

Abbott response to NICE Appraisal Consultation Document for adalimumab for the treatment of chronic plaque psoriasis

21st February 2008

Abbott welcomes the opportunity to comment on the Appraisal Consultation Document (ACD) prepared for the appraisal of adalimumab for the treatment of chronic plaque psoriasis. Abbott welcomes the provisional recommendations for the use of adalimumab for the treatment of patients with severe chronic plaque psoriasis. However, Abbott considers that given the clinical and cost-effectiveness profile of adalimumab compared to etanercept, adalimumab should be recommended as the first choice biologic treatment for patients with severe psoriasis meeting the PASI and DLQI criteria as outlined in the ACD.

Our comments are set out below under the suggested headings for consultation on the ACD.

1 Whether you consider that all of the relevant evidence has been taken into account?

Abbott is not aware of any relevant evidence that has not been taken into account by the appraisal committee.

2 Whether you consider that the summaries of clinical and cost effectiveness are reasonable interpretations of the evidence and that the preliminary views on the resource impact and implications for the NHS are appropriate?

Summary of clinical effectiveness

Abbott considers that patients receiving adalimumab will have a higher probability of treatment response compared to etanercept. This view is supported by the clinical experts and the results of the mixed treatment comparison:

“The Committee heard from the clinical experts that, based on clinical experience, adalimumab could provide greater clinical benefit than etanercept when an anti-TNF is considered appropriate for treatment in a person with severe psoriasis. The Committee also noted the results of the mixed-treatment comparison conducted by the manufacturer, which suggested a higher probability of response following treatment with adalimumab compared with etanercept.” NICE Appraisal Consultation Document. Adalimumab for the treatment of Psoriasis.

Abbott considers that patient heterogeneity in the clinical trials is unlikely to be a major confounding factor that could account for the consistently higher PASI response rates observed in trials for adalimumab, when indirectly compared with trials for etanercept. It should also be noted that the difference in effectiveness of adalimumab and etanercept is consistent with indirect comparisons of the effectiveness of these two agents in treating psoriasis in trials conducted in patients with psoriatic arthritis. Given the strength of data on this point, Abbott considers that the summary of evidence on clinical effectiveness should emphasise the likely greater clinical benefits of adalimumab compared to etanercept.

Summary of cost effectiveness of adalimumab compared to etanercept

Adalimumab versus high initial dose etanercept

Consideration should be given to the dose of etanercept used in UK clinical practice. The model analyses presented by Abbott indicate that etanercept given at the higher initial dose of 100mg weekly is unlikely to be cost effective, in line with previous analyses conducted for the appraisal of etanercept in TA103. Therefore, use of adalimumab is likely to be more cost effective than etanercept, particularly if etanercept is initiated at the licensed but non-NICE recommended

higher dose of 100mg weekly for the first 12 weeks of therapy. Abbott considers that the greater cost-effectiveness of adalimumab compared to etanercept when used at the higher dose should be more clearly stated in the content of the guidance.

Adalimumab versus continuous-use etanercept

It was acknowledged by the clinical experts consulted that some patients with severe psoriasis may require continuous dosing of etanercept. Based on the results of the available economic modelling Abbott considers that the summary of cost-effectiveness should emphasise more clearly the greater cost effectiveness of adalimumab versus continuous-use etanercept.

Adalimumab versus intermittent-use etanercept

Abbott acknowledges that the likely dosing regimen and time off treatment for intermittent use of etanercept in the UK is unclear. However, a greater source of uncertainty for the cost effectiveness of intermittent use etanercept is the effectiveness of long-term intermittent treatment, as data are currently only available for one period of retreatment with etanercept. The model presented by Abbott was highly favourable to etanercept by assuming that all patients retreated will be able to regain response after multiple periods off treatment.

Furthermore, given the uncertainty over the length of time patients receiving etanercept would be off treatment, Abbott used a conservative assumption of 88% of the dose of continuous etanercept in the economic modelling presented in the manufacturers submission. If in UK clinical practice patients with severe psoriasis are off treatment for shorter periods, as was agreed by the clinical experts consulted, the available data indicate that adalimumab will be a more cost effective treatment option than etanercept.

Use of a 12-week stopping rule for adalimumab

Furthermore, it should be borne in mind that the cost effectiveness results presented by Abbott and the ERG utilised a 16-week stopping rule for non-responders. Use of a 12-week stopping rule for adalimumab non-responders in line with that used for etanercept is likely to further reinforce the greater cost effectiveness of adalimumab compared to etanercept.

3 Whether you consider that the provisional recommendations of the Appraisal Committee are sound and constitute a suitable basis for the preparation of guidance to the NHS?

Abbott welcomes the provisional recommendations for the use of adalimumab for the treatment of patients with severe chronic plaque psoriasis. However, as outlined in section 2, Abbott considers that given the clinical and cost-effectiveness profile of adalimumab compared to etanercept, adalimumab should be recommended as the first choice biologic treatment for patients with severe psoriasis meeting the PASI and DLQI criteria as outlined in the ACD.

Factual inaccuracies in the ACD

PASI response in REVEAL study

"During the open-label period of the trial, 89% of people originally randomised to adalimumab had at least a PASI 75 response at week 33". Page 6

The above statement in regard to the REVEAL study is not factually correct and could be amended to read as follows:

"Adalimumab-treated patients who achieved a PASI 75 response at week 16 had a mean 92% PASI score improvement relative to baseline and had a mean 89% PASI score improvement

relative to baseline at week 33.”