National Institute for Health and Care Excellence

Single Technology Appraisal (STA)

Upadacitinib for treating active psoriatic arthritis after inadequate response to DMARDs

Response to consultee and commentator comments on the draft remit and draft scope (pre-referral)

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Comment 1: the draft remit

Section	Consultee/ Commentator	Comments [sic]	Action
Appropriateness	AbbVie	Yes, it is appropriate to refer this topic for appraisal.	Thank you for your comment. No changes to the scope are needed.
	MSD	MSD recognises the debilitating effect psoriatic arthritis has on patients however MSD believes that the submission "Upadacitinib for treating active psoriatic arthritis after inadequate response to DMARDs" should be revaluated as it does not seem to be in line with current NICE guidance. Currently NICE guidance recommends new technologies such as upadacitinib to be administered after at least 2 DMARDs. This submission states that patients will receive upadacitinib after at least 1 DMARDs.	Thank you for your comment. The population in the scope aligns with other scopes for treating active psoriatic arthritis after inadequate response to DMARDs and aligns with the population included in the clinical trial identified in this area. No changes to the scope are needed.

Section	Consultee/ Commentator	Comments [sic]	Action
	Novartis Pharmaceuticals UK	We consider the proposed appraisal appropriate.	Thank you for your comment. No changes to the scope are needed.
	Pfizer	Yes, it is an appropriate topic.	Thank you for your comment. No changes to the scope are needed.
	UCB Pharma	No comments	Comment noted.
	British Society for Rheumatology	This is an entirely appropriate topic for NICE consideration. Although there is already a JAK inhibitor TA for Tofacitinib, it is worthwhile evaluating whether there are any additional cost/treatment benefits, particularly as different JAK inhibitors may have differing therapeutic effects	Thank you for your comment. No changes to the scope are needed.
Wording	AbbVie	Yes, the wording of the remit is appropriate.	Thank you for your comment. No changes to the scope are needed.
	MSD	Upadacitinib for treating active psoriatic arthritis after inadequate response to AT LEAST 2 DMARDs	Thank you for your comment. The wording of the remit is kept broad. No changes to the scope are needed.
	Novartis Pharmaceuticals UK	No comment.	Comment noted.
	Pfizer	The wording of the remit is appropriate.	Thank you for your comment. No changes to the scope are needed.

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	UCB Pharma	No comments	Comment noted.
	British Society for Rheumatology	No suggested changes to the wording other than the grouping of 'JAK inhibitors' in the comparators group as described below.	Thank you for your comment. Further comments regarding the grouping of JAK inhibitors have been addressed below.
Timing Issues	AbbVie	It would be most appropriate for guidance to be produced for this appraisal as close to marketing authorisation as is possible within the NICE appraisal programme.	Thank you for your comment. NICE aims to provide draft guidance to the NHS within 6 months of the date when the marketing authorisation for a technology is granted. No changes to the scope are needed.
	Novartis Pharmaceuticals UK	No comment.	Comment noted.
	Pfizer	No comment.	Comment noted.
	UCB Pharma	No comments	Comment noted.

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	British Society for Rheumatology	There are now a number of different therapeutic options for patients with PsA, but inefficacy, side effects and contraindications do result in some patients having few if any options for treatment. Any new therapeutic agent (and I would see Upadacitinib as potentially quite different from Tofacitinib) can only be to the benefit of this patient group. Subsequent improvements in disease control would lead to likely reductions in pain physical disability and NHS services use.	Thank you for your comment. No changes to the scope are needed.
Additional comments on the draft remit	Novartis Pharmaceuticals UK	None.	Comment noted.
	Pfizer	No additional comments.	Comment noted.
	UCB Pharma	No comments	Comment noted.

Comment 2: the draft scope

Section	Consultee/ Commentator	Comments [sic]	Action
Background information	AbbVie	In the 4th paragraph discussing NICE recommended treatment options, apremilast is included with the TNF-a inhibitors, between golimumab and certolizumab pegol. We suggest that the different mechanisms of action be grouped together. All other wording in the background section is appropriate.	Thank you for your comment. The background section has been updated to group non-conventional DMARDs according to their mechanism of action.

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	Novartis Pharmaceuticals UK	No comment.	Comment noted.
	Pfizer	We suggest a revision of the second sentence of the last paragraph. "*NICE recommends adalimumab, etanercept, infliximab, golimumab, apremilast, certolizumab pegol, ixekizumab, secukinumab or tofacitinib when a person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints, and the psoriatic arthritis has not responded to at least 2 standard DMARDs, given on their own or together (NICE technology appraisal 199, 220, 433, 445, 537, and 543)."*	Thank you for your comment. The background section of the scope has been updated to group non-conventional DMARDs according to their mechanism of action. No further changes are needed.
	UCB Pharma	No comments	Comment noted.
	British Society for Rheumatology	A fair and reasonable background. The prevalence of PsA stated, may be on the lower side of some estimates, but is not unreasonable.	Thank you for your comment. No changes to the scope are needed.
The technology/ intervention	AbbVie	We request that the description of the technology be updated as follows to accurately represent the SmPC: 'Upadacitinib (Rinvoq, AbbVie) is a **selective and reversible** JAK inhibitor that blocks the JAK-signal transducer and activator of transcription (STAT) pathway and inflammatory responses. It is administered orally.'	Thank you for your comment. The technology section of the scope has been updated to include a description of upadacitinib as a selective and reversible Janus-kinase 1 inhibitor. The intervention has been updated to state 'upadacitinib, alone or in combination with non-biological disease modifying anti-rheumatic

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		AbbVie also request that the Intervention box be updated as follows: 'Upadacitinib alone or in combination with conventional disease modifying anti-rheumatic drugs (DMARDs)'	drugs' in line with other scopes for treating active psoriatic arthritis after inadequate response to DMARDs.
	MSD	MSD believes that NICE should collect more data on adults with active psoriatic arthritis whose disease has not responded adequately to at least 1 DMARD. NICE current guidance seems to focus on providing treatment for adults with psoriatic arthritis after failure on at least 2 DMARDs before similar interventions such as upadacitinib is used or after a standard TNF.	Thank you for your comment. If referred, the evaluation of this topic will be based on the evidence submitted to NICE. No changes to the scope are needed.
	Novartis Pharmaceuticals UK	No comment.	Comment noted.
	Pfizer	No comment.	Comment noted.
	UCB Pharma	No comments	Comment noted.
	British Society for Rheumatology	I'm not completely sure that Upadacitinib is a completely pure JAK1 inhibitor. I believe that it also inhibits JAK1/3 dimers.	Thank you for your comment. The technology section of the scope provides a brief background of the technology and additional detail is not necessary. No changes to the scope are needed.
Population	AbbVie	AbbVie request that this wording be updated to be consistent with the wording used in recent appraisals, as follows: '*Adults*	Thank you for your comment. The population in the scope has been

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		with active psoriatic arthritis whose disease has not responded adequately or who have been intolerant to a previous conventional DMARD therapy or biologic DMARD therapy or for whom DMARD therapy is contraindicated.'	updated to align with other scopes for treating active psoriatic arthritis after inadequate response to DMARDs. This includes 'adults with active psoriatic arthritis whose disease has not responded adequately to a previous DMARD therapy, or for whom DMARDs are not tolerated or contraindicated'.
	Novartis Pharmaceuticals UK	No comment.	Comment noted.
	Pfizer	No comment.	Comment noted.
	UCB Pharma	Regarding the 3rd population "For those whose disease has not responded adequately to conventional DMARDs and 1 or more TNF-alpha inhibitors, and have not had previous treatment with a JAK inhibitor", does this mean after 2 DMARDs?	Thank you for your comment. The 3rd population described under the comparator section of the PICO table is correct as this aligns with the population described in the population section of the PICO table (adults with active psoriatic arthritis whose disease has not responded adequately to a previous DMARD) and aligns with the population for whom the listed comparators are recommended by NICE (adults with active psoriatic arthritis whose disease has not responded adequately to 1 or more

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			TNF-alpha inhibitors). No changes to the scope are needed.
	British Society for Rheumatology	No additional comment	Comment noted.
Comparators	AbbVie	The addition of the 'have not had previous treatment with a JAK inhibitor' wording to the bDMARD-IR and TNFa inhibitor contraindicated populations is inappropriate, given that patients receiving a JAK inhibitor may benefit from switching to an alternative JAK inhibitor, due to lack of efficacy of the initial JAK inhibitor or intolerance to methotrexate, particularly given the limited oral advanced therapies available to-date. We therefore request that this wording is removed. In the ≥2 cDMARD-IR population, given that the bDMARDs are listed as with or without methotrexate, we request that a consistent approach is taken and extended to apremilast (with or without cDMARDs) and tofacitinib (with methotrexate) as well.	Thank you for your comment. The inclusion of people who have not had previous treatment with a JAK inhibitor in this comparator group has been updated and removed. It is not necessary to specify the combination drugs alongside each comparator. This is consistent with other scopes in this area. No changes to the scope are needed.
	Novartis Pharmaceuticals UK	We suggest that for patients "whose disease has not responded adequately to conventional DMARDs and 1 or more TNF-alpha inhibitors, and have not had previous treatment with a JAK inhibitor", the comparators should also include adalimumab, etanercept, infliximab and golimumab. Although these anti-TNFs are not explicitly recommended (TA199 and TA220) for patients with prior inadequate response	Thank you for your comment. The comparators listed align with NICE recommendations. The comparators stated here are recommended when there has been inadequate response to at least 2 DMARDs and therefore

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		to an anti-TNF, our understanding is that this was because the anti-TNF inadequate responder population had not emerged at the time of their NICE appraisals. We would expect that in current clinical practice the full range of anti-TNFs are considered as second line biologics. Additionally, we believe that guselkumab (IL-23 inhibitor) should also be considered a relevant comparator alongside other biological DMARDs, subject to the ongoing appraisal (ID1658).	have not been included as comparators for this population. As the appraisal for guselkumab is currently ongoing, it is inappropriate to include as a comparator. No changes to the scope are needed.
	Pfizer	No comment.	Comment noted.
	UCB Pharma	The draft scope mention biosimilars within economic analysis only and not in the comparators section. Could NICE provide some rationale behind this approach, please?	Thank you for your comment. Biosimilars are not listed in the comparator section of the scope. However, as noted in the economic section, biosimilars will be included in the economic analysis where appropriate.

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	British Society for Rheumatology	"For those whose disease has not responded adequately to conventional DMARDs and 1 or more TNF-alpha inhibitors, and have not had previous treatment with a JAK inhibitor" and "For people in whom TNF-alpha inhibitors are contraindicated or not tolerated, and have not had previous treatment with a JAK inhibitor" These descriptors are not entirely reflective of the existent NICE guidance as they add in 'not had previous treatment with a JAK inhibitor" – which is a therapeutic group that did not exist at the time many of the TAs where approved. The issue here is the lumping together of the 'JAK inhibitors' into a single group. JAK inhibitors inhibit various combinations of the x4 JAK molecules (JAK1, JAK2, JAK3, TYK2) Tofacitinib JAK1 + JAK3 Baricitinib JAK1 + JAK2 Upadacitininb JAK1 (+ JAK1/3) Filgotinib JAK1 These combinations appear to have quite markedly different impacts upon the autoimmune system in unexpected ways (i.e. baricitinib has yet to show benefit in PsA, filgotininb tends to reduce cholesterol rather than increase it as seen with the other 3 mentioned). I would suggest that it would be detrimental to 'lump' all JAK inhibitors together as a single group so early in our understanding of these molecules. This may inappropriately	Thank you for your comment. The inclusion of people who have not had previous treatment with a JAK inhibitor in these comparator groups have been updated and removed.

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		exclude the use of different JAK inhibitors, which are subsequently shown to have extremely different therapeutic benefit and adverse event profiles.	

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Outcomes	AbbVie	The outcomes are appropriate.	Thank you for your comment. No changes to the scope are needed.
	Novartis Pharmaceuticals UK	No comment.	Comment noted.
	Pfizer	Additional outcomes that should also be considered: - Pain - Sleep - Nail involvement	Thank you for your comment. The outcomes listed in the scope are key outcomes to be considered and may not list all outcomes which will be considered during the appraisal. The outcomes included align with other scopes for treating active psoriatic arthritis after inadequate response to DMARDs. No changes to the scope are needed.
	UCB Pharma	Regarding the disease progression outcome - is this inhibition of structural damage? if yes, how is it measured? Regarding axial outcomes, could NICE provide the rationale for inclusion, please? Assuming that the company will present the outcomes from PsA trials, how this axial outcome will be measured?	Thank you for your comment. Disease progression is a common outcome in this therapy area. The way in which the outcome should be measured is not usually specified in the scope. No changes to the scope are needed. Axial outcomes have been included as they were considered an outcome of interest for patients and clinicians and for consistency with previous scopes in this disease area. The way in which

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			the outcome should be measured is not usually specified in the scope.
	British Society for Rheumatology	Axial outcomes – see discussion on axial inclusion under 'other considerations'	Thank you for your comment. Please see response below.
Economic analysis	AbbVie	No comments.	Comment noted.
	MSD	MSD believes that if costs are considered from a personal social services perspective than this should be in line with previous submission. If this has not been considered in previous submission it should be made clear why this perspective is considered for future appraisals for psoriatic arthritics. MSD believes that another point that can/should be considered in this submission is if there is going to be a change in frequency of patient visits and drug administration in a post corona virus period. Patients who have psoriatic arthritis are considered to be at a high risk to be infected by the corona virus.	Thank you for your comment. The NICE Technology Appraisals methods guide, section 5.1.9 states that the reference case for a technology appraisal evaluation should be from the perspective of the NHS and Personal Social Services. This is also in line with other scopes for treating active psoriatic arthritis after inadequate response to DMARDs. The frequency of visits and drug administration will be considered during the appraisal, if the topic is referred. However, no changes to the scope are needed.

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	Novartis Pharmaceuticals UK	No comment.	Comment noted.
	Pfizer	No comment.	Comment noted.
	UCB Pharma	No comments	Comment noted.
	British Society for Rheumatology	No additional comment	Comment noted.
Equality and Diversity	AbbVie	No comments.	Comment noted.
	Novartis Pharmaceuticals UK	No comment.	Comment noted.
	Pfizer	No comment.	Comment noted.
	UCB Pharma	No comments	Comment noted.
	British Society for Rheumatology	No additional comment	Comment noted.

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Other considerations	AbbVie	In light of the ongoing COVID-19 situation, the availability of upadacitinib as a once-daily oral therapy may offer additional benefits by minimising time spent in hospital/clinic, with reduced monitoring requirements compared to currently available treatment options.	Thank you for your comment. The potential benefits of upadacitinib, including dose frequency and monitoring will be considered during the appraisal, if the topic is referred. However, no changes to the scope are needed.
	MSD	Further clinical opinion should be considered when addressing if upadacitinib should be administered after at least one or at least 2 failed DMARDs treatments. Do previous submissions and does the trial data support the decision to use the new intervention for adults with active psoriatic arthritis disease who have not responded adequately to at least 1 DMARD.	Thank you for your comment. The place in the treatment pathway will be considered during the appraisal if the topic is referred. However, no changes to the scope are needed.
	Novartis Pharmaceuticals UK	No comment.	Comment noted.
	Pfizer	Consideration should be given to subgroups based on previous number of treatment and mechanism of action of previous treatments.	Thank you for your comment. The mechanism of action or number of previous treatments has been included as a potential subgroup for consideration, if the evidence allows.
	UCB Pharma	No comments	Comment noted.

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	British Society for Rheumatology	'presence or severity of axial involvement' I have suggested inclusion of this consideration before with other TA appraisals in PsA, and I would fully support this. However, this does lead to a couple of issues: a) NICE guidance may risk inconsistency with any subsequent Updacitinib Ankylosing Spondylitis / Axial Spondyloarthritis TAs and this would need to be considered 'Axial involvement in PsA' and 'Axial Spondyloarthritis' (particularly in patients with skin psoriasis) could be argued as referring to almost identical disease groups b) Existent psoriatic arthritis TAs have so far chosen not to include axial involvement. This could result in the use of upadacitinib in PsA axial disease being agreed by NICE, where similar evidence exists, but was not considered for other PsA related TAs	Thank you for your comment. The scoping process can be inclusive of all outcomes and subgroups that are of interest to stakeholders. NICE appraises within the marketing authorisation of a technology and overlap between disease areas are considered within the marketing authorisation. If evidence allows, the presence or severity of axial involvement could provide important differences between subgroups that could be considered by committee.
Innovation	AbbVie	Upadacitinib is an innovative, oral treatment option for patients with psoriatic arthritis, and is the only selective and reversible JAK which preferentially inhibits signalling by JAK1 or JAK1/3. If licenced, upadacitinib will be the only JAK inhibitor that may be administered as monotherapy. The upadacitinib clinical trial programme also provides data in patients after multiple advanced therapy failures, thereby increasing the range of treatment options for patients with this lifelong, relapsing and remitting disease. In the ongoing COVID-19 situation, upadacitinib also offers rapid washout compared to biologic	Thank you for your comment. The innovative nature of the technology will be considered by the appraisal committee based on evidence presented to it, if the topic is referred for appraisal.

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		therapies, thereby allowing the rapid halting of immunosuppression upon treatment discontinuation. PsA has a substantial economic burden, with a large proportion of these costs falling indirectly, largely related to patient's inability to work/remain in employment. As a result, the benefits of upadacitinib in achieving lasting remission could be expected to lead to cost savings that will not be adequately captured within the QALY framework.	
	MSD	MSD believes that this decision can only be made if further data is presented on patients who have started the use of upadacitinib after not responding adequately to at least 2 DMARDs. In addition, it would be useful to provide the results for the number of patients who have discontinued with upadacitinib after at least 2 DMARDs.	Thank you for your comment. The innovative nature of the technology will be considered by the appraisal committee based on evidence presented to it if the topic is referred for appraisal. The mechanism of action or number of previous treatments has been included as a potential subgroup for consideration, if the evidence allows.
	Novartis Pharmaceuticals UK	No comment.	Comment noted.
	Pfizer	No comment.	Comment noted.
	UCB Pharma	No comments	Comment noted.

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	British Society for Rheumatology	Although this is not a major step change in therapeutic choices, the different JAK inhibitors are much more likely to differ from each other than in other 'biologics' groups such as anti-TNF inhibitors and anti IL17 agents. This is therefore a more innovative change than some recent TAs in psoriatic arthritis, with more potential for significant impact on PsA care.	Thank you for your comment. The innovative nature of the technology will be considered by the appraisal committee based on evidence presented to it if the topic is referred for appraisal.
Questions for consultation	AbbVie	Which treatments are considered to be established clinical practice in the NHS for psoriatic arthritis? *The comparators listed in the scope represent established clinical practice for PsA.* In practice, would upadacitinib be used in combination with DMARDs as concomitant therapy? If yes, how many and which DMARDs would be given? *Upadacitinib may be used as monotherapy or in combination with DMARDs. Data from the comprehensive upadacitinib clinical trial programme provides evidence for the efficacy of upadacitinib both as monotherapy and combination therapy.* Have all relevant comparators for upadacitinib been included in the scope? *All relevant comparators have been included.* How should best supportive care be defined?	Thank you for your comment. No changes to the scope are needed.

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		To ensure consistency with previous appraisals, best supportive care should be defined as a 'mixture of csDMARDs and/or usual care (e.g., NSAIDs, corticosteroids)'. Are the outcomes listed appropriate? *The outcomes listed are appropriate.* Are the subgroups suggested in 'other considerations' appropriate? Are there any other subgroups of people in whom upadacitinib is expected to be more clinically effective and cost effective or other groups that should be examined separately? *The subgroups listed are appropriate.* Where do you consider upadacitinib will fit into the existing NICE pathway, musculoskeletal conditions? In particular, after how many previous lines of DMARDs would upadacitinib be used? *We anticipate upadacitinib to be used alongside current treatment options recommended by NICE for PsA, i.e. as an option in patients whose disease has not responded adequately or who have been intolerant to a previous DMARD therapy.* NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that the proposed remit	

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		and scope may need changing in order to meet these aims. In particular, please tell us if the proposed remit and scope: • could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which upadacitinib will be licensed; • could lead to recommendations that have a different impact on people protected by the equality legislation than on the wider population, e.g. by making it more difficult in practice for a specific group to access the technology; • could have any adverse impact on people with a particular disability or disabilities. Please tell us what evidence should be obtained to enable the Committee to identify and consider such impacts. *No comments.* Do you consider upadacitinib to be innovative in its potential to make a significant and substantial impact on health-related benefits and how it might improve the way that current need is met (is this a 'step-change' in the management of the condition)? Do you consider that the use of upadacitinib can result in any potential significant and substantial health-related benefits that are unlikely to be included in the QALY calculation? Please identify the nature of the data which you understand to be available to enable the Appraisal Committee to take account of these benefits. *Please see the innovation section above for more details.*	

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		To help NICE prioritise topics for additional adoption support, do you consider that there will be any barriers to adoption of this technology into practice? If yes, please describe briefly. *We do not anticipate any barriers to adoption of upadacitinib over currently available treatment options. Furthermore, as an oral option we anticipate that upadacitinib will be helpful in removing barriers to treatment that may currently exist for patients with PsA in the current COVID-19 situation, as described above.* NICE intends to appraise this technology through its Single Technology Appraisal (STA) Process. We welcome comments on the appropriateness of appraising this topic through this process. (Information on the Institute's Technology Appraisal processes is available at http://www.nice.org.uk/article/pmg19/chapter/1-Introduction). *Please see below.* NICE has published an addendum to its guide to the methods of technology appraisal (available at https://www.nice.org.uk/Media/Default/About/what-we-do/NICE-guidance/NICE-technology-appraisals/methods-guide-addendum-cost-comparison.pdf), which states the methods to be used where a cost comparison case is made. • Would it be appropriate to use the cost comparison methodology for this topic?	

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		• Is the new technology likely to be similar in its clinical efficacy and resource use to any of the comparators? • Is the primary outcome that was measured in the trial or used to drive the model for the comparator(s) still clinically relevant? • Is there any substantial new evidence for the comparator technology/ies that has not been considered? Are there any important ongoing trials reporting in the next year? *AbbVie would be open to discussions to ensure no further delays to patient access to upadacitinib, including consideration of the fast-track appraisal route.*	
	MSD	MSD does not believe that this is an intervention that is a 'step change' in the management of psoriatic arthritis given the issues raised above.	Thank you for your comment. The innovative nature of the technology will be considered by the appraisal committee based on evidence presented to it if the topic is referred for appraisal.
	Novartis Pharmaceuticals UK	Which treatments are considered to be established clinical practice in the NHS for psoriatic arthritis? **Novartis: No comment.**	Thank you for your comment. No changes to the scope are needed.

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		In practice, would upadacitinib be used in combination with DMARDs as concomitant therapy? If yes, how many and which DMARDs would be given? **Novartis: No comment.** Have all relevant comparators for upadacitinib been included in the scope? Novartis: See comment above on “Comparators”. **How should best supportive care be defined?** Novartis: In line with NICE technology appraisals TA543, best supportive care (BSC) should include a mixture of csDMARDs and/or usual care (e.g., NSAIDs, corticosteroids). Are the outcomes listed appropriate? **Novartis: No comment.** Are the subgroups suggested in ‘other considerations’ appropriate? Are there any other subgroups of people in whom upadacitinib is expected to be more clinically effective and cost effective or other groups that should be examined separately? **Novartis: No comment.**	

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		Where do you consider upadacitinib will fit into the existing NICE pathway, musculoskeletal conditions? In particular, after how many previous lines of DMARDs would upadacitinib be used? **Novartis:** We would expect upadacitinib to be positioned alongside other treatments recommended by NICE for psoriatic arthritis, i.e., for patients whose disease has not responded to adequate trials of at least 2 standard DMARDs. NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that the proposed remit and scope may need changing in order to meet these aims. **Novartis: No comment.** Do you consider upadacitinib to be innovative in its potential to make a significant and substantial impact on health-related benefits and how it might improve the way that current need is met (is this a 'step-change' in the management of the condition)? **Novartis: No comment.**	

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		Do you consider that the use of upadacitinib can result in any potential significant and substantial health-related benefits that are unlikely to be included in the QALY calculation? **Novartis: No comment.** To help NICE prioritise topics for additional adoption support, do you consider that there will be any barriers to adoption of this technology into practice? If yes, please describe briefly. **Novartis: No comment.** Would it be appropriate to use the cost comparison methodology for this topic? **Novartis: Given the range of subpopulations within the remit of the appraisal, we consider the STA process will be more appropriate than a cost comparison.** Is the new technology likely to be similar in its clinical efficacy and resource use to any of the comparators? **Novartis: No comment.** Is the primary outcome that was measured in the trial or used to drive the model for the comparator(s) still clinically relevant?	

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		Novartis: No comment. Is there any substantial new evidence for the comparator technology/ies that has not been considered? Are there any important ongoing trials reporting in the next year? **Novartis:** The following studies for secukinumab in psoriatic arthritis have reported or are expected to report data in 2020: • MAXIMISE (NCT02721966) – Secukinumab improved all evaluated ASAS responses through Wk52 in PsA patients with axial manifestations and inadequate responses to NSAIDs and led to significant reduction of inflammatory MRI lesions in the spine and the Sacroiliac Joints (see reference at the end of the document) ULTIMATE (NCT02662985) – expected to show impact of secukinumab on joint synovitis and enthesitis	
	Pfizer	No comment.	Comment noted.
	UCB Pharma	No comments	Comment noted.
	British Society for Rheumatology	**Which treatments are considered to be established clinical practice in the NHS for psoriatic arthritis?** The description of non bioloigic DMARDs and biologic DMARDs in the draft scope is a good reflection of clinical practice. It does omit the use of recent increasing use of combination therapy to attain tight control (see TICPOA study), which with	Thank you for your comment. Cholesterol and lipid levels has not been included in the scope as a key subgroup for consideration. However, if evidence is available for this subgroup during the appraisal, this may be considered.

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		the reduction in biosimilar costs for biologics is now becoming much more main stream as a clinical approach to care, as it is now perceived as health economically viable. **In practice, would upadacitinib be used in combination with DMARDs as concomitant therapy? If yes, how many and which DMARDs would be given?** In practice upadacitinib is likely to be either as a sole agent or used predominantly with a single additional DMARD such as methotrexate or leflunomide (as is the case with most combination therapeutic use with other biologic agents) If patients are perceived to not be responding to a current DMARD and have severe side effects, then sole agent use becomes more likely **Have all relevant comparators for upadacitinib been included in the scope?** Unless a 'tight control pathway' is seen as a separate comparator, then yes How should best supportive care be defined? **Usually this would comprise return to non biologic DMARDs not previously tried, analgesic and physiotherapy support**	

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		Are the outcomes listed appropriate? **Axial outcomes – see discussion on axial inclusion under 'other considerations'** **If axial is included, then AxSpA specific disease activity measures should be included (such as BASDAI and pain VAS/NRS** Are the subgroups suggested in 'other considerations' appropriate? Are there any other subgroups of people in whom upadacitinib is expected to be more clinically effective and cost effective or other groups that should be examined separately? **Current NICE approved JAK inhibitors in RA/PsA are not used in patients with high cholesterol /lipids. An evaluation of whether this is the case with upadactinib would be worthwhile** **Where do you consider upadacitinib will fit into the existing NICE pathway, musculoskeletal conditions? In particular, after how many previous lines of DMARDs would upadacitinib be used?**	

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		Depending upon the data, it could be used after at least x2 non-biologic DMARDs or after failure of an anti-TNF NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. **No additional comment** No obvious groups that would be discriminated against with this particular TA	
Additional comments on the draft scope	AbbVie	No additional comments.	Comment noted.
	MSD	If this submission goes ahead MSD proposes that the submission should be for “Upadacitinib for treating active psoriatic arthritis after inadequate response to AT LEAST 2 DMARDs” based on current guidance provided by NICE.	The population in the scope aligns with other scopes for treating active psoriatic arthritis after inadequate response to DMARDs and aligns with the population included in the clinical trial identified in this area. No changes to the scope are needed.
	Novartis Pharmaceuticals UK	None.	Comment noted.

Section	Consultee/ Commentator	Comments [sic]	Action
	Pfizer	No additional comments.	Comment noted.
	British Society for Rheumatology	Related NICE pathways – need to add “quality statements for spondlyoarthritis”	Thank you for your comment. The Spondyloarthritis quality standard has been added to the related NICE recommendations section of the scope.

The following consultees/commentators indicated that they had no comments on the draft remit and/or the draft scope

Janssen-Cilag