CADTH

CADTH Reimbursement Review

CADTH Reimbursement Recommendation

(Final)

Tildrakizumab (Ilumya)

For the treatment of adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy

Recommendation: Reimburse with conditions

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Single Technology

What is the CADTH reimbursement recommendation for Ilumya?

CADTH recommends that Ilumya (tildrakizumab), a biologic drug, be reimbursed by public drug plans for the treatment of moderate-to-severe psoriasis only if certain conditions are met.

What are the conditions for reimbursement?

Ilumya should only be reimbursed if it is prescribed by a dermatologist and does not cost more than other biologic drugs.

Which patients are eligible for coverage?

Ilumya should only be provided to patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

Why did CADTH make this recommendation?

Evidence from 2 clinical trials demonstrated that Ilumya improves psoriasis symptoms compared to treatment with placebo. Ilumya is more expensive than many other biologic treatments, but there is no evidence that Ilumya works better than other biologic treatments.

Key Messages

- Clinical evidence suggests that Ilumya should be reimbursed to treat patients with moderate-to-severe psoriasis if it is prescribed by a dermatologist and if it does not cost more than other biologics.
- There is no evidence to suggest that Ilumya should have a higher price than other biologic treatments that are reimbursed for psoriasis.
- If Ilumya is not reimbursed for patients with moderate-to-severe psoriasis, there are other several alternative treatments available for these patients.

What is psoriasis?

Psoriasis is a chronic skin condition that causes red, flaky, crusty patches of skin. In severe cases, the patches can be itchy and sore. There are between 500,000 and 1 million people in Canada with psoriasis. A wide range of treatments are available for psoriasis, including topical (creams and ointments), phototherapy (exposure to ultraviolet light), and systemic (oral and injected medications that work throughout the entire body). Newer treatments, such as Ilumya, are biologic drugs that reduce inflammation by targeting overactive cells in the immune system.

What is Ilumya?

Ilumya is an injectable biologic drug that inhibits the IL-23 receptors, which are proteins involved in the immune response that triggers psoriasis symptoms. Ilumya is approved by Health Canada for the treatment of adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

How much does Ilumya cost?

Treatment with Ilumya is expected to cost approximately $25,000 per patient in the first year and approximately $21,000 per patient in subsequent years.

What other biologic drugs are available for moderate-to-severe psoriasis?

There are several other biologic drugs available to treat moderate-to-severe plaque psoriasis, which cost between $16,000 and $39,000 annually per patient.

Unmet needs in moderate-to-severe psoriasis

Although many treatments are approved in Canada to treat moderate-to-severe plaque psoriasis, some patients may not respond to these treatments. Other treatment options are needed for these patients.

TILDRAKIZUMAB (ILUMYA — SUN PHARMA GLOBAL FZE)

Therapeutic Area: Psoriasis, moderate-to-severe plaque

Recommendation

The CADTH Canadian Drug Expert Committee (CDEC) recommends that tildrakizumab (Ilumya) be reimbursed for the treatment of adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy only if the conditions listed in Table 1 are met.

Rationale for the Recommendation

In 2 multicenter, double-blind, randomized controlled trials (RCT) (P010 and P011) in adults with moderate-to-severe plaque psoriasis, treatment with 100 mg tildrakizumab was associated with statistically significant and clinically meaningful improvements versus placebo at week 12 for the co-primary outcomes: the Psoriasis Area and Severity Index score (PASI) 75 and the Physician's Global Assessment (PGA) response. A significantly higher percentage of patients responded to treatment with tildrakizumab (difference in PASI 75 response at week 12: 58% [95% CI, 51% to 64%] and 56% [95% CI, 48% to 62%] in Study P010 and Study P011, respectively; P < 0.001 for each), compared with placebo. The difference in the proportion of patients who exhibited a PGA score of clear or minimal with at least a two-grade reduction from baseline at week 12 was 51% (95% CI, 44% to 57%; P < 0.001) in Study P010 and 50% (95% CI, 43% to 57%; P < 0.001) in Study P011.

Study P011 included direct evidence for tildrakizumab compared with etanercept. There was no statistically significant difference between tildrakizumab 100 mg and etanercept (absolute difference in proportions: 7%; 95% CI, –0.5% to 15%; P = 0.066) in the PGA score at week 12.

The network meta-analysis (NMA) submitted by the sponsor suggested that tildrakizumab may be less effective than interleukin (IL)-17 inhibitors (ixekizumab, brodalumab, secukinumab), other IL-23 inhibitors (guselkumab, risankizumab), and infliximab, but may be more effective than etanercept or apremilast. Tildrakizumab appeared to be similar to adalimumab, certolizumab, and ustekinumab.

At the sponsor's submitted price of $4,935 per single-dose pre-filled 100 mg syringe of tildrakizumab, the expected annual cost of treatment with tildrakizumab is $24,675 per patient in the first year, and $21,385 in subsequent years. Based on publicly available prices of other products (annual per patient cost ranging from $16,023 to $39,080), the annual cost of tildrakizumab is higher than some of the other biologic products that are currently reimbursed by public drug plans but is lower than some other biologic treatments.

Table 1: Reimbursement Conditions and Reasons

Reimbursement condition	Reason
Initiation	
1. Eligibility for tildrakizumab should be based on the criteria used by each of the public drug plans for reimbursement of other biologics for moderate-to-severe plaque psoriasis.	There is no direct comparative evidence that tildrakizumab is clinically superior or inferior to other biologic treatments currently reimbursed for the treatment of moderate-to-severe plaque psoriasis.
Renewal	
1. Treatment with tildrakizumab may be renewed for patients who exhibit a response to treatment after 12 to 16 weeks. 1.1. A response to treatment is defined as an achievement of at least a 75% reduction in the PASI score (PASI 75).	The co-primary endpoints in studies P010 and P011 were evaluated after 12 weeks. Clinical experts indicated that the PASI score at 16 weeks could be used to assess whether a patient is responding to treatment. An improvement of at least 75% in the PASI score is consistent with the co-primary outcomes in studies P010 and P011.
Prescribing	
1. Patient should be under the care of a dermatologist.	Accurate diagnosis and follow up of patients with moderate-to-severe plaque psoriasis is important to ensure that tildrakizumab is prescribed to the most appropriate patients. In addition, there are several biologic treatment options that may be considered when selecting the most appropriate therapy for patients, which is best determined by dermatologists, who are familiar with this complex treatment paradigm.
2. Tildrakizumab should not be used in combination with other systemic or biologic treatments for moderate-to-severe plaque psoriasis.	There is no evidence to determine the effects of tildrakizumab when used in combination with conventional systemic drugs or other biologics in patients with moderate-to-severe plaque psoriasis.
Pricing	
1. The drug plan cost of tildrakizumab should not exceed the drug plan cost of treatment with the least costly biologic therapy reimbursed for the treatment of moderate-to-severe plaque psoriasis.	As there is no direct or indirect comparative evidence that tildrakizumab is superior to other biologic treatments currently reimbursed for the treatment of moderate-to-severe plaque psoriasis, there is no evidence to warrant a price premium for tildrakizumab over other treatments.

Implementation Guidance

1. After initial renewal at 12 to 16 weeks, tildrakizumab should be renewed in a similar manner to other biologics currently reimbursed for the treatment of moderate-to-severe plaque psoriasis.

Discussion Points

- Comparative evidence between tildrakizumab and other biologic treatments for PASI response is limited. Etanercept was an active comparator in Study P011, but since no statistically significant difference between tildrakizumab 100 mg and etanercept was observed for PGA score at week 12 in Study P011, statistical testing of the secondary outcomes of PASI 75, PASI 90, and PASI 100 at week 12 could not be conducted.

- CDEC noted that there are numerous biologic drugs approved for the treatment of moderate-to-severe plaque psoriasis in Canada. Tildrakizumab is the third IL-23 inhibitor in Canada; the others are risankizumab and guselkumab. There is no direct evidence to suggest that tildrakizumab offers a superior benefit over risankizumab or guselkumab. Results of the indirect treatment comparison (ITC) submitted by the sponsor suggest that tildrakizumab was less likely to to achieve PASI 50, PASI 75, and PASI 90 response compared with risankizumab and guselkumab during short-term induction treatment periods between 10 to 16 weeks.
- In addition to the NMA submitted by the sponsor, 5 other published ITCs that examined the comparative efficacy or safety of immunomodulators used to treat patients with moderate-to-severe plaque psoriasis were included in the CADTH review of tildrakizumab. There was heterogeneity among the studies included in the NMAs due to the proportion of patients with psoriatic arthritis, prior exposure to biologics, the timing of the outcome assessment, and the region affected. Placebo-adjusted models were selected in 2 ITCs, in an attempt to account for potential variability; however it is unclear to what extent placebo response is an adequate proxy for specific characteristics or effect modifiers. Despite these limitations, the efficacy findings of all 6 ITCs were consistent.
- Clinical experts consulted suggested to CDEC that PASI 90 is currently the standard outcome when evaluating whether skin clearance is achieved in patients with moderate-to-severe plaque psoriasis in Canadian clinical practice. Although tildrakizumab was associated with statistically significant and clinically meaningful differences in PASI 90 at 12 weeks compared with placebo, PASI 90 was assessed as a secondary end point in studies P010 and P011; the co-primary end point was based on PASI 75. Further, clinicians anticipate that not all patients would be expected to achieve a PASI 90 response by weeks 12 to 16 and that additional improvement may be observed beyond this time point with continued treatment.
- CDEC noted that the only long-term comparative evidence available for tildrakizumab was compared to etanercept; however, only descriptive statistics were published. Without comparator groups, the interpretation of the results is limited. There is no direct long-term evidence comparing to the other IL-23 inhibitors available in Canada. Given that plaque psoriasis requires lifelong treatment, there is uncertainty regarding the long-term effectiveness and safety of tildrakizumab over other currently available biologics for moderate-to-severe plaque psoriasis.

Background

Tildrakizumab has a Health Canada indication for the treatment of adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy. Tildrakizumab is a humanized monoclonal antibody that binds to the IL-23 cytokine and inhibits its interaction with the IL-23 receptor. It is available as a 100 mg/1 mL pre-filled syringe and the recommended dose is 100 mg by subcutaneous injection at week 0, week 4, and every 12 weeks thereafter.

Summary of Evidence

To make their recommendation, CDEC considered the following information:

- A systematic review that included 2 multicenter double-blind RCT (in adults with moderate-to-severe plaque psoriasis who were candidates for phototherapy or systemic therapy)
- Patients' perspectives gathered by patient groups, including the Canadian Skin Patient Alliance (CSPA), the Canadian Association of Psoriasis Patients (CAPP) and the Canadian Psoriasis Network (CPN), and a second submission from the Canadian Organization for Rare Disorders (CORD)
- One clinical specialist with expertise diagnosing and treating patients with plaque psoriasis
- A review of the pharmacoeconomic model and report submitted by the sponsor.

Summary of Patient Input

Two responses to CADTH's call for patient input for the tildrakizumab submission were received: a cooperative submission from the CSPA, the CAPP, and the CPN, and a second submission from the CORD. Patient perspectives described in the 2 submissions

were obtained from data collected from other recent submissions for risankizumab and certolizumab pegol, online disease discussion boards, interviews with 3 Canadian patients with moderate or severe psoriasis who received tildrakizumab, and survey data from 12 patients diagnosed with plaque psoriasis. The following is a summary of key input from the perspective of the patient groups:

- The patient groups describe psoriasis as a chronic inflammatory skin condition that may vary in severity from a minor nuisance to a painful and disabling condition. Some patients reported frequently feeling embarrassed, losing sleep, having problems with intimacy, and lacking self-confidence. About half of patients indicated that their work is affected frequently, and they often experience feelings of depression.
- Many patients reported feeling that their condition is not adequately controlled with existing therapies. Patients stated that they still have new outbreaks and that their treatments are only temporary fixes. For some patients, the lack of efficacy of their treatments led to the discontinuation of therapy.
- Patient groups stated that resolution of the plaques was an important treatment outcome, as was decreasing symptoms such as itching and pain, and social stigma. New treatments should also be easy to access and use, have minimal side effects, and have little potential impact on organs and/or other long-term negative outcomes.

Clinical Trials

The CADTH systematic review included 2 multicenter double-blind RCTs of adults with moderate-to-severe plaque psoriasis who were candidates for phototherapy or systemic therapy. These trials examined the efficacy and safety of tildrakizumab compared with placebo (Study P010 or reSURFACE 1, N = 772), or compared with placebo and etanercept (Study P011 or reSURFACE 2, N = 1,090). Both trials consisted of 3 parts:

- Part 1: Week 0 to 12. Patients were randomized 2:2:1 to tildrakizumab 100 mg, 200 mg or placebo in Study P010, and randomized 2:2:1:2 to tildrakizumab 100 mg, 200 mg, placebo, or etanercept 50 mg in Study P011.
- Part 2: Week 12 to 28. Patients in active treatment groups continued on therapy, and those initially randomized to placebo were re-randomized to tildrakizumab 100 mg or 200 mg.
- Part 3: Week 28 to Week 52 (P011) or Week 64 (P010). Based on their treatment response at week 28, patients were discontinued, re-randomized or reassigned to tildrakizumab 100 mg or 200 mg in Study P011, or to tildrakizumab 100 mg, 200 mg or placebo in Study P010.

Tildrakizumab was administered by subcutaneous injection at week 0, week 4, and every 12 weeks thereafter. In study PO11, etanercept 50 mg was administered subcutaneously twice weekly during part 1, and once weekly during part 2.

In both trials the risk of bias appears to be low for data reported for part 1 (at 12 weeks); however, the data from part 2 and 3 are difficult to interpret due to the loss of randomization, lack of control group or suboptimal active comparator, and potential attrition bias. The selection of etanercept as an active control in Study P011 may not reflect current clinical practice in Canada.

Outcomes

Outcomes were defined a priori in the CADTH systematic review protocol. Of these, CDEC discussed the following: PASI, PGA score, and health-related quality of life (HRQoL). The co-primary outcomes in both trials were the proportion of patients who achieved at least a 75% improvement in the PASI score from baseline to week 12, and the proportion of patients with a PGA score of clear or minimal with at least a two-grade reduction from baseline for tildrakizumab 200 mg and 100 mg doses versus placebo.

- HRQoL was measured using the Dermatology Life Quality Index (DLQI), is a dermatology-specific questionnaire that covers 6 domains: symptoms and feeling, daily activities, leisure, work and school, personal relationships, and bother with psoriasis treatment. The DLQI is scored between 0 to 30, with lower scores indicating better quality of life, and a score of 0 or 1 indicates the disease has no effect of the patient's quality of life. Estimates of the minimal important difference (MID) range from 2.2 to 6.9.

- PASI combines an assessment of the body surface area affected in 4 anatomical regions (head, trunk, arms, and legs) and the severity of desquamation, erythema, and plaque induration or infiltration (thickness) in each region. Scores range from 0 to 72 points, with a PASI score greater than 10 representing more severe disease. A 75% reduction in the PASI score (i.e., PASI 75), is used as a benchmark in clinical trials in psoriasis; however, the treatment goal in clinical practice has shifted to an achievement of PASI 90 or PASI 100, according to the clinical expert consulted for this review.
- The PGA is a composite score of physician assessment of erythema, average thickness, and scaling of the patient's psoriatic lesions at a given point of time. The composite score falls on a scale of 0 to 5, with 0 interpreted as cleared, 1 interpreted as minimal, and 5 interpreted as severe disease.

Efficacy

In Study P010 and Study P011, 6% of patients in the placebo group, 61% to 66% in the tildrakizumab groups, and 48% in the etanercept group achieved a PASI 75 response at week 12. The difference in percent responders for tildrakizumab 100 mg versus placebo was 58%, 95% CI, 51% to 64%, and 56%, 95% CI, 48% to 62%, in Study P010 and Study P011, respectively (both P < 0.001). The difference between tildrakizumab 100 mg and etanercept at week 12 was not statistically significant due to failure of a prior outcome in the statistical testing procedure (absolute difference 13%, 95% CI, 5% to 21%).

In both trials, a higher proportion of patients achieved a PGA score of clear or minimal with at least a two-grade reduction from baseline at week 12 in the tildrakizumab 100 mg groups compared with placebo. The difference in proportions reported was 51%, 95% CI, 44% to 57%, P < 0.001 in Study P010, and 50%, 95% CI, 43% to 57%, P < 0.001, in Study P011. No statistically significant difference was detected between tildrakizumab 100 mg and etanercept (7%, 95% CI, 0.5% to 15%, P= 0.066).

Tildrakizumab 100 mg was associated with statistically significant differences versus placebo in the proportion of patients who achieved a PASI 90 response in Study P010 (absolute difference 32%, 95% CI, 26% to 38%, P < 0.001) and Study P011 (38%, 95% CI, 31% to 43%, P < 0.001) at week 12. More patients in the tildrakizumab 100 mg group achieved a PASI 100 response at week 12 than placebo with an absolute difference of 13%, 95% CI, 8% to 17%, P < 0.001, in Study P010, and 12%, 95% CI, 9% to 17% in Study P011; however, the differences between tildrakizumab 100 mg versus placebo in P011 were not statistically significant as the testing procedures was stopped due to failure of a prior outcome. The differences between tildrakizumab 100 mg and etanercept for PASI 90 and PASI 100 response were not statistically significant due to failure of a prior outcome in the statistical testing procedure.

The proportion of patients who achieved a DLQI score of 0 or 1 at 12 weeks was higher among those who received tildrakizumab (40% to 47%) and etanercept (36%) than placebo (5% to 8%), with a between-group difference of 36%, 95% confidence interval [CI] 29% to 43%, P < 0.001 (Study P010), and 32%, 95% CI, 25% to 39%, P < 0.001 (Study P011) for tildrakizumab 100 mg versus placebo. The between-group differences in the change from baseline in DLQI scores also favoured tildrakizumab 100 mg versus placebo with a least squares mean difference of –7.4 points, 95% CI, –8.3 to –6.5, P < 0.001 in study P010, and –8.2 points, 95% CI, –9.3 to –7.2, P < 0.001 in study P011. The between-group differences observed exceeded the MIDs reported in the literature (2.2 to 6.9) for the comparison between tildrakizumab and placebo but not compared with etanercept. HRQoL outcomes were not part of the statistical testing hierarchy and thus the DLQI results were considered supportive evidence for the overall effect of tildrakizumab.

Harms (Safety)

The percentage of patients who reported 1 or more adverse events during the first 12 weeks of Study P010 and Study P011 ranged from 48% to 55% for placebo, 42% to 49% for tildrakizumab, and 54% for etanercept groups. Infections and infestations were reported by 20% to 24% of patients in part 1, with a similar frequency across treatment groups.

When reported for the overall study period, the exposure-adjusted incidence of infections or infestations was higher in the placebo groups (74 to 95 events/100 person years [PY]) and etanercept group (86 events/100 PY) than in the tildrakizumab groups (45 to 57 events/100 PY). Serious infections, defined as those that met the criteria for a serious adverse event or that required IV antibiotics, were infrequent (week 12: range 0% to 0.6%; week 52 or 64: 0.6 events/100 PY to 2.9 events/100 PY) in the pivotal trials. More patients in the etanercept group reported injection site adverse events (2% to 9%) than in the tildrakizumab or placebo groups (0% to 3%) during the first 12 weeks of Study P011.

Serious adverse events and discontinuation due to adverse events were infrequent during the first 12 weeks of the trials (0% to 3%). The incidence of serious adverse events ranged from 5.1 to 13.0 events/100 PY, and discontinuation due to adverse events ranged from 0.8 to 5.9 events/100 PY during base study periods (64 weeks in P010 and 52 weeks in P011).

Notable harms specified in the formulary review protocol (malignancies, cardiovascular adverse events, or drug-related hypersensitivity events) were infrequent in the first 12 weeks of the studies (0% to 0.6% of patients per treatment group) and over the entire base study (0 to 2.9 events/100 PY). However, the trials were not designed or powered to detect rare adverse events, or those with a longer lag time.

Indirect Evidence

Indirect evidence on the comparative efficacy or safety of immunomodulators used to treat patients with moderate-to-severe plaque psoriasis included 1 NMA submitted by the sponsor, and 5 other published NMAs. The NMA submitted by the sponsor included data from 47 phase III RCTs. In this NMA, all immunomodulators were statistically significantly more likely to achieve a PASI 50, PASI 75, or PASI 90 response than placebo at the end of the induction period (10 to 16 weeks) in the base-case analysis. The indirect evidence suggests that patients who received tildrakizumab were less likely to achieve PASI 50, PASI 75, and PASI 90 response than those treated with IL-17 inhibitors (ixekizumab, brodalumab, secukinumab), other IL-23 inhibitors (guselkumab, risankizumab), and infliximab. The results also suggest that tildrakizumab was more effective in terms of PASI 50, PASI 75, or PASI 90 response than etanercept or apremilast. The comparisons between tildrakizumab and adalimumab, certolizumab or ustekinumab did not statistically differ as the 95% credible interval included the null. The PASI response results of the other 5 NMAs were generally consistent with those in the sponsor-submitted NMA. Although the trials included in the NMAs used similar inclusion criteria, there was variation across trials in the proportion of patients with psoriatic arthritis, prior exposure to biologics, the timing of the outcome assessment, and region. Placebo-adjusted models were selected in 2 ITCs in an attempt to account for potential variability; however it is unclear to what extent placebo response is an adequate proxy for specific characteristics or effect modifiers.

Cost and Cost-Effectiveness

Tildrakizumab is available as single-dose, 100 mg/mL pre-filled syringe. The recommended dose is 100 mg administered subcutaneously at weeks, 0, 4, and every 12 weeks thereafter. At the sponsor's submitted price of $4,935 per pre-filled syringe, the annual per patient cost of tildrakizumab is $24,675 in the first year, and $21,385 in subsequent years.

The sponsor submitted a cost-utility analysis (CUA) based on a Markov model comparing tildrakizumab with the following biologic therapies reimbursed in Canada for moderate-to-severe plaque psoriasis; adalimumab, brodalumab, etanercept subsequent entry biologic (SEB), guselkumab, infliximab SEB, ixekizumab, secukinumab, ustekinumab, and risankizumab. The CUA was conducted from a Canadian publicly funded health care payer perspective over a 10-year time horizon. The model had 2 time periods: an induction period of 10 to 16 weeks until assessment of treatment response and the maintenance period. Treatment response was defined as achieving a PASI response score of 75 (PASI 75) or greater. Those who did not respond or discontinued therapy could switch to a second active therapy before receiving best supportive care (BSC; topical therapies). Probability of treatment response was derived from the reSURFACE clinical trials and a published NMA. In the sponsor's base case, tildrakizumab was dominated by brodalumab (i.e., tildrakizumab was more costly and associated with fewer quality-adjusted life-years [QALYs]) and had a 0% probability of being cost-effective at a willingness-to-pay (WTP) threshold of $50,000 per QALY.

CADTH identified several key limitations with the model submitted by the sponsor. Methodological limitations were identified with the maintenance treatment phase of the clinical trial that potentially inflated the long-term effectiveness of tildrakizumab. Furthermore, the measure of response used by the sponsor (PASI 75) is not consistent with how treatment success is measured in clinical practice (PASI 90), which also may have overestimated the clinical benefit of tildrakizumab. CADTH could not undertake reanalyses to address these limitations due to the available data and submitted model structure. Other limitations were identified pertaining to the discontinuation rates used, the time point of initial assessment of treatment response, subsequent treatment, and inappropriate cost information.

CADTH addressed some of these limitations by assuming 100% of the patients on second-line treatment received biologic therapy; using a 20% discontinuation rate for all biologics; using the branded price for etanercept and up-to-date costs for the rest of the

biologic drugs; using a consistent time point (16 weeks) for the initial assessment of treatment response for all biologics; and using a Canadian source for BSC costs. Based on the CADTH reanalysis, tildrakizumab, adalimumab, guselkumab, secukinumab, ixekizumab, and ustekinumab were either dominated or extendedly dominated. Etanercept, infliximab SEB, brodalumab, and risankizumab were the optimal treatments (on the cost-effectiveness efficiency frontier). These results aligned with the sponsor-submitted results.

Based on CADTH reanalyses, tildrakizumab is not cost-effective at WTP of $50,000 per QALY. Several biologic drugs provide better efficacy in terms of response at a lower total cost; for example, adalimumab, brodalumab, and infliximab have a better efficacy than tildrakizumab, at a lower total cost. A price reduction of at least 20% would be required for tildrakizumab to be cost-effective at a WTP threshold of $50,000 per QALY, though there are limitations that CADTH could not address that add to the uncertainty of the cost-effectiveness of tildrakizumab.

CDEC Members

Dr. James Silvius (Chair), Dr. Ahmed Bayoumi, Dr. Sally Bean, Dr. Bruce Carleton, Dr. Alun Edwards, Mr. Bob Gagne, Dr. Ran Goldman, Dr. Allan Grill, Mr. Allen Lefebvre, Dr. Kerry Mansell, Ms. Heather Neville, Dr. Danyaal Raza, Dr. Emily Reynen, Dr. Yvonne Shevchuk, and Dr. Adil Virani.

March 17, 2021 Meeting

Regrets

One expert committee member did not attend.

Conflicts of Interest

None

CADTH

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