Section 9.29, Appendix 29

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Technology appraisals

Belimumab for the treatment of active autoantibody-positive systemic lupus erythematosus - Patient access scheme submission template

13 April 2010
1 Introduction

The 2009 Pharmaceutical Price Regulation Scheme (PPRS) (www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Pharmaceuticalpriceregulationscheme/2009PPRS) is a non-contractual scheme between the Department of Health and the Association of the British Pharmaceutical Industry. The purpose of the 2009 PPRS is to ensure that safe and cost-effective medicines are available on reasonable terms to the NHS in England and Wales. One of the features of the 2009 PPRS is to improve patients’ access to medicines at prices that better reflect their value through patient access schemes.

Patient access schemes are arrangements which may be used on an exceptional basis for the acquisition of medicines for the NHS in England and Wales. Patient access schemes propose either a discount or rebate that may be linked to the number, type or response of patients, or a change in the list price of a medicine linked to the collection of new evidence (outcomes). These schemes help to improve the cost effectiveness of a medicine and therefore allow the National Institute for Health and Clinical Excellence (NICE) to recommend treatments which it would otherwise not have found to be cost effective. More information on the framework for patient access schemes is provided in the 2009 PPRS (www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Pharmaceuticalpriceregulationscheme/2009PPRS).

Patient access schemes are proposed by a pharmaceutical company and agreed with the Department of Health, with input from the Patient Access Schemes Liaison Unit (PASLU) within the Centre for Health Technology Evaluation at NICE.
2 Instructions for manufacturers and sponsors

This document is the patient access scheme submission template for technology appraisals. If manufacturers and sponsors want the National Institute for Health and Clinical Excellence (NICE) to consider a patient access scheme as part of a technology appraisal, they should use this template. NICE can only consider a patient access scheme after formal referral from the Department of Health.

The template contains the information NICE requires to assess the impact of a patient access scheme on the clinical and cost effectiveness of a technology, in the context of a technology appraisal, and explains the way in which background information (evidence) should be presented. If you are unable to follow this format, you must state your reasons clearly. You should insert ‘N/A’ against sections that you do not consider relevant, and give a reason for this response.

Please refer to the following documents when completing the template:

- ‘Guide to the methods of technology appraisal’
  (www.nice.org.uk/aboutnice/howwework/devnicetech/technologyappraisalprocessguides/guidetothemethodsoftechnologyappraisal.jsp)
- ‘Specification for manufacturer/sponsor submission of evidence’
  (http://www.nice.org.uk/aboutnice/howwework/devnicetech/singletechnologyappraisalsubmissiontemplates.jsp) and
- Pharmaceutical Price Regulation Scheme 2009

For further details on the technology appraisal process, please see NICE’s ‘Guide to the single technology appraisal (STA) process’ and ‘Guide to the multiple technology appraisal (MTA) process’
(http://www.nice.org.uk/aboutnice/howwework/devnicetech/technologyappraisalprocessguides/technology_appraisal_process_guides.jsp). The
‘Specification for manufacturer/sponsor submission of evidence’ provides details on disclosure of information and equality issues.

Make the submission as brief and informative as possible. Only mark information as confidential when absolutely necessary. Sufficient information must be publicly available for stakeholders to comment on the full content of the technology appraisal, including details of the proposed patient access scheme. Send submissions electronically to NICE in Word or a compatible format, not as a PDF file.

Appendices may be used to include additional information that is considered relevant to the submission. Do not include information in the appendices that has been requested in the template. Appendices should be clearly referenced in the main submission.

When making a patient access scheme submission, include:

- an updated version of the checklist of confidential information, if necessary
- an economic model with the patient access scheme incorporated, in accordance with the ‘Guide to the methods of technology appraisal’ ([www.nice.org.uk/aboutnice/howwework/devnicetech/technologyappraisalprocessguides/guidetothemethodsoftechnologyappraisal.jsp](http://www.nice.org.uk/aboutnice/howwework/devnicetech/technologyappraisalprocessguides/guidetothemethodsoftechnologyappraisal.jsp)).

If you are submitting the patient access scheme at the end of the appraisal process, you should update the economic model to reflect the assumptions that the Appraisal Committee considered to be most plausible. No other changes should be made to the model.
3 Details of the patient access scheme

3.1 Please give the name of the technology and the disease area to which the patient access scheme applies.

Belimumab (Benlysta®) – Systematic Lupus Erythematosus (SLE)

3.2 Please outline the rationale for developing the patient access scheme.

SLE is a relapsing and remitting disease. It is a chronic condition associated with significant morbidity and mortality. Many patients with SLE experience general symptoms including fatigue, malaise, fever, anorexia, weight loss, skin rash and muscle and joint pain. SLE can lead to arthritis, kidney failure, heart and lung inflammation, neuropsychiatric disease, vasculitis, severe skin rash and blood dyscrasias such as anaemia, leucopoenia and thrombocytopenia (Manson et al. 2006). These all contribute towards a decrease in their quality of life.

SLE also has a substantial impact on employment, with over half of patients no longer working 15 years after diagnosis. It is associated with a 2.4-fold greater risk of mortality than the general population (Bernatsky et al. 2006).

SLE is more prevalent in women and African-Caribbean, South Asian and Chinese populations than in European white populations (Danchenko et al. 2006; Manzi 2009). The demographic of SLE patients is likely to include a significant portion of women of child-bearing age.

Patients with SLE are currently managed by a range of treatments (NSAIDs, corticosteroids, immunosuppressants and anti-malarials); variously used alone or in different combinations constitutes standard or care (SoC).

Current standard of care may be associated with undesirable effects, either from chronic use of steroids (osteoporosis, diabetes and cardiovascular disease) or side effects associated with immunosuppressants (infection, toxicity and infertility). Many of these treatments used are unlicensed and a significant number of patients with advanced SLE do not respond to current
treatments even at high doses. Those patients with more severe, active SLE are managed in tertiary centres and many routinely receive rituximab (MabThera®), an unlicensed biologic, which although appearing to have some benefit in clinical practice, failed to demonstrate efficacy in Phase 2/3 trials. There has been little therapeutic innovation in treatments for SLE, with no evidence leading to the development of new licensed treatments for several decades.

Belimumab, a human IgG1λ monoclonal antibody that binds to soluble human B-lymphocyte stimulator (BLyS) and inhibits its biological activity, has been specifically developed for the treatment of SLE and demonstrated efficacy in two Phase 3 clinical trials, showing a significant degree of innovation in addressing an area of unmet need. As SLE is a relapsing remitting disease with long term consequences, the full clinical benefit may not be identified in the studies available at launch.

In order to make the PAS competitive while still reflecting the innovation and value GSK believe belumimab delivers, the proposed PAS would involve a straight discount from the NHS list price.

3.3 Please describe the type of patient access scheme, as defined by the PPRS.

The patient access scheme is a straight discount from the NHS list price of belimumab.

3.4 Please provide specific details of the patient population to which the patient access scheme applies. Does the scheme apply to the whole licensed population or only to a specific subgroup (for example, type of tumour, location of tumour)? If so:

- How is the subgroup defined?
- If certain criteria have been used to select patients, why have these been chosen?
- How are the criteria measured and why have the measures been chosen?
As the patient access scheme is a straight discount and in order to remove any administrative burden on the NHS, the availability of the patient access scheme applies to the whole licensed population. However, being mindful of NHS resources, GSK proposes NICE consider issuing guidance on a specific subgroup (high disease activity subgroup).

The proposed subgroup is for adults with active autoantibody-positive systemic lupus erythematosus with evidence for serological disease activity (low complement, positive anti-dsDNA) and SELENA-SLEDAI $\geq 10$; this comprises 34% of the overall belimumab trial population, and we refer to this as the high disease activity subgroup.

The two serological markers, low complement and positive anti-dsDNA are objective measures used routinely in SLE and accessible to physicians in general practice. They are widely considered important measures of disease activity. Patients with positive anti-dsDNA and low complement are immunologically active and at higher risk for flares and lupus nephritis.

SELENA-SLEDAI (SS) is the efficacy component of the composite endpoint of the Phase 3 trials and measures disease activity. A score of $\geq 10$ is likely to indicate a patient with highly active disease.

Details of this subgroup are presented in the main submission (Section 5.3.7 and Section 6.8).

3.5 Please provide details of when the scheme will apply to the population specified in 3.4. Is the scheme dependent on certain criteria, for example, degree of response, response by a certain time point, number of injections? If so:

- Why have the criteria been chosen?
- How are the criteria measured and why have the measures been chosen.

The scheme will apply to the licensed population outlined in 3.4 from the time they are deemed eligible for treatment with belimumab, i.e. they are receiving standard therapy and still require additional reduction in their disease activity.
Patients would have to be serologically active (low complement and positive anti-dsDNA), however given the more severe nature of these patients they would be being managed in tertiary care settings for a large portion of their care and clinicians have indicated that the serological status of patients is measured on a routine basis.

We are proposing that patients would have to have a SELENA-SLEDAI ≥10, an indication of highly active disease, to be eligible for treatment. The use of SELENA-SLEDAI is usually confined to clinical trials; however the majority of patients would have treatment initiated by a specialist in a tertiary setting. Most of these clinicians have indicated that they have familiarity with this measure and would be prepared to use it if it was a requirement to gain access to an innovative treatment for their SLE patients.

The current draft SPC for belumunab states in the “Posology and method of administration” section that “The patient’s condition should be evaluated continuously. Discontinuation of treatment with Benlysta should be considered if there is no improvement in disease control after 6 months of treatment.” This allows the assessment of adequate response to belumunab to be made on the basis of the physicians’ clinical judgement after six months treatment. Six months is identified as a suitable time period after which to assess response to treatment as it allows sufficient time for the drugs mode of action to have an impact on the clinical manifestations of the disease. As mentioned above, physicians do not routinely measure SELENA-SLEDAI for disease activity or SLICC scores for organ damage in the clinical management of their SLE patients; they will assess response based on the general wellbeing of the patient and on how many disease flares they have experienced and of what severity.

In order to reflect the wording of the SPC, and the concept of “responders” or “non-responders”, a more objective assessment as to whether belumunab should be continued or discontinued after six months treatment was used. Therefore, the criterion of a SS disease activity score increase of 4 or greater, indicating a ‘response’ has been used in the economic modelling. This is discussed in more detail in Section 6.2.8.
3.6 What proportion of the patient population (specified in 3.4) is expected to meet the scheme criteria (specified in 3.5)?

The proposed subgroup is for adults with active autoantibody-positive systemic lupus erythematosus with evidence for serological disease activity (low complement, positive anti-dsDNA) and SELENA-SLEDAI ≥10; this comprises 34% of the overall belimumab trial population.

The proportion of patients specified in 3.4 should be equivalent to those specified in 3.5.

As the patient access scheme is a straight discount and in order to remove any administrative burden on the NHS, the availability of the patient access scheme applies to the whole licensed population. However, being mindful of NHS resources, GSK proposes NICE consider issuing guidance on a specific subgroup (high disease activity subgroup). Therefore, while the scheme in principle would be available to the entire licensed population any NICE guidance is likely to be followed to ensure usage is in line with the proposed subgroup.

3.7 Please explain in detail the financial aspects of the scheme. How will any rebates be calculated and paid?
3.8 Please provide details of how the scheme will be administered. Please specify whether any additional information will need to be collected, explaining when this will be done and by whom.

3.9 Please provide a flow diagram that clearly shows how the scheme will operate. Any funding flows must be clearly demonstrated (CiC).

3.10 Please provide details of the duration of the scheme.
3.11 Are there any equity or equalities issues relating to the scheme, taking into account current legislation and, if applicable, any concerns identified during the course of the appraisal? If so, how have these been addressed?

SLE is more prevalent in women and African-Caribbean, South Asian and Chinese populations than in European white populations (Danchenko et al. 2006; Manzi 2009), and the demographic of SLE patients is likely to include a significant portion of women of child-bearing age (Danchenko et al. 2006).

The patient access scheme does not seek to specifically address any equity or equality issues; however the availability of belimumab, through a positive NICE recommendation and the corresponding patient access scheme, will allow these patients access to an innovative treatment in an area of significant unmet need.

3.12 If available, please list any scheme agreement forms, patient registration forms, pharmacy claim forms/rebate forms, guides for pharmacists and physicians and patient information documents. Please include copies in the appendices.

N/A

3.13 In the exceptional case that you are submitting an outcome-based scheme, as defined by the PPRS, please also refer to appendix B.

N/A
4 Cost effectiveness

4.1 If the population to whom the scheme applies (as described in sections 3.4 and 3.5) has not been presented in the main manufacturer/sponsor submission of evidence for the technology appraisal (for example, the population is different as there has been a change in clinical outcomes or a new continuation rule), please (re-)submit the relevant sections from the ‘Specification for manufacturer/sponsor submission of evidence’ (particularly sections 5.5, 6.7 and 6.9). You should complete those sections both with and without the patient access scheme. You must also complete the rest of this template.

The patient access scheme relates to a specific subgroup of the overall trial and licensed population. Being mindful of NHS resources, the proposed subgroup aims to identify those individuals who are likely to benefit the most from belimumab.

The subgroup to which the PAS relates has been presented as part of the main submission (Section 5 and Section 6.8). The results presented here relate to the updated ICERs based on the discounted drug acquisition cost.

4.2 If you are submitting the patient access scheme at the end of the technology appraisal process, you should update the economic model to reflect the assumptions that the Appraisal Committee considered to be most plausible. No other changes should be made to the model.

N/A – The proposed patient access scheme is being submitted for consideration during the technology appraisal process.
4.3 Please provide details of how the patient access scheme has been incorporated into the economic model. If applicable, please also provide details of any changes made to the model to reflect the assumptions that the Appraisal Committee considered most plausible.

The patient access scheme involves a straight discount, therefore the updated economic model and results reflect only the discounted drug acquisition cost and does not impact on the clinical outcomes for the subgroup under consideration.

4.4 Please provide the clinical effectiveness data resulting from the evidence synthesis and used in the economic model which includes the patient access scheme.

The clinical evidence for the subgroup to which the economic model relates has been presented as part of the main submission (Section 5.3.7 and Section 5.5).

4.5 Please list any costs associated with the implementation and operation of the patient access scheme (for example, additional pharmacy time for stock management or rebate calculations). A suggested format is presented in table 1. Please give the reference source of these costs. Please refer to section 6.5 of the ‘Specification for manufacturer/sponsor submission of evidence’.

N/A

4.6 Please provide details of any additional treatment-related costs incurred by implementing the patient access scheme. A suggested format is presented in table 2. The costs should be provided for the intervention both with and without the patient access scheme. Please give the reference source of these costs.
**Summary results**

**Base-case analysis**

4.7 Please present in separate tables the cost-effectiveness results as follows.¹

- the results for the intervention without the patient access scheme
- the results for the intervention with the patient access scheme.

A suggested format is shown below (table 3).

**Table 3.1: Base-case results – Pooled Total Population**

<table>
<thead>
<tr>
<th>Technologies</th>
<th>Total costs (£)</th>
<th>Total LYG</th>
<th>Total QALYs</th>
<th>Incremental costs (£)</th>
<th>Incremental LYG</th>
<th>Incremental QALYs</th>
<th>ICER (£) incremental (QALYs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SoC</td>
<td>£97,583</td>
<td>16.74</td>
<td>9.55</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Belimumab</td>
<td>£133,167</td>
<td>17.33</td>
<td>9.98</td>
<td>£35,584</td>
<td>0.59</td>
<td>0.43</td>
<td>£82,909</td>
</tr>
</tbody>
</table>

ICER, incremental cost-effectiveness ratio; LYG, life years gained; QALYs, quality-adjusted life years

**Table 3.2: Base-case results – High Disease Activity Subgroup**

<table>
<thead>
<tr>
<th>Technologies</th>
<th>Total costs (£)</th>
<th>Total LYG</th>
<th>Total QALYs</th>
<th>Incremental costs (£)</th>
<th>Incremental LYG</th>
<th>Incremental QALYs</th>
<th>ICER (£) incremental (QALYs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SoC</td>
<td>£105,366</td>
<td>17.05</td>
<td>9.81</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Belimumab</td>
<td>£157,291</td>
<td>18.11</td>
<td>10.61</td>
<td>£51,925</td>
<td>1.05</td>
<td>0.806</td>
<td>£64,410</td>
</tr>
</tbody>
</table>

ICER, incremental cost-effectiveness ratio; LYG, life years gained; QALYs, quality-adjusted life years

In the high disease activity subgroup, belimumab-treated patients are estimated to live longer, however, due to their increased life expectancy and due to belimumab treatment, costs are higher than for SoC patients. The incremental costs are £51,925, resulting in 1.05 added life years (discounted)

¹ For outcome-based schemes, please see section 5.2.8 in appendix B.
or 0.806 added QALYs. This results in an incremental cost effectiveness ratio (ICER) of £64,410 per QALY gained.

Table 3.3: High Disease Activity Subgroup – including PAS

<table>
<thead>
<tr>
<th>Technologies</th>
<th>Total costs (£)</th>
<th>Total LYG</th>
<th>Total QALYs</th>
<th>Incremental costs (£)</th>
<th>Incremental LYG</th>
<th>Incremental QALYs</th>
<th>ICER (£) incremental (QALYs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SoC</td>
<td>£105,366</td>
<td>17.05</td>
<td>9.81</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belimumab</td>
<td>£**********</td>
<td>18.11</td>
<td>10.61</td>
<td>£*********</td>
<td>1.05</td>
<td>0.806</td>
<td>£**********</td>
</tr>
</tbody>
</table>

ICER, incremental cost-effectiveness ratio; LYG, life years gained; QALYs, quality-adjusted life years

When the patient access scheme discount is considered for the high activity subgroup, the total costs for the belimumab-treated patients are estimated to be £********** and the incremental costs are £*********, while the incremental LYG and incremental QALYs remain the same as the presented previously, at 1.05 and 0.806, added life years (discounted) and added QALYs, respectively. This results in an incremental cost effectiveness ratio (ICER) of £********** per QALY gained.

4.8 Please present in separate tables the incremental results as follows. ²

- the results for the intervention without the patient access scheme
- the results for the intervention with the patient access scheme.

List the interventions and comparator(s) from least to most expensive. Present the incremental cost-effectiveness ratios (ICERs) in comparison with baseline (usually standard care), and the incremental analysis ranking technologies in terms of dominance and extended dominance. A suggested format is presented in table 4.

Please see results above (Question 4.8).

² For outcome-based schemes, please see section 5.2.9 in appendix B.
Sensitivity analyses

4.9 Please present deterministic sensitivity analysis results as described for the main manufacturer/sponsor submission of evidence for the technology appraisal. Consider using tornado diagrams.

Tornado diagrams for the ICER, incremental QALYs and incremental costs are presented in Figures F1, F2, F3 respectively. Full details of sensitivity analysis can been found in Section 6.6 of the full submission.

Figure F1: Tornado diagram for univariate sensitivity analyses on the ICER – High Disease Activity Subgroup including PAS

Figure removed as commercial in confidence data.
Figure F2: Tornado diagram for univariate sensitivity analyses on the incremental QALYs (delta E) – High Disease Activity Subgroup including PAS

Figure F3: Tornado diagram for univariate sensitivity analyses on the incremental costs (delta C) – High Disease Activity Subgroup including PAS

Figure removed as commercial in confidence data.
4.10 Please present any probabilistic sensitivity analysis results, and include scatter plots and cost-effectiveness acceptability curves.

**Figure F4: Scatter plot of the PSA – High Disease Activity Subgroup including PAS**

Figure removed as commercial in confidence data.

**Figure F5: PSA Acceptability Curve – High Disease Activity Subgroup including PAS**

Figure removed as commercial in confidence data.

In the high disease activity subgroup, there is a [X]% probability that belimumab is cost-effective compared to standard of care at a willingness to pay (WTP) of
£30,000 per QALY gained.

4.11 Please present scenario analysis results as described for the main manufacturer/sponsor submission of evidence for the technology appraisal.

Table T4: Summary of Scenario Results - High Disease Activity Subgroup (without PAS)

<table>
<thead>
<tr>
<th>Description of Scenario</th>
<th>Scenario Details</th>
<th>Incremental Cost Belimumab</th>
<th>Incremental LYs Belimumab</th>
<th>Incremental QALYs Belimumab</th>
<th>Incremental Cost per QALY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Case for High Disease Activity Subgroup</td>
<td>Time horizon = lifetime, lifetime max effect of belimumab; responder rule of SS reduction ≥4 at week 24; adjusted natural history model; no vial sharing</td>
<td>£51,925</td>
<td>1.05</td>
<td>0.806</td>
<td>£64,410</td>
</tr>
<tr>
<td>Responder rule excluded</td>
<td>As base case but with responder rule at 24 weeks excluded</td>
<td>£56,631</td>
<td>1.01</td>
<td>0.784</td>
<td>£72,207</td>
</tr>
<tr>
<td>Alternative Responder rule</td>
<td>As base case but with responder rule of SS reduction of ≥6 at week 24;</td>
<td>£30,760</td>
<td>0.81</td>
<td>0.614</td>
<td>£50,114</td>
</tr>
<tr>
<td>Increased vial price</td>
<td>As base case but with vial price increased (120mg=£127.80; 400mg=£426)</td>
<td>£57,478</td>
<td>1.05</td>
<td>0.806</td>
<td>£71,297</td>
</tr>
<tr>
<td>Original natural history model</td>
<td>As base case but with original natural history model chosen</td>
<td>£51,227</td>
<td>0.82</td>
<td>0.659</td>
<td>£77,707</td>
</tr>
<tr>
<td>With vial sharing</td>
<td>As base case</td>
<td>£49,717</td>
<td>1.05</td>
<td>0.806</td>
<td>£61,671</td>
</tr>
<tr>
<td>Higher drug administration cost</td>
<td>As base case but with a drug administration cost of £159 as recommended by ERG as a sensitivity analysis for the tocilizumab appraisal for rheumatoid arthritis</td>
<td>£54,298</td>
<td>1.05</td>
<td>0.806</td>
<td>£67,353</td>
</tr>
</tbody>
</table>

4.12 If any of the criteria on which the patient access scheme depends are clinical variable (for example, choice of response measure,
level of response, duration of treatment), sensitivity analyses around the individual criteria should be provided, so that the Appraisal Committee can determine which criteria are the most appropriate to use.

N/A
Impact of patient access scheme on ICERs

4.13 For financially based schemes, please present the results showing the impact of the patient access scheme on the ICERS for the base-case and any scenario analyses. A suggested format is shown below (see table 5). If you are submitting the patient access scheme at the end of the appraisal process, you must include the scenario with the assumptions that the Appraisal Committee considered to be most plausible.

Table T5: Summary of Scenario Results - High Disease Activity Subgroup (including PAS)

<table>
<thead>
<tr>
<th>Description of Scenario</th>
<th>Scenario Details</th>
<th>Incremental Cost Belimumab</th>
<th>Incremental LYS Belimumab</th>
<th>Incremental QALYs Belimumab</th>
<th>Incremental Cost per QALY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Case for High Disease Activity Subgroup</td>
<td>Time horizon = lifetime, lifetime max effect of belimumab; responder rule of SS reduction ≥4 at week 24; adjusted natural history model; no vial sharing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responder rule excluded</td>
<td>As base case but with responder rule at 24 weeks excluded</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternative Responder rule</td>
<td>As base case but with responder rule of SS reduction of ≥6 at week 24;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Original natural history model</td>
<td>As base case but with original natural history model chosen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With vial sharing</td>
<td>As base case</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher drug administration cost</td>
<td>As base case but with a drug administration cost of £159 as recommended by ERG as a sensitivity analysis for the tocilizumab appraisal for rheumatoid arthritis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5 Appendices

5.1 Appendix A: Additional documents

5.1.1 If available, please include copies of patient access scheme agreement forms, patient registration forms, pharmacy claim forms/rebate forms, guides for pharmacists and physicians, patient information documents.

N/A
5.2 Appendix B: Details of outcome-based schemes

5.2.1 If you are submitting a proven value: price increase scheme, as defined in the PPRS, please provide the following information:

- the current price of the intervention
- the proposed higher price of the intervention, which will be supported by the collection of new evidence
- a suggested date for when NICE should consider the additional evidence.

N/A

5.2.2 If you are submitting an expected value: rebate scheme, as defined in the PPRS, please provide the following details:

- the current price of the intervention (the price that will be supported by the collection of new evidence)
- the planned lower price of the intervention in the event that the additional evidence does not support the current price
- a suggested date for when NICE should consider the additional evidence.

N/A

5.2.3 If you are submitting a risk-sharing scheme, as defined in the PPRS, please provide the following details:

- the current price of the intervention (the price that will be supported by the collection of new evidence)
- the proposed relationship between future price changes and the evidence to be collected.

N/A
5.2.4 For outcome-based schemes, as defined in the PPRS, please provide the full details of the new information (evidence) planned to be collected, who will collect it and who will carry the cost associated with this planned data collection. Details of the new information (evidence) may include:

- design of the new study
- patient population of the new study
- outcomes of the new study
- expected duration of data collection
- planned statistical analysis, definition of study groups and reporting (including uncertainty)
- expected results of the new study
- planned evidence synthesis/pooling of data (if applicable)
- expected results of the evidence synthesis/pooling of data (if applicable).

N/A

5.2.5 If you are submitting a risk-sharing scheme, please specify the period between the time points when the additional evidence will be considered.

N/A

5.2.6 Please provide the clinical effectiveness data resulting from the evidence synthesis and used in the economic modelling of the patient access scheme at the different time points when the additional evidence is to be considered.

N/A
5.2.7 Please provide the other data used in the economic modelling of the patient access scheme at the different time points when the additional evidence is to be considered. These data could include cost/resource use, health-related quality of life and utilities.

N/A

5.2.8 Please present the cost-effectiveness results as follows.

- For proven value: price increase schemes, please summarise in separate tables:
  - the results based on current evidence and current price
  - the anticipated results based on the expected new evidence and the proposed higher price.

- For expected value: rebate schemes, please summarise in separate tables:
  - the results based on the expected new evidence and the current price (which will be supported by the additional evidence collection)
  - the results based on the current evidence and the lower price (if the new evidence is not forthcoming).

- For risk-sharing schemes, please summarise in separate tables:
  - the results based on current evidence and current price
  - the results based on the expected new evidence and the current price (which will be supported by the additional evidence collection)
  - the results based on the current evidence and the lower price (if the new evidence is not forthcoming)
  - the anticipated results based on the expected new evidence and the proposed higher price.

A suggested format is shown in table 3, section 4.7.
5.2.9 Please present in separate tables the incremental results for the different scenarios as described above in section 5.2.8 for the type of outcome-based scheme being submitted.

List the interventions and comparator(s) from least to most expensive. Present the incremental cost-effectiveness ratios (ICERs) in comparison with baseline (usually standard care), and the incremental analysis ranking technologies in terms of dominance and extended dominance. A suggested format is presented in table 4, section 4.8.

N/A