



Resource impact summary report

Resource impact

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Resource impact summary report

This summary report is based on the NICE assumptions used in the [resource impact template](#). Users can amend the 'Population and uptake' and 'Unit costs' worksheets in the template to reflect local data and assumptions.

Guidance recommendations

See [NICE's recommendations on vorasidenib for treating astrocytoma or oligodendroglioma with IDH1 or IDH2 mutations after surgery in people 12 years and over](#).

Financial and capacity resource impact

The company has a commercial arrangement. This makes vorasidenib available to the NHS with a discount. The size of the discount is commercial in confidence.

Users can input the price of vorasidenib 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.

Clinical trial evidence shows that vorasidenib increases how long people have before their cancer gets worse compared with placebo. But it is uncertain whether vorasidenib affects how long people live. People in the clinical trial stopped treatment with vorasidenib when the cancer got worse.

The clinical experts stated that CT scans are rarely used to monitor low-grade glioma (LGG). It is assumed that 6-monthly MRI scans are required for people with LGG's. The template includes a weighted average over 3 years depending on healthcare state for MRI scans, outpatient appointments, GP appointments and seizure management. This was based on data from the company submission and clinical expert opinion.

There will be a capacity benefit due to a reduction in seizure management in people having vorasidenib.

Table 1 shows the impact on capacity activity in each of the next 3 years.

Table 1 Capacity impact (activity) in England

Year	Number of administrations	Number of specialist appointments
Current practice (without vorasidenib)	0	933
Year 1	2,184	817
Year 2	2,520	799
Year 3	2,856	781

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

Eligible population for vorasidenib

Table 2 shows the population who are eligible for vorasidenib and the number of people who are expected to have vorasidenib in each of the next 3 years, excluding forecast population growth.

Table 2 Population expected to be eligible for vorasidenib in England

Eligible population and uptake	Number of people eligible for vorasidenib	Uptake for vorasidenib (%)	Number of people having vorasidenib each year
Current practice without vorasidenib	276	0	0
Year 1	276	65	179
Year 2	276	75	207
Year 3	276	85	235

The following assumptions have been used to calculate the eligible population:

- There are around 10,300 new brain, other central nervous system and intracranial tumour cases in England every year. Of these 9% are assumed to be astrocytoma tumours and 3% are oligodendroglioma tumours ([Cancer Research UK](#)).
- Of those with new brain, other central nervous system and intracranial tumours, 1.6% are grade 2 astrocytoma tumours, which is equivalent to 17.74% of astrocytoma brain

tumours ([National Brain Tumor Society](#)).

- Of those with oligodendroglioma, 83.87% are estimated to be grade 2 tumour ([Kalra et al 2024](#)).
- The company submission estimates the prevalent population by using the median progression-free survival for the vorasidenib group from the INDIGO trial, which was 27.7 months (2.3 years). This is because people would stop taking vorasidenib at the point of progression ([Mellinghoff et al. 2023](#)). The 2.3 years is used as a multiplier to the incident population for both grade 2 astrocytoma and oligodendroglioma tumours.
- The company submission estimates that 80% have had surgery within 1 year, with 45% not in need of immediate chemotherapy or radiotherapy and 80% of these are non-enhancing gliomas.

The uptake for vorasidenib is based on clinical expert opinion. Users can amend the uptake in the [resource impact template](#).

Treatment options for the eligible population

Usual care for grade 2 astrocytoma or oligodendroglioma with an IDH1 or IDH2 mutation for people whose cancer has not progressed (got worse) and who do not immediately need chemotherapy or radiotherapy after surgery is active surveillance.

For more information about the treatments, such as dose and average treatment duration, see the [resource impact template](#).

Key information

Table 3 Key information

Time from publication to routine commissioning funding	90 days
Programme budgeting category	02X - Cancers and Tumours
Commissioner	NHS England
Provider	NHS Hospital trusts
Pathway position	Astrocytoma or oligodendroglioma with IDH1 or IDH2 mutations after surgery

About this resource impact summary report

This resource impact summary report accompanies the [NICE technology appraisal guidance on vorasidenib for treating astrocytoma or oligodendroglioma with IDH1 or IDH2 mutations after surgery in people 12 years and over](#) and should be read with it.

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