NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

MULTIPLE TECHNOLOGY APPRAISAL

Immunosuppressive therapy for kidney transplantation in children and adolescents (review of technology appraisal guidance 99) [ID346]

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:
   - Astellas
   - Novartis
   - British Kidney Patient Association (BKPA)
   - British Association for Paediatric Nephrology (BAPN)
   - The Efficacy and Safety of PRescribing In Transplantation (ESPRIT) Group

A 'no comment' response was received from NHS England. There were no responses to the consultation from the clinical or patient experts and none received through the NICE website.

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

Multiple Technology Appraisal

Immunosuppressive therapy for kidney transplant in children and young people (review of technology appraisal guidance 99)

Response to consultee, commentator and public comments on the Appraisal Consultation Document 2 (post-appeal)

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
Astellas Pharma Ltd	Thank you for the opportunity to comment on the above Appraisal Consultation Document (ACD). We have provided our main responses below under the specific ACD consultations questions. **Has all of the relevant evidence been taken into account?** Given the scope of the appraisal and the methodology used, we consider that no additional evidence has been published relevant to recommendation 1.1 since the response to the ACD in August 2015. Studies are expected to report over the next 12 months, but are not available for the timeline of this appraisal. **Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?** Given the limitations of the evidence base and the inclusion criteria of the systematic review, we consider that the summaries of clinical and cost-effectiveness are reasonable. **Are the recommendations sound and a suitable basis for guidance to the NHS?** While we consider the revised recommendations are largely a sound and suitable basis for guidance to the NHS, in order ensure complete guidance is given we recommend the inclusion of the following additional underlined text to recommendation 1.5 1.5 The committee was unable to make recommendations on any of the technologies considered in this appraisal as options for preventing organ rejection in adults who are, or become, unable to have the technologies recommended in sections 1.1 to 1.3 or the standard triple therapy regimen of ciclosporin, azathioprine and a corticosteroid (for example, because of contraindications, or intolerance such as nephrotoxicity associated with calcineurin inhibitors, or thrombotic microangiopathy). This includes adults who: □ are unable to continue having their initial therapy and need to switch to another therapy during the life of their graft or	Comment noted. Comment noted. Comment noted. The committee understood that the choice between immunosuppressive therapies is influenced by a number factors, including the characteristics and preferences of the person having the treatment and the side effect profiles of the drugs. It also recognised that it is important for clinicians to have access to a choice of treatment options to meet the needs of different people. See paragraph 4.1 of the FAD. No change to the FAD.

Consultee	Comment [sic]	Response
	□ have a second or subsequent transplant, having previously found that 1 or more of the recommended initial treatments or standard treatments are clinically unsuitable for example, because of contraindications or intolerance. The precise choice of treatment in these patients should be based on clinical judgement taking into account the needs and preferences of the patient **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?** We are not aware of any aspects of the recommendations that need consideration with respect to discrimination. **Are there any outstanding clinical and commissioning issues that arise during immunosuppressive therapy for kidney transplant for which further guidance is needed? Is there sufficient evidence available that could support the development of additional technology appraisal recommendations to address these issues? Would additional NICE technology appraisal guidance add value, or would other routes be more appropriate to eliminate these issues, such as other NICE programmes or NHS England commissioning policies?** Given the reliance on evidence from randomized controlled clinical trials as the basis for guidance to the NHS, we do not consider that there would be value in further work by NICE to develop additional technical appraisal recommendations for immunosuppression in adult renal transplant patients. We consider that an NHS commissioning policy would be a more appropriate route to provide additional guidance to the NHS. This may be assisted by the recent publication of COMMIT guidelines that provide specific practical recommendations for the management of modifiable risks in those kidney transplant patients who have survived the first post-operative year. (ref Neuberger et al 2017 – available here http://journals.lww.com/transplantjournal/pages/articleviewer.aspx?year=2017&issue=04002&article=00001&type=abstract, last accessed 8 May 2017)	Comment noted. Comment noted.
Novartis Pharmaceuticals UK Ltd	Thank you for the opportunity to comment on the second Appraisal Consultation Documents for these appraisals. We welcome the committee's clarification, within both documents, that the recommendations relate solely to initial immunosuppressive therapy, and that no recommendations were possible in patients for whom the recommended therapies are clinically unsuitable. We propose that treatment failure be added to the examples of situations in which the recommended therapies may be clinically unsuitable. Suggested additional text for paragraph 1.5 in both documents is highlighted below;	Comment noted. The committee recognised that treatment failure is an additional situation in which the

Consultee	Comment [sic]	Response
	• "The committee was unable to make recommendations on any of the technologies considered in this appraisal as options for preventing organ rejection in adults [children or young people] who are, or become, unable to have the technologies recommended in sections 1.1 to 1.3 or the standard triple therapy regimen of ciclosporin, azathioprine and a corticosteroid (for example, because of ***treatment failure,*** contraindications, or intolerance such as nephrotoxicity associated with calcineurin inhibitors, or thrombotic microangiopathy). This includes adults [children or young people] who: o are unable to continue having their initial therapy and need to switch to another therapy during the life of their graft or o have a second or subsequent transplant, having previously found that 1 or more of the recommended initial treatments or standard treatments are clinically unsuitable for example, because of ***failure,*** contraindications or intolerance." Other minor text clarifications we suggest are as follows: 1. At paragraph 4.17 of the latest ACD for ID346 the second sentence refers to Adoport, whereas the third sentence does not. We suggest the third sentence be changed to: "The committee concluded that its preferred analysis used eMIT prices when available and the prices agreed with the Commercial Medicines Unit for Modigraf, Advagraf ***and Adoport***." The same sentence occurs towards the bottom of page 17 of the latest ACD for ID456, and we suggest the same amendment to that document. 2. At parapgraph 4.7 of the latest ACD for ID456 there is some duplicate text; "of that of that", which we suggest is removed so that the third sentence reads "The model was independent of that built for NICE's technology appraisal guidance on immunosuppressive therapy for renal transplantation in adults."	recommended therapies may be clinically unsuitable. Paragraph 1.5 of the recommendations has been amended to include treatment failure in addition to contraindications and intolerance. Comment noted. Paragraph 4.17 of the FAD has been amended to include 'Adoport'. Comment noted. This does not apply to the ACD for ID346. No change to the FAD.
British Association for Paediatric Nephrology	Thank you for inviting the British Association for Paediatric Nephrology to comment on the above appraisal consultation document. Please forgive the late submission of this response, as a result of last week's 'cyber attack' on NHS IT systems that has paralysed much communication. The comments that I have received are as followed: 1. We are pleased to note that recommendation 1.5 now suggests that clinical judgement should be applied where children and young people are unable to continue having their initial therapy and need to switch to another therapy during the life of their graft or have a second or subsequent transplant, having previously found that 1 or more of the recommended initial treatments or standard treatments are clinically unsuitable, for example because of contraindications or intolerance. 2. We note for recommendation 1.5, that the committee was unable to make recommendations for the standard triple therapy regimen of ciclosporin, azathioprine and a corticosteroid. However, since no UK paediatric transplant unit uses ciclosporin as standard therapy, we request that this is changed	Comment noted. Comment noted. Paragraph 1.5 has been amended for clarity.

Consultee	Comment [sic]	Response
	to reflect the current 'standard therapy, namely: tacrolimus, azathioprine and a corticosteroid'. It would also be helpful if NICE would state more clearly in the recommendation that this 'standard' approach is acceptable within the context of the recommendations, since the evidence in the reported literature does not confirm improved outcomes in children and young people receiving basiliximab and MMF over those receiving tacrolimus, azathioprine and a corticosteroid in terms of patient and graft survival 3. We should like to seek clarification on the use of immunosuppression, including rATG in patients (highly) sensitised for reasons other than previous transplantation	Comment noted. The committee considered that there was not enough evidence to support recommendations in specific subgroups such as children and young people with different levels of immunological risk (paragraph 4.3). No change to FAD.
British Kidney Patient Association	The British Kidney Patient Association (BKPA) is a national charity which works to improve quality of life for kidney patients through advocacy, direct grants, educating and informing patients, counselling and funding patient-centred research, healthcare professionals and projects. The BKPA was extremely concerned about the previously proposed multiple technology appraisal on immunosuppressant therapies, which recommended that just 3 drugs (basiliximab, immediate-release tacrolimus and mycophenolate mofetil) should be used to prevent rejection of a kidney transplant. The appraisal did not take account the impact of the recommendations on patients who may be unable to tolerate the recommended drugs, thereby making up to 20% of transplants likely to fail. It also had the potential to affect second or subsequent transplants when access to the range of drugs might be even more important if problems had developed with the three drugs. We note that the revised recommendations in 1.5 go some way to recognising this issue:	Comment noted.

Consultee	Comment [sic]	Response
	1.5 The committee was unable to make recommendations on any of the technologies considered in this appraisal as options for preventing organ rejection in adults who are, or become, unable to have the technologies recommended in sections 1.1 to 1.3 or the standard triple therapy regimen of ciclosporin, azathioprine and a corticosteroid (for example, because of contraindications, or intolerance such as nephrotoxicity associated with calcineurin inhibitors, or thrombotic microangiopathy). This includes adults who: • are unable to continue having their initial therapy and need to switch to another therapy during the life of their graft or • have a second or subsequent transplant, having previously found that 1 or more of the recommended initial treatments or standard treatments are clinically unsuitable for example, because of contraindications or intolerance.	
	We would like to thank the patient experts from our patient advisory group who attended the recent committee meeting. We hope that this revised guidance will allow sufficient flexibility for prescribing of currently commissioned immunosuppression agents (listed in 1.4) where clinical indications exist; we are encouraged that NICE accepted the points we made in our submissions to the appeal meeting in April 2016.	Comment noted.
	We note the reference to 'haemodialysis' three times on page 25 in the revised consultation document and request that this is amended to state '**dialysis**' as patients may choose to go onto either haemo or peritoneal dialysis and have the right to chose the therapy which suits them. The revised consultation makes it clear that both clinical and patient experts believe that a successful transplant offers the opportunity for an improved quality of life. We believe that the conclusions could be clearer on the costs in quality of life and side effects as well as costs to the system of the patient returning to dialysis if a transplant fails (dialysis is estimated at £30,800 pa not including transport costs, certain drugs, and the cost to carers	Comment noted. Text changed from 'haemodialysis' to 'dialysis'. The committee was aware that returning to dialysis if a transplant fails can have a significant effect on quality of life as well as

Consultee	Comment [sic]	Response
	http://www.england.nhs.uk/wp-content/uploads/2014/04/a07-renal-transpl-ad-0414.pdf and the costs of a failed transplant at £17,000).	incurring costs to the NHS. See paragraph 4.25 of the FAD.
ESPRIT	As an independent group, the ESPRIT Group (www.esprit.org.uk) does not advocate any particular product and our opinions, recommendations and activities are all our own. As such we could not contribute to NICE's assessment of the *comparative* efficacy and cost-effectiveness of individual immunosuppressants included in the MTA. However, where the efficacy and safety of treatment of transplant patients is potentially threatened, we feel it of vital importance to highlight our concerns and the principles underlying them. This underpinned all the various arguments which we presented as part of the Appeal process following the last FAD. Overall we were pleased with the provisions of this ACD and consider the latest recommendations to be sound and a suitable basis for guidance to the NHS. In particular we welcome: • That the recommendations clearly only apply to the initial period of immunosuppression after transplantation • It is reasonable that NICE is 'unable to make recommendations' for patients who are, or become, unable to have the recommended initial agents or the standard triple therapy regimen of ciclosporin, azathioprine and a corticosteroid. This reflects the importance of maintaining flexibility for experienced transplant professionals to provide tailored immunosuppression in line with the varying needs of individual transplant patients • That it clearly states the recommendations are not intended to affect treatment with any technologies started in the NHS before the guidance is published - i.e. does not affect patients who are already being managed on clinically-tailored regimens - and clearly states that funding for these patient treatments should continue We are in agreement with the proposal that the guidance gets reviewed again in three years.	Comment noted. Comment noted Comment noted.

Comments received from clinical specialists and patient experts

None

Comments received from commentators

None

Comments received from members of the public

None

Astellas Pharma Limited Response – 20 May 2017

NICE Appraisal Consultation Document - Immunosuppressive therapy for kidney transplant in children and young adults(review of technology appraisal guidance 99)

Thank you for the opportunity to comment on the above Appraisal Consultation Document (ACD). We have provided our main responses below under the specific ACD consultations questions.

Has all of the relevant evidence been taken into account?

Given the scope of the appraisal and the methodology used, we consider that no additional evidence has been published relevant to recommendation 1.1 since the response to the ACD in August 2015. . Studies are expected to report over the next 12 months, but are not available for the timeline of this appraisal.

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

Given the limitations of the evidence base, we consider that the summaries of clinical and cost-effectiveness are reasonable.

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

While we consider the revised recommendations are largely a sound and suitable basis for guidance to the NHS, in order ensure complete guidance is given we recommend the inclusion of the following additional underlined text to recommendation 1.5

> 1.5 The committee was unable to make recommendations on any of the technologies considered in this appraisal as options for preventing organ rejection in children or young people who are, or become, unable to have the technologies recommended in sections 1.1 to 1.3 or the standard triple therapy regimen of ciclosporin, azathioprine and a corticosteroid (for example, because of contraindications, or intolerance such as nephrotoxicity associated with calcineurin inhibitors, or thrombotic microangiopathy). This includes children and young people who:
>
> - are unable to continue having their initial therapy and need to switch to another therapy during the life of their graft or
> - have a second or subsequent transplant, having previously found that 1 or more of the recommended initial treatments or standard treatments are clinically unsuitable, for example because of contraindications or intolerance.

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Registered Office as above

We would suggest including the wording below:

<u>The precise choice of treatment in these patients should be based on clinical judgement taking into account the needs and preferences of the patient</u>

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?

We are not aware of any aspects of the recommendations that need consideration with respect to discrimination.

Are there any outstanding clinical and commissioning issues that arise during immunosuppressive therapy for kidney transplant for which further guidance is needed? Is there sufficient evidence available that could support the development of additional technology appraisal recommendations to address these issues? Would additional NICE technology appraisal guidance add value, or would other routes be more appropriate to eliminate these issues, such as other NICE programmes or NHS England commissioning policies?

Given the reliance on evidence from randomized controlled clinical trials as the basis for guidance to the NHS, we do not consider that there would be additional value in further work by NICE to develop additional technical appraisal recommendations for immunosuppression in renal transplant patients.

We consider that an NHS commissioning policy would be a more appropriate route to provide additional guidance to the NHS. This may be assisted by the recent publication of COMMIT guidelines that provide specific practical recommendations for the management of modifiable risks in those kidney transplant patients who have survived the first post-operative year. (ref Neuberger et al 2017 – available here http://journals.lww.com/transplantjournal/pages/articleviewer.aspx?year=2017&issue=04002&article=00001&type=abstract, last accessed 8 May 2017).

Regards,

[redacted]

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Mr M Boysen
Programme Director, Centre for Health Technology Evaluation
National Institute for Health and Care Excellence
Level 1A, City Tower, Piccadilly Plaza
Manchester
M1 4BT

22nd May 2017

Dear Mr Boysen,

Re: Novartis response to the second Appraisal Consultation Document for ID346 & ID 456

Thank you for the opportunity to comment on the second Appraisal Consultation Documents for these appraisals. We welcome the committee's clarification, within both documents, that the recommendations relate solely to initial immunosuppressive therapy, and that no recommendations were possible in patients for whom the recommended therapies are clinically unsuitable.

We propose that treatment failure be added to the examples of situations in which the recommended therapies may be clinically unsuitable. Suggested additional text for paragraph 1.5 in both documents is highlighted below;

- "The committee was unable to make recommendations on any of the technologies considered in this appraisal as options for preventing organ rejection in adults [children or young people] who are, or become, unable to have the technologies recommended in sections 1.1 to 1.3 or the standard triple therapy regimen of ciclosporin, azathioprine and a corticosteroid (for example, because of ***treatment failure,*** contraindications, or intolerance such as nephrotoxicity associated with calcineurin inhibitors, or thrombotic microangiopathy). This includes adults [children or young people] who:
    - are unable to continue having their initial therapy and need to switch to another therapy during the life of their graft or
    - have a second or subsequent transplant, having previously found that 1 or more of the recommended initial treatments or standard treatments are clinically unsuitable for example, because of ***failure,*** contraindications or intolerance."

Other minor text clarifications we suggest are as follows:

1. At paragraph 4.17 of the latest ACD for ID346 the second sentence refers to Adoport, whereas the third sentence does not. We suggest the third sentence be changed to: "The committee concluded that its preferred analysis used eMIT prices when

available and the prices agreed with the Commercial Medicines Unit for Modigraf, Advagraf ***and Adoport***." The same sentence occurs towards the bottom of page 17 of the latest ACD for ID456, and we suggest the same amendment to that document.

2. At parapgraph 4.7 of the latest ACD for ID456 there is some duplicate text; "of that of that", which we suggest is removed so that the third sentence reads "The model was independent of that built for NICE's technology appraisal guidance on immunosuppressive therapy for renal transplantation in adults."

I hope that these comments are helpful.

Yours sincerely,

[redacted]

British Kidney Patient Association
[redacted]

21st May 2017

Response to NICE TA99 ACD on use of immunosuppressive therapy for children and young people

The British Kidney Patient Association (BKPA) is a national charity which works to improve quality of life for kidney patients through advocacy, direct grants, educating and informing patients, counselling and funding patient-centred research, healthcare professionals and projects.

The BKPA was extremely concerned about the previously proposed multiple technology appraisal on immunosuppressant therapies, which recommended that just 3 drugs (basiliximab, immediate-release tacrolimus and mycophenolate mofetil) should be used to prevent rejection of a kidney transplant.

The appraisal did not take account the impact of the recommendations on patients who may be unable to tolerate the recommended drugs, thereby making up to 20% of transplants likely to fail. It also had the potential to affect second or subsequent transplants when access to the range of drugs might be even more important if problems had developed with the three drugs.

We note that the revised recommendations in 1.5 go some way to recognising this issue:

1.5 The committee was unable to make recommendations on any of the technologies considered in this appraisal as options for preventing organ rejection in adults who are, or become, unable to have the technologies recommended in sections 1.1 to 1.3 or the standard triple therapy regimen of ciclosporin, azathioprine and a corticosteroid (for example, because of contraindications, or intolerance such as nephrotoxicity associated with calcineurin inhibitors, or thrombotic microangiopathy). This includes adults who:

- are unable to continue having their initial therapy and need to switch to another therapy during the life of their graft or
- have a second or subsequent transplant, having previously found that 1 or more of the recommended initial treatments or standard treatments are clinically unsuitable for example, because of contraindications or intolerance.

We would like to thank the patient experts from our patient advisory group who attended the recent committee meeting. We hope that this revised guidance will allow sufficient flexibility for prescribing of currently commissioned immunosuppression agents (listed in 1.4) where clinical indications exist; we are encouraged that NICE accepted the points we made in our submissions to the appeal meeting in April 2016.

We note the reference to 'haemodialysis' three times on page 25 in the revised consultation document and request that this is amended to state '**dialysis**' as patients may choose to go onto either haemo or peritoneal dialysis and have the right to chose the therapy which suits them. The revised consultation makes it clear that both clinical and patient experts believe that a successful transplant offers the opportunity for an improved quality of life. We believe that the conclusions could be clearer on the costs in quality of life and side effects as well as costs to the system of the patient returning to dialysis if a transplant fails (dialysis is estimated at £30,800 pa not including transport costs, certain drugs, and the cost to carers http://www.england.nhs.uk/wp-content/uploads/2014/04/a07-renal-transpl-ad-0414.pdf and the costs of a failed transplant at £17,000).

Yours sincerely

[redacted]
Tel: [redacted]

University Hospitals Bristol NHS
NHS Foundation Trust

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DEPARTMENT OF PAEDIATRIC NEPHROLOGY DR JAN DUDLEY MRCP, FRCPCH, PhD Secretary: LISA JEFFERIES
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Dear colleagues,

Re: **Multiple Technology Appraisal (MTA): Immunosuppressive therapy for kidney transplantation in children and adolescents (review of technology appraisal guidance 99) [ID346]**

Thank you for inviting the British Association for Paediatric Nephrology to comment on the above appraisal consultation document. Please forgive the late submission of this response, as a result of last week's 'cyber attack' on NHS IT systems that has paralysed much communication. The comments that I have received are as followed:

1. We are pleased to note that recommendation 1.5 now suggests that clinical judgement should be applied where children and young people are unable to continue having their initial therapy and need to switch to another therapy during the life of their graft or have a second or subsequent transplant, having previously found that 1 or more of the recommended initial treatments or standard treatments are clinically unsuitable, for example because of contraindications or intolerance.
2. We note for recommendation 1.5, that the committee was unable to make recommendations for the standard triple therapy regimen of ciclosporin, azathioprine and a corticosteroid. However, since no UK paediatric transplant unit uses ciclosporin as standard therapy, we request that this is changed to reflect the current 'standard therapy, namely: tacrolimus, azathioprine and a corticosteroid'. It would also be helpful if NICE would state more clearly in the recommendation that this 'standard' approach is acceptable within the context of the recommendations, since the evidence in the reported literature does not confirm improved outcomes in children and young people receiving basiliximab and MMF over those receiving tacrolimus, azathioprine and a corticosteroid in terms of patient and graft survival
3. We should like to seek clarification on the use of immunosuppression, including rATG in patients (highly) sensitised for reasons other than previous transplantation

Kind regards

[redacted], [redacted]
British Association for Paediatric Nephrology

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Multiple Technology Appraisal (MTA)

Immunosuppressive therapy for kidney transplantation in children and young people (review of technology appraisal guidance 99)

RESPONSE TO ACD

From: [redacted] on behalf of The Efficacy and Safety of PRescribing In Transplantation (ESPRIT) Group

As an independent group, the ESPRIT Group (www.esprit.org.uk) does not advocate any particular product and our opinions, recommendations and activities are all our own. As such we could not contribute to NICE's assessment of the *comparative* efficacy and cost-effectiveness of individual immunosuppressants included in the MTA. However, where the efficacy and safety of treatment of transplant patients is potentially threatened, we feel it of vital importance to highlight our concerns and the principles underlying them. This underpinned all the various arguments which we presented as part of the Appeal process following the last FAD.

Overall we were pleased with the provisions of this ACD and consider the latest recommendations to be sound and a suitable basis for guidance to the NHS. In particular we welcome:

- That the recommendations clearly only apply to the initial period of immunosuppression after transplantation
- It is reasonable that NICE is 'unable to make recommendations' for patients who are, or become, unable to have the recommended initial agents or the standard triple therapy regimen of ciclosporin, azathioprine and a corticosteroid. This reflects the importance of maintaining flexibility for experienced transplant professionals to provide tailored immunosuppression in line with the varying needs of individual transplant patients
- That it clearly states the recommendations are not intended to affect treatment with any technologies started in the NHS before the guidance is published - i.e. does not affect patients who are already being managed on clinically-tailored regimens - and clearly states that funding for these patient treatments should continue

We are in agreement with the proposal that the guidance gets reviewed again in three years.