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Technology Appraisals,
NICE

22 February 2012

Dear NICE,

Re: Single technology appraisal (STA) - Abiraterone for castration-resistant metastatic prostate cancer previously treated with a docetaxel-containing regimen

The NCCC would like to submit the following comments on this STA:

1. From Nicola James, member of the Prostate Cancer Guideline Development Group

> I believe that not recommending Abiraterone may be considered unfair when compared to the use of Herceptin in patients with breast cancer and NICE may find themselves with a backlash on their hands.
>
> I worry that rejecting Abiraterone may impede the development of the drug as something we could use BEFORE chemotherapy (STAMPEDE is looking at this).
>
> Why is the cost so high? Could pressure be brought to reduce the cost?

2. From Peter Kirkbride, Clinical Lead, Prostate Cancer Guideline Development Group

> Firstly I acknowledge that, although Abiraterone is a very effective drug, with relatively minimal toxicity, its benefit, in terms of prolonged survival at least, is insufficient to justify NICE approval using current cost–effectiveness criteria, even when applying the less stringent criteria for end-of –life cancer treatments. This could be rectified at a stroke if the drug was made cheaper, and it could be argued that all manufacturers of new cancer drugs need to take a long and hard look at their pricing policies, as it could be argued that the more relaxed cost criteria that NICE accepts for these drugs allows them to charge higher prices and yet still fit within cost-effectiveness criteria.
>
> Having said that, I think the recommendations can be criticised on the basis of the conclusions drawn in para 4.19, which state:
>
> 'The Committee agreed that the criteria related to short life expectancy (less than 24 months) without treatment and extension to life (at least 3 months)

with treatment were met. However, the Committee concluded that ***abiraterone was not licensed for a small population***, and therefore considered that it does not meet the criteria for an end-of-life treatment.'

I am unable to find a definition of 'small population' and it seems unreasonable that a drug of comparative cost-effectiveness are approved simply because they are for patients with rarer cancers

It is also disappointing that the appraisal committee did not include an oncologist, and consequently, it is not clear that the potential 'cost-benefits' of this novel treatment with a very favourable side-effect profile (as Abiraterone is not a chemotherapeutic agent in the traditional sense) have been appropriately acknowledged and considered. Accordingly, it is worthwhile noting a comment in the submission from NCRI/RCP/RCR/ACP/JCCO:

'Abiraterone not only improves survival, but also very effectively controls symptoms and reduces skeletal related events. We believe it will reduce the resources required to look after these patients because of better symptom control'.

3. From John Graham, Director NCCC

The health economic modelling is very messy. The randomised trial measured quality of life using a different instrument to that required by NICE. It also stopped measuring quality of life on treatment discontinuation so a uniform health utility value (derived from a Swedish study) was applied after that. It might be the case that the abiraterone patients had a different clinical course from the control arm after treatment discontinuation but we will never know this. The conversion of the trial quality of life measurements to the EQ-5D measure required by NICE adds more uncertainty. Basically the manufacturer failed to measure quality of life or health utility values adequately so the health economic modelling is full of uncertainties.

NICE has no choice but to make it assessment based on the poor quality cost effectiveness evidence provided (even though the clinical effectiveness is beyond doubt). In the absence of robust cost effectiveness data the only conclusion one can draw from this is that abiraterone is too expensive.

Yours faithfully,

[redacted]