NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Final draft guidance

Delgocitinib for treating moderate to severe chronic hand eczema

1 Recommendations

1.1 Delgocitinib can be used, within its marketing authorisation, as an option to treat moderate to severe chronic hand eczema in adults when topical corticosteroids have not worked or are not suitable. Delgocitinib can only be used if the company provides it according to the commercial arrangement (see section 2).

1.2 Delgocitinib should be started and monitored by a healthcare professional with experience in diagnosing and treating chronic hand eczema in secondary care.

1.3 Consider how skin colour could affect the assessment of severity and make any adjustments needed.

What this means in practice

Delgocitinib must be funded in the NHS in England for the condition and population in the recommendations, if it is considered the most suitable treatment option. Delgocitinib must be funded in England within 90 days of final publication of this guidance.

There is enough evidence to show that delgocitinib provides benefits and value for money, so it can be used routinely across the NHS in this population

Why the committee made these recommendations

Usual treatment for moderate to severe chronic hand eczema when topical corticosteroids have not worked or are not suitable includes phototherapy (ultraviolet light therapy) or alitretinoin.

Clinical trial evidence shows that delgocitinib is more effective at improving symptoms of chronic hand eczema than alitretinoin or 'vehicle cream' (a cream that does not contain an active ingredient).

Delgocitinib has not been directly compared in a clinical trial with phototherapy, but an indirect comparison suggests that delgocitinib is more effective.

There are some uncertainties in the economic model. But the most likely cost-effectiveness estimates for using delgocitinib in secondary care are within the range that NICE considers an acceptable use of NHS resources. So, it can be used.

2 Information about delgocitinib

Marketing authorisation indication

2.1 Delgocitinib (Anzupgo, Leo Pharma) is indicated for 'the treatment of moderate to severe chronic hand eczema (CHE) in adults for whom topical corticosteroids are inadequate or inappropriate'.

Dosage in the marketing authorisation

2.2 The dosage schedule is available in the summary of product characteristics for delgocitinib.

Price

2.3 The list price of delgocitinib cream (20 mg per 1 g) is £595 per 60-g tube (excluding VAT; BNF online, accessed May 2025).

2.4 Costs may vary in different settings because of negotiated procurement discounts.

2.5 The company has a commercial arrangement (simple discount patient access scheme). This makes delgocitinib available to the NHS with a discount. The size of the discount is commercial in confidence.

Carbon Reduction Plan

2.6 Information on the Carbon Reduction Plan for UK carbon emissions for Leo Pharma will be included here when guidance is published.

3 Committee discussion

The evaluation committee considered evidence submitted by Leo Pharma, a review of this submission by the external assessment group (EAG), and responses from stakeholders. See the committee papers for full details of the evidence.

The condition

3.1 Hand eczema is an inflammatory skin condition that causes the hands to become dry, itchy, cracked and painful. Chronic hand eczema is defined as hand eczema that lasts for more than 3 months or relapses at least twice a year. Hyperkeratotic hand eczema includes thickening and scaling of the skin and typically affects the palms. The committee understood that the severity of chronic hand eczema symptoms often fluctuates in cycles of flare-ups and remission. The company said that although clinically validated scales are available to assess severity, they can be complex and time consuming to use. So typically, clinical judgement is used to identify moderate or severe cases. The patient expert described how chronic hand eczema can affect the ability to carry out usual activities. People may avoid tasks that cause pain, such as opening doors or gripping items. Sleep can be disrupted, causing tiredness during the day. Chronic hand eczema can also affect mental health and emotional wellbeing. The patient expert described how people often feel self-conscious because the eczema is visible on their hands, and this can lead to self-isolation. The ability to maintain employment may be affected, particularly for people whose work is manual or involves regular handwashing. This includes tradespeople and people working in childcare

or healthcare. The committee recognised the substantial impact that chronic hand eczema has on quality of life.

Treatment pathway

Current treatment and unmet need

3.2 First-line treatment for chronic hand eczema includes topical corticosteroids with or without topical calcineurin inhibitors (treatments applied to the skin). Second-line treatment includes phototherapy and oral alitretinoin (treatment taken by mouth). Subsequent treatments may include immunosuppressants, oral corticosteroids, biological medicines and oral Janus kinase (JAK) inhibitors. Phototherapy includes psoralen (treatment that makes the skin sensitive to sunlight) and ultraviolet light A (collectively known as PUVA).

The patient group submission and consultation response highlighted that current treatments are not effective for some people and alternative treatment options are needed to effectively manage the different subtypes of chronic hand eczema. They explained how current treatments can cause significant side effects, particularly alitretinoin, which can cause birth defects. So a pregnancy prevention programme is necessary for people who could become pregnant. The clinical experts described how phototherapy is inconvenient for most people because it involves regular visits to hospital (20 to 30 sessions). The committee concluded that people with chronic hand eczema would welcome an additional treatment option.

Positioning of delgocitinib and comparators

3.3 In the company's submission, delgocitinib was positioned as a second-line treatment option for adults with moderate to severe chronic hand eczema when topical corticosteroids have not worked or are not suitable. For moderate disease, the company did not consider alitretinoin a relevant treatment option because NICE's technology appraisal guidance on alitretinoin for the treatment of severe chronic hand eczema did not

evaluate alitretinoin for moderate chronic hand eczema. The clinical experts explained that it is often difficult to differentiate between moderate and severe disease because severity can be subjective (see section 3.1). They said that PUVA would typically be used for people with moderate chronic hand eczema but accepted that there may be a proportion of people with moderate disease who have alitretinoin 'off label'. They also noted that treatment choice is guided by method of administration, as well as safety and efficacy. For example, some people may prefer the convenience of a topical cream, even if it means a slower or less complete therapeutic response. The committee noted the summary of product characteristics states that delgocitinib should be 'initiated and supervised by physicians with experience in the diagnosis and treatment of chronic hand eczema'. It also considered the consultation response from the British Association of Dermatologists, which stated that people are usually referred to secondary care when their eczema has not responded to first-line treatments and that delgocitinib would be used in secondary care. The committee concluded that delgocitinib would be prescribed in secondary care by a dermatologist. It decided that the company's positioning of delgocitinib reflected how it would likely be used in clinical practice. Based on this positioning, it concluded that PUVA and alitretinoin were the most relevant comparators for both moderate and severe chronic hand eczema.

Clinical evidence

Data sources

3.4 The key clinical trial evidence for delgocitinib came from the DELTA trials. These included DELTA 1 (n=487) and DELTA 2 (n=473), which were phase 3, randomised, double-blind trials comparing delgocitinib with vehicle cream (no active treatment). The population included adults with moderate or severe chronic hand eczema for whom topical corticosteroids had not worked or were not suitable. The Investigator's Global Assessment for chronic hand eczema (IGA-CHE) scale was used to define moderate (IGA-CHE score of 3) and severe (IGA-CHE score of 4)

disease. The scale assesses severity based on the level of erythema (redness), scaling (flaky skin), hyperkeratosis or lichenification (thickened or hardened skin), vesiculation (blisters), oedema (swelling) and fissures (cracks). People were randomised to delgocitinib cream or vehicle cream twice daily for up to 16 weeks. People who completed 16 weeks of treatment in DELTA 1 or 2 were able to enrol in DELTA 3 (n=801), which was a phase 3, open-label extension study of 36 weeks' duration. In DELTA 3, everyone had delgocitinib twice daily as needed (based on IGA-CHE score). The company also presented evidence from DELTA FORCE (n=513), which was a phase 3, randomised, assessor-blinded trial of 24 weeks' duration comparing delgocitinib with alitretinoin. The population included adults with severe chronic hand eczema (IGA-CHE score of 4) for whom topical corticosteroids had not worked or were not suitable. People were randomised to delgocitinib cream twice daily for 16 weeks or alitretinoin daily for 12 weeks. After these time points, each treatment was used as needed (based on IGA-CHE score). The EAG thought the DELTA trials had a low risk of bias. It noted that there was no trial data that compared delgocitinib with alitretinoin in people with moderate chronic hand eczema. The committee acknowledged this but concluded that the DELTA trials were appropriate for decision making.

Clinical effectiveness

3.5 The primary outcome in DELTA 1 and 2 was IGA-CHE treatment success at week 16, defined as an IGA-CHE score of 0 (clear) or 1 (almost clear) and an improvement from baseline of at least 2 points. The committee noted that this was consistent with the summary of product characteristics, which says treatment should stop once the affected skin is 'clear or almost clear'. In the full-analysis set, the proportion with IGA-CHE treatment success at week 16 was significantly higher for the delgocitinib arm than for the vehicle-cream arm in DELTA 1 (mean difference 9.8%, p=0.006) and DELTA 2 (mean difference 22.2%, p<0.001). The primary outcome in DELTA FORCE was the mean change in Hand Eczema Severity Index (HECSI) score from baseline to week 12, with higher

scores indicating greater disease severity. In the full-analysis set, the percentage reduction in mean HECSI score at week 12 was significantly larger in the delgocitinib arm than in the alitretinoin arm (mean difference -16.1%, 95% confidence interval -23.28% to -8.86%, p<0.001). The committee concluded that delgocitinib is an effective treatment for improving chronic hand eczema symptoms.

Indirect treatment comparisons

3.6 Because of a lack of direct evidence comparing delgocitinib with PUVA, the company did a network meta-analysis (NMA). The analysis included data from 5 randomised controlled trials to compare the efficacy of delgocitinib with vehicle cream, alitretinoin and PUVA. These included DELTA 1 and 2, DELTA FORCE, Worm 2022 and ALPHA (alitretinoin compared with PUVA in people with severe chronic hand eczema). For all analyses, the company selected the fixed-effects models to inform the initial 12 week treatment effects in the model. The results showed that people who had delgocitinib cream were statistically significantly more likely than those having PUVA or alitretinoin to have clear or almost clear skin. The company said the fixed-effects model results reflected the direct evidence for delgocitinib and alitretinoin, because DELTA FORCE was the only study in the NMA informing this comparison. The EAG noted that there was substantial clinical and methodological heterogeneity among the studies. For example, there were differences in the baseline characteristics of the included populations and the endpoints used to determine treatment success. It said that using a fixed-effects model was not appropriate because of this heterogeneity. Instead, it preferred to use direct evidence from DELTA FORCE to estimate the treatment effects for delgocitinib compared with alitretinoin. To estimate the treatment effects for delgocitinib compared with PUVA, the EAG asked the company to perform unanchored matching-adjusted indirect comparisons (MAICs) comparing delgocitinib (pooled population from DELTA 1 and 2) with PUVA (population from ALPHA). The EAG's preferred MAIC compared delgocitinib with PUVA in people with severe disease and based on

hyperkeratotic status. The company considers the results of the MAIC to be confidential, so they cannot be reported here. The committee noted that the effective sample size for the matched population in the MAIC was small (n=39). It concluded that the company's NMA was more appropriate because it pooled the relative treatment effects using methods that preserved within-trial randomisation. So, the committee preferred the company's fixed-effects NMA over the EAG's approach to estimate the relative treatment effects for delgocitinib, vehicle cream, alitretinoin and PUVA.

Imputation of missing data

3.7 The company used the worst observation carried forward (WOCF) approach to impute missing trial data to estimate treatment effects. The EAG thought that using the WOCF approach could bias comparisons of delgocitinib with vehicle cream or alitretinoin in favour of delgocitinib. It said this was because the WOCF approach generated bias against the arms with the highest dropout rates (vehicle cream and alitretinoin). Instead, it suggested that multiple imputation, with a 'missing not at random' assumption, should be used because it is likely to be associated with a lower risk of bias. The company explained that, in the DELTA trials, most people stopped vehicle cream or alitretinoin because of adverse events or a lack of efficacy. Because of this, the company thought that a multiple-imputation approach could introduce bias and potentially underestimate the relative treatment effect of delgocitinib. The committee thought that it was unclear how using an alternative to the WOCF imputation method would affect the cost-effectiveness results. It thought that analyses using the first (baseline) and last observation carried forward method (known as BOCF and LOCF respectively) may help to reduce some of this uncertainty.

At the second meeting, the company provided analyses using the alternative imputation methods requested by the committee. These approaches were applied to all the DELTA trials included in the company's NMA (see section 3.6). The fixed-effects NMA results

(moderate and severe subgroups) remained in favour of delgocitinib for IGA-CHE treatment success irrespective of the choice of imputation method (WOCF, BOCF or LOCF). But the EAG noted that there were still considerable differences in the relative efficacy of delgocitinib based on which imputation approach was used. It noted that the LOCF method resulted in the most conservative efficacy estimates for delgocitinib and so it preferred to use this in its base case (over WOCF and BOCF). The company explained that it had retained the WOCF approach in its base case because this meant that intercurrent events (such as treatment discontinuation) could be accounted for in the analyses. The committee thought there was uncertainty with each of the approaches presented. But it noted that the choice of imputation method had a minimal impact on the cost-effectiveness results. It concluded that the LOCF approach was the most appropriate because this was associated with the lowest risk of decision error.

Economic model

Company's modelling approach

3.8 The company presented a Markov cohort model. The population included adults with moderate (IGA-CHE score of 3) or severe (IGA-CHE score of 4) chronic hand eczema for whom topical corticosteroids had not worked or were not suitable. The comparators modelled included PUVA for people with moderate and severe disease and alitretinoin for people with severe disease. The time horizon was 10 years and the model included a 4-week cycle with half-cycle correction. In the model, everyone had 12 weeks of initial treatment with delgocitinib, alitretinoin or PUVA. The company included stopping rules based on response to initial treatment, continued treatment and retreatment. Response to treatment was based on IGA-CHE score and included full, partial, low and insufficient response health states. The committee noted that this was consistent with the summary of product characteristics for delgocitinib, which says treatment should stop 'if no improvement is seen after 12 weeks of continuous treatment'. The EAG thought the model structure was appropriate for

addressing the decision problem. The committee recalled that although alitretinoin is licensed for severe disease, it may be used off label for some people with moderate disease (see section 3.3). The committee concluded that the company's model was acceptable for decision making. It also concluded that the model should consider alitretinoin as a comparator for people with moderate disease.

Treatment effects in moderate disease

3.9 There was no evidence for the safety or efficacy of alitretinoin or PUVA in moderate disease. The committee recalled that both DELTA FORCE and ALPHA included only people with severe chronic hand eczema. In the model, the company assumed that the relative treatment effect of delgocitinib to alitretinoin and delgocitinib to PUVA in moderate chronic hand eczema was consistent with that seen in severe chronic hand eczema. So, although there may be a difference in the treatment effect between moderate and severe chronic hand eczema, this difference would be consistent across treatment comparisons. The company did subgroup analyses from the DELTA 1 and 2 trials, which it said supported its assumption. The EAG thought that the company's subgroup analyses were insufficient to confirm whether the relative treatment effects between moderate and severe disease were consistent. So, the EAG's base case compared delgocitinib with alitretinoin or PUVA in only the severe population. The clinical experts said that all treatments may be slightly more effective in moderate disease, but agreed that the relative effectiveness of treatments would likely be consistent across moderate and severe populations. The committee also noted that the EAG's scenario analyses in moderate disease had a minimal to small impact on the cost-effectiveness results. It concluded that the company's assumption of equivalence in the relative treatment effects between moderate and severe chronic hand eczema was reasonable.

Treatment effects based on hyperkeratotic status

3.10 Some people with chronic hand eczema experience thickening of the outermost layer of the skin (hyperkeratosis). The EAG's clinical experts said the presence of hyperkeratosis influences how well treatments work and can guide treatment decisions. DELTA FORCE was the only trial for delgocitinib that was stratified by hyperkeratotic status. The committee discussed the subgroup results from the trial, which showed that the relative treatment effects for delgocitinib compared with alitretinoin differed by hyperkeratotic status. The company considers the results of the analyses to be confidential, so they cannot be reported here. The clinical experts said that hyperkeratotic status would guide treatment decisions only when hyperkeratosis is very pronounced. In this case, they would typically recommend alitretinoin because it is more effective than delgocitinib in this population. But they would also consider other factors, such as convenience and safety (see section 3.3). The committee noted that using the treatment effects based on hyperkeratotic status had a large impact on the cost-effectiveness results for delgocitinib compared with alitretinoin. The company explained that there was a lack of hyperkeratotic and non-hyperkeratotic subgroup data in the ALPHA trial, which meant that an indirect comparison between delgocitinib and PUVA was not possible. The committee concluded that the treatment effects in the model should be informed by the full population from DELTA FORCE rather than based on hyperkeratotic status.

Time on treatment

3.11 The company's model used discontinuation rates from week 12 to week 24 in DELTA FORCE to estimate the discontinuation rate for people having retreatment. So, the model used discontinuation rates informed by data from people whose eczema did not have a full response to inform discontinuation rates for people whose eczema previously did have a full response. Because of this, the EAG said the discontinuation rates used for people having retreatment were too high, and time on treatment was likely underestimated. The EAG's clinical experts stated that around 25% of people on alitretinoin are still having treatment after 2 years in clinical

practice. This was much higher than the proportion of people having alitretinoin in the model at 2 years (the company considers the exact figures to be confidential so they cannot be reported here). The clinical experts said it was difficult to predict how long people remain on treatment. But they said that the proportion of people remaining on treatment in the model at 1, 2 and 3 years appeared too low for all treatments. They thought it was reasonable to assume that 25% of people would have long-term intermittent courses of alitretinoin to manage their chronic hand eczema. They thought it would be easier for people to restart treatment with delgocitinib than the other treatments when their symptoms flare up. This is because delgocitinib is a topical treatment with a year-long shelf life once opened, in contrast to the other treatments for which a new hospital visit would be needed to restart treatment each time. The committee considered that modelled time on treatment did not reflect clinical practice. It thought that the proportion of people remaining on treatment at 2 years in the model should be 25% for alitretinoin, at least 25% for delgocitinib, but the proportion on PUVA may be lower than 25%.

At the second meeting, the company revised its base case to increase the modelled time on treatment in line with the committee's preferences. This was done as follows:

- for severe disease: increasing the severity threshold for retreatment eligibility with alitretinoin and PUVA to severe symptoms (previously moderate symptoms)
- for moderate and severe disease: reducing per-cycle discontinuation during retreatment to half of that previously assumed for alitretinoin (from 6.83% to 3.54%) and to 0% for delgocitinib (from 2.8%).

  The EAG preferred to assume that people on alitretinoin and PUVA would be eligible for retreatment when their eczema relapses to moderate symptoms, based on clinical expert opinion. It also thought that the company's assumption of no discontinuation during retreatment with delgocitinib was unrealistic. So, it amended the per-cycle

discontinuation during retreatment to half of that previously assumed for delgocitinib (from 2.8% to 1.42%) in its base case analyses. These adjustments reduced the proportion of people remaining on alitretinoin at 2 years in the model to much lower than 25%. The company explained that its expert elicitation suggested that between 7 and 25% of people whose eczema has responded to alitretinoin are expected to still be on treatment at 2 years. The committee noted that the proportion remaining on alitretinoin at 2 years in the model was still within this range when using the EAG's preferred amendments. It concluded that time on treatment was uncertain in the model, but that it preferred the EAG's approach because this better reflected how each treatment would likely be used in clinical practice.

Dosing data for delgocitinib

3.12 After the first committee meeting, the company updated its base case to use delgocitinib dosing data from DELTA FORCE (see section 3.14). Because of this, it also used DELTA FORCE to inform treatment effects after week 12 for the comparison of delgocitinib with alitretinoin. The company accepted that it was appropriate to use dosing data from DELTA FORCE for people with severe disease at baseline because this reflected the trial population. But it considered that applying this same dosing data to people with moderate disease at baseline may overestimate resource use and costs for this population. It said people with severe chronic hand eczema typically have greater intensity of symptoms and a larger surface area of the hands are affected compared with people with moderate chronic hand eczema. And that descriptive statistics from DELTA 1, DELTA 2 and DELTA FORCE suggested that delgocitinib usage was higher among people with severe disease at baseline than people with moderate disease at baseline. So, it provided a scenario using dosing data from the subgroups with moderate disease at baseline in DELTA 1 and 2 to inform delgocitinib dosing in the moderate population. The EAG base case assumed that people with the same IGA-CHE score used the same amount of delgocitinib, regardless of whether they had moderate or

severe disease at baseline. The committee acknowledged that people with severe symptoms would likely use more delgocitinib than those with moderate symptoms. But they said it was appropriate to assume that people with the same severity of symptoms would use the same amount of delgocitinib, regardless of their severity at baseline. It also recalled that because treatment outcomes came from DELTA FORCE for the comparison of delgocitinib with alitretinoin, it preferred to use dosing data from the same source in the model (see section 3.14). So it concluded that when comparing delgocitinib with alitretinoin, DELTA FORCE was the most appropriate source of delgocitinib dosing data for people with both moderate and severe chronic hand eczema at baseline.

Utility values

3.13 The company pooled EQ-5D-5L data from DELTA 1 and 2 and mapped it to the EQ-5D-3L for the moderate and severe subgroups. A mixed model for repeated measures (MMRM) was used to analyse the pooled utility data in terms of health state, treatment and baseline disease severity. This modelled the change in EQ-5D-3L from baseline to week 16 with response based on IGA-CHE. The company thought that differences in health-related quality of life between people having active treatment and people having best supportive care were not fully captured in the IGA-CHE scoring. It explained that, because of this, it had modelled a utility difference for people having active treatments (delgocitinib, alitretinoin and PUVA) relative to best supportive care. The utility values for active treatments were weighted using data from RWEAL (an international chart review study) to estimate utilities for next-line treatment. Best supportive care utilities were estimated by weighting vehicle-cream utilities from the MMRM based on response data from DELTA 1 and 2. The EAG thought there was no evidence to suggest a treatment- or severity-specific utility difference. Instead, it preferred to use health-state-specific utilities using pooled utility data for delgocitinib across all the DELTA trials. The choice of utilities had a large impact on the incremental cost-effectiveness ratio (ICER) for delgocitinib compared with alitretinoin. The committee

concluded that the EAG's approach of using health-state-specific utilities was the most appropriate based on the evidence presented.

Other EAG amendments to the model

3.14 At the first meeting, the EAG proposed additional amendments to the model. These included:

- using delgocitinib dosing data from DELTA FORCE (rather than all DELTA trials) to inform the comparison between delgocitinib and alitretinoin
- using the weighted average of week 12 and week 24 delgocitinib dosing data from DELTA 1, DELTA 2 and DELTA FORCE to inform the comparison between delgocitinib and PUVA
- basing the proportion of people who move to next-line treatment and best supportive care on the ALPHA trial
- removing alitretinoin from the group of next-line treatments and reducing the efficacy of the group to 25.6%
- adjusting frequencies of dermatologist visits in each health state to align with the EAG's clinical expert opinion
- not including adverse events from DELTA FORCE.

The committee noted that the dose of delgocitinib assumed in the model had a large impact on the ICER for the comparison of delgocitinib with alitretinoin. It noted that all of the EAG's other amendments had a minimal impact on the cost-effectiveness results. The committee understood that the company's base case included adverse events from DELTA FORCE if they had an incidence of at least 10% and the difference between treatments was at least 1.5%. It recognised that adverse events did not substantially affect the cost-effectiveness results, but it preferred for these to be included in the analyses. It concluded that all the EAG's other amendments to the model were appropriate. At the second meeting, the company and EAG

updated their base cases to reflect all the committee's preferred model amendments.

Cost-effectiveness estimates

Acceptable ICER

3.15 NICE's manual on health technology evaluations notes that, above a most plausible ICER of £20,000 per quality-adjusted life year (QALY) gained, judgements about the acceptability of a technology as an effective use of NHS resources will take into account the degree of certainty around the ICER. The committee will be more cautious about recommending a technology if it is less certain about the ICERs presented. But it will also take into account other aspects, including uncaptured health benefits. At the first meeting, the committee noted the high level of uncertainty, specifically:

- the use of the WOCF approach to impute missing data for estimating treatment effects
- time on treatment in the model being underestimated for delgocitinib, alitretinoin and PUVA and not reflecting clinical practice.

At the second meeting, the committee acknowledged the efforts of the company to address these uncertainties. The committee thought that the evidence presented by the company suggested that the choice of imputation method for missing data did not substantially affect the cost-effectiveness results (see section 3.7). It noted that there was still some uncertainty around the time on treatment for delgocitinib, alitretinoin and PUVA in clinical practice (see section 3.11). The committee understood that the cost-effectiveness estimates were sensitive to the difference in the proportions of people remaining on treatment. The committee recognised that because of its topical administration and manageable safety profile, delgocitinib offers benefits over current second-line treatments for chronic hand eczema. This includes being able to restart delgocitinib more easily than alitretinoin and PUVA when

symptoms flare up. It recalled that patients and healthcare professionals would value having access to a range of treatments that can effectively manage the different subtypes of chronic hand eczema. When considering the uncaptured health benefits and remaining uncertainty, the committee concluded that an acceptable ICER would be towards the lower end of the range NICE considers a cost-effective use of NHS resources (£20,000 to £30,000 per QALY gained).

Committee's preferred assumptions

3.16 The committee concluded that its preferred modelling assumptions included:

- using the company's fixed-effects NMA results to inform the initial treatment effects in the model (see section 3.6)
- using the LOCF approach to impute missing data across the DELTA trials (see section 3.7)
- using the EAG's preferred amendments to increase time on treatment in the model (see section 3.11)
- using health state-specific utility values (see section 3.12)
- including the EAG's preferred amendments to the model, except for adverse events (see section 3.14)
- including adverse events from DELTA FORCE (see section 3.14).

The committee agreed that alitretinoin and PUVA are both used for treating chronic hand eczema in the population under consideration. It recalled that although alitretinoin is licensed only for severe disease, it may be used off label for moderate disease. But that most people with moderate disease would typically use PUVA (see section 3.3). The company presented a scenario using a case-mix of people with moderate disease (60%) and severe disease (40%) at baseline. The committee noted that the proportions used were evidence-based and likely reflected the expected case-mix that would be seen in clinical practice. The committee agreed that the relevant cost-effectiveness

estimates would be those which included its preferred assumptions and were weighted by the case-mix distribution presented in the company's scenario. The exact ICERs are confidential and cannot be reported here because they include confidential discounts for delgocitinib, alitretinoin and other treatments in the pathway. The most plausible ICERs for delgocitinib compared with alitretinoin and delgocitinib compared with PUVA were below the committee's preferred threshold. So, it concluded that delgocitinib can be used for treating moderate to severe hand eczema when topical corticosteroids have not worked or are not suitable.

Other factors

Equality

3.17 The committee acknowledged that chronic hand eczema disproportionally affects people from certain groups, and can present differently on different skin tones. For example, erythema (skin redness) is often less apparent in people with brown or black skin. The committee noted that this could affect the assessment of severity, which could lead to undertreatment. So, healthcare professionals should take skin colour into account when assessing disease severity and make any adjustments needed. The committee also noted that current treatments and services for chronic hand eczema may not be suitable for all people and their availability may depend on where a person lives. But it concluded that the recommendations would not have a different effect on people protected by equality legislation than on the wider population.

Conclusion

3.18 The most plausible ICERs for delgocitinib compared with alitretinoin or PUVA were below the committee's preferred threshold. So, delgocitinib can be used routinely in secondary care in the NHS to treat moderate to severe chronic hand eczema in adults when topical corticosteroids have not worked or are not suitable.

4 Implementation

4.1 Section 7 of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 requires integrated care boards, NHS England and, with respect to their public health functions, local authorities to comply with the recommendations in this evaluation within 90 days of its date of publication.

4.2 The Welsh ministers have issued directions to the NHS in Wales on implementing NICE technology appraisal guidance. When a NICE technology appraisal guidance recommends the use of a drug or treatment, or other technology, the NHS in Wales must usually provide funding and resources for it within 60 days of the first publication of the final draft guidance.

4.3 When NICE recommends a treatment 'as an option', the NHS must make sure it is available within the period set out in the paragraphs above. This means that, if a patient has moderate to severe chronic hand eczema and the healthcare professional responsible for their care thinks that delgocitinib is the right treatment, it should be available for use, in line with NICE's recommendations.

5 Evaluation committee members and NICE project team

Evaluation committee members

The 4 technology appraisal committees are standing advisory committees of NICE. This topic was considered by committee B.

Committee members are asked to declare any interests in the technology being evaluated. If it is considered there is a conflict of interest, the member is excluded from participating further in that evaluation.

The minutes of each evaluation committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

Chair

Baljit Singh

Vice chair, technology appraisal committee B

NICE project team

Each evaluation is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the evaluation), a technical adviser, a project manager and an associate director.

Anita Sangha

Technical lead

Alexandra Sampson

Technical adviser

Vonda Murray and Thomas Feist

Project managers

Richard Diaz

Associate director

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