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

Name	[redacted]
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 (Clinical need and practice)	
Section 3 (The technologies)	We have reviewed the appraisal consultation document alongside the related NICE TAs 226, 110 & 137. The PCT can confirm that the treatment is not currently listed as one of those approved by the North West Cancer Drugs Fund. From the evidence reviewed, the PCT is satisfied that whilst there was a significant incidence of leukocytopenia, neutropenia and granulocytopenia in those treated with rituximab and chemotherapy, this was not associated with an increase in the rate of infection. Furthermore, from a patient safety perspective, the addition of rituximab to the four chemotherapy regimes did not appear to increase adverse event rates.
Section 4 (Evidence and interpretation)	The PCT acknowledge the 4 good quality RCTs that have been included in the review by NICE. The evidence supports the preliminary recommendation for the use of rituximab as an option in the treatment of symptomatic stage III and IV follicular lymphoma in previously untreated people. From a cost effectiveness point of view, the PCT acknowledge the three economic models for rituximab combined with CVP, CHOP and MCP. However, the PCT would like to seek further clarification on whether or not the economic model for the combination of rituximab with CHVPi will be reconsidered before the final TA. Furthermore, clarification on whether or not the economic model will be reviewed to take further account of the use of rituximab as first-line maintenance treatment, and, the assumption that the efficacy of rituximab will be maintained when used second line. The prevalence indicates that the additional cost to Trafford would be in the region of £40k. This is based on Trafford?s population. At this stage, it is not possible to predict which service would need to be reviewed in order to fund this additional cost. This would need to be considered by the PCT?s Prioritisation Panel.
Section 5 (Implementation)	

Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date for review of guidance)	
Date	26/09/2011 15:33

Name	[redacted]
Role	[redacted]
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I support the preliminary recommendation as described above.
Section 2 (Clinical need and practice)	
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	I agree with the committees interpretation and application of the evidence.
Section 5 (Implementation)	I note that the gains in overall survival are modest with certain regimens but are well within the range usually considered cost-effective. However, this will still require funding and will add to the financial pressures. It highlights the issue of needing robust processes in place to enable effective prioritisation particularly in the near future and changes in the NHS.
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date for review of guidance)	
Date	26/09/2011 14:58

Name	[redacted]
Role	other
Other role	Representing NHS Commissioners
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	There is evidence to suggest that rituximab in combination with specified combination chemotherapy regimens may be a cost effective use of NHS resources. In NICEs cost-effectiveness estimates, the addition of rituximab to CVP, CHOP, MCP and

	CHVPi gave incremental cost-effectiveness ratios (ICERs) of: £7720, £10,800, £9320 and £9251 respectively per QALY gained, and these are well below NICE?s usual ceiling of £20,000-£30,000/QALY.
Section 2 (Clinical need and practice)	
Section 3 (The technologies)	Rituximab in combination with CVP, CHOP, MCP and CHVPi is more effective than CVP, CHOP, MCP and CHVPi alone for the treatment of advanced follicular lymphoma. The addition of rituximab to CVP, CHO and MCP produced statistically significantly improved rates of overall survival at 4 or 5 years. The addition of rituximab to CVP, CHOP, MCP and CHVPi improved progression-free survival and duration of response. The addition of rituximab to CVP, CHOP, MCP and CHVPi did not significantly increase adverse event rates.
Section 4 (Evidence and interpretation)	The assessment of efficacy is based on four good quality trials, which included chemotherapy regimens used in the NHS (CVP, CHOP, MCP and CHVPi). These results are not generalisable to other chemotherapy regimens, for example, those containing chlorambucil, fludarabine or bendamustine. There were limitations to the inputs in the economic model. Neither the manufacturer nor the Assessment Group models included the use of rituximab as maintenance treatment after induction therapy, or modelled the re-use of rituximab as second-line treatment where it may be less effective. Crude cost estimates suggest that the addition of rituximab to CVP, CHOP, MCP and CHVPi would cost an additional £20,000 per 100,000 population per year (to treat two patients per 100,000 population per year) in drug costs alone. The impact of VAT and locally negotiated prices could make an important difference to the true cost to commissioners.
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date for review of guidance)	
Date	19/09/2011 14:34