Comments on the ACD Received from the Public Through the NICE Website

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	pharmacist with responsibility for commissioning and funding drugs considered by NICE
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	This recommendation is supported Any change in this recommendation would significantly distort the priorities of all PCTs as they look to balance investment in cancer and other therapeutic areas. Â NICE is to be commended for its work to ensure that only treatments that make a significant difference to patients at an affordable cost are recommended for NHS funding
Section 2 (the technology)	Administration costs add significantly to the overall cost to the NHS NICE is asked to consider how, for all guidance involving cancer drugs, they will adjust their costing methodology over the next 6 to 18 months to reflect the fact that chemotherapy drug costs will be moving onto HRG4 mandatory tariffs Any patient access scheme for bevacizumab has yet to be approved so could not be taken into account in the cost effectiveness analysis. If it is negotiated later, this could substantially change the unit cost, average monthly cost and cost effectiveness of this intervention. The transaction costs of administistering and monitoring such a scheme would also need to be considered
Section 3 (manufacturer's submission)	The evidence shows small significant improvements in progression-free survival and no overall survival benefit of adding bevacizumab to treatment with a taxane. Â This is not a good reason to fund this treatment ahead of other priorities. The cost effectiveness ratio of this technology far exceeds the thresholds are currently accepted by NICE for recommending NHS funding. The most plausible ICER for BV+paclitaxel versus weekly paclitaxel is between Â£118,000 and Â£259,000 per QALY gained (assuming no patient access scheme and using current NHS list prices), clearly cost effective technologies are in the Â£20,000 to Â£30,000 range or less.
Section 4 (consideration of the evidence)	There were limitations to the quality of the research: The pivotal trials being considered by NICE are phase III randomised controlled trials but have the following limitations: One trial was not blinded and did not have a placebo in the paclitaxel only arm. One study also failed to collect information on treatments given after disease progression (which may explain why overall survival was not significantly different between the arms). I agree that this technology did not meet the criteria for NICE?s

	policy on end-of-life treatment. Specifically: Â· Â Â Â Â Â evidence suggests that any extension to life is less than three months ? actually the evidence does not demonstrate improvement in overall survival Â· Â Â Â Â Â the treatment was not for a ?small population? as it is also indicated for a number of other patient groups Â· Â Â Â Â Â the life expectancy for patients receiving first line treatment for metastatic breast cancer exceeds NICE?s threshold of 24 months I support NICE?s judgement that the end-of-life policy does not apply.
Section 5 (implementation)	The additional cost for each patient treated with this technology makes it unaffordable for PCTs without compromising other aspects of care. The incremental costs of BV+ weekly paclitaxel are Â£30,469, Â£31,416 or Â£27,358 relative to weekly paclitaxel, docetaxel and gemcitabine plus paclitaxel therapy respectively. Costs based on the NHS list prices before VAT is added and activity costs(at new HRG 4 prices) allowed for.
Section 6 (proposed recommendations for further research)	Only trials that are fully funded by the industry should be undertaken as the cost-benefit balance is not consistent with the resources available
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	8/2/2010 2:57:00 AM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	None
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	We support the Committees recommendation, based on the evidence of limited efficacy and high cost of treatment
Section 2 (the technology)	
Section 3 (manufacturer's submission)	The evidence shows only small significant improvements in progression-free survival and no overall survival benefit from adding bevacizumab to treatment with a taxane. The cost effectiveness ratio of this technology far exceeds the thresholds thqat are currently accepted by NICE for recommending NHS funding. The most plausible ICER for bevacizumab plus paclitaxel versus weekly paclitaxel is between Â£118,000 and Â£259,000 per QALY gained

	(assuming no patient access scheme and using current NHS list prices), this is clearly not cost effective: cost effective technologies are in the Â£20,000 to Â£30,000 range or less.
Section 4 (consideration of the evidence)	There were limitations to the quality of the research. The pivotal trials being considered by NICE are phase III randomised controlled trials but have the following limitations: - One trial was not blinded and did not have a placebo in the paclitaxel only arm - One study also failed to collect information on treatments given after disease progression (which may explain why overall survival was not significantly different between the arms). This technology does not meet the criteria for NICE?s policy on end-of-life treatment. Specifically: - evidence suggests that any extension to life is less than three months, but in fact the evidence does not demonstrate improvement in overall survival - the treatment was not for a ?small population? as it is also indicated for a number of other patient groups - the life expectancy for patients receiving first line treatment for metastatic breast cancer exceeds NICE?s threshold of 24 months
Section 5 (implementation)	The additional cost for each patient treated with this technology makes it unaffordable for PCTs without compromising other aspects of care. The incremental costs of bevacizumab plus weekly paclitaxel are Â£30,469, Â£31,416 or Â£27,358 relative to weekly paclitaxel, docetaxel and gemcitabine plus paclitaxel therapy respectively. Costs based on the NHS list prices.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/30/2010 5:28:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Recommendations are accepted based on the current evidence, given the lack of impact on overall survival rates this would not represent best use resources against other interventions.It is also a very expensive treatment if the current price continues. The preliminary recommendations are supported. NW PCTs scored this intervention prior to 10/11 and then all three constituent zones (Cheshire and Merseyside, Greater Manchester and Cumbria & Lancashire) recommended against funding in the commissioning rounds for 10/11 and this was agreed.

Section 2 (the technology)	The summaries and interpretations of the evidence presented are reasonable and the current recommendation concurrs with NW PCT commissioning intentions. Even if the price reduced via a patient acess scheme then the detail would need careful review as these can be very time consuming to implement by Trusts and review by PCT commissioners.
Section 3 (manufacturer's submission)	This far outstrips the current cost-effectiveness thresholds for NHS funding. The outcomes in progression free survival are noted and more promising evidence may be forthcoming but on current evidence the lack of impact on overall survival cannot be justified agaisnt other interventions competing forthe same resources.
Section 4 (consideration of the evidence)	End of life criteria are not considered to be met regarding the three month life extension, population,life expectancy criteria of 24 months. NICEs recommendation on this is supported.
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/30/2010 5:17:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I support the judgments made by NICE as they appear to have been reasonably made on the basis of the available evidence and the very high cost of treatment.
Section 2 (the technology)	The cost effectiveness analysis did not take into account any patient access scheme for bevacizumab. If it is negotiated later, this could substantially change the unit cost, average monthly cost and cost effectiveness of this intervention. The transaction costs of administistering and monitoring such a scheme would also need to be considered.
Section 3 (manufacturer's submission)	The evidence shows small significant improvements in progression-free survival and no overall survival benefit of adding bevacizumab to treatment with a taxane. The cost effectiveness ratio of this technology far exceeds the thresholds that are currently accepted by NICE for recommending NHS funding. The most plausible ICER for BV+paclitaxel versus weekly paclitaxel is between Â£118,000 and Â£259,000 per QALY gained (assuming no patient access scheme and using current NHS list prices. This is way outside the current accepted band.

Section 4 (consideration of the evidence)	Limitations: Â One trial was not blinded and did not have a placebo in the paclitaxel only arm. One study also failed to collect information on treatments given after disease progression (which may explain why overall survival was not significantly different between the arms). I would support NICEs judgement that the end of life policy does not apply.This technology did not meet the criteria for NICE?s policy on end-of-life treatment as the evidence does not demonstrate improvement in overall survival
Section 5 (implementation)	The additional cost for each patient treated with this technology makes it unaffordable for PCTs without compromising other aspects of care. The incremental costs of BV+ weekly paclitaxel are Â£30,469, Â£31,416 or Â£27,358 relative to weekly paclitaxel, docetaxel and gemcitabine plus paclitaxel therapy respectively. Costs based on the NHS list prices.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/30/2010 12:55:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	This submission represents the views of North Yorkshire and York PCT
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	We would strongly support this recommendation which does not recommend the use of bevacizumab in combination with a taxane. This regime (if supported) would have massive financial impact on NHS expenditure in this area, representing significant investment with no evidence to demonstrate that there are improvements in overall survival. A regime with such significant costs, decommissioning of other services seem highly likely to be necessary to remain financially within balance. We endeavour to provide effective, equitable and efficient services to the population, within the given resources and excess demand with investment in bevacizumab and a taxane would inevitably result in significant opportunity costs.
Section 2 (the technology)	
Section 3 (manufacturer's submission)	Clinical evidence does demonstrate small significant improvement in PFS however, there is no statistically significant overall survival benefit of adding bevacizumab + taxane. Â Furthermore, improvements in PFS may not necessarily provide a better quality of life. Â Noted from ERG that significant improvement in FACT-B score stated by manufacturer may not

	be reliable, and additionally measures of psychological and emotional wellbeing were not provided, this provides little confidence that investment would deliver significant patient benefits. Â Note that no robust evidence to support differential benefit in clinically relevant subgroups. Recently the FDA has taken the view that the license for this indication should be revoked as risks outweigh the benefits. Despite the report indicating most adverse reactions could be managed, it is difficult not to acknowledge that 131 patients withdrew from therapy at time of interim analysis because of toxicity reported increase in grade 3-5 adverse effects. Limitations to quality of research as indicated by the ERG in relation to lack of blinding, lack of data collection to establish reasons for no significant difference in overall survival.
Section 4 (consideration of the evidence)	We would ask that all potentially relevant published clinical evidence should be considered (with reference to AVADO) but equally recognising that a docetaxel regime is unlikely to be more cost effective that the paclitaxel based regime. The most plausible ICER for bevacizumab and paclitaxel versus weekly paclitaxel is between Â£118,000 and Â£259,000 per QALY gained (assuming no patient access scheme and using current NHS list prices), this is significantly in excess of the Â£20,000-Â£30,000 considered acceptable and still above the costs for the NICE advice on the end of life scheme, which furthermore this regime does not meet. In terms of any patient access scheme, there is scope clearly to introduce such a scheme which could substantially change the unit cost, average monthly cost and cost effectiveness of this intervention. Â However, our experiences to date would ask that any such scheme is straightforward and deliverable for the NHS as a whole ensuring that it can operate and serve its purpose, to improve access, rather than generate administrative burden. Â It is however, difficult at present to see how a PAS can make this regime affordable to the NHS with ICERs in the range quoted earlier.
Section 5 (implementation)	Given the large budget impact for this PCT, it seems improbable that it could be affordable without compromising other aspects of care within the programme budget or elsewhere if the decision was taken to support this regime.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/29/2010 4:37:00 PM

Role	NHS Professional
Other role	Clinical Effectiveness Practitioner
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	

Section 1 (Appraisal Committee's preliminary recommendations)	I support the judgments made by NICE in this case as beingreasonably made on the basis of the available evidence and the very high cost of treatment. The FDA panel has recommended that the approval for the use of bevacizumab in breast cancer be revoked based on a conclusion that studies show insufficient benefit for patients, and that the risks outweigh these benefit.
Section 2 (the technology)	Any patient access scheme for bevacizumab has yet to be approved so could not be taken into account in the cost effectiveness analysis. If it is negotiated later, this could substantially change the unit cost, average monthly cost and cost effectiveness of this intervention. The transaction costs of administistering and monitoring such a scheme would also need to be considered.
Section 3 (manufacturer's submission)	The evidence shows small significant improvements in progression-free survival and no overall survival benefit of adding bevacizumab to treatment with a taxane. The cost effectiveness ratio of this technology far exceeds the thresholds are currently accepted by NICE for recommending NHS funding. The most plausible ICER for BV+paclitaxel versus weekly paclitaxel is between Â£118,000 and Â£259,000 per QALY gained (assuming no patient access scheme and using current NHS list prices), clearly cost effective technologies are in the Â£20,000 to Â£30,000 range or less. The FDA panel has concluded that the risks outweigh the insufficient benefit.
Section 4 (consideration of the evidence)	There were limitations to the quality of the research: The pivotal trials being considered by NICE are phase III randomised controlled trials but have the following limitations: One trial was not blinded and did not have a placebo in the paclitaxel only arm. One study also failed to collect information on treatments given after disease progression (which may explain why overall survival was not significantly different between the arms). This technology did not meet the criteria for NICE?s policy on end-of-life treatment. Specifically: * evidence suggests that any extension to life is less than three months ? the evidence does not demonstrate any improvement in overall survival * the treatment was not for a ?small population? as it is also indicated for a number of other patient groups * the life expectancy for patients receiving first line treatment for metastatic breast cancer exceeds NICE?s threshold of 24 months I support NICE?s judgement that the end-of-life policy does not apply.
Section 5 (implementation)	The additional cost for each patient treated with this technology makes it unaffordable for PCTs without compromising other aspects of care. The incremental costs of BV+ weekly paclitaxel are Â£30,469, Â£31,416 or Â£27,358 relative to weekly paclitaxel, docetaxel and gemcitabine plus paclitaxel therapy

	respectively. Costs based on the NHS list prices.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/29/2010 4:25:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	My role at the PCT is Head of medicines management and pharmacy
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Agree with the statement based on current evidence and very high cost of treatment.
Section 2 (the technology)	Concerns that based on this ACD the manufacturers may consider offering a Patient Access Scheme (PAS)- if this becomes the case then PAS must take into account the resource implications and burden of administering the schemes both to providers and commissioners, i.e. these costs of administering PAS should be taken into account when considering the final cost-effectiveness ratios. Commissioners have yet to see the benefits of previous PASs.
Section 3 (manufacturer's submission)	The evidence shows small significant improvements in progression-free survival and no overall survival benefit of adding bevacizumab to treatment with a taxane. The cost effectiveness ratio of this technology far exceeds the thresholds are currently accepted by NICE for recommending NHS funding. The most plausible ICER for BV+paclitaxel versus weekly paclitaxel is between Â£118,000 and Â£259,000 per QALY gained (assuming no patient access scheme and using current NHS list prices), clearly cost effective technologies are in the Â£20,000 to Â£30,000 range or less.
Section 4 (consideration of the evidence)	There were limitations to the quality of the research: The pivotal trials being considered are phase III randomised controlled trials but have the following limitations: One trial was not blinded and did not have a placebo in the paclitaxel only arm. One study also failed to collect information on treatments given after disease progression (which may explain why overall survival was not significantly different between the arms). This technology did not meet the criteria for NICE?s policy on end-of-life treatment. Specifically: - evidence suggests that any extension to life is less than three months & actually the evidence does not demonstrate improvement in overall survival - the treatment was not for a ?small population? as it is also indicated for a number of other patient groups - the life expectancy for patients receiving first line treatment for

	metastatic breast cancer exceeds NICE?s threshold of 24 months
Section 5 (implementation)	The additional cost for these patients if the recommendation changed would need to be funded from current revenue, i.e. it would compromise care for other patients who do not have the voice of those lobbying for cancer.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/28/2010 1:35:00 PM

Name	Louise Wilson
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Torbay Care Trust healthcare treatment funding panel agrees with the approach taken by NICE in their appraisal and support the NICE recommendation.
Section 2 (the technology)	
Section 3 (manufacturer's submission)	The evidence shows no overall survival benefit of adding bevacizumab to treatment with a taxane, although we recognise there is a small improvement in progression free survival. We are concerned at the high ICERs, which are well above the normal range that we would consider to be cost-effective.
Section 4 (consideration of the evidence)	We were concerned by the quality of the research. One key trial was not blinded and did not have a placebo in the paclitaxel only arm. Â On e study also failed to collect information on treatments given after disease progression. We did not feel that technology met the criteria for the NICE policy on end of life, as there was no demonstrated improval in overall survival. Also life expectancy for patients receiving first line treatment for metastatic breast cancer exceeds NICE?s threshold of 24 months. The treatment is also not for a "small population". We therefore support NICEs judgement that the end of life policy does not apply.
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/28/2010 1:17:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The PCT agree with this decision as resources can be spent in a more cost effective way
Section 2 (the technology)	
Section 3 (manufacturer's submission)	Only small significant improvements have been found in progression free survival and importantly no overall survival benefit by adding bevacizumab to a taxane. The cost per QALY far exceeds the currently agreed NICE threshold to recommend funding to the NHS
Section 4 (consideration of the evidence)	The trials have limitations. One trial was not blinded and did not have a placebo in the paclitaxel arm. One study failed to collect information on treatments given after disease progression and therefore is not a fair trial and may expalin why overall survival was not significantly different between arms - has a sub analysis been completed? The technology does not meet NICEs policy on the end-of-life treatment ie.particurlarly in the fact that if evidence suggests extension to life of less than 3 mths - this does not demononstrate improvement in survival.
Section 5 (implementation)	The additional cost this would represent for each patient makes it unaffordable for PCTs without comprimising other aspects of care. Elective care and care in the community projects would be the first to be compromised. With most PCTs now having very little if any contingency funds remaining.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/27/2010 6:21:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	From the evidence supplied the Clinical Effectiveness team at NHS Devon support the NICE ACD. Â The small improvement in progression free survival (with no overall survival benefit)does not support the huge cost of the treatment. Â The addition of yet another patient access scheme (if submitted by

	the manufacturer)would add another complexity, and judging by the previous scheme for bevacizumab and metastatic colorectal cancer, one would assume it would be a complicated scheme and there is no guarantee that the scheme will be used to its full potential within the NHS due to the burdensome nature of these schemes. Â The manufacturer is currently offering a scheme to individual trusts whereby the first three months of treatment is rebated if the patient does not respond. Â We agree that it does not meet NICEs policy on end of life treatment and feel the clinical evidence isnt there to support this very high cost drug treatment. Â Resources would be better spent elsewhere, especially given the current financial climate of the NHS.
Section 2 (the technology)	
Section 3 (manufacturer's submission)	
Section 4 (consideration of the evidence)	
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/27/2010 5:07:00 PM

Role	NHS Professional
Other role	
Location	Wales
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	On behalf of NHS Milton Keynes, I write to give our support to the preliminary recommendation, on the basis that the intervention does not improve overall survival and the cost effectiveness ratio exceeds that which is affordable for the NHS. Its acceptance would compromise care for other groups of patients as the anticipated cost for Milton Keynes population would be in the region of Â£1.6m (drug cost only).
Section 2 (the technology)	No comments on the technology. Price - we would not support a patient access scheme as these entail additional costs for administration and monitoring. A chnage to the actula cost that brought CER down to an acceptable level would be a preferable option.
Section 3 (manufacturer's submission)	The E2100 trial showed no overall survival benefit and only a modest improvement in progression-free survival from adding bevacizumab to a taxane. The gain to quality of life was uncertain. The results from E2100 are supported by AVADO study. We

	see no reason why the manufacturer chose to disregard this study. There were
Section 4 (consideration of the evidence)	The two pivotal studies are phase III RCTs although E2100 was not blinded and there was no placebo in the paclitaxel only arm. One study failed to collect information on treatment given after disease progression. The impact of toxicity seems to have been disregarded but for an average PCT, 8 additional patients will have grade 3 or 4 hypertension, 3 will have neuropathy, 4 will have infections. This technology does not meet the criteria for NICEs end of life policy.This is beacuse the evidence does not demonstrate survival. The treatment is for a substantial population (not small) and the life expectancy criteria is not met.
Section 5 (implementation)	The additional cost of treatment would be of huge concern if this intervention is accepted.
Section 6 (proposed recommendations for further research)	No comments
Section 7 (related NICE guidance)	No comments
Section 8 (proposed date of review of guidance)	No comments
Date	7/27/2010 2:04:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	
Section 2 (the technology)	
Section 3 (manufacturer's submission)	The evidence shows small significant imnprovements in progression free survival and no overall survival benefit of adding bevacizumab to treatment with taxane. Â The cost effectiveness ratio of this technology far exceeds the thresholds currently accepted by NICE for recommended NHS funding. Â The potential additional costs of this intrevention make it unaffordable for Liverpool PCT without compromising other aspects of patient care. Â Any patient access scheme offered would need to vastly reduce the cost of this intervention to the NHS-it should be noted by NICE that these PAS schemes are difficult to administer and providers find it almost impossible to provide PCTs with the information required to allow appropriate administration of these schemes. In conclusion: Locally via the cancer network we had assigned this therapy a red status i.e. not for prescribing, this was based

	on little evidence for overall survival benefit, or cost effectiveness and no case for end of life status. Â Therefore, our thought is for this combination to get through NICE it would need to evidence all of the above.
Section 4 (consideration of the evidence)	
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/27/2010 9:02:00 AM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	NHS Hertfordshire supports preliminary recommendations of the NICE as the PCT beleives these are reasonable on the basis of the available evidence and the very high cost of treatment.
Section 2 (the technology)	This technology will incur very high costs to the current treatment pathway both directly in terms of additonal drug costs as well as well other costs to the health system.
Section 3 (manufacturer's submission)	The evidence shows small significant improvements in progression-free survival and no overall survival benefit of adding bevacizumab to treatment with a taxane. Â The cost effectiveness ratio of this technology far exceeds the thresholds currently accepted by the NICE for recommending NHS funding
Section 4 (consideration of the evidence)	We support NICEs evaluation of the eivdence and limitations to the quality of research. We also support that this technology did not meet the criteria for NICE?s policy on end-of-life treatment. Specifically: Â· the evidence does not demonstrate improvement in overall survival Â· the treatment was not for a ?small population? as it is also indicated for a number of other patient groups Â· the life expectancy for patients receiving first line treatment for metastatic breast cancer exceeds NICE?s threshold of 24 months
Section 5 (implementation)	The additional cost for each patient treated with this technology makes the technology unaffordable for NHS Hertfordshire without significantly compromising other aspects of care and

	especially, disinvesting very signficant amounts of money from existing services.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/26/2010 6:22:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The current policy of all PCTs in Greater Manchester is not to fund bevacizumab in combination with a taxane for the first-line treatment of metastatic breast cancer. Â This policy was developed following detailed work by the Greater Manchester Medicines Management Group. Â If the final TA approves this drug all 10 PCTs in Greater Manchester will have to find funding by displacing funding from other services as no budget will have been set aside for this drug combination in this condition.
Section 2 (the technology)	Any patient access scheme negotiated for bevacizumab could substantially change the unit cost, average monthly cost and cost effectiveness of this intervention. The transaction costs of administistering and monitoring such a scheme would also need to be considered.
Section 3 (manufacturer's submission)	The evidence shows small significant improvements in progression-free survival and no overall survival benefit of adding bevacizumab to treatment with a taxane. The cost effectiveness ratio of this technology far exceeds the thresholds currently accepted by NICE for recommending NHS funding as the most plausible ICER for BV+paclitaxel versus weekly paclitaxel is between Â£118,000 and Â£259,000 per QALY gained (assuming no patient access scheme and using current NHS list prices).
Section 4 (consideration of the evidence)	Any patient access scheme negotiated for bevacizumab could substantially change the unit cost, average monthly cost and cost effectiveness of this intervention. The transaction costs of administistering and monitoring such a scheme would also need to be considered. This technology did not meet the criteria for NICE?s policy on end-of-life treatment. Specifically: Â· Â Â Â Â evidence suggests that any extension to life is less than three months ? actually the evidence does not demonstrate improvement in overall survival

	Â· Â Â Â Â the treatment was not for a ?small population? as it is also indicated for a number of other patient groups Â· Â Â Â Â the life expectancy for patients receiving first line treatment for metastatic breast cancer exceeds NICE?s threshold of 24 months
Section 5 (implementation)	The additional cost for each patient treated with this technology makes it unaffordable for PCTs without compromising other aspects of care. The incremental costs of BV+ weekly paclitaxel are Â£30,469, Â£31,416 or Â£27,358 relative to weekly paclitaxel, docetaxel and gemcitabine plus paclitaxel therapy respectively. Costs based on the NHS list prices.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/26/2010 4:03:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	NHS Mid-Essex supports this recommendation.
Section 2 (the technology)	Any patient access scheme for bevacizumab has yet to be approved so could not be taken into account in the cost effectiveness analysis. If it is negotiated later, this could substantially change the unit cost, average monthly cost and cost effectiveness of this intervention. The transaction costs of administistering and monitoring such a scheme would also need to be considered.
Section 3 (manufacturer's submission)	The evidence shows small significant improvements in progression-free survival and no overall survival benefit of adding bevacizumab to treatment with a taxane. Â The cost effectiveness ratio of this technology far exceeds the thresholds which are currently accepted by NICE for recommending NHS funding. The most plausible ICER for BV+paclitaxel versus weekly paclitaxel is between Â£118,000 and Â£259,000 per QALY gained (assuming no patient access scheme and using current NHS list prices), clearly cost effective technologies are in the Â£20,000 to Â£30,000 range or less.
Section 4 (consideration of the evidence)	There were limitations to the quality of the research. The pivotal trials being considered by NICE are phase III randomised controlled trials but have the following limitations: One trial was not blinded and did not have a placebo in the paclitaxel only arm. One study also failed to collect information on treatments given after disease progression (which may

	explain why overall survival was not significantly different between the arms). This technology dose not meet the criteria for NICE?s policy on end-of-life treatment. Specifically: evidence suggests that any extension to life is less than three months ? actually the evidence does not demonstrate improvement in overall survival the treatment was not for a ?small population? as it is also indicated for a number of other patient groups the life expectancy for patients receiving first line treatment for metastatic breast cancer exceeds NICE?s threshold of 24 months We support NICE?s judgement that the end-of-life policy does not apply.
Section 5 (implementation)	The additional cost for each patient treated with this technology makes it unaffordable for PCTs without compromising other aspects of care. The incremental costs of BV+ weekly paclitaxel are Â£30,469, Â£31,416 or Â£27,358 relative to weekly paclitaxel, docetaxel and gemcitabine plus paclitaxel therapy respectively. Costs based on the NHS list prices.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/24/2010 12:49:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	no
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	We would strongly support this recommendation. Given the FDA recent recommendation that licensing approval is withdrawn it seems hard to support that it is clinically effective option, never mind cost effective. This drug will have a big (unaffordable) impact on expenditure if NICE change their current negative opinion. I suspect that a patient access scheme will be used to try to achieve a more favourable ICER, but the drug will still blow budgets ? even likely to exceed money available Â for the proposed cancer drug fund. Increasing evidence that patient access schemes DO NOT deliver value for money, and are not implementable. Given the large budget impact, it seems inevitable that disinvestments will need to be made to other breast cancer services and cancer services more generally. Given that these cuts will inevitably be in interventions that are more cost effective (often significantly) than Avastin in breast cancer, this will lead to a net social loss in health - entirely the opposite reason why NICE was established.

Section 2 (the technology)	
Section 3 (manufacturer's submission)	
Section 4 (consideration of the evidence)	The evidence shows small significant improvements in progression-free survival and no overall survival benefit of adding bevacizumab to treatment with a taxane. There were limitations to the quality of the research: The pivotal trials being considered by NICE are phase III randomised controlled trials but have the following limitations: One trial was not blinded and did not have a placebo in the paclitaxel only arm. One study also failed to collect information on treatments given after disease progression (which may explain why overall survival was not significantly different between the arms). This technology did not meet the criteria for NICE?s policy on end-of-life treatment. Specifically: evidence suggests that any extension to life is less than three months ? actually the evidence does not demonstrate improvement in overall survival the treatment was not for a ?small population? as it is also indicated for a number of other patient groups the life expectancy for patients receiving first line treatment for metastatic breast cancer exceeds NICE?s threshold of 24 months We do not consider that hte end-of-life policy does not apply.
Section 5 (implementation)	Given the large budget impact, it seems almost certain that PCTs will need to reduce services elsewhere in breast oncology and oncology more generally were NICE to make a positive recommendation on this drug. The cost effectiveness ratio of this technology far exceeds the thresholds are currently accepted by NICE for recommending NHS funding. The most plausible ICER for BV+paclitaxel versus weekly paclitaxel is between Â£118,000 and Â£259,000 per QALY gained (assuming no patient access scheme and using current NHS list prices), clearly cost effective technologies are in the Â£20,000 to Â£30,000 range or less. The additional cost for each patient treated with this technology makes it unaffordable for PCTs without compromising other aspects of care. The incremental costs of BV+ weekly paclitaxel are Â£30,469, Â£31,416 or Â£27,358 relative to weekly paclitaxel, docetaxel and gemcitabine plus paclitaxel therapy respectively. Costs based on the NHS list prices.
Section 6 (proposed recommendations for further research)	Any patient access scheme for bevacizumab has yet to be approved so could not be taken into account in the cost effectiveness analysis. If it is negotiated later, this could substantially change the unit cost, average monthly cost and cost effectiveness o
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/23/2010 4:33:00 PM

Role	NHS Professional

Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Strongly agree with this recommendation on the basis of available evidence.
Section 2 (the technology)	
Section 3 (manufacturer's submission)	The evidence shows improvement in progression-free survival but not overall survival. At ICERs calculated, this intervention is not cost-effective.
Section 4 (consideration of the evidence)	This intervention does not improve survival. It is unlikely to fall within current thresholds for cost-effectiveness. Even if a patient access scheme is used to reduce the price and Â£/QALY, bevacizumab is not affordable in this indication for the NHS. A positive decison will divery funds away from other patient care.Reported benefits do not justify its very high cost.
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/23/2010 2:57:00 PM

Role	NHS Professional
Other role	Consultant in Public Health Medicine
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I am in agreement based on the available evidence and the very high cost of treatment
Section 2 (the technology)	Any patient access scheme for bevacizumab has yet to be approved so could not be taken into account in the cost effectiveness analysis. If it is negotiated later, this could substantially change the unit cost, average monthly cost and cost effectiveness of this intervention. The transaction costs of administistering and monitoring such a scheme would also need to be considered.
Section 3 (manufacturer's submission)	The evidence shows small significant improvements in progression-free survival and no overall survival benefit of adding bevacizumab to treatment with a taxane. The cost effectiveness of this technology far exceeds the thresholds are currently accepted by NICE for recommending NHS funding. The most plausible ICER for BV+paclitaxel versus weekly paclitaxel is between Â£118,000 and Â£259,000

	per QALY gained (assuming no patient access scheme and using current NHS list prices).
Section 4 (consideration of the evidence)	The pivotal trials being considered by NICE are phase III randomised controlled trials but have the following limitations: One trial was not blinded and did not have a placebo in the paclitaxel only arm. One study also failed to collect information on treatments given after disease progression (which may explain why overall survival was not significantly different between the arms). This technology did not meet the criteria for NICE?s policy on end-of-life treatment. Specifically: 1 evidence suggests that any extension to life is less than three months ? actually the evidence does not demonstrate improvement in overall survival 2 the treatment was not for a ?small population? as it is also indicated for a number of other patient groups 3 the life expectancy for patients receiving first line treatment for metastatic breast cancer exceeds NICE?s threshold of 24 months
Section 5 (implementation)	The additional cost for each patient treated with this technology makes it unaffordable for PCTs without compromising other aspects of care. E.g. funding of such expensive drugs will stop us for developing a hospice service for our population. It will be the same patients receiving this drug that will receive suboptimal end of life care just a few weeks/months later when they need it. The incremental costs of BV+ weekly paclitaxel are Â£30,469, Â£31,416 or Â£27,358 relative to weekly paclitaxel, docetaxel and gemcitabine plus paclitaxel therapy respectively. Costs based on the NHS list prices.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/22/2010 7:20:00 PM

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I fully agree with this recommendation based on the published evidence
Section 2 (the technology)	This drug, as an IV preparatnion, will also attract significnat administration costs.

Section 3 (manufacturer's submission)	I share the concerns raised by the ERG.
Section 4 (consideration of the evidence)	Bevacizumab offers little benefit over paclitaxel, has increased harms and does not justify the enormous cost.
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	7/15/2010 4:03:00 PM