



January 8, 2021

Steven D. Pearson, MD, MSc
President, Institute for Clinical and Economic Review
Two Liberty Square, Ninth Floor
Boston, MA 02109

Dear Dr. Pearson:

The National Eczema Association (NEA) is looking forward to working with the Institute for Clinical and Economic Review (ICER) as a “Key Stakeholder” during the development of the report entitled “JAK Inhibitors and Monoclonal Antibodies for the Treatment of Atopic Dermatitis: Effectiveness and Value.” Given ICER’s experience modeling the effectiveness and value of dupilumab and crisaborole for atopic dermatitis¹ in 2017 and interactions with multiple stakeholders in this clinical area, we have confidence that this updated evaluation will advance the value discussion for treatments available to our community.

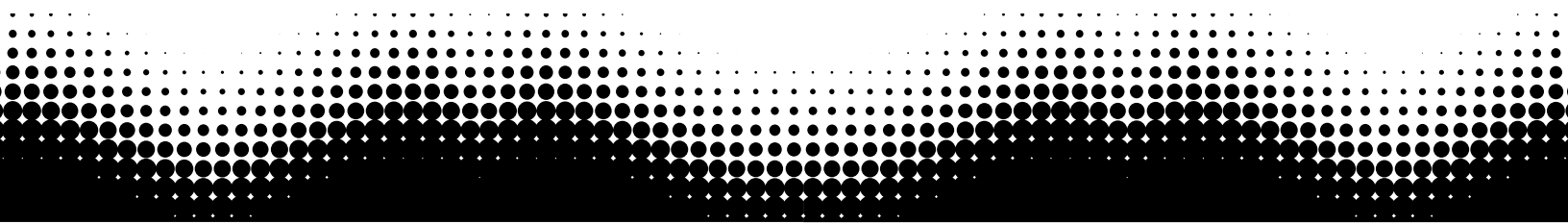
Since ICER’s last atopic dermatitis treatment assessment in 2017, five organizations serving the eczema community collaborated with the US Food and Drug Administration to host **More Than Skin Deep**, a patient-focused drug development meeting on September 23, 2019.² With over 160 in-person participants, more than 1,500 respondents to a companion survey, and thousands in attendance via webcast, our community gathered to share the lived experiences of patients and caregivers affected by atopic dermatitis. We hope our summary report will provide additional contextual factors for your team as you work to develop this updated atopic dermatitis model.²

Our team has had the opportunity to review the draft background and scoping document published on December 10, 2020 and we would like to submit the following public comments and questions for your consideration as you develop the research protocol that focus on the following 5 key areas:

1. Atopic Dermatitis Model Structure
2. Patient Heterogeneity
3. Caregiver Impact
4. Protecting the Most Vulnerable Among Us
5. Reporting of Health Care System and Modified Societal Perspective Reference Case

Atopic Dermatitis Model Structure

While the recent scoping document did not supply a new structural model, it did specify the model will be “based in part on ICER’s previous atopic dermatitis model, as well as a literature review of prior published models of inflammatory skin disorders and moderate-to-severe atopic dermatitis.”³ In the 2017 ICER atopic dermatitis model, a Markov process was developed to



simulate the transitions between the health states based on treatment response (Figure 1).¹

As your modeling team updates the model structure for this report, we would like to pose the following comments and questions for consideration:

- Will the same model structure be used for all patient populations and subgroups?
 - From the scoping document, it appears the age groups would be stratified but possibly entering the same model. For pediatric patients, it may be more realistic to consider different health states that more accurately reflect the experience of this population.
- Will the model address or have the ability to address the differences in costs or benefits for patients with severe vs. moderate or moderate vs. mild disease?
 - The current scope includes 2 populations, “mild-to-moderate” and “moderate-to-severe,” likely reflecting clinical trial design. Will the modeling team be able to estimate the effects for each group separately where evidence exists, possibly additionally considering absolute changes in EASI scores that could account for different baseline levels of disease?
- Will treatment holidays or breaks in therapy be modeled along with consistent treatment?
 - We anticipate many patient groups to be prescribed periods of therapy with periods of therapy discontinuation throughout a patient’s lifetime, or at least periods where maintenance therapy could be substantially less costly than the JAK regimen.
- Would there be additional health states for patients who experience anxiety and depression?
 - The scoping document specifies “anxiety and depression” as an outcome of interest, but it is not clear how this outcome would be reflected in the existing model, or how the model might include other frequently co-occurring health issues such as skin infections and sleep loss.⁴⁻⁶
- Would the model be flexible enough to allow for periods where patients may experience higher or lower out-of-pocket costs?
 - Out-of-pocket expenses reported by 1,118 NEA members vary greatly and can be compounded by multiple prescriptions copayments, frequent provider visits, and over-the-counter therapy.⁷

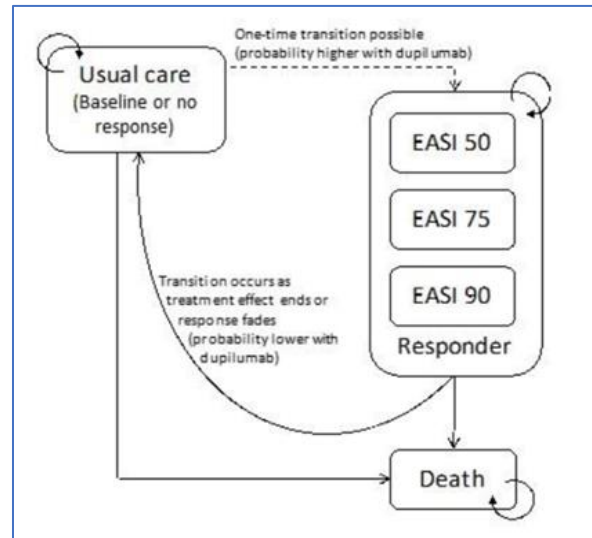


Figure 1. Markov model structure for 2017 ICER report on atopic dermatitis

Patient Heterogeneity

When considering evaluating treatments for atopic dermatitis, the impact on different age groups could have a profound impact on the overall value assessment results. We applaud ICER’s plan to focus on both adult and pediatric populations and further specifying plans to consider stratifying your assessment by children, adolescents, and adults.³ Our initial subgroup concerns revolve

around the model structure listed above. Regardless of the model structure, we recognize it may be difficult to fully account for patient heterogeneity in all variables as there may be a lack of real-world evidence to support differing assumptions. We hope the NEA can serve as a resource to ICER's team to help answer some of these data gaps through engaging our members.

Caregiver Impact

Along the lines of our comments to patient heterogeneity, we anticipate the effects of atopic dermatitis to have extensive spillover effects for caregivers – especially for parents of pediatric patients. A recent review of cost-utility analyses in pediatric patients, 72% of studies included family spillover effects but these primarily focused on time costs.⁸ The inclusion of these additional spillover effects had significant impacts on results, generally reducing the incremental cost-effectiveness ratio.⁸ While we recognize that inclusion of these caregiver costs in the primary analysis could present the unintended consequence of justifying a higher treatment price, we do feel it is critical that special attention be paid to the potential value to caregivers.

Protecting the Most Vulnerable Among Us

In the revised Value Framework for 2020-2023, ICER has stated the importance of health inequality for policy makers and has committed to (when feasible) exploring scenario analyses to capture the impact of new technologies on disparities across different subpopulations in the US health care system.⁹ While the “average” eczema patient experiences substantial financial difficulties due to the well documented economic burden of this disease and access differences based on payer type,^{10,11} patients of lower socioeconomic status are particularly vulnerable.⁹ Special consideration for the most economically vulnerable patients in this updated report on atopic dermatitis would greatly advance the discussion on treatment value in the eczema community and align with ICER's stated end goal: sustainable access to high-value care for *all* Americans.

Reporting of Health Care System and Modified Societal Perspective Reference Cases

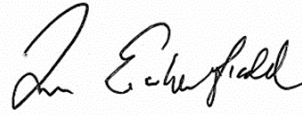
We understand that it is ICER's position to report the health care system perspective as its reference or base case as ICER's value assessment methodology clearly states its intended use is to inform population-based medical policy and pricing decisions within the US health care system.¹² We agree with this emphasis on these health care system costs, however we ask that ICER consider aligning with the Second Panel on Cost Effectiveness, which recognized that the societal perspective (originally recommended as the preferred reference case) was rarely conducted and modified their recommendations such that economic models should report both perspectives and produce an impact inventory to aid in decision making.^{13,14} From the scoping document, it appears that you would only report both perspectives as a co-base case when societal costs are “large relative to direct health care costs.”³ What is the harm in planning on reporting both as your standard? We feel this is a reasonable solution for health economists and value assessment frameworks to produce both reference cases and report side-by-side for comparison. This does not diminish the importance of the health care system or payer perspective, but rather recognizes that any “value assessment” that relegates the broader costs and outcomes important to patients to a secondary table or sensitivity analysis may actually bias the interpretation of the results.

We hope that these comments are helpful as you finalize your assessment, and we thank you for willingness to engage with our organization and our patient community.

Sincerely,



Julie Block
NEA President and CEO



Lawrence F Eichenfield, MD
Chair, NEA Scientific & Medical Advisory Council

With Support From:

Kenneth Mendez
President and CEO
Asthma and Allergy Foundation of America

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