NICE National Institute for Health and Care Excellence

Resource impact summary report

Resource impact
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This summary report is based on the NICE assumptions used in the resource impact template. Users can amend the 'Inputs and eligible population' and 'Unit costs' worksheets in the template to reflect local data and assumptions.

Recommendation

NICE has recommended ruxolitinib as an option for treating acute graft versus host disease (GvHD) that has an inadequate response to corticosteroids in people 12 years and over. Ruxolitinib is only recommended if the company provides it according to the commercial arrangement (see section 2 of the guidance).

Eligible population for ruxolitinib

Table 1 shows the population who are eligible for ruxolitinib and the number of people who are expected to have ruxolitinib in each of the next 5 years, including forecast population growth.

Table 1 Population expected to be eligible for and have ruxolitinib in England

Eligible population and uptake	People eligible for ruxolitinib	Uptake of ruxolitinib (%)	People having ruxolitinib each year
Current practice (without ruxolitinib)	286	0	0
Year 1	289	20	58
Year 2	292	30	88
Year 3	295	40	118
Year 4	298	50	149
Year 5	300	50	150

The following assumptions, which are based on haematology clinical expert opinion included in the company budget impact submission, have been used to calculate the

eligible population:

- The incidence of people who have acute GvHD as a percentage of those who receive allogenic haematopoietic stem cell transplantation (allo-HSCT) is 50%.
- 50% of this population have steroid refractory GvHD.

The market share for ruxolitinib is based on haematology clinical expert opinion.

Treatment options for the eligible population

First-line standard care for acute GvHD is corticosteroids. If corticosteroids have not worked well enough, second-line standard care can include extracorporeal photopheresis (ECP) when a person's blood is treated and reinfused back, and drug treatments such as mycophenolate mofetil, etanercept and infliximab. Ruxolitinib is an alternative to these second-line treatments.

Ruxolitinib is taken as an oral tablet twice daily. Other drug options are either taken as oral tablets or subcutaneous injections which are self-administered. These together have around 48% use. ECP is widely used (45% uptake) and involves regular hospital attendance for transfusions which take between 2 and 3 hours. For acute GvHD, data from the REACH 2 trial showed an average treatment duration for ECP of 61.7 days (around 9 weeks), involving weekly sessions taking place on 2 consecutive days.

For more information about the treatments, such as dose and average treatment duration, see the resource impact template.

The company has a commercial arrangement. This makes ruxolitinib available to the NHS with a discount.

Users can input the confidential price of ruxolitinib and amend other variables in the resource impact template.

The payment mechanism for the technology is determined by the responsible commissioner and depends on the technology being classified as high cost.

- We expect the resource impact of implementing the recommendations in England will be less than £5 million per year (or approximately £8,800 per 100,000 population,

based on a population for England of 57.16 million people).

- This is because the population size is small and any cost is likely to be offset by displacement of more resource-intensive options that are part of established clinical management.

For further analysis or to calculate the financial impact of cash items, see the resource impact template.

Capacity impact

There are potential capacity benefits from reduced use of ECP. The patient experts from the committee explained that some people commit significant time and money to travel for treatment, require invasive venous access, and may need to be hospitalised.

Table 2 shows the impact on capacity activity in each of the next 5 years.

Table 2 Capacity impact (activity) in England

Capacity impact	Year 1	Year 2	Year 3	Year 4	Year 5
Change in number of IV infusions (ECP)	800	1,100	1,400	1,700	1,700
Nurse staffing (hours)	2,000	2,800	3,600	4,200	4,200

For further analysis or to calculate the financial capacity impact from a commissioner (national) and provider (local) perspective, see the resource impact template.

Key information

Table 3 Key information

Time from publication to routine commissioning funding	Innovative Medicines Fund interim funding has been agreed for ruxolitinib. Interim funding will end 90 days after positive final guidance is published, at which point funding will switch to routine commissioning budgets.
Programme budgeting category	3 Disorders of blood.
Commissioner(s)	NHS England

Provider(s)	NHS hospital trusts / tertiary providers.
Pathway position	Second-line alternative treatment.

About this resource impact summary report

This resource impact summary report accompanies the NICE technology appraisal guidance on ruxolitinib for treating acute graft versus host disease that responds inadequately to corticosteroids in people 12 years and over and should be read with it. See terms and conditions on the NICE website.

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