NCPE Assessment

Summary Document

Durvalumab (Imfinzi®)

25010

02 April 2026

Applicant: AstraZeneca

Durvalumab as treatment for limited-stage small cell lung cancer in adult patients whose disease has not progressed after platinum-based chemoradiation therapy.

NCPE
National Centre for Pharmacoeconomics, Ireland

The National Centre for Pharmacoeconomics (NCPE) has issued a recommendation regarding the cost-effectiveness of durvalumab (Imfinzi®) as treatment for limited-stage small cell lung cancer in adult patients whose disease has not progressed after platinum-based chemoradiation therapy.

Following assessment of the Applicant's submission, the NCPE recommends that durvalumab (Imfinzi®) be considered for reimbursement for this indication if cost-effectiveness can be improved relative to existing treatments.

The Health Service Executive (HSE) asked the NCPE to carry out an evaluation of the Applicant's (AstraZeneca) Health Technology Assessment of durvalumab (Imfinzi®). The NCPE uses a decision framework to systematically assess whether a technology is cost-effective. This includes comparative clinical effectiveness and health related quality of life benefits, which the new treatment may provide and whether the cost requested by the pharmaceutical company is justified.

Following the recommendation from the NCPE, the HSE examines all the evidence which may be relevant for the decision; the final decision on reimbursement is made by the HSE. In the case of cancer drugs the NCPE recommendation is also considered by the National Cancer Control Programme (NCCP) Technology Review Group.

About the National Centre for Pharmacoeconomics

The NCPE are a team of clinicians, pharmacists, pharmacologists and statisticians who evaluate the benefit and costs of medical technologies and provide advice to the HSE. We also obtain valuable support from clinicians with expertise in the specific clinical area under consideration. Our aim is to provide impartial advice to help decision makers provide the most effective, safe and value for money treatments for patients. Our advice is for consideration by anyone who has a responsibility for commissioning or providing healthcare, public health or social care services.

Summary

In September 2025, AstraZeneca submitted a dossier which investigated the comparative clinical effectiveness, cost-effectiveness and budget impact of durvalumab (Imfinzi®) for the treatment of limited-stage small cell lung cancer (LS-SCLC) in adult patients whose disease has not progressed after platinum-based chemoradiation therapy (CRT). AstraZeneca is seeking reimbursement of durvalumab on the Oncology Drug Management System.

Durvalumab is a human monoclonal antibody that acts as a programmed death-ligand 1 (PD-L1) inhibitor, by binding to PD-L1, preventing it from interacting with programmed-death 1 (PD-1) and CD80 (cluster of differentiation 80) receptors, enabling T-cells to destroy tumour cells. The recommended dose of durvalumab is 1,500mg once every four weeks, administered via intravenous infusion. Treatment duration is until disease progression, unacceptable toxicity, or for a maximum of 24 months.

There are currently no systemic consolidation therapies reimbursed for LS-SCLC in Ireland and the current standard of care (SoC) for patients with LS-SCLC whose disease has not progressed after platinum-based CRT is active surveillance, henceforth referred to as 'watch and wait'. The Applicant's proposed positioning of durvalumab is in line with the licensed indication and watch and wait is the sole included comparator. The Review Group consider this to be appropriate.

1. Comparative effectiveness of durvalumab

The efficacy and safety of durvalumab was assessed in the ADRIATIC trial. ADRIATIC is an ongoing phase III, double-blind, placebo-controlled trial designed to evaluate the efficacy and safety of durvalumab monotherapy, and durvalumab plus tremelimumab, compared with placebo, as consolidation treatment in participants with LS-SCLC whose disease had not progressed following platinum-based CRT (of note participants with concurrent CRT [cCRT] were included the trial). Dosing was as per the SmPC recommended dosing. The durvalumab plus tremelimumab arm is not considered relevant to this assessment, and only the durvalumab and placebo (a proxy for 'watch and wait') arms are presented hereafter. The Review Group note that ADRIATIC did not remove the durvalumab plus tremelimumab arm

due to safety or efficacy failure; rather, it remains blinded and in progress for the final analysis. The co-primary endpoints were progression free survival (PFS) and overall survival (OS) per RECIST.

In the interim analysis (data cut 15 January 2024) median PFS was 16.6 months (95% confidence interval [CI] 10.2 to 28.2 months) in the durvalumab arm and 9.2 months (95% CI 7.4 to 12.9 months) in the placebo arm. The hazard ratio (HR) was 0.76 (95% CI 0.61 to 0.95; p=0.0161). Median PFS follow-up was 27.4 months with durvalumab and 27.7 months with placebo. OS was derived from the same data cut (15 January 2024) where the median OS was 55.9 months (95% CI 37.3 to not reached) in the durvalumab arm and 33.4 months in the placebo arm (95% CI 25.5 to 39.9 months). The HR was 0.73 (95% CI 0.57, 0.93; p=0.0104). Median OS follow-up for censored patients was 37.2 months in both arms.

Limitations of ADRIATIC include: that OS data are not yet fully mature and the long term OS benefit is therefore uncertain; subsequent treatments received in the trial are not reflective of the Irish SoC; the trial excluded participants with an Eastern Cooperative Oncology Group (ECOG) performance score (PS) >1 and those who received sequential CRT (sCRT) for LS-SCLC. Patients with an ECOG PS of 0 or 1 are considered in better health, and patients with sCRT are often more unwell and less fit for treatment. However, the product licence does not restrict use in these patients. Furthermore, half of the population in ADRIATIC were of Asian ethnicity which may limit applicability to the Irish population. ADRIATIC provided head-to-head comparative efficacy data for durvalumab versus watch and wait (placebo), therefore no indirect treatment comparison was required.

2. Safety of durvalumab

The clinical safety of durvalumab was informed by the interim analysis (15 January 2024). Adverse events (AE) of any cause were reported in 94.3% of participants in the durvalumab arm and in 88.3% of participants in the placebo arm. Investigator-assessed treatment-related adverse event (TRAEs) (defined in the trial as AEs possibly related to treatment) were reported in 67.2% versus 48.7% of participants in the durvalumab and placebo arms, respectively. Grade 3-4 TRAEs occurred in 9.5% of participants in the durvalumab arm and 6.0% of participants in the placebo arm, while serious TRAEs were reported in 12.2% and 6.4% of participants in the durvalumab and placebo arms,

respectively. TRAEs led to permanent discontinuation in 11.5% of durvalumab treated patients and 5.7% of those on placebo; dose interruptions occurred in 34.7% vs 28.7% in the durvalumab and placebo arms, respectively. TRAEs resulting in death occurred in 0.8% of participants receiving durvalumab and none receiving placebo.

3. Cost effectiveness of durvalumab

The Applicant has compared the cost-effectiveness of durvalumab to watch and wait in the base case.

Methods

The cost-effectiveness model (CEM) is a partitioned survival model with three health states: Progression Free [PF], Progressed Disease [PD], and Death. These health states capture PFS and OS. A lifetime horizon (38 years) was modelled with a four-week cycle length in line with the recommended dosing for durvalumab. A half-cycle correction was applied. Patients, with LS-SCLC who have not progressed following platinum-based CRT, enter the model in the PF health state and receive treatment with either durvalumab or watch and wait as consolidation treatment. In each model cycle, patients either remain in their current state, transition to the PD health state, or transition from the PF or PD health states to the death state.

OS and PFS are modelled using individual patient level data (IPD) from the ADRIATIC trial, which provides direct clinical evidence on the efficacy of durvalumab versus watch and wait in the licensed population. Survival analysis using the IPD is performed including fitting parametric models to PFS and OS. In each cycle, patients accrue QALYs and incur costs based on the utility (health related quality of life) values and costs specified for the health state occupied, the relevant treatment arm, and the time to treatment discontinuation (TTD). Fully mature TTD data from ADRIATIC are used to inform treatment-related costs for durvalumab.

Results

An incremental analysis of the costs and benefits of durvalumab versus placebo was presented by the Applicant. The probabilistic results, which were estimated for 5,000 simulations, are stable and similar to the deterministic results.

Table 1: Applicant base case incremental cost-effectiveness results [a,b]

Treatments	Total costs (€)	Total QALYs	Incremental costs (€)	Incremental QALYs	ICER (€/QALY)
Watch and wait	40,145	3.77	-	-	-
Durvalumab	130,533	5.28	90,389	1.51	59,810

QALY: quality adjusted life year; **ICER:** incremental cost-effectiveness ratio

[a] Corresponding probabilistic ICER using 5,000 iterations =€61,326/QALY. Figures in the table are rounded, and so calculations may not be directly replicable. A discount rate of 4.0% is applied to costs and outcomes

[b] A commercial in confidence (CIC) patient access scheme (PAS) has been proposed for durvalumab for the current indication, not included here.

The Review Group assessment made one change to the Applicant's base case which was explored in the NCPE adjusted base case. This included the choice of OS extrapolation curve (whereby the Applicant's chosen curve was overly optimistic in terms of OS in the long-term).

Table 2: NCPE adjusted base case incremental cost-effectiveness results [a,b]

Treatments	Total costs (€)	Total QALYs	Incremental costs (€)	Incremental QALYs	ICER (€/QALY)
Watch and wait	40,392	3.45	-	-	-
Durvalumab	130,095	4.71	89,703	1.26	71,307

QALY: quality adjusted life year; **ICER:** incremental cost-effectiveness ratio; **NCPE**: National Centre for Pharmacoeconomics

[a] Corresponding probabilistic ICER using 5,000 iterations =€72,028/QALY. Figures in the table are rounded, and so calculations may not be directly replicable. A discount rate of 4.0% is applied to costs and outcomes.

[b] A commercial in confidence (CIC) patient access scheme (PAS) has been proposed for durvalumab for the current indication, not included here.

Sensitivity analysis

Durvalumab has a 0% probability of cost effectiveness at the €20,000/QALY threshold versus watch and wait (in the Applicant's and NCPE adjusted base cases). Durvalumab has a 25% probability and 18% probability of cost effectiveness at the €45,000/QALY threshold versus watch and wait (in the Applicant's and NCPE adjusted base cases respectively). A Price-ICER analysis, conducted using the NCPE-adjusted base case, indicated that a 43.44% in the price-to-wholesaler (PtW) of durvalumab was required to meet the €45,000/QALY threshold when compared to watch and wait. At the €20,000/QALY threshold a 76.16% price reduction was required versus watch and wait.

4. Budget impact of durvalumab

The PtW of durvalumab is €2,565.08 per pack (1 x 500mg vial). The estimated cost of durvalumab treatment per-patient, per-treatment course is €108,754 (including VAT), based on the mean number of durvalumab administrations (12.9 cycles) observed in the ADRIATIC

trial. The Applicant's gross and net drug budget impact estimates were considered very uncertain, and an NCPE adjusted budget impact model is presented with the following changes: the Applicant applied incidence rates per 100,000 of the total population across all ages, to adult population estimates (i.e. only applied to those aged 18 years and older). This may underestimate the eligible population. The NCPE adjusted base case applied the age-standardised incidence rate for lung cancer among individuals aged 20 to 85 years, sourced from the National Cancer Registry Ireland live incidence statistics tool. The Applicant's five-year gross and net drug budget impact estimates for durvalumab are €49.71 million (including VAT). The NCPE adjusted five-year gross and net drug budget impact estimates for durvalumab are €61.10 million (including VAT).

5. Patient Organisation Submission

A patient organisation submission was received from the Irish Lung Cancer Community and has been shared with the HSE. This submission will form part of the information that the HSE considers when making their drug-funding decision.

6. Conclusion

The NCPE recommends that durvalumab be considered for reimbursement for this indication if cost-effectiveness can be improved*.

*Next steps: The NCPE Assessment Report and recommendation, will be considered by the HSE when making their decision on reimbursement, while also having regard to the criteria specified in the Health (Pricing and Supply of Medical Goods) Act 2013. Further information on this process may be found here.