National Institute for Health and Care Excellence

Health Technology Evaluation

Tislelizumab with platinum-based chemotherapy for untreated advanced oesophageal squamous cell cancer

Response to stakeholder organisation comments on the draft remit and draft scope

Please note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees.

Comment 1: the draft remit and proposed process

Section	Stakeholder	Comments [sic]	Action
Appropriateness of an evaluation and proposed evaluation route	BeOne Medicines UK	BeOne consider that the most appropriate route is that of a cost comparison approach. Please see the justification for this approach in comments box below.	Thank you for your comment. No action required.
	OG Support	As a patient support group facilitator I am seeing more patients diagnosed with SCC, especially women who are younger than the expected age of 70 and over, so I do feel this evaluation route proposed is appropriate. Option C	Thank you for your comment. No action required.
Wording	BeOne Medicines UK	Suggest rewording of the remit to more accurately reflect the marketing authorisation, as follows: 'To appraise the clinical and cost effectiveness of tislelizumab in combination with chemotherapy as a first-line treatment for adult patients with unresectable, locally advanced or metastatic oesophageal squamous cell cancer (OSCC) whose tumours express PD-L1 with a TAP score of 5% or more.'	Thank you for your comment. The remit has been updated. It now states 'To appraise the clinical and cost effectiveness of tislelizumab within its marketing authorisation

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			for treating unresectable, locally advanced or metastatic, PD-L1-positive oesophageal squamous cell cancer with a TAP score of 5% of more that has not been previously treated.'
	OG Support	The remit wording is clear and reflects the issue(s) of clinical and cost effectiveness.	Thank you for your comment. No action required.
Timing issues	BeOne Medicines UK	Tislelizumab is expected to provide the NHS with a clinically-effective immunotherapy that is cost-saving when compared with current standard-of-care for patients with PD-L1–positive advanced or metastatic OSCC.	Thank you for your comment. No action required.
	OG Support	For me as a patient and support group facilitator it is urgent to get treatment options to patients that will be beneficial.	Thank you for your comment. No action required.
Additional comments on the draft remit	BeOne Medicines UK	The company propose that a cost-comparison is the most appropriate evaluation route for tislelizumab in the first-line treatment of patients with advanced or metastatic PD-L1–positive OSCC. Evidence supporting a cost-comparison approach comes from an indirect treatment comparison (ITC), in addition to expert clinical opinions gathered during the preparation of this submission. As detailed in 'Comment 2' of this form, results of an ITC (to be included as part of this submission), have confirmed that tislelizumab plus	Thank you for your comment. Having considered the decision problem, evidence that is likely to be available, stakeholder views and the relevant risks, NICE has concluded that this

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		chemotherapy is equivalent to pembrolizumab plus chemotherapy and to nivolumab plus chemotherapy, both in terms of clinical efficacy and safety profile. Despite the absence of head-to-head clinical study data, clinical experts in the UK have stated that equivalent clinical effectiveness is to be expected given the shared mechanism of action between the three treatments.[1] Given the indirect-comparison data and clinician insights, a cost-comparison approach may be considered appropriate. The company anticipate that tislelizumab will provide the NHS with an effective treatment that offers substantial savings relevant to the current standard-of-care for advanced or metastatic PD-L1–positive OSCC.	appraisal will proceed as an STA. No action required.

Comment 2: the draft scope

Section	Consultee/ Commentator	Comments [sic]	Action
Background information	BeOne Medicines UK	Recommend two minor editorial changes in the second paragraph of the Background: 1. 'Between 2021 and 2022, 56% of cases are diagnosed…' change to: 'Between 2021 and 2022, 56% of cases ***were*** diagnosed…' 2. '……1-year survival rate for people with all types of oesophageal cancer is around 57% and 5-year survival rate is 18%.' Change to: ……1-year survival rate for people with all types of oesophageal cancer ***was around*** 57% and **the** 5-year survival rate ***was*** 18%. The third paragraph of the Background should specify that palliative chemotherapy is offered in the first-line for patients with locally advanced or metastatic OSCC that is **not positive for PD-L1.** While this is not stated in NG83, it is supported by NICE recommendations based on TA737 and TA865.	Thank you for your comment. The editorial changes in paragraph 2 have been implemented in the final scope. A broad description of chemotherapy options remains in the background section of the scope at this stage. The committee can

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			consider how chemotherapy is used in the relevant population for chemotherapy during the appraisal process, as appropriate. No action required.
	OG Support	Background information is accurate and reflect national figures published.	Thank you for your comment. No action required.
Population	BeOne Medicines UK	Yes, the population is appropriately defined.	Thank you for your comment. No action required.
	OG Support	Yes, the population is defined well but does not reflect the rising cases of early onset cancers of this cancer.	Thank you for your comment. No action required.
Subgroups	BeOne Medicines UK	The only subgroup within the licensed indication for tislelizumab is patients with a PD-L1 TAP score of 5% or more, and this subgroup will be the focus of this submission.[2]	Thank you for your comment. The subgroup section is kept inclusive at this stage. No action required.

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	OG Support	Early onset patients will benefit most as often healthier and fitter to cope with the treatment, which show in better quality of life and overall survivorship, which will mean better clinical effectiveness for this group.	Thank you for your comment. No action required.
Comparators	BeOne Medicines UK	1. The company agrees that pembrolizumab with chemotherapy (TA737) and nivolumab with chemotherapy (TA865) are the relevant comparators for tislelizumab.[3, 4] 2. However, chemotherapy alone is not a relevant comparator for this specific indication (i.e., patients with a PD-L1 TAP score of 5% or more). Patients with locally advanced or metastatic OSCC who are PD-L1 positive are recommended to receive chemotherapy in combination with a PD-L1 inhibitor.[3-5]	Thank you for your comment. In order to keep the scope broad at this stage, chemotherapy alone will remain as a potential comparator at this stage. The committee will consider the relevant comparators during the appraisal.
	OG Support	Yes, the comparators are consider standard treatment within the NHS.	Thank you for your comment. No action required.
Outcomes	BeOne Medicines UK	Yes, the outcomes are appropriate.	Thank you for your comment. No action required.
	OG Support	The outcomes are appropriate and do capture the health benefits for patients, benefits that we as patients need. We also look for well-being, mental and physical, this can be affected by adverse side effects.	Thank you for your comment. No action required.

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Equality	BeOne Medicines UK	The company is not aware of any equality issues that specifically impact this remit and scope. However, for awareness, the company highlights the socioeconomic influence on incidence and mortality in patients with oesophageal cancer living in England. Data available from NHS England for patients diagnosed with oesophageal cancer between 2016 and 2020 showed an age-standardised 5-year survival rate of 13.6% (95% CI: 12.4, 15.0) for patients in the most deprived quintile, compared with 21.2% (95% CI: 19.9, 22.7) for patients in the least deprived quintile.[6]	Thank you for your comment. Any equality issues will be considered by the committee. No action required.
	OG Support	I do not see any obvious exclusions within the aims.	Thank you for your comment. No action required.
Other considerations	BeOne Medicines UK	Not applicable	Thank you for your comment. No action required.
Questions for consultation	BeOne Medicines UK	**Given the different ways of measuring and different requirements for PD-L1 expression for the populations in TA737, TA865 and this appraisal, how much overlap is there expected to be between these populations?** Strong concordance between TAP and CPS scoring for PD-L1 positivity has been published.[7, 8] Due to this concordance, PD-L1 expression levels can be regarded as being on a scale of zero to ten, whether measured by TAP or CPS. Results of an agreement analysis across TAP and CPS expression cut-offs in the RATIONALE-306 trial are available in the publication by Moehler et al., 2025.[7] Results expressed as overall percent agreement (OPA) are summarised as follows:[7] TAP 1% vs. CPS 1: 97% (95% CI: 96, 98)	Thank you for your comment. No action required.

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		TAP 5% vs. CPS 5: 85% (95% CI: 82, 88) TAP 10% vs. CPS 10: 89% (95% CI: 86, 92) The degree of concordance between TAP and CPS scoring suggests that the patient population identified through TAP or CPS scoring is also concordant. This is evidenced when comparing the efficacy of tislelizumab plus chemotherapy vs. pembrolizumab plus chemotherapy across tumours with different levels of PD-L1 positivity. CPS and TAP scoring methods are similar in that both quantify tumour cell and immune cell PD-L1 positivity.[7] In contrast, TPS methodology (used to determine patient eligibility for nivolumab) considers only tumour cell positivity.[9] Despite this difference, an indirect comparison supports equivalent efficacy between tislelizumab plus chemotherapy vs. nivolumab plus chemotherapy in tumours with varying degrees of PD-L1 expression. Indirect comparisons of tislelizumab with pembrolizumab and nivolumab will be included as part of this submission. **How strong, if any, is the correlation between PD-L1 CPS, TPS and TAP scoring and is there any way to make assumptions to convert between these scores?** Please see the company's response to question one, where we address concordance between CPS and TAP scoring. NHS England pathologists interviewed in preparation for this submission have confirmed that pathologists are normally trained in CPS and TPS analysis.[10] TAP scoring would be a much-welcomed alternative to CPS, as TAP scoring is considered to be more reproducible, and also time-saving compared with CPS.[10] **Where do you consider tislelizumab will fit into the existing care pathway untreated advanced oesophageal squamous cell cancer?**	

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		In alignment with current guidance from ESMO, tislelizumab would be used as first-line treatment for patients with advanced or metastatic OSCC who are PD-L1 positive, with a TAP score of 5 or more, as an alternative to available PD-L1 inhibitors.[5] **Please select from the following, will tislelizumab be:** **A. Prescribed in primary care with routine follow-up in primary care** **B. Prescribed in secondary care with routine follow-up in primary care** **C. Prescribed in secondary care with routine follow-up in secondary care** **D. Other (please give details).** **For comparators and subsequent treatments, please detail if the setting for prescribing and routine follow-up differs from the intervention** Tislelizumab would be prescribed in secondary care with routine follow-up in secondary care, in line with the current use of pembrolizumab and nivolumab. **Should any other comparators for tislelizumab be included in scope?** No. **Which ICD codes would most accurately capture the population for this appraisal (please give ICD-O-3 codes if this would help better reflect the specific population)?** The ICD code malignant neoplasm of the oesophagus is C15. **Do you consider that any real-world evidence (for example SACT data) could help inform this appraisal? If yes, please give details.** There is real-world evidence for tislelizumab in the first-line treatment of OSCC. **Would tislelizumab be a candidate for managed access?** It is not currently anticipated that tislelizumab will be a candidate for managed access.	

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		Do you consider that the use of tislelizumab can result in any potential substantial health-related benefits that are unlikely to be included in the QALY calculation? Please identify the nature of the data which you understand to be available to enable the committee to take account of these benefits. As the company are seeking to submit a cost-comparison, QALY calculations will not be conducted. Health-related quality-of-life benefits were evaluated in the RATIONALE-306 trial using EORTC-QLQ-C30 and will be presented as part of the submission. **Please let us know if you think that the proposed remit and scope may need changing in order to meet these aims. In particular, please tell us if the proposed remit and scope could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which tislelizumab 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 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.	

The following stakeholders indicated that they had no comments on the draft remit and/or the draft scope

MSD