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

Name	XXXXXXXXXXXXX
Role	NHS Professional
Other role	
Location	England
Conflict	
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	At present within our PCT we are in discussions with our local hospital trusts around defining a cohort of patients who we wish to consider the use of rivaroxaban as a treatment option. AT present we would wisk to consider the following patients: Patients who present with there first DVT we would consider rivaroxaban in patients who have an allergy/ intolerance to warfarin this would also include patients with poor venous access which prevents them having INR monitoring associated with warfarin. In these cases it would be more cost effective to treat with rivaroxaban. Patients considered for long term anti-coagulation in addition to the above criteria we would also consider patients with poor INR control defined as time within range of less than 60% following a 6 month trial, these patients would be considered for rivaroxaban. To date these patients would be treated with long term low molecular weight heparins. Regards to length of treatment course most of patients within our PCT would be treated on average for 6 months.
Section 2 (The technology)	No further comments to be made.
Section 3 (The manufacturer's submission)	I agree with the evidence that clearly supports the use of rivaroxaban for the treatment of DVT but further evidence is required for long term ant-coagulation in high risk patients. Haematologists within out area do not wish to consider the use or rivaroxaban in cancer patients and will continue to treat this cohort with low molecular weight heparins. I agree that the cost of INR monitoring at Â£656 is an overestimate. At present we commissioned this anti-coagulant clinics as a block contract but plan to change this to payment per case. I am aware that other PCTs pay significantly less than this for the service.
Section 4 (Consideration of the evidence)	It should be noted within our experience most patients are treated for 6 months then a decision is taken at that point to whether to continue with long term anti-coagulation. These would include patients with recurrent DVTs/ PEs, patients with significant thrombophilia, patients with significant risk factors Â but also some patients have a wish to continue with long term anti-coagulation due to concerns of having a recurrence. The evidence does suppport the use of rivaroxaban as a treatment option for this indication and clearly should be considered for patients undable to have the standard treatment of warfarin as the only other alternative would be a low moleular weight heparin and the majority of patients would much prefer taking a tablet that have a daily injection. Compliance should be considered as a possible downside to rivaroxaban in elderly

	patients who have a history of poor compliance and therefore may not be a treatment of choice in this case.
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	
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