AWTTC
All Wales Therapeutics & Toxicology Centre
Canolfan Therapiwteg a Thocsicoleg Cymru Gyfan

# One Wales Medicines Assessment Group (OWMAG)

## Minutes of the Teams meeting held Monday, 12th May 2025

**Members in attendance**
Andrew Champion, Program Director, AWTTC, OWMAG Chair
Tim Banner, Clinical Director Pharmacy & Medicines Management, representative Cardiff and Vale
Sue Beach, Clinical Development Pharmacist, alternate representative, Hywel Dda
Anthony Cadogan, Deputy Chief Pharmacist, representative Velindre
Joe Castle, Head of External Affairs and Operations, ABPI Cymru Wales
Chris Commins, Assistant Finance Director, Aneurin Bevan
Stuart Wyn Evans, Clinical Effectiveness Pharmacist, representative Swansea Bay
Laurence Gray, Clinical Pharmacologist alternate representative
Will Hardy, Research Fellow, Bangor University, Health Economist
Kathryn Howard, Head of Pharmacy, Royal Glamorgan Hospital, representative Cwm Taf Morgannwg
William King, Consultant in Public Health, representative Powys
Malcolm Latham, Community Health Council, Lay representative
Anghard Lawson, Advanced Pharmacist, NHS Wales Joint Commissioning Committee

**AWTTC**
Clare Elliott, Senior Appraisal Scientist
Laura Phillips, Admin Manager
Rosie Spears, Senior Appraisal Scientist
Gail Woodland, Senior Appraisal Pharmacist
Tom Winfield, Senior Health Economist

**Observers**
Lorraine Coyle, AWTTC

**Clinical experts**
Dr Craig Barrington
Dr Louise Hanna
Dr Emma Hudson

**List of Abbreviations:**

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| ABPI | Association of the British Pharmaceutical Industry |
| AWMSG | All Wales Medicines Strategy Group |
| AWTTC | All Wales Therapeutics and Toxicology Centre |
| ESR | Evidence Status Report |
| IPFR | Individual Patient Funding Request |

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| JCC | NHS Wales Joint Commissioning Committee |
| NICE | National Institute for Health and Care Excellence |
| OWMAG | One Wales Medicines Assessment Group |

- **Welcome and Introduction**

The Chair opened the meeting and welcomed members.

- **Apologies**
  - Michael Thomas, Consultant in Public Health Medicine, representative Hywel Dda
  - Leo Pinto, Consultant in Public Health, representative Aneurin Bevan
  - Craig Roberts, Assistant Director of Therapies and Health Science, alternate representative Aneurin Bevan

- **Welcome**

Dr Andrew Champion welcomed the group and introduced himself as the newly appointed interim Chair of OWMAG. He thanked Professor John Watkins for his work as Chair for the preceding years. He introduced two new OWMAG members, Angharad Lawson from NWJCC and Chris Commins from Aneurin Bevan.

- **Declarations of Interests/Confidentiality**

The Chair reminded members that all OWMAG proceedings are confidential and should not be disclosed outside of the meeting. Members were reminded that declarations of interest and confidentiality statements are signed by each member on an annual basis. The Chair invited any declarations of interest; there were none.

- **Assessment 1**

**Panitumumab for the treatment of stage IV metastatic left-sided colorectal cancer with RAS wildtype confirmed by circulating tumour DNA following successful first line treatment with an epidermal growth factor inhibitor and at least one other treatment.**

Rosie Spears presented an overview of the key aspects of the panitumumab evidence status report (ESR).

The Chair introduced the clinical expert, Dr Craig Barrington, consultant Clinical Oncologist from Singleton Hospital. The Chair described the role of the clinical expert as an invited observer of the OWMAG meeting to answer questions and input into discussions to enable members to gain a better understanding of the clinical context. The Chair highlighted that clinical experts were nominated by their specialist group or network and should not express personal opinion or promote the use of a medicine. The Chair invited any declarations of interest from the clinical expert; Dr

Barrington informed the group that he has received speaker fees from Amgen, the marketing authorisation holders for panitumumab. The Chair was satisfied that this would not constitute a conflict of interest.

Dr Barrington provided additional insight into the evidence presented, with respect to the clinical pathway for these patients and where panitumumab would most likely sit. He drew attention to the response rates reported in clinical trials for treatments at third line which favours trifluridine-tipiracil (Lonsurf®) with bevacizumab, especially for patients who are naïve to bevacizumab, which would be most patients in the UK. He also highlighted the response rates for EGFRi re-challenge as presented in the network meta-analysis which included a lot of heavily pre-treated patients. He described patients as typically being relatively fit and well and focus is often on whether it is prudent to treat at all with some patients who do not want any further treatments. As panitumumab is delivered by IV infusion every two weeks this can be a burden on the patient and impact quality of life negatively. Conversely there are another group of patients who appreciate active treatment and regular attendance at hospital which can be reassuring. Dr Barrington explained that he had accessed panitumumab for his patients via the Individual Patient Funding Request (IPFR) process and to date all have responded well to treatment with panitumumab guided by ctDNA RAS status. He did highlight the issue of severe skin reactions as a significant adverse effect from treatment with panitumumab and how clinicians have become much better at preventing and managing these effects.

The Chair asked about the availability of ctDNA testing for these patients. Dr Barrington explained that the test gives opportunity to establish RAS status without the need for colonoscopy and tumour biopsy. He informed the group that the genomics service are positive about the proposal and would be able to accommodate the additional tests without impacting their turnaround time of approximately 5 days for ctDNA.

The Chair invited questions for the clinical expert from the group. The group asked Dr Barrington if the use of panitumumab would replace a step in the treatment pathway or if it would be expected to be in addition to current treatment options. He explained that they would mainly be considering use in patients who had already received third line trifluridine-tipiracil (Lonsurf®) with bevacizumab. Current treatment options for these patients are regorafenib or best supportive care. In those patients who were eligible he expects panitumumab would replace regorafenib at fourth line.

The group asked why panitumumab was under consideration rather than cetuximab. Dr Barrington explained that there are some ongoing studies looking at cetuximab re-challenge however, all of these are in combination with chemotherapy rather than monotherapy. There are currently no published studies of cetuximab monotherapy rechallenge guided by ctDNA. AWTTC staff confirmed that cetuximab had been considered alongside panitumumab by the AWMSG Scrutiny Panel and had agreed

that there was insufficient evidence for proceeding cetuximab as a monotherapy treatment through the One Wales process.

The group asked for some clarity around the RAS status and ctDNA testing. Dr Barrington explained that these patients will initially have tested as RAS wildtype through tumour biopsy before first line treatment. The repeat test would ensure that patients had reverted to or maintained RAS wildtype since the initial biopsy.

Tom Winfield presented an overview of the cost effectiveness evidence. The Chair invited questions from the group. The group asked Dr Barrington to confirm that the likely line of therapy would be fourth line and what the comparator would be for that setting. Dr Barrington confirmed that panitumumab would most likely be used as fourth line treatment, he informed the group that he personally would not use regorafenib due to toxicity and best supportive care would be his preferred alternative treatment option. He did stress that this was his personal choice and so other oncologists may offer regorafenib at fourth line so agreed that the comparator is likely to be a mix of regorafenib and best supportive care.

The group health economist asked Tom Winfield about the inputs into the cost effectiveness analysis, in particular if the results are biased in favour of treatments with shorter progression free survival due to the assumption that quality of life decreases in a linear fashion rather than being higher pre-progression and lower after progression. Tom acknowledged that this was a limitation of the model presented and that it might have been possible to conduct a partition survival model approach or to apply more nuanced curves to the quality of life trajectory. He concluded that it would be unlikely that either of these approaches would be impactful enough to change the narrative of the analysis.

Rosie Spears presented an overview of the budget impact and of additional factors for consideration. The lay member was then invited to provide comment on the patient and public perspective. The lay member highlighted the expected improvement or maintenance of quality of life for the patient and that this would likely be reflected in an improvement of quality of life for family and carers. From a wider public perspective, as the medicine is likely to provide an advantage for a small group of patients and costs are considered reasonable then there is no reason why the wider public would not agree with this medicine being made available.

The Chair invited questions on the budget impact. The group questioned the discrepancy between IPFR numbers and the estimated numbers provided by the clinical expert. The clinical expert explained that patient numbers are typically lower than estimated in the years following a One Wales recommendation as adoption by multi-disciplinary teams can take time. The numbers provided in the budget impact are therefore likely to be an overestimate initially and then rise in the following years to the estimate provided in the evidence summary by year three. This would be due

to increased uptake and also to an increasing trend in mCRC diagnoses. The group noted that the budget impact therefore is likely to be lower than estimated in the first few years.

The Chair invited the group to ask any further questions not covered in the discussions so far. The group asked about NICE advice for fruquintinib which is undergoing appraisal for previously treated mCRC. Rosie Spears informed the group that on publication of any new NICE advice for this patient group AWTTC would consult the clinical experts to establish if the advice would displace panitumumab for the patient group under consideration. If this was found to be the case then any OWMAG decision would be reviewed ahead of the scheduled review date.

The OWMAG health economist provided an estimate of where the likely incremental cost effectiveness ratio (ICER) would fall if panitumumab were considered as a fourth- or fifth- line intervention and a severity modifier of 1.7 were applied.

The Chair thanked Dr Barrington who left the meeting.

The Chair asked the group if there were any outstanding issues that required discussion before the vote was opened for the panitumumab assessment. The OWMAG recommendation to go to the All Wales Medicines Strategy Group (AWMSG) for endorsement was agreed:

**Date of Advice: Monday 12 May 2025**

Using the agreed starting and stopping criteria panitumumab (Vectibix®) can be made available within NHS Wales for the treatment of stage IV metastatic left-sided colorectal cancer with RAS wildtype confirmed by circulating tumour DNA following successful first line treatment with an epidermal growth factor inhibitor and at least one other treatment.

The risks and benefits of the off-label use of panitumumab (Vectibix®) for this indication should be clearly stated and discussed with the patient to allow informed consent.

Providers should consult the relevant guidelines on prescribing unlicensed medicines before any off-label medicines are prescribed.

This advice will be reviewed after 12 months or earlier if new evidence becomes available.

- **Assessment 2**

**Trametinib (Mekinist®) for the treatment of recurrent low-grade serous ovarian carcinoma (LGSOC) that has progressed after at least one previous platinum-based regimen**

Dr Clare Elliott presented an overview of the key clinical aspects of the trametinib ESR.

The Chair introduced the clinical experts, Dr Louise Hanna and Dr Emma Hudson, both consultant clinical oncologists from Velindre Cancer Centre. The Chair described the role of the clinical expert as an invited observer of the OWMAG meeting to answer questions and input into discussions to enable members to gain a better understanding of the clinical context. The Chair highlighted that clinical experts were nominated by their specialist group or network and should not express personal opinion or promote the use of a medicine. The Chair invited any declarations of interest from the clinical experts; there were none.

Dr Hanna and Dr Hudson provided additional insight into the evidence presented, with respect to the clinical pathway for these patients and where trametinib would most likely sit. They highlighted that because of the low-grade nature of the cancer, it is more resistant to chemotherapy. Quite often, relentless disease progression occurs which doesn't respond to any of the conventional treatments offered. Trametinib would offer an additional treatment which has shown a significant improvement in progression-free survival which would be welcomed by both clinicians and patients. They also said that the American Society of Clinical Oncology issued a recent alert stating that trametinib is now the standard of care for recurrent LGSOC and this approach is increasingly being adopted worldwide. They pointed out that it is made routinely available for this patient population in both NHS England and NHS Scotland. Dr Hanna highlighted that patients with LGSOC tend to be 10-15 years younger than patients with high-grade ovarian cancer and are more likely to be of working age and have dependent children. Both experts stated that patient numbers are expected to be very low at 11 or less per year for the whole of Wales. Dr Hudson also highlighted that some patients would also discontinue treatment due to unacceptable side-effects of trametinib.

The Chair queried about the standard-of-care treatments commonly used in Wales compared to those included in the GOG 281/LOGS study. The experts confirmed that there isn't a standard pathway of treatments in Wales but that three of the five standard-of-care treatments used in the study are commonly used, and although the other treatments are available in Wales, they would be seldom used for this patient population as they are ineffective, and patients are generally not well enough to

receive them. Both clinicians re-iterated that the response to all these standard-of-care treatments is generally poor.

Comment was made from the group about patients from Wales living near the border who may receive treatment for their cancer in England and how they may not have the same access to trametinib as patients resident in England treated at the same centre. The clinical experts highlighted that access to trametinib in Wales is currently via IPFR to the patient's health board. Having all-Wales advice on access for this patient group will avoid any disparity in decisions between IPFR panels which causes difficulty for patients and clinicians alike.

Clare Elliott presented an overview of the cost effectiveness evidence. The Chair invited questions from the group. A query was raised by the group's health economist about the large difference in the ICER reported in the published study and the illustrative one included in the ESR and that the illustrative ICER compared costs with a one-year horizon to lifetime effects and therefore overestimated the cost-effectiveness. Clare Elliott explained that the ICER included in the ESR was simplistic and had a high degree of uncertainty as caveated in the report and should be interpretated with caution. She pointed out that due to the severity of the disease, a severity modifier of between 1.2 and 1.7 would be applied, thus increasing the threshold for cost-effectiveness. The Chair noted that AWTTC considered that a severity modifier of 1.2 may apply in this case. There followed a discussion on the implications of this figure and the potential for a higher modifier to be used. Gail Woodland explained that the cost-effectiveness of this intervention in NHS Wales cannot be established from the evidence available, although simplistic analysis would indicate it is likely to be favourable, and that the group should instead focus on the value of trametinib in terms of the difference in cost between it and standard-of-care comparators used in Wales and the increased benefits in survival and quality of life.

Clare Elliott presented an overview of the budget impact and of additional factors for consideration. Following on from the presented summary of the health equality impact assessment, group members raised the Welsh Government Women's Health Plan for Wales to improve healthcare services for women as an additional factor for consideration. The clinical experts also highlighted increased government focus on the treatment of gynaecological cancers in Wales following the publication of a report by the Senedd's Health and Social Care Committee in 2023. The lay member was then invited to provide comment on the patient and public perspective. The lay member highlighted the inequity of access to this treatment in Wales compared to England and Scotland. He also commented that this treatment may allow patients to be able to contribute for longer to their communities and society and have more time with their families. From a wider public perspective, as the medicine is likely to provide benefit for a small group of patients and costs are considered reasonable,

there is no reason why the public of Wales would not agree with this medicine being made available.

The Chair thanked Dr Hudson and Dr Hanna who left the meeting.

The Chair asked the group if there were any outstanding issues that required discussion before the vote was opened for the trametinib assessment. The OWMAG recommendation to go to AWMSG for endorsement was agreed:

**Date of Advice: Monday 12 May 2025**

Using the agreed starting and stopping criteria trametinib (Mekinist®) can be made available within NHS Wales for the treatment of recurrent low grade serous ovarian carcinoma (LGSOC) which has progressed following at least 1 previous platinum-based regimen.

The risks and benefits of the off-label use of trametinib (Mekinist®) for this indication should be clearly stated and discussed with the patient to allow informed consent.

Providers should consult the relevant guidelines on prescribing unlicensed medicines before any off-label medicines are prescribed.

This advice will be reviewed after 12 months or earlier if new evidence becomes available.

The Chair thanked the group and closed the meeting at 12.45 pm