Stakeholder Organisation:		AstraZeneca UK Ltd
Name of responder:		[redacted]
Page Number	**Recommendation number**	**Comments**
General		AstraZeneca UK Ltd would like to thank NICE for providing the opportunity to comment on the technology appraisal for rivaroxaban for preventing adverse outcomes after acute management of acute coronary syndrome.
2	1.1	Given UK clinical practice and NICE guidelines, AstraZeneca firmly believes that the recommendation for rivaroxaban in combination with aspirin (alone) should be restricted to those patients who cannot take a second antiplatelet (ticagrelor, clopidogrel or prasugrel). In UK practice, the patients who receive aspirin without a second antiplatelet are those with lowest CV risk or those who cannot take a second antiplatelet. The NICE guideline – Early management of unstable angina and NSTEMI (CG94) recommends that dual antiplatelet therapy be prescribed to all post-MI patients bar those with the 'lowest' CV risk[1]. In these patients of lowest CV risk, the benefits of prescribing a second antiplatelet are not deemed to outweigh the risks (of bleeding). As such, if a clinician has determined that the prescribing of a second antiplatelet is not justified, it would not be logical that the prescribing of rivaroxaban would be, given the bleeding risk carried by rivaroxaban. As such the recommendation for rivaroxaban in combination with aspirin (alone) should be restricted to those patients who cannot take a second antiplatelet. Suggested wording for recommendation 1.1: "Rivaroxaban is recommended as an option, in combination with aspirin plus clopidogrel, or in combination with aspirin alone when the patient cannot take a second antiplatelet, for preventing atherothrombotic events in people who have had an acute coronary syndrome with elevated cardiac biomarkers" [1] National Institute for Health and Care Excellence. Clinical guideline CG94 - The early management of unstable angina and non-ST-segment-elevation myocardial infarction
3	1.2	AstraZeneca believes that the recommendation for rivaroxaban after acute management of ACS should be restricted to specialist initiation only, since specialists are best placed to assess the balance of risks and benefits associated with initiation. According to the Summary of Product Characteristics (SmPC), rivaroxaban should only be initiated in patients with elevated cardiac biomarkers, who have been stabilised, with no previous TIA/stroke. Further, rivaroxaban should

		be prescribed with caution in patients aged under 75 years and in patients who weigh <60Kg[2]. It is the specialist in the acute setting (post stabilisation) who is best positioned to have all the necessary information at their disposal upon which to base the prescribing decision. The SmPC also states that rivaroxaban should be commenced as soon as possible after stabilisation. In UK clinical practice, patients are typically discharged from hospital with 4 weeks drug therapy following an ACS event, meaning these patients do not come into contact with their GP for this period of time [2] Xarelto 2.5mg Summary of Product Characteristics <https://www.medicines.org.uk> (accessed November 2014)
3	1.3	AstraZeneca suggests that the wording of recommendation 1.3 "Clinicians should reassess the relative benefits and risks of continuing treatment with rivaroxaban, no later than 12 months after starting treatment" be amended to reflect the wording used at section 2.2 "Treatment with rivaroxaban should be regularly evaluated in the individual patient, weighing the risk of ischaemic events against the bleeding risks. Extension of treatment beyond 12 months should be done on an individual patient basis because experience up to 24 months is limited" which reflects section 4.2 of the SmPC[2]