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National Institute of Health and Clinical Excellence
Level 1A
City Tower
Piccadilly Plaza
Manchester M1 4BD

BY EMAIL

26th September 2011

Rituximab for the first-line treatment of stage III–IV follicular lymphoma (review of NICE technology appraisal guidance 110)

Dear [redacted],

Thank you for giving us the opportunity to comment upon the ACD for the above multiple technology appraisal. Our comments are summarized under the four standard headings below.

If any further clarification or analyses are required in order to aid the Committee's deliberations we would be more than happy to provide them.

Yours sincerely,

[redacted]

I. Has all of the relevant evidence been taken into account?

Yes. Roche broadly supports the committee's recommendations, as detailed in the ACD, and will present no further data.

Roche Products Limited

[redacted]

Health Economics and Strategic Pricing

[redacted]

Roche shares the committee's concerns, as discussed in the previous committee meeting, about the inequality of access to rituximab for older or less-fit patients who would be suitable for R-chlorambucil and who will now receive chlorambucil alone. Roche is firmly convinced that the addition of rituximab to chlorambucil would be of significant benefit to a subset of older, less-fit patients, and would be a cost-effective use of NHS resources. This is a view shared by clinical experts.

Unfortunately, there are no randomized controlled trials to support this treatment combination, and despite the overwhelming evidence for the value of rituximab in combination with other chemotherapy agents, we must acknowledge that NICE's evidence requirement cannot be met.

Roche would like to emphasise to the committee that in the treatment of follicular lymphoma, expert opinion and all available trial data indicates that the chemotherapy regime chosen is of less importance than ensuring that rituximab is given with that chemotherapy. This explains the heterogeneity observed in the choice of chemotherapy: the combination of rituximab and chemotherapy is widely held to be of value for all patients (with the possible exception of patients too frail or unwell to visit the hospital for infusions) while there is less certainty about the best chemotherapy agent.

II. Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

Roche continues to have concerns, as previously discussed in our response to the AG report, around the AG's approach to the issue of a potential reduction in efficacy of rituximab when used second-line, following first-line R-chemo and R-maintenance. In the ACD (sections 4.2.20 and 4.3.8) it is highlighted that the AG conducted a sensitivity analysis exploring a 25% reduction in efficacy of second-line rituximab treatment.

Roche believes that there is no basis for the arbitrary assumption of a 25% reduction in efficacy. Inasmuch as there is uncertainty around this question (as noted in section 4.3.8) and given the possibility that an increase in efficacy is theoretically plausible, it would have been equally reasonable to explore an arbitrary assumption of a 25% increase in efficacy – or maybe to explore and present both.

III. Are the provisional recommendations sound and a suitable basis for guidance to the NHS?

Yes, with reference to the comments made above.

IV. Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any

group of people on the grounds of gender, race, disability, age, sexual orientation, religion or belief?

As discussed previously, Roche is concerned that the current recommendation will deny a subset of older patients access to rituximab therapy on the basis of their age.

While a patient's level of biological fitness and comorbidity is of importance when determining fitness for a given therapy, age is also a consideration for many clinicians. While not all older patients who would receive chlorambucil would be suitable for treatment with R-chlorambucil, a proportion may be. Roche is concerned that as these patients may be deemed unfit for more aggressive therapies partly due to their age, they will therefore also be denied access to treatment with rituximab—from which they could otherwise derive benefit— due to their age, with the recommendations as they stand in the ACD.