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Sent via email

[redacted]
Head of Oncology Business Unit UK
Pfizer Ltd

16 May 2013

Dear [redacted]

Final Appraisal Determination: axitinib for the treatment of advanced renal cell carcinoma after failure of prior systemic treatment

Thank you for your comments on my initial scrutiny letter. This is my final decision on the validity of your appeal points.

Ground 1

1.1. The lack of transparency in relation to a submission relied upon for the purposes of the guidance is procedurally unfair

Accepted as valid

1.2. The fact that Pfizer had no adequate opportunity to respond to the additional matters raised by the pharmaceutical industry commentator in response to the ACD, is unfair

In light of your further comments I accept this point as valid

1.3. The Scope for this appraisal produces results that inevitably lack certainty.

I have considered your further comments. The appropriateness of BSC as a comparator was accepted by you in the consultation on the draft scope. The issue is whether any uncertainty introduced by a comparison with BSC requires a "pragmatic" approach.

I am afraid I am still not with you on this. Uncertainty is a factor that the committee has to deal with, and if it does so without appropriate transparency that is a matter that can potentially be appealed against under ground one (if, for instance, a committee is concerned about uncertainty but does not say so). I can see no suggestion that that applies here. The requirements of fairness would be to identify uncertainty as an issue in sufficient detail for intelligent comment, and to receive and consider such comments in a proper and open minded way. That does seem to have been done in the ACD and the comments received on it.

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I am also not persuaded that the source of the uncertainty is relevant, once it is accepted as it has been that the scoped comparator is appropriate. Limitations in the evidence base are no doubt one consideration when selecting a comparator, but there are others such as relevance to NHS practice. All comparators will have uncertainty associated with them to a greater or lesser extent. If a comparator is properly selected having regard to all of the pros and cons of that choice, I doubt that it is right to treat the uncertainty that comes with that selection in a different way to uncertainty introduced by other factors. There is a need for broad consistency across appraisals. It seems to me that uncertainty is uncertainty regardless of its cause. I have not been able to find an explanation in your grounds of why the approach taken to uncertainty was procedurally unfair. I would therefore not allow this point to go forward.

1.4. The Appraisal Committee's refusal to find that use of axitinib in post-cytokine patients satisfied the "end of life" criteria on the basis that no comparison with sunitinib or pazopanib had been provided was inconsistent with the Scope for this appraisal

Accepted as valid

1.5. The Committee's approach to the assessment of QALY gains occurring in the post- sunitinib group following disease progression and its conclusion that the post-progression model outputs lacked "clinical plausibility" was not transparent

I have considered your further comments, and now consider that this point should proceed but as you suggest under ground 2.

1.6. While the Committee found explanations for post progression QALY gains "clinically implausible", they failed to request attendance by the clinical specialist at the second Appraisal Committee meeting so that any concerns could be discussed

I agree that the approach taken in TA 237 must be applied in the light of the facts of each appeal. However in TA 237 the appeal panel concluded that *the role of the clinical specialists is essentially evidential. It is not to assist in the formation of judgments on evidence.* They felt that the role might extend to clarifying evidence, but not to "*fill[ing] gaps in the technical skills of the committee, [or] participat[ing] in the exercise of judgement*"; I have applied that approach to this appeal point. It seems to me that the issue is a concern about the committee's judgment on the evidence before it (your reference to the committee having no internal renal oncology experience, for example). That is an argument for the role of the expert that goes beyond the evidential, and that point was dealt with in TA 237. I would not allow this point to go forward.

1.7. The Appraisal Committee's final conclusions in relation to the cost-effectiveness of axitinib are not stated and its reasons for failing to recommend second-line treatment in patients with advanced or metastatic RCC are therefore

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unclear, in circumstances where the ICER values appear to fall within the range generally regarded as acceptable in other appraisals.

Accepted as valid

This is the final decision on initial scrutiny. The valid points are 1.1, 1.2, 1.4, and 1.7 under ground 1, and 1.5 under ground 2.

Yours sincerely

[redacted]
Appeals Committee Chair