NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Appraisal consultation document

Andexanet alfa for reversing anticoagulation from apixaban or rivaroxaban

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

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

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

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

Issue date: September 2020

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

After consultation:

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

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

The key dates for this appraisal are:

Closing date for comments: 2 October 2020

Second appraisal committee meeting: TBC

Details of membership of the appraisal committee are given in section 7.

1 Recommendations

1.1 Andexanet alfa is recommended as an option for reversing anticoagulation from apixaban or rivaroxaban in adults with life-threatening or uncontrolled bleeding, only if:

- the bleed is in the gastrointestinal tract and
- the company provides andexanet alfa according to the commercial arrangement (see section 2).

1.2 Andexanet alfa is recommended only in research for reversing anticoagulation from apixaban or rivaroxaban in adults with life-threatening or uncontrolled bleeding in the skull (intracranial haemorrhage).

Why the committee made these recommendations

Apixaban and rivaroxaban are anticoagulants used for preventing and treating thromboembolism (blood clots). They can increase the risk of major bleeding, which may be life-threatening. If someone has a major bleed the anticoagulation effects need to be reversed. Andexanet alfa aims to reverse the effects of apixaban and rivaroxaban, in case of uncontrolled or life-threatening bleeding.

There is no clinical trial evidence directly comparing andexanet alfa with an existing treatment, prothrombin complex concentrate, so an indirect comparison of 2 trials was done. This suggests that andexanet alfa improves survival in people with gastrointestinal bleeding or intracranial haemorrhage (ICH), but lowers survival for people with bleeds in other parts of the body. However, there are differences between the 2 trials in the indirect comparison, so the results are uncertain. Also, there is not enough evidence about whether it reduces long-term disability in ICH.

Because of the limitations of the clinical evidence, the cost-effectiveness estimates for andexanet alfa are uncertain. They are likely to be within what NICE considers a cost-effective use of NHS resources for gastrointestinal bleeding, but not for ICH or bleeds in other parts of the body. Therefore, andexanet alfa for reversing

anticoagulation is recommended only in gastrointestinal bleeding. It is recommended only in research in ICH.

2 Information about andexanet alfa

Marketing authorisation indication

2.1 Andexanet alfa (Ondexxya, Portola Pharmaceuticals) has a conditional marketing authorisation for 'adult patients treated with a direct factor Xa (FXa) inhibitor (apixaban or rivaroxaban) when reversal of anticoagulation is needed due to life-threatening or uncontrolled bleeding'.

Dosage in the marketing authorisation

2.2 The dosage schedule is available in the summary of product characteristics.

Price

2.3 The list price for andexanet alfa is £11,100 per 4-vial pack of 200 mg of powder for solution for infusion (excluding VAT, BNF online accessed March 2020). The average cost of a course of treatment at list price is £15,000 per patient.

2.4 The company has a commercial arrangement (simple discount patient access scheme). This makes andexanet alfa 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 appraisal committee (section 7) considered evidence submitted by Portola Pharmaceuticals, a review of this submission by the evidence review group (ERG), NICE's technical report, and responses from stakeholders. See the committee papers for full details of the evidence.

In March 2020 the appraisal committee decided not to recommend andexanet alfa within its marketing authorisation. In June 2020 the committee discussed the following issues, some of which were new issues that were not included in the first appraisal consultation document.

Treatment pathway and clinical need

Direct anticoagulants are associated with a serious risk of major bleeding

3.1 Direct anticoagulants such as apixaban and rivaroxaban are used for preventing and treating thromboembolism in conditions such as deep vein thrombosis and pulmonary embolism, and for preventing stroke and systemic embolism in people with non-valvular atrial fibrillation. Although anticoagulants have a greater overall benefit than risk, major bleeding is a serious risk. People with a major bleed are at an increased risk of death and an increased risk of subsequent thrombotic events when coagulation is interrupted. The patient experts explained that thrombotic events can have a substantial physical and psychological effect on people's lives. Treatment for a thrombosis can affect employment, family planning, travel and social life. Also, many people fear having further blood clots. Anticoagulants therefore are of benefit to people, but they increase the risk of a major bleeding event. The committee concluded that direct anticoagulants are associated with a risk of major bleeding events.

There is a clinical need for effective anticoagulation reversal agents

3.2 The patient experts explained that anticoagulation treatments are accepted by people because they are lifesaving, but there are concerns about safely managing anticoagulation should a major bleed occur. If bleeding is life-threatening then anticoagulation needs to be reversed. Treatment is challenging if there is no reversal agent and relies on treating symptoms until the effects of the anticoagulant stop, in line with the normal half-life of the drug. The patient experts explained that there is an unmet need for a safe reversal agent for direct factor Xa anticoagulants such as apixaban and rivaroxaban. The committee concluded that the

availability of an effective reversal agent would be greatly valued by people and healthcare professionals.

Clinical need is increasing because of changes in clinical practice

3.3 The patient experts explained that the recently published NICE guideline on venous thromboembolic diseases recommends offering apixaban or rivaroxaban as first choice for anticoagulation, including for people with cancer-associated thrombosis. Also, NHS England's clinical guide for managing anticoagulation services has been updated considering the COVID-19 pandemic. This has resulted in more people starting or switching treatment to a direct oral anticoagulant. The patient experts explained that anxiety will be high because of COVID-19 and a reversal agent not being available would increase people's concerns. The committee concluded that because more people are having direct oral anticoagulants there is an increased need for a reversal agent.

Most relevant population

It is not appropriate to combine all bleed types for decision making

3.4 The clinical evidence came from ANNEXA-4, a single-arm trial of andexanet alfa in people taking a direct factor Xa inhibitor who had an acute major bleed. Initially, the company submitted results for 3 groups: the whole trial population, a cohort of people with intracranial haemorrhage (ICH) and severe gastrointestinal (GI) bleeds, and a cohort of people with ICH alone. After technical engagement, the company also provided results for a cohort of people with severe GI bleeds alone. The clinical experts explained that different types of bleeds should be considered separately because their treatment and outcomes vary. The clinical experts explained that most GI bleeds can be managed using measures such as endoscopy, embolisation or surgery. The committee noted that ICH may occur within the brain tissue (intracerebral) or outside the brain (subdural or subarachnoid) and can lead to mortality and long-term disability. Treatment options are very limited for ICH, particularly if

the bleed is in the brain tissue. The effect of bleeding in other places in the body would vary considerably, depending on where the bleed occurred. For example, a bleed into the eye could lead to blindness in that eye. The committee concluded that different types of bleeds should be considered separately for decision making.

Clinical evidence

The evidence on clinical events was limited to 30-day mortality

3.5 The committee noted that the 2 primary outcomes in the trial were both haematological: change in 'anti-factor Xa activity' and haemostatic efficacy. The only outcome related to clinical events was the safety endpoint of 30-day mortality. However, the trial excluded all patients with an expected lifespan of less than 1 month. The clinical experts explained that in clinical practice all patients would be offered treatment, rather than only a selected group based on anticipated survival. Therefore, the generalisability of the 30-day mortality data from ANNEXA-4 to routine NHS practice is questionable. In their response to technical engagement, the clinical experts questioned the definitions of haemostatic efficacy in relation to intracerebral haemorrhage. They considered that haemostatic efficacy as defined in the trial could not be considered predictive of clinical outcomes. The clinical expert explained that ICH types are heterogenous and have different management strategies and outcomes. They noted that outcomes following intracerebral haemorrhage are related to bleed volume. A large bleed volume at first presentation is a poor prognostic sign, and patients with large bleeds were excluded from ANNEXA-4. Not all bleeds enlarge, and it is difficult to say that a haematoma growth of less than 35% for intracerebral haemorrhage can be considered a positive outcome or a good haemostatic efficacy as defined in the trial. The committee concluded that the clinical evidence available for andexanet alfa was limited to only 30-day mortality in a trial that had several potentially relevant exclusion criteria.

There is no evidence directly comparing andexanet alfa with prothrombin complex concentrate and the indirect comparison has limitations

3.6 Because ANNEXA-4 is a single-arm trial there is no direct evidence for the efficacy of andexanet alfa compared with other treatments, which added to the uncertainty about its benefit in clinical practice. The company used data for prothrombin complex concentrate (PCC) from the ORANGE study to do an indirect treatment comparison. ORANGE was a UK observational study in people taking anticoagulants who were admitted to hospital with a major bleed. In ANNEXA-4 people were excluded if survival was expected to be less than 1 month, they had a Glasgow Coma Score lower than 7 or an intracerebral bleed volume of more than 60 ml. However, these criteria were not used in ORANGE. The committee noted that this could affect the comparability of results for 30-day mortality. The company explained that the proportion of patients excluded based on the survival criterion was extremely low. However, the committee noted that some patients may not have been screened for inclusion if the clinicians considered that they were too ill to meet the criteria. The clinical experts pointed out that every patient with a life-threatening bleed should have been screened for inclusion unless they were on a known end-of-life pathway. The committee concluded that the evidence for andexanet alfa compared with PCC had limitations.

The indirect treatment comparison predicts a reduced 30-day mortality with andexanet alfa compared with PCC, but the results are uncertain

3.7 The company did a propensity score matching analysis to compare 30-day mortality rates from ANNEXA-4 and ORANGE. The results showed a reduced 30-day mortality with andexanet alfa compared with PCC for the GI cohort and the ICH cohort but not for the 'other major bleeds' cohort (pericardial, retroperitoneal, intraspinal and intraocular bleeds). The committee understood that important prognostic factors such as severity and volume of the bleed could not be included as covariates, because these were not collected in ORANGE. It also noted that 30-day mortality was a key driver of the economic model. The company explained that only

patients from ORANGE who had PCC were matched to patients in ANNEXA-4. The company assumed that patients who had PCC in ORANGE were a good proxy for those with more severe bleeds, because PCC is used off-label and would be reserved for more severely affected patients. The clinical experts explained that severity and volume of bleeds are the primary prognostic factors for bleed-related mortality. The committee considered that without key prognostic factors accounted for, the results of the propensity score matching analysis were uncertain. The committee also noted that for GI bleed, no comparative data were available on what other treatments people had in the 2 studies, particularly endoscopic therapy. The clinical experts explained that in the absence of a randomised controlled trial it was very difficult to reach any conclusion about the clinical benefit of andexanet alfa compared with PCC. The committee considered that the propensity score matching analysis predicted a reduced 30-day mortality for the GI cohort and the ICH cohort, but the results were uncertain.

Andexanet alfa is likely to reduce 30-day mortality for people with GI bleeds

3.8 The committee had concerns about the effect of andexanet alfa on 30-day mortality for GI bleeds, because the ANNEXA-4 trial excluded patients with an expected survival of less than 1 month. In its response to the first appraisal consultation document, the company submitted an analysis of in-hospital mortality results from a US multicentre real-world study of patients who had andexanet alfa within its licensed indication. The study did not exclude patients with an expected survival of less than 1 month, unlike ANNEXA-4. But the criteria for who had treatment in the study and what other treatments the patients had were not clear. The committee noted that in-hospital mortality in the real-world study was lower than in ANNEXA-4, even though an exclusion criterion based on expected survival was not applied. The committee considered that this potentially supported the generalisability of the trial outcomes to a broader population. The committee also considered the Rockall score submitted by the company for patients with GI bleeds in ANNEXA-4. The clinical

expert explained that the Rockall score is a validated predictor of mortality. In ANNEXA-4, patients had a lower mortality rate than predicted by the Rockall score, suggesting that andexanet alfa reduces mortality. The clinical expert noted that this data increased confidence about the benefit of andexanet alfa. The committee noted that the Rockall score was not developed in an anticoagulated population. However, it considered that the Rockall score submitted by the company was broadly supportive of andexanet alfa reducing 30-day mortality in patients with GI bleeds. Nevertheless, in the absence of any direct evidence, some uncertainties remain around the efficacy of andexanet alfa in GI bleeds. This is particularly because other treatments are available and andexanet alfa itself carries a risk of thrombosis. The clinical expert noted that andexanet alfa would be best used as part of a major GI bleed protocol, in line with its use in ANNEXA-4. The committee concluded that andexanet alfa is likely to reduce 30-day mortality for people with life-threatening or uncontrolled GI bleeds.

The extent that andexanet alfa reduces mortality in ICH is unclear

3.9 The indirect treatment comparison predicted that andexanet alfa reduces mortality in ICH. The committee considered this to be plausible. However, the size of the benefit was unclear. The committee was concerned by comments received at consultation from the British Association of Stroke Physicians, stating that it was unclear whether andexanet alfa improves 'very disabled survival in people who would otherwise die, or is improving the number of people with excellent recovery'. This uncertainty would make treatment decisions difficult and might involve discussions with relatives about whether to use andexanet alfa for ICH. The committee also noted that the European Stroke Organisation 2019 guideline on reversal of oral anticoagulants for ICH recommended early reversal 'using andexanet alfa if available'. However, it also recommended 'randomising into trials as based on the low quality of evidence' because 'there is significant uncertainty whether desirable outweigh undesirable effects'. The British Association of Stroke Physicians commented at consultation

that it was 'difficult to estimate any effect of this treatment on quality of life or recovery as the size of any beneficial treatment effect is unclear'. The committee considered that the aim of treatment is to improve survival with less risk of long-term disability. But the survival improvement may lead to people being alive but with severe disability. It noted that the marketing authorisation for andexanet alfa was conditional upon a randomised controlled trial being completed in people with ICH. This trial will collect relevant clinical outcome data rather than only 30-day mortality data as in ANNEXA-4, and it will record the thrombotic risk associated with the treatment. The committee concluded that it is uncertain whether andexanet alfa reduces mortality in ICH and additional data collection is needed on relevant clinical outcomes from a randomised controlled trial.

The benefit of andexanet alfa on long-term disability after an ICH is not supported by evidence

3.10 The company assumed that andexanet alfa would reduce the severity of long-term disability in people who had had an ICH, compared with PCC. This assumption had a large effect on the incremental cost-effectiveness ratio (ICER). Long-term disability after an ICH is assessed using modified Rankin scale (mRS) scores, and in the economic model these affected mortality risk, costs and utilities. The company used 2 different sources for mRS scores. For andexanet alfa, it used data from ANNEXA-4. For PCC it used data from Øie et al. (2018), a study that included patients with intracerebral haemorrhage only and excluded those with other intracranial bleeds. The ERG and the clinical experts explained that intracerebral haemorrhage is the most severe type of ICH and therefore the company's comparison overestimated the severity of disability and mRS scores for PCC. The committee noted that there was no direct evidence that people would have better mRS scores and less disability after andexanet alfa than PCC, and that the company's assumption was based on a naive comparison of data from ANNEXA-4 and Øie et al. The clinical experts noted that without evidence from a study, it was impossible to predict a benefit in long-term disability. The clinical expert explained that around

80% of people who survive an ICH are on the dependent scale of mRS (scores of 3 or higher) and that evidence would need to demonstrate a clear shift in mRS scores to prove an improvement in disability. No additional evidence on long-term disability was submitted by the company. The committee was concerned that andexanet alfa may keep people alive but not improve their recovery, leaving them with severe disability (see section 3.9). The committee concluded that a benefit from andexanet alfa on long-term disability was not shown in the evidence.

The evidence in 'other major bleeds' is too unreliable for decision making

3.11 The committee noted that the indirect treatment comparison results for 'other major bleeds' showed that 30-day mortality was worse with andexanet alfa than PCC. The committee appreciated that the analysis was done with a very small sample size, however it considered it would be unreasonable to ignore these results. The committee concluded that andexanet alfa reducing mortality in 'other major bleeds' had not been shown or quantified.

Cost effectiveness

The company's economic model is suitable for decision making

3.12 The company submitted a decision tree followed by a Markov model to estimate the cost effectiveness of andexanet alfa compared with PCC. The committee considered that the model was suitable for decision making.

The company's assumptions about 'other major bleeds' are not sufficiently justified

3.13 The propensity score matching analysis was based on a small number of patients for bleeds classified as 'other major bleeds' (pericardial, retroperitoneal, intraspinal and intraocular bleeds). The analysis results for these bleeds did not favour andexanet alfa compared with PCC, so the company considered it was counterintuitive and several assumptions were

made to model these bleeds. The company assumed that andexanet alfa would lead to a 25% relative reduction in mortality for pericardial and retroperitoneal bleeds, and it set the mortality to 0 for intraspinal and intraocular bleeds. The company also assumed that andexanet alfa would reduce paralysis and blindness by 25% after intraspinal and intraocular bleeds, which reduced the long-term management costs and improved the long-term utilities. These assumptions were based on clinical opinion only. The clinical experts explained that the evidence was too scarce to make assumptions of 25% relative reduction in mortality, paralysis and blindness and that the ERG's assumption of 0% relative reduction was more reasonable in the absence of robust evidence. The committee concluded that the company's assumptions were not supported by evidence.

The long-term outcomes and utilities after ICH are highly uncertain

3.14 The committee noted that there was no direct evidence that people who had an ICH had better long-term outcomes with andexanet alfa than if they had PCC (see section 3.10). Differences in mRS scores affected the long-term mortality risk, costs and utilities in the model. The long-term utility value for people who had an ICH in the PCC arm in the company's model was 0.61. This was obtained from a 3-month post-acute care utility value for people who had an ICH, which was used in NICE's guidance on apixaban for the treatment and secondary prevention of deep vein thrombosis and/or pulmonary embolism. The company calculated that andexanet alfa increased the long-term utility of people who had an ICH by 0.11 compared with PCC, based on the difference in mRS scores between ANNEXA-4 and Øie et al (2018). This resulted in a long-term utility of 0.72 after an ICH for people who had andexanet alfa. The ERG was concerned that a utility of 0.72 is not plausible because it is only 0.01 lower than the UK general population aged 75 and over. Also, the differences in long-term outcomes were driven by the naive comparison of mRS scores from ANNEXA-4 and Øie et al. The ERG's preferred scenario was to use the mRS scores from Øie et al. only in people who had an

intracerebral haemorrhage in ANNEXA-4, or alternatively to use the ANNEXA-4 mRS scores for both treatments (assuming no benefit in mRS scores). In its updated base case, the ERG's preferred scenario was to assume no benefit in morbidity and use the same mRS scores from the trial. The committee concluded that differences in the long-term outcomes and utilities for people after an ICH, depending on the treatment they had, are highly uncertain.

Cost-effectiveness estimates

Andexanet alfa is likely to be cost effective compared with PCC in GI bleeds

3.15 The committee considered the company's and ERG's ICERs for the GI cohort. Despite the uncertainty, the committee concluded that ICERs for the GI cohort are likely to be within what NICE considers a cost-effective use of NHS resources, in a population similar to the trial population.

Andexanet alfa has not been shown to be cost effective compared with PCC in ICH

3.16 The committee noted that there was heterogeneity in the ICH cohort and that the extent of clinical benefit for ICH was uncertain. Therefore, the most plausible ICERs for ICH were uncertain. The company's ICER was within the range NICE normally considers a cost-effective use of NHS resources. However, the committee had concerns about the methods and assumptions used in the model, particularly the assumption of a benefit from andexanet alfa on long-term disability after an ICH that had not been adequately justified or evidenced. The committee was concerned that it was unclear if people who had andexanet alfa would make a good recovery, or whether they would be severely disabled. The committee considered the ERG's updated base case for the ICH cohort, which resulted in a higher ICER. Therefore, the committee was not confident that the results for ICH were robust. It recognised the need for an effective reversal agent for direct factor Xa inhibitors, such as apixaban and rivaroxaban, in people with uncontrolled or life-threatening ICH. However,

it was not convinced that andexanet alfa had been shown to be a cost-effective use of NHS resources for ICH.

Andexanet alfa has not been shown to be cost effective compared with PCC for 'other major bleeds'

3.17 The committee noted that the indirect treatment comparison for 'other major bleeds' showed that mortality was worse with andexanet alfa than PCC. Also, the company's assumptions on a potential morbidity benefit were not supported by evidence. Therefore, the committee considered that the ICERs for 'other major bleeds' were very uncertain and that andexanet alfa had not been shown to be a cost-effective use of NHS resources for 'other major bleeds'.

Other considerations

Equalities

3.18 The committee noted an equality concern. Some people do not accept blood products, so would be unable to have PCC. The committee noted that PCC is not an established treatment for reversing anticoagulation with apixaban or rivaroxaban. The committee also noted that the company used data from people who had PCC in the ORANGE study for its indirect treatment comparison. This was because this group was thought to better represent the population who would have andexanet alfa, not because of an expectation that all people with life-threatening or uncontrolled bleeds would have PCC. The committee concluded that uncertainty about the effectiveness of andexanet alfa applied equally to people who would not have PCC, therefore there was no need to alter its recommendation.

Conclusion

Andexanet alfa is recommended for reversing anticoagulation in life-threatening or uncontrolled bleeding in GI bleeds

3.19 Andexanet alfa is likely to reduce 30-day mortality for people with GI bleeds. Despite the uncertainty, the committee concluded that the ICER

for the GI cohort is likely to be within what NICE considers a cost-effective use of NHS resources. Therefore, it concluded that andexanet alfa is recommended in GI bleeds as defined in the ANNEXA-4 trial and used as part of a major GI bleed protocol.

Andexanet alfa is recommended only in research for reversing anticoagulation in life-threatening or uncontrolled bleeding in ICH bleeds

3.20 The extent of benefits in terms of mortality and long-term disability from andexanet alfa in ICH are unclear and the committee was not confident that the cost-effectiveness results for ICH were robust. There is a need for an effective reversal agent for direct factor Xa inhibitors, such as apixaban and rivaroxaban, in people with uncontrolled or life-threatening bleeding in ICH. However, the committee was not convinced that andexanet alfa had been shown to be a cost-effective use of NHS resources in ICH. Therefore, andexanet alfa should be used only in research in ICH.

Andexanet alfa is not recommended for reversing anticoagulation in life-threatening or uncontrolled bleeding in 'other major bleeds'

3.21 The potential benefits of andexanet alfa in the 'other major bleeds' cohort were not supported by evidence and the cost-effectiveness estimates were very uncertain. Therefore, andexanet alfa is not recommended for reversing anticoagulation in life-threatening or uncontrolled bleeding in 'other major bleeds'.

4 Implementation

4.1 Section 7(6) of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 requires clinical commissioning groups, NHS England and, with respect to their public health functions, local authorities to comply with the recommendations in this appraisal within 3 months of its date of publication.

4.2 The Welsh ministers have issued directions to the NHS in Wales on implementing NICE technology appraisal guidance. When a NICE technology appraisal 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 appraisal document.

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 a life-threatening or uncontrolled gastrointestinal bleed and the doctor responsible for their care thinks that andexanet alfa is the right treatment, it should be available for use, in line with NICE's recommendations.

5 Recommendations for research

5.1 The committee noted an ongoing randomised controlled trial of the effectiveness of andexanet alfa compared with prothrombin complex concentrate in people with ICH. The main outcomes of interest are mortality, long-term disability and the risk of thromboses and thromboembolic events.

6 Proposed date for review of guidance

6.1 NICE proposes that the guidance on this technology is considered for review by the guidance executive when the results are available from the randomised controlled trial of andexanet alfa compared with prothrombin complex concentrate in intracranial haemorrhage. The results are anticipated in 2023. NICE welcomes comment on this proposed date. The guidance executive will decide whether the technology should be reviewed based on information gathered by NICE, and in consultation with consultees and commentators.

Jane Adam
Chair, appraisal committee
June 2020

7 Appraisal committee members and NICE project team

Appraisal committee members

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

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

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

NICE project team

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

Caroline Bregman
Technical lead

Rufaro Kausi
Technical adviser

Thomas Feist
Project manager

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