Royal College of Physicians

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From [redacted]

Meindert Boysen
Programme Director, Centre for Health Technology Evaluation
By email:
kate.moore@nice.org.uk

18 December 2013

Dear Mr Boysen

Re: NICE ACD: Lung cancer (non small cell, non squamous) - pemetrexed (maintenance following pemetrexed and cisplatin) [ID489]

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 29,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

I write on behalf of the NCRI/RCP/RCR/ACP/JCCO with regard to the above ACD consultation. We are pleased that this has taken into account the comments we previously submitted regarding the double counting of patients. However, we note that the committee remains unwilling to consider the 'real life' numbers of patients treated with pemetrexed in the second line setting (paragraph 4.24). The rationale proposed for this view is that the calculation of patient numbers should be potential (rather than actual) when determining whether the technology being appraised is applicable to 'a small population for an end of life treatment'. Nonetheless, even if this argument is accepted, second line pemetrexed is not NICE approved and, therefore, is not available through NHS treatment (although it is available on the CDF). As such, our experts fail to understand how this can be included as a potential group of patients who might be treated with pemetrexed in the UK where NICE guidance governs treatment pathways. We would argue that this falsely inflates potential patient numbers to an extent which prevents pemetrexed being considered for 'a small population for an end of life treatment', and that this may ultimately impact on the final decision made about the technology.

That important point aside, the main reason for the negative ACD would appear to be the high ICER per QUALY gained. We are aware that there has been much discussion between the manufacturer's health economists and the committee with regard to the methods used to determine this.

Yours sincerely

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