NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Single Technology Appraisal (STA)

Abiraterone for the treatment of metastatic castration resistant prostate cancer following previous cytotoxic therapy

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

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

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

About you

Your name:

Name of your organisation: NHS Hertfordshire

Please indicate your position in the organisation:

- commissioning services for the PCT specific to the condition for which NICE is considering this technology?
- a specialist in the clinical evidence base that is to support the technology (e.g. participation in clinical trials for the technology)?
- other (please specify)
    - Provision of specialist pharmaceutical advice to commissioners.

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

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

The following information has been discussed at the London Cancer New Drugs Group of which we are members.

- **Docetaxel was approved in 2004 for use in combination with prednisone for the treatment of hormone-refractory metastatic prostate cancer and was approved by NICE for this indication in 2006, for those with a Karnofsky performance status of ≥60%. It has become the standard first-line chemotherapy in this setting, on the basis of an improvement in survival compared with mitoxantrone plus prednisone. The standard treatment for those who progress following first-line therapy with docetaxel is evolving and many studies have investigated the role of salvage chemotherapy (e.g. mitoxantrone; vinorelbine). The only agent to have demonstrated a survival advantage in this setting to date is the taxane derivative cabazitaxel, which was associated with a 2.4 month improvement in overall survival, compared to mitoxantrone (both in addition to prednisolone/prednisone), in a Phase III study.**

It was unclear where in therapy abiraterone may be placed after first-line docetaxel chemotherapy in relation to other therapies e.g. cabazitaxel and whether sequential therapy with other treatments is supportable by the evidence. The Group agreed to ask the relevant specialists across London for their view.

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

It is not routinely commissioned in Hertfordshire and not used in patients of Hertfordshire.

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

As this treatment currently used many of the above questions cannot be answered.

- what is your opinion on the appropriate use of the technology?

- **See previous answer.**

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Potential impact on the NHS if NICE recommends the technology
What impact would the guidance have on the delivery of care for patients with this condition?
If the guidance was positive, it would increase the number of chemotherapy options available for this relatively small group of patients with progressive castration resistant metastatic prostrate cancer with potential increase in survival of 3-4months. As this drug has not been compared to mitoxantrone, the actual increase in survival compared to current alternative is not known.

LCNDG provisionally estimate the numbers of patients eligible for treatment;

Population estimates for the London SHA	**N**
Total London SHA population	**7,753,600**
0.052% incidence of prostate cancer	4,027
22% of patients diagnosed at the metastatic stage (stage IV)	886
17% of patients diagnosed at an earlier stage will go on to develop metastases	685
All patients with stage IV disease will go on to develop CRPC	1,570
50% of patients with CRPC will receive treatment with docetaxel plus prednisolone	785
75% of patients who have received docetaxel will be alive following treatment	589
90% of patients who are alive following docetaxel will be eligible for treatment with abiraterone	**530**
Drug cost estimates	
CDF cost per 28-day course	[redacted]
Average annual cost per patient (based on an average of 8 cycles)	[redacted]

Local specialists were unable to quantify the number of patients who would be eligible for treatment every year.

Extrapolating the estimates undertaken by LCNDG to Hertfordshire population of 1.12m would suggest approximate numbers of new patients per year of around 60 and drug costs of [redacted] excluding VAT. This also excludes any associated service costs.

As there is no growth in the NHS, [redacted] of additional resource implications for 60 people only would result in significant decrease in service provision for the majority of the population of Hertfordshire of 1.12m.

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

Specialist services in secondary care.

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

See above. It is assumed that for NHS Hertfordshire there will be about 60 new patients a year who would qualify for treatment and if all has treatment for 8 months, at the price quoted, this will be a resource implication of > [redacted] a year. This resource can only be provided by significant disinvestment from other service areas.

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

Yes – [redacted] is a lot of money to find. Such amount will impact to a great extent on non-NICE approved services and treatment. As current chemotherapy used is very inexpensive.

The opportunity costs will be significant as the NHS has no growth money. Any service re-design would have to significant to release such resources.

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

Yes

Equality

Are there any issues that require special attention in light of the NICE's duties to have due regard to the need to eliminate unlawful discrimination and promote equality and foster good relations between people with a characteristic protected by the equalities legislation and others?

No

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Other Issues

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

It would be helpful if NICE could define an evidence-based treatment pathway for prostate cancer including appropriate use of chemotherapy. NICE needs to consider the other guidance e.g. Cabazitaxel in relation to abiraterone, mitoxantrone and vinorelbine.