EE473

Health Care Resource Use in the Management of Patients with Relapsed/Refractory Diffuse Large B-Cell Lymphoma in Canada

Guinan K[1], Pelletier M[1], Ham M[1], Tankala D[2], Paul Roc N[2], Barakat S[2], Klil-Drori AJ[2], Fleury I[3], MacDonald D[4], Lachaine J[1]

[1]PeriPharm Inc., Montreal, QC, Canada, [2]AbbVie Corporation, QC, Canada, [3] Maisonneuve-Rosemont Hospital, Montreal, QC, Canada, [4]University of Ottawa and The Ottawa Hospital, Ottawa, ON, Canada

OBJECTIVE

Primary objective: Estimate costs of health care resource utilization (HCRU) of approved relapsed/refractory diffuse large B-cell lymphoma (R/R-DLBCL) treatments for patients who are transplant ineligible (TI) and have received at least two prior lines of systemic therapy, from a healthcare (HC) perspective, to inform Canadian institutional decision makers, the Canadian Agency for Drugs and Technologies in Health (CADTH), and healthcare professionals.

Secondary objectives:

- Use a societal perspective to evaluate HRCU costs.
- Estimate chair time and health care personnel (HCP) time involved in administering treatments

DISCUSSION

Strengths of this study included validation of study inputs by Canadian clinical experts and the conduct of robust scenario analyses to verify the core assumptions. The study also included drugs approved for R/R DLBCL in Canada, regardless of funding status to allow for a comprehensive comparison of HCRU costs reflected in clinical practice.

Potential limitations of this analysis: cost data primarily sourced from Ontario which may result in some assumptions not applicable to patients in other provinces and model inputs from product monographs that may not align precisely with real-world practice. The model was built to be easily adapted with cost data of other jurisdictions to address some of these limitations.

CONCLUSIONS

Considering the highly constrained Canadian HC system, epcoritamab offers valuable HCRU-related cost savings and substantial time savings when compared to available treatments described in this study, making it an effective, efficient, and patient-centric treatment option for R/R-DLBCL in Canada.

In contrast to other IV treatment alternatives, subcutaneous (SC) epcoritamab simplifies the treatment administration process for HCPs and enhances convenience for patients and caregivers.

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Disclosures

Author Disclosures:

- **JL** is a partner at PeriPharm Inc., a company that has served as a consultant to AbbVie and has received funding from AbbVie.
- **KG, MP and MH** are employees of PeriPharm Inc.
- **DT, NPR, SB and AJD** are employees of AbbVie Corporation. Employees of AbbVie may hold equity.
- **KG, MP, MH, DT, NPR, SB, AJD and JL** have participated in the study conduct, data interpretation and preparation of the poster.
- **Dr. DM and Dr. IF** have received honoraria from AbbVie .**Dr. DM and Dr. IF** have provided advisory consultations for AbbVie .

AbbVie Disclosures:

- No honoraria or payments were made for authorship. AbbVie participated in the design and provided financial support for the study. AbbVie reviewed and approved this publication.

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BACKGROUND

- In October 2023, epcoritamab was the first SC bispecific drug approved by Health Canada for R/R-DLBCL, not otherwise specified, DLBCL transformed from indolent lymphoma, high grade B-cell lymphoma, primary mediastinal B-cell lymphoma or follicular lymphoma Grade 3B, after two or more lines of systemic therapy and who have previously received or are unable to receive CAR T-cell therapy and are TI. [1,2]
- Currently, no published Canadian HCRU studies in R/R-DLBCL exist to assess HCRU of a novel therapy like epcoritamab versus other R/R-DLBCL treatments, each with different dosing schedules, administration routes, adverse event rates and monitoring requirements. There was a need to understand the differences in HCRU between treatments. .
- This study is an adaptation of a previously published model in the United States. The study considers a representation of the Canadian HC and a societal perspective.[3]

STUDY DESIGN

- **Target population:** Canadian patients with R/R-DLBCL who are TI and have received at least two prior lines of systemic therapy, in line with the approved Health Canada indication of epcoritamab.[1,2]
- **Time horizon:** 1 year for base-case. Multiple time horizons were assessed in scenario analyses (i.e., first 30 days, 6 months and 2 years).
- **Comparators:** glofitamab, CAR T-cell therapies (axicabtagene ciloleucel [Axi-cel], tisagenlecleucel [Tisa-cel], and lisocabtagene maraleucel [Liso-cel]), chemotherapy (i.e. R-GemOx) and polatuzumab vedotin + bendamustine + rituximab (Pola-BR).
- **Perspective/costs:**
  - HC perspective: direct medical costs only including pretreatment, administration (i.e., inpatient and outpatient), follow up and monitoring and adverse event (AE).
  - Societal perspective: direct and indirect costs (i.e., patient and caregiver lost productivity and patient out-of-pocket costs)
- **Time analysis:** infusion chair time and HCP time (i.e., pharmacist and nurse time) were based on times retrieved from Cancer Care Ontario and clinical expert's input.[4]
- Acquisition costs of active treatments were excluded.
- **Estimation of productivity loss**: full day off work for SC injection.
- Model inputs were from approved product labels and were validated by Canadian clinical experts to reflect practice.

RESULTS

- From the HC perspective, total one-year HCRU costs ranged from $11,009 to $54,946, with CAR T-cell therapy representing the most resource intensive treatment (**Figure 1a**).
- Epcoritamab ranked as the 2nd least costly comparator at $13,526, with notable HCRU savings driven by low administration and AE management costs (**Figure 1a**).
- Epcoritamab incurred HCRU-related savings versus all CAR T-cell therapies (-64% to -75%), followed by glofitamab (-39%), Pola-BR (-20%), while being more costly than R-GemOX (23%).
- From a societal perspective, epcoritamab also ranked as the 2nd least costly comparator, after Pola-BR (**Figure 1b**).

Figure 1. Total HCRU Costs in Canada

Figure 1a

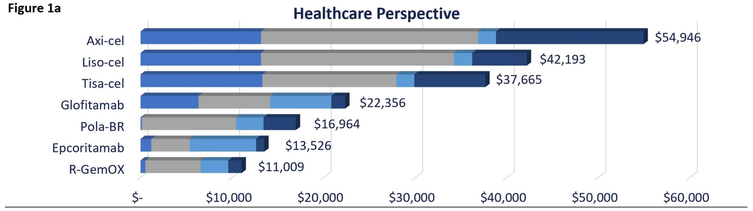
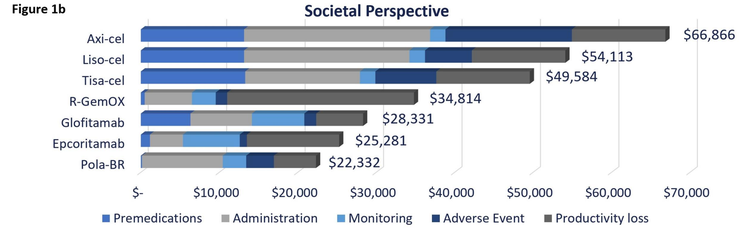


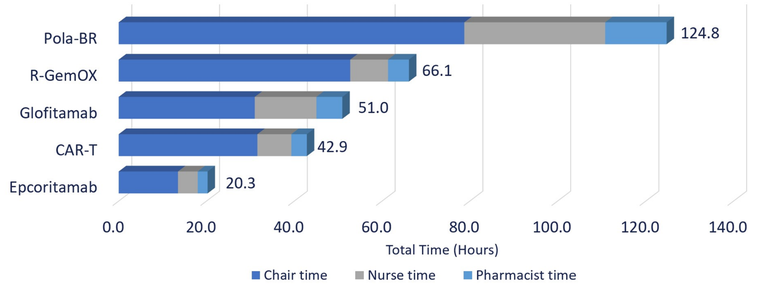
Figure 1b



Abbreviations: Axi-cel: axicabtagene ciloleucel; **Liso-cel:** lisocabtagene maraleucel; **Pola-BR**: polatuzumab vedotin + bendamustine + rituximab; **R-GemOX** : Rituximab + Gemcitabine + Oxaliplatin **Tisa-cel:** tisagenlecleucel**.**

- Epcoritamab represented the comparator associated with the least total chair time (i.e., infusion time) and HCP time combined (**Figure 2**).
- Epcoritamab had the lowest annual chair time of 13.5 hours amongst comparators. For every 100 hypothetical patients treated, epcoritamab could potentially free up capacity to treat between 90 and 483 more patients (depending on the comparator).

Figure 2. Total Chair and Healthcare Personnel Time in Canada



Abbreviations: CAR-T: chimeric antigen receptor T-cell; **Pola-BR**: polatuzumab vedotin + bendamustine + rituximab; **R-GemOX** : rituximab + gemcitabine + oxaliplatin.

- Productivity savings: Epcoritamab resulted in more productivity savings compared to R-GemOX (+83 days) and CAR-T cell therapies (+31 days), with slightly lower productivity savings when compared to glofitamab (-14 days) and Pola-BR (-16 days).

Scenario analyses were conducted on the base-case analysis:

- Time horizon: Epcoritamab ranked as the least costly comparator over a 6-month time horizon and 2nd least costly over the first 30-day and 2-year time horizon from the HC perspective.
- Exclusion of hospitalization for the 1st two doses for bi-specifics (since not mandated in product monograph)**:** Results were similar to the base-case analysis, from the HC perspective.
- Rituximab SC: From the HC and societal perspectives, epcoritamab ranked as the 3rd least costly comparator over a the 1-year time horizon. This resulted from the lower costs of R-GemOX SC in the HC perspective and Pola-BR SC in the societal perspective.