**NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE**

**Health Technology Evaluation**

# Ruxolitinib for treating moderate atopic dermatitis ID6602

**Draft scope**

## Draft remit/evaluation objective

To appraise the clinical and cost effectiveness of ruxolitinib within its marketing authorisation for treating moderate atopic dermatitis.

## Background

Atopic dermatitis (also known as atopic eczema) is a long-term condition that affects the skin. It is characterised by a blotchy rash, dry, itchy and inflamed skin. The skin can also ooze and weep. Symptoms may differ between people with different skin tones. Constant scratching can cause the skin to split and bleed, which can cause skin infections. Atopic dermatitis can affect any part of the body but it most often affects the hands in adults[1].

Estimates of the prevalence of atopic dermatitis vary. It is more common in childhood, affecting around 15 – 20% of children, and around 1 – 3% of adults in the UK[2, 3]. Of the people with atopic dermatitis, 8% will have moderate to severe disease. Around 62% of these people will need systemic treatment[3].

Atopic dermatitis is usually managed in primary care. Treatment strategies include advice on avoiding factors that can provoke dermatitis, such as soap, and the use of emollients to moisturise and relieve symptoms. For flares, or dermatitis that does not respond to these measures, NICE technology appraisal 81 recommends topical corticosteroids with continued use of emollients. Second line treatment options include topical cacineurin inhibitors (technology appraisal guidance 82). Phototherapy and photochemotherapy (psoralen–ultraviolet A; PUVA) can be used to manage moderate to severe atopic dermatitis in selected adults and older children [4].

People with moderate or severe atopic dermatitis not responding to topical treatments may be referred to secondary care and offered stronger oral medications such as oral steroids or systemic immunosuppressants (azathioprine, ciclosporin, mycophenolate mofetil and methotrexate).[5]

If the condition does not respond to systemic immunosuppresents, or if these are not tolerated or not suitable, then a biological medicine or a Janus kinase (JAK) inhibitor can be offered for treating moderate to severe atopic dermatitis:

- Nemolizumab with topical corticosteroids or calcineurin inhibitors, or both, is recommeneded for people aged 12 and over with a body weight of 30 kg or more when systemic treatment is suitable and if a biological medicine would otherwise be offered (technology appraisal 1077).
- Lebrikizumab is recommended for people aged 12 and over with a bodyweight of 40 kg or more if a biologic would otherwise be offered (technology appraisal 986).
- Abrocitinib and upadacitinib are recommended in people aged 12 years and over (technology appraisal 814)
- Dupilumab (technology appraisal 534), baricitinib (technology appraisal 681) and tralokinumab (technology appraisal 814) are recommended in adults.

**The technology**

Ruxolitinib (Opzelura) does not currently have a marketing authorisation in the UK for moderate atopic dermatitis. It has been studied in placebo-controlled clinical trials in people with atopic dermatitis.

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| **Intervention(s)** | Ruxolitinib |
| **Population(s)** | People with moderate atopic dermatitis |
| **Subgroups** | If the evidence allows the following subgroup will be considered:<br>• people with atopic dermatitis affecting the hands<br>• skin colour subgroups |
| **Comparators** | For people who have not previously had a systemic therapy:<br>• Immunosuppressive therapies (azathioprine, ciclosporin, methotrexate, mycophenolate mofetil)<br>For people whose condition has not responded to at least 1 other systemic therapy, or these are not suitable:<br>• Biological medicines (nemolizumab, dupilumab, tralokinumab, lebrikizumab)<br>• JAK inhibitors (abrocitinib, upadacitinib, baricitinib) |
| **Outcomes** | The outcome measures to be considered include:<br>• measures of disease severity<br>• measures of symptom control including improvement in itch<br>• disease free period/maintenance of remission<br>• time to relapse/prevention of relapse<br>• adverse effects of treatment<br>• health-related quality of life. |

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| **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.<br><br>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.<br><br>Costs will be considered from an NHS and Personal Social Services perspective.<br><br>The availability of any commercial arrangements for the intervention, comparator and subsequent treatment technologies will be taken into account.<br><br>The availability and cost of biosimilar and generic products should 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:**<br><br>Delgocitinib for treating moderate to severe chronic hand eczema (2025). NICE technology appraisal 1107.<br><br>Nemolizumab for treating moderate to severe atopic dermatitis in people 12 years and over (2025). NICE technology appraisal 1077.<br><br>Lebrikizumab for treating moderate to severe atopic dermatitis in people 12 years and over (2024). NICE technology appraisal 986.<br><br>Abrocitinib, tralokinumab or upadacitinib for treating moderate to severe atopic dermatitis. (2022) NICE technology appraisal 814.<br><br>Baricitinib for treating moderate to severe atopic dermatitis (2021). NICE technology appraisal 681.<br><br>Dupilumab for treating moderate to severe atopic dermatitis (2018). NICE technology appraisal 534.<br><br>**Related NICE guidelines:**<br><br>Secondary infection of common skin conditions including eczema: antimicrobial prescribing**.** NICE guideline NG190.<br><br>**Related interventional procedures:**<br><br>Grenz rays therapy for inflammatory skin conditions (2007) NICE interventional procedures guidance 236**.** |

### Questions for consultation

Where do you consider ruxolitinib will fit into the existing care pathway for moderate atopic dermatitis?

Please select from the following, will ruxolitinib 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 ruxolitinib be a candidate for managed access?

Do you consider that the use of ruxolitinib 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.

Please indicate if any of the treatments in the scope are used in NHS practice differently than advised in their Summary of Product Characteristics. For example, if the dose or dosing schedule for a treatment is different in clinical practice. If so, please indicate the reasons for different usage of the treatment(s) in NHS practice. If stakeholders consider this a relevant issue, please provide references for data on the efficacy of any treatments in the pathway used differently than advised in the Summary of Product Characteristics.

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 ruxolitinib 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 intends to evaluate this technology through its Single Technology Appraisal 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).

## References

1 NHS (2024) Atopic eczema, Accessed March 2026
2 BMJ Best Practice Epidemiology (2025) Accessed March 2026
3 Kleyn C.E, McKenzie R, Meeks A, Gittens B, von Arx L, Prevalence and treatment patterns of adult atopic dermatitis in the UK Clinical Practice Research Datalink (2023) Skin Health and Disease, 10;3(4):e232
4 Simpson EL, Bruin-Weller M, Flohr C, Ardern-Jones MR, Barbarot S (2017) When does atopic dermatitis warrant systemic therapy? Recommendations from an expert panel of the International Eczema Council. Journal of the American Academy of Dermatology 2017; 77(4):623-633.
5 British Association of Dermatologists (2022) Atopic eczema. Accessed March 2026