NHS organisation statement template

Thank you for agreeing to give us your views on the technology and the way it should be used in the NHS.

Primary Care Trusts (PCTs) provide a unique perspective on the technology, which is not typically available from the published literature. NICE believes it is important to involve NHS organisations that are responsible for commissioning and delivering care in the NHS in the process of making decisions about how technologies should be used in the NHS.

To help you give your views, we have provided a template. The questions are there as prompts to guide you. You do not have to answer every question. Short, focused answers, giving a PCT perspective on the issues you think the committee needs to consider, are what we need.

About you

Your name: [redacted]

Name of your organisation: **NHS Dorset**

Please indicate your position in the organisation:

- **commissioning services for the PCT in general**
- commissioning services for the PCT specific to the condition for which NICE is considering this technology?
- responsible for quality of service delivery in the PCT (e.g. medical director, public health director, director of nursing)?
- a specialist in the treatment of people with the condition for which NICE is considering this technology?
- a specialist in the clinical evidence base that is to support the technology (e.g. participation in clinical trials for the technology)?
- other (please specify)

What is the expected place of the technology in current practice?

How is the condition currently treated in the NHS? Is there significant geographical variation in current practice? Are there differences in opinion between professionals as to what current practice should be? What are the current alternatives (if any) to the technology, and what are their respective advantages and disadvantages?

Rheumatoid arthritis (RA) is a chronic and progressive inflammatory arthritis in which the synovial tissue becomes inflamed leading to tenderness and stiffness and progressive destruction of the joints. Patients are initially treated with combinations of non-steroidal anti-inflammatory drugs (**NSAIDs**), analgesics, corticosteroids and disease modifying anti-rheumatic drugs (**DMARDs**) including methotrexate.

The tumour necrosis factor α (TNF-α) inhibitor therapies **adamilumab** (Humira, Abbott Laboratories), **etanercept** (Enbrel, Wyeth Pharmaceuticals) and **infliximab** (Remicade, Schering-Plough Ltd) are approved by the NHS for adult patients who have a disease activity score (DAS28) greater than 5.1 confirmed on at least two occasions 1 month apart and have undergone trials of two DMARDs.

Certolizumab pegol is also recommended by NICE (TA 186) for use in line with TA 130, and only if the manufacturer provides the first 12 weeks of treatment free. **Abatacept** is not recommended by NICE for the treatment of rheumatoid arthritis (TA 141).

Rituximab in combination with **methotrexate** is recommended by NICE (TA 126) as an option for the treatment of adults with severe active rheumatoid arthritis who have had an inadequate response to or intolerance of other disease-modifying anti-rheumatic drugs (DMARDs), including treatment with at least one TNF-α inhibitor therapy.

There are no clinical trials that have directly compared golimumab with other recommended TNF-α inhibitors (adalimumab, etanercept, infliximab, or certolizumab pegol). Indirect comparisons suggest that a similar proportion of patients respond to golimumab as to the other TNF-α inhibitors, but this indirect comparison should be interpreted with caution as the characteristics of patients and the prior and concomitant treatment regimens included in these studies may have differed.

A Cochrane review has conducted a meta-analysis that suggests that, at least in the short term, golimumab has a similar safety profile to methotrexate monotherapy, with similar rates of adverse events, serious infections, cancer, tuberculosis or deaths.

TNF-α inhibitors are being used in line with the respective NICE Technology Appraisals by our local clinicians. In Dorset, we have a block funding agreement with Dorset County Hospital and our rheumatologists have moved to intiating new patients who require TNF-α inhibitor therapy on certolizumab pegol, as this is the least costly option. In the east of the county, funding is on a cost per case arrangement and the rheumatologists appear to have some reservations about the relative effectiveness of certolizumab; therefore, some patients are still being initiated on the more established TNF-α inhibitors (adalimumab, infliximab, etanercept). We would expect this variation in funding arrangements, and therefore incentive to use the most cost-effective TNF-α inhibitor, to be found across the NHS.

To what extent and in which population(s) is the technology being used in your local health economy?

- is there variation in how it is being used in your local health economy?
- is it always used within its licensed indications? If not, under what circumstances does this occur?
- what is the impact of the current use of the technology on resources?
- what is the outcome of any evaluations or audits of the use of the technology?
- what is your opinion on the appropriate use of the technology?

Golimumab is not currently being used in Dorset, nor across the South West region.

TNF-α inhibitors are being used in line with the respective NICE Technology Appraisals in Dorset. Across Dorset county (NHS Dorset and NHS Bournemouth & Poole), the Acute Trusts are required to notify the relevant PCT when a patient is initiated on a TNF-α inhibitor, and demonstrate that the patient meets the relevant NICE Technology Appraisal. Where patients do not meet the criteria that have been developed by NICE, clinicians are required to make an Individual Funding Request outlining the patients clinically exceptional circumstances that would justify treating the patient outside of the commissioning policy. If golimumab was recommended for use by NICE, it would also be included in these requirements.

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The reduced frequency of golimumab injections, compared other TNF-α inhibitors, may be preferred by patients. However, the drug has not been shown to have better outcomes (i.e. to be more effective or less harmful) than other TNF-α inhibitors, as there have been no head to head trials. The cost effectiveness of golimumab for this indication is unknown. However, other comparable countries have found that golimumab is of comparable cost-effectiveness as other TNF-α inhibitors.

Potential impact on the NHS if NICE recommends the technology

What impact would the guidance have on the delivery of care for patients with this condition?

Patients with rheumatoid arthritis currently have access to a range of treatments, including up to four TNF-α inhibitors.

No clinical trials have been carried out directly comparing the effectiveness of golimumab for rheumatoid arthritis against other TNF-α inhibitors, and there is little evidence to inform a choice about which agent to use, or how to sequence the different therapies.

New Zealand's Pharmacology and Therapeutics Advisory Committee (PTAC) considered the evidence for second-line use of a TNF-α inhibitor:

> "…evidence indicated that if a patient had ceased treatment with a TNF inhibitor due to ineffectiveness or adverse effects, the expected benefit upon trial of a second-line agent would be 70% - 80% of that expected for any patient receiving a TNF inhibitor for the first time. Expected benefit was higher for patients stopping the first TNF inhibitor for adverse effects than for those stopping for lack of efficacy. …did not seem to be any serious safety concerns about exposing patients to a second TNF inhibitor, although adverse effects were more likely in those who stopped the first TNF inhibitor for adverse effects."[1]

Golimumab has marketing approval for self-administration by patients and if it is suitable, the training procedures currently in place for etanercept self-injection should be relevant for golimumab. The lower frequency of golimumab subcutaneous injections (monthly) compared to the other subcutaneous TNF-α inhibitors may be preferred by patients.

In what setting should/could the technology be used – for example, primary or secondary care, specialist clinics? Would there be any requirements for additional resources (for example, staff, support services, facilities or equipment)?

We would expect this drug to be used in secondary care, and from within existing resources. There may be a very small group of patients who have not responded to, or are intolerant of, the other TNF-α inhibitors, for whom there is currently an unmet need that golimumab could meet.

This drug has marketing approval for self-administration by patients and if it is suitable, the training procedures currently in place for etanercept self-injection should be relevant for golimumab.

While there is evidence to suggest that a second TNF-α inhibitor can be effective where a first has failed, there was little evidence to inform a choice about which agent to use, or how to sequence the different therapies.

[1] http://www.pharmac.govt.nz/2006/05/01/140607c.pdf

Can you estimate the likely budget impact? If this is not possible, please comment on what factors should be considered (for example, costs, and epidemiological and clinical assumptions).

Rheumatoid arthritis affects 0.8% of the population. It is estimated that for an average PCT of 300,000 people there would be 2,400 individuals with RA and that out of these 48 would be eligible for and receive TNF-α inhibitors. However, these figures are based on current usage of these drugs and may under-estimate of the number of eligible patients. There is likely to be a small sub-group of patients who are intolerant of or have not responded to another TNF-α inhibitor.

The manufacturer's submission is expected to contain further information on the acquisition cost of golimumab in Britain. Once this information is available, the cost-effectiveness of using golimumab in the NHS can be analysed. This analysis should take into account the relative effectiveness of other TNF-α inhibitors, surgery to replace or resurface damaged joints and physiotherapy.

The Canadian Agency for Drugs and Technologies in Health (CADTH) reviewed the Cost-Effectiveness of golimumab:

> "The manufacturer submitted a cost-minimization analysis comparing golimumab with etanercept, adalimumab, infliximab, rituximab, anakinra, and abatacept in patients with active rheumatoid arthritis and who had not responded to adequate trials of DMARDs. The Committee accepted the cost minimization analysis and considered the costs of golimumab and other TNF alpha inhibitors. The annual cost of golimumab ($17,364; 50 mg monthly) is less than etanercept ($18,995; 50 mg weekly) and adalimumab ($18,438; 40 mg every other week). Golimumab may cost more or less than infliximab depending on patient weight, dosing of infliximab and potential vial wastage."

The National Centre for Pharmacoeconomics (NCPE) in Ireland also reviewed the cost-effectiveness of golimumab earlier this year:

> "Following the price reduction the ICER for golimumab plus MTX versus MTX alone was estimated at €26,727/QALY. Probabilistic sensitivity analysis (PSA) indicated that the probability of golimumab being cost-effective as being compared with the other anti-TNF drugs at the €20,000/QALY threshold increased to 23%.
>
> Following the price review we believe golimumab (Simponi®) to be a cost-effective option for the treatment of rheumatoid arthritis in patients who failed MTX. The cost-effectiveness of golimumab was similar to other available anti-TNF agents. We are happy to recommend reimbursement of golimumab at the revised price."

Would implementing this technology have resource implications for other services (for example, the trade-off between using funds to buy more diabetes nurses versus more insulin pumps, or the loss of funds to other programmes)?

In agreeing to fund one treatment or service, there is always opportunity cost within finite resources. This opportunity cost may have an impact on the PCTs ability to provide any of a range of treatments and services, depending on the PCTs priorities for commissioning.

Would there be any need for education and training of NHS staff?

This drug has marketing approval for self-administration by patients and if it is suitable, the training procedures currently in place for etanercept self-injection should be relevant for golimumab.

Other Issues

Please include here any other issues you would like the Appraisal Committee to consider when appraising this technology.

While there is evidence to suggest that a second TNF-α inhibitor can be effective where a first has failed, there is little evidence to inform a choice about which agent to use, or how to sequence the different therapies. Guidance about sequencing of TNF-α inhibitor therapy would be potentially more helpful to PCTs, than guidance about whether or not an additional TNF-α inhibitor of comparable efficacy (essentially a "me-too") should be added as another treatment option.

ADDITIONAL INFORMATION

In addition to the attached Rapid Evidence Review, here is a link to the Canadian Agency for Drugs and Technologies in Health (CADTH) review of golimumab for rheumatoid arthritis:
http://www.cadth.ca/media/cdr/complete/cdr_complete_Simponi-RA_March-17-2010_e.pdf

The National Centre for Pharmacoeconomics (NCPE) in Ireland also reviewed the cost-effectiveness of golimumab earlier this year:
http://www.ncpe.ie/document.php?cid=33&sid=138&docid=189