Sent by e-mail only: XXXXXXXXXXXXXXXX

FAO XXXXXXXXXX and XXXXXXXXXXXX

British Association of Dermatologists

27 August 2024

Dear XXXXXXXXXX and XXXXXXXXXX

**Re:** **Final Draft Guidance For Ruxolitinib Cream For Treating Non-Segmental Vitiligo In People 12 Years And Over [ID 3998]**

Thank you for your letter of 22 August 2024 responding to my initial scrutiny views. This is my final decision on initial scrutiny.

I assess each of your points in turn.

***Ground 1(a): In making the assessment that preceded the recommendation, NICE has failed to act fairly***

**Appeal point 1(a).2: In section 3.10, the Committee appears to believe that the model is fundamentally flawed, being based around the response from a baseline for facial vitiligo only but does not explain why it thinks this is the case.**

I explained in my letter of 8 August 2024 why I am not minded to refer this point to the Panel, setting out my view that the Committee understood and discussed the limitations of the model and appropriately took these limitation into account in decision-making without discarding the model.

 With reference to your response of 22 August:

1. I see no procedural unfairness (or unreasonableness) in a Committee concluding both that a model has limitations (or is "unreliable", per your letter) and that the same model is good enough for decision-making. The alternative would be for NICE Committees never to take a decision (and therefore by default never to recommend a topic) where it has concerns about the reliability of a model. Your letters have not persuaded me that it was procedurally unfair for the Committee to identify concerns with the model yet take a decision in this appraisal. I remain of the view that the Committee provided adequate explanation of its conclusions about the model.
2. I see no procedural unfairness in the Committee's explanation of its concerns with the model. I refer to my response to this point in my letter of 8 August 2022. In addition, I note that the Committee followed NICE's published methods in noting it would be "more cautious about recommending a technology if it is less certain about the ICERs presented" (i.e. a lower ICER threshold would be applied). It also followed NICE's processes in explaining its concerns about the company's model and why it preferred the scenarios resulting in ICERs that ranged from £33,065 to £167,585 per QALY. As to the clarity of that explanation, I note that both the utilities (see para 3.17 of the FDG) and the facial vitiligo issues (see slides 24-27 of the public committee slides[[1]](#footnote-1) and pages 172-175 of the Final Draft Guidance Committee Papers[[2]](#footnote-2)) and paragraphs 3.8-3.10 of the FDG) were concerns for the Committee; there is no procedural obligation to identify one issue only as key to its decision.

Your elaboration has therefore not persuaded me that the Committee failed to provide an adequate explanation of its reasoning so I will not refer this appeal point.

**Appeal point 1(a).3:** **The weight applied to adverse events in the Committee’s deliberation lacks transparency, despite this question having been the subject of some discussion in Committee meetings.**

I remain of the view that this appeal point should not proceed to an oral hearing. Your letter acknowledges that this point "becomes relevant only if it is accepted that phototherapy is the proper comparator, which [you] contend it should be."

The FDG explains the Committee's conclusions on comparator and position at paragraph 3.4.

I have not identified an arguable case in your letter that the choice of comparator was procedurally unfair or unreasonable, which in any event would be a new point not related to your appeal or my response of 8 August 2022. I therefore proceed on the basis that the comparator was no active treatment (followed by some people having phototherapy), and – for the reasons in my letter of 8 August – I will not refer this point.

***Ground 2:******the recommendation is unreasonable in the light of the evidence submitted to NICE***

**Appeal point 2.1: More patients would have phototherapy than the Committee assumes. As this would involve whole-body phototherapy, which is widely available, this has significant cost implications for the NHS, so the assumption on which the Committee has relied is unreasonable.**

Having considered the additional arguments made in your letter of 22 August 2024, I remain of the view that this appeal point should not proceed to an oral hearing. That is because eligibility for phototherapy under national guidelines or otherwise is not evidence of the numbers of patients in fact receiving this treatment in current NHS clinical practice (as noted in my letter of 8 August 2024).

I understand your additional argument to be that the Committee's conclusions on proportion of patients receiving phototherapy was unreasonable because the “committee asked a very brief, single question, which seems to address only one of the clinical experts and did not discuss this response with the rest of the clinical and patient experts who were present.” And that “the clinical expert did not have the chance to provide a more considered and detailed response and explain the real-world situation with phototherapy.” I see no arguable case that this renders the conclusion unreasonable in light of the evidence. I note that the expert view appears to align with much of the consultation comments on this issue and it appears to me the Committee took into account the totality of the evidence submitted to it.

**Appeal point 2.2: The Committee is wrong to say that improvements in F-VASI did not necessarily correspond directly to the improvement in quality of life (QoL) for people with vitiligo. Whilst changes in F-VASI will not always correlate with changes to T-VASI on all measures, there clearly is a relationship and, in any case, improvements in F-VASI have been shown to be hugely important to patients. The Committee’s assertion is, therefore, unreasonable.**

I remain of the view that this appeal point should not proceed to an oral hearing for the reasons set out in my letter of 8 August. You have provided no further arguments or evidence to support an arguable point that the guidance is obviously wrong or illogical. I therefore confirm this point will not be referred.

**Appeal point 2.3: The Committee seems to believe that the model is fundamentally flawed, being based around the response from a baseline for facial vitiligo only, but this assumption is not supported by focus-groups and consensus exercise with vitiligo patients and is therefore unreasonable.**

Having considered the additional arguments made in your letter of 22 August 2024, I remain of the view that this appeal point should not proceed to an oral hearing.

As noted in my letter of 8 August 2024, I was not minded to refer this appeal point as your appeal did not appear to present an arguable case that the Committee's approach or its decision as set out in the FDG was unreasonable in light of the evidence submitted to it. In particular, I explained that I considered that the Committee's view (that it was a limitation of the model that it used changes in F-VASI to drive clinical state transitions) appeared to be based on logical reasoning and I could not identify an arguable case in your appeal that this was unreasonable on the evidence i.e. obviously wrong, illogical, or 'does not add up'.

Your response letter restates your argument that the Committee's "dismissal of the use of response from baseline for facial vitiligo alone, seems counter-intuitive…given how important improvement in facial vitiligo is for most patients." I do not agree that the Committee dismissed the model (see my letter of 8 August). In my view the Committee did not underestimate or dismiss the importance of F-VASI but was rightly mindful that vitiligo can also affect the body, with consequences for benefits and costs of treatment, meaning that the model does not fully reflect the real world. I see no unreasonableness there.

You add that there was very little discussion around the issue of using F-VASI only in the model, but you do not point to any further evidence or make further arguments as to why this arguably rendered the Committee's approach to the model or its conclusions unreasonable.

To the extent that your letter seeks to argue that it was *unreasonable* for the committee to take a decision using the model in light of its concerns about the model, I disagree. The Committee gave a logical explanation of its concerns about the model (see paras 3.10 and 3.17 of the FDG) and why it preferred and felt able to take a decision using the scenarios resulting in ICERs ranging from £33,065 to £167,585 per QALY gained, despite the uncertainty and its preferred assumptions not having been modelled (see paras 3.17 and 3.19 of the FDG). I've identified nothing to suggest that this was unreasonable.

Therefore I will not refer this point.

Conclusion

Therefore your valid appeal point is:

* 1(a).1 as regards whether adequate reasons or explanation was provided in the FDG as to the committee's conclusions about the indirect treatment comparison

NICE shares the valid appeal grounds of each appellant with the other appellants to assist with preparation for the hearing.

NICE will be in contact with you regarding the administration of the appeal, which will be held orally.

Yours sincerely

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Dr Mark Chakravarty

Lead Non-Executive Director for Appeals & Vice Chairman

National Institute for Health and Care Excellence

1. <https://www.nice.org.uk/guidance/gid-ta10893/documents/1-2> [↑](#footnote-ref-1)
2. <https://www.nice.org.uk/guidance/gid-ta10893/documents/committee-papers-2> [↑](#footnote-ref-2)