Healthcare Improvement Scotland | SMC Advice on new medicines

SMC2446

sacituzumab govitecan 180mg powder for concentrate for solution for infusion (Trodelvy®)

Gilead Sciences Ltd

4 February 2022

The Scottish Medicines Consortium (SMC) has completed its assessment of the above product and advises NHS Boards and Area Drug and Therapeutic Committees (ADTCs) on its use in NHSScotland. The advice is summarised as follows:

ADVICE: following a full submission assessed under the end of life and orphan equivalent process.

sacituzumab govitecan (Trodelvy®) is accepted for use within NHSScotland.

Indication under review: Treatment of adult patients with unresectable locally advanced or metastatic triple-negative breast cancer (mTNBC) who have received two or more prior lines of systemic therapies, at least one of them given for unresectable locally advanced or metastatic disease.

Sacituzumab govitecan, compared with a range of single-agent chemotherapies, significantly improved progression free survival and overall survival in adults with mTNBC, without brain metastases, who had received at least two prior chemotherapy regimens including a taxane.

This advice applies only in the context of an approved NHSScotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/ list price that is equivalent or lower.

This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting.

Chairman
Scottish Medicines Consortium

Indication

Treatment of adult patients with unresectable locally advanced or metastatic triple-negative breast cancer (mTNBC) who have received two or more prior lines of systemic therapies, at least one of them given for unresectable locally advanced or metastatic disease.[1]

Dosing Information

Sacituzumab govitecan 10mg/kg administered as an intravenous (IV) infusion once weekly on Days 1 and 8 of 21-day treatment cycles. Continue treatment until disease progression or unacceptable toxicity. The initial infusion should be administered over 3 hours, with subsequent infusions given over 1 to 2 hours if prior infusions were tolerated. Patients must be observed during the infusions and for at least 30 minutes after, for signs or symptoms of infusion-related reactions. Premedication for prevention of infusion reactions and prevention of chemotherapy-induced nausea and vomiting is recommended and detailed in the summary of product characteristics (SPC), which also provides information on dose modifications to manage infusion reactions and adverse events.

Sacituzumab govitecan must only be prescribed and administered to patients by healthcare professionals experienced in the use of anti-cancer therapies and should be administered in an environment where resuscitation facilities are available.[1]

Product availability date

10 September 2021

Sacituzumab govitecan meets SMC end-of-life and orphan equivalent criteria.

Sacituzumab govitecan received an Innovation Passport allowing entry into the Innovative Licensing and Access Pathway.

Summary of evidence on comparative efficacy

Sacituzumab govitecan is a trophoblast cell surface antigen-2 (Trop-2) antibody-drug conjugate. Sacituzumab (an anti-Trop-2 antibody) is attached to SN-38, a topoisomerase I inhibitor, by a linker. After sacituzumab govitecan binds to Trop-2-expressing cancer cells, it enters the cell and undergoes hydrolysis to release SN-38, which causes DNA damage, apoptosis and cell death.[1]

An open-label phase III study (ASCENT) recruited patients with mTNBC that was relapsed or refractory after at least two standard chemotherapy regimens for unresectable, locally advanced or metastatic disease, which included a taxane. Patients had an Eastern Cooperative Oncology Group (ECOG) performance score of 0 or 1. Randomisation was stratified by number of previous chemotherapy regimens for advanced disease (2 or 3 versus >3), presence of brain metastases (yes versus no) and geographic region (North America versus rest of the world). Patients were equally assigned to sacituzumab govitecan 10mg/kg IV infusion on days 1 and 8 of 21-day cycle or single-agent chemotherapy as determined before randomisation (eribulin 1.4mg/m^2 in North America or 1.23mg/m^2 in Europe IV on days 1 and 8 of 21-day cycle; vinorelbine 25mg/m^2 IV on

day 1 weekly; capecitabine 1000 to 1250mg/m^2 orally twice daily on days 1 to 14 of 21-day cycle; or gemcitabine 800 to 1200mg/m^2 IV on days 1, 8, and 15 of 28-day cycle). Treatment continued until disease progression or unacceptable toxic effects. The primary outcome was progression-free survival (PFS), defined as the time from randomisation to death or progression assessed by blinded independent central review (ICR) using Response Evaluation Criteria in Solid Tumours (RECIST) version 1.1. This was primarily assessed in patients without known brain metastases at baseline. Overall survival was included in a hierarchical testing strategy, which assessed both outcomes in the primary analysis group and then the total study population .[2,3]

At the data cut-off 11 March 2020, in the primary analysis population (that is, patients without brain metastases) median follow-up was 17.7 months (range 5.8 to 28.1). Sacituzumab govitecan compared with chemotherapy significantly improved PFS and overall survival in the primary analysis population and overall study population. Overall response rate (ORR), which was not included in the hierarchical testing, appears greater with sacituzumab govitecan. Results are detailed in Table 1 below.[2]

Table 1: Primary and key secondary outcomes of ASCENT study.[1,2,4]

	Primary analysis population		Total population	
	Sacituzumab (N=235)	**Chemotherapy (N=233)**	**Sacituzumab (N=267)**	**Chemotherapy (N=262)***
Progression free survival (ICR-assessed, RECIST v1.1)				
PFS Events	166	150	190	171
Hazard ratio (95% CI)	0.41 (0.32 to 0.52), p<0.001		0.43 (0.35 to 0.54), p<0.001	
Median, months	5.6	1.7	4.8	1.7
Overall Survival				
Deaths	155	185	179	206
Hazard ratio (95% CI)	0.48 (0.38 to 0.59), p<0.001		0.51 (0.41 to 0.62), p<0.001	
Median	12.1	6.7	11.8	6.9
Best overall response (ICR-assessed, RECIST v1.1)				
ORR, n (%)	82 (35)	11 (4.7)	83 (31)	11 (4.2)
Odd ratio (95% CI)	10.9 (5.6 to 21.1)		**	
Complete, n (%)	10 (4.2)	2 (0.9)	10 (3.7)	2 (0.8)
Partial, n (%)	72 (31)	9 (3.9)	73 (27)	9 (3.4)
Duration of overall response				
Median, months	6.3	3.6	6.3	3.6

ORR = overall response rate, defined as complete or partial response assessed by independent central review (ICR) on response evaluation criteria in solid tumours (RECIST) version 1.1; CI = confidence interval; * Chemotherapy choice was eribulin for 139 (53%), capecitabine for 33 (13%), gemcitabine for 38 (14%) and vinorelbine for 52 (20%).** SMC is unable to present this result

Health Related Quality of Life (HRQoL) was assessed using the European Organisation for Research and Treatment of Cancer Quality-of-Life Questionnaire-Core 30 (EORTC QLQ-C30). There was no difference between the groups in change from baseline for global health status at each cycle from 1 to 10 and at end-of-treatment visit.[5]

*Other data were also assessed but remain confidential.**

Summary of evidence on comparative safety

In the ASCENT study at data cut-off 11 March 2020, the median duration of treatment in the sacituzumab govitecan group was 4.4 months and in the chemotherapy group was between 1.0 and 1.6 months for the various medicines (1.6 months for eribulin, 1.2 months for capecitabine, 1.4 months for gemcitabine and 1.0 months for vinorelbine). In the sacituzumab govitecan and chemotherapy groups adverse events were reported by 99.6% (257/258) and 98% (219/224) of patients and these were considered treatment-related in 98% and 86%, respectively. Serious adverse events were reported by 27% and 28% and these were considered treatment-related in 15% and 8.5%, respectively. Adverse events lead to a dose reduction in 22% and 26%, drug interruption in 63% and 39% and treatment discontinuation in 4.7% and 5.4%, respectively.[2,5]

Within the sacituzumab govitecan group, compared with the chemotherapy group, there were higher rates of treatment-related haematological adverse events such as neutropenia (63% versus 43%), anaemia (34% versus 24%) and leucopenia (16% versus 11%) but a lower incidence of thrombocytopenia (5.4% versus 11%). There were also higher rates of treatment-related gastrointestinal adverse events including diarrhoea (59% versus 12%), nausea (57% versus 26%), vomiting (29% versus 10%), constipation (17% versus 14%) and abdominal pain (11% versus 4.0%). Treatment-related fatigue (45% versus 30%) and alopecia (46% versus 16%) were also reported more frequently with sacituzumab govitecan.[2]

Summary of clinical effectiveness issues

Patients with mTNBC (defined by a lack of tumour-cell expression of the oestrogen receptor, progesterone receptor, and human epidermal growth factor receptor 2 [HER2]) have poor survival outcomes. After initial treatment, which may include immunotherapy, single-agent chemotherapy remains the standard of care.[2] The European Society of Medical Oncology (ESMO) guidelines on advanced breast cancer note that for most patients chemotherapy remains the only available non-investigational systemic treatment option for non-BRCA-mutated advanced TNBC, with no specific recommendations regarding types of agents, with the possible exception of platinum compounds for patients with BRCA-mutated advanced TNBC.[6] The 2021 National Institute of Health and Care Excellence (NICE) pathway for treatment of advanced breast cancer notes that patients with TNBC who are not suitable for anthracyclines, should be offered systemic chemotherapy in the following sequence: single-agent docetaxel, single-agent vinorelbine or capecitabine and then single-agent capecitabine or vinorelbine (whichever not used second-line). The pathway also references NICE technology assessments for other medicines including gemcitabine and eribulin.[7] SMC has issued advice for capecitabine (number 34/03), vinorelbine (number 324/06), gemcitabine (number 154/05) and eribulin (number 1065/15) that permits their use in mTNBC after at least two prior lines of therapy.

Clinical experts consulted by SMC advised that single-agent chemotherapies are used to treat mTNBC after at least two previous lines of therapy. These can include capecitabine, eribulin, carboplatin, cisplatin, gemcitabine and vinorelbine. However, they noted that these medicines

have limited efficacy and response rates. Clinical experts consulted by SMC considered that sacituzumab govitecan fills an unmet need in this therapeutic area, namely improved efficacy and response rates.

Key strengths

- Sacituzumab govitecan is the first antibody-drug conjugate combining a Trop-2 directed antibody and a topoisomerase I inhibitor licensed in the UK for mTNBC, where it is indicated for use in patients who have received two or more prior lines of systemic therapies, at least one of them given for unresectable locally advanced or metastatic disease.[1] In this indication it meets SMC end-of-life and orphan equivalent criteria.

- In the ASCENT study sacituzumab govitecan, compared with single-agent chemotherapies, significantly improved PFS and overall survival by approximately 4 and 5.5 months, respectively, in patients without brain metastases. ORR appeared approximately 30% greater with sacituzumab govitecan in these patients also.[2]

- In the primary analysis and total study populations, subgroup analysis of PFS and overall survival were generally consistent with the primary analyses across subgroups defined by various baseline characteristics and by type of chemotherapy in the control group.[2,5,8]

Key Uncertainties

- There are limited data in patients with brain metastases as these patents comprised 12% (61/529) of the study population and were excluded from the primary analysis. Subgroup analyses in the group with stable previously treated brain metastases indicated that the PFS stratified hazard ratio (HR) was 0.65 (95% CI: 0.35 to 1.22), with median PFS of 2.8 and 1.6 months in the sacituzumab govitecan and chemotherapy groups, respectively. The overall survival stratified HR was 0.87 (95% CI: 0.47 to 1.63), with median overall survival of 6.8 and 7.5 months in the respective groups. This suggests less benefit with sacituzumab govitecan in patients with brain metastases.[1]

- Due to the open-label design fewer patients assigned to sacituzumab govitecan compared with chemotherapy did not commence study treatment: 3.4% (9/267) versus 14% (38/262) in the total study population[5] and 3.0% (7/235) versus 14% (32/233) in the primary analysis subgroup.[2] Some patients in the chemotherapy group elected not to participate in the study when they were not randomised to sacituzumab govitecan.[5] Patients who did not receive study treatment were included in analyses of PFS and overall survival, although PFS analyses censored patients who received alternative anticancer treatment before progressive disease.[5]

- There was no adjustment for multiplicity in the analyses of ORR, duration of response, health-related quality of life on EORTC CLC-C30 and the study was not powered to assess these outcomes.

- The chemotherapy group comprised a range of medicines, which may have produced a greater array of adverse events than with one particular single-agent chemotherapy. The study was not powered to assess efficacy of sacituzumab govitecan versus individual chemotherapies.

Despite the uncertainties, the clinical case is considered acceptable.

Clinical experts consulted by SMC considered that sacituzumab govitecan is a therapeutic advance due to improved efficacy compared with current alternative chemotherapy treatment options. They believe that it would be used in place of these medicines.

Patient and clinician engagement (PACE)

A patient and clinician engagement (PACE) meeting with patient group representatives and clinical specialists was held to consider the added value of sacituzumab govitecan, as an end-of-life and orphan equivalent medicine, in the context of treatments currently available in NHSScotland.

The key points expressed by the group were:

- Metastatic triple negative breast cancer is an incurable, aggressive disease with poor, life-limiting prognosis. It has substantial physical and psychological impact on patients and may limit their ability to work, socialise and care for family.
- Patients who have received at least two prior lines of therapy have few treatment options, all of which have limited efficacy. At this stage of disease, there is an unmet need for effective treatment options that extend progression-free and overall survival with acceptable tolerability.
- In the trial, sacituzumab govitecan, compared with standard chemotherapies, prolonged progression-free survival and overall survival in patients with mTNBC who had received at least two prior line of therapy. These benefits are unprecedented at this stage of the disease and particularly remarkable as the population was heavily pre-treated, with many in the trial at a later stage of disease than those likely to be treated in practice.
- Improved progression-free and overall survival would allow the patient more time to continue to work, care for family, socialise, achieve milestones, plan and make memories. The impact of this for those with young children and their families would be immense.
- Many patients are aware of the benefits with sacituzumab govitecan, which is regarded as a novel highly effective medicine. Access may provide reassurance that they are receiving the optimum treatment and this can have psychological benefits. Some patients may derive hope that increased survival with sacituzumab govitecan may be a bridge to future novel therapies
- Although side effects with sacituzumab govitecan are more frequent than with chemotherapy, patients are willing to endure these to obtain the survival benefits. There is clinical experience of using sacituzumab govitecan already though compassionate use programmes and clinicians noted that the adverse effects can be effectively managed.
- Treatment with sacituzumab govitecan would require more visits to hospital compared to treatment with some orally administered chemotherapies but patients consider this manageable in view of the potential benefits of treatment.

Additional Patient and Carer Involvement

We received patient group submissions from Breast Cancer Now and METUP UK. Breast Cancer Now is a registered charity and METUP UK is a charitable incorporated organisation. Breast Cancer Now has received 4.25% pharmaceutical company funding in the past two years, including from the submitting company. METUP UK has not received any pharmaceutical company funding in the past two years. Representatives from both organisations participated in the PACE meeting. The key points of their submissions have been included in the full PACE statement considered by SMC.

Summary of comparative health economic evidence

The company submitted a cost-utility analysis of sacituzumab govitecan indicated for the treatment of adult patients with unresectable locally advanced or mTNBC who have received two or more prior lines of systemic therapies, with at least one of them given for unresectable locally advanced or metastatic disease. The economic analysis was presented against physician's choice of single agent chemotherapy – either eribulin, vinorelbine, gemcitabine, or capecitabine

A partitioned survival model was implemented, comprising three mutually-exclusive health states that represent the disease course and survival of patients over time: 'progression-free (PF)', 'progressed disease (PD)' and 'death' as the absorbing state. The cycle length was one-week with patients either remaining in the starting PF state, or transitioning to the disease progression state or death at the end of each cycle. An NHS perspective and a 10-year time horizon were selected in the base case of the economic model.

Key effectiveness data for sacituzumab govitecan and single agent chemotherapy were taken from the ASCENT study. [2,3] Pooled efficacy of single agent chemotherapies was used to quantify effectiveness of the comparator arm. The outcomes from ASCENT were PFS and overall survival, which were determinants of treatment effect in the economic model. Fully mature data from ASCENT (March 2020 cut-off), with a median follow up of 17.7 months, were used to model long-term extrapolations for the economic analysis.

Fitting of parametric curves to survival data was performed under the assumption that the underlying conditional hazard profile is described by some continuous function of time. For both PFS and overall survival, examination of the hazard plots for sacituzumab govitecan and the chemotherapy arm did not show distinct portions of the hazard profile, hence the use of semi-parametric or spline models was not warranted.

Separate parametric curves were fitted to treatment arms to extrapolate PFS. Statistically, the log-normal and the log-logistic distributions provided the best fit to the observed PFS data for sacituzumab govitecan and chemotherapy respectively. Visual assessment provided further confirmation that these distributions were appropriate for the base case analysis. The log-normal distribution for sacituzumab govitecan predicted a median PFS of 4.62 months which was slightly lower than the observed median of 4.8 months.

Jointly fitted parametric curves were fitted to treatment arms to estimate overall survival. The log-logistic distribution was selected for sacituzumab govitecan and chemotherapy based on the best

overall statistical fit and long-term survival projections. The model predicted 10.93%, 4.55% and 1.30% of patients treated with sacituzumab would survive at three, five and ten years respectively.

In the model, treatment duration was modelled independently from efficacy, although the input parameters of the PFS and time to treatment discontinuation (TTD) curves were naturally correlated. For long-term projection of TTD, parametric fitting was selected as the most appropriate approach based on input from clinical advisors. The exponential distribution was selected based on the goodness-of-fit statistics and visual inspection of the predicted vs. observed TTD curves.

Treatment specific utilities were applied in the model. Utility values were based on EORTC QLQ-C30 data from the ASCENT study, which were then mapped to EQ-5D-3L scores. A total of 411 patients were considered eligible for inclusion in the utility regression analysis. The mean utility at baseline was 0.662 (95% CI: 0.641, 0.683). In general, the mean utility observed at baseline and at scheduled cycle visits in the sacituzumab govitecan treatment arm was higher than in the chemotherapy arm. Multivariate regression analyses indicated that treatment arm and progression status had significant impact on EQ-5D utility. Base case utilities are presented in Table 2.

Table 2: Utility model including treatment arm and progression status as predictors

Health state	Health state	Utility value	SE	95% CIs
Progression-free	SG	0.710	0.010	0.690-0.730
	TPC	0.626	0.013	0.601-0.651
Progressed disease	SG	0.653	0.012	0.631-0.676
	TPC	0.569	0.013	0.543-0.596

CI = confidence interval; SE = standard error; SG = sacituzumab govitecan; TPC = treatment of physician's choice

The difference in PFS was attributed to higher, durable response rates with sacituzumab govitecan compared to chemotherapy, resulting in better symptom control (eg pain). Post-progression utilities also remained higher in the sacituzumab govitecan arm, which was attributed to a lower tumour burden for patients at the time of progression and the availability of eribulin for a larger proportion of patients after progression.

Acquisition costs for sacituzumab govitecan, single agent chemotherapies and subsequent treatments were included in the analysis. Unit costs for disease management, managing adverse events, co-medications and end of life care were also accounted for.

A Patient Access Scheme (PAS) was submitted by the company and was assessed by the Patient Access Scheme Assessment Group (PASAG) as acceptable for implementation in NHS Scotland. Under the PAS, a simple discount was offered on the list price for sacituzumab govitecan. A comparator PAS is also in place for eribulin.

The results presented below do not take account of the PAS for sacituzumab govitecan or the PAS for eribulin but estimates of the PAS were considered in the results used for decision-making. SMC is unable to present the results provided by the company which used an estimate of the PAS price for comparator medicines due to commercial confidentiality and competition law issues. As such all results are presented using the list prices for all medicines.

The base case analysis presented by the submitting company produced an ICER of £123,353 against chemotherapy.

Table 3: Base case result and selected scenario analysis

	Scenario	List price ICER
	Base Case	***£123,353***
1	Time Horizon – 5 years	£135,043
2	PFS extrapolation: Weibull distribution for SG and TPC	£125,213
3	OS extrapolation: Generalised gamma distribution for SG and TPC	£141,071
4	Treatment duration: KM+ parametric fit (exponential distribution)	£126,441
5	Relative dosing intensity – 94.2% for SG, 84% for TPC	£124,016
6	Alternate utility mapping algorithm used in Eribulin NICE appraisal	£114,535

Abbreviations: ICER, incremental cost-effectiveness ratio; SG, sacituzumab govitecan; TPC, treatment of physician's choice

There were a number of limitations with the analysis, which include the following:

- There is uncertainty regarding the long- term extrapolation of overall survival. Whilst the log-logistic distribution had the best statistical fit, the generalized gamma distribution was equally plausible. The 5 and 10-year survival projections from the log-logistic distribution were the highest amongst all the parametric models tested but were considered to be clinically plausible based on real-world evidence in this population. Applying the generalized gamma distribution did have an upward impact on the ICER, but also ensured that all patients were deceased within the model's 10- year time horizon. However, additional data subsequently provided by the company provided further support for the validity of the company's base case approach.
- There is some uncertainty about the utility values included in the analysis. Utilities were sourced from EORTC QLQ-C30 data collected as part of the ASCENT study but the data presents a mixed picture of effects on health related quality of life. There are questions about whether a consistent pattern of benefit in the functional scales can be attributed to sacituzumab govitecan. Furthermore, treatment specific utilities have been applied in the model. The company argues that higher utility in PFS was attributed to more durable response rates with sacituzumab compared to chemotherapy, resulting in better symptom control (e.g., pain). For the PD state, higher utility in the sacituzumab arm was attributed to a lower tumour burden for patients at the time of progression and the availability of eribulin for a larger proportion of patients after progression. The application of treatment specific utility values tends to result in higher incremental QALY gains and a lower ICER when compared to the use of state specific utility values.
- There is some uncertainty about the long-term TTD projection. A fully parametric model in which treatment duration was modelled independently from efficacy was used in the base case analysis. An alternative model using KM data plus parametric fit was tested in the scenario analysis and led to a 2% uplift to the base case ICER. TTD was also a key driver of cost-effectiveness in the one-way sensitivity analysis.

The Committee also considered the benefits of sacituzumab govitecan in the context of the SMC decision modifiers that can be applied when encountering high cost-effectiveness ratios and agreed that the criterion for a substantial improvement in life expectancy was satisfied. In addition, as sacituzumab govitecan is an orphan medicine, SMC can accept greater uncertainty in the economic case.

After considering all the available evidence and the output from the PACE process, and after application of the appropriate SMC modifiers, the Committee accepted sacituzumab govitecan for use in NHSScotland.

Additional information: guidelines and protocols

In 2021, the National Institute of Health and Care Excellence (NICE) pathway on managing advanced breast cancer noted that on disease progression, sequential systemic therapy should be offered to patients with advanced TNBC who have decided to be treated with chemotherapy. Consideration should be given to combination chemotherapy for whom a greater probability of response is important and who understand and are likely to tolerate the additional toxicity. For patients who are not suitable for anthracyclines, systemic chemotherapy should be offered in the following sequence:

- first-line: single-agent docetaxel
- second-line: single-agent vinorelbine or capecitabine
- third-line: single-agent capecitabine or vinorelbine (whichever not used second-line)

The pathway also references NICE technology assessments for other medicines including gemcitabine in the treatment of metastatic breast cancer (which recommends that it can be used in combination with paclitaxel as an option for the treatment of metastatic breast cancer only when docetaxel monotherapy or docetaxel plus capecitabine are also considered appropriate) and eribulin for treating locally advanced or metastatic breast cancer after two or more chemotherapy regimens (which is recommended as an option only when it has progressed after at least two chemotherapy regimens which include an anthracycline or taxane and capecitabine).[7]

In 2020, the European Society of Medical Oncology (ESMO) published the 5th ESO-ESMO international consensus guidelines for advanced breast cancer. This notes that in general combination and sequential, single-agent chemotherapy are reasonable options. Sequential monotherapy is preferred, with combination chemotherapy reserved for patients with rapid clinical progression, life-threatening visceral metastases or the need for rapid symptom and/or disease control. In the absence of medical contraindications or patient concerns, anthracycline- or taxane-based regimens, preferably as single agents, would usually be considered as first-line chemotherapy for HER2-negative advanced breast cancer in those patients who have not received these regimens as (neo)adjuvant treatment and for whom chemotherapy is appropriate. Other options are, however, available and effective, such as capecitabine and vinorelbine, particularly if avoiding alopecia is a priority for the patient.[6]

Additional information: comparators

Single-agent chemotherapies such as capecitabine, eribulin, carboplatin, cisplatin, gemcitabine, and vinorelbine.

Additional information: list price of medicine under review

Medicine	Dose Regimen	Cost per cycle (£)
Sacituzumab govitecan	10mg/kg IV infusion day 1 and 8 of 21-day cycle	6,344

Costs from Dictionary of Medicines and Devices Browser on 4 November 2021. Costs based on 70kg bodyweight. Costs calculated using the full cost of vials/ampoules assuming wastage. Costs do not take patient access schemes into consideration.

Additional information: budget impact

The submitting company estimated there would be 64 patients eligible for treatment with sacituzumab govitecan in each year, to which confidential uptake rates were applied.

SMC is unable to publish the with PAS budget impact due to commercial in confidence issues. A budget impact template is provided in confidence to NHS health boards to enable them to estimate the predicted budget with the PAS. This template does not incorporate any PAS discounts associated with comparator medicines.

*Other data were also assessed but remain confidential.**

References

1. Gilead Sciences Ltd. Sacituzumab govitecan 180mg powder for concentrate for solution for infusion (Trodelvy®) summary of product characteristics. Electronic Medicines Compendium www.medicines.org.uk/emc/ Last updated 13 September 2021.

2. Bardia A, Hurvitz SA, Tolaney SM, et al. Sacituzumab Govitecan in Metastatic Triple-Negative Breast Cancer. N Engl J Med 2021; 384(16): 1529-41.

3. ClinicalTrials.gov. ASCENT-study of sacituzumab govitecan in refractory/relapsed triple-negative breast cancer (ASCENT) 2020 [Available from: https://clinicaltrials.gov/ct2/show/NCT02574455.

4. *Commercial in Confidence**

5. *Commercial in Confidence**

6. Cardoso F, Paluch-Shimon S, Senkus E, et al. 5th ESO-ESMO international consensus guidelines for advanced breast cancer (ABC 5). Ann Oncol. 2020;31(12):1623-49.

7. National Institute for Health and Care Excellence. Managing advanced breast cancer 2021 [Available from: https://pathways.nice.org.uk/pathways/advanced-breast-cancer.

8. O'Shaughnessy J, Punie K, Oliveira M, et al. Assessment of Sacituzumab Govitecan vs Treatment of Physician's Choice Cohort by Agent in the Phase 3 ASCENT Study of Patients with Metastatic Triple-Negative Breast Cancer. Virtual American Society of Clinical Oncology (ASCO) Annual Meeting; June 4-8 2021.

This assessment is based on data submitted by the applicant company up to and including 10 December 2021.

**Agreement between the Association of the British Pharmaceutical Industry (ABPI) and the SMC on guidelines for the release of company data into the public domain during a health technology appraisal: http://www.scottishmedicines.org.uk/About_SMC/Policy*

Medicine prices are those available at the time the papers were issued to SMC for consideration. SMC is aware that for some hospital-only products national or local contracts may be in place for comparator products that can significantly reduce the acquisition cost to Health Boards. These contract prices are commercial in confidence and cannot be put in the public domain, including via the SMC Detailed Advice Document. Area Drug and Therapeutics Committees and NHS Boards are therefore asked to consider contract pricing when reviewing advice on medicines accepted by SMC.

Patient access schemes: A patient access scheme is a scheme proposed by a pharmaceutical company in order to improve the cost-effectiveness of a medicine and enable patients to receive access to cost-effective innovative medicines. A Patient Access Scheme Assessment Group (PASAG), established under the auspices of NHS National Services Scotland reviews and advises NHSScotland on the feasibility of proposed schemes for implementation. The PASAG operates separately from SMC in order to maintain the integrity and independence of the assessment process of the SMC. When SMC accepts a medicine for use in NHSScotland on the basis of a

patient access scheme that has been considered feasible by PASAG, a set of guidance notes on the operation of the scheme will be circulated to Area Drug and Therapeutics Committees and NHS Boards prior to publication of SMC advice.

Advice context:

No part of this advice may be used without the whole of the advice being quoted in full.

This advice represents the view of the Scottish Medicines Consortium and was arrived at after careful consideration and evaluation of the available evidence. It is provided to inform the considerations of Area Drug & Therapeutics Committees and NHS Boards in Scotland in determining medicines for local use or local formulary inclusion. This advice does not override the individual responsibility of health professionals to make decisions in the exercise of their clinical judgement in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.