National Institute for Health and Care Excellence

Health Technology Evaluation

Amivantamab with lazertinib for untreated EGFR mutation-positive advanced non-small-cell lung cancer [ID6256]
Response to stakeholder organisation comments on the draft remit and draft scope

Please note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees.

Comment 1: the draft remit and proposed process

Section	Stakeholder	Comments [sic]	Action
Appropriateness of an evaluation and proposed evaluation route	Johnson & Johnson (J&J)	The evaluation and proposed evaluation route are appropriate. J&J understand that a cost-comparison evaluation process is being considered for this evaluation, but would like to highlight that due to the therapeutically superior benefit of amivantamab with lazertinib compared to osimertinib, in addition to the increased cost associated with a branded doublet, a full quantitative analysis, in the form of a cost-effective analysis, will be required (this is discussed further in Other Considerations).	Thank you for your comment. This appraisal is being routed as a single technology appraisal.
	AstraZeneca	The cost comparison route is not appropriate for amivantamab as it is a combination treatment and possesses a different mechanism of action from the tyrosine kinase inhibitors listed in the NICE draft scope. Published evidence indicates amivantamab does not have similar efficacy to the comparators listed.[1] Further, the formulation and administration route differ from current care and likely entail an increase in healthcare resource use.	Thank you for your comment. This appraisal is being routed as a single technology appraisal.

Section	Stakeholder	Comments [sic]	Action
		Further comments relating to appropriateness of proposed evaluation route can be found in the 'Questions for consultation' section below. 1. Cho BC, Felip E, Spira AI, Girard N, Lee JS, Lee SH, Ostapenko YV, Danchaivijitr P, Liu B, Alip A, Korbenfeld EP. LBA14 Amivantamab plus lazertinib vs osimertinib as first-line treatment in patients with EGFR-mutated, advanced non-small cell lung cancer (NSCLC): Primary results from MARIPOSA, a phase III, global, randomized, controlled trial. Annals of Oncology. 2023 Oct 1;34:S1306.	
	British Thoracic Oncology Group (BTOG)	Agreed appropriateness. Single Technology appraisal appropriate	Thank you for your comment.
	EGFR+ UK	This appraisal is both needed and welcome for this patient group.	Thank you for your comment.
Wording	J&J	J&J suggests aligning the wording of the remit with the wording of the anticipated license from the Medicines and Healthcare products Regulatory Agency (MHRA), as per the following: "*To appraise the clinical and cost effectiveness of amivantamab with lazertinib within its marketing authorisation as a treatment* [redacted]	Thank you for your comment. As the anticipated licence wording is still confidential the remit has been amended to better reflect the clinical trial population.
	AstraZeneca	No comments	N/A

Section	Stakeholder	Comments [sic]	Action
	BTOG	yes	Thank you for your comment.
	EGFR+ UK	Yes, this seems appropriate.	Thank you for your comment.
Timing issues	J&J	Although osimertinib monotherapy is available to patients with untreated advanced epidermal growth factor receptor mutations-positive (EGFRm) non-small-cell lung cancer (NSCLC) and represents the current standard of care, acquired resistance is almost inevitable and a major driver for disease progression.[1] The need for better, more effective treatment options for patients in 1L is crucial as most patients do not go on to receive 2L treatment, and therefore are in critical need of the best treatment option upfront. A low proportion of patients (26.7%) receiving 2L treatment was documented in a recent study by Pérol et al., 2024.[2] The results of this retrospective analysis also confirms the poor outcomes with osimertinib shown in clinical trials, with 24% of patients with 1L osimertinib dying before receiving a 2L treatment. Therefore, there is a clear unmet need for the development of targeted treatments for patients with EGFR-mutated NSCLC, while improving survival outcomes.	Thank you for your comment.
	AstraZeneca	No comments	N/A
	BTOG	Moderate	Thank you for your comment.

Section	Stakeholder	Comments [sic]	Action
	EGFR+ UK	EGFR patients with common mutations currently have several efficacious treatments with tolerable side effects. As such, while this is important, it may not be urgent.	Thank you for your comment.
Additional comments on the draft remit	J&J	None	N/A
	AstraZeneca	None	N/A
	BTOG	None	N/A
	EGFR+ UK	None	N/A

Comment 2: the draft scope

Section	Consultee/ Commentator	Comments [sic]	Action
Background information	J&J	1. J&J would like to replace the existing wording in the Background section to the following, in order to best capture the most recent epidemiology data for lung cancer in the UK: Lung cancer is the third most common cancer and the most common cause of cancer death in the UK, accounting for 10% of all new cancer cases and 20% of all cancer deaths in 2020.[1] More recent data published in the last two years continues to shed light on the ever-evolving landscape of NSCLC in the UK. Since 2020, lung cancer remains among the top 5 most common causes of cancer in England,[2] with the number of newly diagnosed patients increasing from 31,371 in 2020, to 36,886 in 2022.[3] Most cases of newly diagnosed lung cancer were at an advanced stage, when the cancer has spread to lymph nodes and other organs in the chest (locally advanced disease; stage 3) or to other parts of the body (metastatic disease; stage 4).[3]	Thank you for your comment and suggested changes. The background is intended to give a brief overview of the condition and treatment options. Given the close similarity between the current background and more recent stats the current wording has been retained. The 91%

Section	Consultee/ Commentator	Comments [sic]	Action
		In 2022, 58.2% (around 21, 500) of people diagnosed with lung cancer in England had NSCLC.[3] Around 14% of people with NSCLC in Europe have mutations in the gene coding the epidermal growth factor receptor (EGFR).[4] The treatment pathway for NSCLC can be divided into interconnected decision points based on the number staging system and line of therapy. Treatment choices are influenced by the presence of biological markers (including programmed cell death 1 ligand PD-L1 status), oncogenic driver genetic alterations, histology (squamous or non-squamous) and previous treatment. For NSCLC with commong EGFR mutation, NICE guidance recommends various tyrosine kinase inhibitors (TKIs) for untreated disease including gefitinib (TA192), erlotinib (TA258), afatinib (TA310), dacomitinib (TA595) and osimertinib (TA654). Although not in scope, an important consideration is the treatment options available for NSCLC patients after first line treatment. For these patients, who have been previously treated with an EGFR TKI, platinum doublet chemotherapy and atezolizumab combination are treatment options (NICE guideline 122 and NICE technology appraisal 584). NICE guidance also recommends osimertinib in EGFR T790M mutation-positive disease (TA653). For previously treated NSCLC without targetable mutations, NICE guidance recommends nivolumab (TA655 and TA713), atezolizumab (TA520) and pembrolizumab (TA428) monotherapies as well as docetaxel with nintedanib (TA347). Docetaxel alone may also be offered. References 1. NHS England. Cancer Registration Statistics, England 2020. Accessed June 2024 2. NHS England. Cancer Registration Statistics, England 2021. Accessed June 2024	value has been retained for NSCLC to reflect the fact that the 33.4% of people in the NLCA report who had unassessed lung cancer were analysed with NSCLC.

Section	Consultee/ Commentator	Comments [sic]	Action
		3. National Lung Cancer Audit. State of the Nation Report 2024. Accessed June 2024. 4. Zhang, YL., Yuan, JQ., Wang, KF. et al. (2016). The prevalence of EGFR mutation in patients with non-small cell lung cancer: a systematic review and meta-analysis. *Oncotarget,* 7(48), 78985. Accessed June 2024	
	AstraZeneca	No comments.	N/A
	BTOG	Yes. This line seems irrelevant: For previously treated NSCLC without targetable mutations, NICE guidance recommends nivolumab (TA655 and TA713), atezolizumab (TA520) and pembrolizumab (TA428) monotherapies	Thank you for your comment. The background section is intended to give a broad overview of the condition and treatment landscape and not the specific decision problem, which is covered in the PICO table.
	EGFR+ UK	The background information seems broadly accurate. Just one thing to note. Where it says "For NSCLC which has been previously treated with an EGFR TKI, platinum doublet chemotherapy and atezolizumab combination are treatment options (NICE guideline 122 and NICE technology appraisal 584).", TA584 includes atezolizumab *plus bevacizumab*, carboplatin and paclitaxel.	Thank you for your comment. This has been amended to clarify what TA584 recommends.
Population	J&J	J&J requests the population to be defined as follows, to align with MHRA licence:	Thank you for your comment. The

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		[redacted]	marketing authorisation is still considered confidential but the population has been updated to better reflect the clinical trial.
	AstraZeneca	The population described in the current remit does not specify whether the patients have been previously treated.	Thank you for your comment. This has now been amended.
	BTOG	Yes	Thank you.
	EGFR+ UK	Yes	Thank you.
Subgroups	J&J	The registrational Phase 3 MARIPOSA trial met its primary endpoint of PFS and has demonstrated consistent efficacy across all pre-specified subgroups, therefore subgroup analyses as proposed in the draft scope, are not considered appropriate.	Thank you for your comment. Subgroups are kept inclusive at this stage to allow committee to consider any subgroups for which evidence is identified.
	AstraZeneca	No comments.	N/A
	BTOG	Could consider other high risk cohorts: Liver mets at baseline ctDNA present at baseline TP-53 co-mutations	Thank you for your comment. The subgroups section has been amended to

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			incorporate some of these suggestions.
	EGFR+ UK	Given recent evidence, co-mutations and additional TP53 mutations may be useful to look at too. Presence of CNS mets is likely to be important, as laz is a bbb penetrant, and may be particularly beneficial for patients with brain mets (over current standard of care).	Thank you for your comments. The subgroups section has been updated to reflect these.
Comparators	J&J	Of the comparators listed in the scope, osimertinib monotherapy is the current standard of care for untreated advanced cEGFR NSCLC (TA654) and is therefore the only relevant comparator to amivantamab and lazertinib. This is supported by recent clinical advisory boards and an RWE study utilising data collected by Johnson & Johnson from the National Cancer Registration and Analysis Service (NCRAS) dataset.[9] The advisory board and RWE study demonstrated that [redacted] Although alternative first- (erlotinib, gefitinib) and second-generation (afatinib, dacomitinib) EGFR TKIs have been recommended by NICE for this population, these therapies are rarely used and therefore not relevant to this appraisal and should be removed from the scope. J&J acknowledges that osimertinib with chemotherapy for untreated advanced cEGFR is currently undergoing the NICE appraisal process, but do not believe it should be included as a relevant comparator as it is not	Thank you for your comments. The comparators are kept inclusive at this stage to allow committee to consider which comparators are established in practice and are relevant to the decision problem. Osimertinib with chemotherapy (subject to NICE appraisal) has been retained in the scope as current timings mean that it may be established in practice by the time of this appraisal and in line with the NICE manual

<table>
<tr><th>Section</th><th>Consultee/ Commentator</th><th>Comments [sic]</th><th>Action</th></tr>
<tr><td></td><td></td><td>licenced, does not have a NICE recommendation, and is therefore not considered established clinical practice in the NHS.</td><td>for health technology evaluation.</td></tr>
<tr><td></td><td>AstraZeneca</td><td>See comments relating to appropriateness of proposed evaluation route.</td><td>Thank you for your comment.</td></tr>
<tr><td></td><td>BTOG</td><td>Yes
Osi with chemotherapy should be included</td><td>Thank you for your comment.</td></tr>
<tr><td></td><td>EGFR+ UK</td><td>These seem appropriate, and represent current standard practice well. We recently carried out a survey of over 200 EGFR patients (who are members of our charity). Of those with Exon 19 and 21 mutations, over 80% were on some form of TKI. The most common treatments were:

<table><tr><td>Osimertinib</td><td>73.42%</td></tr><tr><td>Gefitinib</td><td>2.53%</td></tr><tr><td>Afatanib</td><td>3.80%</td></tr><tr><td>Eroltonib</td><td>1.27%</td></tr><tr><td>Dacomitinib</td><td>0.00%</td></tr><tr><td>Amivantamab</td><td>1.27%</td></tr></table>
The remaining patients were either on chemo, or no treatment.</td><td>Thank you for your comment. This has been considered during finalisation of the scope.</td></tr>
<tr><td>Outcomes</td><td>J&J</td><td>The following additional outcome measure should be considered to fully capture the most important health benefits of amivantamab with lazertinib:</td><td>Thank you for your comment. The outcomes section of the</td></tr>
</table>

Section	Consultee/ Commentator	Comments [sic]	Action
		• duration of response	scope is not exhaustive. The company can report and submit additional outcomes to those listed on the scope.
	AstraZeneca	No comments.	N/A
	BTOG	Yes	Thank you.
	EGFR+ UK	Yes -outcomes seem appropriate. Given the toxicity profile of this drug combination, quality of life is going to really important to consider here.	Thank you for your comment.
Equality	J&J	The United Kingdom Lung Cancer Coalition (UKLCC) report on health inequalities in lung cancer highlights the crucial fact that lung cancer has the biggest deprivation gap compared to any other cancer in the UK.[3] Deaths associated with socio-economic variation is shown to be most commonly reported in lung cancer and as such, there is an ever growing need to not only acknowledge the health inequality associated with this disease, but also identify drivers of health inequality in order to ensure all patients have equal access to life changing treatments. Health inequality associated with stigma is a major concern for lung cancer patients as it is largely driven by a perception that it is 'self-inflicted' due to the public recognising the link between lung cancer and smoking.[4] This is particularly damaging for patients with common EGFR mutated NSCLC as these mutations disproportionately affect never-smokers, women and patients of Asian ethnicity.[3,5]	Thank you for your comments. These will be incorporated and considered in the equalities impact assessment form and will be considered by the committee during the appraisal.

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		The impact of stigma on people living with lung cancer, including patients and caregivers has been well-reported. In one qualitative study, barriers to symptom reporting for lung cancer patients included blame, stigma and cultural influences.[6] Additionally, an observational, cross-sectional study has shown that some patients report feeling uncomfortable communicating their symptoms leading to delay in presentation, diagnosis and treatment (or low uptake of treatment).[7] The effects of stigma associated with lung cancer should be included within the decision-making process and are not inherently captured within the cost per QALY framework. Stigma is included in the NICE social value judgements principles document and as such, should be considered when deciding whether amivantamab with lazertinib is cost-effective in this population. Please identify the nature of the data which you understand to be available to enable the committee to take account of these benefits. • Literature • Reports from a patient / caregiver study that Johnson & Johnson conducted in 2021 • Reports from market research on the impact of EGFR mutated NSCLC on quality of life that Johnson & Johnson conducted in 2023 and 2024	
	AstraZeneca	No comments.	N/A
	BTOG	No - None	Thank you.

Section	Consultee/ Commentator	Comments [sic]	Action
	EGFR+ UK	I don’t see any issues with equality.	Thank you.
Other considerations	J&J	The draft scope suggests that a cost-comparison evaluation process is being considered for this submission, if the technology is likely to provide similar or greater health benefits at similar or lower cost than technologies recommended in published NICE technology appraisal guidance for the same indication. The results of the Phase 3 MARIPOSA study met its primary endpoint with a statistically significant and clinically meaningful improvement in PFS by BICR (Blinded Independent Central Review) and a favourable OS trend for amivantamab with lazertinib compared to osimertinib monotherapy. Patients receiving amivantamab with lazertinib achieved longer PFS (23.7 months) compared to those who received osimertinib alone (16.6 months, HR, 0.70 [95% CI, 0.58-0.85; P<0.001]). A planned interim OS analysis showed a trend favouring the combination of amivantamab and lazertinib compared to osimertinib monotherapy (HR, 0.80 (95% CI, 0.61-1.05); P=0.11). The safety profile is also consistent with previously reported data for amivantamab plus lazertinib, where the most commonly reported AEs were mostly grades 1 and 2. Furthermore, the cost of a branded doublet is unlikely to be similar to that of a monotherapy, and therefore will need to be assessed for its cost-effectiveness versus current standard of care. Overall, considering the results of the trial, which are demonstrative of the therapeutically superior benefit of amivantamab with lazertinib compared to	Thank you for your comment and the data provided. This appraisal will follow the single technology appraisal route with a cost-utility analysis.

Section	Consultee/ Commentator	Comments [sic]	Action
		osimertinib, in addition to the cost associated with a branded doublet, a full quantitative analysis, in the form of a cost-effective analysis, will be required.	
	AstraZeneca	None	N/A
	BTOG	Nil	N/A
	EGFR+ UK	The economic section says “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.” – what is this exactly? More clarity needed here.	Thank you for your comment. This is standard text taken from the NICE reference case (please see sections 4.2.22 to 4.2.25 of the NICE manual for health technology evaluation). It essentially means that the time horizon for the model should fully capture all costs and benefits of the technologies. For oncology appraisals this is usually a lifetime time horizon.
Questions for consultation	J&J	Questions for consultation	Thank you for your responses to the consultation questions these have been

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		Where do you consider amivantamab with lazertinib will fit into the existing care pathway for EGFR mutation positive NSCLC? Amivantamab in combination with lazertinib will fit in the NICE pathway for untreated advanced EGFR mutation positive NSCLC, by offering a targeted combination therapy option for these patients. It is anticipated that amivantamab plus lazertinib will be positioned alongside osimertinib monotherapy as a first-line treatment option with better survival outcomes than current standard of care. The MARIPOSA trial appropriately offers a head-to-head comparison of these two treatment approaches. **Would amivantamab plus lazertinib be a candidate for managed access?** J&J consider that mature evidence is available, and any evidence gaps are unlikely to result in significant uncertainty for decision making. Amivantamab plus lazertinib would therefore not be a candidate for managed access. **Are the suggested comparators appropriate?** No. Osimertinib monotherapy is the current standard of care in the UK for this patient population and is the only appropriate comparator for inclusion in this scope. First- and second-generation EGFR TKIs, although recommended by NICE, are rarely used and therefore not relevant to this appraisal. Osimertinib with chemotherapy should not be included as a relevant comparator as it is not considered established clinical practice in the NHS. **Are the suggested subgroups appropriate?** MARIPOSA trial has demonstrated consistent efficacy across all pre-defined subgroups, therefore subgroup analyses as proposed in the draft scope, are not considered appropriate.	considered in finalising the scope and process for this appraisal.

Section	Consultee/ Commentator	Comments [sic]	Action
		Would the effectiveness of amivantamab with lazertinib be expected to vary depending on whether or not CNS metastases are present? No, J&J do not expect the effectiveness of amivantamab with lazertinib to vary depending on whether or not CNS metastases are present. Data from the MARIPOSA interim analysis showed that PFS benefit by BICR was consistent in patients with or without a history of brain metastases.[8,9] **Would the effectiveness of amivantamab with lazertinib be expected to vary depending on whether or not the patient had newly diagnosed advanced or metastatic disease or disease recurrent after surgery or radiotherapy?** J&J do not expect the effectiveness of amivantamab with lazertinib to vary depending on whether or not the patient had newly diagnosed advanced or metastatic disease or disease recurrent after surgery or radiation. The MARIPOSA study is inclusive of the above specified patient population and was not a stratification factor for the purpose of assessing efficacy and safety of amivantamab with lazertinib in treating EGFR-mutated NSCLC. **Do you consider that the use of amivantamab with lazertinib 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. The impact of stigma on people living with lung cancer, including patients and caregivers has been well-reported. In one qualitative study, barriers to symptom reporting for lung cancer patients included blame, stigma and cultural influences.[6] Additionally, an observational, cross-sectional study has shown that some patients report feeling uncomfortable communicating their	

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		symptoms leading to delay in presentation, diagnosis and treatment (or low uptake of treatment).[7] The effects of stigma associated with lung cancer should be included within the decision-making process and are not inherently captured within the cost per QALY framework. Stigma is included in the NICE social value judgements principles document and as such, should be considered when deciding whether amivantamab with lazertinib is cost-effective in this population. Furthermore, Data sources that will enable the committee to take account of these benefits include: • Literature • Reports from a patient / caregiver study that Johnson & Johnson conducted in 2021 • Reports from market research on the impact of EGFR mutated NSCLC on quality of life that Johnson & Johnson conducted in 2023 and 2024 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 amivantamab with lazertinib will be licensed	

Section	Consultee/ Commentator	Comments [sic]	Action
		• 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. Please see response above in equality considerations.	
	AstraZeneca	**Where do you consider amivantamab with lazertinib will fit into the existing care pathway for EGFR mutation positive NSCLC?** Amivantamab with lazertinib is described in the draft scope as being studied as a first line treatment for patients with NSCLC which has an EGFR exon 19 deletion or exon 21 L858R substitution mutation. **Are the suggested comparators appropriate?** The draft scope does not mention the line of therapy in the population of interest however, it describes the technology as being compared to osimertinib alone and lazertinib alone in people with NSCLC that has an exon 19 deletion or an exon 21 L858R substitution mutation in a phase 3 clinical study. Treatment options for previously treated patients differ from those for the frontline population. NICE is considering evaluating this technology through its cost comparison evaluation process.	Thank you for your responses to the consultation questions these have been considered in finalising the scope and process for this appraisal.

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		Please provide comments on the appropriateness of appraising this topic through this process. *Is the technology likely to be similar in its clinical effectiveness and resource use to any of the comparators? Or in what way is it different to the comparators?* *Will the intervention be used in the same place in the treatment pathway as the comparator(s)? Have there been any major changes to the treatment pathway recently? If so, please describe* *Will the intervention be used to treat the same population as the comparator(s)?* *Overall is the technology likely to offer similar or improved health benefits compared with the comparators?* *Would it be appropriate to use the cost-comparison methodology for this topic?* The technology is unlikely to provide similar clinical effectiveness and resource use to any of the comparators. The listed comparators are TKIs used as monotherapy (with the exception of osimertinib with chemotherapy [subject to NICE Appraisal]). Amivantamab is an epidermal growth factor receptor (EGFR) and Mesenchymal-epithelial Transition Factor (MET) Bispecific Antibody expected to be used in combination with lazertinib.[1] Resource use is also expected to differ for the amivantamab treatment regimen because, in contrast to currently reimbursed oral TKIs, amivantamab is administered via infusion.	

Section	Consultee/ Commentator	Comments [sic]	Action
		Amivantamab with lazertinib is described in the draft scope as being studied as a first line treatment for patients with NSCLC which has an EGFR exon 19 deletion or exon 21 L858R substitution mutation however, the population wording in the draft scope is not clear whether the scope of the appraisal is for untreated patients. It remains to be seen where this new combination treatment would be used in the treatment pathway. The cost comparison route is not appropriate for amivantamab as it is a combination treatment and possesses a different mechanism of action from the tyrosine kinase inhibitors listed in the NICE draft scope. Published evidence indicates amivantamab does not have similar efficacy to the comparators listed.[1] 1. Cho BC, Felip E, Spira AI, Girard N, Lee JS, Lee SH, Ostapenko YV, Danchaivijitr P, Liu B, Alip A, Korbenfeld EP. LBA14 Amivantamab plus lazertinib vs osimertinib as first-line treatment in patients with EGFR-mutated, advanced non-small cell lung cancer (NSCLC): Primary results from MARIPOSA, a phase III, global, randomized, controlled trial. Annals of Oncology. 2023 Oct 1;34:S1306.	
	BTOG	Where do you consider amivantamab with lazertinib will fit into the existing care pathway for EGFR mutation positive NSCLC? High risk patients with EGFR mutant disease Would amivantamab with lazertinib be a candidate for managed access? Yes Are the suggested comparators appropriate? Yes	Thank you for your responses to the consultation questions these have been considered in finalising the scope and process for this appraisal.

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		Are the suggested subgroups appropriate? Yes – as above, may consider other surrogates for high risk disease – eg Liver mets, ctDNA at baseline and TP53 co-mutations. Would the effectiveness of amivantamab with lazertinib be expected to vary depending on whether or not CNS metastases are present? Maybe, but this may be surrogate of high burden / more aggressive disease rather than brain mets as independent factor. Would the effectiveness of amivantamab with lazertinib be expected to vary depending on whether or not the patient had newly diagnosed advanced or metastatic disease or disease recurrent after surgery or radiotherapy? No. Do you consider that the use of amivantamab with lazertinib can result in any potential substantial health-related benefits that are unlikely to be included in the QALY calculation? No	
	EGFR+ UK	"Would the effectiveness of amivantamab with lazertinib be expected to vary depending on whether or not the patient had newly diagnosed advanced or metastatic disease or disease recurrent after surgery or radiotherapy?" – I am not sure about this. "Is the technology likely to be similar in its clinical effectiveness and resource use to any of the comparators? Or in what way is it different to the comparators?" - Resource use varies: TKIs can be taken at home, with	Thank you for your responses to the consultation questions these have been considered in finalising the scope and process for this appraisal.

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		limited need to go into hospital settings. Ami/Laz is delivered via IV. Adverse reactions are common in initial infusion, so this will need to be managed. “Will the intervention be used to treat the same population as the comparator(s)?” - Broadly yes, although Grade 3 toxicities are higher… so may need to take that into account when deciding who is most likely to tolerate it. “Overall is the technology likely to offer similar or improved health benefits compared with the comparators?” – research suggests the health benefits are likely to be higher with Ami/Laz than with comparators. Additionally, adding another treatment option in to accepted treatment pathways is likely to have a positive impact on the wellbeing of EGFR patients.	
Additional comments on the draft scope	J&J	No additional comments	N/A
	AstraZeneca	No additional comments.	N/A
	BTOG	Nil	N/A
	EGFR+ UK	While this appraisal is for untreated patients, there is significant anxiety amongst our members around what happens when they progress on Osi. Could this be considered as a subsequent line therapy as well? And how would first line use effect Osimertinib (or other TKI use) at a subsequent line?	Thank you for your comments. The final scope reflects the clinical trial population for this treatment which is for people with untreated EGFR mutation positive NSCLC.

The following stakeholders indicated that they had no comments on the draft remit and/or the draft scope

EGFR Positive UK (patient consultee)
Roy Castle Lung Cancer Foundation