Lori Farrar
Committee C Project Manager
National Institute for Health and Care Excellence
Level 1A
City Tower|
Piccadilly Plaza
Manchester M1 4BT

20th September, 2013

Dear Lori

Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, tocilizumab and abatacet for the treatment of RA not previously treated with treated with disease modifying anti-rheumatic drugs nd after the failure of conventional DMARDs only Systematic review and economic evaluation – Assessment Report

Thank you for the opportunity to make a personal patient statement in response to the above Assessment Report.

I agree with the findings of the Assessment Report that the cost effectiveness of treating moderate disease is similar to severe disease. However, I have great concerns about the conclusions in regard to the ICERS, which are substantially more than in any of the previous health economic evaluations undertaken for biologic treatment of rheumatoid arthritis in all the previous technology appraisals. The consequences of acting on the conclusions in this report which raises doubt regarding the cost effectiveness of *all* treatment, would be catastrophic to people like me.

Cost Effectiveness

I was one of the early patients who went onto the Register - I been on Biologic therapy for nearly 13 years - and am typical of the kind of patient with long standing disease described by the BSR in their response to the Assessment Report. I have severe disease which was refractory to cDMARDs and only when I went onto Anti-TNF therapy was I able to regain quality of life which was rapidly diminishing up to that point, and avoid having to give up work. I am now able to work between 50 – 70 hours a week and employ 22 people. However, such is the damage that long term disease causes, in spite of being successfully controlled I have had 12 operations (most major joint replacements/fusions) since 2000 when I started on Anti-TNF therapy. The kind of patient now going onto biologic therapy has

much less damage and less likely to have already had surgery, and their HAQ is much more responsive in the first year or two of disease as the main driver of their disease is inflammation, not long standing mechanical damage like mine.

It seems inconceivable to me that these vital, effective therapies could be denied to people in England. I simply cannot imagine the devastating effect that this would have on people whose disease does not respond to cDMARDs. I totally agree with comments by the BSR in regard to inappropriate referencing to cohorts from ERAS and the States within the model.

The Case for early aggressive combination therapy (to save on use of biologics)
We understand the pressure on NHS finances and though we would like to see a small number of people with aggressive onset of disease who are both sero-positive and ACPA positive, have access to biologics on diagnosis, we appreciate this is not realistic. However, we believe that there are patients who could be better controlled on cDMARDs but to achieve this, CG79 needs to be much more widely implemented. The guideline recommends early referral and commencement on treatment, ideally with combination therapy (more cost effective than monotherapy), followed by tight control[i]. There is quite a lot of data available now (eg tREACH trial[ii] and a meta analysis reported in the Annals of Rheumatic Diseases in Nov. '12[iii]) demonstrating that RA patients treated early with aggressive double or triple combination therapy and prednisolone have both higher remission rates and less radiographic progression than those treated with initial MTX montherapy, even when intensified with prednisolone and if this happens, the need to use biologics reduces significantly. We would therefore like to see much wider implementation of CG79 which encourages use of combination therapy and close review until the disease is in remission or low disease activity state. If the Assessment report had looked at studies where better use had been made of combination therapies, this would have increased the cost effectiveness of the biologics.

I hope that with the advent of the Best Practice Tariff which came in on 1st April this year, and the HQIP Early RA national audit due to start early next year, that these will be additional powerful incentives to drive implementation of the NICE RA Guideline and gradually reduce these variations in practice.

There is a pressing need to address current eligibility criteria
With substantial Registry and further research data available to us, the current eligibility criteria are no longer appropriate and we need to address the dilemma faced by patients who are doing badly and yet not quite reaching the currently required eligibility criteria. These patients continue to sustain irreversible damage which is costly both to the individual and their family as well as the NHS and wider society and often, their quality of life is miserable.

Quote from a Consultant Rheumatologist

"On a personal note, I am a strong believer that the eligibility DAS should be lowered. This would map to other guidelines across Europe (eg Sweden, Germany). To what level is up for debate, but I see so many patients who have had a partial response to say 2 DMARDs but still have very bad persistent arthritis in a few joints (just last week a lady with very active wrists who has tried almost every DMARD and I really believe the addition of a biologic would be a great choice for her, but her DAS28 is only high 4's. I fear she is going to lose her wrist function completely and I feel like I am standing by and watching this happen".

However, we are mindful of increasing the burden of cost in respect of biologic therapies and we appreciate that it would be financially unsustainable to simply ask that the DAS criteria be reduced to an arbitrary figure such as 3.2 for everyone at the current time. It is worth noting, however, that there is substantial clinical evidence that the outcome of RA is worse in England compared to many areas of Western Europe, where this is the threshold for entry to a biologic.

Approximately 15-20% of RA patients in England will move onto biologic therapy due to inadequate response to DMARD treatment. The measuring of DAS28 on two separate occasions, one month apart, can cause delay and considerable distress to those who are in pain and struggling to cope day to day. Given that patients with another form of autoimmune inflammatory arthritis – psoriatric arthritis – only require one single assessment, seems to us to be discriminating unfairly against RA patients.

We know that those with a DAS score between 3.2 and 5.1 have outcomes that are similar to those with persistent disease activity which is greater than 5.1.[(v)] Therefore, further non-evidenced based restriction to accessing highly effective biologic treatments is likely to substantially worsen outcomes for patients with severe disease living in England compared to patients in other European countries.

Proposal re: revised eligibility criteria

We speak to people who fail to reach a DAS score of 5.1, yet have persistent disease, on a regular basis through our helpline, community groups and through our social media sites. I myself fell into that bracket for nearly 20 years and it was only the advent of the Anti-TNFs which gave me back a quality of life which enabled me to carry on working. If it were not for the biologics, I would certainly be in a wheelchair permanently instead of occasionally and, as mentioned earlier, would have had to give up work years ago.

It was being on Anti-TNF treatement which enabled me to finally get off steroids. I was on a relatively 'so-called' low dose at an average of 5 mg daily, although I did increase the steroids (as many do) when I had a flare. However, had I known the damage they would cause me when I first started on them in 1983, I would have done anything to get off them much sooner than I was able to. NICE RA Guidelines only recommend very short term use of steroids (CG79) and it seems inconceivable that in one guideline they are recommended for short term use only and yet the consequence of other guidance could potentially leave people on steroids long term with no alternative treatment when effective and safe options

do exist; or force clinicians to withdraw treatment in order to 'push' their patients over the 5.1 DAS score which seems completely inappropriate.

We therefore would urge NICE to consider a change to the eligibility criteria to allow patients with a DAS between 3.2 and 5.1 who are unable to wean themselves off steroids, to be given access to biologic therapy.

We also support the wider usage of parenteral MTX. We have undertaken at least two surveys in recent years about patient use of MTX which have both highlighted that there are many patients who are not offered the opportunity of sub-cut MTX either at all or early on when oral MTX may be causing unpleasant side effects which can be minimised by switching to sub-cut. Experience from our helpline tells us that many people struggle with side effects for quite long periods of time sometimes as they are not due to see their consultant for many months.

We would finally add once again that we feel that lost productivity should be included in the model. We know anecdotally from our membership, callers to our helpline, participants in our social media sites and from our 40 community groups across the UK just how much part the biologics play in preventing people from losing their job and getting back to work. Loss of one's job due to RA also impacts hugely on the family as we found when we did our 'Family Matters' survey in 2012 where we surveyed nearly 400 family members of someone with RA. A summary version of the findings of this is enclosed. Many people do find that when they are able to access biologics, they can not only regain quality of life but can get back into the work place again.

From NRAS Family Matters Survey

"Nicky has severe RA, constant flares. No medication even touches the sides really; we're trying to get the doctors to put her onto biologics. She's on methotrexate and it's not working. Any exertion, even putting a couple of shrubs in the garden and she'll pay the price for days afterwards.

It affects your financial situation too, because obviously Nicky isn't working. She was working in property development and it's ground to a halt, because of RA".

It seems inconceivable after all the work over many years which has been done by NICE and all the RA stakeholders, that we would reverse the decisions to allow access to these therapies which have been revolutionary in changing the way in which this disease is treated. The life-changing experience of thousands of patients who have benefitted from these drugs cannot be under-estimated. Whilst I cannot fully get to grips with a lot of the very technical detail contained in this report as I am neither a health professional or health economist, I would fully support tighter stopping rules when a biologic is ineffective and much greater emphasis on early use of combination cDMARDs, both of which if modelled correctly, would I believe increase the cost effectiveness of these drugs.

Yours sincerely,

[redacted]

[redacted], NRAS

References

[i] Rheumatoid Arthritis - National Clinical Guideline for management and treatment in Adults, CG79 (2009)

[ii] De Jong PH, Hazes JM, Barendregt PJ, et al. Induction Therapy with a combination of DMARDs is better than MTX monotherapy: first results of the tREACH tiral. Ann Rheum Dis 2013;72:72-8

[iii] Meta-Analysis suggests that intensive non-biological combination therapy with step-down prednisolone (COBRA strategy) may also 'disconnect' disease activity and damage in rheumatoid arthritis – Maarten Boers et al. Ann Rheum Dis 2013 72 406-409 doi:10 1136/annrheumdis-2012-202333