Appendix G - professional organisation statement template

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Single Technology Appraisal (STA)

Vedolizumab for treating moderately to severely active ulcerative colitis [ID691]

Thank you for agreeing to give us a statement on your organisation's view of the technology and the way it should be used in the NHS.

Healthcare professionals can provide a unique perspective on the technology within the context of current clinical practice which is not typically available from the published literature.

To help you in making your statement, we have provided a template. The questions are there as prompts to guide you. It is not essential that you answer all of them.

Please do not exceed the 8-page limit.

About you

Your name*:* [redacted]

Name of your organisation: University Hospital of Wales, *Cardiff and Vale University Health Board*

Are you (tick all that apply):

☑ a specialist in the treatment of people with the condition for which NICE is considering this technology?

a specialist in the clinical evidence base that is to support the technology (e.g. involved in clinical trials for the technology)?

- an employee of a healthcare professional organisation that represents clinicians treating the condition for which NICE is considering the technology? If so, what is your position in the organisation where appropriate (e.g. policy officer, trustee, member etc)?

- other? (please specify)

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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 of 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?

Are there any subgroups of patients with the condition who have a different prognosis from the typical patient? Are there differences in the capacity of different subgroups to benefit from or to be put at risk by the technology?

In what setting should/could the technology be used – for example, primary or secondary care, specialist clinics? Would there be any requirements for additional professional input (for example, community care, specialist nursing, other healthcare professionals)?

If the technology is already available, is there variation in how it is being used in the NHS? Is it always used within its licensed indications? If not, under what circumstances does this occur?

Please tell us about any relevant **clinical guidelines** and comment on the appropriateness of the methodology used in developing the guideline and the specific evidence that underpinned the various recommendations.

Patients with moderate to severely active UC have generally failed therapy with mesalazine (oral/rectal) and will either have failed maintenance therapy with thiopurines, or be intolerant to these drugs. They are likely to be requiring repeated courses of steroids, or are steroid-dependent or steroid-refractory. Further treatment options currently include ciclosporin, infliximab or adalimumab. Some will be offered surgery as an alternative to long-term steroid therapy.
There is significant variation in practice because of lack of availability of anti-TNF drugs outwith NICE funding, and lack of experience in use of ciclosporin. Most clinicians will not use long-term ciclosporin because of concerns about toxicity (renal impairment, neuropathy and infection risk particularly) and so it will generally only be given for 3 months. Patients with chronic active disease are likely to return to their previous state of active disease or need chronic steroid therapy or surgery. Younger patients, those who have not formed a long-term relationship, and those anticipating starting a family are often extremely reluctant to have surgery because of concerns about fertility, and the impact of an ileostomy on quality of life and relationships.

Vedolizumab is a clear alternative in these situations, offering the potential for long-term therapy with the possibility of lower toxicity due to its gut-selective action.

Vedolizumab would be used by iv infusion in secondary care, in a similar situation to use of infliximab for Crohn's disease.

It is not yet included in guidelines, but the most recent ECCO and BSG guidelines cover the current treatment recommendations for moderate to severe UC.

The advantages and disadvantages of the technology

NICE is particularly interested in your views on how the technology, when it becomes available, will compare with current alternatives used in the UK. Will the technology be easier or more difficult to use, and are there any practical implications (for example, concomitant treatments, other additional clinical requirements, patient acceptability/ease of use or the need for additional tests) surrounding its future use?

If appropriate, please give your view on the nature of any rules, informal or formal, for starting and stopping the use of the technology; this might include any requirements for additional testing to identify appropriate subgroups for treatment or to assess response and the potential for discontinuation.

If you are familiar with the evidence base for the technology, please comment on whether the use of the technology under clinical trial conditions reflects that observed in clinical practice. Do the circumstances in which the trials were conducted reflect current UK practice, and if not, how could the results be extrapolated to a UK setting? What, in your view, are the most important outcomes, and were they measured in the trials? If surrogate measures of outcome were used, do they adequately predict long-term outcomes?

What is the relative significance of any side effects or adverse reactions? In what ways do these affect the management of the condition and the patient's quality of life? Are there any adverse effects that were not apparent in clinical trials but have come to light subsequently during routine clinical practice?

Vedolizumab has a completely different mechanism of action to that of current alternative drugs, and therefore has the potential for treating patients who have primary non-response or secondary loss of response to drugs such as anti-TNF therapy and calcineurin inhibitors. Because of its gut selectivity, it may be a preferred option before these drugs are used, and has the potential to be a significant advantage for this drug. Clinical experience in use of this drug will rapidly increase as clinicians become familiar with it.

Vedolizumab is given by IV infusion every 4 – 8 weeks and would require the use of infusion facilities and nursing support as are currently used for anti-TNF infusions for Crohn's. This is a disadvantage in requirement for attendance at hospitals, particularly if required 4 weekly. The GEMINI trial in UC showed that 8 weekly is as effective as 4 weekly.

The GEMINI trial using Vedolizumab enrolled the relevant group of UC patients with MAYO score of 6 or more, who had failed either steroids or

immunosuppressive therapy. This would be in keeping with current UK practice as the point at which further therapy would be used. End-points (clinical response at week 6 for induction therapy and clinical remission at week 52), are also entirely relevant. There is however the possibility that the response at week 10 to a 3rd infusion given at week 6, might be used as a determinant of response, but this has not been evaluated in clinical trials to date. It is possible, but not yet clear, that this might identify a further group of patients who could obtain long-term response/remission.

The measures used to assess response in the GEMINI UC trial was Mayo score, a simple clinical measure, including a sigmoidoscopy. This has resource implications if sigmoidoscopy were routinely required, and it remains to be seen whether the symptom-based partial Mayo score would be sufficient to determine response.

The monitoring for side-effects of therapy would be no different to that needed for other currently used immunosuppressive therapies.

There is as yet no data available on further toxicity not already identified in trials for Vedolizumab.

Any additional sources of evidence

Can you provide information about any relevant evidence that might not be found by a technology-focused systematic review of the available trial evidence? This could be information on recent and informal unpublished evidence, or information from registries and other nationally coordinated clinical audits. Any such information must include sufficient detail to allow a judgement to be made as to the quality of the evidence and to allow potential sources of bias to be determined.

As yet there are no additional sources of evidence giving further information about Vedolizumab beyond the published papers Feagan et al "Vedolizumab as Induction and Maintenance Therapy for Ulcerative Colitis" NEJM 2013, volume 369, 669-2710

Implementation issues

The NHS is required by the Department of Health and the Welsh Assembly Government to provide funding and resources for medicines and treatments that

have been recommended by NICE technology appraisal guidance. This provision has to be made within 3 months from the date of publication of the guidance.

If the technology is unlikely to be available in sufficient quantity, or the staff and facilities to fulfil the general nature of the guidance cannot be put in place within 3 months, NICE may advise the Department of Health and the Welsh Assembly Government to vary this direction.

Please note that NICE cannot suggest such a variation on the basis of budgetary constraints alone.

How would possible NICE guidance on this technology affect the delivery of care for patients with this condition? Would NHS staff need extra education and training? Would any additional resources be required (for example, facilities or equipment)?

The resources required to adopt Vedolizumab include day-case attendance for infusions (8 or possibly 4 weekly), as for anti-TNF therapy for Crohn's disease.

Equality

NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that this appraisal:

- could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which [the treatment(s)] is/are/will be licensed;
- could lead to recommendations that have a different impact on people protected by the equality legislation than on the wider population, e.g. by making it more difficult in practice for a specific group to access the technology;
- could lead to recommendations that have any adverse impact on people with a particular disability or disabilities.

Please tell us what evidence should be obtained to enable the Committee to identify and consider such impacts.

No evidence that particular groups are disadvantaged.

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