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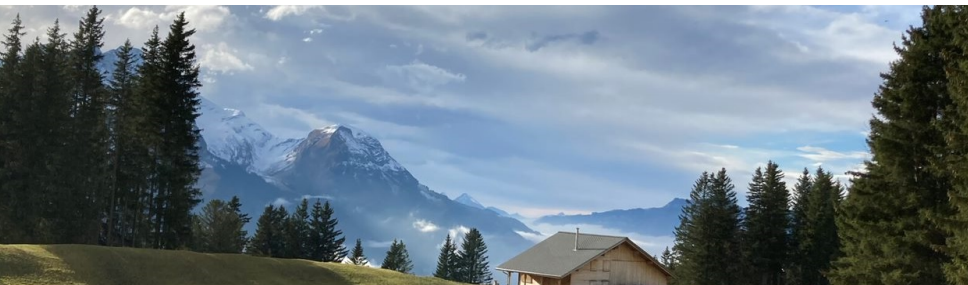
# Futility analyses - a strategic tool in drug development and not futile fat all!

*Kaspar Rufibach*

*Methods, Collaboration & Outreach Group*

*Roche Basel*

*Effective Statistician Academy, 15th February 2024*





Dr. Alexander Schacht • 1st

Fear is a reaction. Courage is a decision. Medical affairs/RWE/HTA expert ...

5d • 🌐

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500 registrations already and still many more register for [The Effective Statistician](#) conference happening next week.  
It is still time for you to register!

One of the reasons for the many registrations is the line-up of speakers.

One of them is [Kaspar Rufibach](#).

Kaspar is not only an outstanding statistician who has a significant influence as a methods statistician at Roche and beyond his company. He is also an excellent speaker.

His presentations are always interesting, relevant, and entertaining.

Having worked closely with many statistical teams, his experience and advice has great relevance for any statistician in clinical research.

I am thrilled that he will speak at my conference again this year.

And his contributions always stimulate a very good discussion.



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**I am a statistician after all!**

**Reduce number of observations  
if drug does not work.**

**Risk to stop working molecule typically small.**

**Not only about "your" trial, but about  
patients, risk mitigation, other projects!**

**No threat to integrity or  
regulatory acceptance.**

# What are futility interim analyses?

**Option to stop trial early.**

**Protect patients.**

**Even if continued to final analysis  
trial unlikely to be significant.**

# How much do we gain with futility interim analyses in clinical trials?

### Design:

- 2-sided significance level:  $\alpha = 0.05$ .
- Power:  $\alpha = 80\%$ .
- Hazard ratio to detect: **0.75**.

### Timing:

- $n = 1200$ .
- Medians in months: 72 and 96.
- Accrual: ramp-up first six months, then 42/month.

### Single-stage design (no interim):

- **380** events needed in any case.
- Time to cutoff (months): 60 under  $H_0$ .



**Add futility interim analysis:**

**After 30% (= 114) of events.**

**Stop trial if hazard ratio  $> 1$ .**

We **do not compensate** for power loss.  
All computations under  $H_0$ .

$$P(\text{stop at interim}) = 0.5.$$

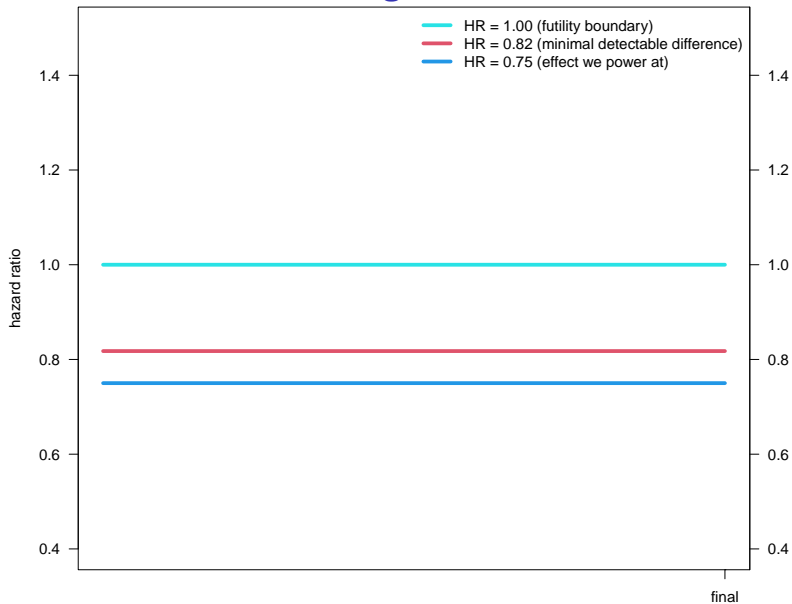
$$0.5 \cdot 114 + 0.5 \cdot 380 = \mathbf{247}.$$

On **average**  $380 - 247 = 133$  or  
35% less events.

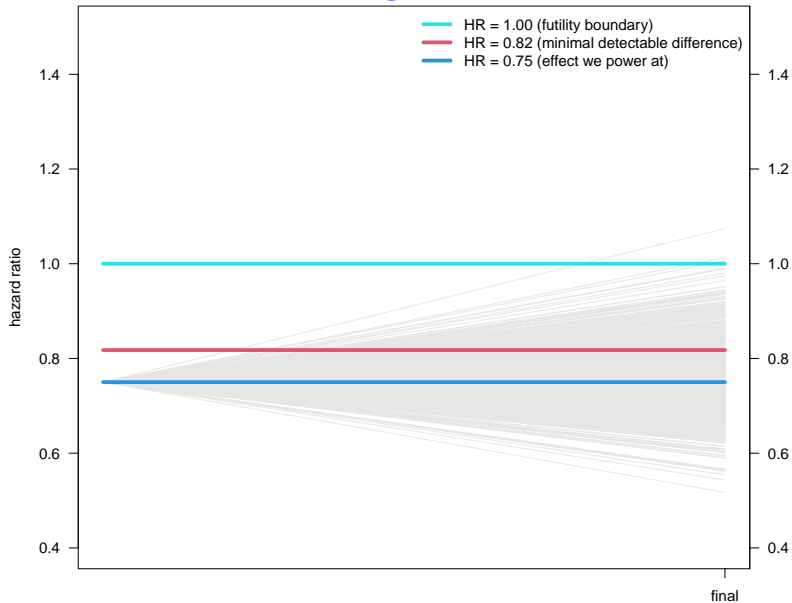
**Expected time to cutoff: 44 vs. 60 months.**

# Power loss

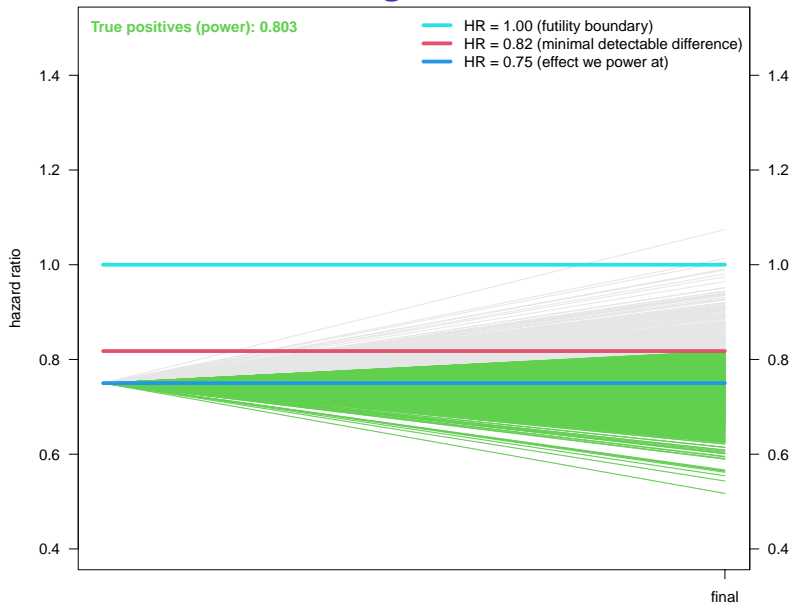
## 1000 simulated trials assuming $HR = 0.75$ , no interim



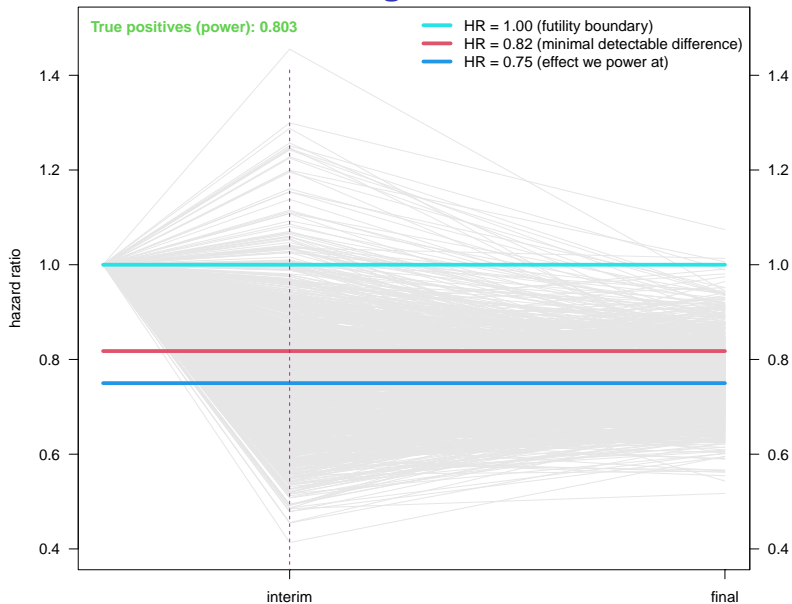
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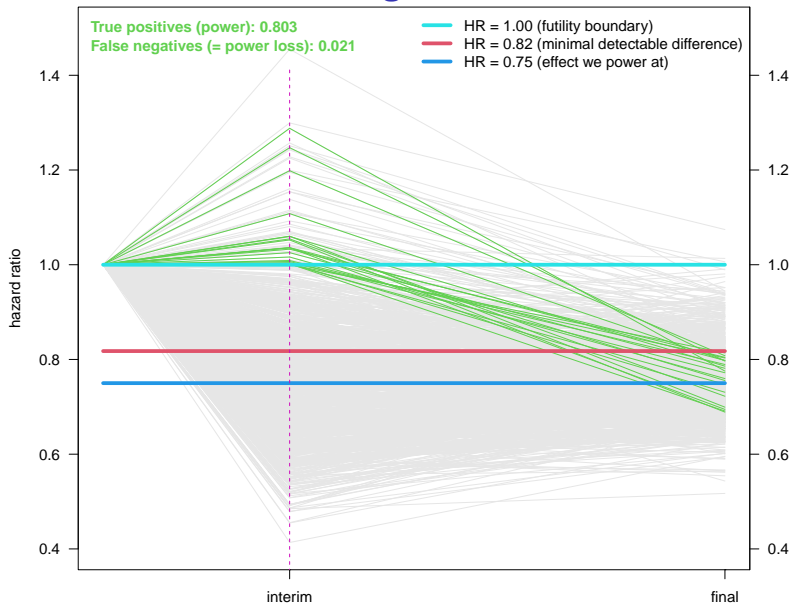
## 1000 simulated trials assuming $HR = 0.75$ , no interim



# 1000 simulated trials assuming $HR = 0.75$ , with interim



## 1000 simulated trials assuming $HR = 0.75$ , with interim





**Fixed design: 380.**

**Futility added, maintain power:  
406 events, + 6.8%.**

**Futility** interim: reduce expected number of patients / events under  $H_0$ .

**Efficacy** interim: reduced expected number of patients / events under  $H_1$ .

**So, among statisticians we agree:**

**Futility analyses are a useful tool.**

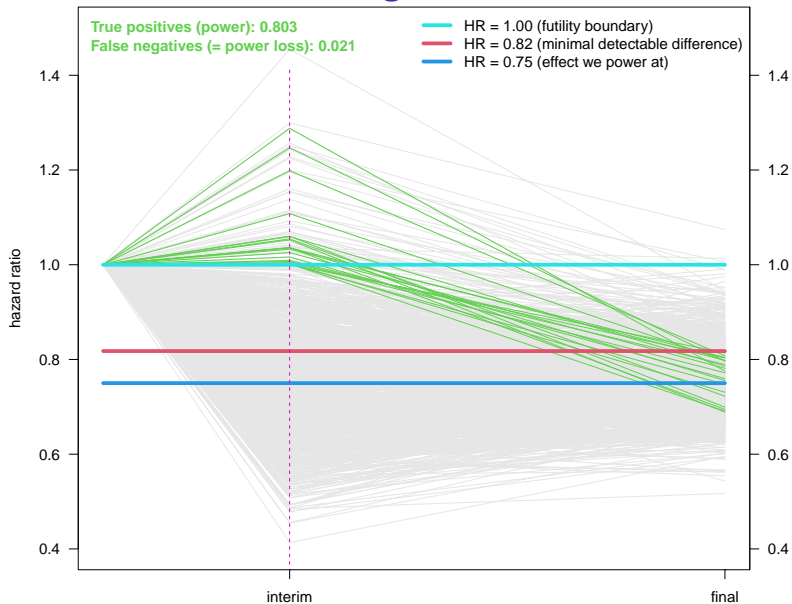
## Meet the team:



Cartoon courtesy of Gaëlle Klingelschmitt.

*"We risk to stop a trial which could be positive at the final analysis."*

## 1000 simulated trials assuming $HR = 0.75$ , with interim



If you power a trial at 80% you already have "false-negative" risk of 20%.

Futility adds 2.4% on top of that.

But reduces average sample size by 35% if drug is useless.

And you can compensate for power loss in trial design, if you wish.

**Roche: retrospective analysis.**

**Virtually never you would have stopped  
a molecule that works.**



**114 events with  $HR > 1$ .**

**266 events with HR such that  
final analysis  $HR \leq 0.818$ .**

**Two heterogeneous parts. Regulatory risk!**

**Sponsor bought in to design  
multimillion trial based on  $HR = 0.75$ .**

**But is not confident to pass futility analysis  
with boundary  $HR > 1$  after 114 events?**

*"Trial costs are not linear in trial duration.  
We do not save much money if we stop at a futility."*

**Often true.**

**But a futility is not only about **your** trial!**

**Protect patients.**

**Portfolio view.**

**Inform other projects. Efficiency of  
drug development.**

*"My molecule may just barely make it  
at the final. A futility is too risk."*

**That is exactly when you need one most!**

*"A futility puts the integrity of the trial at risk."*

**iDMC. Same process as for efficacy interim.**

*"Regulators do not like futilities."*

**Just plain wrong.  
Futility considered sponsor's risk.**

**What regulators do not like: badly designed trials. With or without futility.**

*"We have a delayed effect."*

**Fair point.**

**Need to very carefully design  
a potential futility.**

*"Our primary endpoint is not mature  
at a typical futility timepoint."*

**Fair point.**

**Can use "totality of evidence",  
surrogate endpoints, etc.**

**Much more (regulatory) freedom to  
design futility compared to efficacy.**

**You will not make an efficacy claim!**



**Futilities derisk Phase 3 trials.**

**Potential for acceleration.**

**Reduce number of observations  
if drug does not work.**

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regulatory acceptance.**

## Computations done with rpact.

**Marcel Wolbers**

**Jenny Devenport**

**Gian Thanei**

**Uli Burger**

**Jianmei Wang**

**and many more!**

**Thank you for your attention.**

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**Slides can be downloaded on**

**[www.kasparrufibach.ch](http://www.kasparrufibach.ch)**

# *Doing now what patients need next*

## **R version and packages used to generate these slides:**

R version: R version 4.2.3 (2023-03-15 ucrt)

Base packages: stats / graphics / grDevices / utils / datasets / methods / base

Other packages: reporttools / xtable / biostatKR / survival / rpact

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