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

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 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	I disagree with NICE that currently a third of RRMS patients who have not responded to their first inteferon are moved to best supportive care. In my experience this group of patients would be offered a different inteferon, Copaxone or Tysabri depending upon their MS activity. Gilenya would offer an alternative effective therapy when there are complicating factors such as injection site reaction or treatment related side effects.
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	i have particicated in advisory boards for novartis as i have done for many other ms drug manufacturers. the honorarium gained was negligable part of my annual income
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)	In nottingham, the notes of 72 patients that were on beta interferon as their first line treatment in January 2010 were audited.

	Of the 72 patients 5 stopped their treatment: 2 patients stopped interferon as they developed progressive disease, 1 developed adverse effects, 2 could not tolerate the inteferon. 1 of them elected to stay off treatment and 1 switched to copaxone. Of the remaining 67, over the last 2 years, 14 had a clinical relapse and 53 were relapse free. Of the 14 patients who had a relapse (failed treatment)1 had escalation of his treatment and has been started on natalizumab.The remaining 13 continued on their interferon. In this group of interferon treatment failure (first line failure) , we did not have any switch from interferon to copaxone. We did not have any patients offered best supportive care for their active disease by any of the 4 consultant neurologist responsible for the ms care in Nottingham. Obviously this is the practice of the Nottingham team , but I think it reflects the UK in MS . Only a very small percentage of patients with active disease are not on disease modifying therapies. I hope this helps your committee.
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	Patient
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I have had four relapses in the past year, which has taken up untold time with my consultant and MS nurse . I have had four hospital referrals regarding various symptoms steming from the relapses. My families and my mental health has suffered from the stress of my deterioration. I am undergoing weekly counselling sessions. I do everything possible to maintain my health . I exercise regularly as my condition allows . I follow all advice and adhere to my injections with Capaxone. But unfortunately my drugs are not having any effect.
Section 2 (The technology)	My consultant is looking to treat me with Tysabri , but Fingolimd if it becomes available. The Tysabri option leaves me and my family very anxious at the health risks. The risk of getting this fatal brain condition may be low, but MSers have a bad record of beating the odds , where aware of how easy it is to be the unlucky one.And knowing these odds only get worse over time , coming off it and then what? There are also the regular admissions to hospital and monitoring that can only reinforce the feeling of being a seriously ill person. As well as being time

	consuming. Alternatively Fingolimod promises to be the perfect solution.
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	If I was on Fingolimod and my heath was stable I would resume my career as Senior Mental Health Support Worker, Where I had a track record of keeping patients that had serial admissions to hospital out and in good mental health, saving the taxpayer a lot. In return my work gave me a purpose and quality to life I know longer have. Without Fingolimod I feel I am just being left out in the cold to deteriorate, a feeling that is heightened knowing that MSers all over Europe are having this drug afforded to them. The only consolation to this feeling is knowing that the morality of your average tax payer would priorities drugs for those in need.
Section 5 (Implementation)	This disease unfairly discriminates against young women. The failure to treat it also does. I have seen the distress when mothers have bravely spoken of the shame they feel at being unable to care for their children adequately due to lack of energy when suffering a relapse. Many women have spoken of this at my Support group. When deigning these drugs you also denying them to their children. We can only imagine what impact this could have on a young life having a parent that cannot be quite there.
Section 6 (Proposed recommendations for further research)	When I decided to write into this consultation (which hasnt been an easy process emotionally or practically) I sort advice , I was told to tell you how not having a drug treatment would effect my quality of life. But I will not have a quality of life as I refuse to let this disease take its course and watch myself deteriorate and I refuse to let my family watch. Death is preferable. I will not beg but urge you to get a grip, straighten your backs and be proud to be human. Rejecting Fingolimod goes against all human instincts.
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	NHS Professional
Other role	
Location	England
Conflict	yes
Notes	I am on the nurse advisory board for gilyena
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	as a health professional working with people with this often devastating disease, I am bitterly disappointed with the appraisal committee,s preliminary commendations. fingolimod offers an essential novel treatment choice within MS. I feel that there has been a complete lack of understanding into the impact that MS has upon a person and the current delivery of treatment options. To suggest that "best supportive care"is the most appropriate comparator does not reflect the real world.

	To indicate that this would mean no DMT treatment in this group of patient is not reflective of practice. Patients on beta interferon Would be switched to glatiramar acetate or be considered fro escalation to natalizumab. The preliminary recommendations also fails to take into consideration those sub group of patients that are unable to commence/continue natalizumab. For these patients deemed to have rapidly evolving severe relapsing remitting MS , to remove the option of a viable treatment as a choice is unacceptable. The fact that it is an oral preparation is another essential factor in the treatment choice for patients.
Section 2 (The technology)	
Section 3 (The 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)	

Role	Carer
Other role	brother
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Fingolimod should be approved for highly-active RRMS as it can deliver hope and a better lifestyle to my sister. The stress of being denied a treatment of proven efficacy, when her previous treatment has not produced the expected results, is huge. The combination of multiple relapses and the stress of knowing she may be deniedaccess to this drug is having a profound effect on her quality of life.
Section 2 (The technology)	
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	The knock-on costs of not licensing this drug are huge but incalculable. With the drug my sister, for whom I provide some care, might be able to return to work as a highly qualified and experienced mental-health worker where she has demonstrably kept patients well enough to avoid hospitalization which saves the public purse huge sums of money. I carepart-time for my sister which precludes me from full-time work, leaving me hugely under-employed which again has costs

	for the state. The stress resulting from the prospect of not being allowed this drug hs meant she is now having counselling - again a cost to the state that might be saved. If my sisters MS goes on to become progressive, then the costs to the state will increase vastly and the likelihood of me re-entering meaningful employment diminish.
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	Local government professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Appears to be purely cost driven. Research showed significant improvement in disability. MS is a condition that costs the NHS a tremendous amount (physio, Respite placements, nursing home, appliances etc.) leaving young patients unable to work and rely on benefits. For these reasons it seems unethical not to provide a drug that potentially could make a real impact in a vulnerable patient group. NICE also has to accept that we have a responsibilty to not allow our patients become part of third world health economy and fall behind other devloped countries who are already using this drug to good effect
Section 2 (The technology)	The technology is clearly far more advanced to what is available currently. We know that IFN is outdated and has relatively poor outcomes compared to TYSABRI and Campath. Yet all of these preparations are non oral preparations and cause difficulties in themselves. In terms of side effect profiles it is no worse than these preparations and if anything appears safer from the phase 3 trial evidence.
Section 3 (The manufacturer's submission)	The manufacturer has published in highly regarded Peer reviewed journals It has shown evidence of benefit and also a favourable side effect profile. It is the first drug that can be used orally and the patient should not be denied of this. The

	patients deserve the right to access to treatment that can have such an impact on the quality of life. Furthermore it is a very defined and relatively severely affected/non responder population that is being aimed at who if not treated appropriately are only going to burden the NHS financially more in the future as well as impact on social welfare and work force numbers.
Section 4 (Consideration of the evidence)	
Section 5 (Implementation)	It should be made availbale on the NHS to everyone who needs it. it is shot sighted to cut costs in this area.
Section 6 (Proposed recommendations for further research)	Continue research but make it avaiolable now on the NHS
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	This is far too long

Role	NHS Professional
Other role	Doctor
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I am very disappointed with NICE preliminary recommendations. I am very concerned that the patients with multiple sclerosis will be denied this effective and well tolerated disease modyfing therapy. Patients with an inadequate response to beta interferon ought to have the opportunity to be switched to a drug such as Fingolimod considering the young age at which patients can develop highly active disease and the number of years benefit they will gain in quality of life.
Section 2 (The technology)	Many patients afflicted with highly active MS are of the age 20-25years. the cost-benefit of fingolimod in those who do not respond to beta interferon must be reassessed by NICE urgently.
Section 3 (The manufacturer's submission)	Clinicians consider treatment withdrawal on a case by case basis and may continue for people with EDSS above 6.
Section 4 (Consideration of the evidence)	The effects of Fingolimod or avonex can NOT be modelled over 50 years, using the shorter term trial data.
Section 5 (Implementation)	RR MS is a progressive condition and there are patients in need of it as I write this.
Section 6 (Proposed	Patient on fingolimod trials are doing extremely well. Allow it to

recommendations for further research)	be used whilst further research is undertaken.
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	2015 is too far away for guidance, surely the correct time for guidance is when the present trials have been completed and the results analysed.

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	This is short-sighted. The current guidance on the management of relapsing-remitting MS in England lags behind other countries. Fingolimod has been shown to be an effective medication and should be part of our treatment options in the UK. The population which this drug is intended for is a severely affectd group who need early efffective treatment to avoid long term disabilty which of course has its own enormous cost implications
Section 2 (The technology)	The FREEDOMS study has shown a significant benefit of the use of fingolimod in terms of disability and MRI findings. Weighed up against potential side effects and cost, it appears clear that there would be a huge overall benefit for this patient group. THe risk profile also appears better than that of Tysabri and Campath
Section 3 (The manufacturer's submission)	This area of medicine desperately needs an oral treatment to enable this young, working patient group to continue to contribute economically and socially to society. It is unacceptable to withold the use of an oral preparation where no others are currently available.
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)	

Role	other
Other role	mother of MS patient
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1	it appears to have been proved that Fingolimod is an effective

(Appraisal Committee's preliminary recommendations)	treatment for REMS. Under Copaxone my dtr has had 4 relapses in the year.the worry of this is devastating as we have been told Fingolimod is the only drug that can help, and this is not available to uson NHS.Imyself am now being treated for stress, of course my dtrs state of mind is worse and all adding to NHS costs.
Section 2 (The technology)	it seems grossly unfair that the drug has marketing authorisation for some cases that it is not available to all, regardless of ability to pay. the reputation of UK as a leader in research and development must surely suffer.
Section 3 (The manufacturer's submission)	before her diagnosis my dtr held a post as a mental health support worker. As well as providing cost-saving and life-enhancing help to others, it also gave her life a meaning. with MS this has cruelly been snatched from her and the drug which was believed to give some respite has proved to be otherwise with no lessening of relapse. She would love to be a taxpayer again!
Section 4 (Consideration of the evidence)	It is not possible for NICE to put a definitive coston the situation of my daughter and family. It is immeasurable. simply the fear of her taking her own life is awful, when knowing there exists a drug which you yourselves accept has been proven effective. I beg you to weigh the cost effectiveness of life without this drug with the infinite betterment that would be derived from it for patient and all those associated with the knock-on repurcussions.
Section 5 (Implementation)	please give sincere consideration to the many representations you will have received from both eminent professionals and ordinary sufferers and their families who await your decision with anxiety and hope.
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	Public
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 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	Whilst I appreciate the consideratjion of the evidence, im not sure that full consideration has been given to the result of this

	decision. Im also not convinced that the cost element is right. Surely, with removal of this type of treatment, costs will continue to increase as patients move through the various stages of the disease that would not be as intense if treatment has continued as the trial is now. HOw much can you cost against personal and psycological issues associated with the progression of the disease. I have seen a positive change in my friend which wouold not be there if she was not on this treatment but on someother which may include injections which she has a frightening fobia about - surely the stress associated with just a visit to the hospital or doctors just for regular medication is, in itself the worst thing for MS sufferers. I would strongly urge the revisting of this in its entirety.
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	Surely this date is too far in the future for some. consultation should include indepth with those who suffer from MS and benefit from this treatment.

Role	other
Other role	Stepfather of patient on fingolimod trial
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I am unhappy that NICE have at present not recommended the use of Fingolimod as since my stepdaughter has been on the drug trial her psychological and physical wellbeing have both greatly improved.
Section 2 (The technology)	Many people have a needle phobia and an oral drug gives them choice, especially as they also have to cope with the complexities of coping with MS.
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	Preliminary results suggest that Fingolimod has beneficial effects and relative to the cost of inpatient treatment, local authority costs and disability benefits, I feel it is a cost-efficient treatment.
Section 5 (Implementation)	Decisions taken by local providers would lead to a postcode lottery. The NHS is a national organisation and should cover all patients and not discriminate on the basis of a disability. The quality of life for an MS patient should be the main consideration for the use of a drug.
Section 6 (Proposed recommendations for further research)	The only way to combat MS is further research.
Section 7 (Related NICE guidance)	

Section 8 (Proposed date of review of guidance)	As hopefully trials will be continuing, it would be better surely to review the guidance on an ongoing basis.

Role	Patient
Other role	
Location	England
Conflict	no
Notes	I am currently on the fingolimod final stage trial and I have found it very helpful in reducing the intensity and length of relapses. I believe it has been far more successful than the rebif interferon that i was previously on. The fact it is in tablet form makes it really easy to take and doesnt leave my body in a state through injections which was depressing.
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I am very disappointed by this decision. I have RRMS and have been on the trail since late 2011. I honestly feel that it has helped my symptoms. It has made relapses less frequent and less intense. I am also aware of others on the trial who also feel it is having a positive effect.
Section 2 (The technology)	
Section 3 (The 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)	

Role	Patient
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Having lived with MS for 12 years now and meeting more and more people with it, I find that the proposal not to include Fingolimod (Gilenya) as an alternative to the already recognised therapies somewhat bemusing. Oral therapies are probably the biggest leap in recent times for MS and for those of us who cannot tolerate injections, it is probably our only lifeline at the moment. RRMS (like all variants) is debilitating,

	the log in the fire scenario if you will, the longer you leave patients without any form of treatment, the greater they will draw on the already tight NHS resources. I have had four relapses in 18 months, the amount of time and money that has cost the NHS is quite amazing considering the relatively low cost of the drug per annum. Please consider the thousands of people who are in a similar scenario to myself working, paying tax and contributing to society - remove any chance of stabilising our illness could in turn remove us from being a taxpayer and the subsequent tax receipts to the government taking a huge downturn and the social care implications soaring. Thankyou
Section 2 (The technology)	
Section 3 (The 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)	

Role	Patient
Other role	also work as dietitian in the NHS
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	This doesnt seem to take account of adverse effects from injections which necessitate additional treatment from the GP/practice nurse such as antibiotics, daily dressings, etc and hospital treatment for debridement, iv antibiotic treatment, etc which all incur large costs to the NHS but information is unlikely to be collected. An oral drug would stop all these skin reactions so save the NHS large amounts of money
Section 2 (The technology)	This has been accapted for use accross europe, if interferon causes too many side effects or does not stop relapses an alternative with few side effects should be available as without alternatives costs will increase as the MS is likely to worsen which will involve increased costs to the care sector
Section 3 (The manufacturer's submission)	It seems that there is evidence that Fingolimod does help prevent relapses and would be of benefit as a second line treatment, over time more evidence of efficacy would be available and then use could be reviewed

Section 4 (Consideration of the evidence)	It seems the decision is being made solely on cost but other costs associated with adverse skin reactions would not be looked at, many people suffer adverse skin reactions from injecting needing hospital stays, more medication, extra visits to GPs and practice nurses over extended periods if the costs of these were looked at Fingolimdod would be more cost effective. There may be more evidence available as more people are on it and with ongoing studies but should we have to wait for this all when all the time our disease could be progressing worsening our disabilities and quality of life?
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	If it is not to be approved now 2015 seems to be too long to wait for review. As it has approval for use elsewhere much more data would be available in a much shorter time scale and so should be reviwed sooner

Role	Patient
Other role	Daughter of father with advanced MS
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	It is very upsetting that NICE have not yet recommended the use of fingolimod in England as I am fortunate to currently be a patient taking part in the fingolimod extension trial. The treatment currently available on the NHS for very active (rapidly evolving) relapsing-remitting MS in England and Wales involves monthly transfusions at a hospital. This does not offer a choice of treatments for patients, there is an additional risk from serious side effects, and is not a suitable treatment method for those who are needle phobic (such as myself). It is also an inflexible approach for those still working full-time, it is much more convenient to take a daily tablet. Beta interferons are not always appropriate as injected (with side effects), and are not as effective as fingolimod for the rapidly evolving disease. Given the recognition since the first consultation document of the benefits of fingolimod and additional documentation no change in the NICE decision is rather distressing.
Section 2 (The technology)	This novel technology involving oral medication has a positive effect on daily quality of life, offers flexibility for administration of the drug, and provides hope for a future. I have not experienced adverse side effects, nor experienced a relapse since starting taking fingolimod (despite two mobility relapses in close succession prior to commencing the trial). I would be devastated if I was not permitted to continue to access this oral medication as it has made a positive difference to my life.
Section 3 (The manufacturer's	The specific comparisons with Avonex and placebo have shown

submission)	that fingolimod is more effective than either other approach. Whilst the original submission was criticised for not including a comparison to Natalizumab, additional intervention comparators have subsequently been conducted, but are not included in the economic model. There may therefore be further cost benefits which have not been recognised.
Section 4 (Consideration of the evidence)	Fingolimod has been shown to reduce relapses with few side effects and was licensed by the MHRA in April 2011 as safe and effective. There were previously no treatment options available to help manage this condition. Although treatments have grown in number in recent decades and now include oral medication, access is very limited without support from NICE/NHS. I have grown up watching my father deteriorate from a similar condition without any treatment, best supportive care does not improve the prognosis. Once the nerves are damaged the effects cannot be reversed and has long lasting effects on quality of life. Starting treatment earlier provides a better prognosis. The evidence has proven the effectiveness of fingolimod, therefore resorting to a postcode lottery appears unethical, and still provides no guarantee of access to the licensed treatment. I thought the NHS was established to provide access to the whole population. It is difficult to understand the formula used for the generation of the figures quoted in the consultation document. However, as I thought the cost for fingolimod was similar to that for Natalizumab it appears difficult to justify a negative response for this treatment based on cost effectiveness. For patients whom Natalizumab is not appropriate there are no other options currently available on the NHS. Disease progression if left untreated is likely to exceed these costs if patients are left unable to work, have to be funded by the state, and are further denied a reasonable quality of life. If I cannot work full-time for the foreseeable future due to this illness, I will lose my home and my self-respect.
Section 5 (Implementation)	Implementation of the medication should be made as widely as possible on the NHS for highly active relapsing remitting MS, and for those where beta interferons have not been successful. It would be unethical to remove a treatment from patients who are currently responding well to the new treatment (unless on medical grounds). This applies also to patients taking part in fingolimod clinical trials who may have met the stringent criteria prior to their involvement in the trials. It is also inappropriate to deny access to other patients who may benefit, due simply to a postcode lottery. A positive recommendation by NICE will remove the stress and negative impact on health and wellbeing created by geographical differences and the requirement for individual cases to being submitted to the PCTs. Access to MS medication in England and Wales is known to be very poor compared to other countries and should be expanded without further delay. The whole future of an MS patient needs to be taken into account, this is disability discrimination.
Section 6 (Proposed recommendations for	Novartis should be encourged to continue the fingolimod research, expand the patient pool to enable other comparisons

further research)	to take place, and reconsider the costs of the patient access scheme. At least one trial is still ongoing worldwide and patients should continue to be monitored and the results published.
Section 7 (Related NICE guidance)	If NICE do not recommend fingolimod in the short-term will they consider publishing a guidance document to assist PCTs in considering requests for fingolimod?
Section 8 (Proposed date of review of guidance)	January 2015 is definitely too late. In that time disease progression may advance significantly for patients. There is currently no way to reverse the effects of nerve damage and fingolimod is not thought to be suitable for later stages of the condition. Can this timescale be re-considered or it will be too late for some patients due to the nature of this progressive and debilitating critical illness? Quality of life, ability to work/drive, and dignity are key drivers to daily living, mental health, and ultimately, a future. Without dignity what kind of life do we have left?

Role	Public
Other role	
Location	England
Conflict	no
Notes	My sister is currently one of the people trialling the use of fingolimod
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	While my sister has been participating in the trial of Fingolimod, she has been able to remain in full-time employment, going about her everyday life with minimal disruption. This is important as she lives some distance away.
Section 2 (The technology)	My sister does not react well to injections so having oral treatment is really beneficial for her - she has not suffered any adverse reactions to this form of treatment and has not suffered any relapse during the trial.
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	My father also has MS and this form of treatment was certainly not available for him 20 years ago,he is in a care home unable to look after himself. My sister using this form of treatment can have a much better quality of life and this provides me with reassurance for her future.
Section 5 (Implementation)	I would be annoyed if just because my sister lives in the wrong part of the country she misses out - the postcode lottery is not at all fair. By prescribing fingolimod, this offers a chance for so many people to cope with the condition - surely cost cannot be the only factor here.
Section 6 (Proposed recommendations for further research)	Research is vital to find a way to combat this dreadful debilitating condition.
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	January 2015 is a further 3 years away - why does it have to take so long? Presumably the trial of Fingolimod will continue for this length of time?

Role	other
Other role	Parent of fingolimod trial patient
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Fingolimod has given hope to my daughter during her participation in the trial. She is able to continue working full-time and contribute to society and therefore not have to rely on anyone else, especially as she lives on her own about a hundred miles from us.
Section 2 (The technology)	Oral treatment is more beneficial than injections, especially to patients that have a phobia regarding needles. My daughter has not had any adverse reaction to this drug and has not had side-effects or a relapse during the trial. She has been monitored by her consultant throughout.
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	Anyone who is diagnosed with MS cannot just have an operation and they will be cured. The ongoing cost if no treatment is forthcoming just increases year by year. If fingolimod could be prescribed, it would save on hospital admissions, carers, disability benefits and improve the quality of life for thousands of patients.
Section 5 (Implementation)	It is inappropriate to make certain drugs only available in a postcode lottery. The NHS was designed to cover all patients. Starting treatment early would put less strain on the NHS for the future. The whole future life of an MS patient needs to be taken into account not just what cost at diagnosis. This is disability discrimination.
Section 6 (Proposed recommendations for further research)	Research is vital to find a way to combat this dreadful debilitating condition.
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	Presumably the trials will be able to continue as there would be no point in reviewing the technology. Why January 2015?

Role	Patient
Other role	
Location	England
Conflict	no
Notes	Person with MS
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Apart from Tysabri (which carries some health risks unacceptable to many)it is my experience that there is not an effective enough treatment available for highly active forms of the disease as the literature would suggest this is.
Section 2 (The technology)	I have been taking interferon for many years now and would fall into the category that would be suitable for this drug. Many

	patients would welcome an oral therapy over the current injections and the side effects seem to be no worse than those of the interferons.
Section 3 (The manufacturer's submission)	Quite a lot of this is written in such technical language that I cannot understand it. In terms of quality of life I would submit that an oral treatment would be a huge improvement over the injections and the paraphernalia they require (refrigeration, sharps bins, medical notes for travelling abroad, etc.).
Section 4 (Consideration of the evidence)	Too much emphasis is placed on EDSS scores, which, with a disease like MS can fluctuate. Also whilst, in the current climate now more than ever, cost is important I think more weight should be given to patient needs. Injecting methods are inconvenient and uncomfortable. Many people are uncomfortable with the Tysabri infusion - which is also incredibly inconvenient as it takes pretty much a day out of your life to be at the hospital once a month and (amongst the available therapies) has quite high risk with PML.
Section 5 (Implementation)	No comment.
Section 6 (Proposed recommendations for further research)	Research for this therapy must already be huge as I remember my consultant talking about the trial when I first started DMDs which was about five years ago.
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	2015 is a long time to wait to review something which could be so much help to so many people.

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 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	NICE claims that one third of all RRMS patients who have not responded to their first Interferon are moved to best supportive care (BSC) and have calculated cost-effectiveness on this basis. I do not believe this to be true. Patients frequently switch between agents in an attempt to optimise both efficacy and tolerability. I would estimate that the proportion reverting to best supportive care is more in the range of 5-10%
Section 5 (Implementation)	
Section 6 (Proposed recommendations for	

further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	Carer
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	How can you reject this drug on cost effectiveness? My wife has lost her job, is drawing all the benefits she is entitled to and during a relapse on the current Rebif that dont work that well ends up in hospital costing the NHS even more in care. Yet you propose that its cheaper for a patient to become more disabled and obtain care only? A very selfish view from a Panel that I doubt has any direct experience from someone they care for with MS. Try taking injections that dont work and have intoreable side effects. This drug does work and that is why most of Europe, USA and several parts of the world have approved it. Why do UK citizens have to always deal with these negative guidance from NICE? you dont suffer but patients do. If any one from the panel gets MS I am sure they would regret their decision within seconds. Therefore please reconsider this drug and for a change think about what it does to a huma being!!
Section 2 (The technology)	
Section 3 (The 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)	

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	The response from NICE is highly disappointing. There is an unmet need in the current DMT treatments for an oral therapy. for example those who cannot tolerate injectables due to

	significant lipoatrophy or site reactions. Those who are allergic or sensitive to tysabri or who are having breakthrough relapses but chose not to have tysabri treatment due to the risk of PML. Please reconsider
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The response from NICE is highly disappointing. There is an unmet need in the current DMT treatments for an oral therapy. for example those who cannot tolerate injectables due to significant lipoatrophy or site reactions. Those who are allergic or sensitive to tysabri or who are having breakthrough relapses but chose not to have tysabri treatment due to the risk of PML. Please reconsider
Section 2 (The technology)	
Section 3 (The 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)	

Role	Patient
Other role	Consultan Physician
Location	England
Conflict	no
Notes	I am a Consultant Rheumatologist who works full time in 2 busy hospitals. I see around 240 patients per month and have over 1200 patients under my care. I have been a consultant for 3 years now. 4 months ago my world was turned upside down when I was diagnosed with Severe Relapsing remitting MS. I have had 3 relapses in the last 12 months which have been severe resulting in me taking 5 weeks off work. I live alone and am at the start of my consultant career after many years of hard work. MS is a serious disease and there are lets face it very few effective treatments for a disease which affects young people. Last week I found out my PCT despite the advice of my neurologist had refused to fund my IFR for Gilenya. I am most disappointed now I know how completely devastating it feels to have NO TREATMENT OPTIONS in the face of a disabling disease. NICE should realise the cost of this disease for me and many other sufferers doenst come down to cost effectiveness and QALYS. Gilenya could mean the difference between many people staying fit enough to work and lead their lives independently instead of having to have no future and live a life dependent on the state and others. Where is the sense in

	this? My future and that of my patients may will be affected by my PCTs and ultimately NICEs decision on Gilenya. I urge NICE to reconsider their decision for the sake of all MS patients who have little in the way of effective treatments out there.
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Fingolomod should be recommended for the treatment of highly active relapsing remitting MS when the only treatment out there has a risk of an incurable brain infection the risk of PML rises year on year with Tysabri and this drug is not suitable for all patients with highly active RR MS. More options are desparately needed and Gilenya is one of them.
Section 2 (The technology)	This is appropriate
Section 3 (The manufacturer's submission)	This is wholly appropriate
Section 4 (Consideration of the evidence)	Has been inadequate. This needs to repeated. Best supportive care what a joke!
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	Guidance needs immediate review!

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	it is very disappointing that a drug which has been shown to reduce relapses in severe MS which is already on Binterferon has not passed the NICE evaluation due to cost given that the patient group this affects are young patients who have the most to gain through disease control. I would be keen for the committee to re-evaluate their findings in light of good evidence to show treatment benefit in a therapy which can be taken orally.
Section 2 (The technology)	A novel drug which works through a different mechanism and which has been shown to have both radiological and clinical benefit should be prioritised as an effective treatment available to the cohort of MS patients who would fulfil criteria for treatment.
Section 3 (The manufacturer's submission)	relapse rates and disability progression were significantly improved compared to placebo in the RCTs conducted, which are key aspects to improving the quality of life of patients with MS
Section 4 (Consideration of the	It is extremely disappointing that a drug which has been shown to have good clinical effectiveness is being witheld mainly due

evidence)	to cost considerations
Section 5 (Implementation)	the evidence should be reviewed and more input from patients and clinicians to consider the ramifications of such a decision
Section 6 (Proposed recommendations for further research)	there is already good, well conducted evidence to show treatment benefit
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	This seem to be a pure cost driven statement. FREEDOMS showed significant improvement in disability and MRI endpoints. MS is a condition that has no cure, affects the young and causes much morbiditiy and cost to NHS (physio, OT, Respite placements, nursing home, appliances etc.) not to mention lost money to the economy in leaving young patients unable to work and rely on benefits. For these reasons it seems unethical not to provide a drug that potentially could make a real impact in a vulnerable patient group.
Section 2 (The technology)	The technology is clearly far superior to what is available currently. We already know that IFN is outdated and has relatively poor outcomes compared to TYSABRI and Campath. Yet all of these preparations are non oral preparations and cause difficulties in themselves. In terms of side effect profiles it is no worse than these preparations and if anything appears safer from the phase 3 trial evidence.
Section 3 (The manufacturer's submission)	The manufacturer has referred to 2 well constructed Phase 3 trials that have been published in highly regarded Peer reviewed journals with outstanding impact factors. It has shown evidence of benefit and also a favourable side effect profile. It is the first drug that can be used orally and it seems barbaric to withold this from a patient cohort who deserve the right to access to treatment that can have such an impact on the quality of life. Furthermore it is a very defined and relatively severely affected/non responder population that is being aimed at who if not treated appropriately are only going to burden the NHS financially more in the future as well as impact on social welfare and work force numbers.
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)	

Role	Patient
Other role	health care professional
Location	England
Conflict	no
Notes	we did not cause this disease, there is no cure for the disease! how can you justify giving free help to people who have caused their own illnesses like, obesity, drug users and alcoholics. my issue is that the medications is in oral form. just think about it for a second how depressing it must be for someone with htis illness to also have to inject every week! when diagnosed at 23, when qualifying as a nurse at 21 all i wanted to do was care for peoploe. i now have no compassion in my job, am clinically depressed and find it difficult to walk up stairs. i have changed the ward i work on 2 times now, dropped my hours and work permanent nights to be able to afford to cut my shifts as a am not recieving any finantail help. you keep going on about money, well try saving insted of practically giving it away to people who have clearly caused their own illness! please help me to understand why this medication is not available, the only small bit of hope suffers have.
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	we did not cause this disease, there is no cure for the disease! how can you justify giving free help to people who have caused their own illnesses like, obesity, drug users and alcoholics. my issue is that the medications is in oral form. just think about it for a second how depressing it must be for someone with htis illness to also have to inject every week! when diagnosed at 23, when qualifying as a nurse at 21 all i wanted to do was care for peoploe. i now have no compassion in my job, am clinically depressed and find it difficult to walk up stairs. i have changed the ward i work on 2 times now, dropped my hours and work permanent nights to be able to afford to cut my shifts as a am not recieving any finantail help. you keep going on about money, well try saving insted of practically giving it away to people who have clearly caused their own illness! please help me to understand why this medication is not available, the only small bit of hope suffers have.
Section 2 (The technology)	
Section 3 (The 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)	

Role	Healthcare Other
Other role	
Location	England
Conflict	yes
Notes	I have served on advisory boards for the technology with the manufacturer.
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Like many of my neurological colleagues specializing in the management of multiple sclerosis, I am concerned that the recommendations remove the possibility of treating people with MS who continue to relapse on current first line therapies with a proven and licensed medication which can reduce their risk of further relapse and associated disability.
Section 2 (The technology)	No Comment
Section 3 (The manufacturer's submission)	No comment.
Section 4 (Consideration of the evidence)	I disagree with the suggestion that a significant number of people failing first line therapies would switch to supportive therapy only. In my experience, and in that of my colleagues in the field, the great majority of those patients would switch to Natalizumab, or would remain on their current therapy in the expectation that it was still providing some protection from relapse. I believe this alters the economic model considerably in favour of adoption of the proposed technology.
Section 5 (Implementation)	No comment.
Section 6 (Proposed recommendations for further research)	No comment.
Section 7 (Related NICE guidance)	No comment.
Section 8 (Proposed date of review of guidance)	The proposed date for review in Jan 2015 will cause enormous disappointment to those who consider that the technology offers an effective therapy to people with MS who are relapsing despite treatment with first line drugs, and where the comparators to the technology are either those drugs or else Natalizumab, and not the alternative suggestion of withdrawing disease modifying therapies altogether.

Role	Patient
Other role	
Location	England

Conflict	no
Notes	I am currently on the fingolimod trial and have relapsing/remitting/secondary progressive MS
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I have found fingolimod to be effective in treating my MS. I work full time as a secondary teacher and since starting the trial have had the energy and ability to continue my work. I was previously on Betaferon and then Avonex and the stress of injections, tiredness and red marks left by these were distressing, unpleasant and ineffective. Taking a tablet which has no noticeable side effects, is easy to take and has seemed to be effective in treating me has been wonderful. I do not want to stop taking it. I had to come off it over the summer as it had affected my white blood cell count and had a relapse after 6 weeks, which seems to show I am better on it than off it. I do not know anyone with MS who wouldnt like to be taking tablets instead of injecting and have been impressed by how well I have seemed. This should be available to all patients for whom it may be effective.
Section 2 (The technology)	
Section 3 (The 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)	

Role	Patient
Other role	
Location	England
Conflict	no
Notes	Im just a patient with MS, diagnosed in September/October 1998, and sick of having to inject myself and tablets appear to be the answer. As it stands I see my nurse in late March and hopefully my neurologist in April when I will stop injecting. Ive injected for 8.5 years, it took nearly 3 years to convince me to use injections but after 3 relapses in 1 year thought it was worth ago. Relapses have come down but I never like having to do the painful injection process every other day - I have at least 2 knots in my stomach that have been left from injections since way back. I also get a lot of hassle even receiving my injections now and so will have to use my holidays from work to just to collect the things Id prefer to not have to use. They dont allow me to live my life as Id like to, I give them priority over

	everything else and so stop a lot of things. Tablets would also open the world to me for holidays - a bit of sun (which coincidentally is good for people with MS). I take vitamin D tablets every day anyway. Hopefully the tablet would allow me to carry on working and for longer so in a way claw some money back from me. As far as I know I dont use/abuse the NHS in any other way - even my dentist is semi private subsidised by work (BAE Syatems). I just hope when you reconsider you take into account that I (we!) havent done things to myself to have caused this, I am just unlucky. I also hope that those who have the final say have some first hand experience of having to self inject, people can say they understand but in practice they cant understand the full implications of how it starts to take over your life. I finally live in hope for a different outcome next time. Thank you for letting me have my say.
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)	
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

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 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	NICE is suggesting that 1:3 patients come off treatment which is NOT representative of the reality.As an MS Specialist Nurse in Worcestershire which has a high incidence of MS, patients remain on other therapies even if they are not as effective rather than be on no treatment at all. There are very few people on nothing.Fingolimod is needed as an option so people can receive appropriate therapy for their condition.
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	Patient
Other role	
Location	England
Conflict	no
Notes	Hiya! i was very keen on contacting NICE about this drug that improved 25% of wallking in people with MS.i will be very greatfull if you could tell me whats going on with this drug,i thnk itS NAME STARTED WITH fl...,ANY HOW CAN HOW CAN I CONTACT NICE and in what way and how ?
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)	
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	Patient

Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	It should still be considered if high activity is still seen on beta inferon drugs. The side effects do seem to be a consideration, but of beta inferon is not working, there must be little other choice. Also, high activity might well come on 1 or 2 years down the line and this seems to be the most effective drug out there, so I believe it should be considered for other relapse remit cases, ms is highly different in everyone and evolves at different rates, if this is the most effective thus far, and the easiest, it has to be considered. Use will drive down costs, plus some patientsugur be willing to pay the difference if it is this effective
Section 2 (The technology)	Cost will come down with initial use, patients may well pay the difference on some cases to start the ball rolling. It can potentially perform better than other drugs and keep recurring visit costs lower during the patients lifetime. All drugs must start off the same way until health authorities get involved in the mass market . Who is to tell the future of a patient with ms, surely 6 odd lesions is arbitrary? Patients without might end up worse without this
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	Some shorter term studies with people on the drug with differing criteria, to understand better the lesion or relapse rates should also continue, the more the better informed
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	My main comment regards the frankly bizarre choice of best supportive care as the appropriate comparator (see my comments in section 4).In clinical practice, patients in whom one would consider fingolimod would otherwise be recieving an interferon / glatiramer, or switching to natalizumab, and this should be the comparator. The modelling is very complex and contains so many uncertainties the use of the current DMTs,

	and how fingolimod would be incorporated in practice is much more straightforward.
Section 2 (The technology)	
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	Section 4.18 (issue of a third of patients switching to best supportive care) I disagree with this strongly.In this group, the vast majority of patients would either continue with their current interferon (or glatirmaer), or switch to a more effective treatment ie Natalizumab, or an unlicensed alternative eg alemtuzumab. Switching to best supportive care would apply to the very few patients who by choice decline the other options (eg for fear of side effects). I would estimate this applied to no more than 10% of patients, and this would be even less if there were a relatively safe other treatment option such as fingolimod.
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	I have benefited from travel support from Novartis Pharmaceuticals (attendance to AAN meeting in 2010).
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The recommendations appear difficult to rationalise, and if implemented, would severely restrict therapeutic options for a specific group of MS patients in significant need of additional therapeutic options.
Section 2 (The technology)	No comments. This is a fair representation.
Section 3 (The manufacturer's submission)	See comments below regarding best supportive care.
Section 4 (Consideration of the evidence)	The key issue relates to point 4.18. It is not credible that "approximately one-third of people with relapsing?remitting multiple sclerosis whose disease has a suboptimal response to beta-interferon treatment" receive best supportive care. Patients in particuarly are particularly keen to remain on their therapy, despite apparent limited efficacy. A smilar analogy would be that patients with Epilepsy or Parkinsons Disease who have a suboptimal response to therapy (which is very common), would have their therapy stopped and changed to best

	supportive care. This does not happen in clinical practice.
Section 5 (Implementation)	No additional comments.
Section 6 (Proposed recommendations for further research)	Definitely to be supported.
Section 7 (Related NICE guidance)	No comments.
Section 8 (Proposed date of review of guidance)	No comments.

Role	Patient
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Please reconsider this decision as Fingolimod is a huge improvement as regards quality of life for MS sifferers.
Section 2 (The technology)	
Section 3 (The manufacturer's submission)	I have been on a clinical trial of Fingolimod since December 2010. In that time period I have had no relapses and my disease progression has not increased. I have also suffered no side effects that required any NHS treatment. I was previously on Rebif-44 for 6 years and during that time I had at least one relapse a year and due to adverse side effects I had to discontinue treatment. I would therefore say that Fingolimod has been far more effective in treating my MS than Rebif-44.
Section 4 (Consideration of the evidence)	The commitee has to consider the impact of quality of life more. Having been in a clinical trail of Fingolimod for a year and having been on Rebif-44 for 6 years previously I can confirm that the improvment in quality of life is huge. I really cannot overstate it. It has made an enormous difference to me taking a pill once a day and I have seen a real improvement in my MS symptoms. I am less tired every day and have had no relapses. This must have some impact on cost effectiveness as I have needed less visits to my neurologist and less other treatments and have been able to continue in full time employment thus paying taxes and not claiming benefits nor requiring any care. NICE must embrace new treatments otherwise the state of MS treatment will remain static. The earlier that patients take this treatment the better as it hugely improves their chances for the future. This makes a great difference to the individual patients, their families and society as a whole. Please please reconsider your decision as this will have an enormous impact on my life and the life of many other MS sufferers.
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	

Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	other
Other role	sister of MS sufferer
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	My sister has been on a clinical trial for Fingolimod for over a year and has had a very positive experience with this drug. It has enhanced her quality of life dramatically and she has not experienced any major MS attacks since she has been on the trial.
Section 2 (The technology)	As above
Section 3 (The 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)	

Role	Carer
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	my daughter has been on this drug as a trial since january 2011. Before this she was on avonex, she visited the doctors every week as she could not inject herself, she constantly has gum infections tonsilitis etc, even claiming on her e111 due to antibiotics recieved whilst in france, and dental appointments for painful gums, she had not suffered greatly from any of these infections before and has not since recieving fingolimod, in fact she has only visited her doctors once this year. This is obviously an extra cost due to avonex which must be accounted for
Section 2 (The technology)	a massive move forward, this must be accepted with open arms, if not do we stay static on medical research

Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	taking 1 tablet per day without any flu symptons etc. is obviously far superior than injecting every week and having flu symptons. Surely when our neighbours in Australia, America, Europe, Japan, etc. etc. make this drug available because of the system where private healthcare is like car insurance here, and because we have an ailing healthcare system, perhaps we need a radical change to our NHS because unfortunately it is failing us, and that is no good to anyone
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	this should have been done 10 years ago
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	this cannot come soon enough, whilst other countries move forward our out of date inadequate health system fails and we fall far behind our neighbours

Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	A small number of patients on my case load on on the currant figoloimod trial.
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	In my caseload I have about 5% of people with R/R MS who are still experiencing relapses on DMT. They need to have the choice of an alternative therapy to enable them to return to an active productive lifestyle. It is vital that this therapy is available to this minority.
Section 2 (The technology)	For those patients that meet the criteria for this therapy, the fact that it is an oral therapy is preferable to that of a injectable or IV infusion. It means that complience is likely to be 100%. Cost effectiveness and safety are paramount when prescribing therapy, Fingolimod appears to meet both criteria.
Section 3 (The manufacturer's submission)	Although I have about 5% of my patient case load who are currently failing on their DMT I also have about 5% who have declined the offer of DMTs although eligible. These people with active disease are off work for periods of six to seven months and experience a further decline in their ability to function as they did prior to their most recent relapse. Whatever your QALYs suggest this is the reality for the individual.
Section 4 (Consideration of the evidence)	In my experience, people with active disease are offered the option of more aggressive treatment. No one is excluded from treatment that they are eligible for. Keeping people, with this long term condition, active and enjoying life to the full is a basic right and we should endeavour to do everything possible to affect this untill a cure is discovered.
Section 5 (Implementation)	Its good to know that there is help available to understand the complex nature of NICE approval!

Section 6 (Proposed recommendations for further research)	Good idea!
Section 7 (Related NICE guidance)	These guidence are both informative and helpful. However, CG8 is needing an update as a matter of some urgency.
Section 8 (Proposed date of review of guidance)	Those patients that meet the criteria for this therapy need it now. Time is of the essence, their quality of life is compromised and this decision is vital to future outcomes.

Role	Patient
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I think this is a very short sighted decision by NICE and completely disregards patients livelihood.
Section 2 (The technology)	This treatments is medically proven to reduce the number of relapses for patients who suffer. The fear of having a relapse has ben completely ignored by NICE and shows a complete lack of understanding of NICE of the physical and mental distress experienced by sufferers.
Section 3 (The 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)	That date is a disgrace. As a young professional who is on avonex and whose treatment is proving to be ineffective this is hugeoy disappointing...

Role	Patient
Other role	
Location	England
Conflict	no
Notes	I am on a clinical trial for Gilenya. I have previously taken Betaferon, but had to stop because it caused serious depression. While taking Gilenya, my condition has improved. If I have to stop taking Gilenya, there will be no medication available to me because of side-effects from the usual DMDs. This means I am likely to start to relapse again.
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's	Some people with this condition have problems with or bad

preliminary recommendations)	reactions to injectable DMDs. Fingolimod has been shown to be effective. Denying use of this drug deprives these people of an effective treatment.
Section 2 (The technology)	
Section 3 (The 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)	

Role	Patient
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	While I appreciate the need for some form of cost-benefit analysis, it strikes me that the arguments surrounding this review are about statistics and choice of input data rather than whether or not fingolimod actually works and is affordable. Multiple sclerosis is not a disease that lends itself to statistical modelling: relapses create too many u-shaped data to account for. As such, a far simpler approach is warranted. Natalizumab is the only disease modifying treatment currently available in the UK for those patients who are not responding to beta interferon or glatiramer acetate, however, not all of these patients are eligible to receive natalizumab. In addition, many patients are unwilling to risk the possible side effect of progressive multifocal leukoencephalopathy and so decline the offer of natalizumab. For these individuals, there is a desperate need for an alternative second line treatment. If the manufacturer can be persuaded to provide fingolimod for a cost price (including logistics and implementation costs, etc) that is somewhere in the region of beta-interferon, glatiramer acetate and natalizumab, how on earth can you morally or logically decline it?
Section 2 (The technology)	It appears that the committee has undervalued the advance that fingolimod presents. The requirement to inject is the single largest factor determining the (un)willingness of patients to use beta interferon and glatiramer acetate. While those in group 1b have clearly overcome that issue, it is an ongoing battle for many of them. One reason for this is that while every injection is helping them beat their MS, it brings with it unpleasant side

	effects such as pain, irritation and itching, unsightly bruising, etc, as well as flu-like symptoms if one uses beta interferon. The ERG have urged for fingolimod to be compared to Rebif-44. If that is to be the case, then the QALY costs of having treatment-induced aches, fever, headache, etc, three times a week should also be factored in. Observers may consider these insignificant. As a user myself, I can assure you that they are not.
Section 3 (The manufacturer's submission)	Re 3.30: When the treatment of RRMS fails, the patient begins to relapse. At this time, the treatment is stopped and, if possible, changed. Including several years of declining efficacy in the model is therefore irrelevant and should not be included in the model. At most, a single year of declined efficacy is warranted. Re 3.31: "It noted that the manufacturer only adjusted the drug acquisition cost in the model in line with the patient access scheme." reads like a gauche demand for a bigger discount. If this is the true stumbling block, then why mask it with all the rather meaningless and highly debatable points about the model and its inputs?
Section 4 (Consideration of the evidence)	It is important to note that only a tiny proportion of people with MS have what might be considered "best supportive care" (BSC) by any laymans understanding of the words. The figure of 1/3 is actually laughable. Of the dozens of people with MS I personally know, only one has what might be considered BSC. Not only is there a lack of medication for symptoms, there is a lack of essential physiotherapy, occupational therapy, support of continence needs, counselling and emotional support, etc. Does the model reflect the likely changes in costs of BSC once new government initiatives force improvements in the proportion of patients receiving these services? Thisnotwithstanding, by accepting BSC as an alternative to active treatment of MS, the committee deems it acceptable that people receive nothing to minimise cumulative disability from relapses, never mind the impact of intractable pain, incontinence and debilitating sensory and cognitive symptoms. The variability of recovery and duration mean that these can never be adequately modelled. (And nothing is what some people are left with, when first-line treatments fail and natalizumab is unavailable.)
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	Patient
Other role	

Location	Scotland
Conflict	no
Notes	I suffer from highly active RRMS
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	
Section 2 (The technology)	It is an expensive treatment, but, if it means MS sufferers can have a better quality of life and can, ultimately, get back to work and paying tax. The cost would therefore decrease slightly. Has this been taken into consideration? I also think it would be wrong to deny a patient the opportunity to try Fingolimod if they have not had a positive reaction to other treatments.
Section 3 (The 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)	

Role	Patient
Other role	
Location	England
Conflict	no
Notes	I have suffered with MS for 31/2 years and am currently taking Avonex (Beta Inteferon).
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	
Section 2 (The technology)	From a personal poitn of view I have experienced sever side effects for the the 3.5 years I have taken Avonex, and my only response from healt care proffessionals is oh thats unusual. with your diregard of gilenya you have removed the only option for people like myself who are forced to persist with the use of a drug therapy which currently removes a day from a seven day weak for myself. side effects over 3.5 years are certainly not as bad as 3-4 months. I cureently work a 37 hr week and would like to continue to do so.
Section 3 (The manufacturer's submission)	As an MS patien, to me the clear advantage of this therapy is that it is thought to reduce disease progression, which betainterferons do not. surely cost efectiveness is outweighed by the NHSs duty of care to its patients???
Section 4	

(Consideration of the evidence)	
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	what about people which beta Interferon is no good but do not qualify for tysabri?
Section 8 (Proposed date of review of guidance)	

Role	Patient
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I understand that it has not been recommended on a cost basis but I would question whether full costings have been made in respect of the savings made in not treating relapses and future deterioration of patients health in the absence of this treatment which has been shown to both reduce relapse rates and disease progression faster than other currently used drugs such as beta interferons.
Section 2 (The technology)	Contra-indications seem to be at a low level & are considerably less deleterious than those seen additional from the application of injection-based therapies such as interferon. The patient access route offers cost savings that must be considered.
Section 3 (The manufacturer's submission)	As each persons experience of MS differs and as such PwMS cannot easily be pigeon-holed into categoreis as required for allocating to either groups fro study or EDSS etc scores, there has to be some subjective appreciation of the benefits taken into account in assessing the findings as definitively as stated here.
Section 4 (Consideration of the evidence)	The above evidence is overwhlmiong for a lay person (with a smattering of scientific & statistical knowledge) As a youngish PwMS rapidly going downhill towards total disablement and no light at the end of the tunnel, I would comment that "For the sake of a penorth, the patient was denied a chance of relief.
Section 5 (Implementation)	Costings for emotional well-being must also be employed.
Section 6 (Proposed recommendations for further research)	Treat us! Then gather your information.
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	As per section 6.

Role	Patient
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I failed on Betaferon as a result of unbearable, constant flu-like symptoms and depression caused by the drug. The flu-like symptoms almost certainly contributed to my depression, however I also lost my sense of reality and became paranoid and suicidal, which was a result of the drug itself. The side-effects of the drug were so severe, in fact (far more severe than the symptoms of my MS), that I had no alternative but to resign from my job. On top of that, I am extremely slight in build and had severe injection site reactions. I am now taking Copaxone, a daily injection which has doubled the impact of site reactions due to frequency of treatment. I am in constant unbearable pain, which is once again making me depressed, and would benefit hugely from the possibility of a daily oral therapy. It is yet to be determined whether my relapsing-remitting MS is highly active as a conclusion has yet to be reached on whether or not my last two-week-long episode of diplopia was caused by a relapse or by therapy-related stress. Either way, I find myself in dire need of an alternative therapy and the availability of Fingolimod to me would be invaluable as I continue to cope with the disease.
Section 2 (The technology)	
Section 3 (The 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)	

Role	Patient
Other role	
Location	N Ireland
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	so government target disabled people and their DLA on one hand and refuse the good drugs on the other hardly fair play is it ??
Section 2	agree manufacturers are in it to recover costs of development

(The technology)	but this at more than double the interferons is economic suicide for the company
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	a
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	Carer
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Patients suffering from MS should be offered the widest variety of treatments available. The alternatives, I speak from experience only of Avonex, should also have delivery costs taken into acount. Supplies of hypodermic needles and the disposal of said needles as clinical waste is also a vast cost. Repeated injections over periods of time can also lead to secondary infections around the injection site requiring treatment by further antibiotics.
Section 2 (The technology)	The treatment is being offered as an alternative where beta interferon has failed, there are few viable alternatives at this point and patients quality of life as well as those of carers and dependants should also be taken into concern. The cost of providing care to adults in the above 2 categories would far outweigh the cost of the drug.
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	It appears that whilst the committee say they understand (4.1 - 4.5)in reality they have no concept of this insidious condition and the effects it has - because it does not follow a pre-prescribed pattern in all sufferers its impossible to classify MS conveniently. The reality is that patients live with uncertainty in their daily lives which does lead to stress, depression added to physical disabilities. Any drug that prolongs a persons quality of life adds value to that persons life that cannot be considered in Â£s and pence, however if the committee truly understood the devastating effects of this disease they would take into account the far reaching consequences and burden placed on the NHS and state as a whole as patients become dependant upon the welfare state far sooner, losing their independance and

	livelihoods.
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	

Role	Patient
Other role	Healthn Practitioner
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 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	I am needle phobic and spent a misserable year on beta interferon. I lived in fear and trepidation the whole week for my weekly injection. Despite beta interferon I still had a relapse so came off it. I feel it is cruel and against my human rights to not offer an alternative to people who are needle phobic.
Section 8 (Proposed date of review of guidance)	

Role	Patient
Other role	
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Fingolimod is a godsend to people like me, who have been on Beta Interferon injections. The injections, although good for some people are not for others Im afraid to say. I am on the Fingolimod clinical trial, and since I have been on this, have been almost free from MS relapses. I have had no side effects

	since starting the trial in March this year. I did have horrible side effects while using the injections. What am I supposed to do if the option of taking a new "passed" drug is not available to me? Go backwards I suppose, and will have to learn to cope with the pain etc all over again. How would the committee of NICE feel if there was an option available to one of their family members which was refused?
Section 2 (The technology)	What is the cost of health? I am on the Fingolimod clinical trial, and since I have been on this, have been almost free from MS relapses. I have had no side effects since starting the trial in March this year. I did have horrible side effects while using the injections. What am I supposed to do if the option of taking a new "passed" drug is not available to me? Go backwards I suppose, and will have to learn to cope with the pain etc all over again.
Section 3 (The manufacturer's submission)	As far as I am concerned, Novartis have been nothing but open and honest about the cost of the drug. They are solely thinking of people who would benefit from this drug. Of course every company has to run at a profit, or there wouldnt be any live companies in existence. However, I believe Novartis should be commended for this, and not penalised because of the cost of manufacturing the drug. They have provided discount for this, and if there is any chance of reducing the cost further, I believe they would.
Section 4 (Consideration of the evidence)	I think that NICE should weigh up the pros and cons properly. If a patient is taking Fingolimod, which is reducing relapses, then surely that is to the good. If patients are unable to access any medication,after trying all other avenues, then that will cause people to be potentially significantly unwell and end up being hospitalised. I would have thought that this would increase NHS costs significantly more than the cost of Fingolimod. How would the committee feel if there was an option available to one of their family members, which was refused?
Section 5 (Implementation)	N/A
Section 6 (Proposed recommendations for further research)	Novartis has manufactured a known benefit to sufferers of MS, therefore if Neurology Consultants believe there should be further research, then there should be. However, other countries have passed the use of Fingolimod, so why havent we?
Section 7 (Related NICE guidance)	N/A
Section 8 (Proposed date of review of guidance)	Why take so long?

Re: Fingolimod for the treatment of relapsing remitting multiple sclerosis (RRMS)

Role: I am am a clinician working in the MS field and I see many patients with MS weekly. I administer and monitor treatments for MS and take part in trials of new therapies as well as basic science research. I work in a unit that is the largest user of natalizumab on the NHS in the UK.

Relevant conflicts of interest: I worked on the Fingolimod phase 3 and 4 studies in the UK and received compensation for attending advisory board and giving talks for Novartis. I am a member of the NICE Diagnostics Advisory Committee for which I receive no compensation.

I believe that Fingolimod should be available for some people with MS in the UK through the NHS. The following statement was drafted by Novartis but I agree with the statement.

Statement: Evidence shows that immunomodulatory therapies are most effective during an early therapeutic window of disease, ideally the first 5 years.[1,2] Early in the disease trajectory, there is evidence that immunomodulatory therapies can delay permanent disability accumulation, including for fingolimod.[3]

A 20-year study of the relationship between T2 lesions and disease progression demonstrated that disease activity in the first five years is correlated with development of secondary progressive disease.[4] A recent 21-year follow-up of participants of an interferon trial showed that time to EDSS 6 (marking the use of a walking aid) nearly halved, in those initially assigned to placebo.[5]

Therapies are less effective once patients reach EDSS 4-6, after which secondary progression may be considered to have started; this is reflected in the ABN guidelines for use of DMTs and in the literature.[6] Progression through further EDSS range is fairly consistent after this and marks a phase of significant disability.[1]

Therefore, early and optimal control of inflammatory disease is important to the long-term outcomes of patients with RRMS, in order to delay accumulation of permanent disability for as long as possible, and potentially reduce or prevent it.

It is accepted that 1/3 of patients have a sub-optimal response to first-line DMTs. It is not unreasonable based on the evidence presented above to suggest that discontinuing disease-modifying therapy in patients with aggressive disease puts them at increased risk of early disability and death.

Consensus statements agree that non-responders should be switched to another first-line therapy.[7] Clinical trial evidence for switching is somewhat varied, and limited by size, design and lack of randomisation, but largely concurs that switching non-responder patients is effective.[8-13] Novartis' own trial data for fingolimod confirms that switching non-responder patients to fingolimod is more effective than continued interferon.[14]

Fully powered, randomised controlled trials of DMT switch options are not currently available and are not likely to be carried out soon, and placebo control is unlikely to be ethically permissible in future trials.

On the basis of current epidemiological and pathophysiological evidence, we believe that it is in the best interests of patients with sub-optimal response to first-line DMTs that a more effective therapy is substituted, and this is the current practice of the majority of UK neurologists. Fingolimod represents a reasonable option for many patients in this group, whose disease is still in the active inflammatory phase and subject to potential modification. The licence for fingolimod, and the proposed group for whom NHS funding

is sought, reflects clinical opinion on the group of patients who, based on clinical activity, would benefit from a change in therapy.

Further, best supportive care is only appropriate in the relatively rare circumstances where an appropriate alternative DMT cannot be found. This conclusion is based both on our clinical experience and the best available published evidence.

We urge NICE to allow clinicians the option of offering evidence-based clinical best practice to MS patients with highly active disease and an inadequate response to interferon therapy, by approving fingolimod to meet the unmet need of these patients.

Yours sincerely

[redacted]

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