Tislelizumab

REFUSÉE

Le Comité d'experts, après évaluation, refuse d'inscrire le médicament proposé dans la demande.
La Liste Modèle des Médicaments Essentiels fait état des raisons que les membres du Comité ont identifiées pour refuser l'inscription.

Section: 8. Immunomodulators and antineoplastics > 8.2. Antineoplastics and supportive medicines > 8.2.3. Immunomodulators

Codes ATC: L01FF09

Indication	Malignant neoplasms of urinary tract Code ICD11: 2C9Z
INN	Tislelizumab
Type de médicament	Biological agent
Type de liste	Liste complémentaire
Formulations	**Parenteral > General injections > IV:** 100 mg per 10 mL
Historique des statuts LME	Demande refusée en 2021 (TRS 1035)
Sexe	Tous
Âge	Adolescents et adultes
Équivalence thérapeutique	La recommandation concerne ce médicament spécifique
Renseignements sur le brevet	Main patent is active in several jurisdictions. For more information on specific patents and license status for developing countries visit www.MedsPal.org Lire la suite sur les brevets.
Balises	Cancer
Wikipédia	Tislelizumab
DrugBank	Tislelizumab

Recommandation du comité d'experts

The Expert Committee noted that bladder cancer is a common malignancy worldwide and accounts for the vast majority of cases of urothelial carcinoma. The Committee noted that the EML currently includes the medicines in the cisplatin-based chemotherapy protocols that are considered the standard of care for first-line treatment of locally advanced and metastatic urothelial carcinoma. However, evidence for their use in the treatment of urothelial cancer has not been specifically reviewed. The Committee considered that the application for inclusion of tislelizumab on the EML for locally advanced or metastatic urothelial cancer was premature. The available data for the efficacy and safety of tislelizumab in patients with urothelial carcinoma were limited to one single-arm, non-randomized, open-label phase II study. Comparative evidence of efficacy and safety versus other treatments was also lacking. The available data were therefore considered insufficient to evaluate the benefits and harms of tislelizumab for listing as an essential medicine. The Committee also noted that tislelizumab is expensive, its cost–effectiveness is not known, and it has very limited global regulatory approval and availability. Therefore, the Committee did not recommend inclusion of tislelizumab on the EML as a second-line treatment for locally advanced or metastatic urothelial carcinoma. However, the Committee recognized the potentially important role of immune checkpoint inhibitors, as a therapeutic class, in the treatment of platinum-refractory urothelial cancer.

The Committee advised that it would welcome an application, with more mature data, and including all immune checkpoint inhibitors used in the treatment of urothelial cancer, for consideration for EML listing in the future. The Committee also considered that immune checkpoint inhibitors could be flagged to the Medicines Patent Pool as candidates for consideration for negotiating public health-oriented licences, noting that negotiating such licences can take some time. The outcome of negotiations might provide important insight for future EML consideration on potential accessibility of this class of medicines in low- and middle-income countries.

Contexte

Tislelizumab has not previously been considered for inclusion on the Model List. The Model List does not currently include medicines specifically for the treatment of urothelial carcinoma in any line of therapy.

Pertinence pour la santé publique

Urothelial carcinoma refers to tumours in the epithelial structure from the kidney's exit to the urethra. About 90–95% of urothelial carcinoma tumours originate from the bladder, with the remainder from the ureter, renal pelvis and proximal urethra (1). In 2020, bladder cancer ranked as the 11th most common tumour worldwide and 14th for mortality (2). According to GLOBOCAN, there were about 570 000 new cases of bladder cancer in 2020 and an estimated 212 000 deaths. The global age-standardized incidence and mortality rates were 5.6 and 1.9 per 100 000 persons, respectively (2). The survival rate of bladder cancer patients decreases with disease progression and relapse tends to occur early (3). Patients with distant metastases have a poor prognosis due to the inability to remove the tumour surgically and lack of effective treatments. In these patients the 5-year relative survival rate is about 5% (4). For the past 30 years, cisplatin-based combination chemotherapy has been the standard treatment for locally advanced/metastatic urothelial carcinoma. Classical therapies include: gemcitabine and cisplatin; methotrexate, vinblastine, doxorubicin and cisplatin; and dose-dense methotrexate, vinblastine, doxorubicin and cisplatin (5,6). The overall response rate to these treatments is about 40–50% and the median overall survival is about 14–15 months. However, about 40–50% of patients with metastatic urothelial carcinoma cannot tolerate cisplatin treatment due to their poor physical condition or impaired renal function. These patients can only use carboplatin-based treatment options, which have an overall response rate of about 30–40% with a median overall survival of 9–10 months (7,8). There is currently no standard second-line treatment for people with locally advanced/metastatic urothelial carcinoma and disease progression after first-line chemotherapy. Paclitaxel, pemetrexed, docetaxel, gemcitabine and doxorubicin are commonly used clinically, but their efficacy is limited with an overall response rate of about 12% and overall survival of 5–7 months (8,9).

Bénéfices

The application presented the results of study BGB-A317-204, a single-arm, non-randomized, open-label, multicentre phase II trial conducted in China and South Korea that assessed the efficacy and safety of tislelizumab in 113 participants with locally advanced or metastatic urothelial carcinoma, who had disease progression with platinum-based chemotherapy and who had not received prior PD-(L)1 inhibitor treatment and who had ≥ 25% of tumour/immune cells expressing PD-L1 (10). The primary endpoint was the overall response rate assessed by an independent review committee. After median follow-up of 9.4 months, 20 (18%) participants continued to receive tislelizumab, while the remaining 93 (82%) discontinued treatment. Reasons for discontinuation were disease progression (53 participants), adverse events (19 participants), withdrawn consent (11 participants) and symptomatic deterioration (10 participants). Of 104 patients who could be evaluated, a confirmed objective response was observed in 25 (overall response rate (ORR) 24%, 95% confidence interval (CI) 16% to 33%), including 10 patients with complete response and 15 with partial response as assessed by the independent review committee. Median progression-free survival and overall survival were 2.1 months (95% CI 2.0 to 3.2 months) and 9.8 months (95% CI 7.5 to 12.5 months), respectively. Direct comparative data of tislelizumab with other PD-1 monoclonal antibodies for urothelial carcinoma are lacking. The application presented indirect comparisons of efficacy reported for tislelizumab (10), atezolizumab (11,12), durvalumab (13), avelumab (14), nivolumab (15) and pembrolizumab (16,17). Objective response rates (among PD-L1 positive patients, defined differently across the

studies) were 24% for tislelizumab, 23–26% for atezolizumab, 28% for durvalumab, 24% for avelumab, 28% for nivolumab and 20–30% for pembrolizumab.

Torts

Safety results from study BGB-A317-204 were presented in the application (10). In this study, 106 (94%) participants experienced at least one adverse effect considered to be related to tislelizumab by the investigator. The most common treatment-related adverse events were anaemia (27%) and pyrexia (20%). Most treatment-related adverse events were grade 1–2 in severity. Anaemia (7%) and hyponatraemia (5%) were the only grade 3 or 4 events occurring in ≥ 5% of participants. Treatment-related adverse events led to treatment discontinuation in 14% of participants. Serious treatment-related adverse events occurred in 37% of participants, the most common being pyrexia (4%), and upper respiratory tract infection, urinary tract infection and drug eruption (3% each). Among seven participants with a treatment-related adverse event leading to death, three were considered possibly related to the study treatment by the investigators (hepatic failure, two participants; respiratory arrest, one patient). In the study, 27% of participants experienced immune-related adverse events; events affecting ≥ 5% of participants included skin adverse reactions (12%), hypothyroidism (11%) and hyperthyroidism (6%). Eight (7%) participants had immune-related adverse events of grade ≥ 3; no fatal immune-related adverse events were reported. Overall, safety information of tislelizumab comes from two single-agent clinical studies of the use of tislelizumab in solid tumours (18,19) and a single-agent study of tislelizumab in Hodgkin lymphoma (20), involving a total of 821 participants. The tumour types of the participants included in these studies varied and included 39 participants with urothelial carcinoma. Participants received tislelizumab at a dose of either 200 mg or 5 mg/kg every 3 weeks. The median administration time of tislelizumab was 16 weeks (range 0.6–162 weeks). Tislelizumab treatment continued for at least 6 months in 35.7% of participants, while 20.0% of participants received tislelizumab treatment at least 12 months. The incidence of adverse events of all grades was 71.0% among the 821 participants treated with tislelizumab. Adverse events with an incidence ≥ 10% included fatigue, rash, hypothyroidism, increased alanine aminotransferase and increased aspartate aminotransferase. Since tislelizumab has only completed a single-arm phase II clinical trial, and the phase III clinical trial comparing tislelizumab with other products is still in progress, no comparative safety data with other PD-1 monoclonal antibodies are available.

Rapport coût/efficacité

No cost–effectiveness analysis data for tislelizumab were presented in the application. Tislelizumab is priced at ¥ 10 688 per vial. The administered dose used in the phase II trial was 200 mg every 3 weeks. Vial prices for alternative anti-PD1 monoclonal antibodies presented in the application were US$ 6495 for nivolumab (240 mg/24 mL), US$ 3671 for durvalumab (500 mg/10 mL) and US$ 4800 for pembrolizumab (100 mg/4 mL). The China Primary Health Care Foundation, in conjunction with BeiGene, initiated the Patient Assistance Programme “Wei Ni, Qian Fang Bai Ji”. This programme reduces the cost of first-time medication and the cost for patients who need long-term medication. Patients only need to pay for five cycles of treatment and get 1 year of medical treatment. The minimum annual treatment cost is about ¥ 106 900.

Directives de l'OMS

WHO guidelines for the treatment of urothelial carcinoma are not available.

Disponibilité

Tislelizumab received regulatory approval from the National Medical Products Administration of the People’s Republic of China in April 2020 for the treatment of patients with locally advanced or metastatic urothelial carcinoma with high PD-L1 expression, who have failed prior platinum-containing chemotherapy and whose disease has progressed within 12 months. Tislelizumab was not approved for marketing and use by other national regulatory agencies at the time of EML consideration.

Autres considérations

Tislelizumab has not yet been scored on the European Society for Medical Oncology's magnitude of clinical benefit scale for this indication (21). The application was reviewed by the EML Cancer Medicines Working Group. The Working Group advised that it did not support the inclusion of tislelizumab on the EML for treatment of urothelial carcinoma at this time, noting that the available data for efficacy and safety are very limited (early phase trials, with small patient numbers and with short follow-up), the cost of tislelizumab is high and its cost–effectiveness is not known for this indication. Comments were received from the WHO Department of Noncommunicable Diseases which advised that, in line with the findings from the EML Cancer Medicines Working Group, there were insufficient mature data on the efficacy and safety of tislelizumab. The technical department suggested that tislelizumab for this indication could be reconsidered in the future based on additional evidence and increased understanding of the feasibility of its appropriate use in low-resource settings.

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