To: appeals@nice.org.uk
Subject: Rituximab for the treatment of relapsed or refractory chronic lymphocytic leukaemia
Importance: High

Please note that the email that was sent to you on 19th March 2010 with an appeal on the above appraisal was sent on behalf of the Royal College of Pathologists and the BSH.

Best wishes

[redacted]

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Subject: Rituximab for the treatment of relapsed or refractory chronic lymphocytic leukaemia
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Dear Sir/Madam

I write to you ON BEHALF OF my colleague [redacted] I am aware the deadline for appealing the FAD for above named appraisal was yesterday but we have only just received the information needed. I apologise if the information is not presented in the format that you are used to, if you need it to be amended please do let me know.

1. Clinical trials: The issue of re-treatment with R-FC in patients who have previously received rituximab is inappropriate

The reasons for this are as follows:

Patients coming out of current clinical trials including rituximab are potentially being discriminated against by this policy. The reasons are as follows:

- half of the patients in the NCRI-badged ARCTIC Trial are treated with FCM-miniR in which they only receive a total of 100mg rituximab with each cycle of treatment compared to approximately 1000mg in FCR (the standard arm). We do not know that miniR is as good (hence the trial) and if it isn't these patients would be denied "full dose" rituximab at any stage of their disease! The ARCTIC Trial is testing a significantly economic question and is therefore funded by the HTA. If the guidance is unchanged then it is difficult to enter patients in the ARCTIC trial knowing that R-FC now has an overall survival advantage and entering the trial will deny them this therapy later.

- 100 patients in the UK have received chlorambucil+rituximab in a clinical trial and this is not as effective as R-FC (we know this from the interim results). These patients should be able to receive the acknowledged gold-standard treatment at some point in their disease - i.e. R-FC.

- The current NCRI-badged trial formore elderly patients utilises the next generation of anti-CD20 antibody, namely ofatumumab. Bizarrely these patients would be eligible for R-FC under the current document! This cannot make any sense.

2. R-FC should be available for relapsed patients previously receiving rituximab

The reasons for this are as follows:

- The current BCSH Guidelines recommend that the same therapy should be repeated in patients with durable remissions from front-line therapy. As time goes by the relapsing patients after front-line R-FC will have been in increasing durable remissions - the median will be in excess of 4 years. It makes no clinical sense to re-treat these patients with inferior therapy (i.e. FC without rituximab)

- the acknowledged response rates in the MDACC relapse trial to FCR in patients previously received rituximab is CR rate 32% and overall response rate of 73% compared to patients who were rituximab naive in whom the CR rate was 30% and ORR of 76% --> so no difference. In addition the FC response rate in the REACH study (for rituximab naive relapsed patients) is CR of 13% and ORR of 58%. Thus R-FC is the most effective therapy in patients relapsing after previous rituximab.

- In other similar diseases such as follicular lymphoma the benefit of rituximab in second and subsequent line therapy is also seen in patients who have previously received rituximab.

PLEASE CONFIRM RECEIPT

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