

# **Transplant and Immunosuppressant Subcommittee of PTAC**

**Meeting held 11 May 2015**

**(minutes for web publishing)**

Transplant and Immunosuppressant Subcommittee minutes are published in accordance with the *Terms of Reference for the Pharmacology and Therapeutics Advisory Committee (PTAC) and PTAC Subcommittees 2008*.

Note that this document is not necessarily a complete record of the Transplant and Immunosuppressant Subcommittee meeting; only the relevant portions of the minutes relating to Immunisation Subcommittee discussions about an Application or PHARMAC staff proposal that contain a recommendation are generally published.

The Transplant and Immunosuppressant Subcommittee may:

- a) recommend that a pharmaceutical be listed by PHARMAC on the Pharmaceutical Schedule and the priority it gives to such a listing;
- b) defer a final recommendation, and give reasons for the deferral (such as the supply of further information) and what is required before further review; or
- c) recommend that PHARMAC decline to list a pharmaceutical on the Pharmaceutical Schedule.

These Subcommittee minutes were reviewed by PTAC at its meeting on 13 & 14 August 2015, a record of which is available.

**Record of the Transplant Immunosuppressant Subcommittee of the  
Pharmacology and Therapeutics Committee (PTAC) meeting held at PHARMAC on  
11 May 2015**

## **1 Therapeutic Group Review**

### *Valganciclovir*

- 1.1 The Subcommittee noted that valganciclovir (50mg tablets) was listed on the Community Pharmaceutical Schedule in November 2012 and in April 2015 a sole supply tender was awarded to the incumbent (Roche) with a significant price reduction.
- 1.2 The Subcommittee noted that there were 192 approvals for valganciclovir from July 2014 to February 2015 – the majority for lung transplant cytomegalovirus (CMV) prophylaxis, transplant CMV prophylaxis and CMV treatment in immunocompromised patients.
- 1.3 The Subcommittee considered that there was an anomaly in the Special Authority criteria for lung transplant patients who present with late acute rejection who are CMV positive or received a CMV positive organ. These patients may present with acute rejection 9 to 12 months after transplant. They are treated with pulse methylprednisolone and often require additional valganciclovir prophylaxis. The existing Special Authority criteria allow for 6 months initial prophylaxis for lung transplant patients and a further three months prophylaxis following treatment with ATG rabbit.
- 1.4 The NZ Lung transplant service (based at ADHB) reported that they have had five patients this year with late acute rejection treated with intravenous methylprednisolone who required valganciclovir treatment. Some clinicians are currently working around the Special Authority criteria in order to access treatment. Members noted that clinicians considered that the NPPA process was an obstacle to accessing valganciclovir immediately for these patients.
- 1.5 The Subcommittee considered lung transplant patients receiving pulse methylprednisolone for late acute rejection (usually present 9-12 months post-transplant) were potentially at higher risk of CMV infection compared to other organ transplant recipients. The Subcommittee considered there would be 8 to 10 lung transplant patients per year who would require additional prophylaxis with valganciclovir.
- 1.6 These patients are monitored very closely for CMV infection post- transplant, however viral load testing of CMV is expensive, results can take a long time and it can be difficult to access testing in some regions. CMV levels in the blood may not correlate with presentation of disease and measuring levels in the tissue is invasive.
- 1.7 The Subcommittee **recommended** the Special Authority for valganciclovir be amended to include renewal criteria for patients who had undergone a lung

transplant and received pulse methylprednisolone for acute rejection after the initial 6 months of CMV prophylaxis and requires a further 90 days of valganciclovir for CMV prophylaxis.

- 1.8 Members also considered that other organ transplant recipients with augmented immunosuppression may be at higher risk of CMV infection and that this group should also be considered for widening access to additional prophylaxis.
- 1.9 The Subcommittee noted the December 2014 Nephrology Subcommittee minute highlighting to PHARMAC that it would be beneficial to have funded access to valganciclovir for Epstein-Barr viraemia (EBV) in patients who are immunocompromised in the setting of transplant rejection. The Subcommittee noted EBV in paediatric transplant patients would be relevant to all organ transplants, not just renal transplant. The Subcommittee considered there is limited evidence in this area and agreed with the Nephrology Subcommittee that these patients could be considered for funding via the Named Patient Pharmaceutical Assessment policy.
- 1.10 The Subcommittee **recommended** that the Anti-Infective Subcommittee be asked for their advice on widening access to valganciclovir to that other organ transplant recipients, with augmented immunosuppression, at risk of CMV and/or EBV.

## **2 Matters Arising**

### **Tacrolimus for non-transplant indications**

- 2.1 The Subcommittee noted that at its February 2014 meeting PTAC considered a clinician application for the funding of tacrolimus for nephrotic syndrome that has not responded to other treatments. The Subcommittee noted the PTAC minutes from this discussion and that PTAC recommended tacrolimus be listed on the Pharmaceutical Schedule for patients with steroid and ciclosporin resistant nephrotic syndrome with high priority. Members noted this proposal is a current option for investment for PHARMAC.
- 2.2 The Subcommittee noted that PHARMAC had received a number of NPPA approvals for tacrolimus for non-transplant indications and PTAC noted a possible option to consider would be to list tacrolimus with no indication restriction for non-transplant indications and instead restrict it to any patient who has failed treatment with ciclosporin. PTAC also noted PHARMAC staff would need to assess the financial risk associated with doing this.
- 2.3 The Subcommittee noted that the Nephrology Subcommittee, at its meeting in December 2014, reviewed PTAC's recommendations but considered that other than steroid-resistant nephrotic syndrome, there was no other indication for which it saw a clinical need to widen tacrolimus access..
- 2.4 The Subcommittee noted there was limited evidence to support use in non-transplant indications, however the adverse effect profile of tacrolimus is favourable compared to ciclosporin. The Subcommittee considered tacrolimus should be used as a second line calcineurin inhibitor to ciclosporin for non-

transplant indications and it may be useful for a small group of patients who have not responded to ciclosporin and other immunosuppressants.

- 2.5 The Subcommittee considered there would be a significant fiscal risk from topical use of tacrolimus prepared as an ointment from the capsules for dermatology indications and a funding application for this should be considered separately. Members noted a commercial preparation of tacrolimus ointment is available overseas.
- 2.6 The Subcommittee **recommended** that access to tacrolimus be widened to include patients with non-transplant indications who require long-term systemic immunosuppression and have trialled ciclosporin and discontinued because of unacceptable side effects or inadequate clinical response with medium priority. The Subcommittee noted tacrolimus would remain a first line option for where the patient is an organ transplant recipient.