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

Role	NHS Professional
Location	England
Conflict	
Notes	As a GP I have used dapagliflozin successfully in the management of my patients with diabetes. I have observed reductions in HbA1c, fasting blood glucose and weight
Comments on individual sections of the ACD:	
Section 4 (Consideration of the evidence)	'Newer' glucose-lowering agents such as dapagliflozin are vital to the continous clinical effort in reducing the burden of diabetes and its complications, especially hypoglycaemia and weight gain. The benefits of the agent, rather than the perceived risks should be strongly considered. The evidence of benefit is strong, and more notice should be given to the clinician, striving to reduce the clinical and financial burden of diabetes and its complications.

Role	NHS Professional
Other role	Consultant Diabetologist
Location	England
Conflict	
Notes	
Comments on individual sections of the ACD:	
Section 4 (Consideration of the evidence)	Although further clarification of the evidence may be useful, the current evidence as it stands is enough to make this treatment available to certain groups of patients on trial basis. Withdrawing treatment from patients who do not show adequate response in terms of HbA1c reduction is likely to maximise cost-effectiveness. Patients who might benefit from this treatment include those who are poorly controlled on oral therapy but in whom all other possible add-on therapies are either contraindicated or have been ineffective; i.e. Dapagliflozin should be considered as a pre-insulin option if all other agents have failed including GLP-1 based therapies. Dapagliflozin is also expected to be useful in patients who are poorly controlled on insulin and in who intensifying insulin therapy is not considered appropriate due to risk of hypoglycaemia and/or weight gain. The use of Dapagliflozin with insulin is expected to be more cost-effective given the cost savings associated with reduction in insulin dose or the avoidance of an Â increase in insulin dose.

Role	NHS Professional
Other role	Consultant Diabetologist
Location	England
Conflict	
Notes	I am part of the faculty for a Forxiga (dapagliflozin)launch and education meeting in Glasgow on 26th February 2013
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	One must not underestimate the social, financial and health impact of hypoglycaemia. Â Whilst cost-effective, SUs will always cause hypoglycaemia albeit to varying extents. Potentially vulnerable groups such as those over age 65 are particularly at risk of hypoglycaemia. Â Hospital admissions for these groups can be lengthy costly and overal l detrimental to ongoing quality of life I do not think the QALYs associated with hypoglycaemia should be adjusted
Section 3 (The manufacturer's submission)	Pioglitazone should no longer be considered an alternative 2nd or third line option due to significant concerns of adverse effects in particular hip fracture in both men and women I feel it should not be included as a comparator

Role	NHS Professional
Other role	Consultant Diabetologist
Location	England
Conflict	
Notes	We are in the process of negotiating a contract for research funding on sGLT2 inhibitors
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	I agree with the queries above that should be provided by the manufacturer. Cost-benefit anlysis is extremely complex for diabetes; I think is worth highlighting that sGLT2 inhibitors are new tools that could significantly help clinicians in the treatment of patients with type 2 diabetes.
Section 2 (The technology)	In patients with reduced renal function the sGLT2 transporters are downregulated and therefore sGLT2 inhibitors loose in their effectiveness. Hypoglycaemia is not an adverse reaction driven by sGLT2 inhibitors; hypoglycaemia occurs only when combination therapy is made with hypoglycaemic agents such as sulphonylurea and insulin. SGLT2 inhibitors promote a minor loss of fluids and I would see the combination with ppar-gamma agonists (which promote fluids retention) ideal. Â I am not sure whether there is any clear evidence to refuse this combination, but I can see where is coming from; possibly because of the "noise" in bladder cancer attributed to Pioglitazone. I do not see, for the moment,

	any issue related to the use of sGLT2 inhibitors and neoplasia of the urinary tract. Patient s with familial glycosuria and patients with diabetes (and recurrent glycosuria) do not appear to have higher incidence of neoplastic disease in the urinary tract. Nethertheless, I guess there might be a call for caution in this respect.
Section 4 (Consideration of the evidence)	I agree on all the point raised by the committee. In relation to the Committee note that the majority of the QALY gains associated with dapagliflozin arise from the direct impact of weight change on health-related quality of life rather than diabetic complications and other adverse events is true within the time the drug has been used to date. Weight loss provides, in the long term, significant benefit in the diabetes-associated chronic complication; I wonder if this can be extrapolated or modelled.

Role	NHS Professional
Location	England
Conflict	
Notes	We are confident that dapagliflozin will in fact deliver savings for three main groups of patients. 1. Patients who otherwise would receive a GLP1, o hav no responded to this treatment. Dapagliflozin is approx half the price and has a more predictabl weigh loss response 2. Patients with insulin resistance. Dapagliflozin has a unique mode of action which will avoid the extra weight gain and lack of efficacy associated with high insulin doses in resistant patients 3. Obesity in type 2 diabetics is a big problem and an agent for HbA1c reduction with weight loss an s similar price Â to a DPP4 without resorting to weight loss agents will also sav money We have patients that will benefit from this agent and verbally our CCG believes the intervention will be cost saving not out increasing
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	We believe ha this agent will deliver acceptable HbA1c reductions an weight reductions
Section 2 (The technology)	We have patients with significant issues that will benefit 1. Patients who would otherwise have a GLP1 or have failed to remind to GLP1 therapy or ar becoming increasingly resistant to insulin and are putting weight on
Section 5 (Implementation)	We have a number of patients with significan issues that will benefi from this technology. The price is low enough that extra insulin, GLP1 and weigh loss drugs will be avoided. The CCG feels that we will DVD money by using dapagliflozin in the identify patient groups a well as

	potentially avoiding a number of referrals fo increased insulin resistance and to our primary care diabetes service fo GLP1 initiation

Role	NHS Professional
Other role	Lecturer in Diabetes
Location	England
Conflict	
Notes	
Comments on individual sections of the ACD:	
Section 4 (Consideration of the evidence)	We must be looking at combined benefits of this drug including modest reduction to HbA1c AND weight loss for around 66% of clinical trial participants. I feel that drugs that both address glycaemic and weight issues are an invaluable new addendum to our diabetes drugs armoury. Forxega is being priced at around half the cost of GLP1 therapy and I believe NICE should be fully supporting the use of this drug in Type 2 Diabetes as 2nd or 3rd line glucose lowering therapy after Metformin. The weight loss we see with Forxega and GLP1 therapy is for many patients their first recent success and weight management and changes to confidence and beliefs about their own ability to lose weight should be supported and maximimised by health professionals support and behavioural intervention