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)	i agree with the Appraisal Committees preliminary recommendations
Section 2 (The technology)	
Section 3 (The manufacturer's submission)	I believe the manufacturers comments and cost modeling in relation to patients who cannot self inject is flawed in that in such situations, other means of injection for sub cutaneous preparations are available either through other carers being trained, or via nurse administration. cost modeoling i relation to cost effectiveness of abatacept are also flawed in relation to real life use of DMARDs and bioloics, inlcuding vial sharing etc. by applying limitations within the manufacturers cost model the model favours abatacept. if real life use of biologic and non biologic DMARDs are considered i do not belive abatacept to be a cost effective sue of NHS resources for this inication. The trial information used to assess effectiveness of abatacept vs other biologics is not robust - trials used have patients with differing baseline characteristics, which makes it difficult to assess the true efficacy of the comparator treatments (five different biologics). I agree with the comments made by the evidence review group in relation to omitted trial data, and inconsistent presentation of data, and ommisions of data from key trials.
Section 4 (Consideration of the evidence)	i agree that abatcaept plus methotrexte is not a cost effective sue of NHS resource comoared to subcuaneous biologic DMARDs based on the informaetion provided. i agree with the view that the use of mortality estimates in relation to HAQ from old trials using older treatment modalities,

	is not in line with current practice, and is misleading re the relative benefits of Abatacept in relation to cost efectiveness. I agree with the recommendations of the appraisal committee. were abatacept to be given a positive appraisal, there would be considerable costs to the NHS, over and above those for other biologics in relation to the same patient cohort, not including additional costs for administration of an intravenous preparation - using abatacept would not be a cost effective sue of NHS resources.
Section 5 (Implementation)	
Section 6 (Related NICE guidance)	no comment
Section 7 (Proposed date of review of guidance)	this review date is acceptable.
Date	18/04/2011 23:59

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)	Is clearly written. Locally we do not anticipate our rheumatologists to disagree with this as we have not had any requests to fund this to date as an exceptional treatment
Section 2 (The technology)	No comment
Section 3 (The manufacturer's submission)	How do you assess problems handling the injection devices, with mental health problems, or with an aversion to, or phobia of, needles. Can see more than 10% patients not wanting to inject themselves.
Section 4 (Consideration of the evidence)	
Section 5 (Implementation)	
Section 6	

(Related NICE guidance)	
Section 7 (Proposed date of review of guidance)	
Date	18/04/2011 09:08

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	Uncertainties about the effectiveness of abatacept in this indication remain. Although direct evidence showed that abatacept plus methotrexate is more effective than placebo plus methotrexate, the manufacturer's mixed treatment comparison that compared the combination with five biological DMARDs (adalimumab, certolizumab pegol, etanercept, golimumab and infliximab) plus methotrexate, was viewed with caution by the Appraisal Committee because it omitted key trials and included trials of participants with different baseline characteristics. 3) Abatacept is not considered to be a cost effective use of NHS resources when realistic assumptions are made. The Committee had concerns about the quality and presentation of the manufacturer's economic model, in particular: the mapping of HAQ scores to EQ-5D utility values failure to include patient disutility in attending for infusions assumptions around how disease progresses on and off different treatments not reflecting current practice where multiple DMARDs may be used not allowing for dose escalation with abatacept not allowing for vial sharing for infliximab and using a lifetime time horizon. A model that relied on a combined set of more plausible assumptions is expected to produce an ICER greater than £29,700, which exceeds the range considered to represent an appropriate use of NHS resources (£20-30,000 per QALY or more). 3) The Appraisal Committee did not accept the manufacturer?s

	suggested focus on the population subgroup who cannot self-inject. In addition to the main population and comparison (the decision problem) described in the scope, the manufacturer?s submission focused on the use of intravenous abatacept as an alternative to intravenous infliximab for people with rheumatoid arthritis who experience an inadequate response to traditional DMARDs and for whom a self-administered subcutaneous administered biological agent is not suitable. The Evidence Review Group (ERG) noted that many of the patients who were identified in the submission as being unsuited to subcutaneous pharmacotherapy would be able to receive subcutaneous therapy administered by nursing personnel in the home. As a result, the Appraisal Committee concluded that the question of cost-effectiveness of abatacept versus infliximab (plus methotrexate) for this subgroup was irrelevant for the NHS.
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	
Section 2 (The technology)	
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	The included trials found no significant difference between abatacept (10mg/kg) and placebo in rates of serious adverse events at 6 or 12 months. Abatacept was associated with lower rates of serious adverse events, lower discontinuation rates and lower rates of both serious infections and acute infusional events than infliximab.
Section 5 (Implementation)	
Section 6 (Related NICE guidance)	
Section 7 (Proposed date of review of guidance)	
Date	15/04/2011 15:19

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)	Abatacept shouls be reserved for patients who fail other biologics or wheree these are contradicated.
Section 2 (The technology)	Rather expensive treatment. It may be worth negotiating discounts with the manufacturer.
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	Abatacept does not appear to be superior in efficacy to other biologics.
Section 5 (Implementation)	
Section 6 (Related NICE guidance)	
Section 7 (Proposed date of review of guidance)	
Date	01/04/2011 11:35