

**NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE**

**Proposed Health Technology Appraisal**

**Grazoprevir–elbasvir for treating chronic hepatitis C [ID842]**

**Draft scope (pre-referral)**

**Draft remit/appraisal objective**

To appraise the clinical and cost effectiveness of grazoprevir–elbasvir within its marketing authorisation for treating chronic hepatitis C.

**Background**

The hepatitis C virus (HCV) causes inflammation of the liver and affects the liver's ability to function. HCV is a blood-borne virus, meaning that it is spread by exposure to infected blood. Contaminated needles used to inject drugs are currently the most common route of HCV transmission. Symptoms of chronic hepatitis C are typically mild and non-specific, including fatigue, flu-like symptoms, anorexia, depression, sleep disturbance, pain, itching and nausea. Often, people with hepatitis C do not have any symptoms, and approximately 20% of infected people naturally clear their infections within 6 months<sup>1</sup>. However, the remainder develop chronic hepatitis C which can be life-long.

Chronic hepatitis C is categorised according to the extent of liver damage, as mild, moderate, or severe (where severe refers to cirrhosis). About 20% of people with chronic hepatitis C will develop cirrhosis<sup>2</sup>; the time for progression to cirrhosis varies, but takes 20-30 years on average<sup>2</sup>. Cirrhosis can progress to become 'decompensated', where the remaining liver can no longer compensate for the loss of function. A small percentage of people with chronic hepatitis and cirrhosis also develop hepatocellular carcinoma. Liver transplantation may be needed for people with decompensated cirrhosis or hepatocellular carcinoma.

The true prevalence of HCV infection is difficult to establish and likely to be underestimated because many people do not have symptoms. More than half of people with chronic hepatitis C are unaware of their infection<sup>3</sup>. There are 6 major genotypes and several subtypes of HCV; the prevalence of each varies geographically. Recent estimates (2012) suggest that around 160,000 people are chronically infected with HCV in England<sup>4</sup>, and that approximately 90% of these people are infected with genotype 1 or genotype 3<sup>4</sup>.

The aim of treatment is to cure the HCV infection, and prevent liver disease progression, hepatocellular carcinoma development, and HCV transmission. The HCV genotype influences treatment decisions and response. For those with mild hepatitis C, a 'watchful waiting' approach may be agreed between the patient and clinician on an individual basis. NICE guidance on hepatitis C

(NICE technology appraisal guidance 75, 106, 200, 252, 253, 330 and 331) recommend:

- combination therapy with ribavirin and either peginterferon alfa-2a or peginterferon alfa-2b for people with chronic hepatitis C regardless of disease severity, genotype or treatment experience.
- monotherapy with peginterferon alfa-2a or peginterferon alfa-2b is recommended for people who are unable to tolerate ribavirin or for whom ribavirin is contraindicated.
- telaprevir in combination with peginterferon alfa and ribavirin for people with genotype 1 chronic hepatitis C.
- boceprevir in combination with peginterferon alfa and ribavirin for people with genotype 1 chronic hepatitis C.
- sofosbuvir in combination with ribavirin, with or without peginterferon alfa, as an option for specific people with genotypes 1–6 chronic hepatitis C.
- simeprevir in combination with peginterferon alfa and ribavirin as an option for people with genotypes 1 and 4 chronic hepatitis C.

**The technology**

Grazoprevir–elbasvir (brand name unknown, Merck Sharp & Dohme) disrupts the biogenesis of components necessary for HCV replication by inhibiting key HCV proteins. It is orally administered as a fixed-dose combination.

Grazoprevir–elbasvir does not currently have a marketing authorisation in the UK for treating chronic hepatitis C. It has been studied in clinical trials compared with placebo in adults with genotype 1–6 HCV.

<b>Intervention(s)</b>	Grazoprevir–elbasvir
<b>Population(s)</b>	<p>People with chronic hepatitis C:</p> <ul style="list-style-type: none"> <li>• who have not had treatment for chronic hepatitis C (treatment-naive)</li> <li>• who have had treatment for chronic hepatitis C (treatment-experienced)</li> </ul>

<p><b>Comparators</b></p>	<ul style="list-style-type: none"> <li>• best supportive care (watchful waiting) (genotypes 1-6)</li> <li>• boceprevir in combination with peginterferon alfa and ribavirin (for genotype 1 only)</li> <li>• daclatasvir in combination with ribavirin, with or without peginterferon alfa (genotype 4; subject to ongoing NICE appraisal [ID766])</li> <li>• daclatasvir in combination with sofosbuvir, with or without ribavirin (genotype 1, 3 or 4; subject to ongoing NICE appraisal [ID766])</li> <li>• ledipasvir–sofosbuvir with or without ribavirin (genotypes 1, 3 or 4; subject to ongoing NICE appraisal [ID742])</li> <li>• ombitasvir/paritaprevir/ritonavir with or without dasabuvir (genotypes 1 or 4; subject to ongoing NICE appraisal [ID731])</li> <li>• peginterferon alfa with ribavirin (genotypes 1-6)</li> <li>• simeprevir in combination with peginterferon alfa and ribavirin (genotype 1 or 4)</li> <li>• sofosbuvir in combination with ribavirin, with or without peginterferon alfa (for specific people with genotypes 1-6; as recommended by NICE)</li> <li>• telaprevir in combination with peginterferon alfa and ribavirin (for genotype 1 only)</li> </ul>
<p><b>Outcomes</b></p>	<p>The outcome measures to be considered include:</p> <ul style="list-style-type: none"> <li>• sustained virological response</li> <li>• development of resistance to grazoprevir–elbasvir</li> <li>• mortality</li> <li>• adverse effects of treatment</li> <li>• health-related quality of life.</li> </ul>

<b>Economic analysis</b>	<p>The reference case stipulates that the cost effectiveness of treatments should be expressed in terms of incremental cost per quality-adjusted life year.</p> <p>The reference case stipulates that the time horizon for estimating clinical and cost effectiveness should be sufficiently long to reflect any differences in costs or outcomes between the technologies being compared.</p> <p>Costs will be considered from an NHS and Personal Social Services perspective.</p>
<b>Other considerations</b>	<p>If evidence allows the following subgroups will be considered:</p> <ul style="list-style-type: none"> <li>• genotype</li> <li>• co-infection with HIV</li> <li>• people with and without cirrhosis</li> <li>• people who have received treatment pre- and post-liver transplantation</li> <li>• response to previous treatment (non-response, partial response, relapsed)</li> <li>• people who are intolerant to or ineligible for interferon treatment</li> </ul> <p>If evidence allows the impact of treatment on reduced onward HCV transmission will also be considered.</p> <p>Guidance will only be issued in accordance with the marketing authorisation. Where the wording of the therapeutic indication does not include specific treatment combinations, guidance will be issued only in the context of the evidence that has underpinned the marketing authorisation granted by the regulator.</p>
<b>Related NICE recommendations and NICE Pathways</b>	<p>Related Technology Appraisals:</p> <p>‘Simeprevir for treating genotype 1 or 4 chronic hepatitis C’ (2015). NICE Technology Appraisal 331. Review date February 2016.</p> <p>‘Sofosbuvir for treating chronic hepatitis C’ (2015). NICE Technology Appraisal 330. Review date February 2016.</p> <p>‘Boceprevir for the treatment of genotype 1 chronic hepatitis C’ (2012). NICE Technology Appraisal 253. Review Date April 2015.</p> <p>‘Telaprevir for the treatment of genotype 1 chronic hepatitis C’ (2012). NICE Technology Appraisal 252.</p>

	<p>Review Date April 2015.</p> <p>'Peginterferon alfa and ribavirin for the treatment of chronic hepatitis C' (2010). NICE Technology Appraisal 200. Guidance added to static list December 2013.</p> <p>'Peginterferon alfa and ribavirin for the treatment of mild chronic hepatitis C (partially updated in TA200)' (2006). NICE Technology Appraisal 106. Guidance added to static list December 2013.</p> <p>'Interferon alfa (pegylated and non-pegylated) and ribavirin for the treatment of chronic hepatitis C (partially updated in TA200)' (2004). NICE Technology Appraisal 75. Guidance added to static list December 2013.</p> <p>Appraisals in development:</p> <p>'Daclatasvir for treating chronic hepatitis C'. NICE Technology Appraisal Guidance [ID766]. Publication date to be confirmed.</p> <p>'Ledipasvir–sofosbuvir for treating chronic hepatitis C'. NICE Technology Appraisal Guidance [ID742]. Publication date to be confirmed.</p> <p>'Paritaprevir/ritonavir/ombitasvir with or without dasabuvir for treating chronic hepatitis C'. NICE Technology Appraisal Guidance [ID731]. Publication date to be confirmed.</p> <p>Related Guidelines:</p> <p>'Hepatitis C: Diagnosis and management of hepatitis C'. NICE Clinical Guideline. Publication date to be confirmed.</p> <p>Related Public Health Guidance:</p> <p>'Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection' (2012). NICE Public Health Guidance 43.</p> <p>Related NICE Pathways:</p> <p>'Hepatitis B and C' (2012). NICE pathway.  <a href="http://pathways.nice.org.uk/pathways/hepatitis-b-and-c-testing">http://pathways.nice.org.uk/pathways/hepatitis-b-and-c-testing</a></p>
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<b>Related National Policy</b>	<p>Clinical Commissioning Policy Statement: Treatment of chronic Hepatitis C in patients with cirrhosis:</p> <p><a href="http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/06/hep-c-cirrhosis-policy-statmnt-0615.pdf">http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/06/hep-c-cirrhosis-policy-statmnt-0615.pdf</a></p> <p>NHS England Manual for prescribed specialised services 2013/2014. Sections 16 and 65:</p> <p><a href="http://www.england.nhs.uk/wp-content/uploads/2014/01/pss-manual.pdf">http://www.england.nhs.uk/wp-content/uploads/2014/01/pss-manual.pdf</a></p> <p>Department of Health, NHS Outcomes Framework 2014-2015, Nov 2013. Domains 2–4.</p> <p><a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf</a></p>
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### Questions for consultation

Have all relevant comparators for grazoprevir–elbasvir been included in the scope? Which treatments are considered to be established clinical practice in the NHS for chronic hepatitis C?

‘How should best supportive care be defined?’

Have all relevant outcomes been included in the scope?

Are the subgroups suggested in ‘other considerations appropriate? Are there any other subgroups of people in whom grazoprevir–elbasvir is expected to be more clinically effective and cost effective or other groups that should be examined separately?

Where do you consider grazoprevir–elbasvir will fit into the existing NICE pathway, ‘[Hepatitis B and C](#)’?

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 the proposed remit and scope may need changing in order to meet these aims. In particular, please tell us if the proposed remit and scope:

- could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which grazoprevir–elbasvir 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 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.

Do you consider grazoprevir–elbasvir to be innovative in its potential to make a significant and substantial impact on health-related benefits and how it might improve the way that current need is met (is this a ‘step-change’ in the management of the condition)?

Do you consider that the use of grazoprevir–elbasvir can result in any potential significant and substantial health-related benefits that are unlikely to be included in the QALY calculation?

Please identify the nature of the data which you understand to be available to enable the Appraisal Committee to take account of these benefits.

NICE intends to appraise this technology through its Single Technology Appraisal (STA) Process. We welcome comments on the appropriateness of appraising this topic through this process. (Information on the Institute’s Technology Appraisal processes is available at <http://www.nice.org.uk/article/pmg19/chapter/1-Introduction>)

### References

1. Hepatitis C Trust (2014). About hepatitis C. Accessed April 2015. Available at: <http://www.hepctrust.org.uk/about-hepatitis-c>
2. World Health Organisation (2015). Hepatitis C. Accessed April 2015. Available at: <http://www.who.int/csr/disease/hepatitis/Hepc.pdf?ua=1>
3. Department of Health (2004). Hepatitis C: Essential information for professionals and guidance on testing. Accessed April 2015. Available at: <http://www.nhs.uk/hepatitisc/SiteCollectionDocuments/pdf/essential-information-for-professionals-and-guidance-on-testing.pdf>
4. Public Health England (2014). Hepatitis C in the UK: 2014 report. Accessed April 2015. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/337115/HCV\\_in\\_the\\_UK\\_2014\\_24\\_July.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/337115/HCV_in_the_UK_2014_24_July.pdf)