Rethinking the Approach to Expanded Access Programs

Forum for Collaborative HIV Research

TMC114 EAP

16th February 2007

Karen Manson

Agenda

- TMC114 EAP summary statistics to date
- Key learnings
- Numbers ..
- Why don’t sites participate
- Administrative burden
- Reimbursement
- Data collection
- What’s needed?

TMC114 EAP

- Started during enrollment of phase 3 program
- Start/finish (end of enrollment) dates
  - USA: 5 October 2005 - 26 June 2006
  - Europe/ROW: 7 November 2005 - ongoing
    - except Switzerland - finished 12 January 2007
- 45 countries have/have had the TMC114 EAP
    - either clinical trial or Named Patient program
- Patients enrolled
  - US ~ 900
  - ROW still recruiting
- Gender - 85% male
- Race
  - 67% white/Caucasian; 12% black; other 21%

Learnings

- Company perspective
  - Past is not a good predictor of the future
  - Forecasting need & supply management
  - Choice of EAP approach - clinical trial or NPP
  - Lack of clearcut guidelines
  - Communication versus promotion
  - Data collection
- Physician/patient perspective
  - Timing of start
  - Administrative burden
  - Reimbursement
  - Data collection

Numbers ..

- Objective: Provide access as broadly as possible to patients in need
- 45 countries currently provided expanded access to PREZISTA
  - Expect that 50 countries will provide early access
- EAP sites
  - US: initiated sites = 225
    - Sites enrolling 1 or more patients = 166
    - ~15% approached declined to participate, others didn't respond, others didn't reach initiation
  - ROW: sites able to enroll ~470 (to 1st Feb 2007)

Why didn't sites participate

- Lack of patients needing new drugs
- Lack of 2 active agents
- Administrative burden
- Insufficient reimbursement
- Competition for time/resources from clinical trials
- Insufficient time to complete initiation

- Is there EAP fatigue?

Reducing administrative burden

- Major obstacle for clinical trial EAPs!
- Learnings
  - Simplify CRFs and paperwork
  - For aim to have SOC as protocol
    - Limit labs to SOC
    - Minimise need for exemptions eg lab tests
    - Minimise need for amendments
  - Use of 2nd investigational agent
    - Huge effort but significant patient benefit
  - CROs work to normal CT SOPs
- Is there a way to minimize admin burden of set-up?
- Will we see a move toward NPP?
  - Safety monitoring?

Need for transparent payment structure

- EAPs meet a critical medical need but substantial work required
  - Nowadays fewer patients/site
- Fixed fees - pharmacy, ethics
- Up-front/set-up fee
- Per patient fee

- What is appropriate?
  - Meeting clinical need
    - Risk of being seen to promote recruitment
  - Not a clinical trial
    - Data not of benefit to registration package
  - What fees do health authorities allow?

Data collection

- Do we collect too much data? What is it used for?

- Limited value for publications
- Sick patients - SAEs mostly not drug-related

- What is really needed?
  - CD4, VL, ALT, AST …

Health authorities and ethics committees

- Lack of guidelines on how to provide access prior to product being approved in first country
- Limited understanding about objectives of EAP resulting in lot of discussion with authorities in smaller countries
- Fast-changing guidelines
- Legislation doesn't distinguish between clinical trial and EAP CT

EAP in 2007

- What is really needed today?
- What are criteria for success?
  - # of patients surviving as a result of drug access prior to approval ?
- What is the best approach
  - EMEA harmonization ?
- What should we pay?
  - Should governments/MOH pay?
- What data should we collect?