NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Appraisal consultation document

Tildrakizumab for treating moderate to severe plaque psoriasis

The Department of Health and Social Care has asked the National Institute for Health and Care Excellence (NICE) to produce guidance on using tildrakizumab in the NHS in England. The appraisal committee has considered the evidence submitted by the company and the views of non-company consultees and commentators, clinical experts and patient experts.

This document has been prepared for consultation with the consultees. It summarises the evidence and views that have been considered, and sets out the recommendations made by the committee. NICE invites comments from the consultees and commentators for this appraisal and the public. This document should be read along with the evidence (see the committee papers).

The appraisal committee is interested in receiving comments on the following:

- Has all of the relevant evidence been taken into account?
- Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?
- Are the recommendations sound and a suitable basis for guidance to the NHS?
- Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

Note that this document is not NICE's final guidance on this technology. The recommendations in section 1 may change after consultation.

After consultation:

- The appraisal committee will meet again to consider the evidence, this appraisal consultation document and comments from the consultees.
- At that meeting, the committee will also consider comments made by people who are not consultees.
- After considering these comments, the committee will prepare the final appraisal document.
- Subject to any appeal by consultees, the final appraisal document may be used as the basis for NICE's guidance on using tildrakizumab in the NHS in England.

For further details, see NICE's guide to the processes of technology appraisal.

The key dates for this appraisal are:

Closing date for comments: 4 January 2019

Second appraisal committee meeting: 22 January 2019

Details of membership of the appraisal committee are given in section 5.

1 Recommendations

1.1 Tildrakizumab is not recommended, within its marketing authorisation, for treating moderate to severe plaque psoriasis in adults for whom systemic treatment is appropriate.

1.2 This recommendation is not intended to affect treatment with tildrakizumab that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop.

Why the committee made these recommendations

Treatment for moderate to severe plaque psoriasis includes systemic biological treatments for disease that does not respond to systemic non-biological treatments. Tildrakizumab is proposed as an alternative to other systemic biologicals already recommended by NICE.

Clinical trial results show that tildrakizumab improves severe plaque psoriasis compared with placebo or etanercept. When compared indirectly, it appears to be as effective as adalimumab and ustekinumab but not as effective as other biologicals.

The most plausible cost-effectiveness estimates for tildrakizumab compared with most other available biologicals are higher than what NICE normally considers to be cost effective. Therefore tildrakizumab is not recommended.

2 Information about tildrakizumab

Marketing authorisation indication	Tildrakizumab (Ilumetri, Almirall) has a marketing authorisation 'for the treatment of adults with moderate to severe plaque psoriasis who are candidates for systemic therapy.'
Dosage in the marketing authorisation	Tildrakizumab is administered by subcutaneous injection at a dose of 100 mg at weeks 0 and 4 and every 12 weeks thereafter. In patients with certain characteristics (for example, high disease burden, body weight of 90 kg or more) a 200 mg dose may provide greater efficacy.
Price	The price of tildrakizumab has been agreed with the Department of Health and Social Care, but is currently confidential and cannot be reported here. The company has a commercial arrangement which would apply if the technology had been recommended.

3 Committee discussion

The appraisal committee (section 5) considered evidence submitted by Almirall and a review of this submission by the evidence review group (ERG). See the committee papers for full details of the evidence.

Experience of people with psoriasis

Psoriasis is a lifelong condition that affects all aspects of a person's life

3.1 Psoriasis at any level of severity can be distressing and debilitating, affecting all aspects of life (physical, psychological, social and financial), and it is a lifelong condition. The committee noted that having treatments with few or manageable side effects, and which are effective for psoriasis on the face, hands, feet and genitals, is especially important to people with psoriasis, as is having a choice of treatments.

Clinical management

Psoriasis can be treated with topical therapies, phototherapy, and systemic non-biological and biological treatments

3.2 People with plaque psoriasis may have topical therapies first line, followed by phototherapy second line. If these do not control the psoriasis, people may have systemic conventional non-biological treatments third line (such as methotrexate, ciclosporin or acitretin). If the disease does not respond to these, people may have fourth-line treatment including systemic biological treatments (such as adalimumab, brodalumab, etanercept, guselkumab, ixekizumab, infliximab, secukinumab or ustekinumab), or apremilast or dimethyl fumarate. Biosimilar versions of some biologicals are also available. The drugs are used for as long as they continue to work. If the disease no longer responds to 1 biological, people will be offered another biological. This pattern is likely to be repeated over their lifetime. However, 1 clinical expert explained that switching treatments is likely to affect the effectiveness of subsequent drugs, although there is uncertainty about the degree to which this occurs. Also, switching treatments can have a negative psychological effect on people with psoriasis. The clinical expert also stated that a variety of treatments are needed, because patients can respond very differently to treatments with the same biological method of action. For people whose disease does not respond to multiple biologicals, apremilast or dimethyl fumarate, the only remaining treatment option is best supportive care, which usually consists of topical agents and bandaging.

Treatment pathway

Tildrakizumab is positioned as an alternative to other systemic biological treatments

3.3 The marketing authorisation for tildrakizumab is for 'adults who are candidates for systemic therapy'. However, in the company submission tildrakizumab was positioned as an alternative only to systemic biological

treatments, which are used after systemic non-biological treatments in current NHS practice. The positioning therefore captures a narrower population than the marketing authorisation. However, the clinical expert confirmed that this is the most likely stage in the treatment pathway at which NHS clinicians would consider using tildrakizumab. The committee concluded that this position in the treatment pathway was appropriate and that it would appraise tildrakizumab compared with other biologicals.

Infliximab is a relevant comparator to tildrakizumab

3.4 The company suggested that infliximab was not a relevant comparator because it was recommended only for people with very severe plaque psoriasis. The ERG explained that a large proportion of the population in the tildrakizumab trials (see section 3.7) had very severe plaque psoriasis. Also, infliximab was included as a comparator in previous appraisals at the same position in the treatment pathway as tildrakizumab. The committee concluded that infliximab was a relevant comparator to tildrakizumab.

Apremilast and dimethyl fumarate are not relevant comparators to tildrakizumab

3.5 The company suggested that the systemic non-biological treatments apremilast and dimethyl fumarate, used in NHS clinical practice at the same position as systemic biological treatments, were not relevant comparators. The clinical expert explained that these options were rarely used in practice because they are perceived to be less effective than biologicals. The committee concluded that apremilast and dimethyl fumarate were not relevant comparators to tildrakizumab.

Clinical evidence

The reSURFACE trials provide the main clinical evidence for tildrakizumab

3.6 The main evidence for tildrakizumab came from the reSURFACE trials (reSURFACE 1 and reSURFACE 2). These were randomised, double-

blind trials that included a total of 1,862 patients with plaque psoriasis. They compared 2 doses of tildrakizumab (100 mg and 200 mg) with placebo, and reSURFACE 2 also included an etanercept arm. The primary outcomes were the Psoriasis Area and Severity Index (PASI) and the Physician Global Assessment (PGA). Both PASI and PGA were assessed at 12 weeks and 28 weeks, as follows:

- PASI 75: a 75% reduction in the PASI score from when treatment started and
- PGA: a PGA rating of 'clear' (score of 0) or 'almost clear' (score of 1).

Patients in reSURFACE 1 and reSURFACE 2 were followed up for longer-term outcomes, for 64 weeks and 52 weeks respectively.

The population in reSURFACE is similar to patients in the NHS who may have tildrakizumab

3.7 The committee considered whether patients in reSURFACE were similar to those in NHS clinical practice:

- Severity of disease: reSURFACE included patients with moderate to severe psoriasis with a PASI score of 12 or more. No minimum Dermatology Life Quality Index (DLQI) score was included. Previous NICE technology appraisals defined severe and very severe psoriasis based on the PASI and DLQI, and the PASI threshold for severe is 10 or more.
- Previous systemic non-biological treatment: the committee noted that 24% of patients in reSURFACE 1 and 40% of patients in reSURFACE 2 had previous systemic non-biological treatment. The clinical expert stated that these proportions were lower than in the relevant population in NHS clinical practice. The committee was aware that subgroup analyses did not find previous systemic non-biological treatment to be a statistically significant determinant of response to tildrakizumab.
- Previous systemic biologicals: the committee noted that 23% of patients in reSURFACE 1 and 13% of patients in reSURFACE 2 had

previous systemic biologicals. The ERG suggested that this might not represent clinical practice at the proposed positioning of tildrakizumab. The committee recalled the clinical expert's advice that previous treatment could change the effectiveness of subsequent treatment (see section 3.2). However, the committee was also aware that there was uncertainty as to the extent that this may occur and that subgroup analyses did not find previous systemic biological treatment to be a statistically significant determinant of response to tildrakizumab.

The committee noted the results of the reSURFACE trials may have overestimated tildrakizumab's effectiveness, because of the proportions of patients who had not had previous non-biological and biological systemic treatment. The clinical expert advised that this would not be expected to have a large effect on the relative efficacy results. The committee concluded that the trial patients generally reflected those who would have treatment with tildrakizumab in NHS clinical practice.

Tildrakizumab is more clinically effective than placebo or etanercept

3.8 The committee noted that:

- At week 12, patients randomised to tildrakizumab were more likely to have a PASI 75 and PGA clear or minimal response than patients randomised to placebo or etanercept.
- At week 28, patients randomised to tildrakizumab were more likely to have a PASI 75 and PGA clear or minimal response than those randomised to etanercept, but no information compared with placebo was available.

The committee concluded that tildrakizumab was more clinically effective than placebo or etanercept.

Both 100 mg and 200 mg doses of tildrakizumab are appropriate

3.9 The company presented results for both licensed doses of tildrakizumab (100 mg and 200 mg). The company representative explained that the

higher dose is intended for use from treatment induction in people with a higher body weight or disease burden, determined by the clinician. The committee noted that there was no difference in efficacy between the 2 doses in the reSURFACE trials. The clinical expert explained that clinicians would welcome flexibility in available doses of the same treatment. The committee concluded that it was appropriate to consider both licensed doses in its decision making.

Tildrakizumab treatment response should be assessed at 28 weeks

3.10 The committee was aware that tildrakizumab's marketing authorisation states that discontinuation should be considered at 28 weeks. It was also aware that the PASI 75 response rate for tildrakizumab at 28 weeks was higher than at 12 weeks, and that this effect was seen with other biological treatments. But it considered that tildrakizumab's less frequent dosing schedule meant that this late treatment effect was more noticeable (only 2 doses had been given before assessment of treatment response at 12 weeks). The clinical expert advised that assessment at 12 weeks would be premature, and they would prefer to minimise the risk of a patient switching from a potentially effective treatment (see section 3.2). The committee concluded that there was evidence of clinically and statistically significant improvement in outcomes with tildrakizumab at 28 weeks compared with 12 weeks. It concluded that response to tildrakizumab should be assessed at 28 weeks, in line with its marketing authorisation, to avoid the possibility of people switching from an effective treatment.

Network meta-analysis

The network meta-analysis including infliximab is appropriate for decision making

3.11 The company did a network meta-analysis to indirectly compare tildrakizumab with other biological treatments (adalimumab, brodalumab, etanercept, guselkumab, ixekizumab, secukinumab and ustekinumab)

using data from 45 trials. The included trials assessed PASI 75 response at various time points, which the company grouped into separate stages for its analysis: response measured at 12 weeks to 16 weeks (stage I), and response measured at 24 weeks to 28 weeks (stage III). Stage II was a separate planned analysis that excluded the placebo arms, resulting in an incomplete network. Therefore it was not considered in this appraisal. No trials reported placebo outcomes at stage III. Therefore, to include placebo in its stage III network, the company used placebo response rates from the same trials at stage I. The ERG noted that this made the stage III analysis weaker than the stage I analysis. This was because there were no direct placebo data at 24 weeks to 28 weeks, and because most trials were open label at this point, though a stage III etanercept control group was included. The ERG also advised that excluding infliximab from the network was inconsistent with previous appraisals, and that including it would strengthen the network. The ERG therefore included 6 additional trials in an exploratory analysis. The committee concluded that the network meta-analysis, including infliximab, was appropriate for decision making.

Tildrakizumab is more effective after 28 weeks, when it has similar efficacy to guselkumab, than after 14 weeks, when it has similar efficacy to adalimumab

3.12 For the stage I (12 weeks to 16 weeks) analysis the committee noted that the PASI 75 response rates for tildrakizumab were higher than those for etanercept, similar to adalimumab and ustekinumab, and lower than for other targeted biologicals, including guselkumab (also an IL-23 inhibitor). For the stage III (24 weeks to 28 weeks) analysis the committee noted that the network meta-analysis suggested that the PASI 75 response rates for tildrakizumab were statistically significantly higher than at stage I. It noted that tildrakizumab at stage III had a higher PASI 75 response rate than etanercept and adalimumab at stage III, and similar efficacy to other targeted biologicals at stage I, which reflected the stopping rules used in NHS practice for those treatments. The committee concluded that tildrakizumab was more effective at stage III than at stage I. It also

concluded that the efficacy of tildrakizumab at stage I was closest to adalimumab at stage I, and the efficacy of tildrakizumab at stage III was closest to guselkumab at stage I.

Company's economic model

The model has a Markov state transition structure

3.13 A Markov state transition model was used to assess the cost effectiveness of tildrakizumab. It assumed that treatments improved quality of life but did not extend length of life. The model contained 4 health states: induction treatment, maintenance treatment, best supportive care and death. All patients entered the model in the induction state and had the first treatment in a given sequence (see section 3.14). They moved from the induction state to the maintenance state if they had at least a PASI 75 response measured at the end of induction. From there, some patients could stop treatment for any reason and move to the next treatment in the sequence. Patients in whom there was not a PASI 75 response moved to the induction phase of the next treatment in the sequence. Patients moved to the best supportive care state between treatments in a sequence or if their psoriasis did not respond to the last active treatment in a sequence. All patients could move to the death state at any time.

The company compared treatment sequences in the model

3.14 The company's decision problem compared a sequence of treatments including tildrakizumab with 7 other sequences excluding tildrakizumab. Each sequence comprised 4 treatments:

- The first treatment was either tildrakizumab or another biological treatment (adalimumab, brodalumab, etanercept, guselkumab, ixekizumab, secukinumab or ustekinumab).

- The second treatment was ustekinumab, except in the sequence in which ustekinumab was used as the first treatment; in that sequence, adalimumab was used as the second treatment.
- The third treatment was secukinumab, except in the sequence in which secukinumab was used as the first treatment; in that sequence, adalimumab was used as the third treatment.
- The fourth treatment in all sequences was best supportive care.

The company chose these sequences based on expert advice. The committee understood that, over time, a sequence of biologicals would be used to treat severe psoriasis in current NHS practice as people switch from 1 option to another. The committee was aware that additional factors should be considered when comparing treatment sequences, such as the best ordering of treatments and the effect of including treatments that may not be cost effective. The committee agreed that, in principle, it was appropriate to compare treatment sequences in this appraisal.

Assumptions in the economic model

A common 14-week induction period for the drug is inappropriate

3.15 The company included a common 14-week induction period for tildrakizumab and all comparators in its economic model. The company explained that this was to simplify the model, and that a 14-week induction period was chosen to represent the midpoint of the range of typical induction periods (stage I from the network meta-analysis; 12 weeks to 16 weeks). The ERG explained that this method would create bias in the costs of the induction period, and explored a scenario of modelling treatment-specific induction period costs to reflect the recommended induction duration of each one. The committee recognised that a common 14-week induction period was particularly inconsistent with a potential 28-week induction for tildrakizumab (see section 3.10). The committee concluded that assuming a common induction period could apply to treatments with different induction durations was inappropriate. It

therefore preferred the ERG's modelling of treatment-specific induction period costs.

Tildrakizumab with a 28-week induction period should be compared with the induction periods used in current practice for other biological treatments

3.16 The company included a scenario analysis in its submission presenting the cost effectiveness of tildrakizumab with a 28-week induction period compared with all other treatments at 28 weeks. The ERG noted that no other treatments had a recommended assessment time in the stage III time range, and so the appropriate comparison would be with treatments at their recommended assessment times. The ERG therefore included tildrakizumab with 14-week and 28-week induction periods as separate interventions in its exploratory analysis. The committee recalled that the network meta-analyses showed a statistically significant improvement in the PASI 75 response rate for tildrakizumab between the 2 assessment points (see section 3.12). The committee concluded that it preferred the ERG's approach; namely, that tildrakizumab with both a 14-week and 28-week assessment point should be compared with other biologicals at their recommended 12-week to 16-week induction periods, to reflect the stopping rules used in NHS practice for those treatments.

Utility values in the economic model

Company utility values are appropriate, without adjustment for age

3.17 The company used EQ-5D data collected in the reSURFACE 1 trial to inform utility values in its economic model. Utility values were stratified by the level of PASI response. The committee was aware that the utility values were consistent with those from a recent review by the Institute for Clinical and Economic Reviews. The company implemented its utility values in the economic model by assuming a percentage change from general age-related population values. The ERG suggested that adjusting utility values for age in this way may be inappropriate, because it assumes a constant relationship between age and PASI score. It also noted that

because no extension of life for any treatment had been modelled, adjusting for age added a complexity to the model that was not needed. The committee concluded that the ERG's scenario analysis using the company's absolute utility scores without adjustment for age was more appropriate.

Best supportive care utility should return to baseline

3.18 The company assumed, in its model, that patients having best supportive care have a utility value equal to the utility value associated with the lowest PASI reduction (less than 50%). The clinical expert considered this to be inappropriate, advising that a patient who switches from an active treatment to best supportive care would revert to their baseline quality of life shortly after switching. The ERG noted limitations in stratifying utility score by PASI response; namely, a person with a PASI response below 50% (a 'non-responder') might still have some improvement in their PASI that has a positive effect on quality of life, and that PASI response may not fully capture improvements in the psoriasis from treatment. This may explain why the utility score for the 'PASI response less than 50%' group was notably higher than the baseline score. The ERG did an exploratory analysis using the baseline utility score for those having best supportive care. The committee concluded that baseline utility is more appropriate for representing health-related quality of life than the utility of patients with the lowest response to treatment.

Costs in the economic model

ERG drug costs and resource use are appropriate for decision making

3.19 The company presented drug costs adjusted for a 14-week induction period and annual maintenance costs adjusted for a 14-week cycle length. The ERG revised these costs for each treatment-specific induction period (see section 3.15) and corrected maintenance costs. Biosimilar price reductions for etanercept were considered by the company. The ERG included additional healthcare costs for those whose psoriasis did not

respond to biological treatments, increasing the company's one-off switching costs to reflect a 14-week cycle cost. The committee concluded that the ERG's amendments to costs and resource use were appropriate for decision making. In an exploratory analysis, the ERG also included potential price reductions for adalimumab, because adalimumab biosimilars have recently become available.

The cost of best supportive care is uncertain

3.20 In its model, the company included the cost of best supportive care from NICE's guideline on psoriasis: assessment and management, which includes drug treatment, day centre care and inpatient care. The committee understood that previous psoriasis appraisals obtained direct costs from an observational study (Fonia et al. 2010). The ERG advised that the cost of best supportive care from this source, used in previous appraisals, was considerably lower than the company's estimate from the psoriasis guideline. The ERG advised that despite being lower than the company's estimates, the costs in Fonia et al. may still have overestimated the true cost of best supportive care in NHS practice, because the secondary care resource use in the study appeared to be high. The committee concluded that the cost of best supportive care for people whose psoriasis does not respond to treatment is uncertain because of a lack of recent studies to quantify the true cost in clinical practice. It concluded that, for this appraisal, the Fonia et al. costs should be used because they are more likely to reflect current clinical practice than the costs used in the company's model, and this is consistent with previous appraisals. The committee further concluded that defining the costs associated with psoriasis that reflect current clinical practice was an important area for research.

Cost-effectiveness estimates

Treatment sequences may result in misleading cost-effectiveness estimates

3.21 The committee was aware that treatment sequences, although more likely to reflect the treatment switching seen in clinical practice, may have provided misleading cost-effectiveness estimates for tildrakizumab. It noted that some of the treatments were not cost effective in the model. Therefore, the cost effectiveness of any new treatment included early in these sequences would likely be driven by avoiding potentially cost-ineffective subsequent treatments and best supportive care. The committee was also aware that the company's model compared a limited number of all potential treatment sequences. The ERG compared individual treatments with best supportive care in its own base case, setting the second and third options in all sequences to best supportive care. The committee concluded that it would consider these comparisons of individual treatments with best supportive care in its decision making to account for potential bias caused by analysing treatment sequences.

Considering incremental net monetary benefit in addition to ICERs is appropriate for decision making

3.22 The company did a fully incremental analysis of treatment sequences, using the cheapest biological treatment (etanercept) as a baseline. The committee noted that several treatments had only small differences in total costs and quality-adjusted life year (QALY) gains, and that these small differences could be difficult to see using incremental cost-effectiveness ratios (ICERs) from fully incremental or pairwise analyses. The ERG therefore presented the cost-effectiveness results in a net monetary benefit framework. The incremental net monetary benefit of each comparator was compared with best supportive care at opportunity costs of £20,000 and £30,000 per QALY gained. The committee concluded that incremental net monetary benefit was useful in determining the relative cost effectiveness of the interventions with similar

costs and QALYs, and that it should be considered alongside the company's and the ERG's ICERs.

Tildrakizumab is less cost effective than other biological treatments

3.23 The committee considered whether tildrakizumab would be a cost-effective use of NHS resources for people with severe psoriasis for whom biological treatments are an option, taking into account the patient access schemes associated with brodalumab, guselkumab, ixekizumab and secukinumab. The committee considered deterministic results from the company's base case, which showed that tildrakizumab was dominated by brodalumab. The committee then considered the results of the ERG's base case, comparing individual treatments with best supportive care (see section 3.21). This analysis used baseline utility for patients having best supportive care (see section 3.18) and used the committee's preferred cost estimates (see sections 3.19 and 3.20).

- For tildrakizumab assessed at 28 weeks, the total QALY gain was closer to the QALY gains of other targeted treatments when assessed at 12 weeks to 16 weeks (brodalumab, guselkumab, ixekizumab, infliximab and secukinumab). The committee agreed that this meant that tildrakizumab, when assessed at 28 weeks rather than 14 weeks, could potentially displace these treatments, particularly guselkumab which has the same biological target. The committee therefore considered the cost-effectiveness estimates for tildrakizumab assessed at 28 weeks compared with these comparators. It noted that they were less expensive and more effective than tildrakizumab, except for infliximab, which is only used for very severe psoriasis. The committee concluded that tildrakizumab assessed at 28 weeks was unlikely to be a cost-effective use of NHS resources.
- The committee then considered whether tildrakizumab would be cost effective with a short induction period. For tildrakizumab assessed at 14 weeks, the total QALY gain compared with best supportive care was not among the highest of the biologicals. The committee considered

that tildrakizumab would be unlikely to displace more effective (higher QALY) options. The committee agreed that the comparators most likely to be displaced at this level of effectiveness were adalimumab and ustekinumab (see section 3.12). The committee was aware that with only a modest discount on the adalimumab list price, to reflect the potential price of its biosimilars, adalimumab produces the highest net benefit of all options, including tildrakizumab. The committee therefore concluded that tildrakizumab with assessment at 14 weeks is unlikely to be a cost-effective use of NHS resources.

Other factors

The PASI and DLQI may not be appropriate for all people with psoriasis

3.24 The committee noted, as in previous NICE technology appraisals on psoriasis, potential equality issues:

- the PASI might underestimate disease severity in people with darker skin
- the DLQI has limited validity in some people, and may miss anxiety and depression.

The committee concluded that, when using the PASI, healthcare professionals should take into account skin colour and how this could affect the PASI score, and make the clinical adjustments they consider appropriate. Also, it concluded that, when using the DLQI, healthcare professionals should take into account any physical, psychological, sensory or learning disabilities, or communication difficulties, that could affect the responses to the DLQI and make any adjustments they consider appropriate.

Tildrakizumab is not innovative

3.25 The committee understood that tildrakizumab is an interleukin-23 inhibitor with a 12-week dosing schedule. The committee was aware that the 12-week interval between doses is longer than for other biological treatments

currently available in NHS practice. The clinical expert advised that this would be welcomed by patients as a less burdensome treatment option. The committee concluded that although less frequent dosing may reduce the burden to people with psoriasis, it was unlikely that there were additional gains in health-related quality of life over those already included in the QALY calculations.

4 Proposed date for review of guidance

4.1 NICE proposes that the guidance on this technology is considered for review by the guidance executive 3 years after publication of the guidance. NICE welcomes comment on this proposed date. The guidance executive will decide whether the technology should be reviewed based on information gathered by NICE, and in consultation with consultees and commentators.

Sanjeev Patel
Vice-chair, appraisal committee
November 2018

5 Appraisal committee members and NICE project team

Appraisal committee members

The 4 technology appraisal committees are standing advisory committees of NICE. This topic was considered by committee B.

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

The minutes of each appraisal committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

NICE project team

Each technology appraisal is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the appraisal), a technical adviser and a project manager.

Adam Brooke
Technical lead

Jamie Elvidge
Technical adviser

Jeremy Powell
Project manager

ISBN: [to be added at publication]

