# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## Single Technology Appraisal (STA)

## Secukinumab for treating moderate to severe plaque psoriasis

Thank you for agreeing to give us a statement on your view of the technology and the way it should be used in the NHS.

Healthcare professionals can provide a unique perspective on the technology within the context of current clinical practice which is not typically available from the published literature.

To help you in making your statement, we have provided a template. The questions are there as prompts to guide you. It is not essential that you answer all of them.

Please do not exceed the 8-page limit.

**About you**

**Your name: Catherine Smith**

**Name of your organisation Guys and St Thomas' Foundation Trust**

**Are you (tick all that apply):**

- a specialist in the treatment of people with the condition for which NICE is considering this technology?
- a specialist in the clinical evidence base that is to support the technology (e.g. involved in clinical trials for the technology)?
- an employee of a healthcare professional organisation that represents clinicians treating the condition for which NICE is considering the technology? If so, what is your position in the organisation where appropriate (e.g. policy officer, trustee, member etc.)?
- other? (please specify)

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**What is the expected place of the technology in current practice?**

**How is the condition currently treated in the NHS?**
Depending on disease severity and impact, treatment comprises topicals, phototherapy, traditional systemic therapy (principally ciclosporin, methotrexate, acitretin) and biologic therapies. People with a BSA involvement of 10% or more, pustular psoriasis, severe nail disease, associated psoriatic arthritis, and/or limited disease but major impact (for example at high need sites not responding to topicals) require systemic treatments.

The majority of people with psoriasis have limited disease and will be managed in primary care. Those requiring phototherapy, complex topicals, systemics (including biologics) will be treated in secondary/tertiary care.

NICE CG153 provides comprehensive guidance on all types of psoriasis up to and including use of all the biologic therapy currently licensed for use in psoriasis. The only intervention that is used in the UK, but not covered by CG153 is fumaric acid esters (FAE). This is an unlicensed drug (for any indication) in the UK but is widely used in Germany.
The BAD guidelines on use of Biologic therapy – last published in 2009 are currently being updated and include secukinumab in the revised scope.

**Is there significant geographical variation in current practice? Are there differences of opinion between professionals as to what current practice should be?**

In general, clinicians follow NICE recommendations on use of biologic therapy for psoriasis. Growth of community-based services/loss of hospital services (eg; Nottingham) may threaten access to specialist dermatology services and therefore treatments (particularly phototherapy, systemic therapy, biologics) so leading to geographical variation in practice.

**What are the current alternatives (if any) to the technology, and what are their respective advantages and disadvantages? Are there any subgroups of patients with the condition who have a different prognosis from the typical patient? Are there differences in the capacity of different subgroups to benefit from or to be put at risk by the technology?**

There are no other licensed IL-17 agents available.
There are 4 other licensed, NICE approved biologics for use in psoriasis, TNFi (etanercept, infliximab, adalimumab) and IL12-23 antagonist ustekinumab. All are effective in the short term and, based on data from European (inc UK) registries, also in the long term. However, rates of clearance (the primary outcome measure of efficacy used in the NICE CG153, equivalent to PASI 90) run @ 37% Adalimumab 47% Ustekinumab at 12-16 weeks based on trial data; real-life efficacy is probably lower. There is therefore an important group of patients with severe disease for whom existing biologic agents are not effective. Secondary failure is also estimated

to occur at @ 15% of patients by end of year one. Infection, particularly reactivation of TB is the principal AE.
Given the license for secukinumab in theory, ciclosporin, methotrexate and PUVA could also be considered 'alternative' treatments. As per NICE CG153, disadvantages of these interventions are that ciclosporin should not be used for longer than one year and PUVA only used in exceptional circumstances given the risk of skin cancer; methotrexate is effective in @40% and cannot be used in men and women of child bearing potential.

FAEs tend to be used in patients who do not qualify for biologic therapy or who have failed biologic therapy. Major problems comprise poor tolerability. Dimethyl fumarate (licensed for MS) and the active component of FAE may improve access (and therefore use) to this approach.

There are no well validated prognostic markers in psoriasis.

**In what setting should/could the technology be used – for example, primary or secondary care, specialist clinics? Would there be any requirements for additional professional input (for example, community care, specialist nursing, other healthcare professionals)?**

Secukinumab should only be used in secondary care, by clinicians with knowledge and expertise on use of biologic therapy, and according to the service specifications as set out in NICE commissioning guidance for biologic therapy.

**If the technology is already available, is there variation in how it is being used in the NHS? Is it always used within its licensed indications? If not, under what circumstances does this occur?**

Not applicable

**Please tell us about any relevant clinical guidelines and comment on the appropriateness of the methodology used in developing the guideline and the specific evidence that underpinned the various recommendations.**

See comment above re: CG153 and BAD guidelines.

**The advantages and disadvantages of the technology**

**NICE is particularly interested in your views on how the technology, when it becomes available, will compare with current alternatives used in the UK. Will the technology be easier or more difficult to use, and are there any practical implications (for example, concomitant treatments, other additional clinical requirements, patient acceptability/ease of use or the need for additional tests) surrounding its future use?**

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**If appropriate, please give your view on the nature of any rules, informal or formal, for starting and stopping the use of the technology; this might include any requirements for additional testing to identify appropriate subgroups for treatment or to assess response and the potential for discontinuation.**

**If you are familiar with the evidence base for the technology, please comment on whether the use of the technology under clinical trial conditions reflects that observed in clinical practice. Do the circumstances in which the trials were conducted reflect current UK practice, and if not, how could the results be extrapolated to a UK setting? What, in your view, are the most important outcomes, and were they measured in the trials? If surrogate measures of outcome were used, do they adequately predict long-term outcomes?**

**What is the relative significance of any side effects or adverse reactions? In what ways do these affect the management of the condition and the patient's quality of life? Are there any adverse effects that were not apparent in clinical trials but have come to light subsequently during routine clinical practice?**

Data from secukinumab trials indicate high rates of efficacy up to one year, more effective than etanercept, and although there are no head to head trials, efficacy at least comparable to ustekinumab. Efficacy is also reported in psoriatic arthritis. The safety profile to date appears comparable to the biologics currently available. The inclusion criteria for the phase III studies do include patients previously exposed to biologic therapy, and at a disease severity level consistent with use of biologics in the UK.

Disadvantages primarily relate to the limited numbers of patients so far exposed to the drug, and lack of information about use in 'real life' practice.
Subgroups of people with psoriasis where the benefit (efficacy) may outweigh risk (limited safety data) would include:

(i) patients who have not adequately responded to TNFi / ustekinumab or who have developed secondary failure or in whom TNFi are contra-indicated.

(ii) patients with psoriasis and psoriatic arthritis who have not adequately responded to/developed secondary failure to TNFi or cannot use TNFi.

RE: rules The current rules for starting biologics restrict use to people with a PASI 10 and DLQI 10 (or PASI 20 in the case of infliximab) and treatment stopped in the event of not achieving a PASI 75 (or PASI 50/DLQI 5). In clinical practice, in general, these rules correctly identify a high need group likely to benefit from biologics and also, ensure that treatment is not continued inappropriately.
However, the evidence review for NICE 153 (and also the recent update) recognised the limitations of these tools such that, assessment of psoriasis should also include other measures (for example, measure of distress, mood), and disease at high impact sites (not adequately captured by the PASI). Restriction of biologics *in general* (ie not specifically for secukinumab) to those with a PASI 10 and DLQI 10 does therefore result in an important, minority of patients with severe disease, likely

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to benefit from biologics (including secukinumab) who do not qualify either because the PASI is not 10 (due to less extensive but nevertheless severe disease ) and/ or because the DLQI fails to capture impact.
Consideration should be given to extending use of biologic therapy (including secukinumab) to this group.

**Equality and Diversity**

NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that this appraisal:

- Could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which [the treatment(s)] is/are/will be licensed;
- Could lead to recommendations that have a different impact on people protected by the equality legislation than on the wider population, e.g. by making it more difficult in practice for a specific group to access the technology;
- Could lead to recommendations that have any adverse impact on people with a particular disability or disabilities

Please tell us what evidence should be obtained to enable the Committee to identify and consider such impacts

**Not applicable.**

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**Any additional sources of evidence**

Can you provide information about any relevant evidence that might not be found by a technology-focused systematic review of the available trial evidence? This could be information on recent and informal unpublished evidence, or information from registries and other nationally coordinated clinical audits. Any such information must include sufficient detail to allow a judgement to be made as to the quality of the evidence and to allow potential sources of bias to be determined.

**Implementation issues**

The NHS is required by the Department of Health and the Welsh Assembly Government to provide funding and resources for medicines and treatments that have been recommended by NICE technology appraisal guidance. This provision has to be made within 3 months from the date of publication of the guidance.

If the technology is unlikely to be available in sufficient quantity, or the staff and facilities to fulfil the general nature of the guidance cannot be put in place within 3 months, NICE may advise the Department of Health and the Welsh Assembly Government to vary this direction.

Please note that NICE cannot suggest such a variation on the basis of budgetary constraints alone.

How would possible NICE guidance on this technology affect the delivery of care for patients with this condition? Would NHS staff need extra education and training? Would any additional resources be required (for example, facilities or equipment)?

There should be no specific implementation issues provided use is retricted to those with experience in use of biologics. Enrolment of all patients treated with secukinumab on the UK Biologics registry (ie: BADBIR) will allow comprehensive safety (and efficacy) assessment in clinical practice, and importantly, allow comparison with existing biologics and should be a requirement for use (should it be approved), as is stipulated in NICE guidance on commissioning biologics services.

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