NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

CDF Rapid Reconsideration

Everolimus with exemestane for treating advanced breast cancer after endocrine therapy (Cancer Drugs Fund reconsideration of TA295)

The following documents are made available to the consultees and commentators:

1. **Response to consultee, commentator and public comments on the Appraisal Consultation Document (ACD)**

2. **Consultee and commentator comments on the appraisal consultation document** from:
   - **Novartis**
   - **Breast Cancer Now**
   - **Association of Breast Surgery**
   - **Pfizer**

   Please note we received notification of no comments from the Department of Health

3. **ERG's validation of the company's revised cost effectiveness results**

Any information supplied to NICE which has been marked as confidential, has been redacted. All personal information has also been redacted.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Single Technology Appraisal

Everolimus with exemestane for treating advanced breast cancer after endocrine therapy

Response to consultee, commentator and public comments on the Appraisal Consultation Document (ACD)

Definitions:

Consultees – Organisations that accept an invitation to participate in the appraisal including the companies, national professional organisations, national patient organisations, the Department of Health and the Welsh Government and relevant NHS organisations in England. Consultees can make a submission and participate in the consultation on the appraisal consultation document (ACD; if produced). All non-company consultees can nominate clinical experts and/or patient experts to verbally present their personal views to the Appraisal Committee. Company consultees can also nominate clinical experts. Representatives from NHS England and clinical commissioning groups invited to participate in the appraisal may also attend the Appraisal Committee as NHS commissioning experts. All consultees have the opportunity to consider an appeal against the final recommendations, or report any factual errors, within the final appraisal determination (FAD).

Clinical and patient experts and NHS commissioning experts – The Chair of the Appraisal Committee and the NICE project team select clinical experts and patient experts from nominations by consultees and commentators. They attend the Appraisal Committee meeting as individuals to answer questions to help clarify issues about the submitted evidence and to provide their views and experiences of the technology and/or condition. Before they attend the meeting, all experts must either submit a written statement (using a template) or indicate they agree with the submission made by their nominating organisation..

Commentators – Commentators can participate in the consultation on the ACD (if produced), but NICE does not ask them to make any submission for the appraisal. Non-company commentator organisations can nominate clinical experts and patient experts to verbally present their personal views to the Appraisal Committee. Commentator organisations representing relevant comparator technology companies can also nominate clinical experts. These organisations receive the FAD and have opportunity to report any factual errors. These organisations include comparator technology companies, Healthcare Improvement Scotland any relevant National Collaborating Centre (a group commissioned by NICE to develop clinical guidelines), other related research groups where appropriate (for example, the Medical Research Council and National Cancer Research Institute); other groups such as the NHS Confederation, the NHS Commercial Medicines Unit, the Scottish Medicines Consortium, the Medicines and Healthcare Products Regulatory Agency, the Department of Health, Social Services and Public Safety for Northern Ireland).

Public – Members of the public have the opportunity to comment on the ACD when it is posted on the Institute's web site 5 days after it is sent to consultees and commentators. These comments are usually presented to the appraisal committee in full, but NICE reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of NICE, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.

Please note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees.

Comments received from consultees

Consultee	Comment [sic]	Response
Novartis	Novartis would like to thank the National Institute for Health and Care Excellence (NICE) Technology Appraisal Committee for the opportunity to comment on the Appraisal Consultation Document (ACD) for the above appraisal and to provide further clarifications for consideration. Our comments are provided in response to the standard four questions on which NICE have stated they are interested in receiving comments, as detailed on Page 1 of the ACD. The primary comment that we have on the ACD, which have been outlined below: I. The ACD recommendations have been formed based upon a Patient Access Scheme (PAS) which has now been revised. We have presented updated analysis within this response which captures the revised PAS, which we now believe justifies everolimus as cost effective treatment option in the above appraisal. We believe that the ACD recommendations should not be considered as a basis for guidance to the NHS. Overall, we believe that the ACD represents a fair summary of the evidence presented by Novartis and the subsequent Evidence Review Group (ERG) review. We are disappointed, however, to see that the NICE Committee has accepted the ERG's methods for modelling Progression-Free Survival (PFS) and Overall Survival (OS) and not giving due consideration to the uncertainties associated with these, rather than the company's methods for	Comments noted. The committee concluded that everolimus plus exemestane with the revised patient access scheme was a cost-effective use of NHS resources and could be recommended for routine commissioning in the NHS for treating advanced HER2-negative hormone receptor-positive breast cancer in postmenopausal women that has recurred or progressed after a non-steroidal aromatase inhibitor. Everolimus, in combination with exemestane, is recommended within its marketing authorisation as an option for treating advanced human epidermal growth factor receptor 2 (HER2)-negative hormone-receptor-positive breast cancer in postmenopausal women without symptomatic visceral disease that has recurred or progressed after a non-steroidal aromatase inhibitor. Everolimus is recommended only if the company provides it with the discount agreed in the patient access scheme.

	which there was statistical goodness of fit tests employed as validation. Although, we agree with the committee that both the modelling approaches for OS had a small effect on the ICER. However, we have accepted the committees chosen preferences to derive the most plausible ICER. Following the ACD, we have revised the PAS, relevant to this appraisal, along with applying all the committees preferred assumptions in order to derive a new base case ICER of [redacted] (with PAS). **1. Has all the relevant evidence been taken into account?** Novartis considers that all the relevant clinical evidence for everolimus has been taken into account. In response to the ACD, Novartis has amended the PAS relevant for this submission. The revised PAS is reflected in new analysis presented within this response. **2. Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?** Novartis does not agree with NICE's conclusion that everolimus did not have plausible potential to be cost effective for the treatment of patients who are HER2 negative, oestrogen receptor positive locally advanced or metastatic breast cancer following prior endocrine therapy as uncertainty still remains with the modelling methods for both PFS and OS as preferred by the committee. However, Novartis remains committed to achieving patient access for this important treatment option and has accepted the committees preferred modelling methods while revising the PAS applicable to this appraisal. **3. Are the recommendations sound and a suitable basis for guidance to the NHS?** No, the recommendations formed in the ACD were based upon a PAS which has since been revised, and as such should not been seen as sound and	For more details, please see sections 1 and 4.33 of the FAD.

suitable basis for guidance to the NHS. Novartis has provided updated analysis with a new base case ICER within this response, which should be seen as the most appropriate basis for guidance to the NHS.

4. Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

Novartis does not consider that there are any aspects of the recommendations that require particular consideration in this regard.

5. Economic analysis and results

The economic model has been updated to incorporate the committee's preferred assumptions as specified within the ACD, presented in Table 1, along with applying the revised PAS, a [redacted] discount at the point of invoice. The resulting ICER per QALY gained is [redacted] (with PAS), presented in Table 2.

Table 1 Assumptions used in the new economic analysis

	Appraisal Committee's preferred assumption	ACD response economic analysis
PFS extrapolation	K-M directly and simple exponential model (ERG's approach)	As per the Appraisal Committee's preferred assumption
OS extrapolation	Landmark analysis (ERG's approach)	As per the Appraisal Committee's preferred assumption

	Time horizon	20 years	As per the Appraisal Committee's preferred assumption

Table 2 Results

	Everolimus	Comparator 1
Everolimus cost (£)	[redacted]	[redacted]
Other costs (£)	[redacted]	[redacted]
Total costs (£)	[redacted]	[redacted]
Difference in total costs (£)		[redacted]
LYG	[redacted]	[redacted]
LYG difference		[redacted]
QALYs	[redacted]	[redacted]
QALY difference		[redacted]
ICER (£)		[redacted]

Association of Breast Surgery	The Association of Breast Surgery does not have any specific contribution to add to the work of the Appraisal Committee.	Comments noted. No action required.
Breast Cancer Now	**Has all of the relevant evidence been taken into account?** Yes, to the best of our knowledge. **Are the summaries of clinical and cost effectiveness reasonable**	Comments noted.

	interpretations of the evidence? Yes, to the best of our knowledge. **Are the recommendations sound and a suitable basis for guidance to the NHS?** Everolimus plus exemestane is a drug combination used to treat advanced or metastatic breast cancer in patients who have oestrogen receptor positive, HER2 negative breast cancer. Around 80% of all breast cancer patients are estimated to have hormone positive breast cancer and most of these patients will also be HER2 negative. As a result this drug has the potential to benefit a significant proportion of the total number of breast cancer patients and is therefore a really important treatment option, which ought to be available consistently on the NHS. Once aromatase inhibitors stop working for this group of patients, there will be few treatment options available to them. This medicine may provide an option for this group of patients, before they are offered general chemotherapies, which are associated with serious side effects. The removal of this drug from the CDF and from routine use will be devastating news to patients who are still taking aromatase inhibitors to control their disease and will be looking at this drug as their next treatment option once they progress. Whilst the previous appraisal, conducted back in 2013, lacked mature overall survival data, the re-appraisal committee for this drug agreed with the Evidence Review Group that this drug provided patients with extension to life. Whilst the original ICER for everolimus plus exemestane was £68,000, when it was assessed by NICE in 2013, the new revised ICER, as a result of the	The guidance has been updated. Everolimus, in combination with exemestane, is recommended within its marketing authorisation as an option for treating advanced human epidermal growth factor receptor 2 (HER2)-negative hormone-receptor-positive breast cancer in postmenopausal women without symptomatic visceral disease that has recurred or progressed after a non-steroidal aromatase inhibitor. Everolimus is recommended only if the company provides it with the discount agreed in the patient access scheme. For more details, please see sections 1 and 4.33 of the FAD.

	new Patient Access Scheme and the re-evaluation of the evidence on overall survival, presented to the committee, is closer to the cost-effectiveness threshold accepted by NICE. We need to ensure that the NICE system for appraising cancer medicines is working for NHS patients. We therefore urge NICE to work with NHS England and with Novartis over the next few months to agree a price that would ensure that this drug is able to be recommended for routine use on the NHS. **Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?** Everolimus has been available to NHS patients in Scotland since April 2016 and the Welsh Government has agreed a deal with Novartis, making this drug available to NHS patients in Wales since November 2015. If the Final Access Determination on everolimus plus exemestane is negative, this will be the first time that a breast cancer drug is available to patients in Wales and Scotland but not in England. We urge NICE to work together with NHS England and Novartis to agree a deal similar to the Scottish and Welsh Governments so that English breast cancer patients can also benefit from this drug.	
Department of Health	No comments.	Comments noted. No action required.

Comments received from commentators

Commentator	Comment [sic]	Response
Pfizer	1. Pfizer agrees with the comments of the patient expert (section 4.2) that the prolonging of PFS, by using everolimus in combination with exemestane, would be valuable to the patients as it delays the need for chemotherapy and its associated toxicity. 2. Pfizer notes that fulvestrant was not considered an appropriate comparator, however in 2015 we conducted an advisory board with leading clinical experts from multiple key breast cancer centres across the UK, during which it was indicated that around 50% of centres in the UK offer fulvestrant as a treatment option in previously treated metastatic patients. Although not NICE recommended, this would suggest it is a relevant comparator in previously treated ER+ HER2- patients in the NHS.	Comments noted. Everolimus, in combination with exemestane, is recommended within its marketing authorisation as an option for treating advanced human epidermal growth factor receptor 2 (HER2)-negative hormone-receptor-positive breast cancer in postmenopausal women without symptomatic visceral disease that has recurred or progressed after a non-steroidal aromatase inhibitor. Everolimus is recommended only if the company provides it with the discount agreed in the patient access scheme. For more details, please see sections 1 and 4.33 of the FAD. The committee did not hear any evidence that fulvestrant can be considered routine practice when non-steroidal aromatase inhibitors have failed in the original appraisal or the Cancer Drugs Fund consideration of NICE TA295 in line with NICE's Guide to the methods of technology appraisal.

National Institute for Health and Care Excellence

Everolimus in combination with an aromatase inhibitor for the treatment of HER2 negative, oestrogen receptor positive locally advanced or metastatic breast cancer after prior endocrine therapy

RESPONSE TO APPRAISAL CONSULTATION DOCUMENT

08 September 2016

1. Summary

Novartis would like to thank the National Institute for Health and Care Excellence (NICE) Technology Appraisal Committee for the opportunity to comment on the Appraisal Consultation Document (ACD) for the above appraisal and to provide further clarifications for consideration.

Our comments are provided in response to the standard four questions on which NICE have stated they are interested in receiving comments, as detailed on Page 1 of the ACD.

The primary comment that we have on the ACD, which have been outlined below:

I. The ACD recommendations have been formed based upon a Patient Access Scheme (PAS) which has now been revised. We have presented updated analysis within this response which captures the revised PAS, which we now believe justifies everolimus as cost effective treatment option in the above appraisal. We believe that the ACD recommendations should not be considered as a basis for guidance to the NHS.

Overall, we believe that the ACD represents a fair summary of the evidence presented by Novartis and the subsequent Evidence Review Group (ERG) review. We are disappointed, however, to see that the NICE Committee has accepted the ERG's methods for modelling Progression-Free Survival (PFS) and Overall Survival (OS) and not giving due consideration to the uncertainties associated with these, rather than the company's methods for which there was statistical goodness of fit tests employed as validation. Although, we agree with the committee that both the modelling approaches for OS had a small effect on the ICER. However, we have accepted the committees chosen preferences to derive the most plausible ICER. Following the ACD, we have revised the PAS, relevant to this appraisal, along with applying all the committees preferred assumptions in order to derive a new base case ICER of £XXX (with PAS).

2. Has all the relevant evidence been taken into account?

Novartis considers that all the relevant clinical evidence for everolimus has been taken into account. In response to the ACD, Novartis has amended the PAS relevant for this submission. The revised PAS is reflected in new analysis presented within this response.

3. Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

Novartis does not agree with NICE's conclusion that everolimus did not have plausible potential to be cost effective for the treatment of patients who are HER2 negative, oestrogen receptor positive locally advanced or metastatic breast cancer following prior endocrine therapy as uncertainty still remains with the modelling methods for both PFS and OS as preferred by the committee. However, Novartis remains committed to achieving patient access for this important treatment option and has accepted the committees preferred modelling methods while revising the PAS applicable to this appraisal.

4. **Are the recommendations sound and a suitable basis for guidance to the NHS?**

No, the recommendations formed in the ACD were based upon a PAS which has since been revised, and as such should not been seen as sound and suitable basis for guidance to the NHS. Novartis has provided updated analysis with a new base case ICER within this response, which should be seen as the most appropriate basis for guidance to the NHS.

5. **Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?**

Novartis does not consider that there are any aspects of the recommendations that require particular consideration in this regard.

6. **Economic analysis and results**

The economic model has been updated to incorporate the committee's preferred assumptions as specified within the ACD, presented in Table 1, along with applying the revised PAS, a XX% discount at the point of invoice. The resulting ICER per QALY gained is £XXX (with PAS), presented in Table 2.

Table 1 Assumptions used in the new economic analysis

	Appraisal Committee's preferred assumption	ACD response economic analysis
PFS extrapolation	K-M directly and simple exponential model (ERG's approach)	As per the Appraisal Committee's preferred assumption
OS extrapolation	Landmark analysis (ERG's approach)	As per the Appraisal Committee's preferred assumption
Time horizon	20 years	As per the Appraisal Committee's preferred assumption

Table 2 Results

	Everolimus	Comparator 1
Everolimus cost (£)	£XXX	£XXX
Other costs (£)	£XXX	£XXX
Total costs (£)	£XXX	£XXX
Difference in total costs (£)		£XXX
LYG	XXX	XXX
LYG difference		XXX
QALYs	XXX	XXX
QALY difference		XXX
ICER (£)		£XXX

Jenna Dilkes
Project Manager
NICE
10 Spring Gardens
London
SW1A 2BU

9 September 2016

Dear Ms Dilkes,

Re: Response to Advance Decision Consultation on everolimus with exemestane for treating advanced breast cancer after endocrine therapy

Has all of the relevant evidence been taken into account?

Yes, to the best of our knowledge.

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

Yes, to the best of our knowledge.

Are the recommendations sound and a suitable basis for guidance to the NHS?

Everolimus plus exemestane is a drug combination used to treat advanced or metastatic breast cancer in patients who have oestrogen receptor positive, HER2 negative breast cancer. Around 80% of all breast cancer patients are estimated to have hormone positive breast cancer and most of these patients will also be HER2 negative. As a result this drug has the potential to benefit a significant proportion of the total number of breast cancer patients and is therefore a really important treatment option, which ought to be available consistently on the NHS.

Once aromatase inhibitors stop working for this group of patients, there will be few treatment options available to them. This medicine may provide an option for this group of patients, before they are offered general chemotherapies, which are associated with serious side-effects. The removal of this drug from the CDF and from routine use will be devastating news to patients who are still taking aromatase inhibitors to control their disease and will be looking at this drug as their next treatment option once they progress. Whilst the previous appraisal, conducted back in 2013, lacked mature overall survival data, the re-appraisal committee for this drug agreed with the Evidence Review Group that this drug provided patients with extension to life.

Whilst the original ICER for everolimus plus exemestane was £68,000, when it was assessed by NICE in 2013, the new revised ICER, as a result of the new Patient Access Scheme and the re-evaluation of the evidence on overall survival, presented to the committee, is closer to the cost-effectiveness threshold accepted by NICE. We need to ensure that the NICE system for appraising cancer medicines is working for NHS patients. We therefore urge NICE to work with NHS England and with Novartis over the next few months to agree a price that would ensure that this drug is able to be recommended for routine use on the NHS.

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

Everolimus has been available to NHS patients in Scotland since April 2016[1] and the Welsh Government has agreed a deal with Novartis, making this drug available to NHS patients in Wales since November 2015.[2] If the Final Access Determination on everolimus plus exemestane is negative, this will be the first time that a breast cancer drug is available to patients in Wales and Scotland but not in England. We urge NICE to work together with NHS England and Novartis to agree a deal similar to the Scottish and Welsh Governments so that English breast cancer patients can also benefit from this drug.

Yours sincerely,

T. Sandell

[redacted]
Breast Cancer Now

[1] Drug ID: 872/13 (resubmission), Scottish Medicines Consortium, April 2016.
[2] New cancer drugs to be available in Wales through new deal, Welsh Government press release, November 2015.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Single Technology Appraisal (STA)

CDF Rapid Reconsideration

Everolimus in combination with exemestane for treating advanced HER2-negative hormone-receptor-positive breast cancer after endocrine therapy (review of TA295) [ID1011]

Appraisal consultation document

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: Association of Breast Surgery
Are you (tick all that apply):

- a specialist in the treatment of people with the condition for which NICE is considering this technology? YES
- a specialist in the clinical evidence base that is to support the technology (e.g. involved in clinical trials for the technology)? NO
- 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)? YES, CLINICIAN
- other? (please specify)

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Single Technology Appraisal (STA)

CDF Rapid Reconsideration

Everolimus in combination with exemestane for treating advanced HER2-negative hormone-receptor-positive breast cancer after endocrine therapy (review of TA295) [ID1011]

Appraisal consultation document

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.

The Association of Breast Surgery has reviewed the evidence and the conclusion of the Appraisal Committee with a view to any potential factors that may influence the surgical care of the patient population being studied.

The Association of Breast Surgery does not have any specific contribution to add to the work of the Appraisal Committee.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Single Technology Appraisal (STA)

CDF Rapid Reconsideration

Everolimus in combination with exemestane for treating advanced HER2-negative hormone-receptor-positive breast cancer after endocrine therapy (review of TA295) [ID1011]

Appraisal consultation document

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?

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.

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)?

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.

Pfizer comments on ACD received via email

Thank you for the opportunity for Pfizer to respond to this consultation. We would like to make the following comments:

1. Pfizer agrees with the comments of the patient expert (section 4.2) that the prolonging of PFS, by using everolimus in combination with exemestane, would be valuable to the patients as it delays the need for chemotherapy and its associated toxicity;
2. Pfizer notes that fulvestrant was not considered an appropriate comparator, however in 2015 we conducted an advisory board with leading clinical experts from multiple key breast cancer centres across the UK, during which it was indicated that around 50% of centres in the UK offer fulvestrant as a treatment option in previously treated metastatic patients. Although not NICE recommended, this would suggest it is a relevant comparator in previously treated ER+ HER2- patients in the NHS.

ERG REPORT

LIVERPOOL REVIEWS AND IMPLEMENTATION GROUP (LRiG)

Cancer Drugs Fund rapid reconsideration of NICE Guidance TA295

Everolimus in combination with exemestane for treating advanced HER2-negative hormone-receptor-positive breast cancer after endocrine therapy

[ID1011]

This report was commissioned by the NIHR HTA Programme as project number 08/206/01

Completed 16th September 2016
ERG's validation of company's revised cost effectiveness results (response to appraisal consultation document)

CONTAINS CIC

UNIVERSITY OF LIVERPOOL
LIVERPOOL REVIEWS AND IMPLEMENTATION GROUP

A MEMBER OF THE RUSSELL GROUP

The ERG can confirm that previous calculations done by the ERG related to this appraisal indicated that if the patient access scheme was increased to [redacted] that the ICER would indeed be just slightly below £30,000 per QALY gained (see table 1).

Table 1: Modelling approaches applied in company's revised cost effectiveness analysis

PFS extrapolation	K-M directly and simple exponential model (ERG's approach)
OS extrapolation	Landmark analysis (ERG's approach)
Time horizon	20 years