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# Rapid access to innovative medicinal products while ensuring relevant health technology assessment. Position of the French National Authority for Health

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10.1136/bmjebm-2022-112091

► Additional supplemental material is published online only. To view, please visit the journal online (<http://dx.doi.org/10.1136/bmjebm-2022-112091>).

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**To cite:** Vanier A, Fernandez J, Kelley S, et al. *BMJ Evidence-Based Medicine* 2024;**29**:1–5.

## The challenge of accelerated clinical developments

In France, decisions for reimbursement taken by the Ministry of Health are based on appraisal by an independent Health Technology Assessment body (HTAb): the ‘Haute Autorité de santé’ (HAS). HAS grades the clinical added value of any medicinal product for which a manufacturer seeks reimbursement. This appraisal considers different types of clinical and patient-centred outcomes, including patient-reported ones. Under certain conditions, a concomitant economic assessment which accounts for patients’ preferences in the form of utility values is also performed.

As providing fast access to breakthrough therapies is a critical expectation from patients, clinicians and health policy makers, the European Medicines Agency and the Food and Drug Administration have established various accelerated approval pathways. These procedures lead to conditional approvals frequently based on uncontrolled (ie, single arm) pivotal trials.<sup>1–4</sup> Approvals based on uncontrolled trials are also motivated by randomisation sometimes being considered unfeasible or unethical, or because the pathophysiological rationale is assumed to be important when proving effectiveness (eg, a treatment with molecular target in oncology).<sup>5,6</sup>

However, expected benefits based on uncontrolled trials as evidence are frequently not confirmed. The results of meta-epidemiological studies illustrate that appraisals based on such evidence entail a high level of uncertainty leading to ethical concerns.<sup>7,8</sup> For patients, this may have deleterious consequences such as the use of products for which the benefits remain unknown,<sup>9,10</sup> the overestimation of benefits with no further confirmation<sup>11,12</sup> or the increased risks of adverse events.<sup>12,13</sup> This high level of uncertainty may also impact health system sustainability.

While ensuring rapid access to valuable treatments is of utmost importance to patients, maintaining an adequate balance with the performance

of relevant HTA in this context is highly challenging. Thus, the French Minister of Health requested HAS to provide recommendations. A consultation of patient associations, academics, manufacturers and various institutions was conducted from October 2021 to January 2022. With the support of an expert committee, a qualitative summary of the consultation has led to the prioritisation of recommendations, which are developed below (details on the consultation process are available in an online supplemental appendix 1).

## Need for evidence from comparative designs allowing causal interpretation of treatment effect estimation

Performing relevant HTA requires that an unbiased estimate of the treatment effect is available. Thus, the additional effect must be disentangled beyond effects due to the natural course of the medical condition, the placebo effect, various sources of bias and the effect of alternative(s). To produce such an estimate, the simplest and most consensual methodological choice is a comparison of the treatment of interest to a control by conducting a randomised controlled trial (RCT). Randomising treatment allocation balances both known and unknown confounders between groups, which enables the causal attribution of an observed effect to the investigated treatment. Other characteristics such as blinding and intention to treat analysis principles reduce the risk of bias and thereby lead to an estimation of treatment effect with the highest certainty of results.

Therefore, RCTs should still be systematically considered by manufacturers during clinical development.

## Accelerating rapid access to innovative treatments by adapting the traditional RCT design

While RCTs are the gold standard for producing clinical evidence, HAS acknowledges that the strict

**Table 1** Adaptation of randomised controlled designs leading to good enough certainty of results that can accelerate treatment access to patients

Type of design	Brief description and usage	Some methodological points of attention for HAS
Adaptive designs in clinical trials	Their design can be modified in several aspects prospectively (eg, sample size, stopping rules due to effectiveness, futility or safety, enrichment of subgroups that are the most susceptible to exhibit effectiveness), which can decrease the number of patients to be included compared with what was initially expected.	They require the frequent review of accrued data at multiple time points to decide or not for modifications, which may reveal information about effectiveness to stakeholders. Defining adequately the role, process and interactions of the unblind independent data monitoring committee and blind trial steering committee is therefore crucial.
Platform trials	A subset of adaptive designs allowing the comparison either simultaneously and/or sequentially of multiple interventions to a common or multiple control groups, with possible addition and dropping of interventions, and adaptation of the control to new standard of care.	The design of the trial must ensure the control group is contemporaneous of the intervention(s) of interest(s). Blinding of patients and investigators can be difficult to achieve as it can require the use of multiple dummies.
Seamless trials	A subset of adaptive designs where there is no interruption between the conduct of different phases such as between phase 2 and phase 3, allowing reuse of data from patients from phase 2 for which the investigated treatment appeared to be beneficial.	It could be argued a seamless phase 2/3 trial does not allow the phase 3 to be an independent confirmation of the results of suggested effectiveness of the phase 2.
Pragmatic trials	An umbrella term that can define trials which try to enhance enrolment and applicability by defining less stringent eligibility criteria than 'traditional' randomised controlled trials, or the partial or complete use of real-world data allowing the conduct of 'trials within a cohort', 'registry-based randomised controlled trials', 'contactless trial' or 'direct-to-patient trial' (when all data are collected using real-world data and data coming from fully remote pathways).	Relying partially or completely on sources of data that were not primarily designed for research purposes can lead to issues regarding data validity, integrity, and monitoring. The follow-up of patients may not be as standardised as de novo clinical studies. Assessment of endpoints is at risk to be unblinded and/or adjudicated in a decentralised manner. Collection of safety data can be problematic.
Cross-over designs	Trials where the sequence of interventions is randomised and therefore each patient receives all interventions and is its own control, leading to the enrolment of fewer patients to conclude than the parallel-group design for a given effect of interest.	They assume an identical baseline state at the start of each treatment exposure, no effect of the first treatment to which a patient is exposed during the period of exposition to the second treatment, and no interaction between treatments and periods of exposure.

HAS, Haute Autorité de santé.

adherence to the traditional fixed-sample RCT design can lead to long delays before patients access treatments. Several alternatives to the traditional design, such as adaptive designs, platform trials, seamless trials, pragmatic trials or cross-over designs, can be better suited choices for accelerating clinical developments. An overview of main strengths and methodological points of attention is described in [table 1](#). All these adaptations are considered compatible with the principles of RCT design and can produce evidence with high certainty of results.

They should, therefore, be encouraged first when considering the issue of balancing rapid access to beneficial medicinal products to patients while performing relevant HTA.

### Increasing the certainty of results when uncontrolled trials are pivotal studies

Apart from the exceptional condition where an unequivocal response on a patient-centred outcome for almost all patients compared with an otherwise certain pejorative evolution is observed, the value of uncontrolled trials alone is strongly limited when estimating the effect of a treatment. Nonetheless, market approval relying on uncontrolled trials is prevalent,<sup>14</sup> as is the number of dossiers submitted for HTA based on these trials. Thus, HAS proposes points of attention that should be considered providing a manufacturer wants to submit a dossier based on uncontrolled trial(s) only. They are summarised below and are detailed in [box 1](#). Any deviation from these points of attention will further impair the certainty of results.

#### Justifying the suitability of the data generation programme

Lack of randomisation is a major deviation from evidence-based medicine principles and should remain an exceptional option. Therefore, a rationale for the lack of randomisation must be

provided by the manufacturer. They are invited to discuss the suitability of the evidence data package during European joint scientific consultations or national early dialogues.

#### Gathering source(s) of data for external comparison

Performing an adequate comparison vs an external control, using for example data from cohorts or other clinical trials, can be an option for mitigating uncertainties in the absence of RCTs. Availability of external controls may be scarce (eg, in case of targeted therapies for very rare mutation(s) in oncology). Real-world data generation should therefore be anticipated by the manufacturer during the early stages of the clinical development if no pre-existing data set has been identified for the comparison.

#### Performing transparent and appropriate analyses

To follow an hypothetico-deductive approach, external comparison must be planned as early as possible during clinical development. The framework of the emulation of a target trial can help to define the appropriate estimand, eligibility criteria as well as exposition and outcome(s) of the targeted (ie, ideal) RCT that the external comparison tries to emulate.<sup>15</sup> It also helps to avoid the occurrence of immortal-time bias that results from a failure to align start of follow-up.

To avoid a post hoc selection, the choice of an external control must be done prior to conducting the trial, after a well-performed systematic search. It must fit the standard of care. The retained external source of data must be chosen because it fits best the research question and not because it would arbitrarily favour the treatment of interest.

When performing an external comparison, the attribution of the observed effect to the treatment (causal statement) supposes the absence of any confounders. It requires a well performed

### Box 1 Methodological points of attention HAS should consider when assessing an external comparison between an uncontrolled trial and an external control

1. Justification of the lack of randomisation
  - A rationale appraised as acceptable by Haute Autorité de santé is provided.
2. Study design
  - Early planning during clinical development and before the conduct of the uncontrolled trial of the treatment of interest.
  - A priori definition of the clinical question, study population, intervention, comparator and outcomes in a protocol and statistical analysis plan.
  - An emulation of a target trial can enhance eliciting the appropriate clinical question (estimand) and designing the external comparison.
3. Search and selection of relevant sources of data
  - Well-performed systematic review identifying relevant prognostic variables, confounders and effect modifiers.
  - Well-performed systematic review (with eligibility criteria defined a priori) identifying relevant sources for external control.
4. Choice of the external control
  - The comparator and external source(s) of data has been chosen independently of the results of the uncontrolled trial, fit best the clinical question (does not arbitrarily favour the treatment of interest) and correspond to standard of care.
5. Analysis of the results
  - The study protocol, statistical analysis plan and report allow a transparent and appropriate assessment of the study.
  - A model for causal inference controlling an appropriate set of confounders and targeting the predefined estimand has been properly specified and estimated.
  - The model is preferably based on a method using individual patient data only such as propensity scores, g-computation or doubly robust estimation.
  - Underlying assumptions have been explored and seems to be met (such as positivity, sufficient overlap and sufficient balance for propensity scores).
  - If ‘trimming’ (ie, excluding patients in areas of the propensity score without overlap) have been performed, the resulting target population for which results can apply is described.
  - Residual confounding has been explored with analyses such as the use of negative and positive controls, consistency in results when using other external controls, or quantitative bias analysis and excludes a conclusion of no treatment effect.

Continued

### Box 1 Continued

- Study characteristics of the uncontrolled trial and external control are sufficiently similar for excluding other sources of bias such as selection bias, attrition bias, measurement bias.
  - Safety can be properly documented for both groups.
6. Grading the clinical added value
    - The clinical added value of the treatment of interest is appraised considering the certainty of results, the relevance and magnitude of treatment effect and safety.

causal inference analysis, using appropriate methods. Approaches based on the use of individual patient data only are preferred (eg, propensity scores analysis, g-computation, doubly robust estimation). Indeed, population-based adjusted methods using individual patient data from an uncontrolled trial and aggregate statistics from external data are sometimes considered. However, they rely on the assumption of the conditional constancy of absolute effects (ie, the absolute treatment effects are assumed constant at any given level of the effect modifiers and prognostic variables),<sup>16</sup> which is unlikely to be met. To select the appropriate set of covariables to use for conditioning the statistical analyses, a well-performed systematic search of prognosis variables, confounders and effect modifiers must be conducted.

The possibility of residual confounding must be discussed. All methods assume exhaustivity of the confounders considered, a property that will ultimately remain unverifiable. This discussion should not be based on expert opinion only and should be documented, for example, using either negative or positive controls, or a quantitative bias analysis. Sources of bias (eg, selection bias, measurement bias) due to the characteristics of the trial and external control(s) must be discussed.

Safety must be properly documented, including for the external control.

### Discussion of cross-cutting implications

This paper delineates proposals for an adequate balance between fast access to valuable medicinal products and performing relevant HTA. RCT, as the simplest and most consensual design for allowing causal reasoning, must be systematically considered for clinical development. However, various adaptations of its design, as proposed in [table 1](#), may accelerate clinical development and are encouraged whenever appropriate.

Conducting uncontrolled trials is regularly justified by arguing that randomisation is deemed unfeasible, or that there is a conflict between individual and collective ethics because there is no other alternative than best supportive care. However, results from meta-epidemiological studies showed that RCTs are regularly conducted when investigating rare diseases, even vs placebo, providing clinical equipoise (ie, the genuine uncertainty regarding the benefit of a new treatment) is appropriately explained to patients.<sup>17</sup> Urgent response to an emergent disease, or a strong pathophysiological rationale, are also frequently argued to justify the absence of RCTs. But, randomising the first patients when an emergent disease occurs has been considered ethically appropriate for decades, as it leads to the quickest generation of evidence with the highest certainty of results.<sup>18</sup> A strong pathophysiological rationale does not necessarily translate into clinical value and what is considered

an 'innovative' treatment should be based on clinical evidence. Therefore, HAS cannot propose a definitive list of conditions where absence of randomisation would be de facto acceptable.

To some extent, HAS acknowledges that exceptional conditions may exist that make it unreasonable to conduct an RCT. From the HAS perspective, evidence must, however, still comply to a hypothetico-deductive approach allowing causal reasoning. Should an uncontrolled trial with a comparison vs an external control be provided, the methodological points of attention HAS should consider are described in [box 1](#) to reduce uncertainty. Most of these points of attention (sections 2–5 of [box 1](#)) allow assessing factual elements according to good clinical and statistical principles. As such, they could be proposed as consistent points of attention applicable by different HTAbs when assessing external comparisons. However, the acceptance of the rationale justifying the lack of randomisation, as well as some elements leading to the appraisal of clinical added value (eg, relevance and magnitude of treatment effect, impact on public health), are relative to the organisation of health systems and must be assessed considering the national context.

A consequence of relying increasingly on uncontrolled trials as pivotal evidence would be a shift in demonstrating the effectiveness of medicinal products during clinical development towards post-approval. In this context, the use of real-world data, as primary or complementary source of data, is a possible way to address remaining uncertainties. Regardless of the source of data, quality of study design is a cornerstone for certainty of results. To close evidence gap quickly, appropriate studies must thus be anticipated and not limited to uncontrolled designs.<sup>19</sup> Usage of real-world data and compliance to RCT design should not be seen as antinomic. When appropriate, the conduct of RCTs can be facilitated by collecting some of the necessary data from pre-existing databases (see [table 1](#)). In addition, HAS calls for greater transparency in the whole process of generating evidence through initiatives such as registered report publications, data and clinical study reports sharing.<sup>20</sup>

Finally, HAS will remain attentive to emerging methods to reduce evidence gaps and accelerate clinical developments. In particular, the increasing use of artificial intelligence, in silico trials and disease modelling, might become a complementary path to optimising clinical development, as illustrated by CRESIM in helping to choose the best design in rare diseases.<sup>21 22</sup>

## Conclusion

Decisions for reimbursement in France are based on an assessment and appraisal process performed by an independent HAS committee which includes healthcare providers, methodologists and patients' representatives. Members of HAS and especially this committee are eager to secure rapid patient access to valuable medicinal products and that must be weighed against the duty to propose treatment with a clear demonstration of their clinical added value. As evidence-based medicine is an impartial decision model for coverage authorisations and as causal reasoning is essential for continuous improvement of care, HAS reaffirms the importance of RCTs to establish the value of new treatments. However, to balance rapid access for patients with evidential uncertainties, the traditional fixed-sample RCT design can be adapted. Moreover, properly conducted external comparisons as detailed in this paper may represent reasonable alternatives under exceptional conditions.

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**Contributors** AV, JF, SK and LA were responsible for the organisation and synthesis of the consultation of stakeholders as detailed in the online supplemental appendix. Preliminary scientific work on the issue of the methodological qualities of external comparisons was performed for HAS by PS and MC. All authors have participated in producing the recommendations proposed in the paper. AV, JF, SK and LA wrote the initial draft and oversaw subsequent steps of the writing process. All authors contributed to the conceptualisation and revisions of this analysis and approved the final version.

**Funding** The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

**Competing interests** DC reports an HIV grant from Janssen (2019–2020), personal fees from Gilead (2020) and Pfizer (2022) for lectures outside the submitted work. RT has been the coordinator of the IMI2 EBOVAC2 project in collaboration with Janssen (2014–2021). Other authors have no competing interests to disclose.

**Patient consent for publication** Not applicable.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Supplemental material** This content has been supplied by the author(s). It has not been vetted by BMJ Publishing Group Limited (BMJ) and may not have been peer-reviewed. Any opinions or recommendations discussed are solely those of



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#### References

- Kesselheim AS, Wang B, Franklin JM, *et al.* Trends in utilization of FDA expedited drug development and approval programs, 1987-2014: cohort study. *BMJ* 2015;351:h4633.
- Pontes C, Fontanet JM, Vives R, *et al.* Evidence supporting regulatory-decision making on orphan medicinal products authorisation in Europe: methodological uncertainties. *Orphanet J Rare Dis* 2018;13:206.
- Frank RG, Emanuel EJ. Paying for cancer drugs that prove their benefit. *JAMA* 2021;326:1579-80.
- Naci H, Davis C, Savović J, *et al.* Design characteristics, risk of bias, and reporting of randomised controlled trials supporting approvals of cancer drugs by European medicines Agency, 2014-16: cross sectional analysis. *BMJ* 2019;366:l5221.
- Davi R, Mahendraratnam N, Chatterjee A, *et al.* Informing single-arm clinical trials with external controls. *Nat Rev Drug Discov* 2020;19:821-2.
- Park JJH, Hsu G, Siden EG, *et al.* An overview of precision oncology basket and umbrella trials for clinicians. *CA Cancer J Clin* 2020;70:125-37.
- Hwang TJ, Carpenter D, Lauffenburger JC, *et al.* Failure of investigational drugs in late-stage clinical development and publication of trial results. *JAMA Intern Med* 2016;176:1826-33.
- Hwang TJ, Ross JS, Vokinger KN, *et al.* Association between FDA and EMA expedited approval programs and therapeutic value of new medicines: retrospective cohort study. *BMJ* 2020;371:m3434.
- Davis C, Naci H, Gurpinar E, *et al.* Availability of evidence of benefits on overall survival and quality of life of cancer drugs approved by European medicines agency: retrospective cohort study of drug approvals 2009-13. *BMJ* 2017;359:j4530.
- Onakpoya IJ, Spencer EA, Thompson MJ, *et al.* Effectiveness, safety and costs of orphan drugs: an evidence-based review. *BMJ Open* 2015;5:e007199.
- Ladanie A, Schmitt AM, Speich B, *et al.* Clinical trial evidence supporting US food and drug administration approval of novel cancer therapies between 2000 and 2016. *JAMA Netw Open* 2020;3:e2024406.
- Salas-Vega S, Iliopoulos O, Mossialos E. Assessment of overall survival, quality of life, and safety benefits associated with new cancer medicines. *JAMA Oncol* 2017;3:382-90.
- Gaddipati H, Liu K, Pariser A, *et al.* Rare cancer trial design: lessons from FDA approvals. *Clin Cancer Res* 2012;18:5172-8.
- Hatswell AJ, Baio G, Berlin JA, *et al.* Regulatory approval of pharmaceuticals without a randomised controlled study: analysis of EMA and FDA approvals 1999-2014. *BMJ Open* 2016;6:e011666.
- Hernán MA, Robins JM. Using big data to emulate a target trial when a randomized trial is not available. *Am J Epidemiol* 2016;183:758-64.
- Phillippo DM, Ades AE, Dias S, *et al.* Methods for population-adjusted indirect comparisons in health technology appraisal. *Med Decis Making* 2018;38:200-11.
- Logviss K, Krievins D, Purvina S. Characteristics of clinical trials in rare vs. common diseases: a register-based latvian study. *PLOS ONE* 2018;13:e0194494.
- Chalmers TC. Randomization of the first patient. *Med Clin North Am* 1975;59:1035-8.
- Booth CM, Karim S, Mackillop WJ. Real-world data: towards achieving the achievable in cancer care. *Nat Rev Clin Oncol* 2019;16:312-25.
- Naudet F, Siebert M, Boussageon R, *et al.* An open science pathway for drug marketing authorization-registered drug approval. *PLOS Med* 2021;18:e1003726.
- Bajard A, Chabaud S, Cornu C, *et al.* An in silico approach helped to identify the best experimental design, population, and outcome for future randomized clinical trials. *J Clin Epidemiol* 2016;69:125-36.
- Nony P, Kassai B, Cornu C, *et al.* A methodological framework for drug development in rare diseases. the cresim program: epilogue and perspectives. *Therapie* 2020;75:149-56.

## **Vanier at al. Rapid access to innovative medicinal products while ensuring relevant health technology assessment. Position of the French National Authority for Health**

### **Online Supplementary appendix. Detailed method of the consultation**

On October 2021, the *Haute Autorité de santé* (HAS) was asked by the French Ministry of Health to elaborate recommendations on the methodological challenges associated to accelerated clinical developments.

#### **1. Constitution of an expert committee**

An expert committee of 23 members was constituted with permanent members of HAS and experts outside of the institution. External experts were directly contacted by HAS for their academic expertise in biostatistics, methodology for clinical research, pharmacology, or clinical expertise. They have filled a standardized form listing potential conflict of interests which was published on a governmental website publicly accessible (<https://dpi.sante.gouv.fr/dpi-public-webapp/app/home>).

A first gathering of all the members of the committee has taken place on October 28<sup>th</sup>, 2021, to introduce the problematic and conduct of the consultation.

#### **2. Auditions of relevant stakeholders by the expert committee**

From November 2021 to January 2022, various stakeholders' representatives were auditioned by the expert committee. They were directly contacted by HAS. Several days before the audition, the broad problematic of the methodological challenges associated to accelerated clinical developments was introduced to them, and a conductor in the form of a brief questionnaire (see [section 7](#) below) was proposed to help structuring their presentation during the audition.

Six auditions of representative members of one institution were conducted (approximately one hour long each). Each institution was free to choose the persons who were auditioned. During these auditions, each institution was invited to first deliver the messages they wanted to the expert committee. Then, there was the conduct of an open discussion with the members of the expert committee.

The institutions that were auditioned were:

- “Les entreprises du médicament” and “France Biotech”: representatives of the manufacturers in France,

- “La conference nationale des CPPs”, representatives of the ethics committees in France,
- Academics from the “Assistance Publique – Hôpitaux de Paris” (University Hospital of Paris),
- “Le Groupe des Associations de Malade de l’Inserm” and “France Assos Santé”, representatives of the users of the health system in France.

Three auditions on a specific theme with several institutions invited at once were conducted (approximatively two hours long each).

An audition on oncology was conducted with:

- The oncology department of the “Agence Nationale de Sécurité du Médicament et des produits de santé”, the French regulatory body,
- “L’institut national du cancer” (INCa), the French national institute for cancer research,
- “UNICANCER”, a French federation of major cancer treatment centres,
- “Patients en réseau”, patients’ representatives,
- “La ligue contre le cancer”, a non-governmental organization promoting cancer research in France.

An audition on rare diseases was conducted with:

- The rare disease department of the French ministry of health,
- “OrphanDev”, a national network for clinical research for rare diseases,
- “Eurordis”, patients’ representatives in Europe,
- The center for clinical research for rare diseases of Lyon (University of Lyon).

An audition on in silico methodology and artificial intelligence was conducted with:

- Novadiscovery, contract research organization,
- Owkin, contract research organization,
- ARIIS, a network for clinical research.

### **3. Public consultation**

During the whole month of November, a public consultation was organized by HAS. The public consultation was available through a public website. The public consultation was advertised through press coverage and massive e-mailing.

Any person interested was invited to complete an online, short, unspecific, and open questionnaire regarding the problematic of the methodological challenges associated to accelerated clinical developments (the questionnaire is available below, see [section 7](#)). The public consultation was available in French and English, but only contributions from French stakeholders were received.

### **4. Synthesis of the audition and public consultation**

An internal qualitative non-systematic synthesis of all the auditions and all the received public consultation (50 answers) was performed by permanent members of the HAS from November 2021 to January 2022. Supports used by presenters during each audition (such as slide decks or other types of documents) were systematically recovered. During each audition, notes were taken by one member of the HAS. After each audition, a synthesis was written and sent to all the members of the expert committee. After closing of the public consultation, responses were classified into recurring themes and the occurrence of the themes were quantified. A synthesis of the public consultation was written and sent to all the members of the expert committee.

### **5. Definition of a specific problematic to be addressed**

All the members of the expert committee were gathered for a meeting that has taken place on January 25<sup>th</sup>, 2022. A qualitative synthesis of the auditions and public consultation was restituted followed by an open discussion between the members of the expert committee. At the end of the meeting, the problematic tackled by the current manuscript was finally selected by weighting the initial request of the French ministry of health against the qualitative results of the synthesis of the auditions and public consultation.

### **6. Endorsement of the problematic by the board of HAS**

The focus and problematic prioritized was validated by the board of HAS.



## **7. Online questionnaire that was used for the public consultation.**

### **Where are you from?**

- Academic world (e.g., research lab, university, university hospital)
- Academy of health professionals
- Health professionals' order
- Health Technology Assessment body
- Industry / CRO / Consultant
- Learned or scientific society
- Patients' representative
- Professionals' union
- Other: Specify

### **Name of your organization:**

### **E-mail:**

### **Does your contribution is endorsed by your organization?**

- My contribution is endorsed by my organization
- I contribute on my behalf

- 1. Are there specific methodological issues for Health Technology Assessment you wish to bring to our attention?**
- 2. Do you identify methodological issues relative to the assessment of innovative drugs in specific therapeutic areas?**
- 3. To accelerate the access to innovative drugs, what could be useful clinical trial designs or methodological specificities?**
  - What are the strengths and weaknesses of these approaches?
  - What are the opportunities and threats to the use of these approaches?
- 4. To accelerate the access to innovative drugs, how the HAS could modify its methodology for Health Technology Assessment?**
- 5. Do you have any additional comments?**
- 6. How did you proceed for answering to the questionnaire?**
  - What are the types of sources you used? (e.g., personal experience, survey, social networks, teamwork, testimony, scoping review, expert's opinion)

**Please, summarize your contribution**

- Please, list the bullet points of your contribution

**What are the relevant references you used to answer the questionnaire?**