NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

CENTRE FOR HEALTH TECHNOLOGY EVALUATION
Technology Appraisals

Consultation on Batch 18 draft remits and draft scopes

Summary of comments and discussions at scoping workshops

	Batch 18 topics
5.1	Adalimumab for children and young people aged 6-17 with moderate to severe Crohn's disease
5.2	Botulinum toxin type A for the prophylaxis of headaches in adults with chronic migraine
5.3	Lenalidomide for the maintenance treatment of multiple myeloma after autologous stem cell transplantation
5.4	Lenalidomide for the treatment of newly diagnosed multiple myeloma
5.5	Lenalidomide for the treatment of myelodysplastic syndromes associated with deletion 5q cytogenetic abnormality
5.6	Erlotinib for the first-line treatment of EGFR-TK mutation positive non-small cell lung cancer

Provisional Title	Adalimumab for children and young people aged 6-17 with moderate to severe Crohn's disease
Topic Selection ID Number	4490
Wave	25
Anticipated licensing information	CONFIDENTIAL
Draft remit	To appraise the clinical and cost effectiveness of adalimumab within its licensed indication for the treatment of moderate to severe Crohn's disease in children and young people aged 6-17 years.
Main points from consultation	Following the consultation exercise and the scoping workshop, the Institute is of the opinion that a technology appraisal of adalimumab for children and young people aged 6-17 with moderate to severe Crohn's disease is not appropriate. Consultees confirmed that adalimumab is already being used in routine clinical practice for people aged 6 to 17 years with moderate to severe Crohn's disease after failure of, or hypersensitivity to infliximab despite not being licensed for this use yet (this is the population which consultees would expect an appraisal to consider). This equates to approximately 50-130 patients per year receiving treatment with adalimumab. Stakeholders at the workshop noted that consideration should be given to including this topic in the ongoing clinical guideline for the management of Crohn's disease. This guideline will incorporate the recommendations from TA187 on the use of adalimumab and infliximab in adults, and the use of infliximab in children and young people aged 6-17 years with Crohn's disease. However, Technology Appraisals have since re-confirmed with Clinical Guidelines that new biologics have not been specifically covered within the draft scope of the guideline and, as such, adalimumab for people aged 6-17 years will not be included within the ongoing clinical guideline.
Process (MTA/STA)	N/A – referral not sought
Proposed changes to remit (in bold)	N/A – referral not sought
Costing implications of remit change	N/A –referral not sought
Timeliness statement	N/A – referral not sought

Provisional Title	Botulinum toxin type A for the prophylaxis of headaches in adults with chronic migraine
Topic Selection ID Number	4830
Wave	26
Anticipated licensing information	Botulinum toxin type A (Botox) achieved UK marketing authorisation for the prophylaxis of headaches in adults with chronic migraine (headaches on at least 15 days per month of which at least 8 days are with migraine), in July 2010.
Draft remit	To appraise the clinical and cost effectiveness of botulinum toxin type A within its licensed indication for the prophylaxis of headaches associated with chronic migraine.
Main points from consultation	Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of botulinum toxin type A for the prophylaxis of headaches associated with chronic migraine is appropriate. The proposed remit is appropriate and is in line with the marketing authorisation. Consultees highlighted their concern that the criteria to define chronic migraine (from the International Headache Society) are not currently universally accepted and therefore the size of the population relevant to this appraisal is uncertain. It was noted that new criteria to define chronic migraine will be published in 2014. Consultees at the workshop confirmed that botulinum toxin type A will be used for patients whose condition has failed to respond to at least three prior pharmacological prophylaxis therapies. Currently, these patients can only receive botulinum toxin type A privately (approximately 500 patients are currently receiving treatment across 10 private centres in the UK). No other brands of botulinum toxin type A have a marketing authorisation for this indication so an appraisal of botulinum toxin type A will only consider the Botox brand.
Process (MTA/STA)	STA
Proposed changes to remit (in bold)	No changes proposed.
Costing implications of remit change	The original costing impact calculated an eligible population of around 730,000 who have chronic migraine. Once new criteria are published in 2014 that better defines chronic migraine, the population can be recalculated. The main points from the consultation indicate that the technology will only be used for

	patients whose condition has failed to respond to at least three prior pharmacological prophylaxis therapies. The original briefing note did not include this information and so the costing did not take this into consideration. The impact of this is that the population would again be modified. Numbers are not yet known, however it is anticipated that with an agreed definition of chronic migraine and considering that three prior pharmacological prophylaxis therapies had to have been tried, the population figure will be smaller. This would significantly reduce the cost impact from the original costing.
Timeliness statement	Given that botulinum toxin type A (Botox) achieved UK marketing authorisation in July 2010 for this indication issuing timely guidance for this technology will not be possible.

Provisional Title	Lenalidomide for the maintenance treatment of multiple myeloma after autologous stem cell transplantation
Topic Selection ID Number	5107
Wave	27
Anticipated licensing information	CONFIDENTIAL
Draft remit	To appraise the clinical and cost effectiveness of lenalidomide within its licensed indication for the maintenance treatment of multiple myeloma after autologous stem cell transplantation.
Main points from consultation	This appraisal will only consider part of the proposed marketing authorisation; that is, in people with multiple myeloma after autologous stem cell transplantation. The other populations covered by the marketing authorisation (newly diagnosed multiple myeloma after induction treatment) will be considered as a separate appraisal. Please refer to item 5.4. Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of lenalidomide for the maintenance treatment of multiple myeloma after autologous stem cell transplantation is appropriate. The proposed remit for is appropriate. It was agreed at the scoping workshop that the draft scope presented a discrete decision-problem that should be considered as an STA to ensure that the guidance is timely.
Process (MTA/STA)	STA
Proposed changes to remit (in bold)	No changes proposed.
Costing implications of remit change	No change to cost impact.
Timeliness statement	Assuming the anticipated date of the marketing authorisation is the latest date that we are aware of and the expected referral date of this topic, issuing timely guidance for this technology will be possible.

Provisional Title	Lenalidomide for the treatment of newly diagnosed multiple myeloma
Topic Selection ID Number	4956
Wave	27
Anticipated licensing information	CONFIDENTIAL
Draft remit	To appraise the clinical and cost effectiveness of lenalidomide within its licensed indications (i) as induction therapy for newly diagnosed multiple myeloma and (ii) as maintenance therapy for newly diagnosed multiple myeloma in people who have previously received induction chemotherapy.
Main points from consultation	This appraisal will only consider part of the proposed marketing authorisation (that is, in people with newly diagnosed multiple myeloma for whom autologous stem cell transplantation is not appropriate). The other population covered by the marketing authorisation (newly diagnosed multiple myeloma after autologous stem cell transplantation) will be considered as a separate appraisal. Please refer to item 5.3. Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of lenalidomide for the treatment of newly diagnosed multiple myeloma <u>is appropriate</u>. The proposed remit is appropriate. During the scoping workshop there was debate about whether it will be possible to appraise lenalidomide as initial therapy (referred to as 'induction therapy' in the draft scope). Some consultees suggested that it would be appropriate to appraise lenalidomide in the maintenance phase alone. However, it was noted that the proposed marketing authorisation specifies that lenalidomide would be indicated for maintenance treatment following initial treatment with melphalan, prednisone *and lenalidomide (emphasis added)*. The manufacturer's representatives clarified that it intends that this marketing authorisation will give an 'implicit' licence for the use of lenalidomide in the first-line treatment phase. However, the focus of the regulatory application is on the maintenance phase, and no separate evidence will be submitted to the regulators to support an authorisation for use in induction alone. It was noted that, if the proposed marketing authorisation is accepted by the EMA, NICE would not be able to go beyond the explicit terms of the marketing authorisation and appraise lenalidomide in the initial phase of treatment alone (in which it would not be explicitly licensed). Moreover, the only people eligible for maintenance treatment with lenalidomide would be those who have already received first-line therapy with

	lenalidomide and it is likely that, in the absence of an explicit marketing authorisation and subsequent NICE appraisal, few people would meet this criterion. Clinical specialists expressed concern that, if a single initial–maintenance lenalidomide strategy were recommended, this would effectively limit the initial therapies available to people with newly diagnosed multiple myeloma to lenalidomide alone (because giving first-line lenalidomide would be the only way to ensure subsequent access to maintenance lenalidomide). This was of significant concern to the clinical specialists for two reasons: firstly, they would like to be able to provide a wider range of first-line therapies tailored for each individual and, secondly, they noted that there is presently no evidence demonstrating the efficacy of first-line lenalidomide. Considering that the multiple technology appraisal on thalidomide and bortezomib for the first-line treatment of multiple myeloma is due to be published shortly, it was considered appropriate for the appraisal of maintenance therapy with lenalidomide to concentrate on the population on which the marketing authorisation is based, and to take into account the outcome of the multiple technology appraisal.
Process (MTA/STA)	STA
Proposed changes to remit (in bold)	None
Costing implications of remit change	The original costing used a population that was the number of people newly diagnosed with multiple myeloma who were not eligible for autologous stem cell transplant (ASCT). It assumed lenalidomide would be used as induction treatment and as a subsequent maintenance treatment. This gave a population of around 2000. If the proposed approach above is undertaken, it would reduce the population. The original costing estimated an impact of between £88 million and £116 million depending on the number of cycles of treatment and the offsetting savings that may be achieved. These factors are still unknown and so the cost impact is still variable and has a large range. If the population is reduced as may be seen as a result of the proposed approach, the cost impact is likely to reduce. Despite these unknowns, the topic is still considered to be high cost (above £15 million).
Timeliness statement	Assuming the anticipated date of the marketing authorisation is the latest date that we are aware of and the expected referral date of this topic, issuing timely guidance for this technology will be possible.

Provisional Title	Lenalidomide for the treatment of myelodysplastic syndromes associated with deletion 5q cytogenetic abnormality
Topic Selection ID Number	4955
Wave	27
Anticipated licensing information	CONFIDENTIAL
Draft remit	To appraise the clinical and cost effectiveness of lenalidomide within its licensed indication for the treatment of myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality in people with red blood cell transfusion dependence.
Main points from consultation	Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of lenalidomide for the treatment of myelodysplastic syndromes associated with deletion 5q cytogenetic abnormality is appropriate. The proposed remit is appropriate.
Process (MTA/STA)	STA
Proposed changes to remit (in bold)	No changes proposed. Remit is in line with proposed marketing authorisation.
Costing implications of remit change	No change to cost impact.
Timeliness statement	Assuming the anticipated date of the marketing authorisation is the latest date that we are aware of and the expected referral date of this topic, issuing timely guidance for this technology will be possible.

Provisional Title	Erlotinib for the first-line treatment of EGFR-TK mutation positive non-small cell lung cancer
Topic Selection ID Number	4931
Wave	27
Anticipated licensing information	CONFIDENTIAL
Draft remit	To appraise the clinical and cost effectiveness of erlotinib, within its licensed indication, for the first-line treatment of epidermal growth factor receptor (EGFR) mutation positive locally advanced or metastatic non-small-cell lung cancer.
Main points from consultation	Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of erlotinib for the first-line treatment of epidermal growth factor receptor (EGFR) mutation positive locally advanced or metastatic non-small-cell lung cancer is appropriate. The proposed remit is generally appropriate but should be amended to specify that patients should have EGFR-TK mutations. This wording is in line with the clinical trial population for erlotinib, and also the population considered in TA192 (gefitinib for EGFR-TK mutation positive non-small-cell lung cancer).
Process (MTA/STA)	STA
Proposed changes to remit (in bold)	To appraise the clinical and cost effectiveness of erlotinib, within its licensed indication, for the first-line treatment of epidermal growth factor receptor (EGFR) **tyrosine kinase (TK)** mutation positive locally advanced or metastatic non-small-cell lung cancer.
Costing implications of remit change	The proposed change to better define the patients with EGFR mutations does not affect the population considered in the original costing. There is no change to the cost impact.
Timeliness statement	Assuming the anticipated date of the marketing authorisation is the latest date that we are aware of and the expected referral date of this topic, issuing timely guidance for this technology will be possible.