NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Appraisal consultation document

Cetuximab for treating recurrent or metastatic squamous cell cancer of the head and neck

The Department of Health has asked the National Institute for Health and Care Excellence (NICE) to produce guidance on using cetuximab in the NHS in England. The appraisal committee has considered the evidence submitted by the company and the views of non-company consultees and commentators, clinical experts and patient experts.

This document has been prepared for consultation with the consultees. It summarises the evidence and views that have been considered, and sets out the recommendations made by the committee. NICE invites comments from the consultees and commentators for this appraisal and the public. This document should be read along with the evidence (see the committee papers).

The appraisal committee is interested in receiving comments on the following:

- Has all of the relevant evidence been taken into account?
- Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?
- Are the recommendations sound and a suitable basis for guidance to 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?

Note that this document is not NICE's final guidance on this technology. The recommendations in section 1 may change after consultation.

After consultation:

- The appraisal committee will meet again to consider the evidence, this appraisal consultation document and comments from the consultees.
- At that meeting, the committee will also consider comments made by people who are not consultees.
- After considering these comments, the committee will prepare the final appraisal determination (FAD).
- Subject to any appeal by consultees, the FAD may be used as the basis for NICE's guidance on using cetuximab in the NHS in England.

For further details, see NICE's guide to the processes of technology appraisal.

The key dates for this appraisal are:

Closing date for comments: 22 November 2016

Second appraisal committee meeting: 29 November 2016

Details of membership of the appraisal committee are given in section 6.

1 Recommendations

1.1 Cetuximab in combination with platinum-based chemotherapy is not recommended within in its marketing authorisation for treating recurrent or metastatic squamous cell cancer of the head and neck in adults.

1.2 This guidance is not intended to affect the position of patients whose treatment with cetuximab was started within the NHS before this guidance was published. Treatment of those patients may continue without change to whatever funding arrangements were in place for them before this guidance was published until they and their NHS clinician consider it appropriate to stop.

2 The technology

Description of the technology	Cetuximab (Erbitux; Merck) is a recombinant monoclonal antibody that blocks human epidermal growth factor receptor (EGFR). It inhibits the proliferation of cells that depend on EGFR activation for growth.
Marketing authorisation	Cetuximab has a UK marketing authorisation 'for the treatment of patients with squamous cell cancer of the head and neck…in combination with platinum-based chemotherapy for recurrent and/or metastatic disease.'
Adverse reactions	Very common adverse reactions with cetuximab include skin reactions, which occur in more than 80% of patients, and low blood magnesium levels, mild or moderate infusion-related reactions (such as fever, chills, nausea, vomiting, headache, dizziness or shortness of breath), inflammation of the lining of the digestive tract, and raised liver enzymes, which all occur in 10% or more of patients. Common side effects (occurring in 1% or more and less than 10% of patients) include severe infusion-related reactions (including anaphylactic reactions), dehydration, low blood calcium levels, anorexia, headache, conjunctivitis, fatigue, diarrhoea, nausea and vomiting. Cetuximab in combination with platinum-based chemotherapy may increase the frequency of severe leukopenia or severe neutropenia, and this may lead to a higher rate of infectious complications than platinum-based chemotherapy alone. For full details of adverse reactions and contraindications, see the summary of product characteristics.
Recommended dose and schedule	Cetuximab is administered intravenously. It is used in combination with platinum-based chemotherapy followed by cetuximab as maintenance therapy until disease progression. The initial loading dose is 400 mg/m² body surface area (BSA) given at a rate not exceeding 5 mg/minute. Subsequent weekly maintenance doses are 250 mg/m² BSA each.

Price	The list price of cetuximab is £178.10 for a 5 mg/ml 20 ml vial and £890.50 for a 5 mg/ml 100 ml vial (excluding VAT; 'British national formulary' [BNF] online, accessed October 2016). Assuming that vials are not shared among patients, a person with a BSA of 1.75 m^2 would have 7 vials per loading dose and 5 vials per maintenance dose, equating to a cost of £1,246.70 for the loading dose and £890.50 for each maintenance dose. The company has agreed a patient access scheme with the Department of Health. If cetuximab had been recommended, this scheme would have provided a simple discount to the list price of cetuximab with the discount applied at the point of purchase or invoice. The level of the discount is commercial in confidence. The Department of Health considered that this patient access scheme would not constitute an excessive administrative burden on the NHS.

3 Evidence

3.1 The appraisal committee (section 6) considered evidence submitted by Merck and a review of this submission by the evidence review group. This appraisal was a Cancer Drugs Fund reconsideration of NICE's technology appraisal guidance on cetuximab for the treatment of recurrent and/or metastatic squamous cell cancer of the head and neck (SCCHN). Sections 4.2 to 4.11 reflect the committee's consideration of the evidence submitted in the original appraisal. Sections 4.12 to 4.21 reflect the committee's considerations of the evidence submitted for the Cancer Drugs Fund reconsideration. It focused on the subgroup of patients with cancer of the oral cavity from the EXTREME trial, and cost-effectiveness analyses using a patient access scheme that provides cetuximab at a reduced cost. The level of discount is commercial in confidence.

3.2 See the committee papers for full details of the Cancer Drugs Fund reconsideration evidence, and the history for full details of the evidence used in NICE's original technology appraisal guidance on cetuximab for the treatment of recurrent and/or metastatic SCCHN.

4 Committee discussion

4.1 The appraisal committee reviewed the data available on the clinical and cost effectiveness of cetuximab, having considered evidence on the nature of recurrent or metastatic squamous cell cancer of the head and neck (SCCHN) and the value placed on the benefits of cetuximab by people with the condition, those who represent them, and clinical experts. It also took into account the effective use of NHS resources.

Clinical effectiveness (NICE technology appraisal guidance 172)

4.2 The committee reviewed the evidence available on the clinical effectiveness of cetuximab as presented in the company's submission and the evidence review group's (ERG's) report. It noted that there was only 1 relevant randomised controlled trial that compared cetuximab plus platinum-based chemotherapy with chemotherapy alone in patients with recurrent or metastatic SCCHN (the EXTREME trial). The committee noted that few of the patients included in the clinical trial were from the UK although many were from other European countries. The committee was also aware of the ERG's concern that the patients in the trial appeared younger and fitter, on the basis of a higher Karnofsky performance status (KPS), than patients in UK clinical practice. Therefore, there was some uncertainty about whether the benefits of cetuximab would be seen in patients with this condition in the UK. Additionally, the committee heard from the clinical experts that most patients presenting with recurrent or metastatic SCCHN in the UK were older and had poorer general health than those recruited to the trial. However, patients for whom platinum-based chemotherapy would be considered appropriate were more likely to be of a similar age and performance status to those in the EXTREME trial. Overall, the committee accepted the evidence from the clinical experts that the results of the EXTREME trial would be applicable to the UK population.

4.3 The committee discussed the reported results from the clinical trial. It noted that the company had presented results for the total population in the trial and for a number of pre-planned subgroups. The committee noted the statistically significant improvement in overall survival associated with cetuximab in the total population represented in the trial. The committee was aware that, in the pre-planned subgroup analyses, only tumour location showed a significant interaction with treatment, suggesting greater effectiveness in tumours in the oral cavity. The committee heard from the clinical experts that patients with tumours in the oral cavity have a relatively favourable prognosis compared with the average prognosis for recurrent or metastatic SCCHN. The experts were not aware of any biological reason for cetuximab to be more clinically effective in oral cavity tumours. The committee accepted that the trial showed the efficacy of cetuximab plus platinum-based chemotherapy in patients with recurrent or metastatic SCCHN, but it was not persuaded that the evidence supported using the subgroup estimate for clinical effectiveness in the economic model.

4.4 The committee reviewed the additional cost-effectiveness analyses submitted by the company for additional subgroups based on age (younger than 65 years) and KPS (KPS of 90 or more and KPS of 80 or more). The committee was aware that the pre-planned subgroup analyses in the clinical study presented results for patients with a KPS of 80 or more (rather than 90 or more) and for patients who were younger than 65 years, but subgroups combining age and KPS were not included. The committee noted the concerns raised by the ERG about the validity of the modelled overall survival gains for the additional subgroup and whether the number of patients included was sufficient to provide robust evidence of efficacy. The committee was therefore not persuaded that the evidence provided by the company supported the predicted life years gained for the combined age and KPS subgroup. On this basis, the committee concluded that the estimates of cost effectiveness for the subgroup of

patients who were younger than 65 years with a KPS of 90 or more could not be considered reliable.

4.5 The committee discussed the adverse effects of cetuximab treatment. The committee noted that the incidence of severe adverse events in the cetuximab plus platinum-based chemotherapy group and the platinum-based chemotherapy only group were generally similar with the exception of acne and acneiform dermatitis, which were reported only for the cetuximab plus platinum-based chemotherapy group. The clinical experts and a patient expert advised the committee that the adverse events reported for the trial were consistent with those seen in clinical practice when cetuximab had been used for locally advanced SCCHN and colorectal cancer.

Cost effectiveness (NICE technology appraisal guidance 172)

4.6 The committee discussed the cost effectiveness of cetuximab plus platinum-based chemotherapy compared with platinum-based chemotherapy alone. The committee was aware that the incremental cost-effectiveness ratios (ICERs) presented by the company for the base-case and pre-planned subgroup analyses were substantially higher than those normally considered to be an acceptable use of NHS resources. In addition, the committee noted the concerns raised by the ERG about extrapolation of the trial results to estimate survival in the economic model, and the uncertainty about the number of patients available for analysis in each of the pre-planned subgroups. The committee noted the exploratory analyses done by the ERG using alternative assumptions and parameters in the economic model. The committee concluded that there remained considerable uncertainty around the results of the company's analyses, and that it was plausible that the true cost-effectiveness estimate for cetuximab plus platinum-based chemotherapy would be even higher than that presented by the company.

End-of-life considerations (NICE technology appraisal guidance 172)

4.7 The committee considered supplementary advice from NICE that should be taken into account when appraising treatments that may extend the life of patients with a short life expectancy, and that are licensed for indications that affect small numbers of people with incurable illnesses. For this advice to be applied, all the following criteria must be met:

- The treatment is indicated for patients with a short life expectancy, normally less than 24 months.
- There is sufficient evidence to indicate that the treatment offers an extension to life, normally of at least an additional 3 months, compared with current NHS treatment.
- No alternative treatment with comparable benefits is available through the NHS.
- The treatment is licensed or otherwise indicated for small patient populations.

In addition, when taking these criteria into account, the committee must be persuaded that the estimates of the extension to life are robust and that the assumptions used in the reference case economic modelling are plausible, objective and robust.

4.8 The committee discussed whether cetuximab, in combination with platinum-based chemotherapy for the treatment of recurrent or metastatic SCCHN, fulfilled the criteria for consideration as a life-extending, end-of-life treatment. The committee considered the criteria only in relation to the estimate of overall survival for the cohort population because it did not consider the subgroup data to be robust (see sections 4.3 and 4.4). The committee noted from the EXTREME trial that life expectancy for patients treated with chemotherapy alone was unlikely to be more than 24 months and could be as low as 7 months. The committee observed that the trial data suggested that cetuximab plus platinum-based chemotherapy

extended median survival by 2.7 months compared with platinum-based chemotherapy alone. The committee was concerned about the uncertainty associated with this estimate because of the wide confidence interval. It was also aware that the predicted life years gained from the economic modelling for this group was 0.187, reflecting a gain in overall survival of approximately 2.2 months. The committee therefore did not consider that this estimate of gain in overall survival was in keeping with the criteria relating to extension of life or that the addition of cetuximab represented a marked change from current treatment for SCCHN.

4.9 The committee also understood that an estimated 3000 people in England and Wales are diagnosed with recurrent or metastatic SCCHN every year. However, based on the evidence from clinical experts, cetuximab plus platinum-based chemotherapy would be appropriate for only a small proportion of these patients (that is, those whose disease was unsuitable for local treatment and who were well enough to have platinum-based chemotherapy). However, the committee understood that it should take into account the cumulative population for each product in considering the strength of any case, for justifying decisions which employ, in whole or part, the supplementary criteria for appraising life-extending, end-of-life treatments. It noted that cetuximab was licensed for a number of other indications involving much larger patient groups.

4.10 In summary, the committee was not persuaded that the use of cetuximab plus platinum-based chemotherapy fulfilled all the criteria to be considered as a life-extending, end-of-life treatment. The committee came to this conclusion taking into account the importance of supporting the development of innovative treatments licensed for small groups of patients who have an incurable illness.

4.11 The committee concluded that cetuximab, given in combination with platinum-based chemotherapy for the treatment of recurrent or metastatic SCCHN, could not be recommended as a cost-effective use of NHS

resources. The committee noted that some people may be currently having cetuximab in combination with platinum-based chemotherapy for this indication, and recommended that these people should have the option to continue treatment until they and their clinician consider it appropriate to stop.

Cancer Drugs Fund reconsideration

4.12 This appraisal was a Cancer Drugs Fund reconsideration of NICE's technology appraisal guidance on cetuximab for the treatment of recurrent and/or metastatic squamous cell cancer of the head and neck. The committee considered the company's submission for the Cancer Drugs Fund reconsideration:

- It included only the oral cavity cancer subgroup.
- It included a revised patient access scheme that provides a simple discount to the list price of cetuximab.
- It addressed some of the committee's preferred assumptions (see section 4.6).

The committee also considered the ERG's critique of the company's reconsideration submission and the ERG's exploratory analyses.

Cetuximab in the clinical management of head and neck cancer

4.13 The committee heard from the clinical experts that the EXTREME trial population represented patients who would be offered cetuximab plus platinum-based chemotherapy in the UK. The clinical experts also noted that the comparator used in the trial is the standard of care in the UK, although the clinical effectiveness of cisplatin plus fluorouracil was not studied in clinical trials before being introduced into clinical practice. The clinical experts stated that cetuximab is used according to the protocol described in the EXTREME trial in their clinics, and that they have seen similar outcomes to the trial. However, they noted that they were aware of

other clinicians using different dosing protocols in the UK. The committee was satisfied that the results of the EXTREME trial remained generalisable to current clinical practice in the UK.

Subgroup analysis

4.14 The committee noted that the company had based its submission on a subgroup of patients with cancer of the oral cavity. It also noted that, in its earlier deliberations, it had not been persuaded that the estimate from the subgroup was sufficiently reliable for use in the economic model. The company argued that, in the EXTREME trial, these patients had a poorer prognosis and gained greater benefit from cetuximab than the overall population of the trial. It noted that, in the trial, cetuximab increased median overall survival by 6.6 months in patients with tumours of the oral cavity compared with an increase of 2.7 months in the whole population of the trial. The results for progression-free survival were also better in the oral cavity cancer subgroup than in the whole trial population (3.3 months compared with 2.3 months). However, the committee noted that the subgroup was small (n=88) compared with the whole trial population (n=442), adding to the uncertainty inherent when considering estimates of effectiveness based on subgroup data. The clinical experts at the meeting confirmed that, in the EXTREME trial, patients with tumours in the oral cavity had a poorer prognosis than people with tumours in other locations. They also confirmed that, before the EXTREME trial, no other treatments had been shown to be of benefit in clinical trials in this patient group. This suggested an unmet need in this patient group, who were often older and had co-morbidities. However, the experts were not aware of a biological mechanism that could explain why cetuximab would differ in its relative effects between different tumour types. The committee concluded that it was possible that cetuximab might have greater benefits in oral cavity tumours. However, the evidence in support of this was limited, and consequently the estimate of effectiveness based on the subgroup data was uncertain.

Estimating mean progression-free and overall survival from the EXTREME trial

4.15 The committee considered the economic model that the company had submitted and the critique provided by the ERG. The committee noted that the ERG had taken a different approach to estimating mean progression-free survival and overall survival. It noted that the ERG's approach to modelling progression-free survival reduced the ICER relative to the company's base case, while the approach to modelling overall survival increased the ICER to a similar degree. The ERG noted that the difference between overall survival and progression-free survival estimates in the models implied that between 36% and 40% of the overall survival benefit occurred after disease progression. The ERG thought it unusual that such a large survival gain should be seen after the disease had progressed and treatment had been stopped. The clinical experts considered that this might be plausible because of potential immune effects attributed to cetuximab and a lower disease burden because of tumour response. The committee noted that the company had calibrated its model against 5-year follow-up data that became available after publication of NICE's technology appraisal guidance on cetuximab for the treatment of recurrent and/or metastatic squamous cell cancer of the head and neck. The committee heard from the company that the model did not overestimate overall survival gain for the whole trial population, but that it had not checked for this in the oral cavity cancer subgroup. In the absence of long-term follow-up data for the oral cavity cancer subgroup, the committee noted that the company's and ERG's estimates of the net effect on the modelled advantage for cetuximab were comparable. It found no reason to prefer 1 method over the other.

Choice of utility values

4.16 The committee noted that the company had estimated utility based on the quality-of-life data collected in the trial but that the questionnaire used did

not include a measure of adverse events. The data were subsequently converted to utilities using an algorithm. Based on this, the company used different estimates of utility for the same health states in each of the 2 treatment arms. The ERG commented that the quality-of-life data were not specific to the oral cavity cancer subgroup and that the evidence was insufficiently robust to support treatment-specific utility values. When the ERG used a common utility value for both treatment arms, the ICER increased. The committee concluded that the pre-progression utility value used by the company may have resulted in an ICER for cetuximab that was too favourable.

Drug acquisition costs

4.17 The committee considered the drug acquisition costs that had been included in the company model. It noted that the ERG had re-estimated the drug doses based on the mean value and the distribution seen in body surface area (BSA) of people with head and neck cancer in the UK. It had also applied an adjustment for gender ratio based on the EXTREME trial and 2 observational sources. This adjustment resulted in a higher ICER compared with the company's base-case ICER; BSA had a greater influence than gender on the ICER. The ERG preferred either the gender ratio from the EXTREME trial or from an audit of patients with head and neck cancer having chemotherapy at 3 UK cancer centres. However, there were limited differences between the ICERs calculated using the different gender ratios. The committee concluded that using both the mean and distribution of BSA, and accounting for gender mix in the model, provided a better estimate of the costs of treatment for patients in the NHS.

4.18 The committee noted that the company model included an adjustment to correct for differences in the predicted and actual numbers of vials of cetuximab used in the EXTREME trial. The adjustment assumed that a fixed number of vials are used per dose. The ERG noted that an

adjustment may be necessary to account for doses being missed, delayed or reduced either temporarily or permanently. However, the method used by the company was not transparent and in the absence of patient-specific data it had not been possible to validate the approach it had taken. Disabling the adjustment assumed that patients have 100% of the doses they are prescribed and that treatment is continued until progression. This resulted in a significant increase in the ICER. The committee noted that it was unlikely that no doses would be missed or delayed. The clinical experts present at the meeting agreed that patients frequently miss weekly doses for various reasons. The committee concluded that the ICER obtained by disabling the adjustment was too high but an adjustment was needed to account for missed doses. It also concluded that the method used by the company was unconventional, and that it was unclear to the committee how well it reflected the use of vials in clinical practice.

Probabilistic sensitivity analysis

4.19 The committee noted that the probabilistic sensitivity analysis included some simulations in which cetuximab was associated with fewer QALYs that the comparator (that is, values reflecting a worse outcome with cetuximab compared with platinum-based chemotherapy alone). The committee questioned the face validity of this given that the upper limit of the 95% confidence interval of the hazard ratios for both progression or death, or death, were below 1. However as a matter of principle, the committee would have preferred to see probabilistic rather than deterministic estimates of the ICERs.

End-of-life considerations

4.20 The committee considered the advice about life-extending treatments for people with a short life expectancy in NICE's final Cancer Drugs Fund technology appraisal process and methods. The committee noted that, in the EXTREME trial, the median survival was 4.4 months for people with

oral cavity cancer randomised to platinum-based chemotherapy alone and was 11.0 months for those randomised to cetuximab plus platinum-based chemotherapy. The committee noted that evidence from the trial suggested that cetuximab plus platinum-based chemotherapy increased median survival by 6.6 months for the oral cavity cancer subgroup, compared with 2.7 months for whole population of the EXTREME trial. However, given the small number of people with oral cavity cancer included in the EXTREME trial, it regarded the extended survival seen in this subgroup as unconfirmed. The committee concluded that the enhanced survival seen with cetuximab in the oral cavity subgroup may be closer to the enhanced survival seen in the whole population in the trial. This would make it less likely that cetuximab met the criteria for being a life-extending, end-of-life treatment for oral cavity cancer.

Conclusions

4.21 The committee discussed the most plausible ICER for cetuximab plus platinum-based chemotherapy compared with platinum-based chemotherapy alone. To protect the level of discount, the ICERs including the patient access scheme were considered commercial in confidence and cannot be presented here. The committee went on to discuss the range of cost-effectiveness estimates. It highlighted that:

- There remained considerable uncertainty about the robustness of the evidence for clinical effectiveness of cetuximab to treat oral cavity cancer, in particular because of:
  - the small group size in the EXTREME trial (see section 4.14) and
  - the lack of a biological explanation as to why these patients had greater benefit from cetuximab than the wider population in the trial (see section 4.14).
- There was some uncertainty about the pre-progression utility value used in the company model, which may have caused an underestimation of the ICERs (see section 4.16).

- It preferred drug costs to be estimated using the mean and distribution of BSA values from the UK audit study, with adjustment for the ratio of genders (see section 4.17).
- There was considerable uncertainty about the dose intensity adjustment and the effect this had on the ICERs. The committee preferred the company to include data on the average dose administered in the economic model (see section 4.18).

In the absence of statistical confirmation, the committee agreed that the most plausible ICER should not be based on the assumption that the outcomes in the oral cavity cancer subgroup were necessarily different from the outcomes seen in whole population of the EXTREME trial. The committee concluded that a more reasonable assumption was that the ICER for the oral cavity subgroup was closer to the ICER estimated for the whole population of this trial. It agreed that the most plausible ICER should be based on the ERG's exploratory analyses using drug acquisition costs based on the mean BSA and distribution of BSA from the UK audit data corrected for the proportion of men and women. The committee also agreed that average dose data should be used rather than the vial reconciliation adjustment used in the company's model. It also preferred probabilistic rather than deterministic estimates of the ICERs. Taking into account the robustness of the clinical- and cost-effectiveness evidence for cetuximab in patients with oral cavity cancer, including the discount in the revised patient access scheme, the committee considered that cetuximab plus platinum-based chemotherapy did not have plausible potential to be cost effective. Therefore, the committee could not recommend cetuximab for routine commissioning in the NHS.

Summary of appraisal committee's key conclusions

TAXXX	Appraisal title: Cetuximab for treating recurrent or metastatic squamous cell	Section

	cancer of the head and neck	
Key conclusion: Cancer Drugs Fund reconsideration		
Cetuximab in combination with platinum-based chemotherapy is not recommended within its marking authorisation for treating recurrent or metastatic squamous cell cancer of the head and neck in adults.		1.1
The committee discussed the most plausible incremental cost-effectiveness ratio (ICER) for cetuximab plus platinum-based chemotherapy compared with platinum-based chemotherapy alone. To protect the level of discount, the ICERs including the patient access scheme were considered commercial in confidence and cannot be presented here. Taking into account the robustness of the clinical- and cost-effectiveness evidence for cetuximab in patients with oral cavity cancer, including the discount in the revised patient access scheme, the committee considered that cetuximab plus platinum-based chemotherapy did not have plausible potential to be cost effective. Therefore, the committee could not recommend cetuximab for routine commissioning in the NHS.		4.21

5 Proposed date for review of guidance

5.1 NICE proposes that the guidance on this technology is considered for review by the guidance executive 3 years after publication of the guidance. NICE welcomes comment on this proposed date. The guidance executive will decide whether the technology should be reviewed based on information gathered by NICE, and in consultation with consultees and commentators.

David Barnett

Chair, TA172 appraisal committee, April 2009

Andrew Stevens
Chair, Cancer Drugs Fund reconsideration of TA172 appraisal committee
September 2016

6 Appraisal committee members and NICE project team

Appraisal committee members

The technology appraisal committees are standing advisory committees of NICE. This topic was considered by members of the existing standing committees who have met to reconsider drugs funded by the Cancer Drugs Fund. The names of the members who attended are in the minutes of the appraisal committee meeting, which are posted on the NICE website.

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

NICE project team

Each technology appraisal is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the appraisal), a technical adviser and a project manager.

TA172

Nicola Hay
Technical Lead

Janet Robertson
Technical Adviser

Jeremy Powell
Project Manager

Cancer Drugs Fund reconsideration of TA172

Janet Robertson

Associate Director

Helen Powell

Technical Lead

Jenna Dilkes

Project Manager

ISBN: [to be added at publication]