NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Draft guidance consultation

Amivantamab with lazertinib for untreated EGFR mutation-positive advanced non-small-cell lung cancer

The Department of Health and Social Care has asked the National Institute for Health and Care Excellence (NICE) to produce guidance on using amivantamab with lazertinib in the NHS in England. The evaluation committee has considered the evidence submitted by the company and the views of non-company stakeholders, clinical experts and patient experts.

This document has been prepared for consultation with the stakeholders. It summarises the evidence and views that have been considered, and sets out the recommendations made by the committee. NICE invites comments from the stakeholders for this evaluation and the public. This document should be read along with the evidence (see the committee papers).

The evaluation committee is interested in receiving comments on the following:

- Has all of the relevant evidence been taken into account?
- Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?
- Are the recommendations sound and a suitable basis for guidance to the NHS?
- Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex or sexual orientation?

Issue date: July 2025

Note that this document is not NICE's final guidance on these technologies. The recommendations in section 1 may change after consultation.

After consultation:

- The evaluation committee will meet again to consider the evidence, this evaluation consultation document and comments from the stakeholders.
- At that meeting, the committee will also consider comments made by people who are not stakeholders.
- After considering these comments, the committee will prepare the final draft guidance.
- Subject to any appeal by stakeholders, the final draft guidance may be used as the basis for NICE's guidance on using amivantamab with lazertinib in the NHS in England.

For further details, see NICE's manual on health technology evaluation.

The key dates for this evaluation are:

- Closing date for comments: 25 July 2025
- Second evaluation committee meeting: 13 August 2025
- Details of the evaluation committee are given in section 4

1 Recommendations

1.1 Amivantamab plus lazertinib should not be used for untreated advanced non-small-cell lung cancer (NSCLC) in adults whose tumours have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations.

1.2 This recommendation is not intended to affect treatment with amivantamab plus lazertinib that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

What this means in practice

Amivantamab plus lazertinib is not required to be funded in the NHS in England to treat NSCLC in adults whose tumours have EGFR exon 19 deletions or exon 21 L858R substitution mutations. It should not be used routinely in the NHS in England.

This is because there is not enough evidence to determine whether amivantamab plus lazertinib is value for money in this population.

Why the committee made these recommendations

Usual treatment for NSCLC with EGFR exon 19 deletions or exon 21 L858R substitution mutations is osimertinib alone or osimertinib plus pemetrexed and platinum-based chemotherapy (from now, osimertinib plus chemotherapy).

Clinical trial evidence shows that amivantamab plus lazertinib increases how long people have before their condition gets worse and how long people live compared with osimertinib alone. But it is uncertain whether amivantamab plus lazertinib works as well for people of different ages.

It is also uncertain how well amivantamab plus lazertinib works compared with osimertinib plus chemotherapy because these treatments have not been compared.

There are uncertainties with some of the assumptions in the economic model comparing amivantamab plus lazertinib with osimertinib alone, including:

- how long people live
- how long people continue treatment
- how each treatment affects quality of life.

Also, osimertinib plus chemotherapy has not been included as a comparator.

Because of the uncertainties in the economic model, it is not possible to determine the most likely cost-effectiveness estimates for amivantamab plus lazertinib. So, it should not be used.

2 Information about amivantamab with lazertinib

Marketing authorisation indication

2.1 Amivantamab (Rybrevant, Janssen) with lazertinib (Lazcluze, Janssen) is indicated 'for the first-line treatment of adult patients with advanced non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) Exon 19 deletions or Exon 21 L858R substitution mutations'.

Dosage in the marketing authorisation

2.2 The dosage schedules are available in the summary of product characteristics for summary of product characteristics for amivantamab and lazertinib.

Price

2.3 The price of amivantamab is £1,079 per 350 mg per 7-ml vial (excluding VAT; BNF online accessed June 2025). The price of lazertinib for a pack of 56 80 mg tablets is £4,128.50, and for a pack of 28 240 mg tablets is £6,192.75 (company submission).

2.4 The company has a commercial arrangement for each technology, which would have applied if amivantamab plus lazertinib had been recommended.

Carbon Reduction Plan

2.5 Information on the Carbon Reduction Plan for UK carbon emissions for Johnson & Johnson will be included here when guidance is published.

3 Committee discussion

The evaluation committee considered evidence submitted by Johnson & Johnson, a review of this submission by the external assessment group (EAG), and responses from stakeholders. See the committee papers for full details of the evidence.

The condition

Details of condition

3.1 Non-small-cell lung cancer (NSCLC) is staged from 1A to 4B according to the size of the tumour, location of involved lymph nodes and the presence of distant metastases. NSCLC diagnosed as stage 3 (locally advanced) or stage 4 (metastatic) is advanced. People with locally advanced NSCLC commonly present with a cough. Other symptoms include shortness of breath, coughing up blood and pain. People with metastatic NSCLC may also have headaches, an enlarged liver, changes in mental health, weakness and seizures. Epidermal growth factor receptor (EGFR) mutation-positive NSCLC is more common in women and people who do not smoke. The patient expert noted that a diagnosis of EGFR mutation-positive NSCLC can cause high levels of psychological distress. The committee concluded that advanced EGFR mutation-positive NSCLC can substantially affect health-related quality of life.

Clinical management

3.2 There are several NICE recommended options for treating EGFR mutation-positive NSCLC:

- First-line treatments include:
  - tyrosine kinase inhibitors (TKIs), which are no longer widely used
  - osimertinib monotherapy (NICE technology appraisal 654)
  - osimertinib plus pemetrexed and platinum-based chemotherapy (from now, osimertinib plus chemotherapy), which was recommended in May 2025 (NICE technology appraisal 1060).
- Second-line treatments include:
  - atezolizumab with bevacizumab, carboplatin and pemetrexed (NICE technology appraisal 584)
  - platinum-doublet chemotherapy
  - best supportive care

The patient expert explained that there was uncertainty about whether people might have osimertinib after progression on amivantamab plus lazertinib. This is because NICE has recommended second-line osimertinib after an EGFR TKI (NICE technology appraisal 653). The clinical expert explained that because osimertinib and lazertinib are very similar drugs, there would be no biological rationale to use osimertinib monotherapy after progression on amivantamab plus lazertinib. The NHS Cancer Drugs Fund (CDF) clinical lead agreed. The clinical expert further explained that if someone experienced high toxicity with amivantamab plus lazertinib, they would likely stop amivantamab, which is associated with a greater adverse events profile, and continue with lazertinib. The committee concluded that there would be no reason to switch to osimertinib at second line given the similarities between lazertinib and osimertinib.

Comparators

3.3 The NICE final scope included osimertinib plus chemotherapy 'subject to NICE appraisal' as a comparator. The company did not submit any modelling for osimertinib plus chemotherapy. The company stated that:

- it did not consider osimertinib plus chemotherapy to be established in clinical practice
- it was not recommended at the time it made the evidence submission
- its clinical experts did not consider it to be established clinical practice when questioned
- despite being recommended by NICE, it is still not in routine commissioning.

The clinical expert explained that there is no single standard care for EGFR mutation-positive advanced NSCLC, with osimertinib monotherapy preferable for some but osimertinib plus chemotherapy better for others. They said that there is no clear clinical consensus on which groups might benefit more from either osimertinib plus chemotherapy or amivantamab plus lazertinib. But they noted that both treatments show similar improvements over osimertinib monotherapy. The clinical expert said that osimertinib monotherapy will be used less over time because healthcare professionals prefer to use an escalated (combination) therapy when possible. But they noted that people over 80 might prefer osimertinib monotherapy, rather than amivantamab plus lazertinib or osimertinib plus chemotherapy because of concerns about adverse events. The patient expert explained that there is a clear split among members of EGFR Positive UK who have EGFR mutation positive NSCLC, with many people preferring not to add chemotherapy to osimertinib monotherapy. They noted that, generally, younger people would prefer the combination treatment. The patient expert also noted that some people may choose osimertinib monotherapy because they want an oral-only treatment, to avoid clinical environments and intravenous infusions, and preferred a feeling of normality. But, some people want the best possible outcomes and are willing to tolerate a worse adverse event profile and higher treatment burden. The committee noted this and thought that it was plausible that osimertinib plus chemotherapy was the more important comparator. This is

because people who are willing or able to tolerate a combination treatment would likely choose between amivantamab plus lazertinib or osimertinib plus chemotherapy. It also noted that seeing an indirect comparison of these 2 treatments might help people with the condition choose between them if amivantamab plus lazertinib was recommended.

The CDF clinical lead explained that cancer treatments generally take about 3 months after recommendation to reach 'steady state' usage. They explained that in the first month after osimertinib plus chemotherapy was recommended, 23% of osimertinib usage for this indication was with chemotherapy, adding that they expected this to rise further. The committee noted that osimertinib plus chemotherapy was included as a potential comparator in the NICE scope but acknowledged that it was not recommended at the time of the company submission. However, it agreed that osimertinib plus chemotherapy is established in NHS clinical practice. The committee concluded that both osimertinib monotherapy and osimertinib plus chemotherapy are relevant comparators. It noted that it would need to see clinical and cost-effectiveness estimates comparing amivantamab plus lazertinib with osimertinib plus chemotherapy before it could make a decision.

Clinical effectiveness

The MARIPOSA trial

3.4 The clinical-effectiveness evidence came from the MARIPOSA trial, which was a phase 3 open label randomised controlled trial that compared amivantamab plus lazertinib with osimertinib monotherapy. The trial recruited 429 people to the amivantamab plus lazertinib arm and 429 people to the osimertinib arm. Key outcomes of the trial that informed the cost-effectiveness model (see section 3.6) were:

- progression-free survival (informed by an August 2023 data cut off)

- overall survival (informed by a December 2024 data cut off)
- time to discontinuation (informed by a December 2024 data cut off).

The MARIPOSA trial demonstrated a statistically significant improvement for amivantamab plus lazertinib over osimertinib monotherapy for:

- progression-free survival, hazard ratio (HR) 0.70 (95% confidence intervals [CI] 0.58 to 0.85)
- overall survival, HR 0.75 (95% CI 0.61 to 0.92).

The company considered the time to discontinuation data for the individual components of amivantamab plus lazertinib to be confidential, so they cannot be reported here. The committee questioned why progression-free survival data had not been provided from the most recent data cut. The company stated that progression-free survival had met its statistical endpoint in that no further statistical analysis could be done (because the alpha was spent). The EAG commented that statistical analyses were not needed for the economic modelling because the company could simply fit curves to the updated Kaplan–Meier data. The committee noted that the amivantamab plus lazertinib arm had a greater incidence of adverse events than the osimertinib arm, including pulmonary embolism, infusion-related reactions, rashes and nail toxicity. Clinical experts explained that this was largely because of amivantamab. The committee thought that MARIPOSA showed that amivantamab plus lazertinib was superior to osimertinib, although it noted there was some uncertainty about this benefit in certain subgroups. It concluded that it would like to see progression-free survival modelled using the latest available data.

Generalisability

3.5 The mean age in the MARIPOSA trial is considered confidential by the company and cannot be reported here. The median age was 64 in the

amivantamab plus lazertinib arm and 63 in the osimertinib arm and 55% of patients in the trial were below 65. The CDF clinical lead explained Systemic Anti-Cancer Dataset data showed that for the last 4,000 patients to use osimertinib monotherapy for advanced NSCLC, the median age was 70 and the mean age was 68.5. The committee noted that in MARIPOSA, there appeared to be some important differences in progression-free survival between age subgroups, including

- people under 65 (n=472), HR 0.50 (95% CI 0.39 to 0.65)
- people over 65 (n=386), HR 1.06 (95% CI 0.80 to 1.41)
- people under 75 (n=754), HR 0.70 (95% CI 0.57 to 0.85)
- people over 75 (n=104), HR 0.77 (95% CI 0.46 to 1.30).

The committee thought that the clinical trial data indicated amivantamab plus lazertinib may be less effective in older patients. The clinical expert stated that there was no biological reason that amivantamab plus lazertinib would work less well according to age. However, the committee noted that it could be linked to older people stopping treatment faster because of the adverse event profile and therefore getting less benefit. The company explained that the trial was not powered to detect subgroup differences. Both the company and the clinical expert thought that the effect size in the over 75 group appearing similar to the whole population meant that assumptions around effectiveness and age should be treated with caution. The committee noted that the over 75 subgroup was much smaller and its confidence intervals overlapped with those of the over 65 subgroup. The committee understood that, because the median age in NHS practice was 70, most people in the target population would be over 65, while in the MARIPOSA study most patients were below 65. People over 65 may plausibly get less benefit from amivantamab plus lazertinib, which may be a generalisability issue. The committee acknowledged the patient and clinical expert statements that older people might be more likely to choose osimertinib monotherapy (see

sections 3.2 and 3.3) but it still considered this was a generalisability issue. To ensure that differences in age between the trial and NHS populations are not an important generalisability concern, the committee concluded that it would like to see:

- subgroup analyses for the over 65 subgroup
- Kaplan–Meier curves for the over 65 subgroup for all relevant time-to-event outcomes
- cost-effectiveness modelling of the over 65 subgroup.

Economic model

Company's modelling approach

3.6 To model the cost effectiveness of amivantamab plus lazertinib and osimertinib monotherapy, the company used a partitioned survival model with 3 health states: 'progression free', 'progressed disease' and 'death'. The efficacy of amivantamab plus lazertinib was informed directly from extrapolations of progression-free survival, overall survival and time to treatment discontinuation data (considering amivantamab and lazertinib separately [see section 3.7]) from MARIPOSA trial (see section 3.4). The company chose a cycle length of 1 week with a half-cycle correction and a lifetime time horizon of 30 years. The committee concluded that the overall structure of the model was generally acceptable for decision making. But, it recalled the generalisability issue (see section 3.5) and noted that it would like to see model baseline characteristics match NHS practice when possible (for example, age set to mean age provided by CDF clinical lead, see section 3.5).

Modelling of time to treatment discontinuation

3.7 The company modelled longer-term time to treatment discontinuation by fitting parametric curves to the time to treatment discontinuation Kaplan–Meier data from MARIPOSA for osimertinib monotherapy and separately for both amivantamab and lazertinib. The company selected the exponential distribution to extrapolate the time to treatment

discontinuation curves for all 3 components. It stated that it had a strong statistical and visual fit and close alignment with its clinical expert estimates. Both the clinical expert estimates and the landmark estimates predicted by the model are considered confidential by the company and cannot be reported here. The EAG explained that the exponential distribution could only model a constant hazard. It did not think that the risk of discontinuation would be constant across the entire model time horizon, which is implied by use of the exponential distribution. It preferred to fit a:

- 2-knot normal spline model for amivantamab
- 1-knot hazard spline model for lazertinib
- 1-knot normal spline for osimertinib.

The EAG thought that these distributions had a good statistical and visual fit. It also thought that they provided estimates that were in line with, and in some cases closer than the exponential distribution to, the company's clinical experts' 8-year predictions. The committee considered that the risk of discontinuation was unlikely to be the same across the lifetime of the model. It noted that it was likely that discontinuation might be in the early stages of the model, while people who experience adverse events stop treatment, before possibly evening out. It concluded that it preferred the EAG's distributions for modelling time to treatment discontinuation.

Modelling of overall survival

3.8 The company modelled overall survival using extrapolations from the Kaplan–Meier data from MARIPOSA (see section 3.4). The company chose a Weibull distribution to extrapolate the overall survival data. It said the Weibull extrapolation had strong statistical and visual fit, and close alignment with the company's clinical experts' predictions (these are considered confidential by the company and so cannot be reported here) when modelling both amivantamab plus lazertinib and osimertinib

monotherapy. The EAG believed that the Weibull distribution was the most suitable parametric distribution to model amivantamab plus lazertinib but noted that 1- and 2-knot hazard splines were also appropriate. But it noted that neither the Weibull nor the spline models provided a great representation of the observed hazard function from the trial. The EAG used the Weibull distribution in its base case to model overall survival for amivantamab plus lazertinib but explored the impact of the 1-knot hazard spline as a plausible alternative scenario. For osimertinib monotherapy, the EAG believed that parametric models were suitable for modelling overall survival. It believed that the Weibull and the gamma distributions were appropriate. It noted that both extrapolations had good statistical fit, a reasonable hazard shape and were close to the company clinical experts' estimates. The EAG used the Weibull distribution in its base case for osimertinib monotherapy but explored the impact of the gamma model as a plausible alternative scenario. The committee considered that in both arms, the Weibull distribution appeared plausible and broadly in line with clinical expert estimates. It noted that the EAG's scenarios were also plausible. The committee concluded that the Weibull models were suitable for decision-making. But it recalled that there may be differences in the efficacy of amivantamab plus lazertinib in different age groups (see section 3.5). So, the committee noted that the choice of overall survival extrapolation was associated with uncertainty.

Utility values

Source of utility values in the progression-free health state

3.9 The company modelled treatment-independent utilities (the same value for both arms of the model) in the progression-free health state in its base case. The company also modelled disutility for treatment-emergent grade 3 or 4 adverse events and grade 2 or lower venous thromboembolisms. The EAG explained that even when accounting for these adverse events that were modelled separately, there still appeared to be a difference in utility between the model arms. The EAG preferred to

model treatment-dependent utilities (different values for amivantamab plus lazertinib and osimertinib monotherapy) in the progression-free health state. The utility values used are considered confidential by the company and cannot be reported here. The committee questioned why the progression-free value for amivantamab plus lazertinib appeared to be close to the progressed disease value used in the model and whether this was plausible. The clinical expert replied that amivantamab infusion was associated with a range of adverse events (see section 3.2). They also stated that people in clinical trials are under very close observation. So, any progression would be detected quickly and would potentially be small-volume progression that was not associated with an immediate change in symptom burden. They considered it plausible that the progression-free utility for amivantamab plus lazertinib would be close to the progressed disease utility. The patient and clinical experts both reported that management of adverse events had improved since the MARIPOSA trial was done. They suggested that this meant that the utility values derived from the trial may be lower than in NHS clinical practice. So, they suggested that using the same utility values for amivantamab plus lazertinib and osimertinib monotherapy may be suitable. The committee acknowledged that management of adverse events had improved. The committee also noted that some of the difference in utility was accounted for in modelling of adverse events. But it noted that only the most severe adverse events were modelled and there were many others not modelled that would have a cumulative effect. The committee also recalled the input from the patient expert that some people may prefer to avoid a clinical environment required for infusions and that there would be a trade-off between better outcomes and worse adverse event profile (see section 3.3). So, it considered that it was not plausible that people having amivantamab plus lazertinib would have the same utility as people having osimertinib monotherapy. The committee concluded that the utility values for the progression-free health state should be modelled separately for the amivantamab plus lazertinib and the osimertinib monotherapy arms.

Costs

Administration costs for amivantamab

3.10 Amivantamab incurs administration costs to cover its administration by intravenous (IV) infusion. Various administration costs are available to represent different complexities of IV infusion and differing lengths of time spent in the chemotherapy day centre. These costs are represented by Healthcare Resource Group (HRG) codes. The EAG noted that the company HRG codes were for an infusion time of less than 1 hour, while the summary of product characteristics for amivantamab suggested an infusion time of over 2 hours. So, the EAG preferred different cost codes. The CDF clinical lead reported information verified by an NHS clinical pharmacologist that showed different cost codes were relevant for the different doses of amivantamab (see table 1). They explained that the risk of infusion reactions with amivantamab was greatest in the earlier weeks, so 'chair time' would be longer and a higher cost code would be needed.

Table 1 HRG codes for each cycle provided by the company, EAG, and CDF clinical lead

Dose	Company	EAG	CDF clinical lead
Cycle 1, day 1 (week 1)	SB12Z	SB14Z	SB14Z
Cycle 1, day 2 (week 1)	SB15Z	SB15Z	SB15Z
Cycle 1, day 8 (week 2)	SB12Z	SB14Z	SB15Z
Cycle 2, day 1 (week 3)	SB12Z	SB14Z	SB14Z
Cycle 2, day 8 (week 4)	SB12Z	SB14Z	SB15Z
Cycle 3, day 1 (week 5)	SB12Z	SB14Z	SB13Z
Subsequent 2-weekly cycles	SB12Z	SB14Z	SB13Z
Lazertinib alone after amivantamab discontinuation	SB11Z	SB11Z	SB11Z

The committee concluded that the HRG codes provided by the CDF clinical lead were the most appropriate to use for decision making. There was also uncertainty around whether the day-case or outpatient version and the NHS payment scheme or NHS reference cost of each cost code should be used. The committee thought that many centres administered IV infusions as a day case, even though an outpatient appointment should be used. The CDF clinical lead explained that the NHS reference costs are what a hospital will actually pay for the procedure, whereas the NHS payment scheme costs are what NHS England will pay the hospital for that same procedure. The NHS payment scheme costs are usually lower than the NHS reference costs to encourage efficiencies (such as moving from day-case to outpatient procedures). The committee concluded that the NHS reference scheme costs better reflected the total expenditure across the health service and were more appropriate for decision making. The committee also concluded that because many centres are using day-cases procedures over outpatient procedures, the day-case costs should be used for decision making. However, it noted that, because some centres are using outpatient costs, this might be a conservative assumption.

Cost-effectiveness estimates

Committee's preferred assumptions

3.11 The committee concluded that the company's overall model structure was acceptable for decision making (see section 3.6). It recalled that its preferred assumptions were to use:

- the age from the Systemic Anti-Cancer Therapy Dataset cohort to inform the baseline model characteristics (see section 3.5)
- the EAG's preferred time to treatment discontinuation extrapolations (see section 3.7)
- the Weibull extrapolation to model overall survival (see section 3.8)

- treatment-specific utilities for the progression-free health state (see section 3.9)
- the amivantamab administration costs provided by the CDF clinical lead (see section 3.10).

The committee acknowledged that, even when its preferred assumptions were incorporated into the model, substantial uncertainty remained, including on:

- the effect of including osimertinib plus chemotherapy as a comparator (see section 3.3)
- progression-free survival at the most recent data cut (see section 3.4)
- the generalisability of the results to the NHS population (see section 3.5)
- the longer-term extrapolation of overall survival (see section 3.8).

The committee would like to see the following analyses and further evidence to help it to decide on the cost effectiveness of amivantamab plus lazertinib:

- analysis including osimertinib plus chemotherapy as a comparator (see section 3.3)
- exploration of outcomes for the over 65 subgroup including Kaplan–Meier data for progression-free survival, overall survival and time to treatment discontinuation (see section 3.5)
- modelling progression-free survival from the latest data cut (see section 3.4).

Acceptable ICER

3.12 NICE's manual on health technology evaluations notes that, above a most plausible ICER of £20,000 per QALY gained, judgements about the acceptability of a technology as an effective use of NHS resources will take into account the degree of certainty around the ICER. The committee will be more cautious about recommending a technology if it is less certain

about the ICERs presented. But it will also take into account other aspects including uncaptured health benefits. The committee noted the high level of uncertainty, specifically that:

- osimertinib plus chemotherapy was not included as a comparator (see section 3.3)
- there were some concerns around the generalisability of the MARIPOSA results to the NHS (see section 3.5)
- progression-free survival was not included in the latest data cut (see section 3.4).

The committee was unable to identify a threshold ICER. This was because an acceptable ICER is intended to account for unresolvable uncertainty in the model and there were additional analyses needed that might resolve some uncertainty in the modelling. The committee concluded that it would reconsider the ICER threshold at the second committee meeting. This would take into account any new analyses presented.

Other factors

Equality

3.13 The committee considered that EGFR mutation-positive NSCLC is more common in women and people from Asian ethnic groups. The committee also noted that amivantamab plus lazertinib may also have different efficacy in people over 65. Race, age and sex are protected characteristics under the Equality Act 2010. But because its recommendation does not restrict access to treatment for some people over others, the committee agreed these were not potential equalities issues.

Uncaptured benefits

3.14 The committee considered whether there were any uncaptured benefits of amivantamab plus lazertinib. It did not identify additional benefits of

amivantamab plus lazertinib not captured in the economic modelling. So, the committee concluded that all additional benefits of amivantamab plus lazertinib had already been taken into account.

Conclusion

Recommendation

3.15 The committee was not able to establish its preferred cost-effectiveness estimates for amivantamab plus lazertinib due to the uncertainties in the clinical- and cost-effectiveness evidence. The committee concluded that the most plausible estimates were likely to be higher than the range NICE considers to be cost effective. The committee concluded that additional evidence is needed, and that amivantamab plus lazertinib should not be used for untreated EGFR mutation-positive advanced NSCLC.

4 Evaluation committee members and NICE project team

Evaluation committee members

The 4 technology appraisal committees are standing advisory committees of NICE. This topic was considered by committee D.

Committee members are asked to declare any interests in the technologies being evaluated. If it is considered there is a conflict of interest, the member is excluded from participating further in that evaluation.

The minutes of each evaluation committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

Chair

Megan John

Chair, technology appraisal committee D

Raju Reddy

Vice chair, technology appraisal committee D

NICE project team

Each evaluation is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the evaluation), a technical adviser, a project manager and an associate director.

George Millington

Technical lead

Sam Slayen

Technical adviser

Jeremy Powell

Project manager

Emily Crowe

Associate director

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