NHS Cambridgeshire

Our ref: [redacted]
Your ref:
Date: 26 August 2008

Please reply to:
Heron Court
Ida Darwin
Fulbourn
Cambridge
CB21 5EE

Switchboard: [redacted]
Direct Tel:
Fax:
Email:
Website: www.cambridgeshire.nhs.uk

Christopher Feinmann
Technology Appraisal Project Manager
NICE
Level 1A
City Tower
Piccadilly Plaza
MANCHESTER
M1 4BD

Dear Mr Feinmann

Health Technology Appraisal:
Bevacizumab, sorafenib, sunitinib and temsirolimus for renal cell carcinoma

This is the formal response of the NHS Cambridgeshire (Cambridgeshire PCT.

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

Yes: the evidence that the renal oncologists appear most likely to consider critical is the data presented to ASCO week commencing 30 May 2008 giving updated results and information on patients who did not receive any post study treatment for metastatic renal cell carcinoma. The conference data was supplied to us by NICE as the Pfizer HTA from study A6181034.

2. Do 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?

Agree that the summaries are reasonable interpretations of the evidence but that the evidence base is not yet mature and current research may affect future understanding of which populations to use these drugs for.

We support the approach taken in this ACD of minimising the impact to the NHS of the (repeated) proposal from the manufacturer to provide one free cycle (treatment for 6 weeks) of sunitinib – as noted on Pfizer HTA p1. We note from the Pfizer HTA that this did not bring sunitinib within the NHS' normal cost effectiveness frame and therefore the absence of this information may affect the understanding of OS with sunitinib but cost effectiveness would not be substantially changed.

One free cycle is also insufficient time in which to expect to see a difference in the disease. The cost to the NHS (both providers and commissioners) of administering the scheme substantially reduces the actual gain for the NHS and is mostly misleading.

Costing that does not reflect the true cost to the NHS is a great concern at PCT level – the cost of a treatment is often misrepresented and the enduring debate about the treatment fails to address the actual cost to the NHS. The example in this ACD is the manufacturer quoting part vials rather than whole vials. We would ask NICE to consider that all cost calculations should omit free stock or capped scheme. These are principally ways to manipulate the cost per Qualy on the basis of the misunderstanding that it causes away from NICE.

3. **Do you consider that the provisional recommendations of the Appraisal Committee are sound and constitute a reasonable basis for the preparation of guidance to the NHS?**

Patients who have had a nephrectomy and have good or intermediate performance status appear to do better on sunitinib. The cost-effectiveness of selecting a therapy according to performance status appears not to have been explored.

4. **Are there any equality issues that may need special consideration?**

There are none that we are aware of.

Yours sincerely

[redacted]

Cambridgeshire and Peterborough Public Health Network

Emailed to christopher.feinmann@nice.org.uk on 29 August 2008