**NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE**

**CENTRE FOR HEALTH TECHNOLOGY EVALUATION**
**Technology Appraisals**

# Consultation on Batch 36 draft remits and draft scopes and summary of comments and discussions at scoping workshops

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| Olaparib for maintenance treatment of BRCA 1 or 2 mutated, relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer in people whose relapsed disease has responded to platinum-based chemotherapy |
| ABT-450/ritonavir/ombitasvir with or without dasabuvir for treating chronic hepatitis C |
| Sofosbuvir-ledipasvir for treating chronic hepatitis C |
| Ofatumumab for the maintenance treatment of relapsed chronic lymphocytic leukaemia |
| Naltrexone-bupropion (prolonged release) for treating obesity and overweight |
| Ceritinib for previously treated anaplastic lymphoma kinase-positive non-small-cell lung cancer |
| Panobinostat for treating multiple myeloma in people who have received at least 1 prior therapy |

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| **Provisional Title** | Olaparib for maintenance treatment of BRCA 1 or 2 mutated, relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer in people whose relapsed disease has responded to platinum-based chemotherapy | | |
| **Topic Selection ID Number** | 6813 | **Wave / Round** | R73 |
| **TA ID Number** | 735 | | |
| **Manufacturer** | AstraZeneca | | |
| **Anticipated licensing information** | ***CONFIDENTIAL INFORMATION REMOVED*** | | |
| **Draft remit** | To appraise the clinical and cost effectiveness of olaparib within its licensed indication for the maintenance treatment of relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer in people who have tested positive for BRCA 1 or 2 mutations, following response to prior platinum-based chemotherapy. | | |
| **Main points from consultation** | Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of olaparib for the maintenance treatment of BRCA 1 or 2 mutated, relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer in people whose relapsed disease has responded to platinum-based chemotherapy is appropriate.<br><br>The proposed remit is not appropriate and should be changed to: 'To appraise the clinical and cost effectiveness of olaparib within its licensed indication for maintenance treatment of BRCA 1 or 2 mutated relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer in people whose relapsed disease has responded to platinum-based chemotherapy'.<br><br>The population should also be amended in line with the remit to 'People with BRCA 1 or 2 mutated, relapsed, platinum-sensitive ovarian, fallopian tube or peritoneal cancer whose relapsed disease has responded to platinum-based chemotherapy'.<br><br>Stakeholders agreed that the draft remit should be changed to make the position of olaparib in the treatment pathway clearer. They agreed that eligible patients should have received platinum-based therapy and the disease should have relapsed after 6 months and then been re-challenged with platinum-based therapy. After completion of the last platinum-based therapy, the disease should be in complete or partial response and while in response, the patient would be eligible for olaparib maintenance treatment until disease progression.<br><br>Stakeholders advised that there are somatic and germline BRCA 1 or 2 gene mutations and clinicians have access to germline testing but somatic testing is not yet widely available. The manufacturer advised that its main clinical trial only used germline testing but that they are looking for more data outside of the main trial in order to include people with somatic BRCA gene mutations (and are seeking a CE mark for the diagnostic | | |

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| | test). The manufacturer also explained that the marketing authorisation for olaparib is not expected to specify whether the mutation is somatic or germline. Stakeholders were concerned that the current wording of the draft remit would imply that only people who have been tested for germline mutation would be eligible to receive treatment with olaparib and the proposed remit has been changed to make it clearer that this is not the case.<br>Stakeholders discussed the comparators for olaparib, in particular whether bevacizumab should be included. They considered that although data available for bevacizumab does not allow for a direct comparison with olaparib (because olaparib is used solely for maintenance treatment, whereas bevacizumab is used as a treatment for the first relapse of platinum-sensitive ovarian cancer [in combination with gemcitabine and carboplatin] and continued for maintenance treatment), it is an alternative for people at the first relapse and therefore could be considered a comparator. They also noted that although bevacizumab is not recommended by NICE for the first relapse of platinum-sensitive ovarian cancer, it is widely available through the Cancer Drugs Fund and it is considered established clinical practice in the NHS.<br><br>Consultees advised that response rate should be removed from the outcomes because the disease should be in complete or partial response after the last platinum-based chemotherapy regimen, and therefore response rate is not relevant. They also advised that progression-free survival 2 is a relevant outcome measure and regulatory agencies are actively asking for this outcome to be included in regulatory submissions. It was noted that progression-free survival 2 would determine whether olaparib has any impact on progression-free survival on the next line of therapy once the disease has progressed after treatment with olaparib. Stakeholders also stated that another relevant outcome for maintenance treatments is time to next line of therapy. The clinical specialists advised that this outcome does not necessarily show the same as progression-free survival because the moment in which the patient receives the next line of therapy does not necessarily correspond with the moment in which the disease progresses.<br><br>Stakeholders discussed the role of the diagnostic test for detecting BRCA 1 or 2 gene mutations in the appraisal. Some stakeholders commented that the diagnostic test is widely used in the NHS and is becoming standard practice for ovarian cancer, other stakeholders believed that there is variation in use within the NHS. Clarifications around the companion diagnostic have been added to the 'Other considerations' section of the scope. Therefore, in line with section 5.9 of the Guide to the Methods of Technology Appraisal, the 'Other considerations' now state that 'evidence is needed to show if testing for the presence or absence of BRCA 1 or 2 mutations in people with ovarian cancer is standard practice in the NHS'. The 'Other considerations' also now state that 'the economic modelling should include sensitivity analyses that include the cost |

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| | associated with the diagnostic testing for BRCA 1 or 2 mutations in people with ovarian cancer'. |
| **Population size** | The costing team at NICE estimated the patient population eligible to potentially receive treatment with olaparib: 'In 2010 there were around 5800 diagnoses of ovarian cancer, of which around 20% (1160) have the BRCA1 or 2 genetic mutation. Applying the costing template estimates for topic TA222 (Ovarian cancer (relapsed) - trabectedin) (2011), it is estimated that 80% (930) may relapse after first line treatment and that of these 85% (790) may respond to initial platinum-based chemotherapy. However, it is estimated that around 81% (640) may relapsed more than 6 months after completion of initial platinum-based chemotherapy and are termed 'platinum sensitive'. It is this population who it is estimated is eligible for this new technology. The briefing note states that the manufacturer estimates an eligible population of around 200 women. Using a midpoint there may be around 420 women who may be eligible'. |
| **Process (MTA/STA/HST)** | STA |
| **Proposed changes to remit (in bold)** | To appraise the clinical and cost effectiveness of olaparib within its licensed indication for maintenance treatment **of BRCA 1 or 2 mutated** relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer in people **whose relapsed disease has responded to platinum-based chemotherapy**. |
| **Costing implications of remit change** | No changes as a result of change in remit:<br><br>The unit cost of olaparib is not yet known. Potential offsetting savings from other treatment options avoided are also not known. From the information available the cost impact cannot be estimated. |
| **Timeliness statement** | Assuming that 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. |

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| **Provisional Title** | ABT-450/ritonavir/ombitasvir with or without dasabuvir for treating chronic hepatitis C | | |
| **Topic Selection ID Number** | 6878 | **Wave / Round** | R78 |
| **TA ID Number** | 731 | | |
| **Manufacturer** | AbbVie | | |
| **Anticipated licensing information** | ***CONFIDENTIAL INFORMATION REMOVED*** | | |
| **Draft remit** | To appraise the clinical and cost effectiveness of ABT-450/ritonavir/ABT-267 in combination with ABT-333 within its licensed indication for treating genotype 1 chronic hepatitis C. | | |
| **Main points from consultation** | Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of ABT-450/ritonavir/ombitasvir with or without dasabuvir for treating chronic hepatitis C is appropriate.<br><br>It was noted that recent publications of the pivotal trials for this technology (SAPPHIRE I and II and TURQUOISE I) included the international non-priority names for ABT-267 and ABT-333 which are 'ombitasvir' and 'dasabuvir' respectively. The remit, title and scope have been updated to include these names. The manufacturer confirmed that the generic name for ABT-450 has not been decided yet.<br><br>***CONFIDENTIAL INFORMATION REMOVED***<br><br>It should be noted that clinical trials have also been conducted in patients with genotype 2 and 3 HCV, and with and without dasabuvir; therefore, an even broader marketing authorisation may be granted.<br><br>The proposed remit is not appropriate and should be ***CONFIDENTIAL INFORMATION REMOVED*** amended to: "To appraise the clinical and cost effectiveness of ABT-450/ritonavir/ombitasvir with or without dasabuvir within its licensed indication for treating chronic hepatitis C".<br><br>The population in the scope has also been broadened to "Adults with chronic hepatitis C who have not been previously treated or in whom previous treatment has not resulted in a sustained virological response".<br><br>At the manufacturer's request, the intervention has been amended in the scope to "Co-formulated ABT-450/ritonavir/ombitasvir with or without dasabuvir, co-administered with or without ribavirin".<br><br>Clinical specialists at the scoping workshop highlighted that the treatment of chronic hepatitis C is rapidly evolving and new directly acting agents (such as sofosbuvir) are expected to be more efficacious with better safety profiles than existing treatment options (such as peginterferon alfa and ribavirin). It was noted that sofosbuvir in combination with other medicinal | | |

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| | products (that is, in combination with ribavirin, with or without peginterferon alfa) has recently received a marketing authorisation in the UK for the treatment of chronic hepatitis C in adults and the clinical specialists considered that once available, it would become the standard treatment for chronic hepatitis C. It is currently being appraised for this indication. Therefore, stakeholders suggested that "Sofosbuvir in combination with ribavirin, with or without peginterferon alfa (subject to ongoing NICE appraisal)" should be added to the scope as a comparator. Stakeholders also commented that currently there is no treatment option for (maybe 10-15%) people who are interferon-intolerant (or unsuitable) and therefore best supportive care should be included as a comparator for these patients. It was noted that, if sofosbuvir in combination with ribavirin (that is, an interferon-free regimen) became established clinical practice it would be the preferred treatment option for this patient group and therefore best supportive care would no longer be needed as a comparator for this group of patients. Therefore, best supportive care should only be added as a comparator (if appropriate) once the outcome from the ongoing sofosbuvir appraisal is known.<br><br>The manufacturer commented that rapid viral response (RVR) is a surrogate outcome that predicts sustained virological response (SVR) in patients receiving interferon based therapies. RVR is used to guide the duration of interferon based therapies and clinical utility of RVR in interferon free therapies has not been established, therefore it is not an appropriate outcome to include for this topic. Clinical specialists also agreed that RVR is not an appropriate endpoint, because unlike interferon based therapies, ABT-450 combination therapy would not be a response guided therapy (meaning that the duration of treatment would not depend upon the virological response at week 4); therefore 'Rapid virological response' has been removed as an outcome from the scope. |
| **Population size** | The most recent national estimates (2012) suggest that approximately 160,000 people are chronically infected with HCV in England. Most of this infection is due to genotype 1 (46%) and 3 HCV (43%). Genotypes 2, 4, 5 and 6 HCV constitute the remaining 11% of cases. |
| **Process (MTA/STA/HST)** | STA |
| **Proposed changes to remit (in bold)** | To appraise the clinical and cost effectiveness of ABT-450/ritonavir/**ombitasvir with or without dasabuvir** within its licensed indication for treating ~~**genotype 1**~~ chronic hepatitis C. |
| **Costing implications of remit change** | Updated to reflect updated technology names in remit<br>***CONFIDENTIAL INFORMATION REMOVED***<br><br>The estimated annual number of people with chronic hepatitis C eligible to receive treatment with ABT-450/ritanovir/ombitasvir with or without dasabuvir is at least 12,300.<br><br>This is based on assumptions in the costing template for NICE |

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| | TA252 and TA253 (Telaprevir for the treatment of genotype 1 chronic hepatitis C and Boceprevir for the treatment of genotype 1 chronic hepatitis C). It is estimated that there are 3 groups of patients who make up the eligible population: around 7100 people who are treatment-experienced and either did not achieve a sustained virological response, or have become re-infected; around 3200 people who are already diagnosed and have chosen not to receive treatment, and are waiting for new treatment options; and around 2000 newly diagnosed people each year. ***CONFIDENTIAL INFORMATION REMOVED***<br><br>The unit cost of the drug is unknown. The cost of other treatment options vary significantly but may be as high as around £70,000 (24 week course of sofosbuvir) or around £22,400 (telaprevir/boceprevir) per person. There may also be some savings from avoiding the use of interferon through new treatment regimens. The large eligible population suggests a potential for the topic to be high cost. However, the unknown drug cost, the unknown number of people who may switch from current treatments and the variation in the cost of comparators means that the cost impact cannot be estimated at this time from the information available. If a large number of people switch from a more expensive treatment option, savings are potentially significant. |
| **Timeliness statement** | Assuming that 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. |

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| **Provisional Title** | Sofosbuvir-ledipasvir for treating chronic hepatitis C | | |
| **Topic Selection ID Number** | 6885 | **Wave / Round** | R79 |
| **TA ID Number** | 742 | | |
| **Manufacturer** | Gilead Sciences | | |
| **Anticipated licensing information** | ***CONFIDENTIAL INFORMATION REMOVED*** | | |
| **Draft remit** | To appraise the clinical and cost effectiveness of sofosbuvir-ledipasvir within its licensed indication for treating genotype 1 chronic hepatitis C. | | |
| **Main points from consultation** | Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of sofosbuvir-ledipasvir for treating chronic hepatitis C is appropriate.<br><br>***CONFIDENTIAL INFORMATION REMOVED***<br><br>The proposed remit is not appropriate and should be ***CONFIDENTIAL INFORMATION REMOVED*** amended as follows 'To appraise the clinical and cost effectiveness of sofosbuvir-ledipasvir within its licensed indication for treating chronic hepatitis C". The title has also been amended.<br><br>The population in the scope has also been broadened to "Adults with chronic hepatitis C who have not been previously treated or in whom previous treatment has not resulted in a sustained virological response".<br><br>Stakeholders noted that sofosbuvir in combination with other medicinal products (that is, in combination with ribavirin, with or without peginterferon alfa) has recently received a marketing authorisation in the UK for the treatment of chronic hepatitis C in adults and the clinical specialists considered that once available, it would become the standard treatment for chronic hepatitis C. It is currently undergoing appraisal for this indication. Therefore stakeholders suggested that "Sofosbuvir in combination with ribavirin, with or without peginterferon alfa (subject to ongoing NICE appraisal)" should be added as a comparator in the scope. Stakeholders also commented that currently there is no treatment option for (maybe 10-15%) people who are interferon-intolerant (or unsuitable) and therefore best supportive care should be included as a comparator for these patients. It was noted that, if sofosbuvir in combination with ribavirin (that is, an interferon-free regimen) became established clinical practice it would be the preferred treatment option for this patient group and therefore best supportive care would no longer be needed as a comparator for this group of patients. Therefore, best supportive care should only be added as a comparator (if appropriate) once the outcome from the ongoing sofosbuvir appraisal is known.<br>The manufacturer commented that rapid viral response (RVR) is a surrogate outcome that predicts sustained virological response (SVR) in patients receiving interferon based | | |

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| | therapies. RVR is used to guide the duration of interferon based therapies and clinical utility of RVR in interferon free therapies has not been established, therefore it is not an appropriate outcome to include for this topic. Clinical specialists also agreed that RVR is not an appropriate endpoint, because unlike interferon based therapies, sofosbuvir-ledipasvir therapy would not be a response guided therapy (meaning that the duration of treatment would not depend upon the virological response at week 4); therefore 'Rapid virological response' has been removed as an outcome from the scope.<br><br>Stakeholders are aware of the recent NHS England clinical commissioning policy statement, which outlines an interim funding arrangement for sofosbuvir (in combination with daclatasvir or ledipasvir) for treating patients with chronic hepatitis C (irrespective of genotype) with a significant risk of death or irreversible liver damage within the next 12 months. They noted that this interim funding was available only for a small number of patients with very severe disease (approximately 500) and would not cover the whole licensed population of sofosbuvir-ledipasvir. In addition, the commissioning policy is only considered to be an interim arrangement until final guidance is issued by NICE. Therefore, stakeholders considered that an STA was the most appropriate process to consider this topic. |
| **Population size** | The most recent national estimates (2012) suggest that approximately 160,000 people are chronically infected with HCV in England. Most of this infection is due to genotype 1 (46%) and 3 HCV (43%). Genotypes 2, 4, 5 and 6 HCV constitute the remaining 11% of cases. |
| **Process (MTA/STA/HST)** | STA |
| **Proposed changes to remit (in bold)** | To appraise the clinical and cost of sofosbuvir-ledipasvir within its licensed indication for treating ~~**genotype 1**~~ chronic hepatitis C. |
| **Costing implications of remit change** | ***CONFIDENTIAL INFORMATION REMOVED***<br><br>The estimated annual number of people with chronic hepatitis C eligible to receive treatment with sofosbuvir with ledipasvir is estimated to be at least 12300 people.<br>This is based on assumptions in the costing template for NICE TA252 and TA253 (Telaprevir for the treatment of genotype 1 chronic hepatitis C and Boceprevir for the treatment of genotype 1 chronic hepatitis C). It is estimated that there are 3 groups of patients who make up the eligible population: around 7100 people who are treatment-experienced and either did not achieve a sustained virological response, or have become reinfected; around 3200 people who are already diagnosed and have chosen not to receive treatment, and are waiting for new treatment options; and around 2000 newly diagnosed people each year. ***CONFIDENTIAL INFORMATION REMOVED*** |

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| | The unit cost of the sofosbuvir-ledipasvir is unknown but is likely to be significant. The cost of other treatment options vary significantly but may be as high as around £70,000 (24 week course of sofosbuvir alone) or around £22,400 (telaprevir/boceprevir) per person. There may also be some savings from avoiding the use of interferon with new treatment regimens. The large eligible population suggests a potential for the topic to be high cost. However, the unknown drug cost, the unknown number of people who may switch from current treatments and the variation in the cost of comparators means that the cost impact cannot be estimated from the information available. |
| **Timeliness statement** | Assuming that 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. |

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| **Provisional Title** | Ofatumumab for the maintenance treatment of relapsed chronic lymphocytic leukaemia | | |
| **Topic Selection ID Number** | 5976 | **Wave / Round** | R63 |
| **TA ID Number** | 662 | | |
| **Manufacturer** | GlaxoSmithKline | | |
| **Anticipated licensing information** | ***CONFIDENTIAL INFORMATION REMOVED*** | | |
| **Draft remit** | To appraise the clinical and cost effectiveness of ofatumumab within its licensed indication for the maintenance treatment of relapsed chronic lymphocytic leukaemia. | | |
| **Main points from consultation** | Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of ofatumumab for the maintenance treatment of relapsed chronic lymphocytic leukaemia is appropriate.<br><br>The proposed remit is appropriate. No changes are required.<br><br>Stakeholders discussed whether the population in the scope should be clarified to specify the previous treatment that people had received before ofatumumab maintenance is administered. Clinical specialists considered that the effectiveness of ofatumumab maintenance treatment could be influenced by prior treatment (that is, the treatment received immediately before ofatumumab maintenance treatment). They heard from the manufacturer that the pivotal trial included people who had responded to either second- or third-line treatments, but that specific prior treatment regimens were not outlined in the trial inclusion/exclusion criteria, and were unlikely to be stipulated in the marketing authorisation for ofatumumab. Stakeholders agreed that prior treatments received before ofatumumab maintenance did not need to be specified in the population, but the impact of prior treatments on the clinical effectiveness of ofatumumab should be considered, if the evidence allows.<br><br>Stakeholders also discussed whether 'response' to previous treatment needed to be specified in the population. They heard from clinical specialists that the effectiveness of ofatumumab maintenance treatment would depend upon the initial level of response, as that would be the level of response that the treatment would be aiming to maintain. They understood that response (partial or complete) was an inclusion criterion for the pivotal trial and therefore suggested that the population in the scope should only include people whose disease had responded to previous treatment. The population in the scope has been amended to "People with relapsed chronic lymphocytic leukaemia whose relapsed disease has responded to second-line or subsequent treatment".<br><br>Stakeholders discussed whether stem cell transplant should be included as a comparator. They heard from a clinical specialist that of their ~400 patients, only 5 had received a stem cell transplant, and that overall the procedure is rarely used in | | |

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| | clinical practice. Stakeholders therefore agreed that stem cell transplants are not established clinical practice for CLL and therefore should not be included as a comparator. No changes to the comparators in the scope have been made.<br><br>Stakeholders noted that an appraisal of ofatumumab for the first line treatment of CLL is due to begin soon, and that existing guidance (technology appraisal 202 - Ofatumumab for the treatment of chronic lymphocytic leukaemia refractory to fludarabine and alemtuzumab) will be considered for review once an ongoing clinical trial is completed. Stakeholders discussed whether an MTA that considered ofatumumab for treating CLL in the first line, second line and maintenance treatment settings would be appropriate, but noted that in order to produce timely guidance on use in the maintenance setting, this appraisal should proceed as an STA. |
| **Population size** | There were around 3000 cases of CLL diagnosed in England in 2010. Around 67% of people with CLL in England would be expected to need immediate or eventual treatment for CLL. |
| **Process (MTA/STA/HST)** | STA |
| **Proposed changes to remit (in bold)** | None |
| **Costing implications of remit change** | Updated to take into account more recent data on the number of annual cases of CLL in England:<br><br>There were around 3000 new diagnoses of lymphocytic leukaemia in England in 2010. It is estimated that around two thirds (2000) are likely to need immediate or eventual treatment. Most patients receive a number of different types of treatment during the course of their disease. It is not known what proportion of patients respond to second- or third-line chemotherapy. Given that there is no cure for CLL, it is assumed that all patients will relapse at some point. Therefore it is assumed that up to 2000 people may be eligible to receive ofatumumab each year.<br><br>The briefing note states that the drug cost is not yet known for this indication, however based on the cost for its current licensed indication, it is estimated that the drug cost per person could be up to £24,000. The cost of administration will depend on whether ofatumumab can be given at the same time as current treatment. If treatment is given separately, administration costs could be up to £1,500 per person. This gives a total potential incremental cost impact of up to £51 million per year. The number of people who may choose to receive this technology is unknown but it is anticipated that this topic could be high cost. |
| **Timeliness statement** | Assuming that 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 |

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| | this technology will be possible. |

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| **Provisional Title** | Naltrexone-bupropion (prolonged release) for treating obesity and overweight | | |
| **Topic Selection ID Number** | 7141 | **Wave / Round** | R90 |
| **TA ID Number** | 757 | | |
| **Manufacturer** | Orexigen | | |
| **Anticipated licensing information** | ***CONFIDENTIAL INFORMATION REMOVED*** | | |
| **Draft remit** | To appraise the clinical and cost effectiveness of naltrexone-bupropion prolonged release within its licensed indication for treating adults who are overweight or obese**.** | | |
| **Main points from consultation** | Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of naltrexone-bupropion (prolonged release) for treating obesity and overweight is appropriate.<br><br>The proposed remit should be amended to highlight the importance of dietary and physical activity modifications in the management of obesity as follows: 'To appraise the clinical and cost effectiveness of naltrexone-bupropion prolonged release within its licensed indication, in addition to diet and physical activity, for the management of people with obesity or overweight with risk factors.'<br><br>The intervention in the scope should be amended to 'naltrexone-bupropion in addition to dietary, physical activity and behavioural modifications'.<br><br>The population has been amended to 'adults who are overweight with 1 or more comorbidities or obese' in order to include people who are obese but do not have any comorbidities.<br><br>Stakeholders agreed that only the high dose of orlistat is an appropriate comparator because low dose orlistat is not indicated in people who are obese. They also agreed that diet, physical activity and behavioural changes (including tier 3 interventions - that is specialist weight management services) and bariatric surgery should be included as comparators.<br><br>Stakeholders agreed that 'mortality', 'change in waist circumference' and 'maintenance of weight change' should be added to the list of outcomes. | | |
| **Population size** | The potential population is large, bearing in mind that 62% of adults in England are overweight or obese. | | |
| **Process (MTA/STA/HST)** | **STA** | | |
| **Proposed changes to remit (in bold)** | To appraise the clinical and cost effectiveness of naltrexone-bupropion prolonged release within its licensed indication**, in addition to diet and physical activity,** for **the management** of **people with obesity or overweight with risk factors**. | | |

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| **Costing implications of remit change** | Updated text to reflect change in remit:<br><br>The target group is for this drug is people who are obese (BMI ≥30kg/m2) or overweight (BMI ≥27kg/m2) with one or more risk factors - in combination with diet and physical activity. While around 11 million adults in England have a BMI of 30 or over, the population likely to be treated with naltrexone and bupropion will be those who present to their GP for treatment, in which case it will be an additional treatment option along with current options such as dietary advice, behavioural interventions, pharmacological therapy and surgery. Over 4.6 million people over the age of 16 years were registered as obese in primary care registers between April 2010 and March 2011. Although the cost of the new technology is unknown at present, given the large potential eligible population, it is possible this topic could be high cost.<br><br>Treatment will represent an additional drug cost, but savings could be possible due to the treatment of the comorbidities of obesity. |
| **Timeliness statement** | ***CONFIDENTIAL INFORMATION REMOVED***<br>issuing timely guidance for this technology will be possible. |

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| **Provisional Title** | Ceritinib for previously treated anaplastic lymphoma kinase-positive non-small-cell lung cancer | | |
| **Topic Selection ID Number** | 6667 | **Wave / Round** | R67 |
| **TA ID Number** | 729 | | |
| **Manufacturer** | Novartis | | |
| **Anticipated licensing information** | ***CONFIDENTIAL INFORMATION REMOVED*** | | |
| **Draft remit** | To appraise the clinical and cost effectiveness of ceritinib within its licensed indication for previously treated anaplastic lymphoma kinase-positive 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 ceritinib for previously treated anaplastic lymphoma kinase-positive non-small-cell lung cancer is appropriate.<br><br>The proposed remit is appropriate. No changes are required.<br><br>The manufacturer indicated that there is uncertainty regarding the stage in therapy at which ceritinib will receive its marketing authorisation, as it may be positioned after chemotherapy (second line) or after chemotherapy and crizotinib (third line). Because of this, scoping workshop attendees agreed that the remit and the population in the scope should be kept broad to encompass all the potential licensed indications for ceritinib. Scoping workshop attendees agreed that no changes were needed to the remit or the population in the scope.<br><br>No other changes to the scope were requested by the stakeholders. | | |
| **Population size** | Approximately 700 patients in England with ALK-positive non-small-cell lung cancer may be eligible for second-line treatment. | | |
| **Process (MTA/STA/HST)** | STA | | |
| **Proposed changes to remit (in bold)** | None | | |
| **Costing implications of remit change** | Updated for technology name and that crizotinib was not recommended by NICE (TA296):<br><br>The incidence of lung cancer in England is estimated to give around 34,000 new diagnoses per year. Non-small cell lung cancer (NSCLC) accounts for 85% (approximately 29,000) of all lung cancers. It is estimated that around 4.5% (1300) of NSCLC patients have EML4-ALK positive tumours. Using the manufacturer submission for another topic, Lung cancer (non-small-cell, anaplastic lymphoma kinase fusion gene, previously treated) – crizotinib, it is estimated that around 80% (1000) will receive first line treatment. Of these, around 70% may go on to receive a second line treatment. It is assumed that this may be | | |

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| | the eligible population: around 700 people.<br><br>The unit cost of ceritinib is not yet known. If licensed, it would provide an additional treatment option for this patient group that has not responded to prior treatment. Ceritinib is taken orally once daily. It is not known how many people would switch from other treatments but it would need to have an incremental cost of around £21,000 per person per year to be high cost. The cost impact of this technology cannot be estimated with the data available. |
| **Timeliness statement** | Assuming that 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. |

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| **Provisional Title** | Panobinostat for treating multiple myeloma in people who have received at least 1 prior therapy | | |
| **Topic Selection ID Number** | 6147 | **Wave / Round** | R27 |
| **TA ID Number** | 663 | | |
| **Manufacturer** | Novartis Pharmaceuticals UK | | |
| **Anticipated licensing information** | ***CONFIDENTIAL INFORMATION REMOVED*** | | |
| **Draft remit** | To appraise the clinical and cost effectiveness of panobinostat within its licensed indication for treating relapsed and refractory multiple myeloma previously treated with bortezomib. | | |
| **Main points from consultation** | Following the consultation exercise and the scoping workshop, the Institute is of the opinion that an appraisal of panobinostat for treating multiple myeloma previously treated with at least one prior therapy is appropriate.<br><br>The proposed remit is not appropriate and should be amended to reflect the population included in the clinical trials and the anticipated marketing authorisation. Attendees at the scoping workshop highlighted the importance of not restricting the population to patients who had previously received bortezomib but instead to patients who had previously received at least 1 prior therapy. The manufacturer confirmed that the majority of patients in the pivotal (PANORMA-1) trial had not received prior treatment with bortezomib. In light of these comments, the draft remit has been amended to: 'To appraise the clinical and cost effectiveness of panobinostat within its licensed indication for treating multiple myeloma in people who have received at least 1 prior therapy'. The title and population in the scope have also been amended to align with the remit.<br><br>Clinical specialists at the scoping workshop confirmed that bortezomib plus dexamethasone is the most common treatment for relapsed disease. Consultees noted that although panobinostat will be used as an add-on treatment to bortezomib and dexamethasone, it is expected that it would replace standard treatment with bortezomib and dexamethasone alone. Therefore, it was agreed that bortezomib plus dexamethasone should be included as a comparator in the scope. The clinical specialists also suggested that lenalidomide plus dexamethasone should also be included as a comparator. It was noted that this treatment combination is currently used in clinical practice in line with NICE Guidance (TA171) in people who have received 2 or more prior therapies. However, this guidance is currently under review and therefore use earlier in the treatment pathway may occur once the review is completed. It is also currently available through the Cancer Drugs Fund earlier in the treatment pathway. The scope has been amended to include bortezomib plus dexamethasone, and lenalidomide plus dexamethasone as comparators. | | |
| **Population size** | In 2011, 4039 people were diagnosed with multiple myeloma in England. The proportion of people with relapsed and/or refractory disease after at least 1 prior therapy is unknown. | | |

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| **Process (MTA/STA/HST)** | STA |
| **Proposed changes to remit (in bold)** | To appraise the clinical and cost effectiveness of panobinostat within its licensed indication for treating ~~**relapsed refractory**~~ multiple myeloma in people **who have received at least 1 prior therapy**. |
| **Costing implications of remit change** | Cost impact comments unchanged as a result of change in remit, eligible population updated to reflect updated incidence figure:<br><br>It is estimated that around 1600 people are treated for multiple myeloma each year after 1 prior therapy and could be eligible for treatment with panobinostat. It is administered orally as part of a 21 day cycle in combination with bortezomib and dexamethosone, which is a current treatment option.<br><br>If licensed, panobinostat may offer an additional treatment option in patients with multiple myeloma who have relapsed following initial therapy. The cost of panobinostat is not known. The topic would be high cost if the incremental cost per person was around £9,500 per year. It is not known how many people would switch to this treatment option, what offsetting savings there would be or the cost. The cost impact cannot currently therefore be estimated. |
| **Timeliness statement** | Assuming that 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. |