Canada's Drug Agency
L'Agence des médicaments du Canada
Drugs. Health Technologies and Systems. Médicaments, technologies de la santé et systèmes.

Feedback on Draft Recommendation

Interested party information	
Project number	PC0409-000
Brand name (generic)	Verzenio (abemaciclib)
Indication(s)	For the treatment of hormone receptor-positive, human epidermal growth factor receptor 2-negative, advanced or metastatic breast cancer, in combination with fulvestrant in women with disease progression following endocrine therapy
Organization	REAL Canadian Breast Cancer Alliance
Contact information[a]	Name: Dr. Sandeep Sehdev

Interested party agreement with the draft recommendation		
1. Does the interested party agree with the committee's recommendation.	Yes	☐
	No	☒

Initiation criteria:
Overall, we agree with the proposed reimbursement conditions in Table 1 (items 1, 2.2 and 2.3), as they are consistent with the MONARCH 2 clinical trial and align with most of the evidence and clinical rationale outlined in our REAL Alliance submission (Section 5.1).

However, **we recommend removing the exclusion criterion stating that *"patients should not be eligible if they were previously treated with a CDK4/6 inhibitor in the metastatic setting" (Table 1, item 2.1).*** Our rationale is based on results from the postMONARCH clinical trial, which demonstrated that patients receiving abemaciclib + fulvestrant following first-line palbociclib achieved a considerable progression-free survival (PFS) benefit.

In our submission, we noted:
In the primary analysis of the postMONARCH trial, abemaciclib provided significant PFS benefit [HR 0.73 (95% CI 0.57-0.95)] for patients previously treated with palbociclib [18]. Since many patients in Canada are prescribed palbociclib as first-line treatment [19], these findings highlight the potential of abemaciclib to help this patient group with recurrent disease while delaying chemotherapy (section 5.1).

Accordingly, we recommend that:
For patients whose disease progressed on palbociclib + ET, the combination should be limited to patients who do not have rapid disease progression (i.e., progression within ~6 months of initiating first-line therapy), or a high burden of metastasis (i.e., extensive visceral involvement or symptomatic disease requiring urgent intervention) given the limitation of postMONARCH data (section 5.2).

Based on our experience and available insights, it is estimated that palbociclib represents 10–15% of first-line CDK4/6i use in academic oncology centres and approximately 25–30% in community oncology centres. While usage may be somewhat higher in community settings, **the overall scale of**

this expansion remains small, and the budgetary impact is therefore expected to be minimal. This change would allow access for a limited group of patients who could derive meaningful benefit, without altering current clinical workflows or substantially affecting overall program costs. In other words, while the number of affected patients is small, the importance for them is significant.

Discontinuation criteria:
We support the recommendation that reimbursement should be discontinued upon disease progression or development of unacceptable toxicity (Table 1, item 3.1 and 3.2), in line with the product monograph and clinical standards. In Section 5.4 of our submission, we stated: *"Abemaciclib + fulvestrant combination therapy should be discontinued at the first evidence of disease progression based on clinical or radiographic criteria, or if persistent or unacceptable toxicity occurs."*

We also appreciate the recommendation's flexibility regarding treatment monitoring, which allows for response evaluation based on standard institutional guidelines for metastatic breast cancer, rather than requiring strict adherence to schedules used in MONARCH 2 (Table 1, item 3 implementation guidance). While our submission did not explicitly specify this preference, we noted in section 5.5 that: *"Current health systems have already incorporated follow-up monitoring with the established use of CDK4/6 inhibitors, including health system monitoring models that utilize pharmacists and nurses, when necessary, without adding additional clinical workflow burden."*
This confirms that the existing infrastructure is well equipped to support appropriate treatment evaluation without introducing unnecessary procedural constraints.

Prescribing criteria:
We support the recommendation that clinicians with expertise in managing advanced or metastatic breast cancer should prescribe abemaciclib + fulvestrant (Table 1, item 4). As described in Section 5.5 of our submission, we emphasized the need for experienced oncologists to oversee initiation and early monitoring.

Pricing considerations:
While the REAL Alliance does not conduct cost-effectiveness analyses, we recognize the importance of price alignment across CDK4/6 inhibitors in ensuring equity and feasibility of access (Table 1, item 5). Given that abemaciclib has shown a statistically significant OS benefit and offers a distinct safety profile and continuous dosing schedule, we believe it is a valuable option and agree that reimbursement conditions should be aligned with current CDK4/6 inhibitor standards.

Feasibility of adoption:
We acknowledge the committee's concerns around budget impact (Table 1, item 6). While we defer to health economic experts on the modeling, we emphasize that the clinical infrastructure and monitoring systems required for abemaciclib are already in place, and the proposed use case is consistent with existing clinical workflows. Its inclusion would expand therapeutic flexibility, particularly for patients for whom ribociclib may not be appropriate due to QTc, hepatic, or drug interaction concerns.

The postMONARCH inclusion for "*patients who do not have rapid disease progression, or a high burden of metastasis"* (section 5.2) would create some additional demand by making abemaciclib available to a small, well-defined subset of patients with prior palbociclib exposure. However, given current prescribing patterns for palbociclib, the scale of this expansion is expected to be minimal and readily accommodated within existing capacity.

Expert committee consideration of the input		
2. Does the recommendation demonstrate that the committee has considered the input that your organization provided?	Yes	☐
	No	☒
While we are generally aligned with the draft recommendations, our input is only partially reflected in the inclusion criteria (table 1, item 2.1). The recommendations do not address our expert perspective on patients previously treated with palbociclib, as informed by emerging postMONARCH data, which we believe merits acknowledgment. Including this subgroup would broaden access in a focused way, targeting patients for whom effective post-CDK4/6i options are limited. The size of this expansion is expected to be small relative to the overall metastatic HR+/HER2– population, given current prescribing patterns for palbociclib, and should be readily managed within existing care pathways and resources.		
Clarity of the draft recommendation		
3. Are the reasons for the recommendation clearly stated?	Yes	☒
	No	☐
If not, please provide details regarding the information that requires clarification.		
4. Have the implementation issues been clearly articulated and adequately addressed in the recommendation?	Yes	☐
	No	☒
We recommend considering that use of abemaciclib would integrate seamlessly into existing clinical workflows, with no additional operational burden on providers or health systems.		
5. If applicable, are the reimbursement conditions clearly stated and the rationale for the conditions provided in the recommendation?	Yes	☒
	No	☐
If not, please provide details regarding the information that requires clarification.		

[a] CDA-AMC may contact this person if comments require clarification.

Appendix 2. Conflict of Interest Declarations for Clinician Groups

- To maintain the objectivity and credibility of the CDA-AMC drug review programs, all participants in the drug review processes must disclose any real, potential, or perceived conflicts of interest.
- This conflict of interest declaration is required for participation. Declarations made do not negate or preclude the use of the feedback from patient groups and clinician groups.
- CDA-AMC may contact your group with further questions, as needed.
- Please see the *Procedures for Drug Reimbursement Reviews* for further details.
- For conflict of interest declarations:
    - Please list any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.
    - Please note that declarations are required for each clinician that contributed to the input.
    - If your clinician group provided input at the outset of the review, only conflict of interest declarations that are new or require updating need to be reported in this form. For all others, please list the clinicians who provided input are unchanged
    - Please add more tables as needed (copy and paste).
    - All new and updated declarations must be included in a single document.

A. Assistance with Providing the Feedback		
1. Did you receive help from outside your clinician group to complete this submission?	No	☒
	Yes	☐
If yes, please detail the help and who provided it.		
2. Did you receive help from outside your clinician group to collect or analyze any information used in this submission?	No	☒
	Yes	☐
If yes, please detail the help and who provided it.		
B. Previously Disclosed Conflict of Interest		
3. Were conflict of interest declarations provided in clinician group input that was submitted at the outset of the review and have those declarations remained unchanged? If no, please complete section C below.	No	☐
	Yes	☒
If yes, please list the clinicians who contributed input and whose declarations have not changed: • Dr. Jean-Francois Boileau • Dr. Nathaniel Bouganim • Dr. Christine Brezden-Masley • Dr. Jeffrey Cao • Dr. Stephen Chia • Dr. Scott Edwards • Dr. Karen Gelmon • Dr. Nayyer Iqbal • Dr. Anil Abraham Joy • Dr. Kara Laing • Dr. Nathalie Levasseur • Dr. Mita Manna • Dr. Callista Phillips • Dr. Maged Salem • Dr. Sandeep Sehdev • Dr. Christine Simmons		

C. New or Updated Conflict of Interest Declarations
NONE