NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health Technology Evaluation

Benralizumab with corticosteroids for treating relapsing or refractory eosinophilic granulomatosis with polyangiitis

Draft scope

Draft remit/evaluation objective

To appraise the clinical and cost effectiveness of benralizumab with corticosteroids within its marketing authorisation for treating relapsing or refractory eosinophilic granulomatosis with polyangiitis.

Background

Eosinophilic granulomatosis with polyangiitis (EGPA) is a rare autoimmune disease that causes inflammation of the blood vessels. It is characterised by high levels of white blood cells called eosinophils and mainly affects small to medium-sized blood vessels. Asthma is one of the key features of EGPA. Asthma may begin many years before any other symptoms. Most people with EGPA also have upper airway involvement. Later symptoms may include rashes, joint pain and swelling, peripheral neuropathy, abdominal pain, diarrhoea, shortness of breath, arrhythmia, presence of red blood cells in urine, chest pain, and heart failure.

EGPA affects around 1 in 22,000 people in the UK.[1] Based on this estimated prevalence, there are around 2,600 people in England with EGPA.[2] In the first 12 months following an EGPA diagnosis, around 19% of people had an inpatient stay in hospital related to the condition.[1] Around 50% of people experience a relapse after treatment within 5 years.[3]

The aim of treatment is initially to induce remission, then to maintain remission and treat relapse when necessary. Without treatment, the condition can be fatal. Corticosteroids are the mainstay of treatment.[4] Initially high-dose oral corticosteroid, with or without intravenous corticosteroid is used to induce remission. In addition, inhaled and nasal corticosteroids are used for asthma and nasal symptoms. Corticosteroids can be slowly tapered over several months. In some people cyclophosphamide can be used to induce remission and as maintenance treatment. Rituximab may be used to induce remission when cyclophosphamide is unsuitable. Immunosuppressive agents such as methotrexate and azathioprine may also be used as maintenance therapy.

The technology

Benralizumab (Fasenra, AstraZeneca) does not currently have a marketing authorisation in the UK for treating relapsing or refractory eosinophilic granulomatosis with polyangiitis. It has been studied in clinical trials in people with relapsing or refractory EGPA who were receiving oral corticosteroids, with or without stable immunosuppressive therapy. Benralizumab has a marketing authorisation for the following indication: as an add-on maintenance treatment in adult patients with

severe eosinophilic asthma inadequately controlled despite high-dose inhaled corticosteroids plus long-acting β-agonists.

Intervention(s)	Benralizumab with corticosteroids
Population(s)	People with relapsing or refractory eosinophilic granulomatosis with polyangiitis
Subgroups	If evidence allows, the following subgroups will be considered: • People for whom cyclophosphamide is contraindicated • People with upper respiratory involvement • People with severe disease
Comparators	Established clinical management without benralizumab, including: • Corticosteroids (do not currently have a marketing authorisation in the UK for this indication) • Cyclophosphamide (does not currently have a marketing authorisation in the UK for this indication) • Other immunosuppressive agents (do not currently have a marketing authorisation in the UK for this indication) • Rituximab (does not currently have a marketing authorisation in the UK for this indication)
Outcomes	The outcome measures to be considered include: • mortality • remission rates • total accrued duration of remission • time to first relapse • number and severity of relapses • reduction in steroid use • cumulative dose of immunosuppressants • vasculitis activity scores • pulmonary function • adverse effects of treatment • health-related quality of life

Economic analysis	The reference case stipulates that the cost effectiveness of treatments should be expressed in terms of incremental cost per quality-adjusted life year. The reference case stipulates that the time horizon for estimating clinical and cost effectiveness should be sufficiently long to reflect any differences in costs or outcomes between the technologies being compared. Costs will be considered from an NHS and Personal Social Services perspective. The availability of any commercial arrangements for the intervention, comparator and subsequent treatment technologies will be taken into account. The availability and cost of biosimilar and generic products should be taken into account.
Other considerations	Guidance will only be issued in accordance with the marketing authorisation. Where the wording of the therapeutic indication does not include specific treatment combinations, guidance will be issued only in the context of the evidence that has underpinned the marketing authorisation granted by the regulator.
Related NICE recommendations	**Related technology appraisals:** Benralizumab for treating severe eosinophilic asthma (2019) NICE technology appraisal 565. Mepolizumab for treating severe eosinophilic asthma (2021) NICE technology appraisal 671. Reslizumab for treating severe eosinophilic asthma (2017) NICE technology appraisal 479 **Related technology appraisals in development:** Benralizumab for treating hypereosinophilic syndrome in people 12 years and over [6322] Publication date to be confirmed. Benralizumab with mometasone furoate for treating severe nasal polyps [ID1659] Publication date to be confirmed.
Related National Policy	NHS England (2013/14) NHS Standard Contract for Specialised Rheumatology Services (Adult) Ref A13/S/a NHS England (2015) Clinical Commissioning Policy: Rituximab for the treatment of ANCA-associated vasculitis in adults Ref A13/P/a. The NHS Long Term Plan (2019) NHS Long Term Plan

	NHS England (2023) Manual for prescribed specialist services (2023/2024) Chapter 5.

Questions for consultation

What is established clinical management for relapsing or refractory eosinophilic granulomatosis with polyangiitis?

Does established clinical management in the NHS differ for people with severe vs non-severe disease? If so, how? How is severe disease defined?

Where do you consider benralizumab with corticosteroids will fit into the existing care pathway for relapsing or refractory eosinophilic granulomatosis with polyangiitis?

What proportion of people with relapsing/refractory EGPA are already eligible for benralizumab to treat severe eosinophilic asthma (given the population specified in NICE technology appraisal 565)?

- How many people with relapsing/refractory EGPA would be expected to benefit from benralizumab that are not currently eligible for treatment?

Where people with relapsing/refractory EGPA are already taking benralizumab for asthma, do they typically take the licensed dose for severe eosinophilic asthma (30 mg every 4 weeks for the first 3 doses, then every 8 weeks thereafter)?

Please select from the following, will benralizumab with corticosteroids be:
A. Prescribed in primary care with routine follow-up in primary care
B. Prescribed in secondary care with routine follow-up in primary care
C. Prescribed in secondary care with routine follow-up in secondary care
D. Other (please give details):
For comparators and subsequent treatments, please detail if the setting for prescribing and routine follow-up differs from the intervention.

Would benralizumab with corticosteroids be a candidate for managed access?

Do you consider that the use of benralizumab with corticosteroids can result in any potential substantial health-related benefits that are unlikely to be included in the QALY calculation?

Please identify the nature of the data which you understand to be available to enable the committee to take account of these benefits.

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 the proposed remit and scope may need changing in order to meet these aims. In particular, please tell us if the proposed remit and scope:

- could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which benralizumab with corticosteroids 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 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.

NICE intends to evaluate this technology through its Single Technology Appraisal process. (Information on NICE's health technology evaluation processes is available at https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance/changes-to-health-technology-evaluation).

References

1. Hwee, J., Harper, L., Fu, Q., Nirantharakumar, K., Mu, G., & Jakes, R. W. (2024). Prevalence, incidence and healthcare burden of eosinophilic granulomatosis with polyangiitis in the United Kingdom. ERJ Open Research.

2. Office for National Statistics (ONS), released 23 November 2023, ONS website, statistical bulletin, Population estimates for England and Wales: mid-2022

3 Smith, R. M., et al. (2020). Rituximab as therapy to induce remission after relapse in ANCA-associated vasculitis. Annals of the rheumatic diseases, 79(9), 1243-1249.

4 Emmi, G., et al (2023). Evidence-Based Guideline for the diagnosis and management of eosinophilic granulomatosis with polyangiitis. Nature reviews Rheumatology, 19(6), 378-393.