NICE National Institute for Health and Care Excellence

NICE guidance

Risankizumab for previously treated moderately to severely active Crohn's disease

Technology appraisal guidance
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Your responsibility

The recommendations in this guidance represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take this guidance fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this guidance is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Commissioners and/or providers have a responsibility to provide the funding required to enable the guidance to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

1 Recommendations

1.1 Risankizumab is recommended as an option for treating moderately to severely active Crohn's disease in people 16 years and over, only if:

- the disease has not responded well enough or lost response to a previous biological treatment, or
- a previous biological treatment was not tolerated, or
- tumour necrosis factor (TNF)-alpha inhibitors are not suitable.

Risankizumab is only recommended if the company provides it according to the commercial arrangement.

1.2 If people with the condition and their clinicians consider risankizumab to be 1 of a range of suitable treatments, after discussing the advantages and disadvantages of all the options, use the least expensive. Take account of administration costs, dosage, price per dose and commercial arrangements.

1.3 These recommendations are not intended to affect treatment with risankizumab that was started in the NHS before this guidance was published. People having treatment outside these recommendations 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. For young people, this decision should be made jointly by the clinician, the young person, and their parents or carers.

Why the committee made these recommendations

Standard treatments for moderately to severely active Crohn's disease when conventional treatments stop working are biological treatments (such as TNF-alpha inhibitors [adalimumab and infliximab], ustekinumab and vedolizumab). Risankizumab is another biological treatment.

Clinical trial evidence suggests that risankizumab reduces symptoms and increases the likelihood of disease remission compared with placebo. Results from indirect comparisons of risankizumab with other biological treatments are uncertain. But there is enough

evidence to suggest it is as effective as vedolizumab, a treatment recommended by NICE for use after a TNF-alpha inhibitor or when TNF-alpha inhibitors are not suitable.

A cost comparison of risankizumab with vedolizumab suggests that risankizumab has similar or lower costs than vedolizumab. NICE considers risankizumab an acceptable use of NHS resources. This is when it is used after a biological treatment has not worked well enough, has stopped working, or was not tolerated, or TNF-alpha inhibitors are unsuitable. So, risankizumab is recommended.

2 Information about risankizumab

Marketing authorisation indication

2.1 Risankizumab (Skyrizi, AbbVie) is indicated for 'the treatment of patients 16 years and older with moderately to severely active Crohn's disease who have had an inadequate response to, lost response to, or were intolerant to conventional therapy or a biological therapy, or if such therapies are not advisable'.

Dosage in the marketing authorisation

2.2 The dosage schedule is available in the summary of product characteristics for risankizumab 600-mg concentrate for solution for infusion and risankizumab 360-mg solution for injection in cartridge.

Price

2.3 The company has stated that the list prices of the 600-mg concentrate for solution for infusion (induction treatment) and the on-body device with 360-mg solution for injection (maintenance treatment) are confidential until they are available, and cannot be reported here.

2.4 The company has a commercial arrangement. This makes risankizumab available to the NHS with a discount. The size of the discount is commercial in confidence. It is the company's responsibility to let relevant NHS organisations know details of the discount.

3 Committee discussion

The evaluation committee considered evidence submitted by AbbVie, a review of this submission by the external assessment group (EAG), and responses from stakeholders. See the committee papers for full details of the evidence.

Crohn's disease

3.1 Crohn's disease is a debilitating, chronic, relapsing systemic inflammatory bowel disease. It causes inflammation and mucosal ulceration anywhere in the digestive system. It is a lifelong condition. Symptoms include diarrhoea, abdominal pain, fatigue, loss of appetite, weight loss, blood or mucus in stool, and anaemia. Symptoms may vary over time and can last anywhere from a few days to several months. Persistent inflammation can lead to scarring of the bowel and further complications needing surgery. Treatments aim to relieve symptoms, promote mucosal healing, and maintain or improve quality of life by inducing disease remission while minimising drug-related toxicity. However, Crohn's disease often relapses and people can experience acute exacerbations (flares). Crohn's disease can present a major barrier to a person's ability to participate in daily life, severely affecting their self-esteem, social functioning, work, personal relationships, family life and other activities. One patient expert explained that treatments that induce remission are of great importance to people with the condition, because debilitating symptoms are not controlled unless the condition is in remission. Treatments which induce remission can also delay the need for surgery, which is also important to people with the condition. People with Crohn's disease fear the loss of remission and the arrival of flares because of the major impact these have on their life. The committee concluded that Crohn's disease can have a profound effect on people's quality of life and ability to do day-to-day activities.

Clinical management

Treatment options

3.2 The standard initial treatment for Crohn's disease is conventional treatment with corticosteroids and immunomodulators such as azathioprine, mercaptopurine and methotrexate. If these treatments fail, people are offered biological treatment. The clinical experts stated that tumour necrosis factor (TNF)-alpha inhibitors (infliximab or adalimumab, including biosimilars) are usually used first. Ustekinumab or vedolizumab are used when a TNF-alpha inhibitor has failed, is contraindicated or cannot be tolerated. These treatments are recommended in NICE's technology appraisal guidance on infliximab and adalimumab, ustekinumab and vedolizumab. A patient expert noted that NICE's recommendations on infliximab, adalimumab and ustekinumab specify that when more than 1 treatment is suitable the least expensive option should be used. NICE's recommendations also state that the benefit of continuing these treatments should be assessed at 1 year. The clinical experts explained that, when there is evidence of clinical benefit, treatment continues beyond 1 year and that stopping effective treatments would be very rare. They stated that if the treatment no longer works (including after a dose increase, if relevant), another biological treatment would be considered. The clinical experts stated that although there are several clinically effective biological treatments for Crohn's disease, these do not cause long-term disease remission for everyone. Some people may have a sequence of biological treatments followed by surgery. A patient expert stated that complications of surgery and the potential effect on fertility can have a large impact on people with the condition. The clinical and patient experts agreed that it is very important to have a range of treatment options to help more people gain and regain disease remission, and delay surgery. The committee concluded that people with Crohn's disease would value the availability of a further treatment option to improve symptoms and induce disease remission.

Risankizumab and its comparators

3.3 Risankizumab is a novel treatment with a different mechanism of action to

existing treatments. The company proposed it can be used either after conventional treatment (conventional care failure population) or after a biological treatment (biological treatment failure population) as an additional biological option. The clinical experts explained that treatment is not dependent on disease location. They agreed with the company's positioning of risankizumab in the clinical pathway and that it was relevant to consider both the conventional care failure and biological treatment failure populations. However, they noted that it would probably be used more after biological treatment. This is because TNF-alpha inhibitors are an effective and less expensive treatment option (because biosimilars are available), so most people have them first. A patient expert highlighted the need for people with the condition to have access to the most effective treatment first. This is because it can take years before they find an effective treatment, and this process can delay finding a treatment that induces disease remission. The committee concluded that risankizumab could be an option for both the conventional care failure and biological treatment failure populations. It further concluded that the relevant comparators for the conventional care failure population are adalimumab, infliximab and ustekinumab. The relevant comparators for the biological treatment failure population are ustekinumab and vedolizumab.

Clinical trials

3.4 The clinical evidence was from the phase 3 trials ADVANCE, MOTIVATE and FORTIFY. ADVANCE (n=931) and MOTIVATE (n=618) were multicentre, double-blind, placebo-controlled randomised induction trials. These recruited people with moderately to severely active Crohn's disease that had an inadequate response to conventional treatments (ADVANCE) or biological treatments (ADVANCE and MOTIVATE). Moderately to severely active disease was defined by a Crohn's Disease Activity Index (CDAI) score of 220 to 450, average stool frequency of 4 or more, or abdominal pain score of 2 or more, and Simple Endoscopic Score for Crohn's Disease (SES-CD) of 6 or more (4 or more for isolated ileal disease). People had intravenous risankizumab (600 mg or 1,200 mg) or placebo at week 0, week 4 and week 8. People whose disease did not respond at week 12 had a second induction treatment with risankizumab (1,200 mg intravenously, 360 mg subcutaneously or 180 mg subcutaneously). The company used data from ADVANCE or MOTIVATE for the subgroups who had the

600-mg induction regimen covered by the marketing authorisation for risankizumab (for moderately to severely active Crohn's disease), or placebo. This included:

- in ADVANCE, 219 people in the conventional care failure subgroup and 292 people in the biological treatment failure subgroup
- in MOTIVATE, 378 people who had a previous biological treatment.

People whose disease responded to treatment entered FORTIFY, a phase 3 multicentre, double-blind, placebo-controlled maintenance trial. FORTIFY sub-study 1 (n=542) re-randomised people to subcutaneous 180 mg or 360 mg risankizumab or placebo (withdrawal) every 8 weeks for 52 weeks. The company included data from FORTIFY from 305 people who had 1 induction treatment with intravenous 360 mg risankizumab, the treatment regimen covered by the marketing authorisation for risankizumab, or placebo. Of these, 80 people were in the conventional care failure subgroup and 225 people were in the biological treatment failure subgroup. The committee concluded that the trials' results were generalisable to how risankizumab would be used in clinical practice.

Primary outcomes

3.5 The co-primary outcomes for all 3 trials were clinical remission and endoscopic response. Clinical remission was measured by either a CDAI score below 150 or patient-reported outcomes on stool frequency and abdominal pain, but both outcomes were collected in all trials. The SES-CD was used to measure endoscopic response alongside either measure of clinical remission. The clinical experts explained that the CDAI is used primarily in clinical trials as a measure of remission but not in clinical practice because of the time needed to complete the measurements included in this index. The clinical experts stated that the Harvey-Bradshaw Index is broadly comparable to the CDAI and is used in clinical practice. A clinical expert stated that the SES-CD is used increasingly in clinical practice. The committee concluded that the measures of remission used in the trials would give applicable estimates of expected remission and endoscopic response rates in clinical practice.

Results

3.6 The results from the induction trials suggested that risankizumab is associated with higher rates of clinical remission and endoscopic response compared with placebo in the conventional care failure and biological treatment failure populations. The results from FORTIFY suggested that risankizumab is associated with higher rates of endoscopic response compared with placebo in the conventional care failure and biological treatment failure populations. The committee noted that the FORTIFY subgroup results in the conventional care failure and biological treatment failure populations were not statistically significant for clinical remission assessed by the CDAI. The committee concluded that risankizumab is associated with higher rates of clinical remission and endoscopic response compared with placebo (withdrawal) when used as a first biological treatment or after a previous biological treatment.

Clinical effectiveness

Network meta-analyses

3.7 Because of the lack of direct comparative evidence, the company's original submission included network meta-analyses for induction and maintenance treatment in the conventional care failure and biological treatment failure populations. The outcomes assessed were clinical remission and response (defined by the CDAI). In its original submission, the company used a Bayesian risk difference fixed-effects model. For the network meta-analyses for maintenance treatment, the company split the clinical trial evidence into 2 separate networks (risankizumab and ustekinumab, and adalimumab, infliximab and vedolizumab). It stated it chose this approach because:

- of differences in drug mechanism of action, induction duration and half-life
- single network analyses lacked face validity (the estimated rates of remission were higher in people who had placebo)
- of methodological challenges in accounting for the heterogeneity.

The EAG disagreed with the company on:

- Splitting networks: The EAG noted that connections in network meta-analyses should be based on comparator connections, not drug characteristics. It also noted ustekinumab and vedolizumab, used in the different networks, have a similar half-life and are comparable treatment options. The EAG presented results using a single network. The committee agreed that a single network was more appropriate.

- Using a fixed-effects model rather than a random-effects model: The EAG agreed with the company that there were several differences between the trials that made doing network meta-analyses more challenging. This included differences in baseline risks, stratification by the conventional care failure and biological treatment failure populations, and an observed temporal effect in which remission rates in placebo groups appeared higher in more recent trials. Given these differences, using a random-effects model is more appropriate. The committee noted the company's concerns that its exploration of a random-effects model produced results with wide confidence intervals and included values which favoured placebo over biological treatments. However, the committee agreed with the EAG that a random-effects model was preferable.

- Lack of adjustment for baseline risks or temporal effect: The EAG noted that the company's risk difference approach was not an adjustment for heterogeneity. The committee agreed that there was no evidence that the company's approach minimised differences between placebo group results between trials in the network. The EAG preferred to include an adjustment for the temporal effect observed in placebo remission rates. The committee agreed an adjustment for temporal effect was needed.

  Overall, the committee concluded that it preferred the EAG's approach because it was more methodologically appropriate, but that the relative clinical effectiveness of risankizumab compared with other biological treatments was highly uncertain with either approach. The committee further noted that models using risk ratios rather than risk differences to compare risankizumab with the other biological treatments may be more informative, given the heterogeneity of studies in the network. This is because relative effect tends to be more stable across risk groups than absolute risk. It would

also allow further, and more straightforward, exploration of data to improve the precision of the modelled comparative effectiveness estimates (by using an informative prior). At the first committee meeting, the committee concluded that updated analyses were needed:

- using a single maintenance network with an adjustment for temporal effect
- using risk ratios rather than risk difference and presenting the credible intervals around the estimates
- exploring both random-effects models and fixed-effects models.

Clinical effectiveness similarity

3.8 In response to draft guidance consultation, the company used the committee's preferred methods for its network meta-analyses. The company stated that the results suggested risankizumab and its comparators had similar clinical effectiveness, consistent with its previous analyses. The company noted that no statistically significant differences were observed. The committee noted that a lack of statistically significant differences between treatments did not mean that they were equally clinically effective. The exact point estimates for the comparisons and credible intervals are confidential and cannot be reported here. However, the committee noted that in all comparisons the point estimates of risk ratios for CDAI-measured clinical remission were below 1 for adalimumab, infliximab and ustekinumab compared with risankizumab, and around 1 for risankizumab compared with vedolizumab. In all comparisons, the 95% credible intervals were wide and included values above and below 1. In these analyses, a value below 1 suggests that clinical remission is more likely with the comparator than risankizumab, and a value above 1 suggests that clinical remission is more likely with risankizumab than the comparator. The EAG did not consider that the network meta-analyses supported equivalent clinical effectiveness across treatments. A clinical expert noted the difficulty in assessing clinical equivalence without clinical trials directly comparing the treatments. Based on experience in clinical practice and clinical trial evidence on risankizumab, the clinical expert considered that risankizumab is likely similarly effective to TNF-alpha inhibitors and ustekinumab, probably more effective than vedolizumab, and likely at least as effective as ustekinumab. They also cited a published meta-analysis

suggesting that risankizumab's effectiveness is similar to other treatments (Barberio et al. 2022). The committee noted difficulties in doing network meta-analyses with the available trial data (for example, because of differences in treatments, trial designs or populations) and agreed that the results are uncertain. It stated that clinical equivalence or inferiority is usually assessed in specifically designed large-scale trials. The clinical expert also said that treatment response has been seen in people having risankizumab after previous biological treatment. The committee agreed that, based on the available evidence, there was only enough certainty that risankizumab had at least equivalent benefits to vedolizumab.

On-body device

3.9 Risankizumab maintenance treatment will be delivered by a single-use on-body injector with a prefilled cartridge. However, in FORTIFY (see section 3.4) risankizumab was administered in 4 subcutaneous injections using a syringe. The committee was satisfied that results from other trials showed bioequivalence of risankizumab administered using the on-body device and using subcutaneous injections. However, it noted that the level of treatment adherence could differ from that observed in FORTIFY because of lack of experience with the device. The patient experts said that a new treatment option is needed regardless of the delivery method, noting that people with the condition are likely to prefer the on-body device to the 4 injections used in the trial. However, they explained that some drug delivery can be painful and they do not know whether it will be with the on-body device. They highlighted a need for a quiet and 'less-jarring' drug delivery mechanism than that associated with some other subcutaneous treatments for Crohn's disease. The EAG said that the implications for costs and patient outcomes are unknown. In particular, the cost of wastage if there were difficulties with self-administering or injection failure. A committee member also questioned the environmental impact of a single-use device that includes a battery and microchips. At the second committee meeting, the committee was reassured by clinical and patient experts that people with the condition and clinicians welcome this new delivery system. They said that injection failure wastage can happen with all self-administration systems, noting that pens for subcutaneous injection need coordination to hold and press a button at the correct pressure. They stated that all self-administration devices are single-use

and highlighted that risankizumab is administered once every 12 weeks, while other treatments are administered more often giving more opportunities for wastage. The company stated that it will provide training and ongoing support for people using the on-body device free of charge to the NHS. The committee concluded that the on-body device is likely to be welcomed by people with Crohn's disease, although environmental concerns remained.

Company's first economic model

Cost-utility model structure

3.10 In its original submission, the company presented a cost-utility model comparing risankizumab with other biological treatments in the conventional care failure and biological treatment failure populations. It consisted of a short-term induction phase (decision tree) and a long-term maintenance phase (Markov state transition model). It assumed that people with moderately to severely active Crohn's disease have the same mortality as the general population. The maintenance phase modelled people having risankizumab or other biological treatments after a response to induction, or having conventional care if their Crohn's disease had not responded to induction treatment. After the first biological treatment, all people were modelled to have conventional care. With each maintenance treatment people were modelled to be in one of 4 health states: remission (CDAI score below 150), mild disease (CDAI score 150 to below 220), moderate to severe disease (CDAI score 220 to below 600), and surgery. It assumed that people with moderately to severely active disease could have surgery (constant rate across treatment arms based on NHS hospital episode statistics annual rates) and return to a CDAI-based health state after 8 weeks. The EAG explained that the CDAI used in the model to define clinical response and remission, and the severity of the disease, is not used in clinical practice. However, the clinical experts explained that the CDAI measure correlates with the Harvey-Bradshaw Index which is commonly used in clinical practice. The EAG further explained that the model does not reflect the lifelong relapsing–remitting nature of Crohn's disease because it does not allow people to have multiple biological treatments. Instead, it assumes all people have conventional treatment after a biological treatment. The company explained that

a similar structure was used in previous NICE technology appraisals of treatments for Crohn's disease. The clinical experts agreed with the EAG that the model does not reflect the current clinical pathway. Overall, the committee concluded that although a CDAI-based model may be appropriate, the model is not suitable for decision making because it did not reflect the treatment pathway in which people can have more than 1 biological treatment.

Treatment duration

3.11 In the model, people could either stop treatment because of a lack of efficacy or once they had reached assumed maximum treatment duration. The company assumed a 1-year maximum treatment duration. The EAG assumed a 20-year maximum treatment duration and applied the company's rate of discontinuing treatment because of a lack of efficacy for 20 years. The company explained that a 1-year maximum duration is consistent with modelling in previous NICE technology appraisals of treatments for Crohn's disease. The EAG noted that most people in FORTIFY were still having treatment at 1 year and that 1 year does not reflect the lifelong nature of Crohn's disease. The clinical and patient experts agreed with the EAG that a 1-year maximum treatment duration does not reflect clinical practice and would not be fair for people with the condition. The company confirmed that it did not intend that there would be a 1-year stopping rule for risankizumab in clinical practice. The committee concluded that the 1-year maximum treatment duration assumption in the model was too short. It concluded that the EAG's 20-year maximum treatment duration was more reflective of clinical practice and appropriate for use in the cost-utility model.

Company's second economic model

3.12 At the first committee meeting, the committee noted the minimal quality-adjusted life-year gain for risankizumab in the company's cost-effectiveness analyses. The committee stated that cost-comparison analyses may be considered in NICE technology appraisals if it is shown that a technology has the same clinical effectiveness as a technology already recommended by NICE for the same indication. The committee outlined its preference for the network meta-analyses structure (see section 3.7). In response to draft guidance consultation, the

company submitted a cost-comparison model because it considered that its updated network meta-analyses showed risankizumab was similarly clinically effective to its comparators. The committee concluded that it was appropriate to consider a cost-comparison model, but it would take into account both the evidence for clinical equivalence and whether risankizumab was cost saving in its decision making.

Cost-comparison model structure

3.13 The company developed a new model for cost comparison that had some different assumptions to its original cost-utility model:

- It used a 10-year treatment duration rather than a maximum of 1 year (company's preference) or 20 years (EAG's preference) used in the cost-utility model (see section 3.11). It also did not account for some people stopping treatment before 10 years. A clinical expert stated that 10 years of treatment would be longer than expected and draft guidance consultation comments stated that 2 to 3 years is the reported median duration of treatment persistence with biologics. The EAG also provided a scenario analysis modelling treatment discontinuation. The committee considered that if using a cost-comparison analysis it was more appropriate to determine a time horizon sufficient to capture any differences in costs rather than to model treatment discontinuation. This is because treatments which are discontinued because of loss of effectiveness or tolerability may appear to be the cheapest option. It also agreed that a shorter time horizon than the company's 10 years may be appropriate.
- Infliximab and vedolizumab maintenance treatments can be delivered intravenously or subcutaneously. The company assumed that half of all people would have intravenous treatment and the other half subcutaneous. The model presented results that assumed 50% of vedolizumab and infliximab was administered subcutaneously and 50% intravenously. In the company's cost-utility model, a comparison of intravenous and subcutaneous vedolizumab and infliximab had been presented separately. A clinical expert agreed with the company, saying that the 50% split between intravenous and subcutaneous treatments, and the percentage of people having high doses assumed in the company's modelling, reflected clinical practice.

- Some maintenance treatments can be used at standard or high doses. The company assumed that 50% of people having adalimumab, 40% having infliximab, 92.5% having ustekinumab and 30% having intravenous vedolizumab start maintenance treatment with the high dose. A clinical expert stated that these assumptions were similar to what they had observed in their own centre. In the cost-utility model, an annual dose escalation using the same percentage was applied. They explained that although not everyone would start with a high dose, the dose would be increased soon after starting treatment, so the assumption reflects a simplification of clinical practice.

  The committee concluded that the company's modelling assumptions were appropriate, but a shorter time horizon should be considered in its decision making.

Cost-effectiveness results

3.14 The committee considered only the cost-comparison model results because the cost-utility model was not suitable for decision making (see section 3.10). The company presented results for the whole population, although clinical-effectiveness evidence was presented separately for the conventional care failure and biological treatment failure populations. The committee already agreed that the relevant comparators for the conventional care failure population were adalimumab, infliximab and ustekinumab, and ustekinumab and vedolizumab for the biological treatment failure population (see section 3.3). The exact cost-effectiveness results cannot be reported here because of confidential prices for comparators. Using the company's assumptions, a 10-year time horizon, and considering people with moderately to severely active Crohn's disease as a single population, risankizumab was:

- not cost saving compared with all comparators
- not cost saving compared with all adalimumab and infliximab comparators
- cost saving when compared with ustekinumab and vedolizumab in the biological treatment failure population.

The company and the EAG did not consider that the total cost of treatments (dosing and administration costs) in the cost-comparison model would differ for the conventional care failure and biological treatment failure populations. The committee noted that the longer the treatment duration was in the cost-comparison model, the more cost saving risankizumab appeared. The committee considered the methods on decision making for cost comparisons. These state that to recommend a treatment there must be enough certainty that the technology has at least equivalent clinical or health and social care system benefits compared with current management, and overall uses fewer resources. The committee considered that, based on the available evidence, there was only enough certainty that risankizumab had at least equivalent benefits to vedolizumab. The committee considered that the cost saving of risankizumab compared with vedolizumab would be maintained over a 3-year time horizon. In a cost-comparison analysis, a technology can be recommended if it is cost saving against a NICE-recommended technology. The committee concluded that it was appropriate to make a recommendation based on a cost comparison of risankizumab with vedolizumab and that in this comparison risankizumab was cost saving. The committee further concluded that because vedolizumab is recommended in clinical practice for use after a TNF-alpha inhibitor or if a TNF-alpha inhibitor is unsuitable, it was appropriate to recommend risankizumab as an option for people who have already had a biological treatment or for whom TNF-alpha inhibitors are unsuitable.

Other factors

Equality issues

3.15 No equality or social value judgement issues were identified.

Conclusion

3.16 The committee agreed that although risankizumab may have similar clinical effectiveness to its comparators, there was uncertainty about its clinical equivalence to TNF-alpha inhibitors and ustekinumab in the conventional care failure population (see section 3.8). Risankizumab costs more than TNF-alpha inhibitors, which are typically the first biological treatments used in clinical practice after conventional care. However, the committee was satisfied that risankizumab was expected to have at least equivalent clinical effectiveness to vedolizumab and that risankizumab was cost saving when compared with vedolizumab in the biological treatment failure population (see section 3.14). The committee therefore recommended risankizumab for treating moderately to severely active Crohn's disease. It is recommended when the disease has not responded well enough or lost response to biological treatment, or this treatment was not tolerated, or when a TNF-alpha inhibitor is unsuitable.

4 Implementation

4.1 Section 7 of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 requires integrated care boards, NHS England and, with respect to their public health functions, local authorities to comply with the recommendations in this evaluation within 3 months of its date of publication or the date that the on-body device receives CE marking (if this is later). Because risankizumab has been available through the early access to medicines scheme, NHS England and integrated care boards have agreed to provide funding to implement this guidance 30 days after publication or the date that the on-body device receives CE marking (if this is later).

4.2 The Welsh ministers have issued directions to the NHS in Wales on implementing NICE technology appraisal guidance. When a NICE technology appraisal guidance recommends the use of a drug or treatment, or other technology, the NHS in Wales must usually provide funding and resources for it within 2 months of the first publication of the final draft guidance or the date that the on-body device receives CE marking (if this is later).

4.3 When NICE recommends a treatment 'as an option', the NHS must make sure it is available within the period set out in the paragraphs above. This means that, if a patient has moderately to severely active Crohn's disease and the doctor responsible for their care thinks that risankizumab is the right treatment, it should be available for use, in line with NICE's recommendations.

5 Evaluation committee members and NICE project team

Evaluation committee members

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

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

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

Chair

James Fotheringham
Chair, technology appraisal committee A

NICE project team

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

Marcela Haasova
Technical lead

Mary Hughes
Technical adviser

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Project manager

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Update information

Minor changes since publication

November 2023: In section 2, we removed information on CE-marking for the on-body device that delivers the 360-mg risankizumab solution for injection because the CE mark has now been granted.