Chair of NICE Appraisal Committee

1/04/2014

Dear Chair

RE:- Single Technology Appraisal (STA). Lenalidomide for treating multiple myeloma after 1 prior treatment with bortezomib (part-review of TA171) [ID667]

I would like to take this opportunity to thank the committee for the opportunity to represent the myeloma community at the original appraisal as the clinical specialist, and also to now comment on the appraisal consultation document.

I am deeply disappointed that the committee did not feel able to recommend lenalidomide in this setting. My understanding from the appraisal documents is that this is due to the uncertainly around the modelling and cost-effectiveness of the therapy, rather than around the clinical evidence.

Within the documentation the clinical evidence, both published and presented by myself and the patient representative at the meeting appears to be accurately recorded. Moving forward I would like to stress a few key points:-

TA171 is only relevant for patients who are unable to take thalidomide at diagnosis and hence have received bortezomib therapy first line. For some of these patients bortezomib re-treatment will be appropriate, however for a group of patients re-treatment with bortezomib will not be appropriate (eg those whose disease has not responded well to bortezomib, or patients who had experienced adverse reactions with to bortezomib). As this group of patients is historically small, I agree that modelling using suitable data sets is very difficult and sadly it seems unlikely that new publications will become available to help in this matter.

In section 4.2 and 4.3 of the appraisal document, the committee have captured and agree with the clinical arguments for using an effective therapy at first relapse. The Committee concluded that, '*when offered second line, lenalidomide was likely to be more effective than placebo and standard chemotherapy, but that it was unclear whether lenalidomide was clinically more effective than retreatment with bortezomib*'. I totally agree with the first part of this statement, however believe the second part of the statement needs further clarification as it is only partially correct. There is no data comparing patients who have had a good response to bortezomib therapy first line who are then treated with lenalidomide or bortezomib retreatment. However, clinically, based on biological data, we would often change the treatment to an agent with a different mechanism of action, hence overcoming clonal heterogeneity and potential drug resistance. It would however be totally inappropriate clinically to expose a patient to retreatment with bortezomib if they had failed to respond the first time or had been intolerant of the therapy. Access to lenalidomide for these patients is extremely important.

In summary given the strong clinical rationale for the use of this agent in patients at first relapse who meet the STA criteria, I would like to urge the Committee and Company to discuss how the uncertainly around the modelling and cost-effectiveness of lenalidomide can be resolved so that myeloma patients can benefit from this important treatment.

Yours sincerely
With best wishes

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