Demographics

1. Background demographic questions

Primary sector

- ○ Academia
- ○ Consultant
- ○ Government: Department or Ministry of Health
- ○ Pharmaceutical industry
- ○ Other

Years of experience

Current position

- ○ Leadership position (e.g. director, head of a department)
- ○ Managerial position (e.g. team lead: people reporting to you)
- ○ Non-managerial position (e.g. evaluator, health economist, statistician)
- ○ Other

Highest academic degree

- ○ Bachelor degree (e.g. BSc)
- ○ Master degree (e.g. MBA, MPH, MSc)
- ○ PhD degree
- ○ Other

Main qualification

- ○ Biology
- ○ Economics
- ○ Medical science
- ○ Medicine
- ○ Pharmacy
- ○ Psychology
- ○ Science (e.g mathematics, statistics)
- ○ Other

General questions on cost-effectiveness of oncology treatments

2. General questions on the cost effectiveness of oncology treatments.

Please indicate level of agreement for each statement:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
Clinical claim is a major source of uncertainty	○	○	○	○	○	○
Extrapolation method is a major source of uncertainty	○	○	○	○	○	○
Quality of life is a major source of uncertainty	○	○	○	○	○	○
Costs and health resource utilization are major sources of uncertainty	○	○	○	○	○	○

Clinical claim

3. A clinical superiority claim often form the basis for cost effectiveness analysis. In oncology it is sometimes not possible to obtain perfect head to head evidence for various reasons and so other sources must be used for health technology assessment.

Please indicate level of agreement with the following statements:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
Clinical superiority needs to be clearly demonstrated in a head-to-head trial	○	○	○	○	○	○
Minimal clinical important difference is not relevant for superiority claims	○	○	○	○	○	○
Clinical superiority claimed on surrogate endpoints leads to major uncertainty	○	○	○	○	○	○
Statistical superiority (as opposed to clinical superiority is sufficient in most instances	○	○	○	○	○	○

Rank the preferred data sources in absence of head-to-head clinical trial data (1=best,...,6=worst)

Local registry (e.g. established hospital registries)

Historical published data

Observational individual patient data on file (e.g. chart reviews)

Drug claims data (e.g. 10% PBS sample, HIRA claims data)

Propensity adjusted data (from any source)

Single arm clinical trials (e.g. phase I trials)

Extrapolation

4. Extrapolation of survival curves is often an integral part of the health economic modelling of oncology treatments.

Please indicate level of agreement with the following statements:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
Extrapolation is a black box and easily manipulated in either direction	○	○	○	○	○	○
Graphical check of survival curves and Akaike or Bayesian Information Criteria are sufficient to justify extrapolation methods	○	○	○	○	○	○
Methods that give a perfect fit such as spline techniques are preferred over probability distributions.	○	○	○	○	○	○
The Kaplan-Meier curve should be used for parts of the modelling time period	○	○	○	○	○	○
Survival curves should converge after a period of time	○	○	○	○	○	○
It is reasonable to assume that patients who have not progressed after a long period of time are cured	○	○	○	○	○	○
The time horizon of the model should be no longer than 10 years	○	○	○	○	○	○
External validation of extrapolation methods are often inadequate	○	○	○	○	○	○
Access to individual patient data would be helpful for validation of the extrapolation	○	○	○	○	○	○

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
There is enough guidance in the local pharmaco-economics guidelines with respect to extrapolation	○	○	○	○	○	○

Quality of life

5. We would now like you to focus on quality of life.

Rank the following QoL instruments for use in cost effectiveness analysis (1=best,...,4=worst)

Disease specific instrument (e.g. QLU-C10D)

Soliciting utilities using standard gamble or time trade off methods

Generic instruments (e.g. EQ-5D)

Mapping of non-utility instruments to utility instruments

Rank source of QoL evidence (1=best,...,3=worst)

Measured directly in clinical trial

From literature

Obtained from separate study

Validation of utilities is not important in terms of cost effectiveness analysis

- ○ Strongly disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree

- ○ Somewhat agree
- ○ Strongly agree
- ○ Don't know

Surveys using proxies such as physicians and healthy people are appropriate for oncology modelling purposes

- ○ Strongly disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Strongly agree
- ○ Don't know

Estimation of costs and health resource utilisation

6. We would now like you to consider health care costs and resource utilisation

Please indicate level of agreement for each statement:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
The duration of treatment is a major source of uncertainty	○	○	○	○	○	○
Post-progression treatment or subsequent lines of therapy should always be taken into account in oncology cost effectiveness analysis	○	○	○	○	○	○
Treatment of adverse events and toxicity are major sources of uncertainty in cost effectiveness analysis of new oncology therapies	○	○	○	○	○	○

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
Treatment beyond progression is a major concern with respect to cost effectiveness analysis of oncology treatments	○	○	○	○	○	○
Palliative costs and/or best supportive care costs should be included	○	○	○	○	○	○
Different discount rates should be used for costs and outcomes (e.g. higher discount rate for costs than for benefits)	○	○	○	○	○	○

Agreements and arrangements

7. Financial and risk share agreements are common in relation to reimbursement of oncology treatments.

Please indicate level of agreement for each statement:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
Financial agreements (e.g. price/volume agreements) are necessary to ensure cost effectiveness of oncology treatments	○	○	○	○	○	○
Rebates (e.g. special pricing arrangements) are good tools for reaching agreement between a payer and a pharma company	○	○	○	○	○	○

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
Outcomes based risk share agreements are good in theory but difficult to implement in practice	○	○	○	○	○	○
Managed entry schemes or coverage with future evidence schemes are good tools for granting access to therapies with limited data	○	○	○	○	○	○
Review of cost effectiveness is useful to assess value for money	○	○	○	○	○	○
Risk share agreements are not balanced and often result in too much risk for either the payer or pharma company	○	○	○	○	○	○

Decision making

8. There are many factors relating to decision making. This section seek to get a better understanding of your experiences with health technology assessments of oncology treatments.

Please indicate level of agreement for each statement:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
Evidence requirements for oncology therapies are higher than for other therapeutic areas	○	○	○	○	○	○
Cost effectiveness analysis of oncology therapies are often black boxes	○	○	○	○	○	○

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
The opinion of patient advocates play an important role in informing cost effectiveness	○	○	○	○	○	○
More public transparency is needed surrounding reimbursement decisions of oncology therapies	○	○	○	○	○	○
The ICER threshold for cost effectiveness of oncology therapies is on average higher than for other therapeutic areas	○	○	○	○	○	○
HTA and cost effectiveness analysis are good tools for determining reimbursement of oncology therapies	○	○	○	○	○	○
Alternative funding methods such as a cancer fund in the UK would be more appropriate than current reimbursement practice in my country	○	○	○	○	○	○
The reimbursement process is too long	○	○	○	○	○	○

Capability and capacity

9. This last section will focus on capability and capacity of assessing and performing cost effectiveness analysis of oncology treatments.

Please indicate level of agreement for each statement:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Don't know
I am comfortable with my technical level in terms of cost effectiveness analysis	○	○	○	○	○	○
My organisation have plenty of capacity to deal with methodological issues	○	○	○	○	○	○
Continued training opportunities in cost effectiveness analysis are scarce	○	○	○	○	○	○
I prefer web-based training that I can do in my own time	○	○	○	○	○	○

My primary source of methodological advances are (1=best,..., 7=worst)

The peer reviewed literature

Courses (e.g. short course at universities)

Attending conferences

Discussion with peers

Guideline updates

On the job learning

Seminars/workshops by professional bodies (e.g. AHES, ISPOR)