NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health Technology Evaluation

Obinutuzumab for treating lupus nephritis ID6420

Draft scope

Draft remit/evaluation objective

To appraise the clinical and cost effectiveness of obinutuzumab within its marketing authorisation for treating lupus nephritis.

Background

Systemic lupus erythematosus (SLE) is a chronic autoimmune condition that causes inflammation in the body's tissues. The manifestations of SLE vary greatly between people and can affect the whole body including the skin, joints, internal organs and serous membranes.

In some people with SLE, the body's immune system targets kidney cells, particularly the filtering units called glomeruli, resulting in inflammation. This complication is called lupus nephritis. Lupus nephritis is divided into classes (I to VI), based on glomerular pathology, following a kidney biopsy.[1] Common signs and symptoms of lupus nephritis include blood or foam in urine, swelling in extremities, and high blood pressure. Untreated lupus nephritis can permanently damage kidneys.[2] People with lupus nephritis are at increased risk of developing end-stage renal disease[3], which will need dialysis or kidney transplantation.[4] Lupus nephritis has an increased mortality risk compared with SLE without lupus nephritis.[3]

There are currently around 60,000 people with SLE in England and Wales and around 3,000 people are diagnosed with SLE each year.[5] Up to 60% of people with SLE develop lupus nephritis.[6,7,8] Compared with people who are described as white, the prevalence of lupus nephritis is around 4, 18 and 19 times higher, respectively, among those with Indo-Asian, Afro-Caribbean and Chinese family backgrounds.[9] Lupus nephritis is also more prevalent in women than in men.[9]

There is no cure for lupus nephritis. The aim of current treatments for lupus nephritis is to preserve renal function, prevent disease flares, improve quality of life, and improve survival.[6] Because lupus nephritis has a relapsing and remitting pattern, treatments are used to either induce or maintain remission. Most people will have hydroxychloroquine and corticosteroids alongside an immunosuppressive. The use of immunosuppressive varies. The immunosuppressives used to induce remission include mycophenolate, cyclophosphamide, rituximab with mycophenolate, and tacrolimus with or without mycophenolate. NICE technology appraisals guidance 882 (2023) also recommends voclosporin, a calcineurin inhibitor, with mycophenolate mofetil for treating active class 3 to 5 (including mixed class 3 and 5, and 4 and 5) lupus nephritis in adults. Maintenance treatments include mycophenolate, azathioprine or tacrolimus monotherapy.

The technology

Obinutuzumab (Gazyro, Roche) does not currently have a marketing authorisation in the UK for adults with lupus nephritis. It has been studied in a phase 3 trial in people

with class 3 or 4 lupus nephritis compared with placebo alongside standard care including mycophenolate mofetil and corticosteroids.

Intervention(s)	Obinutuzumab with immunosuppressive therapies
Population(s)	Adults with lupus nephritis

Comparators	Established clinical management without obinutuzumab including:
	• induction alongside hydroxychloroquine and corticosteroids including:
	  ○ azathioprine
	  ○ calcineurin inhibitor (such as voclosporin, ciclosporin, or tacrolimus) with or without mycophenolate
	  ○ cyclophosphamide
	  ○ mycophenolate
	  ○ rituximab with mycophenolate
	• maintenance treatment with mycophenolate, azathioprine or a calcineurin inhibitor (such as tacrolimus).

Outcomes	The outcome measures to be considered include: • renal response • rate and severity of renal-related events (e.g., flares) • rate and duration of remission • incidence of end-stage renal disease • corticosteroid use • mortality • 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 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:** Voclosporin with mycophenolate mofetil for treating lupus nephritis (2023) NICE technology appraisal guidance 882. Belimumab for treating active autoantibody-positive systemic lupus erythematosus (2021). NICE Technology Appraisal TA752.

Questions for consultation

Where do you consider obinutuzumab will fit into the existing care pathway for lupus nephritis? Would you expect it to be used as maintenance, as well as induction?

Is voclosporin with mycophenolate mofetil currently used for induction or maintenance treatment?

Please select from the following, will obinutuzumab 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 obinutuzumab be a candidate for managed access?

Do you consider that the use of obinutuzumab 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.

Please indicate if any of the treatments in the scope are used in NHS practice differently than advised in their Summary of Product Characteristics. For example, if the dose or dosing schedule for a treatment is different in clinical practice. If so, please indicate the reasons for different usage of the treatment(s) in NHS practice. If stakeholders consider this a relevant issue, please provide references for data on the efficacy of any treatments in the pathway used differently than advised in the Summary of Product Characteristics.

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 obinutuzumab 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 Weening, J.J et al. (2004) The Classification of Glomerulonephritis in Systemic Lupus Erythematosus Revisited. J Am Soc Nephrol 15:241-250

2 Kidney Care UK. Lupus nephritis? Accessed November 2024.

3 Hanly J G, O'Keefe, A G, Su L, Urowitz M R, Romero-Diaz J (2016) The frequency and outcome of lupus nephritis: results from an international inception cohort study. Rheumatology 55:252-262.

4 Bertsias GK, Tektonidou M, Amoura Z, Aringer M, Bajema I, Berden JHM, et al. (2012) Joint European League Against Rheumatism and European Renal Association–European Dialysis and Transplant Association (EULAR/ERA-EDTA) recommendations for the management of adult and paediatric lupus nephritis. Annals of the Rheumatic Diseases 71(11):1771.

5 Rees F, Doherty M, Grainge M et al. (2016) The incidence and prevalence of systemic lupus erythematosus in the UK, 1999-2012. Ann Rheum Dis 75:13641.

6 Fanouriakis A, Kostopoulou M, Cheema K et al. (2020) 2019 Update of the Joint European League Against Rheumatism and European Renal Association–European

Dialysis and Transplant Association (EULAR/ERA–EDTA) recommendations for the management of lupus nephritis. Annals of the Rheumatic Diseases 79:713-723.

7 Saxena R, Mahajan T and Mohan C. (2011). Lupus nephritis: current update. Arthritis research & therapy 13(5):240

8 CPRD (2017) Epidemiology of Systemic Lupus Erythematosus (SLE) and Lupus Nephritis (LN) in England: a retrospective observational study using CPRD-HES linked data

9 Patel M, Clarke AM, Bruce IN and Symmons DPM, (2006) The prevalence and incidence of biopsy-proven lupus nephritis in the UK: Evidence of an ethnic gradient. Arthritis & Rheumatism 54(9):2963-2969.