NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Technology appraisals

Patient access scheme submission template

October 2009

1 Introduction

The 2009 Pharmaceutical Price Regulation Scheme (PPRS) (www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Pharmaceuticalpriceregulationscheme/2009PPRS) is a non-contractual scheme between the Department of Health and the Association of the British Pharmaceutical Industry. The purpose of the 2009 PPRS is to ensure that safe and cost-effective medicines are available on reasonable terms to the NHS in England and Wales. One of the features of the 2009 PPRS is to improve patients' access to medicines at prices that better reflect their value through patient access schemes.

Patient access schemes are arrangements which may be used on an exceptional basis for the acquisition of medicines for the NHS in England and Wales. Patient access schemes propose either a discount or rebate that may be linked to the number, type or response of patients, or a change in the list price of a medicine linked to the collection of new evidence (outcomes). These schemes help to improve the cost effectiveness of a medicine and therefore allow the National Institute for Health and Clinical Excellence (NICE) to recommend treatments which it would otherwise not have found to be cost effective. More information on the framework for patient access schemes is provided in the 2009 PPRS (www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Pharmaceuticalpriceregulationscheme/2009PPRS.

Patient access schemes are proposed by a pharmaceutical company and agreed with the Department of Health, with input from the Patient Access Schemes Liaison Unit (PASLU) within the Centre for Health Technology Evaluation at NICE.

2 Instructions for manufacturers and sponsors

This document is the patient access scheme submission template for technology appraisals. If manufacturers and sponsors want the National Institute for Health and Clinical Excellence (NICE) to consider a patient access scheme as part of a technology appraisal, they should use this template. NICE can only consider a patient access scheme after formal referral from the Department of Health.

The template contains the information NICE requires to assess the impact of a patient access scheme on the clinical and cost effectiveness of a technology, in the context of a technology appraisal, and explains the way in which background information (evidence) should be presented. If you are unable to follow this format, you must state your reasons clearly. You should insert 'N/A' against sections that you do not consider relevant, and give a reason for this response.

Please refer to the following documents when completing the template:

- 'Guide to the methods of technology appraisal' (www.nice.org.uk/aboutnice/howwework/devnicetech/technologyappraisalprocessguides/guidetothemethodsoftechnologyappraisal.jsp)
- 'Specification for manufacturer/sponsor submission of evidence' (http://www.nice.org.uk/aboutnice/howwework/devnicetech/singletechnologyappraisalsubmissiontemplates.jsp) and
- Pharmaceutical Price Regulation Scheme 2009 (www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Pharmaceuticalpriceregulationscheme/2009PPRS).

For further details on the technology appraisal process, please see NICE's 'Guide to the single technology appraisal (STA) process' and 'Guide to the multiple technology appraisal (MTA) process' (http://www.nice.org.uk/aboutnice/howwework/devnicetech/technologyappraisalprocessguides/technology_appraisal_process_guides.jsp). The

‘Specification for manufacturer/sponsor submission of evidence’ provides details on disclosure of information and equality issues.

Make the submission as brief and informative as possible. Only mark information as confidential when absolutely necessary. Sufficient information must be publicly available for stakeholders to comment on the full content of the technology appraisal, including details of the proposed patient access scheme. Send submissions electronically to NICE in Word or a compatible format, not as a PDF file.

Appendices may be used to include additional information that is considered relevant to the submission. Do not include information in the appendices that has been requested in the template. Appendices should be clearly referenced in the main submission.

When making a patient access scheme submission, include:

- an updated version of the checklist of confidential information, if necessary
- an economic model with the patient access scheme incorporated, in accordance with the ‘Guide to the methods of technology appraisal’ (www.nice.org.uk/aboutnice/howwework/devnicetech/technologyappraisalprocessguides/guidetothemethodsoftechnologyappraisal.jsp).

If you are submitting the patient access scheme at the end of the appraisal process, you should update the economic model to reflect the assumptions that the Appraisal Committee considered to be most plausible. No other changes should be made to the model.

3 Details of the patient access scheme

3.1 Please give the name of the technology and the disease area to which the patient access scheme applies.

Table 1

Name of the technology:*	Aflibercept 40mg/ml solution for injection (Eylea)
Disease area for which the proposed patient access scheme applies:	Neovascular wet age-related macular degeneration (AMD)

3.2 Please outline the rationale for developing the patient access scheme.

To provide aflibercept solution for injection to the NHS in a more cost effective manner.

3.3 Please describe the type of patient access scheme, as defined by the PPRS.

The PAS is a commercially confidential discount on the list price of aflibercept 40mg/ml solution for injection (Eylea), reduced from the list price at market introduction of £816 plus VAT to a discounted confidential net price of £XXX plus VAT per vial.

3.4 Please provide specific details of the patient population to which the patient access scheme applies. Does the scheme apply to the whole licensed population or only to a specific subgroup (for example, type of tumour, location of tumour)? If so:

- How is the subgroup defined?
- If certain criteria have been used to select patients, why have these have been chosen?

- How are the criteria measured and why have the measures been chosen?

The patient access scheme applies to aflibercept solution for injection for the treatment of all adults with neovascular wet age-related macular degeneration (AMD).

3.5 Please provide details of when the scheme will apply to the population specified in 3.4. Is the scheme dependent on certain criteria, for example, degree of response, response by a certain time point, number of injections? If so:

- Why have the criteria been chosen?
- How are the criteria measured and why have the measures been chosen.

The patient access scheme applies to aflibercept solution for injection for the treatment of all adults with neovascular wet age-related macular degeneration (AMD).

3.6 What proportion of the patient population (specified in 3.4) is expected to meet the scheme criteria (specified in 3.5)?

The patient access scheme applies to aflibercept solution for injection for the treatment of all adults with neovascular wet age-related macular degeneration (AMD).

3.7 Please explain in detail the financial aspects of the scheme. How will any rebates be calculated and paid?

The PAS will operated as a simple discount scheme, where aflibercept 40mg/ml will be made available with a variable discount from list price

(currently [redacted]) to maintain a fixed purchase price of [redacted] plus VAT per vial. The discount will be applied at the point of invoice. The population of patients covered by the PAS is adults with treatment of neovascular wet AMD in line with the licenced indication. However to avoid the need for individual patient tracking it is confirmed that the same level of discount would be made available for purchases of aflibercept 40mg/ml solution when used in all other future indications.

3.8 Please provide details of how the scheme will be administered. Please specify whether any additional information will need to be collected, explaining when this will be done and by whom.

Straight discount scheme

3.9 Please provide a flow diagram that clearly shows how the scheme will operate. Any funding flows must be clearly demonstrated.

The patient access scheme will allow the NHS to obtain aflibercept solution for injection at a price lower than the list price, subject to a confidentiality agreement. The discount will be applied at the point of invoice so no change to the flow of funds is anticipated.

3.10 Please provide details of the duration of the scheme.

The scheme will run until or after NICE publish their guidance following the review of the appraisal.

3.11 Are there any equity or equalities issues relating to the scheme, taking into account current legislation and, if applicable, any concerns identified during the course of the appraisal? If so, how have these been addressed?

No

3.12 If available, please list any scheme agreement forms, patient registration forms, pharmacy claim forms/rebate forms, guides for pharmacists and physicians and patient information documents. Please include copies in the appendices.

The agreement will be between Bayer plc and the hospital trust subject to a confidentiality agreement.

3.13 In the exceptional case that you are submitting an outcome-based scheme, as defined by the PPRS, please also refer to appendix B.

4 Cost effectiveness

4.1 If the population to whom the scheme applies (as described in sections 3.4 and 3.5) has not been presented in the main manufacturer/sponsor submission of evidence for the technology appraisal (for example, the population is different as there has been a change in clinical outcomes or a new continuation rule), please (re-)submit the relevant sections from the 'Specification for manufacturer/sponsor submission of evidence' (particularly sections 5.5, 6.7 and 6.9). You should complete those sections both with and without the patient access scheme. You must also complete the rest of this template.

The patient access scheme applies to aflibercept solution for injection for the treatment of all adults with neovascular wet age-related macular degeneration (AMD). As presented in the cost-effectiveness analysis (Chapter 7 of 'Specification for manufacturer/sponsor submission of evidence').

4.2 If you are submitting the patient access scheme at the end of the technology appraisal process, you should update the economic model to reflect the assumptions that the Appraisal Committee considered to be most plausible. No other changes should be made to the model.

The scheme is presented together with the submission to NICE.

4.3 Please provide details of how the patient access scheme has been incorporated into the economic model. If applicable, please also provide details of any changes made to the model to reflect the assumptions that the Appraisal Committee considered most plausible.

No changes have been made to the cost-effectiveness model (CEM) and/or the budget impact model (BIM).

The type of patient access scheme presented in this document is a 'Financially-based scheme', where the list price of aflibercept is reduced by [redacted] (price after discount [redacted] per drug injection).

The CEM is an Excel based model with the flexibility to allow the user setting up the model to either consider the patient access scheme or not before calculation of results. The BIM includes a similar option.

4.4 Please provide the clinical effectiveness data resulting from the evidence synthesis and used in the economic model which includes the patient access scheme.

There are no changes to the clinical effectiveness data compared to those presented in the base case analysis.

4.5 Please list any costs associated with the implementation and operation of the patient access scheme (for example, additional pharmacy time for stock management or rebate calculations). A suggested format is presented in table 1. Please give the reference source of these costs. Please refer to section 6.5 of the 'Specification for manufacturer/sponsor submission of evidence'.

The patient access scheme will allow the NHS to obtain aflibercept solution for injection at a price lower than the list price, subject to a confidentiality agreement. The discount will be applied at the point of invoice so no change to the flow of funds is anticipated.

There are no costs associated with the implementation and operation of the patient access scheme since is a 'Financially-based scheme' – straight discount scheme.

4.6 Please provide details of any additional treatment-related costs incurred by implementing the patient access scheme. A suggested format is presented in table 2. The costs should be provided for the intervention both with and without the patient access scheme. Please give the reference source of these costs.

Table 1: Additional treatment-related costs for the intervention without the patient access scheme (PAS)

	Year 1	Year 2	Year 3	Year 4	Year 5
Injections	7	4	4	4	4
Monitoring	7	6	7	7	7
Drug cost (£)	816.00	816.00	816.00	816.00	816.00
Administration cost (£)	257.45	257.45	257.45	257.45	257.45
Total monitoring cost (£), of which:	234.52	197.00	197.00	197.00	197.00
• Visual acuity visit (£)	0	79.74	79.74	79.74	79.74
• OCT (£)	117.26	117.26	117.26	117.26	117.26
• Angiography (£)	117.26	0	0	0	0
Total (£)	9,155.79	5,475.80	5,672.80	5,672.80	5,672.80

Table 2: Additional treatment-related costs for the intervention with the patient access scheme (PAS)

	Year 1	Year 2	Year 3	Year 4	Year 5
Injections	7	4	4	4	4
Monitoring	7	6	7	7	7
Drug cost (£)					
Administration cost (£)	257.45	257.45	257.45	257.45	257.45
Total monitoring cost (£), of which:	234.52	197	197	197	197
• Visual acuity visit (£)	0	79.74	79.74	79.74	79.74
• OCT (£)	117.26	117.26	117.26	117.26	117.26
• Angiography (£)	117.26	0	0	0	0
Total (£)					

Summary results

Base-case analysis

4.7 Please present in separate tables the cost-effectiveness results as follows.[1]

- the results for the intervention without the patient access scheme
- the results for the intervention with the patient access scheme.

[1] For outcome-based schemes, please see section 5.2.8 in appendix B.

A suggested format is shown below (Table 3).

Table 3: Base-case cost-effectiveness results: No PAS

	Aflibercept	Ranibizumab
Intervention cost (£)	18,430	19,826
Other costs (£)	6,579	8,790
Total costs (£)	£25,009	£28,615
Difference in total costs (£)	NA	£3,606
LYG	10.575	10.574
LYG difference	NA	-0.001
QALYs	7.77	7.76
QALY difference	NA	-0.010
ICER (£)	NA	Dominated

LYG: life-year gained; QALY: quality-adjusted life-year; ICER: incremental cost-effectiveness ratio.

Table 4: Base-case cost-effectiveness results: With PAS

	Aflibercept	Ranibizumab
Intervention cost (£)		19,826
Other costs (£)	6,579	8,790
Total costs (£)		£28,615
Difference in total costs (£)	NA	
LYG	10.575	10.574
LYG difference	NA	-0.001
QALYs	7.77	7.76
QALY difference	NA	-0.010
ICER (£)	NA	Dominated

LYG: life-year gained; QALY: quality-adjusted life-year; ICER: incremental cost-effectiveness ratio.

4.8 Please present in separate tables the incremental results as follows. [2]

- the results for the intervention without the patient access scheme
- the results for the intervention with the patient access scheme.

[2] For outcome-based schemes, please see section 5.2.9 in appendix B.

List the interventions and comparator(s) from least to most expensive. Present the incremental cost-effectiveness ratios (ICERs) in comparison with baseline (usually standard care), and the incremental analysis ranking technologies in terms of dominance and extended dominance. A suggested format is presented in Table 5.

Aflibercept dominated ranibizumab in the base case when the list price of £816.00 per injection was used, providing lower total costs (£25,009 vs. £28,615) and slightly higher QALYs (7.77 vs. 7.76) per patient in a lifetime horizon.

Aflibercept also dominated ranibizumab when the [redacted] discount was applied [redacted] per drug injection) decreasing total costs per patient from £25,009 to £[redacted].

Table 5: Base-case incremental results: No PAS

Technologies	Total costs (£)	Total LYG	Total QALYs	Incremental costs (£)	Incremental LYG	Incremental QALYs	ICER (£) versus baseline (QALYs)
Aflibercept	£25,009	10.575	7.77				
Ranibizumab	£28,615	10.574	7.76	£3,606	-0.001	-0.010	Dominated

LYG: life-year gained; QALY: quality-adjusted life-year; ICER: incremental cost-effectiveness ratio.

Table 6: Base-case incremental results: With PAS

Technologies	Total costs (£)	Total LYG	Total QALYs	Incremental costs (£)	Incremental LYG	Incremental QALYs	ICER (£) versus baseline (QALYs)
Aflibercept	[redacted]	10.575	7.77				
Ranibizumab	£28,615	10.574	7.76	[redacted]	-0.001	-0.010	Dominated

LYG: life-year gained; QALY: quality-adjusted life-year; ICER: incremental cost-effectiveness ratio.

Sensitivity analyses

4.9 Please present deterministic sensitivity analysis results as described for the main manufacturer/sponsor submission of evidence for the technology appraisal. Consider using tornado diagrams.

A deterministic sensitivity analysis was performed using the same methodology applied in the base case analysis included in the manufacturer submission. The net monetary benefits approach was undertaken since aflibercept was shown to be dominant versus ranibizumab in the base case scenario. The willingness to pay threshold that was used for the analysis was £20,000 per QALY as this is the lower end of the NICE threshold range.

Parameters tested included drug costs, annual frequency of monitoring, annual number of injections, proportion of patients in one-stop and two-stop models, relative risks applied to ranibizumab treatment for gaining and losing visual acuity, discontinuation and discount rates (for more details please refer to the manufacture submission).

Results of the deterministic sensitivity analysis are presented in the tornado diagram (Figure 1) and Table 7 below. Results indicate that the ICER is most sensitive to drug costs, number of injections, frequency of monitoring, the proportion of patients in one-stop and two-stop models, discount rates and the relative risk of gaining/losing letters with ranibizumab versus aflibercept.

In all instances tested, aflibercept incurred lower costs versus ranibizumab and accrued more QALYs.

Figure 1: Tornado diagram using the patient access scheme

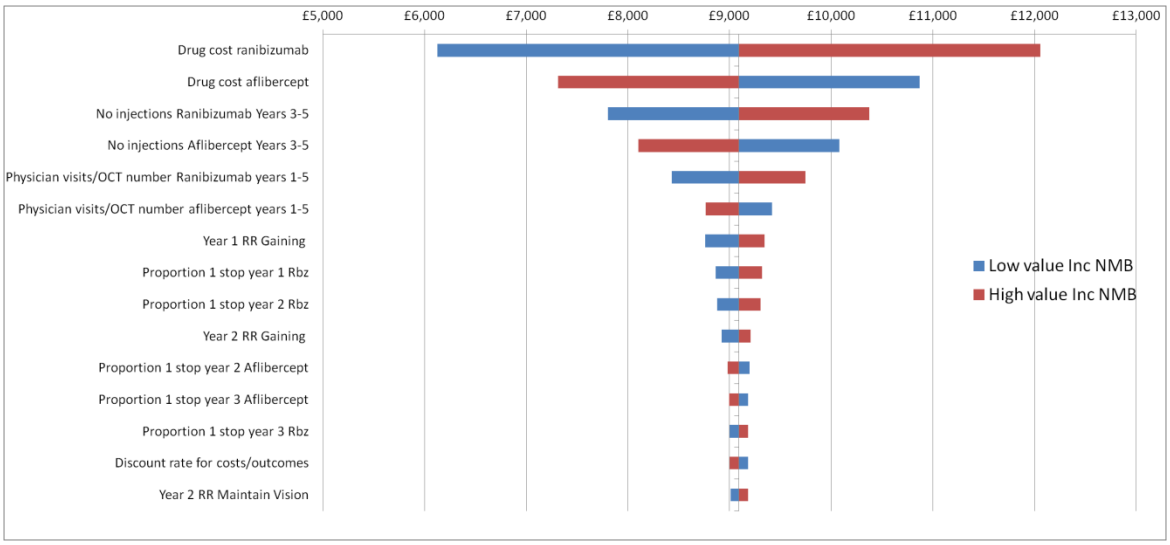


Table 7: Deterministic sensitivity analysis using the patient access scheme

Variable no.	Parameter	Inc Costs (low)	Inc QALYs (low)	Inc Costs (high)	Inc QALYs (high)	Low value Inc NMB	High value Inc NMB
1	Drug cost ranibizumab	-£5,867	0.013	-£11,799	0.013	£6,125	£12,056
2	Drug cost aflibercept	-£10,612	0.013	-£7,054	0.013	£10,870	£7,312
3	No injections Ranibizumab Years 3-5	-£7,547	0.013	-£10,119	0.013	£7,805	£10,377
4	No injections Aflibercept Years 3-5	-£9,822	0.013	-£7,844	0.013	£10,080	£8,101
5	Physician visits/OCT number Ranibizumab years 1-5	-£8,175	0.013	-£9,491	0.013	£8,433	£9,749
6	Physician visits/OCT number aflibercept years 1-5	-£9,159	0.013	-£8,507	0.013	£9,417	£8,764
7	Proportion 1 stop year 1 Rbz	-£8,924	-0.008	-£8,764	0.029	£8,759	£9,342
8	Proportion 1 stop year 2 Rbz	-£8,605	0.013	-£9,061	0.013	£8,863	£9,319
9	Year 1 RR Maintain Vision	-£8,618	0.013	-£9,048	0.013	£8,876	£9,305
10	Proportion 1 stop year 2 Aflibercept	-£8,875	0.002	-£8,804	0.020	£8,923	£9,209
11	Proportion 1 stop year 3 Rbz	-£8,940	0.013	-£8,726	0.013	£9,198	£8,984
12	Proportion 1 stop year 3 Aflibercept	-£8,927	0.013	-£8,739	0.013	£9,184	£8,997
13	Discontinuation rate Aflibercept/Ranibizumab years 3-5	-£8,741	0.013	-£8,925	0.013	£8,999	£9,183
14	Discount rate for costs/outcomes	-£8,924	0.013	-£8,744	0.013	£9,182	£9,002
15	Year 2 RR Maintain Vision	-£8,895	0.006	-£8,761	0.021	£9,013	£9,181

4.10 Please present any probabilistic sensitivity analysis results, and include scatter plots and cost-effectiveness acceptability curves.

A probabilistic sensitivity analysis was performed in the same way as for the base case presented in the 'Specification for manufacturer/sponsor submission of evidence' (Table 8). One thousand iterations were run showing that aflibercept is 81.6% likely to dominate ranibizumab and 18.4% likely to be less effective and less costly. The cost-effectiveness plane in Figure 2 shows how all the iterations lie in the south quadrants.

Table 8: Probabilistic sensitivity analysis with patient access scheme

	Dominant	More effective & more costly	Less effective & less costly	Dominated
Aflibercept vs. Ranibizumab PRN	81.60%	0%	18.40%	0%

Figure 2: Cost-effectiveness plane using the patient access scheme

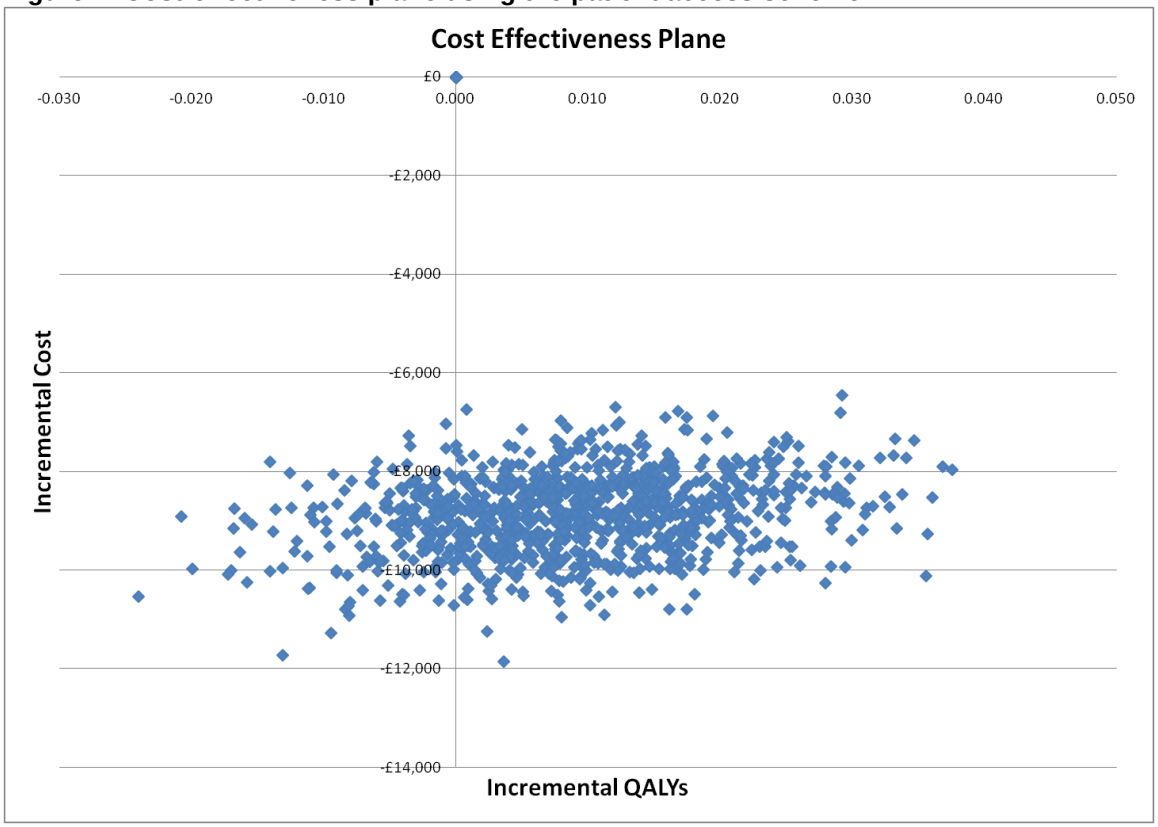
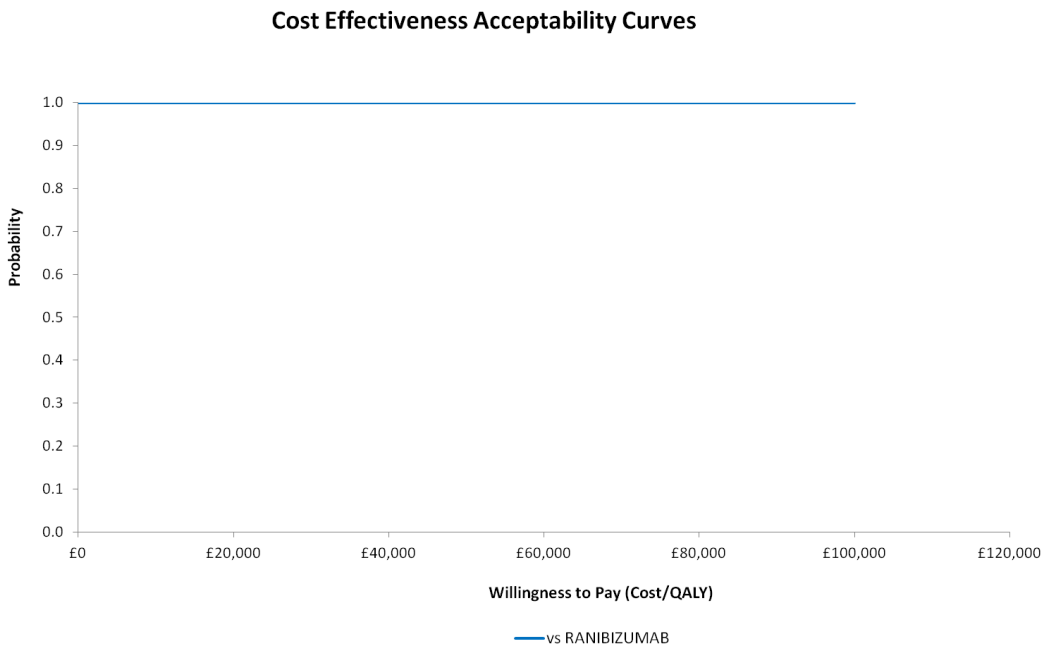


Figure 3: Cost-effectiveness acceptability curve using the patient access scheme



4.11 Please present scenario analysis results as described for the main manufacturer/sponsor submission of evidence for the technology appraisal.

Analyses were performed comparing aflibercept at the discounted price of [redacted] ([redacted] discount) per drug injection to different scenarios of ranibizumab prices per drug injection. Ranibizumab price (£742.17) was tested in discount scenarios ranging from -10% to -50% in 5% increments.

Aflibercept dominated ranibizumab in the base case scenario. Decreasing ranibizumab price per injection didn't change the trend in results. As shown in the tables below, aflibercept dominates ranibizumab even when the price of ranibizumab is discounted at 50% of its list price.

Table 9: Scenario analyses with patient access scheme Ranibizumab: -10%

Technologies	Total costs (£)	Total LYG	Total QALYs	Incremental costs (£)	Incremental LYG	Incremental QALYs	ICER (£) versus baseline (QALYs)
Aflibercept	[redacted]	10.575	7.77				
Ranibizumab	£27,132	10.574	7.76	[redacted]	-0.001	-0.010	Dominated

Table 10: Scenario analyses with patient access scheme Ranibizumab: -15%

Technologies	Total costs (£)	Total LYG	Total QALYs	Incremental costs (£)	Incremental LYG	Incremental QALYs	ICER (£) versus baseline (QALYs)
Aflibercept	[redacted]	10.575	7.77				
Ranibizumab	£26,391	10.574	7.76	[redacted]	-0.001	-0.010	Dominated

Table 11: Scenario analyses with patient access scheme Ranibizumab: -20%

Technologies	Total costs (£)	Total LYG	Total QALYs	Incremental costs (£)	Incremental LYG	Incremental QALYs	ICER (£) versus baseline (QALYs)
Aflibercept	[redacted]	10.575	7.77				
Ranibizumab	£25,650	10.574	7.76	[redacted]	-0.001	-0.010	Dominated

Table 12: Scenario analyses with patient access scheme Ranibizumab: -25%

Technologies	Total costs (£)	Total LYG	Total QALYs	Incremental costs (£)	Incremental LYG	Incremental QALYs	ICER (£) versus baseline (QALYs)
Aflibercept	[redacted]	10.575	7.77				
Ranibizumab	£24,908	10.574	7.76	[redacted]	-0.001	-0.010	Dominated

Table 13: Scenario analyses with patient access scheme Ranibizumab: -30%

Technologies	Total	Total	Total	Increment	Increme	Increm	ICER (£)

	costs (£)	LYG	QALYs	al costs (£)	ntal LYG	ental QALYs	versus baseline (QALYs)
Aflibercept	[redacted]	10.575	7.77				
Ranibizumab	£24,167	10.574	7.76	[redacted]	-0.001	-0.010	Dominated

Table 14: Scenario analyses with patient access scheme Ranibizumab: -35%

Technologies	Total costs (£)	Total LYG	Total QALYs	Incremental costs (£)	Incremental LYG	Incremental QALYs	ICER (£) versus baseline (QALYs)
Aflibercept	[redacted]	10.575	7.77				
Ranibizumab	£23,425	10.574	7.76	[redacted]	-0.001	-0.010	Dominated

Table 15: Scenario analyses with patient access scheme Ranibizumab: -40%

Technologies	Total costs (£)	Total LYG	Total QALYs	Incremental costs (£)	Incremental LYG	Incremental QALYs	ICER (£) versus baseline (QALYs)
Aflibercept	[redacted]	10.575	7.77				
Ranibizumab	£22,684	10.574	7.76	[redacted]	-0.001	-0.010	Dominated

Table 16: Scenario analyses with patient access scheme Ranibizumab: -45%

Technologies	Total costs (£)	Total LYG	Total QALYs	Incremental costs (£)	Incremental LYG	Incremental QALYs	ICER (£) versus baseline (QALYs)
Aflibercept	[redacted]	10.575	7.77				
Ranibizumab	£21,942	10.574	7.76	[redacted]	-0.001	-0.010	Dominated

Table 17: Scenario analyses with patient access scheme Ranibizumab: -50%

Technologies	Total costs (£)	Total LYG	Total QALYs	Incremental costs (£)	Incremental LYG	Incremental QALYs	ICER (£) versus baseline (QALYs)
Aflibercept	[redacted]	10.575	7.77				
Ranibizumab	£21,201	10.574	7.76	[redacted]	-0.001	-0.010	Dominated

4.12 If any of the criteria on which the patient access scheme depends are clinical variable (for example, choice of response measure, level of response, duration of treatment), sensitivity analyses around the individual criteria should be provided, so that the Appraisal Committee can determine which criteria are the most appropriate to use.

Not applicable.

Impact of patient access scheme on ICERs

4.13 For financially based schemes, please present the results showing the impact of the patient access scheme on the ICERs for the

base-case and any scenario analyses. A suggested format is shown below (see table 5). If you are submitting the patient access scheme at the end of the appraisal process, you must include the scenario with the assumptions that the Appraisal Committee considered to be most plausible.

The same scenario analyses presented in the 'Specification for manufacturer/sponsor submission of evidence' were performed using the discounted price for aflibercept (Table 18).

As expected and given the suggested PAS consists on a commercially confidential discount on the list price of aflibercept, results obtained in the current analyses produce higher savings compared to results in the 'Specification for manufacturer/sponsor submission of evidence' demonstrating dominance of aflibercept over ranibizumab in all scenarios.

Scenario number 4 tests the two interventions assuming the same efficacy for both, therefore no incremental QALYs are gained and aflibercept results to be cost-saving.

Table 18: Results showing the impact of patient access scheme on ICERs

Scenario	ICER for intervention versus: ranibizumab	
	Without PAS	With PAS
1 - Base-case	Dominant	Dominant
2 – Inclusion of AEs for ranibizumab	Dominant	Dominant
3 – Utility values from Czoski-Murray, 2009	Dominant	Dominant
4 - Same efficacy in both arms	N/A	N/A
5 - Frequency of injections in year 1 and 2 from trials	Dominant	Dominant
6 - Frequency of monitoring in years 3 to 5: 6 for aflibercept and 12 for ranibizumab	Dominant	Dominant
7 - 100% on one-stop model for aflibercept and 100% in two-stop model for ranibizumab	Dominant	Dominant
8 - Frequency of monitoring for years 3 to 5 in both arms: 6	Dominant	Dominant

5 Appendices

5.1 Appendix A: Additional documents

5.1.1 If available, please include copies of patient access scheme agreement forms, patient registration forms, pharmacy claim forms/rebate forms, guides for pharmacists and physicians, patient information documents.

Not applicable

5.2 Appendix B: Details of outcome-based schemes

5.2.1 If you are submitting a proven value: price increase scheme, as defined in the PPRS, please provide the following information:

- the current price of the intervention
- the proposed higher price of the intervention, which will be supported by the collection of new evidence
- a suggested date for when NICE should consider the additional evidence.

Not applicable.

5.2.2 If you are submitting an expected value: rebate scheme, as defined in the PPRS, please provide the following details:

- the current price of the intervention (the price that will be supported by the collection of new evidence)
- the planned lower price of the intervention in the event that the additional evidence does not support the current price
- a suggested date for when NICE should consider the additional evidence.

Not applicable.

5.2.3 If you are submitting a risk-sharing scheme, as defined in the PPRS, please provide the following details:

- the current price of the intervention (the price that will be supported by the collection of new evidence)
- the proposed relationship between future price changes and the evidence to be collected.

Not applicable.

5.2.4 For outcome-based schemes, as defined in the PPRS, please provide the full details of the new information (evidence) planned to be collected, who will collect it and who will carry the cost associated with this planned data collection. Details of the new information (evidence) may include:

- design of the new study
- patient population of the new study
- outcomes of the new study
- expected duration of data collection
- planned statistical analysis, definition of study groups and reporting (including uncertainty)
- expected results of the new study
- planned evidence synthesis/pooling of data (if applicable)
- expected results of the evidence synthesis/pooling of data (if applicable).

Not applicable.

5.2.5 If you are submitting a risk-sharing scheme, please specify the period between the time points when the additional evidence will be considered.

Not applicable.

5.2.6 Please provide the clinical effectiveness data resulting from the evidence synthesis and used in the economic modelling of the patient access scheme at the different time points when the additional evidence is to be considered.

Not applicable.

5.2.7 Please provide the other data used in the economic modelling of the patient access scheme at the different time points when the additional evidence is to be considered. These data could include cost/resource use, health-related quality of life and utilities.

Not applicable.

5.2.8 Please present the cost-effectiveness results as follows.

- For proven value: price increase schemes, please summarise in separate tables:
  - the results based on current evidence and current price
  - the anticipated results based on the expected new evidence and the proposed higher price.
- For expected value: rebate schemes, please summarise in separate tables:
  - the results based on the expected new evidence and the current price (which will be supported by the additional evidence collection)
  - the results based on the current evidence and the lower price (if the new evidence is not forthcoming).
- For risk-sharing schemes, please summarise in separate tables:
  - the results based on current evidence and current price
  - the results based on the expected new evidence and the current price (which will be supported by the additional evidence collection)
  - the results based on the current evidence and the lower price (if the new evidence is not forthcoming)
  - the anticipated results based on the expected new evidence and the proposed higher price.

A suggested format is shown in table 3, section 4.7.

Not applicable.

5.2.9 Please present in separate tables the incremental results for the different scenarios as described above in section 5.2.8 for the type of outcome-based scheme being submitted.

List the interventions and comparator(s) from least to most expensive. Present the incremental cost-effectiveness ratios (ICERs) in comparison with baseline (usually standard care), and the incremental analysis ranking technologies in terms of dominance and extended dominance. A suggested format is presented in table 4, section 4.8.

Not applicable.