# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## Single Technology Appraisal (STA)

## Alemtuzumab for the treatment of relapsing-remitting multiple sclerosis

Thank you for agreeing to give us a statement on your organisation's view of the technology and the way it should be used in the NHS.

Healthcare professionals can provide a unique perspective on the technology within the context of current clinical practice which is not typically available from the published literature.

To help you in making your statement, we have provided a template. The questions are there as prompts to guide you. It is not essential that you answer all of them.

Please do not exceed the 8-page limit.

**About you**

**Your name:**
[redacted]

**Name of your organisation**
University of Cambridge
Addenbrooke's Hospital

**Are you (tick all that apply):**

- a specialist in the treatment of people with the condition for which NICE is considering this technology? ✓
- a specialist in the clinical evidence base that is to support the technology (e.g. involved in clinical trials for the technology)? ✓
- an employee of a healthcare professional organisation that represents clinicians treating the condition for which NICE is considering the technology? If so, what is your position in the organisation where appropriate (e.g. policy officer, trustee, member etc.)? ✓ Association of British Neurology, MS Section
- other? (please specify)

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**What is the expected place of the technology in current practice?**

I agree with the submission from Genzyme

**The advantages and disadvantages of the technology**

I agree with the submission from Genzyme, except in the following points:

Page 63. Technically, this statement on page page 64 is not absolutely correct: "Alemtuzumab is the first treatment for RRMS to demonstrate a reduction in sustained accumulation of disability compared with an active comparator (see Section 6.5.3)." Because the combination of natalizumab and Avonex was shown to be superior to Avonex alone, in disability outcomes, in a phase 3 trial. However, natalizumab is never used in combination with Avonex in clinical practice as it is felt to be unsafe. So, the correct statement would be that: Alemtuzumab is the first monotherapy treatment for RRMS to demonstrate a reduction in sustained accumulation of disability compared with an active comparator."

Pages 80 and 208. Amendment 10 of the extension of the CAMMS223 protocol was not accepted in all countries. For instance, it was not approved in the UK. So retreatment with alemtuzumab was not available to these patients.

Page 216. I think there may be a missing negative in this sentence: "Alemtuzumab could [not] do this because no data was available to provide "significant increase in T2 lesion load compared to a previous, recent MRI."

Page 277: "The incidence of autoimmune adverse events plateau"d in the trials after 5 years" is not accurate. The incidence of new autoimmune diseases fell after 5 years (thus the *prevalence* plateau'd).

Page 301. I do not agree that "a significant number of patients got re-treated based on T-cell counts not disease activity". If this happened at all, it was a small minority, as this is not a reliable guide to the need for alemtuzumab retreatment.

Page 305
I do not agree with the schedule for alemtuzumab monitoring. In particular, I do not think that there should be just two neurology visits in the first year and once annually thereafter. In my opinion, this is too infrequent to be safe. In the clinical trials, visits were three-monthly. Our current practice in Cambridge, is a visit 3-monthly for 2 years, 6-monthly for another 2 years and thereafter annually, following each administration of alemtuzumab.

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| **Equality and Diversity** |
| --- |
| I agree with the submission from Genzyme<br><br>**Any additional sources of evidence**<br><br>I agree with the submission from Genzyme |

| **Implementation issues** |
| --- |
| I agree with the submission from Genzyme |