www.scottishmedicines.org.uk

Advice document
SMC2636

momelotinib film coated tablet (Omjjara®)

GlaxoSmithKline UK Ltd

10 May 2024

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

ADVICE: following an abbreviated submission

momelotinib (Omjjara®) is accepted for use within NHSScotland.

Indication under review: Treatment of disease-related splenomegaly or symptoms in adult patients with moderate to severe anaemia who have primary myelofibrosis, post polycythaemia vera myelofibrosis or post essential thrombocythaemia myelofibrosis and who are Janus Associated Kinase (JAK) inhibitor naïve or have been treated with ruxolitinib.

Momelotinib offers an additional treatment choice in the therapeutic class of JAK inhibitors in this setting.

Another medicine within this therapeutic class has been accepted via the orphan medicine process.

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.

Vice Chair
Scottish Medicines Consortium

Published 10 June 2024

1. Clinical Context

1.1. Medicine background

Momelotinib is a JAK inhibitor. It is licensed for the treatment of disease-related splenomegaly or symptoms in adult patients with moderate to severe anaemia who have primary myelofibrosis, post polycythaemia vera myelofibrosis or post essential thrombocythaemia myelofibrosis and who are Janus Associated Kinase (JAK) inhibitor naïve or have been treated with ruxolitinib. It is administered orally at a daily dose of 200mg. In patients with severe hepatic impairment (Child-Pugh Class C) a starting dose of 150mg once daily is recommended. In the event of haematologic and non-haematologic toxicities dose modifications should be considered. Where patients are unable to tolerate a daily dose of 100mg, treatment with momelotinib should be discontinued. Treatment may be continued for as long as the benefit-risk remains positive for patients, as assessed by the treating physician. Refer to the summary of product characteristics for further information.[1]

1.2. Relevant comparator(s)

Ruxolitinib (Jakavi ®) (SMC867/13) is a JAK inhibitor licensed for the treatment of disease-related splenomegaly or symptoms in adult patients with primary myelofibrosis (also known as chronic idiopathic myelofibrosis), post polycythaemia vera myelofibrosis or post essential thrombocythaemia myelofibrosis. Fedratinib (Inrebic ®) (SMC2462) is also a JAK inhibitor licensed for the treatment of disease-related splenomegaly or symptoms in adult patients with primary myelofibrosis, post polycythaemia vera myelofibrosis or post essential thrombocythaemia myelofibrosis who are Janus Associated Kinase (JAK) inhibitor naïve or have been treated with ruxolitinib.

2. Summary of Clinical Evidence

2.1. Evidence to support comparable efficacy with relevant comparators

Momelotinib has been compared directly with ruxolitinib (SIMPLIFY-1) and best available therapy (BAT) (SIMPLIFY-2) in the JAK-inibitor naïve and experienced populations respectively.

SIMPLIFY-1 was a multicentre, double blind, randomised phase III non-inferiority trial comparing momelotinib (n=215) with ruxolitinib (n=217) in JAK-inhibitor naïve patients. Patients received 24 weeks of treatment with either momelotinib (200mg, once daily) or ruxolitinib (20mg, twice daily).[2] Baseline characteristics were balanced between the groups. Non-inferiority between momelotinib and ruxolitinib was met for the primary outcome, reduction of ≥35% in spleen volume from baseline at 24 weeks (26.5% versus 29% in the respective groups, proportion difference of 0.9 [95% confidence interval [CI] 0.02 to 0.16]). Fewer patients in the momelotinib arm had a reduction of total symptom score (TSS) of ≥50% from baseline compared with ruxolitinib (28% versus 42%).[2]

The incidence of adverse events (any grade) was similar between momelotinib and ruxolitinib (92% versus 95%). The incidence of the following adverse events were lower for momelotinib compared to ruxolitinib: thrombocytopenia (19% versus 29%) and anaemia (14% versus 38%).

Incidence of dizziness, nausea and fatigue were slightly higher in the momelotinib arm compared to ruxolitinib.[2]

SIMPLIFY-2 was a phase 3, randomised, open label trial comparing momelotinib (n=104) with BAT (n=52) in previously treated patients. Patients received 24 weeks of treatment with either momelotinib (200mg once daily) or best available therapy, which could include ruxolitinib, chemotherapy, steroids, no treatment or other standard treatment.[3] Baseline characteristics were mostly balanced between the groups, with the momelotinib arm having slightly more males than the BAT arm (66% versus 46%). The primary outcome, reduction of ≥35% in spleen volume from baseline at 24 weeks, was achieved in 7% of patients who received momelotinib versus 6% in the BAT group (patients were all receiving ruxolitinib). The primary outcome was not met as superiority of momelotinib against BAT was not demonstrated. A greater proportion of patients in the momelotinib arm had a reduction of TSS of ≥50% from baseline (26% versus 6%).[3]

The incidence of adverse events (any grade) was 97% in the momelotinib arm versus 89% in the BAT arm. The most commonly reported grade 3 or worse adverse event between momelotinib and BAT was anaemia (14% versus 14%); thrombocytopenia (7% versus 6%) and abdominal pain (1% versus 6%). Serious adverse events were reported in 35% in the momelotinib group versus 23% in the BAT group.[3]

The company also provided a published NMA to compare momelotinib with fedratinib and ruxolitinib in the JAK-inhibitor naïve population.[4] The efficacy outcome was a spleen volume reduction (SVR) greater than 35% after 24 weeks of treatment and the safety outcome was main adverse events due to hematologic toxicity. The NMA found that all three medicines had a significant improvement on SVR when compared to placebo. No differences were identified between the three medicines.[4]

The safety outcome found significantly less grade 3/4 anaemia events with momelotinib compared to ruloxitinib and fedratinib. The analysis included all trials, combining the treatment naïve and experienced patients which may have influenced the results. The NMA performed a number of sensitivity analyses removing the treatment experienced patients and found similar results, noting the combination of populations was likely to have no impact on the safety signal.[4]

3. Company Estimate of Eligible Population, Uptake and Budget Impact

3.1. Company's number of patients assumed to be eligible for treatment*

In the JAK inhibitor naïve population the company estimated that there would be 6 patients eligible for treatment with momelotinib each year. In the JAK inhibitor experienced population the company estimated that there would be 39 patients eligible for treatment with momelotinib each year.

3.2. Budget Impact assumption

Medicines reviewed under the abbreviated submissions process are estimated to have a limited net budget impact and resource allocation across NHS Scotland.

References

1. GlaxoSmithKline. Momelotinib (Omijara ®). Summary of product characteristics. MHRA. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://mhraproducts4853.blob.core.windows.net/docs/0c597d673004efd42d4a6249ac2375b85f994898. Last updated [28 March 2024]

2. Mesa RA, Kiladjian J-J, Catalano JV, Devos T, Egyed M, Hellmann A*, et al.* Simplify-1: A phase III randomized trial of momelotinib versus ruxolitinib in janus kinase inhibitor–naïve patients with myelofibrosis. Journal of Clinical Oncology. 2017;35(34):3844.

3. Harrison CN, Vannucchi AM, Platzbecker U, Cervantes F, Gupta V, Lavie D*, et al.* Momelotinib versus best available therapy in patients with myelofibrosis previously treated with ruxolitinib (SIMPLIFY 2): a randomised, open-label, phase 3 trial. The Lancet Haematology. 2018;5(2):e73-e81.

4. Sureau L, Orvain C, Ianotto J-C, Ugo V, Kiladjian J-J, Luque Paz D*, et al.* Efficacy and tolerability of Janus kinase inhibitors in myelofibrosis: a systematic review and network meta-analysis. Blood Cancer Journal. 2021;11(7):135.

Advice context:

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

This advice is based on the estimation of at least similar comparative efficacy and limited net budget impact compared with other medicinal products, within the same therapeutic class, that are in routine use within NHSScotland.

This advice represents the view of the Scottish Medicines Consortium and was arrived at after evaluation of the evidence submitted by the company. 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.

This assessment is based on data submitted by the applicant company up to and including 29 April 2024.

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.