HCV TRIALS IN THE POST-APPROVAL ERA OF TELAPREVIR AND BOCEPREVIR

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A. Is it appropriate to use P/R control arms any longer? What would be the rationale?

B. What is best control arm for P/R + new single DAA regimen for tx-naïve subjects? For tx-experienced subjects?

C. Is there value in having data from a P/R-only control arm?

D. If a P/R control arm is used, is a rollover feature essential and what should it look like?

E. Are there circumstances when a control arm (either P/R or current SOC) is not necessary or appropriate for evaluation of a P/R + new single DAA regimen? Under what circumstances can historical controls be used (e.g., pediatrics, HIV)?

F. What is best control arm for P/R + multiple DAA regimen?

G. What patient populations should be studied for P/R + multiple DAA regimen?

H. What are the most appropriate trial designs and control arms for trials for patients who have failed a P/R + NS3/4A protease inhibitor regimen? Should trials evaluating this patient group now be included or even required in HCV drug development programs?

Session 2: Control Arms for Interferon-Sparing DAA (+/- RBV) Trials

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A. What preclinical and clinical data should be considered for trials using interferon-free regimens for double and triple DAA combinations, either with or without ribavirin?

   I. How can the contribution of each DAA in a regimen be established and what is the level of data required?

   II. When using multiple DAAs how can liver-related safety signals be assessed in a background of hepatitis?

   III. Are there regimens that should no longer be proposed?

B. Under what circumstances should genotypes 1a and 1b be studied in different cohorts or with different regimens?

C. What should be the main stratification factors for DAA combination studies? Should patients be stratified for IL28B or should its impact be studied retrospectively?

D. What information is required to include cirrhotics in DAA combination studies?

E. In a phase 3 trial, what would be the best control arm for a new combination DAA regimen for P/R tx-naïve subjects? For tx-experienced subjects?

F. Should a P/R + DAA (single or multiple, or current SOC) control arm be required for evaluation of an interferon-free combination DAA regimen? If so, for what populations?

G. Under what circumstances can historical controls be used? What size margin of treatment effect compared to a historical control is appropriate?

H. Is a blinded trial design necessary? If so, under what circumstances?

I. What should we do about interferon-incapable patients? Should they be studied separately? How should they be defined?

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Session 3: Logistical Issues with Choice of Control Arms in International Trials

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A. How does the availability of interferon, ribavirin, telaprevir and boceprevir affect the ability to conduct trials (Regional regulatory and access issues)?

B. Can P/R trials enroll patients in areas where telaprevir and boceprevir are available? How can this be presented to patients?

C. Are there trials that are not feasible/ethical in certain regions?

D. Ethical considerations in using peginterferon and ribavirin arm in some trials while others use the new SOC.

E. Complexities of different treatment regimens, particularly response-guided therapy…when is it OK to alter the approved regimen (e.g., TVR BID, LOD/LOQ for RGT, P/R lead-in)? What are the risks of doing this?

F. Impact of longer duration of control arm in delaying completion of trial.

G. Sharing of clinical trial data and other pertinent information by pharmaceutical companies.

H. Are there other important clinical trial design issues that need to be addressed in the immediate future to avoid delays in development programs?

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