Appendix G -Professional organisation statement template

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Single Technology Appraisal (STA)

Aflibercept solution for injection for the first line treatment of wet age-related macular degeneration (AMD) [ID519]

Thank you for agreeing to give us a statement on your organisation's view of the technology and the way it should be used in the NHS.

Healthcare professionals can provide a unique perspective on the technology within the context of current clinical practice which is not typically available from the published literature.

To help you in making your statement, we have provided a template. The questions are there as prompts to guide you. It is not essential that you answer all of them.

Please do not exceed the 8-page limit.

About you

Your name: Sobha Sivaprasad

Name of your organisation: The Royal College of Ophthalmologists

Are you (tick all that apply):

- a specialist in the treatment of people with the condition for which NICE is considering this technology?

Yes

- a specialist in the clinical evidence base that is to support the technology (e.g. involved in clinical trials for the technology)?

Yes

- an employee of a healthcare professional organisation that represents clinicians treating the condition for which NICE is considering the technology? If so, what is your position in the organisation where appropriate (e.g. policy officer, trustee, member etc)?

RCOphth

- other? (please specify)

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Single Technology Appraisal (STA)

Aflibercept solution for injection for the first line treatment of wet age-related macular degeneration (AMD) [ID519]

What is the expected place of the technology in current practice?

How is the condition currently treated in the NHS? Is there significant geographical variation in current practice? Are there differences of opinion between professionals as to what current practice should be? What are the current alternatives (if any) to the technology, and what are their respective advantages and disadvantages?

Are there any subgroups of patients with the condition who have a different prognosis from the typical patient? Are there differences in the capacity of different subgroups to benefit from or to be put at risk by the technology?

In what setting should/could the technology be used – for example, primary or secondary care, specialist clinics? Would there be any requirements for additional professional input (for example, community care, specialist nursing, other healthcare professionals)?

If the technology is already available, is there variation in how it is being used in the NHS? Is it always used within its licensed indications? If not, under what circumstances does this occur?

Please tell us about any relevant **clinical guidelines** and comment on the appropriateness of the methodology used in developing the guideline and the specific evidence that underpinned the various recommendations.

Wet age related macular degeneration is now treated with intravitreal ranibizumab based on NICE technology appraisal guidance TA155. The RCOphth has issued clinical guidelines on the service pathway. All NHS trusts have this service with the exception of very few trusts where intravitreal bevacizumab is used. In the private practice, both intravitreal ranibizumab and bevacizumab are used based on economic considerations. Although non-inferiority studies on bevacizumab and ranibizumab have shown that both drugs are non-inferior, there are several unanswered questions on indemnity, safety, dosing, and quality control of bevacizumab. However, a more important issue is that studies on both these drugs show that patients should be followed up 4 weekly and treated aggressively to obtain optimal results. There are very few NHS trusts who can manage patients at such regular intervals and so appointments are on an average delayed to 6-8 weeks and so the treatment is delayed too. Audits on ranibizumab therapy from several departments in UK suggest that our current treatment regimen is inadequate and so the visual outcomes are inferior to clinical trial outcome data. So this drug. Aflibercept has come in at the time when most trusts are struggling with capacity to manage AMD patients. Ranibizumab is also approved for diabetic macular oedema (DMO) and all trusts need to resource double the existing capacity for AMD to manage both AMD and DMO. 8 weekly dosing of aflibercept is non-inferior to 4 weekly dosing of ranibizumab which means that we can half the capacity issues of providing appointments for patients already on ranibizumab. Secondly, the fixed dosing of aflibercept in the first year will ensure that all patients get the maximal treatment

rather than the PRN physician guided treatment option for ranibizumab. The first year of treatment is crucial.
All services are already resourced for ranibizumab although most are under-resourced. The aflibercept service would not need any further resources and in fact, should allow for saving on resources and allow us to use some of our current AMD resources to DMO when ranibizumab services are initiated for DMO. The services are run in specialist medical retina clinics in secondary care.

The advantages and disadvantages of the technology

NICE is particularly interested in your views on how the technology, when it becomes available, will compare with current alternatives used in the UK. Will the technology be easier or more difficult to use, and are there any practical implications (for example, concomitant treatments, other additional clinical requirements, patient acceptability/ease of use or the need for additional tests) surrounding its future use?

If appropriate, please give your view on the nature of any rules, informal or formal, for starting and stopping the use of the technology; this might include any requirements for additional testing to identify appropriate subgroups for treatment or to assess response and the potential for discontinuation.

If you are familiar with the evidence base for the technology, please comment on whether the use of the technology under clinical trial conditions reflects that observed in clinical practice. Do the circumstances in which the trials were conducted reflect current UK practice, and if not, how could the results be extrapolated to a UK setting? What, in your view, are the most important outcomes, and were they measured in the trials? If surrogate measures of outcome were used, do they adequately predict long-term outcomes?

What is the relative significance of any side effects or adverse reactions? In what ways do these affect the management of the condition and the patient's quality of life? Are there any adverse effects that were not apparent in clinical trials but have come to light subsequently during routine clinical practice?

The technology will be easier to deliver compared to existing ranibizumab services as stated above.
OCT will be used as in ranibizumab but less often as the dosing is 8 weekly.
The clinical trials are well-designed and answers the question on non-inferiority of aflibercept compared to ranibizumab both in terms of efficacy and OCT thickness. There has been no differences in safety issues.
Treatment regimens in the clinical trials (VIEW studies) were based on fixed dosing in the first year followed by PRN dosing in the second year. This is different to current NHS ranibizumab service which is based on 3 loading dose followed by PRN OCT-guided re-treatment. However, the VIEW clinical trials are no different to the ranibizmab trials that were used for TA155 that also used monthly dosing (MARINA and ANCHOR and in fact mirrors real-life well in the second year data where PRN dosing is advocated. I feel that the fixed 8 weekly dosing in the first year will give the

maximum benefit to the patients compared to the present 3+PRN dosing. The number of injections in either regimen should be approximately the same although UK data suggest that we give less number of ranibizumab injections. But this is reflected on the suboptimal visual outcome too. The safety profile of aflibercept is no different to ranibizumab based on reports to date.

Any additional sources of evidence

Can you provide information about any relevant evidence that might not be found by a technology-focused systematic review of the available trial evidence? This could be information on recent and informal unpublished evidence, or information from registries and other nationally coordinated clinical audits. Any such information must include sufficient detail to allow a judgement to be made as to the quality of the evidence and to allow potential sources of bias to be determined.

Novartis is collating data from a few UK departments and the results should be published in EYE in March-April supplement issue.

Medisoft audit on nearly 100,000 ranibizumab injections is also being collated and sponsored by Novartis.

LUMINOUS study is an international study on real-life outcome and safety data on ranibizumab also sponsored by Novartis.

Implementation issues

The NHS is required by the Department of Health and the Welsh Assembly Government to provide funding and resources for medicines and treatments that have been recommended by NICE technology appraisal guidance. This provision has to be made within 3 months from the date of publication of the guidance.

If the technology is unlikely to be available in sufficient quantity, or the staff and facilities to fulfil the general nature of the guidance cannot be put in place within 3 months, NICE may advise the Department of Health and the Welsh Assembly Government to vary this direction.

Please note that NICE cannot suggest such a variation on the basis of budgetary constraints alone.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Single Technology Appraisal (STA)

Aflibercept solution for injection for the first line treatment of wet age-related macular degeneration (AMD) [ID519]

How would possible NICE guidance on this technology affect the delivery of care for patients with this condition? Would NHS staff need extra education and training? Would any additional resources be required (for example, facilities or equipment)?

The NICE guidance on Aflibercept will reduce the capacity issues with ranibizumab for AMD. Indirectly, it will also allow the NHS trusts to roll out the ranibizumab in DMO service. No extra staffing, education or training is required.

Equality

NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that this appraisal:

- could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which [the treatment(s)] is/are/will be licensed;
- could lead to recommendations that have a different impact on people protected by the equality legislation than on the wider population, e.g. by making it more difficult in practice for a specific group to access the technology;
- could lead to recommendations that have any adverse impact on people with a particular disability or disabilities.

Please tell us what evidence should be obtained to enable the Committee to identify and consider such impacts.

NONE as far as I am aware