NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health Technology Evaluation

Acoramidis for treating transthyretin-related amyloidosis cardiomyopathy (ID6354)

Draft scope

Draft remit/evaluation objective

To appraise the clinical and cost effectiveness of acoramidis within its marketing authorisation for treating transthyretin-related amyloidosis cardiomyopathy.

Background

Transthyretin amyloidosis (ATTR) is caused by abnormal transthyretin (TTR) proteins being produced by the liver, which accumulate as deposits in the tissues of the body. These amyloid deposits can disrupt the structure and damage the function of the affected tissues.[1] Transthyretin amyloidosis cardiomyopathy (ATTR-CM) is a type of transthyretin amyloidosis in which most deposits accumulate in the heart, causing the heart tissue to thicken and stiffen.[2] There are two forms of ATTR-CM:

- Wild-type ATTR-CM is the more common of the two types. It mostly affects older individuals and is more common in men than women.[3]

- Hereditary ATTR-CM (also known as familial or variant amyloid cardiomyopathy) affects people born with inherited mutations in the TTR gene. The most prevalent TTR variants in the UK are Val112Ile and Thr60Ala. People with African or Caribbean and Hispanic family backgrounds are more likely to have hereditary ATTR-CM because of the increased prevalence of variants (such as the Val112Ile variant) in these groups.[3,4] People in these groups are also more likely to develop cardiomyopathy, without neuropathy.

Symptoms of ATTR-CM can include shortness of breath, palpitations and abnormal heart rhythms, most frequently atrial fibrillation or atrial flutter, ankle swelling, fatigue, fainting and chest pain.

ATTR-CM is a progressive disease with symptoms usually starting after the age of 70 years in people with wildtype ATTR-CM, or after the age of 60 years in people with the Val112Ile and Thr60Ala variants of hereditary ATTR-CM.[5] Death in most people with ATTR-CM is from sudden death and progressive heart failure.[2] In England, around 1,500 people have been diagnosed with ATTR-CM.[6]

NICE technology appraisal guidance 984 recommends tafamidis for treating transthyretin amyloid cardiomyopathy in adults. Other current treatment options for ATTR-CM, such as diuretics, focus on symptom management and supportive care.

The technology

Acoramidis (Attruby, Bayer) does not have a marketing authorisation in the UK for transthyretin-related amyloidosis cardiomyopathy. It has been studied in a phase 3 double-blind clinical trial compared with placebo in adults with wild-type or hereditary symptomatic transthyretin amyloid cardiomyopathy.

Intervention(s)	Acoramidis
Population(s)	People with transthyretin-related amyloidosis cardiomyopathy (ATTR-CM)
Subgroups	If the evidence allows, the following subgroups will be considered: • severity of heart failure (such as by New York Heart Classification class) • wild type or hereditary ATTR-CM
Comparators	• Tafamidis • Vutrisiran (subject to NICE evalution) • Established clinical management without acoramidis
Outcomes	The outcome measures to be considered include: • overall survival • cardiovascular-related mortality • cardiac function (such as global longitudinal strain or brain natriuretic peptide [BNP] level) • cardiovascular-related hospitalisation • functional exercise capacity • signs and symptoms of heart failure (such as breathlessness) • adverse effects of treatment • health-related quality of life (of patients and carers).

Economic analysis	The reference case stipulates that the cost effectiveness of treatments should be expressed in terms of incremental cost per quality-adjusted life year. If the technology is likely to provide similar or greater health benefits at similar or lower cost than technologies recommended in published NICE technology appraisal guidance for the same indication, a cost-comparison may be carried out. The reference case stipulates that the time horizon for estimating clinical and cost effectiveness should be sufficiently long to reflect any differences in costs or outcomes between the technologies being compared. Costs will be considered from an NHS and Personal Social Services perspective. The availability of any commercial arrangements for the intervention, comparator and subsequent treatment technologies will be taken into account. The availability of any managed access arrangement for the intervention will be taken into account.
Other considerations	Guidance will only be issued in accordance with the marketing authorisation. Where the wording of the therapeutic indication does not include specific treatment combinations, guidance will be issued only in the context of the evidence that has underpinned the marketing authorisation granted by the regulator.
Related NICE recommendations	**Related technology appraisals:** Tafamidis for treating transthyretin amyloidosis with cardiomyopathy (2023) NICE technology appraisal guidance 984. **Related technology appraisals in development:** Vutrisiran for treating transthyretin-related amyloidosis cardiomyopathy. NICE technology appraisal guidance [ID6470] Publication expected November 2025.

Questions for consultation

Where do you consider acoramidis will fit into the existing care pathway for transthyretin-related amyloidosis cardiomyopathy (ATTR-CM)?

What treatment will most people with ATTR-CM have in NHS clinical practice currently?

Is there any evidence available directly comparing tafamidis and acoramidis? Are the populations included in the clinical trial for tafamidis in ATTR-CM (ATTR-ACT) and the clinical trial for acoramidis (ATTRibute-CM) comparable?

Please select from the following, will acoramidis 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.

Would acoramidis be a candidate for managed access?

Do you consider that the use of acoramidis 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.

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 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 acoramidis 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.

NICE is considering evaluating this technology through its cost comparison evaluation process.
Please provide comments on the appropriateness of appraising this topic through this process.
(Information on NICE's health technology evaluation processes is available at https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance/changes-to-health-technology-evaluation).

Technologies can be evaluated through the cost-comparison process if they are expected to provide similar or greater health benefits, at a similar or lower cost, compared with technologies that have been previously recommended (as an option) in published NICE guidance for the same indication. Companies can propose cost-comparison topics to NICE at any stage during topic selection and scoping. NICE will route technologies for evaluation through the cost-comparison process if it is agreed during scoping that the process is an appropriate route to establish the clinical and cost effectiveness of the technology.

NICE's health technology evaluations: the manual states the methods to be used where a cost comparison case is made.

- Is the technology likely to be similar in its clinical effectiveness and resource use to any of the comparators? Or in what way is it different to the comparators?
- Will the intervention be used in the same place in the treatment pathway as the comparator(s)? Have there been any major changes to the treatment pathway recently? If so, please describe.
- Will the intervention be used to treat the same population as the comparator(s)?
- Overall is the technology likely to offer similar or improved health benefits compared with the comparators?
- Would it be appropriate to use the cost-comparison methodology for this topic?

References

1. Amyloidosis UK (2024) ATTR amyloidosis. Accessed November 2024.
2. Tsang C, Huda A, Norman M et al (2023) Detecting transthyretin amyloid cardiomyopathy (ATTR-CM) using machine learning: an evaluation of the performance of an algorithm in a UK setting. BMJ Open 1;13(10):e070028.
3. Gillmore JD, Damy T, Fontana M et al (2018) A new staging system for cardiac transthyretin amyloidosis. European Heart Journal 7;39(30):2799-806.
4. Porcari A, Razvi Y, Masi A et al (2023) Prevalence, characteristics and outcomes of older patients with hereditary versus wild-type transthyretin amyloid cardiomyopathy. European Journal of Heart Failure 25(4):515-24.
5. Patel KS, Hawkins PN (2015) Cardiac amyloidosis: where are we today? Journal of Internal Medicine. 278(2):126-44.
6. NHS England (2024) First ever life-saving treatment for rare heart condition available on the NHS. Accessed February 2025.