Appendix G - professional organisation statement template

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Single Technology Appraisal (STA)

Omalizumab for previously treated chronic spontaneous urticaria [ID707]

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: British Society for Allergy and Clinical Immunology (BSACI)
Are you (tick all that apply):

- a specialist in the treatment of people with the condition for which NICE is considering this technology **yes and I run one of the largest Allergy Clinical Services in the UK**
- 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.) **The BSACI of which I am a member and former chair of the Standards of Care Committee (SOCC) is the primary organisation that supports clinicians treating allergy related conditions which includes urticaria and angioedema. The BSACI SOCC is concerned with the development of allergy management guidelines.**

AND

Your name: Dr Clive Grattan

Name of your organisation: British Society for Allergy and Clinical Immunology (BSACI)
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.) ✓ Consultant Dermatologist, National Health Service

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

How is the condition currently treated in the NHS?

H1 antihistamines are used in all patients and short courses of oral corticosteroids are given as rescue medication. Other pharmacological treatments are used off-licence to manage highly symptomatic patients, including off-licence doses of antihistamines, leukotriene antagonists, the bradykinin B2 receptor antagonist, Icatibant, dapsone, hydroxychloroquine, methotrexate, stanozolol, Sulphasalazine, tacrolimus, tranexamic acid and immunosuppressives.

Are there any subgroups of patients with the condition who have a different prognosis from the typical patient?

A subset of chronic spontaneous urticaria patients have more severe disease with less responsiveness to antihistamines, they are more likely to have angioedema in addition to itchy weals and have a longer disease duration.

In what setting should/could the technology be used – for example, primary or secondary care, specialist clinics?

Secondary care and tertiary clinics would be the main prescribers. Many allergy clinics already have experience in using omalizumab for severe allergic asthma.

If the technology is already available, is there variation in how it is being used in the NHS? Is it always used within its licensed indications? If not, under what circumstances does this occur?

Not available and only used in the context of clinical trials or after IFRs. Therefore very limited experience available.

Please tell us about any relevant clinical guidelines and comment on the appropriateness of the methodology used in developing the guideline and the specific evidence that underpinned the various recommendations.

The British Society for Allergy and Clinical Immunology (BSACI) is presently revising it's own guideline on the management of Urticaria and Angioedema (First edition published in 2007). The guideline development process of the BSACI has been accredited by NICE in 2013 and the new guideline has been developed to NICE accredited standards. The revision is at an advanced stage (to be submitted for publication in *Clinical and Experimental Allergy* shortly) and recommends Omalizumab for chronic urticaria for patients non-responsive to high dose antihistamine.

Maurer M, Rosén K, Hsieh HJ, Saini S, Grattan C, Gimenéz-Arnau A, Agarwal S, Doyle R, Canvin J, Kaplan A, Casale T. 2013. Omalizumab for the treatment of chronic idiopathic or spontaneous urticaria. N Engl J Med. 2013 Mar 7;368(10):924-

35. doi: 10.1056/NEJMoa1215372. Epub 2013 Feb 24. Erratum in: N Engl J Med. 2013 Jun 13;368(24):2340-1.

Metz M, Ohanyan T, Church MK, Maurer M. 2014. Retreatment with omalizumab results in rapid remission in chronic spontaneous and inducible urticaria. JAMA Dermatol. 2014 Mar;150(3):288-90. doi: 10.1001/jamadermatol.2013.8705.

The advantages and disadvantages of the technology

NICE is particularly interested in your views on how the technology, when it becomes available, will compare with current alternatives used in the UK. Will the technology be easier or more difficult to use, and are there any practical implications (for example, concomitant treatments, other additional clinical requirements, patient acceptability/ease of use or the need for additional tests) surrounding its future use?

It is likely that treatment will be most suitable for those truly refractory to high dose antihistamines taking multiple therapies. As in asthma those on frequent courses of corticosteroids or requiring immunosuppression with second-line agents are likely to benefit most. It will be important for the TA to define duration of treatment, assessment markers to define response, and indicate who should manage these patients.

If appropriate, please give your view on the nature of any rules, informal or formal, for starting and stopping the use of the technology; this might include any requirements for additional testing to identify appropriate subgroups for treatment or to assess response and the potential for discontinuation.

If you are familiar with the evidence base for the technology, please comment on whether the use of the technology under clinical trial conditions reflects that observed in clinical practice. Do the circumstances in which the trials were conducted reflect current UK practice, and if not, how could the results be extrapolated to a UK setting? What, in your view, are the most important outcomes, and were they measured in the trials? If surrogate measures of outcome were used, do they adequately predict long-term outcomes?

Omalizumab is a recombinant humanized monoclonal antibody that selectively binds to the FC portion of circulating serum immunoglobulin E (IgE), thus preventing its binding to the high-affinity IgE receptor (FCeRI) on mast cells and basophils thereby reducing release of pro-inflammatory mediators such as histamine, prostaglandins and leukotrienes. This effect of omalizumab eventually leads to down-regulation of FCeRI expression on inflammatory cells and their ingress to the site of inflammation.

Recent studies have shown that omalizumab is highly effective and well-tolerated in patients with uncontrolled chronic urticaria. Many studies suggest that response is

seen after the first dose in those likely to respond. There is evidence of dose-response and a number of studies have shown recurrence of symptoms on cessation of omalizumab treatment.

Extrapolating from studies in asthma it is likely that recurrence of symptoms after discontinuation of treatment will correlate with duration of therapy in chronic urticaria. However, data on duration of therapy in chronic urticaria is lacking with limited data on use beyond 6 months.

The recommended dose of omalizumab is 300mg administered subcutaneously every 4 weeks although biomarkers defining a response-group in chronic urticaria remains elusive.

Opinion on its place in therapy is likely to vary considerably with some advocating use in patients refractory to a daily antihistamine while others recommending treatment to those requiring high doses of antihistamines, a second line agent such as an anti-leukotriene and frequent or maintenance oral corticosteroids. However, chronic urticaria is common and therefore a health economic model based on the TA for asthma will need to be developed in order to define tight parameters for patient selection.

What is the relative significance of any side effects or adverse reactions? In what ways do these affect the management of the condition and the patient's quality of life? Are there any adverse effects that were not apparent in clinical trials but have come to light subsequently during routine clinical practice?

This information should be taken from the longstanding experience of treating people with asthma. Generally a very safe drug but there have been issues with anaphylaxis, increased susceptibility to parasitic disease, and there was also some concern about an increase in malignancy.

Any additional sources of evidence

Can you provide information about any relevant evidence that might not be found by a technology-focused systematic review of the available trial evidence? This could be information on recent and informal unpublished evidence, or information from registries and other nationally coordinated clinical audits. Any such information must include sufficient detail to allow a judgement to be made as to the quality of the evidence and to allow potential sources of bias to be determined.

Implementation issues

The NHS is required by the Department of Health and the Welsh Assembly Government to provide funding and resources for medicines and treatments that have been recommended by NICE technology appraisal guidance. This

provision has to be made within 3 months from the date of publication of the guidance.

If the technology is unlikely to be available in sufficient quantity, or the staff and facilities to fulfil the general nature of the guidance cannot be put in place within
3 months, NICE may advise the Department of Health and the Welsh Assembly Government to vary this direction.

Please note that NICE cannot suggest such a variation on the basis of budgetary constraints alone.

How would possible NICE guidance on this technology affect the delivery of care for patients with this condition? Would NHS staff need extra education and training? Would any additional resources be required (for example, facilities or equipment)?

Medical and nursing staff would need additional training in administration of subcutaneous injections and skills to treat anaphylaxis. Additional nursing staff would be required to administer the drug and it is likely that a special service would need to be created. Therefore the technology should be focused on a few centres with high throughput of patients and the facilities and expertise in selection of patients and administration of drug in order to ensure cost-effectiveness

Equality
NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that this appraisal:

- could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which [the treatment(s)] is/are/will be licensed;
- could lead to recommendations that have a different impact on people protected by the equality legislation than on the wider population, e.g. by making it more difficult in practice for a specific group to access the technology;
- could lead to recommendations that have any adverse impact on people with a particular disability or disabilities.

Please tell us what evidence should be obtained to enable the Committee to identify and consider such impacts.