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2023019379

National Health Care Institute

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Contact
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Date 12 May 2023
Re: Medicine Reimbursement System advice vericiguat (Verquvo®)

Our reference
2023019379

Dear Mr Kuipers,

In your letter of 31 October 2022 (reference CIBG-22-04609), you requested the National Health Care Institute to re-assess Vericiguat (Verquvo®) for the indication treatment of symptomatic chronic heart failure in adult patients with reduced ejection fraction (HFrEF) who have been stabilised following a recent episode of decompensation requiring intravenous treatment. The National Health Care Institute, advised by the Scientific Advisory Board (WAR), has completed this re-assessment. The considerations are set out in the attached reports.

Background
In the initial assessment, the National Health Care Institute found that vericiguat did not meet the criterion of established medical science and medical practice for this indication. For this reason, the National Health Care Institute recommended that vericiguat should not be included in the GVS; see advisory letter dated 24 February 2022 (ref. 2022001532).

Current request
The marketing authorisation holder now requests a re-assessment of vericiguat for the subgroup of patients with an NT-proBNP value of ≤5314 pg/ml based on newly available data for the same indication.

Therapeutic value
The effectiveness of vericiguat added to standard treatment of adult patients with symptomatic chronic heart failure with an NT-proBNP value of ≤5314 pg/ml, stabilised after a recent episode of decompensation requiring intravenous treatment, was investigated in a double-blind, placebo-controlled, randomised phase 3 study; the VICTORIA study. Based on the study results, it can be concluded that vericiguat has a statistically and clinically relevant effect in this population compared to placebo on both the primary composite outcome parameter 'reduction of the risk of cardiovascular death or hospitalisation for heart failure ' and the individual outcome parameters 'hospitalisation for heart failure', 'cardiovascular mortality' and 'all-cause mortality''.
Vericiguat has no statistically and clinically relevant effect on quality of life compared to placebo.

In the VICTORIA study, the standard treatment consisted of a *triple* combination therapy of an ACE inhibitor *or* angiotensin II receptor blocker (ARB) *or* sacubitril/valsartan, a beta blocker and an aldosterone antagonist. According to current European and Dutch treatment guidelines, an SGLT2 inhibitor should now be added as standard: a quadruple combination therapy. In the Netherlands, according to the physicians' association, vericiguat will only be used in patients with HFrEF who have recovered from a recent decompensation episode and where quadruple combination therapy was not sufficient for cardiac stabilisation of the patient. Since only 135 of the 5050 patients (66 in the vericiguat group and 69 in the placebo group) in the VICTORIA study also used an SGLT2 inhibitor, the clinical relevance of a (potentially) additive therapeutic effect of vericiguat cannot be scientifically reliably determined. Specific enquiries from the National Health Care Institute with the physicians' associationalso indicated that *'the effect of vericiguat added to treatment with SGLT2 inhibitors in HFrEF has not been studied'.*

The National Health Care Institute has concluded, based on the above grounds, that vericiguat meets the established medical science and medical practice in the treatment of adult patients with symptomatic chronic heart failure with a reduced ejection fraction (HFrEF) with an NT proBNP value of ≤5314 pg/ml, who have been stabilised with the triple combination therapy mentioned above following a recent episode of decompensation requiring intravenous treatment and who are not taking or are not able to take an SGLT2 inhibitor. The addition of vericiguat to this triple combination therapy has an added therapeutic value compared to this triple combination therapy alone. There is no (adequate) scientific evidence for an added therapeutic value for the addition of vericiguat to quadruple combination therapy.

Budget impact analysis (BIA)
Taking into account the assumptions regarding patient numbers, market penetration and patient compliance, the inclusion of vericiguat (Verquvo®) on List 1B of the GVS for the patient group for which an added value has been established, will be accompanied by additional costs charged to the pharmaceutical budget of approximately €4.0 million in the third year after market introduction.
In the third year, 3,656 patients are expected to be treated with vericiguat. This will cost €1,095 per patient annually. Substitution is not possible because vericiguat is given on top of existing care.
The results of this BIA may be overestimated because the National Health Care Institute was not able to make any correction for patients who are not eligible for vericiguat due to the use of an SGLT2 inhibitor. Data about this are lacking at the present time.

Advice
The National Health Care Institute recommends including vericiguat (Verquvo®) in List 1B of the Health Insurance Regulation.

If vericiguat (Verquvo®) is included in the health insurance package, the National Health Care Institute recommends the following reimbursement condition:

'Only for an adult insured person with symptomatic (NYHA II-IV) chronic heart

failure and reduced ejection fraction (LVEF ≤ 40%) (HFrEF) with an NT-proBNP value of ≤5314 pg/ml,

- *who cannot be adequately treated with combination therapy of an ACE inhibitor or angiotensin II receptor blocker (ARB) or sacubitril/valsartan, a beta-blocker and an aldosterone antagonist* ***and***
- *who is not taking an SGLT2 inhibitor.'*

National Health Care Institute

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Yours sincerely,

Sjaak Wijma
Chairperson of the Executive Board