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RE: Erlotinib and gefitinib for treating non-small-cell lung cancer that has progressed following prior chemotherapy (Review of TA162 and TA175) [ID620]

Dear Nicole,

Thank you for providing the opportunity to comment on the addendum to the assessment report for ID620.

The identification of a significant error at this late stage in the appraisal is disappointing – particularly when it is considered that this error was not identified during peer review or during the Committee's deliberations and was identified by Roche. The correction of this error could potentially result in a third change to the Committee's decision, with future NSCLC patients unable to benefit from any active treatment at second line.

NICE Committees place considerable importance on the data and opinions expressed by assessment groups and evidence review groups. In light of this the identification of a fundamental error in one of the models developed is concerning. We would welcome reconsideration from NICE on the quality assurance steps applied to the work of ERGs/assessment groups in order to ensure analyses are sufficiently robust to support Committee decisions.

We believe that the addendum accurately represents the correction of the episodes of febrile neutropenia (FN) applied to the model. Sensitivity analysis presented considers a range of FN rates from 3.85% to 25%. In line with our response to the first ACD, we believe that rates of hospitalisation for infection as a result of treatment with docetaxel are plausibly in the range of 10 – 20% in clinical practice. We acknowledge that the addendum concludes that at FN rates up to

12.68% docetaxel dominates, and that at the highest FN rate of 25% the ICER of £4,852 favours docetaxel. This is in line with our appraisal submission which stated that we did not consider it possible to demonstrate cost effectiveness of erlotinib in comparison to generic docetaxel.

Despite docetaxel patent expiry in 2010, and its subsequent 90% average price reduction, erlotinib has maintained a position as the most prescribed treatment for second line NSCLC. Comments from clinicians made to NICE on the first ACD for this appraisal were in favour of retaining the option to treat with erlotinib, where it is the most appropriate choice for a patient. We note that the cost differential of treating with erlotinib over docetaxel is less than £550 per episode of care in the corrected base case. This is because, despite a significantly lower acquisition cost for docetaxel, this cost benefit is almost eroded by the high costs of treating toxicities and administration costs. If figures for docetaxel-related infection typically reported by UK clinicians are substituted for trial febrile neutropenia rates, docetaxel and erlotinib are likely to be very close to cost-equivalent, indeed at the highest rate of FN considered in the addendum, docetaxel treatment actually becomes more costly per episode of care than erlotinib (approximately £500).

Efficacy of erlotinib in EGFR WT patients has been questioned by the committee during the course of this appraisal. We are pleased to have observed the committee's changing belief in this respect through conversion of an initial negative ACD for this cohort, to a positive second ACD for all EGFR WT patients who are suitable for docetaxel. The correction of the model error should not result in changing efficacy assumptions for erlotinib.

The correction of the model error concerns the cost of docetaxel only, and does not impact the cost of erlotinib to the NHS. Neither of course, will it impact on the desire of clinicians to keep erlotinib as their most widely-used second-line treatment for NSCLC.

Finally we note that the Committee has not yet discussed the implications of the 2014 PPRS scheme in relation to this appraisal. I refer you back to the Roche response to the first ACD which details our points in this regard.

Kind Regards

[redacted]