

## Summary of Stakeholder responses to the imported plasma and recombinant products consultation paper.

Item	Stakeholder response
	<b>Product demand</b>
1	The introduction of long acting factor concentrates may impact on pattern on clinical use (possibility of more adult patients on prophylaxis).
2	Long acting factor VIII/IX products may decrease overall use in terms of units.
3	Participation in clinical trials both now and in the future needs to be considered when assessing product demand over the next five years. The ability of a treatment centre to participate in trials depends on local resource capacity.
4	Patients are becoming increasingly aware of cost and other pressures on health services and are increasingly interested in participating in models of care that optimise the use of clotting factor concentrate. This includes patient recording, and patients participating in pharmacokinetic studies that allow for more rational and evidence-based dosing of expensive clotting factor concentrate.
5	There are a number of potential new agents in development that are now entering phase 1 & 2 studies that may impact on future use of FVIII/FIX products. It is likely that patients will increasingly seek to access longer acting clotting factors products and this may impact demand.
6	There has generally been a plateauing of product usage over the past 2 years. This is due at least in part to the fact that most patients requiring prophylaxis are now receiving it, and a steady state has been achieved. It is unlikely that there will be a significant change in standard half-life product usage associated with prophylaxis.
7	If the evidence from clinical trials indicates it is possible to extend the half-life of factor IX three-to five-fold, and perhaps one and a half times for factor VIII there is great potential to reduce the frequency of infusions, improve lifestyle and convenience for patients. There might also be a change in thinking in clinical practice - currently, prophylaxis aims to maintain at least a 1% factor level but would doctors prefer a higher trough level to prevent bleeding?
8	Although there may not be unequivocal evidence that changing between different products such as BDD and full length products places patients at risk of inhibitors and other adverse events, there remains a perception for many patients and some of their clinicians that this may in fact be an issue which should be guarded against where possible – therefore an issue might be that clinicians prefer specific products and/or their patients will not consent to changing products and demand for specific products may be affected by this
9	Evidence which may emerge from trials may support better outcomes from prophylaxis vs on demand, and may impact demand

10	<p>There may be an increase in demand for clotting products resulting from:</p> <ul style="list-style-type: none"> <li>• an ageing population - increasing older patients with multiple co-morbidities, and increasing risk of bleeds – eg intercranial and other organ bleeds</li> <li>• due to treatment rationing during childhood many middle aged patients face the need for joint replacement surgery and this group combined with the older cohort of patients already awaiting surgery suggests demand likely to increase – this could also include inhibitor patients with special requirements who have had little access to treatment in their early adulthood</li> <li>• more surgical interventions and general health screening tests i.e. prostate biopsy, and coronary angiograms.</li> <li>• people born overseas with severe haemophilia arriving in Australia</li> <li>• tolerisation therapy</li> </ul>
<b>Product range and choice</b>	
11	<p>Having a greater number of brands of clotting factor concentrate within a haemophilia treatment centre will offer inventory management challenges. Consideration could be made of supporting data management to take on the role of business manager to more accurately take on inventory management of clotting factor concentrate.</p>
12	<p>Patient choice is important given the uncertainty of the risks associated with switching products and the likely inability of any study being designed and undertaken to investigate this issue. The lack of patient/family choice can result in anxiety amongst the families and patient group.</p>
13	<p>Products should have reconstitution devices that allow for choice/selection that is appropriate for patients of different ages and with variable degrees of dexterity.</p>
14	<p>A number of concerns were raised in relation to one current product's administrative set. Comments indicate that it is susceptible to operator error leading to product wastage. Frequent users learn the pitfalls, but treating nurses outside of HTC's constantly making errors and either wasting product or needing troubleshooting advice. Also, it is difficult for young and old hands to manipulate. Comment has been made why this issue was not picked up in the previous tender process.</p>
15	<p>It is important that the products are supplied with required administration devices that are suitable for use by all patients and that they are required to fund alternatives should it be known that other equipment will be necessary.</p>
16	<p>Opinion of staff at one centre that the products are of a generic nature with limited difference in clinical efficacy between each of the products - based on no evidence in the medical literature highlighting significant differences in either safety or efficacy. Although a concern has been raised about the inhibitor rate of B – domain depleted clotting factor concentrate this has not been borne out in robust studies. Anecdote on the differences in clinical effectiveness between products should not be allowed to influence tender processes. Experience when clotting factor concentrate was purchased on individual institutional basis suggests that patients whilst preferring a particular brand of clotting factor concentrate are able to adapt with multiple brand changes within a short period of time.</p>
17	<p>No clinical or medical evidence to suggest that patients commenced on a particular brand of clotting factor concentrate must be required to stay on that clotting factor concentrate indefinitely. Whilst brand switching can be difficult for haemophilia treatment centres and inventory management the benefits of having a greater and more sustained supply of clotting factor concentrate outweigh any disadvantages of brand switching.</p>

18	Product choice important to one clinician due to belief that not all products are equal in respect to their inhibitor risk and also ease of use and monitoring. Therefore keen to see as many products as possible available to the Australian market. As data is being collected and may subsequently be available, it would be disappointing if we were locked into a particular product if that product or type of product was shown to be inferior.
19	Currently there is no 3rd generation full length FVIII product on the market, despite many patients having been stable on such a product for many years.
20	Patient choice is an important component of product choice given the uncertainty of the risks associated with switching products and the likely inability of any study being designed and undertaken that will give a definitive answer to these questions. This lack of patient/family choice resulted in anxiety amongst the families and patient group at the time of the switch and has the potential to produce a negative perception of the institutions involved in the tender process.
21	When choice of product was first introduced in 2005, having a range of products was both novel and important, as it allowed end-users to choose the product that best suited their needs. However, the nature of the product is such that end-users are unlikely to change once they have found an option that suits. Having said this, respondent would not be in favour of a change that limits product choice, or that forces patients to change their products.
22	One respondent rates it important as a patient that they would like to have a range of products for a choice of products to be available. The current products choice is very limited.
23	One respondent would like some choice in case one is not suitable, but not numerous choice eg: reaction, ease of use
24	Although some clinicians and other HTC staff expressly prefer minimal changes and few choices for management reasons, patients on the other hand value choice and consider that having a range of treatment product/ brand options available to them, particularly in the case of adverse events and this continues to be a very important principle.
25	Patients prefer their doctors to have treatment experience with a range of products to help with appropriate decision making should they be faced with unexpected manufacturing failures and interruptions to supply.
26	Decisions should be made based on safety and efficacy, and that generally products manufactured with improved and more modern techniques should be preferred – as a principle, third generation products over first and second for example and the potential for longer acting therapies is significant.
27	Maintaining a range of potential suppliers in the Australian market is important particularly where governments may be seeking price advantages and may wish to vary the purchasing arrangements without impacting as greatly on the range and choice of products available to individual patients
28	The longer acting products are made with different technologies and are therefore different product entities with potentially different risks. There will be little data or exposure until these products have been used more widely. It is anticipated that clinicians will want to use these products for their patients as soon as possible. It is very early days yet so the risks and benefits of these different technologies are yet to be established. Keen to see a range of long acting factor products available in the Australian market place so that clinicians and patients can choose what might be best for them.

29	Some consideration should be given to delaying the tender until there are at least 2 longer acting agents available in order to achieve more competitive pricing, although it is acknowledged that the first product available may already be competitively priced to secure a greater market share. Concerned that if the tender is concluded prior to the approval of these longer acting products, they may be become available shortly afterwards with no provision for access. Dichotomy in that we recommend a longer acting agent is made available through the tender process so that it can be used promptly however do not want to be locked in to a three year period with only one such product.
30	The shortage of FXI in past years has highlighted the need for a more secure supply of this product, either locally produced or imported from multiple suppliers. At present we do not have any choice in the rFIX market - choice would be beneficial and may also drive the price down.
31	Product change was difficult for families who had children undergoing tolerisation, which is stressful enough without the added stress of changing to another product and hoping it won't have an effect on the inhibitor.
32	As clinicians' we need a suite of choice. While each brand of FVIII is similar, there are differences. On PK testing some patients have had very varied responses to the different brands. With choice we can select the one with the best recovery.
33	The current combination of vial sizes is not ideal. Of note, neither of the current rFVIII products is produced in a 1500U vial size. This is a frequently used size for prophylaxis in adolescents and the lack of this size means that patients have to use multiple vials to give a 1500 or 1750 U dose. This leads to the potential of vial size creep, where for convenience, such patients are prescribed 2000 U doses.
34	Would benefit from 750, 1500 unit vials for rFVIII, and 3000 unit vial for rFIX, 2500 unit vial for FEIBA.
35	With long acting FVIII/FIX products and patient pharmacokinetics it may be possible to use a full vial to its maximum potential, rather than over or under dosing prophylaxis/on-demand doses as currently happens to 'fit the vial'.
36	Difficult to pool vials with current product giving sets.
37	Storage and waste of the excess equipment is of concern to patients. Improved and fail-proof administration devices required.
<b>Change in product brands</b>	
38	There is no definite evidence which suggests that changing products significantly alters the risk of developing inhibitors. Anecdotal reports exist and individual practice varies but changing products does not appear to increase the risk of inhibitors. Switching products which may be considered undesirable by many within the haemophilia community is definitely achievable within a relatively short timeframe but does require management of patients and clinicians expectations. These expectations should include a consideration of the financial cost of clotting factor concentrate.
39	The currently available factor VIII concentrates do not cover a first generation product which historically had a very low inhibitor rate. The currently available rFVIII products both have question marks over them in regard to inhibitor development. Therefore patients have been switched from a product with historically a very low inhibitor rate to one or other of these with potentially higher inhibitor rates.
40	The theoretical risk of inhibitor development with switching has not yet been supported by the scientific evidence. There are however anecdotal reports and concerns still exist. Respondent personally would rather not switch patients, particularly in the early high risk period of the first 50 exposure days, given the choice.

41	Transition is time-consuming and costly in terms of informing patient pre-decision, education/familiarisation of product and trouble-shooting, (extenuated for rural patients), and costly also in terms of repeated blood tests for inhibitors. Training and educating hospital and rural hospital / clinic nursing staff re procedures also time-consuming. Time spent re-training would have been spent elsewhere in patient care. Fear of an inhibitor ingrained in patients and sometimes difficult to alleviate in discussions. HTC's need to develop trust, confidence and cooperation with patients over a long period of time, and this is undermined if a patient senses that dollars are being put before patient concerns/safety. If long-acting products introduced, disadvantages of educating for new product would be offset by long-term benefit of less dosing
42	Patients are extremely reluctant to change brands once they have found one that suits their needs. There is a high level of psychological stress that comes with changing products.
43	Even though there are two factor VIII products available, some states and territories have directed their HTC to only use the cheaper brand.
44	Expectations of clinicians and staff in the transition process were probably not sustainable and it is worth reflecting on the transition process that occurred in the United Kingdom where patients received notification in the post of a swap in clotting factor concentrate (as opposed to the extensive consultation that occurred in Australia.)
45	The short time frame from the announcement of the tender results and the commencement of the process was too short, not enabling clinicians adequate time to prepare themselves, especially for previously untreated patients requiring therapy.
46	There was generally poor communication about the tender process, but especially at the time of the announcement of the tender result.
47	Future product brand transitions, greater lead times (for both advice of upcoming tenders and actual product changeover) and an increased emphasis on transparency re product types, their advantages/disadvantages, etc., would be greatly appreciated by most end users
<b>Ordering and delivery of products</b>	
48	Order through both the Blood service and directly from the supplier. For some patients the product is delivered by the Blood service to a local hospital for collection.
49	In the case of the need for redelivery to a patient's home, a view was put forward that future tender processes should require companies or delivery companies should be responsible for; <ul style="list-style-type: none"> <li>• ensuring stocks are adequately stored prior to the redelivery, and</li> <li>• not relying on local hospitals being able to accommodate such stock at short notice, especially in areas remote from the relevant HTC.</li> </ul>
50	Events have been identified where home deliveries have not been successful and the response from the companies involved has been variable and some mistakes have been difficult to identify. The NBA has been requested to take a more pro-active role in managing these cases and ensuring a robust system.
51	The ability to directly fax or email an order to the appropriate company was seen as desirable
52	A patient has raised the following issues: <ul style="list-style-type: none"> <li>• having to order through the hospital treatment centre by a specified date as the order is effectively a script that only the doctor can issue.</li> <li>• having to report usage –failure to do so results in refusal of home delivery</li> <li>• while patient agrees to reporting usage for planning – reporting becomes repetitive where patients are on preventive treatment weekly and using the same amount month after month and have no bleeds - reports could be made when there is a bleed etc.</li> </ul>

53	Efficient ordering process directly through the commercial supplier with approval only being provided by haemophilia treatment centre staff.
54	An additional point of transfer between peripheral hospitals which may have a supply of clotting factor concentrate that is due to expire would be helpful in reducing wastage. A simple business case could be developed to support transfer of clotting factor concentrate between blood banks in order to prevent this source of wastage. An initial investment in surveying outlying hospitals would seem worthwhile and engaging the hospitals in our best clotting factor concentrate can be circulated between hospitals.
55	An issue has been raised about home delivery and companies not taking responsibility for product that cannot be delivered to the patient's home.
56	Rationalisation of ordering and transport systems, whilst difficult, may offer a uniform approach to ordering and delivery; but should try to take into account different existing hospital systems. Funding to implement any significant change in ordering systems will need to be addressed.
57	It is noted that there is no home delivery available for plasma derived products.
58	Varied level of satisfaction from state to state. Overall satisfied, but some dissatisfaction over incorrect patient details or contact details on order/delivery forms. No budget for rotating stock throughout a state (ie between treatment centres). For states ordering through the Blood Service rotation of stock is possible, reducing wastage/costs
59	Contact details, names etc still not right on some ABDR forms.
<b>Product supply</b>	
60	A clinician raised the following issues: Ddd not want suppliers marketing to the patients through training and support programs as these services should be supplied by the HTC and should not be viewed positively at all in the tender process. <ul style="list-style-type: none"> <li>• The expectation that suppliers provide information on the reconstitution of their product that can be provided to ward staff and new patients so that the product is constituted correctly.</li> <li>• Acknowledgement that development of an on-line calculator for determining the patients' PK is a useful concept but should only be available to clinicians, and not contain any patient identifiable data.</li> </ul>
61	A carer has advised that in relation to home delivery, given the regularity of tenders and the need to potentially change products, the continued need for information and training kits is important for end users, as is the requirement for active (clinic run) demonstrations and on-call advice.
62	It is interesting to note that while some health professionals work closely with industry to product training and support materials, others steer well clear and do not think this is appropriate. It is understood that several HTCs prefer not to receive and stock branded support items from companies, whilst others rely on these. So it would seem there could be a wide range of preferences. Governments should not be swayed by suggestions that some of these services truly add value. It should be noted that where suppliers have offered free devices or items of financial value such as smart phones to patients they were influenced to choose the related clotting factor product.
63	Readily available pharmacokinetic dosing tools would be particularly helpful.
64	Although company based reporting of usage is useful this will be made redundant with the introduction of myABDR.
65	Expect the supplier to provide information on the reconstitution of their product that can be provided to ward staff and new patients so that the product is constituted correctly.

66	Companies are now liaising more with HTC staff about needs. They have provided useful in service training for staff. Home delivery has saved pharmacy time, and improved management of stocks in regional hospitals.
67	More educational resources regarding the products condition via books/booklets/online for the patient/family. Especially for rare disorders.
68	Home delivery calendars for people on home delivery
69	Trouble shooting guides for when reconstitution goes wrong. These are essential to stop vials being thrown out!
70	No administration kits supplied for some products
71	There is no formal mechanism to facilitate feedback to suppliers
<b>Other issues</b>	
72	Staff at one HTC believes the tender process has been very successful in making funding available for clotting factor concentrate sustainable. The HTC staff look forward to the tender outcome and will be supporting this outcome in order to continue to effectively manage patients with haemophilia and bleeding disorders.
73	Would like to see more collaboration with the clinicians throughout the tender process and not to have one clinician acting as the representative unable to communicate back to the others because of a confidentiality agreement.
74	The NBA should take into account the emerging research about quality of life outcomes, and some of the new cost effectiveness studies that are using a different paradigm to measure outcomes and effectiveness. A more transparent process and explanation is welcomed about how the NBA will assess products and how it will seek and assess clinical and scientific advice for clotting factor products in the current tender and in future arrangements.