Infusion Chair Time and Clinic Visits as Drivers of Healthcare Resource Utilization in Platinum-Resistant Ovarian Cancer

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Poster 276

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CONCLUSIONS

- **Substantial differences in infusion chair time and clinic visit frequency were observed across the selected platinum-resistant ovarian cancer treatment regimens evaluated in this comparison**
- **Treatment regimens requiring shorter infusion chair time and fewer clinic visits may reduce treatment burden for patients and ease demands on infusion clinic capacity**

BACKGROUND

- For patients with advanced cancer receiving ongoing systemic therapy, time spent receiving cancer care represents an important component of treatment burden
- This burden has been described as "time toxicity," reflecting the time patients spend interacting with the healthcare system rather than at home or engaged in their usual activities
  - Patients with advanced cancer may spend 20–25% of their remaining life on healthcare contact days[1]
- Treatment-related time includes clinic visits, treatment administration, and infusion chair time and may affect patients and caregivers, while also contributing to healthcare resource use and clinic capacity[2,3]
- In platinum-resistant ovarian cancer (PROC), patients often receive ongoing systemic therapy, and recently approved treatments have different routes, schedules, and administration requirements[4–6]
- As treatment options expand, understanding differences in the time required to receive treatment can complement traditional measures of efficacy and safety and provide additional information on treatment burden
  - However, comparative data quantifying treatment time across contemporary PROC regimens are limited

OBJECTIVE

- To compare the treatment time burden across selected systemic therapies for PROC, based on infusion chair time and clinic visit frequency, as measures of patient burden and healthcare resource utilization

METHODS

- Treatment time burden was estimated over a 12-week period for three regimens using descriptive analyses based on their registrational clinical trial dosing, prescribing information, and drug websites:
  - Pembrolizumab plus paclitaxel with or without bevacizumab for patients with programmed death-ligand 1 (PD-L1)-positive tumors who received one to two prior systemic treatments[6]
    - Pembrolizumab (400 mg intravenously [IV] every 6 weeks) with paclitaxel (80 mg/m^2 IV on day 1, 8, and 15 of each 3-week treatment cycle), with or without bevacizumab (10 mg/kg on day 1 every 2 weeks)[7]
  - Mirvetuximab for patients with folate receptor-α-positive PROC who had received one to three prior systemic treatments[5]
    - Mirvetuximab (6 mg/kg IV every 3 weeks)[8,9]
  - Relacorilant plus nab-paclitaxel in patients who had received one to three prior systemic treatment regimens, at least one of which included bevacizumab[4]
    - Relacorilant (150 mg orally the day before, of, and after nab-paclitaxel) plus nab-paclitaxel (80 mg/m^2 IV on day 1, 8, and 15 of each 28-day cycle)[10]

METHODS cont'd

- Infusion chair time was estimated using recommended administration times, with lower and upper time assumptions applied where appropriate:
  - Time assumptions for each regimen component are presented in **Table 1**
  - Time to administer premedication was included where applicable
  - Mirvetuximab infusion times may vary by infusion rate titration, dose, and infusion tolerability
- Clinic visit frequency was defined as the number of infusion visits during a 12-week period

Table 1. Administration Time Estimates Used for Calculating Infusion Chair Time for Each Regimen

Regimen	Administration time, min
Pembrolizumab plus paclitaxel ± bevacizumab	
Hypersensitivity premedications (diphenhydramine + famotidine + dexamethasone) + antiemetic	30–60
Paclitaxel	60
Pembrolizumab	30
± Bevacizumab	20–30
Mirvetuximab	
or Hypersensitivity premedications (acetaminophen + diphenhydramine + dexamethasone) + antiemetic	30
Mirvetuximab	60–180
Relacorilant plus nab-paclitaxel	
or Antiemetic	0–15
Relacorilant	0
Nab-paclitaxel	30

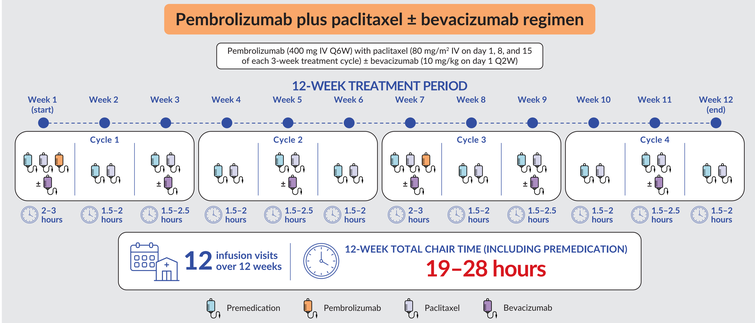
Administration regimens and times were sourced from the prescribing information, clinical studies, and National Comprehensive Cancer Network guidelines. The infusion rate for mirvetuximab varies by cycle, dose, and tolerability, and the time presented here reflects the typical infusion time per cycle (cycle 1, 90–180 min; cycle 2+, 60–120 min).

RESULTS

- Infusion chair time for treatment regimens with pembrolizumab (**Figure 1**), mirvetuximab (**Figure 2**), and relacorilant (**Figure 3**) varied greatly
- For a 12-week treatment duration, the pembrolizumab plus paclitaxel regimen with bevacizumab exhibited the longest chair time (21–28 hours), and relacorilant plus nab-paclitaxel was associated with the shortest chair time (4.5–6.8 hours) (**Figure 4**)
  - In the pembrolizumab regimen, paclitaxel administration was the primary contributor to increased chair time
- The pembrolizumab plus paclitaxel regimen with bevacizumab had the highest frequency of clinic visits over a 12-week treatment duration (12 visits), and mirvetuximab the lowest (four visits) (**Figure 5**)

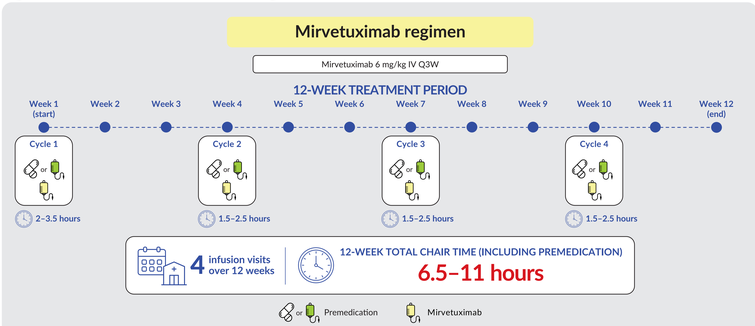
RESULTS cont'd

Figure 1. Pembrolizumab Plus Paclitaxel ± Bevacizumab Treatment Regimen



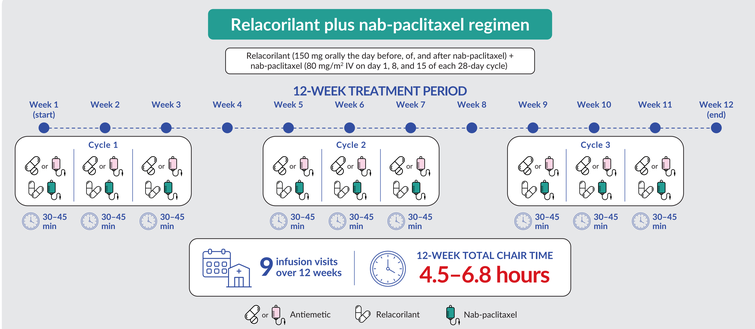
IV, intravenous; PD-L1, programmed death-ligand 1; Q2W, every 2 weeks; Q6W, every 6 weeks.

Figure 2. Mirvetuximab Treatment Regimen



Note that the infusion rate, and thus the administration time, for mirvetuximab varies based on dose and tolerability.
FR-α, folate receptor-α; IV, intravenous; PROC, platinum-resistant ovarian cancer; Q3W, every 3 weeks.

Figure 3. Relacorilant Plus Nab-Paclitaxel Treatment Regimen



Note that relacorilant is taken orally the day before, the day of, and the day after nab-paclitaxel administration.
IV, intravenous.

Figure 4. Infusion Time During a 12-week Treatment Duration

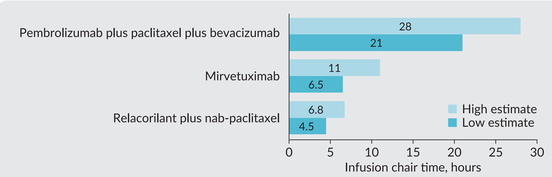
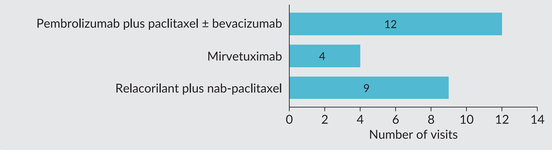


Figure 5. Frequency of Clinic Visits During a 12-week Treatment Duration



DISCUSSION

- Treatment-related time varied across PROC regimens, demonstrating that infusion chair time and visit frequency are important dimensions of treatment burden
- Differences in treatment time may have implications for patients and caregivers, as well as infusion center capacity and healthcare resource use
- These estimates capture treatment administration time only and do not include other sources of time burden, such as travel, waiting, monitoring, or adverse-event management (**Figure 6**)
- Future research should assess time toxicity—including travel, waiting, monitoring, supportive care, and adverse-event management—more comprehensively in order to better characterize the overall time burden of PROC treatment

Figure 6. Additional Sources of Time Toxicity Associated With PROC Treatment



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