estimated PP, commensurate prior, and robust mixture commensurate prior - all vs vague-prior reference

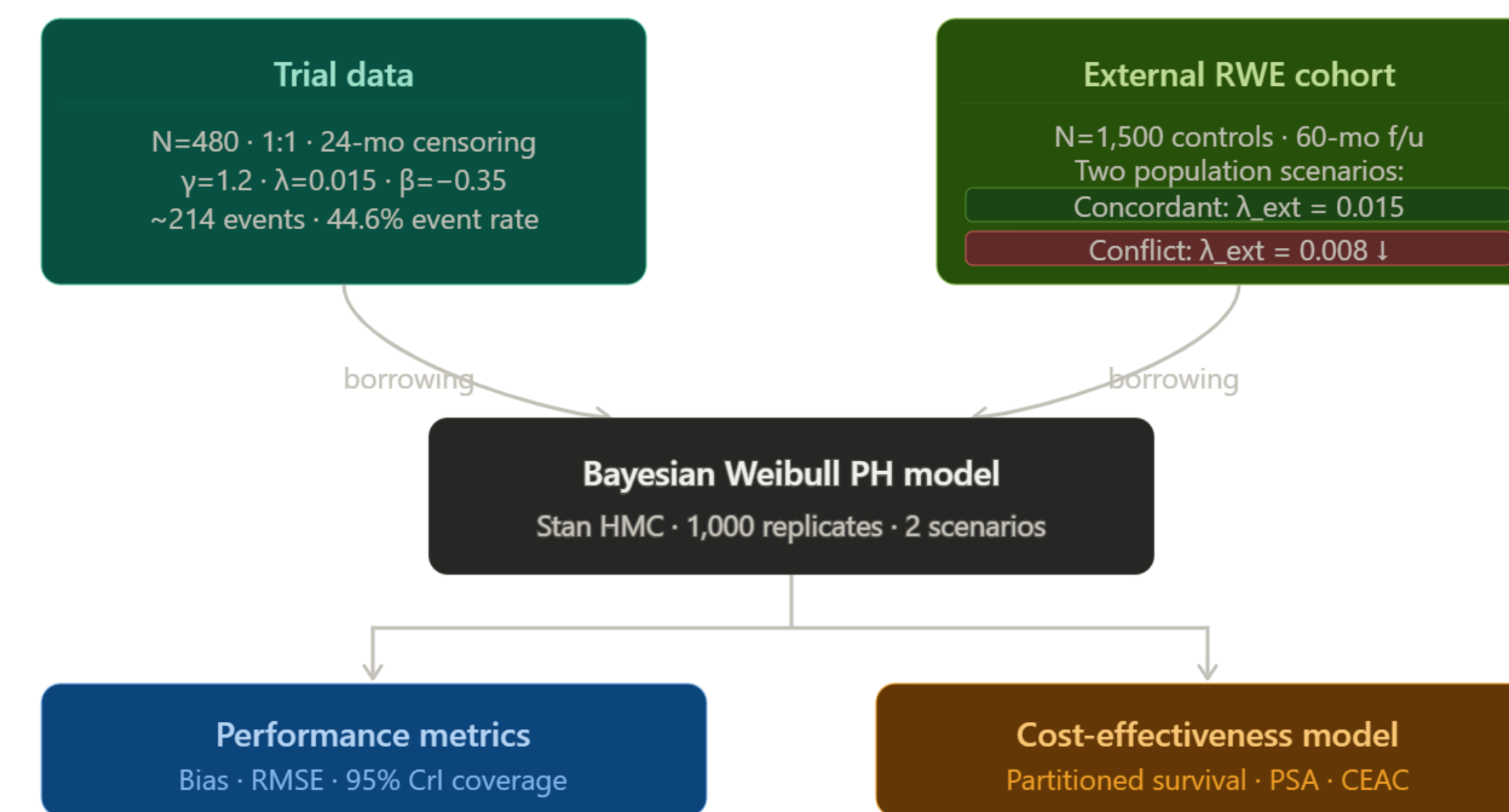
3 Evaluation Framework
1,000 replicates \times 2 scenarios; bias, RMSE, 95% CrI coverage; downstream ICER via partitioned survival PSA

ICER: Incremental Cost-Effectiveness Ratio; PH: Proportional Hazards; PP: Power Prior; RWE: Real-World Evidence; PSA: Probabilistic Sensitivity Analysis; RMSE: root mean square error

Model Structure

- Bayesian Weibull PH likelihood: $h(t_i|x_i) = \lambda t_i^{\gamma-1} \exp(\beta x_i)$; $S(t_i|x_i) = \exp(-\lambda t_i^\gamma \exp(\beta x_i))$; full likelihood = $\sum [d_i \cdot \log h(t_i|x_i) + \log S(t_i|x_i)]$, accommodating right-censoring for both trial and external data
- Three parameters: baseline hazard scale λ , shape γ , and treatment log-HR β ; vague priors as baseline $\log \lambda \sim N(-4, 2)$; $\log \gamma \sim N(0, 1)$; $\beta \sim N(0, 2)$ (Table 1)
- External data exclusively informs (λ, γ); β estimated from trial only across all strategies - borrowing cannot distort the treatment effect estimate
- Each borrowing strategy replaces the vague prior on ($\log \lambda, \log \gamma$) with an externally-informed prior; the likelihood structure and β prior remain unchanged (Figure 3)

Figure 3: Simulation architecture



CEAC: Cost-Effectiveness Acceptability Curve; PH: Proportional Hazards; PSA: Probabilistic Sensitivity Analysis; RMSE: Root mean square error

Borrowing Strategies

- No borrowing: Vague priors retained; external data excluded - serves as precision and coverage reference
- Fixed power prior ($\alpha = 0.2, 0.5, 1.0$): Posterior $\propto L(\theta|D_{trial}) \times L(\theta|D_{ext})^\alpha \times \pi_0(\theta)$; fixed α does not adapt to population compatibility - full borrowing ($\alpha=1.0$) propagates conflict directly into the survival tail
- Estimated power prior: $\alpha \sim \text{Beta}(1,1)$ jointly estimated with model parameters; posterior $\hat{\alpha}$ self limits toward zero under conflict, providing automatic down weighting and a quantifiable borrowing diagnostic
- Commensurate prior (Hobbs et al., 2012): External data fitted first; posterior summary (μ_{ext}, σ_{ext}) used as location prior - $\log \lambda \sim N(\mu_{ext}, \sigma_{ext}^2/\tau)$; commensurability $\tau \sim \text{Half Normal}(0,1)$ estimated from trial data; large τ = tight borrowing, small τ = conflict-protective
- Robust mixture commensurate (Schmidli et al., 2014): $\pi(\log \lambda) = 0.70 \times N(\mu_{ext}, \sigma_{ext}^2/\tau) + 0.30 \times N(-4, 9)$; vague component ensures prior mass away from external location under conflict, vague component dominates and attenuates bias propagation

Table 1: Model Parameters

Strategy	Key parameter	Mathematical form	Conflict-robust
No borrowing	-	Vague prior on (λ, γ)	Reference
PP $\alpha = 0.20$	$\alpha = 0.20$, fixed	$L(\theta D_{ext})^{0.2} \times \pi_0(\theta)$	No
PP $\alpha = 0.50$	$\alpha = 0.50$, fixed	$L(\theta D_{ext})^{0.5} \times \pi_0(\theta)$	No
PP $\alpha = 1.00$	$\alpha = 1.00$, full	$L(\theta D_{ext})^1 \times \pi_0(\theta)$	No - high risk
PP $\hat{\alpha}$ estimated	$\alpha \sim \text{Beta}(1,1)$	α jointly estimated with θ	Partial

PP: Power Prior

RESULTS

- 5-year RMST (control arm): 29.2 months (2.43 years); all borrowing strategies recovered this with near-zero bias under concordance
- Under concordance, all borrowing strategies maintained 93-95% credible interval coverage no meaningful calibration penalty for informative borrowing when populations are compatible
- Posterior uncertainty (mean SD of RMST estimates) reduced 31-38% relative to no borrowing; commensurate and robust mixture achieved 34% reduction; full PP achieved 38%
- RMSE reduced 12-18% across strategies; gains were modest because variance reduction was partially offset by small prior-induced shrinkage toward the external posterior mean
- Mean posterior $\hat{\alpha} = 0.74$ under concordance (estimated PP) data correctly identified the external cohort as highly compatible and assigned high borrowing weight automatically (Table 2)

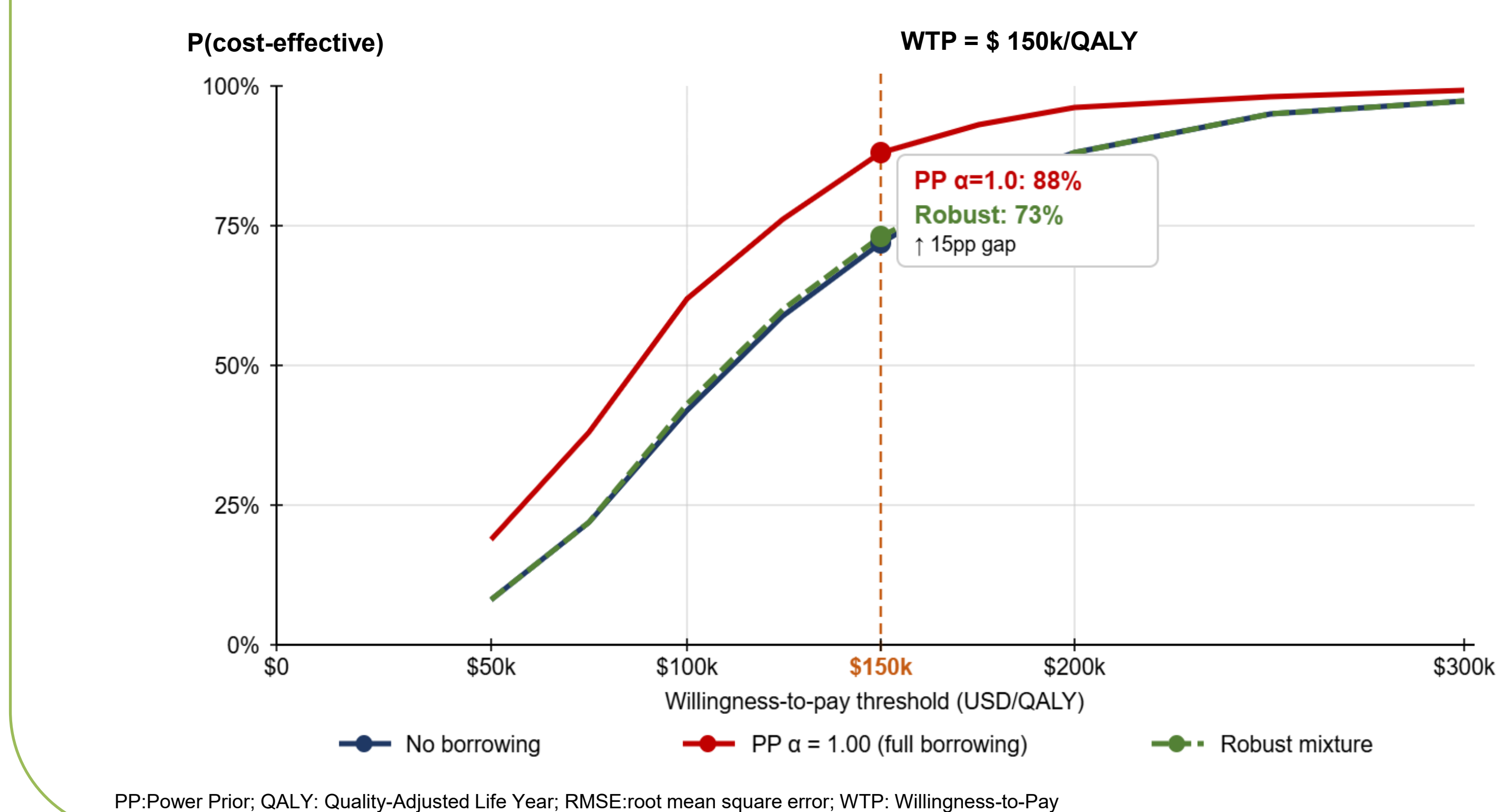
Table 2: Model Performance Summary

Strategy	Bias (LY)	SD (mo)	SD reduction	RMSE (mo)	RMSE reduction	Coverage
No borrowing	-0.01	3.18	—	3.18	—	95.2%
PP $\alpha = 0.20$	0.00	2.19	31%	2.80	12%	95.1%
PP $\alpha = 0.50$	+0.01	2.07	35%	2.72	14%	94.7%
PP $\alpha = 1.00$	+0.02	1.97	38%	2.61	18%	93.8%
PP $\hat{\alpha}$ estimated	+0.01	2.11	34%	2.69	15%	94.3%
Commensurate	0.00	2.09	34%	2.67	16%	94.5%
Robust mixture	+0.01	2.09	34%	2.67	16%	94.3%

LY: Life Years; mo: months; PP: Power Prior; RMSE: Root mean square error; SD: Standard Deviation

- Under concordance, borrowing narrowed ICER credible interval width by ~30% without shifting the mean ICER (\$128,000/QALY) - precision gain at zero cost to validity
- Under conflict, full Power Prior ($\alpha=1.0$) distorted mean ICER to \$99,000/QALY - a \$29,000 downward shift crossing the \$100k/QALY reimbursement threshold; conflict-robust strategies held mean ICER at \$124,000-\$130,000/QALY, within \$6,000 of the true baseline
- At WTP \$150,000/QALY, full Power Prior under conflict inflated the probability of cost-effectiveness from 72% to 88% - a 16 percentage-point overstatement of treatment value that would mislead reimbursement decisions (Figure 4)

Figure 4: Cost-effectiveness acceptability curves



PP: Power Prior; QALY: Quality-Adjusted Life Year; RMSE: root mean square error; WTP: Willingness-to-Pay

CONCLUSION

- Bayesian borrowing from external RWE meaningfully improves OS extrapolation precision under population concordance -reducing posterior uncertainty by 31-38% and RMSE by 12-18% while maintaining nominal 95% coverage, with no distortion to mean ICER estimates
- Full fixed borrowing (PP $\alpha=1.0$) is unsafe under conflict - introducing -0.41 LY bias, collapsing coverage to 62%, and shifting mean ICER by \$29,000/QALY in a direction that would incorrectly favor reimbursement; fixed partial borrowing ($\alpha=0.5$) also degrades materially (coverage 89%), conflict-robust strategies - estimated PP and robust mixture commensurate - self-limit under population heterogeneity, recovering bias to -0.07 LY and coverage to 90-92% without requiring manual specification of the borrowing weight; posterior $\hat{\alpha}$ and τ distributions provide transparent, interpretable diagnostics
- The choice of borrowing strategy is not a statistical technicality - it is a decision-relevant input: a 15 percentage-point overstatement of cost-effectiveness probability at a \$150k/QALY threshold has direct implications for reimbursement conclusions in NICE, CADTH, and EMA-HTA submissions
- Recommended practice for HTA submissions: apply robust mixture commensurate or estimated power prior; report posterior $\hat{\alpha}$ / τ distributions as borrowing diagnostics; pre-specify conflict thresholds in the SAP; and conduct scenario analyses under both concordant and conflict assumptions to bound extrapolation uncertainty transparently

References

- NICE DSU TSD 14, 2014
- Latimer NR et al. Med Decis Making. 2013
- Ciani O et al. Value Health. 2022
- Guyot P et al. BMC Med Res Methodol. 2012
- Ibrahim JG, Chen M-H. Lifetime Data Anal. 2000
- Schmidli H et al. Biometrics. 2014

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Disclosure:

PB, AS, KP, SM, and SP, the authors declare that they have no conflict of interest