National Institute for Health and Care Excellence

Single Technology Appraisal (STA)

Cabazitaxel for hormone-relapsed metastatic prostate cancer previously treated with a docetaxel-containing regimen (review of TA255) ID No. 889

Response to consultee and commentator comments on the draft remit and draft scope (pre-referral)

Comment: the draft scope

Section	Consultee/ Commentator	Comments	Action
Background information	Sanofi	The background information supplied in the draft scope is generally accurate. However we would like to highlight a key aspect of the current pathways of care not fully reflected. Recent changes in clinical practice have been brought about by the introduction of abiraterone or enzalutamide used in line with NICE guidance (TA259 & TA316). Changes in practice have also occurred because of the use of cabazitaxel which is available via the Cancer Drugs Fund. Prostate Cancer is a complex, variable and heterogeneous disease which means that both hormonal and non-hormonal drugs are required to achieve optimal outcomes in patients. This heterogeneity is characterised by large differences in prostate cancer behaviour between patients and the wide of variability of prostate cancer behaviour within the malignant prostate tissue as it spreads through an individual patient.	Comment noted. The background section of the scope is only intended to briefly describe the disease, prognosis associated with the condition, epidemiology and alternative treatments currently used in the NHS. The details of treatment sequencing should be included in the consultees' submission for the Committee's consideration.

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		This means that treatment protocols have to address multiple options. Treatment pathways for prostate cancer are therefore complicated calling for a range of treatments to be available at every stage where their mode of therapeutic action is appropriate for the properties the prostate cancer is expressing. As indicated in the draft scope it is important to note that abiraterone or enzalutamide are not suitable for use in all patients and this may be due to resistance. The mechanisms of resistance to advanced hormonal therapy are now becoming better characterised, in particular ARv7+ve tumours typically show limited response to abiraterone or enzalutamide. Resistance can be characterised as primary or adaptive and it has long been established that as tumours progress and become more aggressive hormone therapy becomes ineffective With this in mind the limitations on the sequencing of these therapies in clinical practice is an important pathway feature for consideration in this appraisal not covered within the background section of the scope. We believe there are two key pathway scenarios to consider. These are delimited by the use of abiraterone or enzalutamide in either the pre- or post-chemotherapy setting where both are licensed but with the greatest uptake in the pre-chemotherapy setting. These agents are both currently funded through the Cancer Drugs Fund whilst NICE undertakes	

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		reviews in this setting, Because they target the same signalling pathway, clinical cross-resistance between abiraterone and enzalutamide is possible. Retrospective studies of abiraterone in patients previously treated with both docetaxel and enzalutamide have been reported [Loriot, 2013 Noonan, 2013]. These show a decrease in the activity of abiraterone compared to that expected. Similarly, whilst the evidence is more limited, enzalutamide treatment as third line therapy after docetaxel and after abiraterone has been evaluated and indication of cross resistance is emerging. [Bianchini, 2014]. Recent reviews of the literature suggest that there is no clear evidence of a clinical benefit of sequential therapy with these agents [Francini, 2014; Sartor 2014]. The sequential use of enzalutamide and abiraterone after docetaxel was also considered in the recent NICE guidance for enzalutamide (TA316) but the committee concluded that there is currently insufficient evidence to reach a decision on the clinical and cost effectiveness of sequential use. Similarly, papers published from the ongoing review by NICE of enzalutamide for use in the pre-chemotherapy setting suggest that on the advice of clinical experts the committee concluded *'that in England it is not standard care for people to have both enzalutamide and abiraterone, and people who have enzalutamide or abiraterone before chemotherapy do not have enzalutamide or abiraterone after chemotherapy'.* This is reflected in the NHS commissioning documents, SSC1438 and SSC1439 for abiraterone and enzalutamide respectively. Review by NHSE identified that there is insufficient evidence to justify funding the sequential	

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		use of these agents. Both documents recognise that abiraterone post enzalutamide (or vice versa) is not routinely funded in England unless the alternative was stopped solely because of dose-limiting toxicities within 3 months and there is clear absence of disease progression. In line with this, the Cancer Drugs Fund has stated that the sequential use of these agents will not be funded in the pre-chemotherapy setting with the same caveat as above. Hence we believe that the sequencing rules discussed above support two key pathways that should be examined during consideration of the evidence. These arise from the use of abiraterone or enzalutamide pre- or post-chemotherapy. In pathway 1 when either abiraterone or enzalutamide have been used **before** docetaxel, then patients who subsequently progress with docetaxel are by definition not suitable for these therapies and cabazitaxel or best supportive care are the only options (with radium-223 being an option for patients with symptomatic bone metastases only). In the second pathway, in which abiraterone or enzalutamide have **not** been used in the pre-chemotherapy setting, they do indeed represent alternative treatment options as outlined in the scope. We would comment however, that best supportive care should also be considered in this setting too. Bianchini D et al. Eur J Cancer 2014; 50: 78-84.	

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		Bournakis E et al. Eur Cancer Congr. 2013, abstract 2906. Francini E et al. Expert Rev Anticancer Ther. 2014 Oct;14(10):1135-40. Loriot Y et al. Ann Oncol 2013; 24: 1807–12. Noonan KL et al. Ann Oncol 2013; 24: 1802–7. Sartor S et al. Asian J Androl. 2014; 16(3): 426–431.	
	Prostate Cancer UK	In paragraph one, we recommend replacing the sentence: "The incidence of prostate cancer increases with age and is higher in men of African-Caribbean family origin" with: "The incidence of prostate cancer increases with age and is higher in Black African and African-Caribbean men and men with a family history of the disease."	Comment noted. The scope has been updated.
	Tackle Prostate Cancer	Correct	Comment noted.
The technology/ intervention	Sanofi	The description of the technology is accurate.	Comment noted.
	Prostate Cancer UK	Yes	Comment noted.
	Tackle Prostate Cancer	Yes	Comment noted.

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Population	Sanofi	The population description in the draft scope should be revised slightly to recognise the two treatment pathways in which the use of abiraterone or enzalutamide may be made in either the pre- or post- chemotherapy setting. We suggest the additional wording below is appended: 'People with hormone refractory relapsed metastatic prostate cancer previously treated with a docetaxel-containing regimen with or without pre-treatment with abiraterone or enzalutamide.'	Comment noted. The details of treatment sequencing should be included in the consultees' submission for the Committee's consideration. No change in the population is required. The population as described in the scope covers 'people with or without pre-treatment with abiraterone or enzalutamide'.
	British Uro-oncology Group	See later comments	Comment noted.
	Prostate Cancer UK	Yes.	Comment noted.
	Tackle Prostate Cancer	All correct	Comment noted.
Comparators	Sanofi	We recognise that all the therapies cited in the scoping document are used to a greater or lesser extent in the treatment of mHRPC in the post-docetaxel setting. The appropriateness of these options as comparators for cabazitaxel	Comment noted. The details of treatment sequencing should be

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		is examined below. As discussed in the background section above the sequencing of either abiraterone or enzalutamide is a key determinant of the appropriate comparator choice for cabazitaxel. Pathway 1. Pre-chemotherapy use of abiraterone or enzalutamide. According to the sequencing rules outlined above the only valid comparator for this group is best supportive care. We interpret this as mitoxantrone chemotherapy which has been considered as equivalent to supportive care and which offers pain palliation by previous committees (TA259). According to the draft scope this is indicated as the only option for 'people for whom abiraterone or enzalutamide are not suitable'. Mitoxantrone is not used widely in clinical practice due to the preferential use of cabazitaxel in this group of patients and it is likely that its use could become more widespread if cabazitaxel were no longer available. Pathway 2. Post- chemotherapy use of abiraterone or enzalutamide. Under this pathway abiraterone, enzalutamide or best supportive care are appropriate comparators. Radium-223 which is cited in the draft scope has received positive recommendation at the ACD stage but is not currently a NICE-recommended technology and cannot be considered to reflect established practice or the standard of care. Funding is available under the CDF but is restricted to use	included in the consultees' submission for the Committee's consideration. Comment noted. The scope enlists all available treatment options alternative to the technology under

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		in patients who have 2 or more symptomatic bone metastases and no visceral metastases. Furthermore, CDF rules state that if patients are receiving treatment with abiraterone or enzalutamide, a sufficient trial of treatment with the abiraterone or enzalutamide must be given to relieve bone symptoms before consideration of radium-223. Uptake of Radium-223 has so far been limited in the post-docetaxel setting. For these reasons we do not believe that radium-223 is a valid comparator for cabazitaxel.	appraisal as potential comparators. The Appraisal Committee will decide on the most relevant comparator(s) for cabazitaxel.
	British Uro-oncology Group	**NICE Consultation Q: Have all relevant comparators for cabazitaxel been included in the scope?** **BUG Response:** Yes, all comparators have been included in the scope. However, it is important to highlight that out of the two novel hormone therapies available (abiraterone and enzalutamide); the real life situation is that a patient with progressing metastatic CRPC will only be able to avail of one of them as per the current NICE guidance in place. Therefore, whilst the comparators have been correctly identified this does not imply the real life use of the comparators in the current regulatory process. **NICE Consultation Q: Which treatments are considered to be established clinical practice in the NHS for hormone-relapsed metastatic prostate cancer previously treated with a docetaxel-containing regimen?** **BUG Response:** The available options are:	Comment noted. The scope lists all available treatment options alternative to the technology under appraisal as potential comparators. NICE clinical guideline No. 175, 'Prostate cancer: diagnosis and treatment' does not recommend 'repeat cycles of treatment with docetaxel if the disease recurs after completion of the planned course of chemotherapy' therefore docetaxel re-

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		Either abiraterone or enzalutamide Radium223 (currently from the NCDF in England) Cabazitaxel (from NCDF in England) Docetaxel re-challenge/mitoxantrone **NICE Consultation Q: How should best supportive care be defined?** **BUG Response:** Best supportive care should be defined as provision of oncological and palliative care support with the aim of optimising the patient's quality of life, but not extending survival. Use of pain control measures such as palliative radiotherapy, radiopharmaceuticals [apart from radium-223 dichloride], analgesics, bisphosphonates, and corticosteroids). **NICE Consultation Q: Is mitoxantrone in combination with prednisolone still used in clinical practice for treating hormone-relapsed metastatic prostate cancer previously treated with a docetaxel-containing regimen?** The use of mitoxantrone in combination with prednisolone is very limited. This is essentially due to the advent and availability of newer treatment options. However, with the restrictions in place regarding either abiraterone or enzalutamide as a treatment option and the increasing use of upfront docetaxel in metastatic cases (based on STAMPEDE data) the likelihood is that if provision for cabazitaxel is not there then mitoxantrone use would increase. An audit of UK Oncology practice in 2005 at the time of introduction	challenge is not included as a comparator. The scope lists all available treatment options alternative to the technology under appraisal as potential comparators. The Appraisal Committee will decide on the most

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		of docetaxel revealed that mitoxantrone was at that time in wide-spread UK usage. It would be a fall back drug, which is considerably less effective but has been shown to have some improvement on quality of life, not survival.	relevant comparator(s) for cabazitaxel.
	Prostate Cancer UK	Mitoxantrone may not be a relative comparator because it is not currently licensed for use in the NHS for treating metastatic, hormone-relapsed prostate cancer. Both abiraterone and enzalutamide can be described as 'best alternative care' for the broad patient population definition, "People with hormone-relapsed metastatic prostate cancer previously treated with a docetaxel-containing regimen". 'Best alternative care' for patients who have received docetaxel and abiraterone or enzalutamide would be best supportive care. 'Best alternative care' for patients who have received docetaxel and abiraterone and have liver metastases would be best supportive care.	Comment noted. Consultees highlighted that use of mitoxantrone is expected to increase for patients whose disease has progressed after abiraterone or enzalutamide, because of unavailability of cabazitaxel. The scope tends to be inclusive for the comparator technologies. The Appraisal Committee will decide on the most relevant comparator(s) for cabazitaxel.
	Tackle Prostate Cancer	Correct	Comment noted.
Outcomes	Sanofi	The outcomes measures presented in the draft scope are appropriate.	Comment noted.

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	Prostate Cancer UK	Yes	Comment noted.
	Tackle Prostate Cancer	Hopefully	Comment noted.
Economic analysis	Sanofi	Abiraterone and enzalutamide are available with confidential discount schemes. To account for this we will examine a range of prices for these therapies in sensitivity analysis.	Comment noted.
	Tackle Prostate Cancer	No Comment	Response noted.
Equality and Diversity	Sanofi	We have not identified any equity or equality issues within the draft scope.	Comment noted.
	Tackle Prostate Cancer	No equality issues	Response noted.
Innovation	Sanofi	Cabazitaxel was the first agent to demonstrate a significant survival benefit in patients with mHRPC that has progressed on or after one docetaxel-containing chemotherapy regimen and emerging audit evidence suggests that the earlier use of chemotherapy in the treatment of mHRPC is may prolong life. Since the initial assessment by NICE of cabazitaxel four additional agents have received licenses in this indication of which, abiraterone and	Comment noted. The innovative nature of cabazitaxel will be considered by the Committee during the appraisal.

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		enzalutamide are recommended in the post chemotherapy setting. However for those patients who have received treatment with one or other of these therapies prior to receiving chemotherapy or who are contraindicated to them there remain few other effective options beyond supportive care.	
	Prostate Cancer UK	Yes, we consider cabazitaxel to be innovative. The Appraisal Committee has the phase III TROPIC trial data available to it (3), including follow-up data (4). There are data available to the Committee on the benefits of receiving cabazitaxel in sequence after abiraterone/enzalutamide (1). There are data which demonstrate an improved clinical benefit in patients with metastatic hormone-relapsed prostate cancer previously treated with docetaxel if they received cabazitaxel then abiraterone, compared to abiraterone then cabazitaxel (5). 1. Pezaro CJ, Omlin AG, Altavilla A, Lorente D, Ferraldeschi R, Bianchini D, et al. Activity of cabazitaxel in castration-resistant prostate cancer progressing after docetaxel and next-generation endocrine agents. Eur Urol. 2014 Sep;66(3):459–65. 2. NHS England. National Cancer Drugs Fund List Ver 4.2 [Internet]. 2015. Available from: http://www.england.nhs.uk/wp-	Comment noted. The innovative nature of cabazitaxel will be considered by the Committee during the appraisal.

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		content/uploads/2015/05/ncdf-list-may15-upd.pdf 3. De Bono JS, Oudard S, Ozguroglu M, Hansen S, Machiels J-P, Kocak I, et al., TROPIC Investigators. Prednisone plus cabazitaxel or mitoxantrone for metastatic castration-resistant prostate cancer progressing after docetaxel treatment: a randomised open-label trial. Lancet. 2010 Oct 2;376(9747):1147–54. 4. Bahl A, Oudard S, Tombal B, Ozgüroglu M, Hansen S, Kocak I, et al., TROPIC Investigators. Impact of cabazitaxel on 2-year survival and palliation of tumour-related pain in men with metastatic castration-resistant prostate cancer treated in the TROPIC trial. Ann Oncol Off J Eur Soc Med Oncol ESMO. 2013 Sep;24(9):2402–8. 5. Wissing MD, Coenen JLLM, van den Berg P, Westgeest HM, van den Eertwegh AJM, van Oort IM, et al. CAST: A retrospective analysis of cabazitaxel and abiraterone acetate sequential treatment in patients with metastatic castrate-resistant prostate cancer previously treated with docetaxel. Int J Cancer J Int Cancer. 2014 Sep 20	
	Tackle Prostate Cancer	Cabazitaxel is the last treatment available to men with advanced prostate cancer, after all of the other hormone treatments and docetaxel have failed. In the clinical setting it has proved to be highly successful, much more successful than the trials would have suggested. After talking with patients who have received this treatment, it has been shown to be well tolerated with	Comment noted. The innovative nature of cabazitaxel will be considered by the Committee during the appraisal.

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		fewer side affects that expected. It has been in use from the Cancer Drugs Fund for four years now and there are many patients who are still alive and doing well four years after treatment. There are men who simply do not respond to the new hormone high cost treatment. We can have insight into who they are based on how they have responded so far and their disease parameters. In addition, new data has shown that 20-40% of patients have a mutated version of the receptor needed in the cancer cell (Androgen receptor) and will not respond to abiraterone or enzalutamide. Giving them these drugs when there is little chance of response not only wastes their time and their life but NHS money Cabazitaxel has the endorsement of the leading prostate cancer oncologists in the country.	
Other considerations	Sanofi	It is likely that end of life criteria will apply to some or all of the populations under discussion.	Comment noted. The Committee will decide on the application of end of life criteria during the course of the appraisal.
	British Uro-	**NICE Consultation Q: Are the subgroups suggested in 'other**	Comment noted. The reference to the

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	oncology Group	**considerations' appropriate?** **BUG Response:** Yes, though the first subgroup is based on clinical factors. People for whom abiraterone or enzalutamide are not suitable include people in whom; • abiraterone or enzalutamide are not expected to be effective (first subgroup) • the disease has progressed after abiraterone or enzalutamide (second subgroup)	subgroup for whom 'abiraterone or enzalutamide are not expected to be effective' has been removed from the scope because it is not routinely identified in clinical practice.
	Prostate Cancer UK	There are specific groups within this population that should also be considered by the Appraisal Committee: • Patients who have received docetaxel and either abiraterone or enzalutamide. A study has demonstrated that cabazitaxel appears active when given after abiraterone and enzalutamide (1). Cabazitaxel is currently available on the Cancer Drugs Fund as a third-line treatment option following docetaxel and abiraterone (2). • Patients with liver metastases who have received docetaxel and abiraterone.	Comments noted. The reference to the subgroup for whom 'abiraterone or enzalutamide are not expected to be effective' has been removed from the scope because it is not routinely identified in clinical practice. Comment noted. 'People who have

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		For men who have received docetaxel and abiraterone and have liver metastases, cabazitaxel is their only active treatment option. This is because treatment with radium-223 is contraindicated in patients with liver metastases and enzalutamide (which can be used in patients with liver metastases) is restricted to patients who have not previously been treated with abiraterone, or to patients who had to stop taking abiraterone within three months as a consequence of dose-limiting toxicity and in the clear absence of disease progression. 1) Pezaro CJ, Omlin AG, Altavilla A, Lorente D, Ferraldeschi R, Bianchini D, et al. Activity of cabazitaxel in castration-resistant prostate cancer progressing after docetaxel and next-generation endocrine agents. Eur Urol. 2014 Sep;66(3):459–65. 2) NHS England. National Cancer Drugs Fund List Ver 4.2 [Internet]. 2015. Available from: http://www.england.nhs.uk/wp-content/uploads/2015/05/ncdf-list-may15-upd.pdf	received abiraterone or enzalutamide' and 'people with bone metastasis only (no visceral metastasis)' have been included as subgroups in the scope. The consultees, in their submission, may also highlight any other subgroup for which cabazitaxel is expected to be more clinically effective and cost effective and that should be examined separately.
	Tackle Prostate Cancer	None	Response noted.
NICE Pathways	Sanofi	**Where do you consider cabazitaxel will fit into the existing NICE pathway, Prostate Cancer?** Second–line chemotherapy after docetaxel (used as first line chemotherapy) in patients treated with abiraterone or enzalutamide before docetaxel (or for	Comment noted. The suggested position(s) of cabazitaxel in the existing NICE pathway will be considered at the

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		whom abiraterone or enzalutamide are contraindicated) or as an option when these therapies are used after docetaxel.	time of the publication of the guidance.
Questions for consultation	Sanofi	**Have all relevant comparators for cabazitaxel been included in the scope?** **Which treatments are considered to be established clinical practice in the NHS for hormone-relapsed metastatic prostate cancer previously treated with a docetaxel-containing regimen?** NICE has recommended abiraterone or enzalutamide post-chemotherapy for mHRPC patients. For those patients contraindicated to abiraterone or enzalutamide or as third line treatment NICE recommends a corticosteroid such as dexamethasone (0.5 mg daily). **How should best supportive care be defined?** In TA101 for docetaxel, mitoxantrone in combination with prednisone was recognised as the standard of care for first line chemotherapy treatment of mHRPC patients. However with the advent of the newer agents including cabazitaxel, use of mitoxantrone in this setting has declined. This was recognised in TA259 for abiraterone where the committee also accepted the assumption that that overall survival and progression-free survival were the same for patients taking mitoxantrone and patients taking prednisolone and so outcomes with mitoxatrone could be considered equivalent to supportive care. This assumption is supported by a very recent, propensity score matched, patient level analysis based on the control arms in the TROPIC and	Comment noted. The scope lists all available treatment options alternative to the technology under appraisal as potential comparators. The Appraisal Committee will decide on the most relevant comparator(s) for cabazitaxel. Comment noted. Both mitoxantrone and best supportive care are included in the scope as comparators. The Appraisal Committee will decide on the most relevant comparator(s) for cabazitaxel, or whether mitoxantrone should be considered

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		SUN studies (Mitoxantrone plus prednisone vs. prednisone) of overall survival for mHRPC patients who had previously taken docetaxel [Green, 2015]. This concluded that there was no significant survival benefit for mitoxantrone plus prednisone over prednisone alone among men with mCRPC after docetaxel therapy. This finding is consistent with prior studies showing no survival advantage with mitoxantrone in the predocetaxel setting. In the light of this evidence and in the opinion of recent NICE committees we believe that outcomes with mitoxantrone recorded in the control arm of TROPIC can be considered to be equivalent to supportive care. Green et al. The Oncologist 2015;20:516–522. **Is mitoxantrone in combination with prednisolone still used in clinical practice for treating hormone-relapsed metastatic prostate cancer previously treated with a docetaxel-containing regimen?** Mitoxantrone was used widely in this setting but its diminishing use has been recognised in TA316 for enzalutamide and TA259 for abiraterone on the basis that the newer agents have displaced it. This includes the use of cabazitaxel in this setting. However when there are no other options beyond best supportive care, for example in 'people for whom abiraterone or enzalutamide are not suitable', then mitoxantrone still represents an option. Indeed it may be the case that if cabazitaxel is no longer available to these patients mitoxantrone could	equivalent to the best supportive care.

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		become more widely used once more. In-line with comments above we contend that mitoxantrone should be considered to be equivalent to best supportive care. **Are the subgroups suggested in 'other considerations' appropriate?** **Are people in whom advanced hormonal therapy (with abiraterone or enzalutamide) is not expected to be effective, identified in the clinical practice?** There is no commonly available diagnostic test to confirm the suitability of patients for these therapies however patients may receive either abiraterone or enzalutamide in the pre-chemotherapy setting if they are asymptomatic or mildly symptomatic. However, as mentioned above ARv7+ve tumours show limited response to advanced hormonal therapy. While this biomarker is not widely available it is being validated in prospective randomised clinical trials. As discussed, previous NICE committees have accepted that once abiraterone or enzalutamide have been used then it is not standard care in England for people to receive another course of either treatment. Hence where patients have received one or other of these therapies before docetaxel then both are by definition removed from the pathway in the post-docetaxel setting.	Comment noted. The reference to the subgroup for whom 'abiraterone or enzalutamide are not expected to be effective' has been removed from the scope because it is not routinely identified in clinical practice.
	British Uro-	**NICE Consultation Q: Are people in whom advanced hormonal therapy**	Comment noted. The

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	oncology Group	**(with abiraterone or enzalutamide) is not expected to be effective, identified in the clinical practice?** **BUG Response:** There are no molecular markers for use at this current time for clinical practice to identify primary resistance to Abiraterone or Enzalutamide. Recent data on ARV7 is being investigated in larger trials to see if this could establish the primary resistance group. It is likely that there will be several molecular mechanisms for primary resistance and therefore this needs to be identified in prospective studies. Currently, the decision in clinical practice regarding the possibility of resistance to abiraterone or enzalutamide is primarily based on clinical parameters like duration of response to first line hormone therapy (Less than 1 year response to first line hormone therapy is associated with a higher rate of resistance to second line hormone therapy). Other factors such as the presence of true visceral metastases together with baseline high gleason score ,may also be taken into account. **NICE Consultation Q: Are there any other subgroups of people in whom cabazitaxel is expected to be more clinically effective and cost effective or other groups that should be examined separately?** **BUG Response:** The recent data on ARV7 suggests that taxane chemotherapy is effective in ARV7 positive and negative cases whilst abiraterone or enzalutamide is not effective in ARV7 positive cases. This subgroup of cases who are likely to have primary resistance to abiraterone or	reference to the subgroup for whom 'abiraterone or enzalutamide are not expected to be effective' has been removed from the scope because it is not routinely identified in clinical practice.

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		enzalutamide should have preferential treatment with Cabazitaxel.	
Additional comments on the draft scope	Sanofi	None	Response noted.
	NCRI/RCP/RCR /ACP	Our experts believe that the draft scope is appropriate and have no comments to add.	Comment noted.
	Prostate Cancer UK	We welcome NICE's intention to appraise cabazitaxel through its Single Technology Appraisal (STA) process. A positive recommendation would ensure consistency of access across England under the mandate for NHS service providers to comply with positive NICE recommendations.	Comment noted. The Appraisal Committee will make its recommendation after due consideration of clinical and cost-effectiveness of cabazitaxel according NICE STA process.
	Tackle Prostate Cancer	None	Response noted.

The following consultees/commentators indicated that they had no comments on the draft remit and/or the draft scope

Royal College of Nursing