NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Appraisal consultation document

Enzalutamide for hormone-relapsed non-metastatic prostate cancer

The Department of Health and Social Care has asked the National Institute for Health and Care Excellence (NICE) to produce guidance on using enzalutamide 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?

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 enzalutamide 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: 31 January 2019

Second appraisal committee meeting: 19 February 2019

Details of membership of the appraisal committee are given in section 5.

1 Recommendations

1.1 Enzalutamide is not recommended, within its marketing authorisation, for treating high-risk hormone-relapsed non-metastatic prostate cancer in adults.

1.2 This recommendation is not intended to affect treatment with enzalutamide that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop.

Why the committee made these recommendations

Currently, when prostate cancer no longer responds to hormone treatment (androgen deprivation therapy) but has not yet spread beyond the prostate, the only option is to continue hormone treatment. The company proposes using enzalutamide in this setting.

Clinical trial evidence shows that adding in enzalutamide extends the time until the cancer starts spreading to other parts of the body. But the evidence on whether it increases how long people live is uncertain.

Cost-effectiveness estimates for enzalutamide plus androgen deprivation therapy compared with androgen deprivation therapy alone are uncertain. This is because there is not much evidence available to estimate how long people live. Also, the costs and benefits of treatments after enzalutamide do not fully reflect these in the NHS. In addition, the estimates are not within the range that NICE usually considers a cost-effective use of NHS resources. Therefore, enzalutamide is not recommended for treating hormone-relapsed non-metastatic prostate cancer.

2 Information about enzalutamide

Marketing authorisation indication	Enzalutamide (Xtandi, Astellas) has a marketing authorisation 'for the treatment of adult men with high-risk non-metastatic castration-resistant prostate cancer'.
Dosage in the marketing authorisation	Enzalutamide is administered orally at a dose of 160 mg (4x40 mg soft capsules) daily.
Price	£2,734.67 per 112 capsules (excluding VAT; British national formulary online, accessed December 2018) The daily dose comprises 4 capsules and costs £97.67. The company has a commercial arrangement which would apply if the technology had been recommended.

3 Committee discussion

The appraisal committee (section 5) considered evidence submitted by Astellas and a review of this submission by the evidence review group (ERG). See the committee papers for full details of the evidence.

Treatment pathway

The company places enzalutamide in a new position within the treatment pathway

3.1 The committee noted that there are different clinical settings in which people with prostate cancer may have treatment. These are broadly defined by whether the cancer has spread (metastasised) or not, and whether it is hormone sensitive or hormone relapsed. This appraisal focuses on enzalutamide for hormone-relapsed non-metastatic prostate cancer. The clinical experts noted that this group is small and becoming smaller. This is because improved radiographic imaging means that there are fewer people with undetected metastases who would otherwise be in this group. NICE technology appraisal guidance already recommends enzalutamide for hormone-relapsed metastatic prostate cancer before and after treatment with docetaxel. This appraisal relates to using enzalutamide at an earlier point in therapy than this. The committee noted that NHS England's policy only offers enzalutamide or abiraterone (another antiandrogen) once in the treatment of prostate cancer. Therefore using enzalutamide at this earlier position in the treatment pathway would mean it would not be an option later, once the cancer had metastasised.

Experience of people with prostate cancer

Prostate cancer causes few symptoms until metastases occur

3.2 Patient experts commented that most people with hormone-relapsed non-metastatic prostate cancer have no or few symptoms. Those who have

symptoms mainly experience urinary difficulties. Symptoms increase when metastases develop. For example, bone metastases may cause pain and visceral metastases may cause site-specific symptoms. The committee noted that patients consider there to be an unmet need for treatments that delay metastasis.

Clinical management

Androgen deprivation therapy is the relevant comparator in this appraisal

3.3 Androgen deprivation therapy (ADT) has long been the standard of care for treating prostate cancer. The clinical experts explained that, after ADT is indicated, it is continued throughout the treatment pathway for prostate cancer, even when the cancer becomes hormone relapsed. This is because stopping treatment may speed up metastasis. The clinical experts commented that bicalutamide and dexamethasone are sometimes used in the hormone-relapsed non-metastatic setting, but the evidence for their effectiveness is limited. The committee heard that docetaxel is also offered to some people in this setting, but understood that this was not supported by NHS England. It considered ADT to be the standard of care in patients with hormone-relapsed prostate cancer, and the relevant comparator in this appraisal.

The company's definition of high risk does not match what is considered high risk in clinical practice

3.4 The company's decision problem focused on the subset of people with hormone-relapsed non-metastatic prostate cancer whose disease is at 'high risk' of metastasis, defined as:

- an absolute prostate specific antigen (PSA) level of 2 ng/millilitre or more
- a PSA doubling time of 10 months or less.

This definition reflected the inclusion criteria in enzalutamide's clinical studies and marketing authorisation. NICE's guideline on prostate cancer:

diagnosis and management recommends starting ADT if the PSA doubling time is less than 3 months in the hormone-sensitive setting. The clinical experts commented that, in clinical practice, assessing risk takes into account PSA doubling time, but also other factors such as the age and fitness of patients. They advised that a clinically meaningful PSA doubling time in this setting would be less than 6 months. The committee concluded that how clinicians define the high-risk group in clinical practice does not match the patients the company defined as having high-risk disease. Although this was a source of uncertainty, the committee did not expect it to affect the generalisability of clinical results from 1 group to the other.

Clinical evidence

The PROSPER trial provides the main clinical evidence for enzalutamide

3.5 The main evidence for enzalutamide came from PROSPER, a double-blind randomised placebo-controlled trial. It included 1,401 patients with hormone-relapsed non-metastatic cancer, allocated to either enzalutamide plus ADT (n=933) or placebo plus ADT alone (n=468). The primary outcome was metastasis-free survival, defined as the time to radiographic evidence of metastases or death, whichever occurred first. Scans were done every 16 weeks, or sooner if metastatic disease was suspected. The committee considered metastasis-free survival to be an appropriate outcome because progression to metastatic disease allows for other treatment options to be started. Secondary outcomes included overall survival, quality of life, time to stopping treatment, and safety.

The population in PROSPER has lower-risk disease but is otherwise similar to patients in the NHS who may have enzalutamide

3.6 The clinical experts advised that, apart from the criterion for PSA doubling time (see section 3.4), patients in PROSPER were generally similar to people who would be offered enzalutamide in the hormone-relapsed non-metastatic setting in clinical practice. The committee noted that, in some

patients, the PSA doubling time was greater than 10 months (which the study protocol did not allow), and the serum PSA was higher than would be expected in the non-metastatic setting. However, the ERG commented that the number of patients who did not meet selection criteria was low, so unlikely to have biased any outcomes. The committee concluded that the population in PROSPER was sufficiently generalisable to NHS clinical practice.

Enzalutamide increases metastasis-free survival

3.7 The median metastasis-free survival with enzalutamide was 36.6 months compared with 14.7 months for placebo (hazard ratio [HR] 0.29, 95% confidence interval [CI] 0.24 to 0.35; p<0.0001) based on the final analysis. The committee recognised that enzalutamide was more effective than placebo at delaying metastasis.

The overall survival data are immature so there is no evidence that enzalutamide confers an overall survival benefit relative to placebo

3.8 The company presented 2 of 3 intended interim analyses of overall survival: the first after 135 deaths (coinciding with the final analysis for metastasis-free survival; see section 3.7), and the second after 285 deaths (about 1 year later). The company stated that it intends to do another interim analysis and a final analysis. The committee appreciated that there needed to be 596 events for a final analysis in the company's amended statistical plan. The company and committee agreed that the overall survival data presented by the company were immature, and provided too few deaths to detect a statistically significant difference between treatment arms. For example, at the second interim analysis, the median overall survival had not been reached and the hazard ratio between the 2 treatment arms was not statistically significant (as defined in the protocol; HR 0.83, 95% CI 0.65 to 1.06; p=0.134). The committee queried whether patients in the placebo arm had been offered active therapies such as enzalutamide after metastasis or further progression and 'caught up' with patients in the enzalutamide arm. However, it heard

from the clinical experts that patients who get enzalutamide later rather than earlier do not appear to catch up. The committee also queried whether the relative effect of enzalutamide appeared to decrease towards the end of follow-up because of the differential rates of drop-off at successive lines of therapy, but heard from the clinical experts that the drop-off rate with enzalutamide was low. The committee concluded that, the latest evidence available did not show a survival benefit with enzalutamide relative to placebo.

Enzalutamide may be less effective in terms of overall survival, both absolutely and relatively, when used earlier in the treatment pathway

3.9 The committee discussed whether the relative effectiveness of enzalutamide at later points in the treatment pathway could provide insight into its survival benefit in the hormone-relapsed non-metastatic setting. In people with hormone-relapsed metastatic disease, the hazard ratios for overall survival were 0.76 (95% CI 0.66 to 0.88) in the pre-chemotherapy setting and 0.62 (95% CI 0.52 to 0.73) in the post-chemotherapy setting, compared with 0.83 (95% CI 0.65 to 1.06) in the hormone-relapsed non-metastatic setting (see section 3.8). The committee also queried how the absolute benefit of enzalutamide differs along the treatment pathway. The clinical experts stated that, for hormone-sensitive prostate cancer, there was some evidence to suggest that the earlier enzalutamide is used, the greater the survival benefit. However, the committee did not see this evidence. For hormone-relapsed disease, the clinical experts stated that the relationship between the timing of enzalutamide treatment and overall survival was unclear, although they agreed that the absolute benefit of enzalutamide was larger after chemotherapy than before. The committee concluded that enzalutamide may be less effective with respect to overall survival when used earlier in the treatment pathway, both absolutely and relatively.

Subsequent treatments in PROSPER confound overall survival

3.10 The company presented information on the treatments used after metastasis for each treatment arm in PROSPER. The committee noted that:

- Some patients in the enzalutamide arm had further treatment with abiraterone and enzalutamide, which would not be available in NHS clinical practice and for which there may be a survival benefit.
- Some patients in both arms had treatments not used in the NHS and which may be associated with a survival benefit (for example, sipuleucel-T).
- The distribution of subsequent therapies differed between arms after metastasis, with a larger proportion of patients in the enzalutamide arm having no active therapies, and a larger proportion in the placebo arm having enzalutamide, abiraterone and docetaxel.

The committee agreed that the use of subsequent therapies in PROSPER introduced bias. This meant that the relative effectiveness of enzalutamide in clinical practice was unlikely to reflect the reported effect in PROSPER. The committee concluded that the company should have adjusted for the effect of the subsequent treatments not available in the NHS and for which there is evidence of a survival benefit. To do this it should have used a method appropriate for the data, as the company did in NICE's technology appraisal guidance on enzalutamide for treating metastatic hormone-relapsed prostate cancer before chemotherapy is indicated.

Quality of life

Enzalutamide does not increase quality of life compared with placebo after 22 months

3.11 The patient experts explained that they had no problems with any aspect of their quality of life while having enzalutamide over several years. The

company presented health-related quality-of-life data from PROSPER, measured after 22 months of follow-up using various quality-of-life instruments. These included the Brief Pain Inventory, the European Organisation for Research and Treatment of Cancer prostate cancer module (EORTC), Functional Assessment of Cancer Therapy – Prostate (FACT-P) and the EQ-5D. The only statistically significant ($p<0.05$) differences between treatments were detected using the EORTC in hormonal-treatment related symptoms and the FACT-P social wellbeing instruments. The committee concluded that there was not enough evidence from PROSPER to show that enzalutamide improved quality of life compared with placebo after 22 months' follow-up.

Company's economic model

The model has a semi-Markov partitioned survival structure

3.12 The company developed a semi-Markov partitioned survival model to assess the cost effectiveness of enzalutamide plus ADT compared with ADT alone. The model contained 3 states: hormone-relapsed non-metastatic, hormone-relapsed metastatic and death. The company used a partitioned survival model, informed by data from PROSPER, to model the transition of patients from the non-metastatic to the metastatic states, and from the non-metastatic or metastatic state to death. Within the metastatic state, there was a Markov model with 3 sub-states (progressed disease states 1 to 3) to capture disease progression beyond metastasis, and associated treatment options, costs and utilities. To model the transitions of patients within this state, the company used other trials, namely PREVAIL (enzalutamide versus placebo in the pre-chemotherapy metastatic setting) and TAX-327 (docetaxel versus mitoxantrone in the metastatic setting).

The company's model structure introduces additional uncertainty

3.13 The model structure chosen by the company meant that the company had to break down the already uncertain outcome of overall survival into death

before or after metastasis. This was to align the data with the model states, which added another layer of uncertainty to the model. The company stated that it chose this model structure because it reflected clinical practice. However, the committee did not consider the company to have justified using a model structure that increased uncertainty. It further considered that the company should have at least validated the output of its model against the standard 3-state partitioned survival model commonly used in oncology, and on which the NICE's Decision Support Unit provides guidance. The committee concluded that the model structure chosen by the company introduced additional uncertainty to the model estimates.

There is no evidence to support the modelled benefit of enzalutamide on survival before metastatic disease occurs

3.14 To model pre-progression survival, the company extrapolated this outcome beyond the follow-up period of the trial. It based this on a few patients who died before metastasis, and the diverging curves translated to a large absolute benefit for enzalutamide compared with ADT. The clinical experts explained that the death rate pre-metastasis was likely to reflect the mortality of the general population because people are unlikely to die from non-metastatic prostate cancer. The committee appreciated that this outcome was unlikely to have a substantial effect on cost effectiveness. However, it agreed that this lacked face validity and was likely to bias results in favour of enzalutamide.

Post-progression survival is prone to selection bias

3.15 The committee noted that the post-metastasis survival extrapolation did not reflect randomised groups. This was because most patients in the ADT arm, but only half of those in the enzalutamide arm, developed metastasis. This also meant that the extrapolation was based on disproportionate numbers at risk between the 2 arms, so was substantially prone to selection bias. The committee agreed that the partitioned survival

approach further divided immature data in inappropriate ways and introduced bias.

Survival in each progressed state is likely to differ

3.16 The company used a single source of data (PROSPER) to model the transition from the metastatic state to death. This was constant over time and so implicitly assumed that all patients with metastatic disease in the model had the same rate of death before, during and after docetaxel for metastatic disease. The clinical experts noted that this was implausible because they would expect to see a lower death rate in early metastatic disease than after progression on chemotherapy. The company's assumption of equal instead of lower rates of mortality in the early metastatic sub-state disproportionately affected the survival rates of patients having ADT, who moved to the metastatic state faster than those having enzalutamide. The committee concluded that the company's model structure and assumptions led to a bias in survival in favour of enzalutamide.

It is more appropriate to use data for overall survival from the second rather than the first interim analysis

3.17 The company used in its base-case results for time to death (overall survival) from the first of 4 planned analyses to coincide with the final analysis of metastasis-free survival. However, the committee preferred using overall survival from the second interim analysis (see section 3.8) because the data, although immature, were more mature than that from the first interim analysis.

It is more appropriate to use metastasis-free survival rather than time to stopping treatment with the second interim analysis

3.18 The company presented 2 scenario analyses to estimate time in the hormone-relapsed non-metastatic health state, one used metastasis-free survival from the first interim analysis, and the other used time to stopping treatment (as a proxy for metastasis-free survival) from the second interim

analyses, because metastasis-free survival was not measured beyond the first interim analysis. The ERG commented that it was uncertain how long people stayed on treatment after metastasis, and that radiographic progression (as measured in the primary outcome) was a better measure of time to metastasis than time to stopping treatment. The committee preferred using time to metastasis from the final analysis for this endpoint, because it was the protocol-defined primary analysis and better reflected the health state in the model.

The company's modelled output does not match what occurred in PROSPER

3.19 The company used the survival data from the first interim analysis, which implied that the rate of death increased more quickly in the ADT arm than in the enzalutamide arm. This meant that the relative effectiveness of the treatments in the enzalutamide arm on overall survival continued to improve over time (the hazard ratio decreased). This modelled survival did not correspond with the latest data for overall survival seen in PROSPER, which showed no survival benefit in this arm (see section 3.8). The ERG used data from the second interim analysis. This resulted in the relative effectiveness of the treatments in the enzalutamide arm improving for up to 8.7 years (hazard ratio decreasing), then waning over the following 8.0 years (hazard ratio increasing to 1) and then reversing (hazard ratio greater than 1). The committee appreciated that, although this was a more reasonable assumption than the company's, it still did not reflect the observed data. The committee concluded that there was a disconnection between observed and modelled overall survival in both the company's and ERG's model.

Treatment sequence in the economic model

The economic model should include the costs of cabazitaxel and radium-223

3.20 The company modelled a treatment sequence based on what the company's clinical expert expected to happen in NHS clinical practice, and applied costs to these treatments. This assumed that everyone

starting on enzalutamide had ADT in the progressed disease state 1 and vice versa. In progressed disease state 2, 40% of people in either arm of the model had docetaxel and 60% had ADT alone. In progressed disease state 3, everyone in the model had best supportive (which included ADT). The committee discussed the sequence of treatments that best reflected NHS practice, appreciating that:

- enzalutamide would be continued for longer in clinical practice than it was in PROSPER because radiographic progression to determine metastasis is not measured as frequently in clinical practice as it was in PROSPER, and because clinicians may offer treatment beyond metastasis in certain clinical circumstances
- abiraterone and enzalutamide are used in approximately equal proportions in the pre-docetaxel setting
- clinical experts consider about 40% of patients to be fit enough to have docetaxel when symptoms appear
- about 20% of patients who have treatment in the post-docetaxel setting have cabazitaxel
- radium-223 is considered for patients with bone metastatic disease and is used only with ADT.

The committee agreed that enzalutamide is likely to be continued for longer in practice than in the trial, but chose not to divorce the trial effectiveness from trial costs. This was because longer treatment might be more effective than was seen in the trial, and it would be difficult to model this. In general, the committee concluded that the company's model reflected current clinical NHS practice, but that the appropriate treatment sequence should have included cabazitaxel and radium-223.

The modelled sequence does not match the observed subsequent treatments in PROSPER

3.21 The committee appreciated that the company modelled subsequent treatments by only applying costs to them. However, the subsequent therapies patients had in PROSPER, from which the clinical data came, did not reflect the sequence included in the model. For example, only 11% of patients with progressed disease in placebo arm of PROSPER had enzalutamide at the follow-up, compared with 100% in the economic model. The committee concluded that dissociating costs and effectiveness in the economic model had biased the estimates of cost effectiveness in favour of enzalutamide.

Assumptions in the economic model

For people having enzalutamide, the time spent in the first progressed disease state is unlikely to be as long as that modelled by the company

3.22 The company's base case assumed that patients whose cancer metastasised having had enzalutamide would remain in the first progressed state (pre-chemotherapy) for 7.3 months, based on the PREVAIL trial. The ERG was concerned that the population of PREVAIL was not generalisable to the PROSPER population because PROSPER included patients with a high risk of progression to metastasis at baseline. The ERG proposed a scenario using the time between metastasis and first use of active treatment seen in the enzalutamide arm of PROSPER, which led to a shorter time. The clinical experts agreed that 7.3 months was an implausible amount of time to have ADT alone in the metastatic state. The committee agreed that the ERG's scenario with a shorter amount of time in the first progressed state was appropriate.

Utility values in the economic model

There is uncertainty about the utility value for the first metastatic progressed disease state

3.23 The company used EQ-5D data collected in PROSPER to inform utility values in its economic model for the non-metastatic and first progressed disease states. The ERG considered the utility for the first progressed disease state to be lower than expected, considering people continued to have few symptoms. It preferred to use the baseline utility from PREVAIL, which measured utility in the metastatic pre-chemotherapy setting. The committee acknowledged the uncertainty around the utility estimates, but considered the utility value derived from PROSPER to be more appropriate because it used the same source of clinical data.

Costs in the economic model

The costs of monitoring disease would be the same whether people have enzalutamide plus ADT or ADT alone

3.24 The company presented higher monitoring costs for people having ADT alone compared with people on enzalutamide plus ADT within the model. The clinical experts said that the frequency of monitoring would not differ, a conclusion also reached by the ERG's clinical expert. The ERG presented a scenario that equalised the monitoring frequencies and costs between both arms. The committee concluded that the ERG's scenario was appropriate.

The costs of major adverse events are not included appropriately

3.25 The committee was concerned that the model did not fully reflect the costs of major adverse events. Major adverse events that occurred substantially more often with enzalutamide than with placebo in the trials included hypertension, memory impairment and major adverse cardiovascular events. The clinical experts also noted that fatigue and osteoporosis are common adverse effects with enzalutamide. The ERG noted that there

were no modelled costs for memory impairment and the costs associated with osteoporosis were not explored. It was also concerned that the costs of major adverse cardiovascular events were not appropriate considering the higher incidence of these events in patients having enzalutamide. The company used the costs of non-elective short stays for all major adverse cardiovascular events, but most were coded as long stays. The company confirmed that it had excluded the costs associated with rehabilitation from strokes. The ERG presented a scenario that included the costs of the total distribution of lengths of inpatient stays, which substantially increased the costs of major adverse cardiovascular events. The company agreed with this. The committee concluded that the scenario with increased costs was appropriate.

Cost-effectiveness estimates

Enzalutamide plus ADT is not cost effective compared with ADT alone

3.26 The committee considered whether enzalutamide would be a cost-effective use of NHS resources for people with non-metastatic hormone resistant prostate cancer, taking into account the patient access scheme (discount) associated with enzalutamide. The company presented a base-case deterministic incremental cost-effectiveness ratio (ICER) of £28,853 per quality-adjusted life year (QALY) gained. However, this included several assumptions that the committee considered inappropriate, and reflected considerable uncertainty. The ERG presented a base-case ICER of £56,168 per QALY gained, which included:

- using data on overall survival from the second interim analysis (see section 3.17)
- reduced duration in the first progressed state for patients in the enzalutamide arm (see section 3.22)
- cost corrections (see sections 3.24 and 3.25)
- increasing baseline utility in the first progressed state (see section 3.23).

The committee concluded that most of the ERG's amendments were appropriate and may even have been conservative because they did not include the costs of radium-223 and cabazitaxel. The committee noted that the ERG provided a scenario that included costs of cabazitaxel and radium-223, both associated with confidential discounts, which increased the ICER. The committee reiterated that both the company's and ERG's ICERs were associated with substantial uncertainty. This mainly arose from: the immaturity of the overall survival data in this clinical setting; the lack of evidence of a survival benefit or quality-of-life improvement by delaying metastasis; and the disconnection between the costs and benefits of subsequent treatments in the model. This was compounded by the model structure, which added more uncertainty to the overall survival data by splitting it into survival before and after metastasis. The committee concluded that enzalutamide did not represent a cost-effective use of NHS resources for hormone relapsed non-metastatic prostate cancer.

Other factors

Enzalutamide is not innovative

3.27 The company noted that this is the first indication for a drug within the high-risk non-metastatic prostate cancer population. The committee agreed that there were no additional gains in health-related quality of life over those already included in the QALY calculations. The committee concluded enzalutamide could not be considered to be innovative.

4 Proposed date for review of guidance

4.1 NICE proposes that the guidance on this technology is considered for review by the guidance executive 3 years after publication of the guidance. 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.

Amanda Adler
Chair, Appraisal Committee
December 2018

5 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 B.

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.

Adam Brooke
Technical Lead

Ahmed Elsada
Technical Adviser

Jeremy Powell

Project Manager

ISBN: [to be added at publication]