NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Final appraisal document

Daratumumab monotherapy for treating relapsed and refractory multiple myeloma

1 Recommendations

1.1 Daratumumab monotherapy is recommended as an option for treating relapsed and refractory multiple myeloma in adults who have had a proteasome inhibitor and an immunomodulator, and whose disease progressed on the last treatment, only if:

- they have daratumumab after 3 treatments and
- the company provides daratumumab according to the commercial arrangement (see section 2).

Why the committee made this recommendation

This appraisal reviews the additional evidence collected as part of the Cancer Drugs Fund managed access agreement for daratumumab monotherapy for relapsed and refractory multiple myeloma in adults who have already had 3 treatments, including a proteasome inhibitor and an immunomodulator, and whose disease progressed on the last treatment (NICE technology appraisal guidance 510).

Usual treatment for relapsed and refractory multiple myeloma in people who have already had 3 treatments is pomalidomide plus dexamethasone.

The new clinical evidence shows that daratumumab monotherapy increases how long people live compared with pomalidomide plus dexamethasone, but by how much is still uncertain.

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Because of this uncertainty, the cost-effectiveness estimates vary. But the most likely estimates are within what NICE considers an acceptable use of NHS resources. Therefore, daratumumab is recommended for routine use.

2 Information about daratumumab

Marketing authorisation indication

2.1 Daratumumab (Darzalex, Janssen) has a marketing authorisation as a monotherapy for 'the treatment of adult patients with relapsed and refractory multiple myeloma, whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who have demonstrated disease progression on the last therapy'.

Dosage in the marketing authorisation

2.2 The dosage schedules for both injection and infusion are available in daratumumab's summary of product characteristics.

Price

2.3 The list prices of daratumumab (excluding VAT; BNF online, accessed January 2022) are:

- £4,320 per 1,800 mg/15 ml solution for injection vial
- £360 per 100 mg/5 ml concentrate for solution for infusion vial
- £1,440 per 400 mg/20 ml concentrate for solution for infusion vial.

2.4 The company has a commercial arrangement (simple discount patient access scheme). This makes daratumumab available to the NHS with a discount. The size of the discount is commercial in confidence. It is the company's responsibility to let relevant NHS organisations know details of the discount.

3 Committee discussion

The appraisal committee considered evidence submitted by Janssen, a review of this submission by the evidence review group (ERG), NICE's technical report, and responses from stakeholders. See the committee papers for full details of the evidence.

This review looks at data collected in the Cancer Drugs Fund to address uncertainties identified during the original appraisal. Further information about the original appraisal is in the committee papers. As a condition of the Cancer Drugs Fund funding and the managed access arrangement, the company was required to collect updated efficacy data from the MMY2002 study for people with relapsed and refractory multiple myeloma. In addition, data was collected on the use of daratumumab monotherapy in the NHS through the Cancer Drugs Fund using the Systemic Anti-Cancer Therapy (SACT) dataset.

The condition

Daratumumab is a highly valued treatment option for people with multiple myeloma

3.1 Multiple myeloma is a chronic condition that affects survival and quality of life. When deciding which treatments to use, response to previous treatments and toxicity are important, so having a range of treatment options is desirable. The Cancer Drugs Fund clinical lead reported that since daratumumab monotherapy was made available through the Cancer Drugs Fund, it has become a preferred fourth-line treatment. Patient experts explained that people with multiple myeloma are anxious about the possibility of their disease relapsing. However, they also reported that there are several new multiple myeloma drugs in development, and so any treatment that offered an extension to life offered hope, because it meant it may bridge getting onto a new trial, or perhaps make it possible to access a new treatment that would become available in the future. The patient and clinical experts stated that daratumumab has a favourable toxicity profile, which not only results in an increased quality of life, but

also means that people are more likely to be well enough for more options later in the treatment pathway. They also stressed the importance of quality of life after multiple lines of therapy, because the adverse effects of treatments can build up over time. The committee recognised the need for effective, well-tolerated treatment options for people with multiple myeloma who have had previous therapies.

Treatment pathway

The treatment pathway for multiple myeloma is rapidly evolving

3.2 Treatment options for multiple myeloma depend on how many previous lines of treatment a person has had, the type of treatments they have had, the response to these treatments, and patient preferences.

For someone with a new diagnosis of multiple myeloma, if a stem cell transplant is suitable, available options are:

- Induction with bortezomib and dexamethasone with or without thalidomide (bortezomib for induction therapy) given before the stem cell transplant, followed by maintenance treatment with lenalidomide (lenalidomide maintenance treatment).
- Induction with daratumumab plus bortezomib, thalidomide and dexamethasone (daratumumab in combination for untreated multiple myeloma when stem cell transplant is suitable) before the stem cell transplant. If daratumumab plus bortezomib, thalidomide and dexamethasone is used as induction treatment, then it is also recommended as consolidation treatment after the transplant. Lenalidomide maintenance treatment is recommended after consolidation, or directly after the transplant if bortezomib and dexamethasone (with or without thalidomide) is used as induction treatment (lenalidomide maintenance treatment).

If a stem cell transplant is not suitable:

- For untreated disease, treatments include thalidomide or bortezomib plus an alkylating agent, for example, melphalan or cyclophosphamide, and a corticosteroid, for example, dexamethasone (bortezomib and thalidomide for the first-line treatment of multiple myeloma). Lenalidomide plus dexamethasone is also an option when thalidomide is not appropriate (lenalidomide plus dexamethasone for previously untreated multiple myeloma).

After 1 previous line of treatment, the following options are available regardless of transplant eligibility:

- Lenalidomide with dexamethasone (lenalidomide plus dexamethasone for multiple myeloma after 1 treatment with bortezomib), carfilzomib with dexamethasone (carfilzomib for previously treated multiple myeloma), carfilzomib with dexamethasone and lenalidomide if the person has had bortezomib before (carfilzomib with dexamethasone and lenalidomide for previously treated multiple myeloma) or bortezomib may be used again (bortezomib monotherapy for relapsed multiple myeloma); however, treatment is only continued in people whose condition has a complete or partial response. Also, daratumumab plus bortezomib and dexamethasone is available in the Cancer Drugs Fund (daratumumab with bortezomib and dexamethasone for previously treated multiple myeloma).

Treatment options at further relapse are influenced by the choice of initial treatment. The following options are available regardless of transplant eligibility:

- After 2 previous lines of treatment, options include lenalidomide plus dexamethasone (lenalidomide for the treatment of multiple myeloma in people who have received at least 2 prior therapies) or panobinostat plus bortezomib and dexamethasone (panobinostat for treating multiple myeloma after at least 2 previous treatments). Also, ixazomib plus lenalidomide and dexamethasone is available in the Cancer Drugs

Fund (ixazomib with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma).

- After 3 previous lines of treatment, options include pomalidomide plus dexamethasone (pomalidomide for multiple myeloma previously treated with lenalidomide and bortezomib), and panobinostat plus bortezomib and dexamethasone (panobinostat for treating multiple myeloma after at least 2 previous treatments). Also available through the Cancer Drugs Fund are ixazomib plus lenalidomide and dexamethasone (ixazomib with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma) and isatuximab plus pomalidomide and dexamethasone (isatuximab with pomalidomide and dexamethasone for treating relapsed and refractory multiple myeloma).

Daratumumab monotherapy can be used whether or not people have had a stem cell transplant. The Cancer Drugs Fund clinical lead explained that, following the publication of isatuximab with pomalidomide and dexamethasone for treating relapsed and refractory multiple myeloma, the use of fourth-line daratumumab monotherapy has decreased, but there is an important cohort of people still receiving this treatment. The recent NICE guidance for daratumumab plus bortezomib plus thalidomide and dexamethasone as first-line treatment if stem cell transplant is suitable may further decrease the need for fourth-line daratumumab. The committee understood that the multiple myeloma pathway is rapidly evolving.

Comparators

After 3 previous lines of treatment, pomalidomide plus dexamethasone is the only relevant comparator

3.3 The committee recalled that treatments recommended in the Cancer Drugs Fund (see section 3.2) are not considered to be comparators because they are not available in routine practice. NICE guidance recommends both pomalidomide plus dexamethasone and panobinostat

plus bortezomib and dexamethasone after 3 previous lines of treatment for multiple myeloma. NICE's final scope for this appraisal lists these as the comparators. The company did provide analyses for both comparators to comply with the scope, but stated that it did not consider panobinostat plus bortezomib and dexamethasone to be a relevant comparator. It explained that this was because of toxic adverse effects and the lack of perceived efficacy noted by clinicians it consulted, which means it is usually used after 4 previous lines of treatment. The ERG's clinical advisers agreed with the company's position. The clinical expert at the meeting explained that daratumumab monotherapy or pomalidomide plus dexamethasone are the most commonly used options after 3 previous lines of treatment. They stated that panobinostat plus bortezomib and dexamethasone is rarely used after 3 previous lines of treatment because of toxicity and perceived poor clinical efficacy. The Cancer Drugs Fund clinical lead explained that clinicians can now offer bortezomib without having to use it with panobinostat, and that few clinicians offer panobinostat plus bortezomib and dexamethasone after 3 previous lines of treatment. The committee concluded that after 3 previous lines of treatment, pomalidomide plus dexamethasone is the only relevant comparator.

Clinical evidence

The clinical trial evidence for daratumumab monotherapy does not include any head-to-head evidence

3.4 The key clinical study was MMY2002, a completed phase II study investigating different doses of daratumumab (n=106). It included people with relapsed and refractory multiple myeloma who had had at least 3 previous lines of treatment (including proteasome inhibitors and immunomodulators) or whose condition was refractory to both a proteasome inhibitor and an immunomodulator. There was no comparator. The primary outcome was overall response rate. Overall survival and progression-free survival were among the secondary

outcomes. In the original appraisal, people in MMY2002 had been followed up for a median of 20.7 months. At the time, median progression-free survival was 3.7 months (95% confidence interval [CI] 2.8 to 4.6) and median overall survival was 18.6 months (95% CI 13.7 to not reached). Since the original appraisal, people in MMY2002 have been followed up for a median of 36.7 months. The company considers the updated progression-free survival and overall survival data to be confidential, so it cannot be reported here. The committee concluded that the longer follow-up data was similar to that which it had seen previously, but that it would prefer to see head-to-head evidence for decision making.

In the absence of comparative data, the SACT dataset provides useful evidence

3.5 Through the Cancer Drugs Fund, Systemic Anti-Cancer Therapy (SACT) data was collected from people having fourth-line daratumumab monotherapy for multiple myeloma. Between 17 January 2018 and 16 November 2020, 2,301 people had daratumumab, with a median age of 71 years. Most people had an Eastern Cooperative Oncology Group (ECOG) performance score of 0 (20%) or 1 (41%). Less than half of people had previously had a stem cell transplant (44%). Compared with participants in MMY2002, people were older, and lower proportions had an ECOG score of 0, had a previous stem cell transplant, and went on to have subsequent therapy. People in MMY2002 were able to receive carfilzomib as a subsequent therapy, which did not reflect UK clinical practice or the SACT dataset. The committee considered that the SACT dataset provided useful information and represented people who would receive daratumumab in NHS clinical practice. The committee discussed the results from MMY2002 and the SACT dataset and concluded that they were similar, with any differences explained by the characteristics of the participants and subsequent therapies received.

The company did a matching-adjusted indirect comparison to compare daratumumab with the comparators

3.6 To compare daratumumab with pomalidomide plus dexamethasone and with panobinostat plus bortezomib and dexamethasone in the absence of a common comparator (an 'anchor'), the company presented 'unanchored' matching-adjusted indirect comparisons (MAICs). Specifically, it adjusted individual patient-level characteristics in the MMY2002 population to match the published study-level summary characteristics of patients in the comparator trials (1 of 2 arms of the MM-003 trial for pomalidomide plus dexamethasone, and the single-arm trial PANORAMA-2 for panobinostat plus bortezomib and dexamethasone).

The SACT trial data is preferred over the single-arm trial data

3.7 The committee discussed the company's approach to matching. It understood that the company presented a partially adjusted MAIC adjusting for the characteristics it considered important in predicting progression and death based on best practice, published evidence, and expert opinion. For pomalidomide plus dexamethasone, 5 characteristics were chosen and adjusted. The company stated that this was necessary to maintain a large enough sample size to use for the analysis. The ERG disagreed with company's approach, referencing NICE technical support document 18 which states that, when only single-arm trial data is available, all the characteristics that could influence the outcomes of interest should be adjusted, that is, a fully adjusted MAIC should be done. Because of this, the ERG considered a fully adjusted MAIC to be methodologically superior to the company's partially adjusted MAIC. However, a fully adjusted MAIC gave implausible survival extrapolations for daratumumab, so the ERG also did a naive comparison of daratumumab against data from MM-003 for pomalidomide with dexamethasone using the SACT data. The company disagreed with this approach, considering it fairer to compare trial data with trial data, rather than real world evidence with trial data. The committee acknowledged that

neither approach was methodologically sound. It discussed several alternatives that may have been useful. One would be an MAIC using a few key characteristics such as age and sex, using the SACT data for daratumumab; however, the Cancer Drugs Fund clinical lead explained this would be difficult because the SACT data is rather crude, so only a few characteristics would be available to be matched on. Another would be collecting real world data on pomalidomide and dexamethasone from the SACT data from when daratumumab entered the Cancer Drugs Fund, but this was not available. Although the committee noted neither of the presented comparisons were ideal, it preferred to use the SACT data because the usual benefit of trial data is that it is comparative. However, in this instance, the data from MMY2002, which compared 2 different doses of daratumumab, provided no head-to-head evidence of the effectiveness of daratumumab with a relevant comparator. As such, the committee preferred the data from SACT, which had both a larger sample size and reflected UK clinical practice.

Daratumumab likely increases overall survival but not progression-free survival compared with pomalidomide and dexamethasone, but this is uncertain

3.8 In the fully adjusted and partially adjusted MAICs, daratumumab showed no difference in progression-free survival compared with pomalidomide with dexamethasone. In the partially adjusted MAIC preferred by the company, daratumumab provided an improvement in overall survival compared with pomalidomide with dexamethasone. In the naive comparison with SACT data preferred by the ERG, the point estimate indicated that daratumumab resulted in improved overall survival, but this was not statistically significant. The committee asked the clinical expert about the plausibility of seeing overall survival gains without progression-free survival gains. The clinical expert explained that in MMY2002, [redacted]% of people had no response to daratumumab, which in part explains why there was no difference in progression-free survival between

daratumumab and pomalidomide plus dexamethasone. Additionally, as discussed in section 3.1, given the favourable tolerability and reduced toxicity of daratumumab, people may go on to receive further treatments later in the pathway, which may impact overall survival. The committee was satisfied with this explanation and agreed it was possible that daratumumab is associated with overall survival gains without providing progression-free survival gains.

The overall survival benefit seen in the naive comparison is generalisable to NHS clinical practice

3.9 Several therapies are available if the cancer comes back after daratumumab (see NICE's technology appraisals on multiple myeloma). The company's submission included several data sources on subsequent treatments, including data from the MMY2002 and MM-003 trials, and the SACT dataset. The ERG expressed concerns about the overall survival data from MMY2002 because people in this trial could have several treatments not available on the NHS, including carfilzomib. The clinical expert agreed that several treatments given after daratumumab in MMY2002 did not reflect UK clinical practice. The evidence for subsequent treatments after daratumumab available from the SACT dataset not only reflects UK clinical practice, but is also a large sample. Because the SACT data is from the UK and is recent, the company, ERG and clinical expert all agreed it best reflects subsequent treatments given after daratumumab in UK clinical practice. The clinical expert explained that the choice of subsequent treatment depends on many factors, including how many previous lines of treatment a person has had, the specific treatments, the response to these treatments, and people's preferences (see section 3.1). They agreed that the subsequent treatments seen in the SACT cohort are consistent with what would be expected in clinical practice. Because MMY2002 included treatments not available on the NHS, they considered there was a greater degree of certainty in the SACT data. The committee concluded that subsequent

treatment data from the SACT cohort best reflects clinical practice. The committee considered the treatments given after pomalidomide with dexamethasone in MM-003. It heard from the clinical expert that these were generally aligned with NHS clinical practice. The committee was therefore satisfied that the overall survival benefit implied by the naive comparison (see section 3.7) is generalisable to NHS clinical practice, while recognising that this was a naive comparison that could be biased by imbalances in patient characteristics.

Adverse events

Daratumumab is well tolerated, improves quality of life, and allows people to receive other treatments further down the pathway

3.10 The clinical expert explained that daratumumab is well tolerated relative to other fourth-line treatments. The patient experts agreed with this, with one pointing out they have been taking daratumumab for some time, saying that it has been the best treatment they've ever had and is why they are still alive today. Additionally, the other patient expert explained that having a treatment that is so well tolerated gives people hope that they may be able to either go on to a clinical trial for a multiple myeloma treatment or that they will survive until they can have a new treatment once it becomes available. The clinical expert agreed with this and again pointed out that a likely reason why an overall survival gain is observed with daratumumab is because of the subsequent treatments people can receive. They also stated that in MMY2002, participants received intravenous daratumumab, which may be less well tolerated than the subcutaneous formulation available in NHS clinical practice. Additionally, people who take daratumumab subcutaneously often find it more convenient because it requires less time spent in a hospital because of the shorter administration time. The committee concluded that daratumumab is well tolerated, improves quality of life for people who take it, and allows them to receive other treatments further down the pathway.

The company's model structure is acceptable for decision making

3.11 The company used a 4-state, partitioned-survival economic model, including states representing pre-progressed disease on treatment, pre-progressed disease off treatment, progressed disease and death. The cycle length was 1 week, and the time horizon was 15 years. The committee noted that this model was similar to previous models used for multiple myeloma, and agreed that it was appropriate to capture the natural history of the disease. The ERG was satisfied that the model structure was suitable for estimating the cost effectiveness of daratumumab compared with pomalidomide plus dexamethasone. The committee concluded that the model structure is acceptable and closely matched its preferred assumptions from the original appraisal.

Survival modelling in the economic model

Estimates of overall survival are highly uncertain despite the additional analyses provided

3.12 As in the original appraisal, the model relied on estimates of relative treatment effects from the company's unanchored MAIC. The ERG raised concerns about the methodology of the partially adjusted MAIC, but recalled that the overall survival extrapolations from the fully adjusted MAIC were implausible. The ERG therefore did a naive comparison using daratumumab data from the SACT dataset (see section 3.7). The company accepted that its estimates were associated with uncertainty. It attempted to explore this uncertainty by performing scenario analyses in which different sources of the relative treatment effects were used, including the fully adjusted MAIC and an adjusted comparison with the SACT dataset. The ERG also explored this uncertainty, using the naive comparison with the SACT dataset as its preferred source of relative treatment effect. The committee considered all the scenarios presented by the company and the ERG and recognised that there were high levels of uncertainty in the estimates of overall survival used in the model.

Costs of subsequent treatments in the economic model

The cost of subsequent treatments should align with the source of clinical data

3.13 The company used data from SACT to inform both the proportion of people having further treatment and the treatments taken after daratumumab and after pomalidomide with dexamethasone. In the ERG's analysis, it aligned the cost of subsequent treatment with the source of clinical evidence. That is, for daratumumab, data from SACT on the proportion of people and type of subsequent therapy was used. But for pomalidomide with dexamethasone, data from MM-003 informed the proportion of people and type of subsequent therapy used. A clinical expert stated that the subsequent therapies used are likely to be influenced by daratumumab, and that those in MM-003 aligned well with NHS clinical practice after pomalidomide with dexamethasone. Taking this into account, the committee preferred the ERG's approach.

End of life considerations

Daratumumab meets the end of life criteria

3.14 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. It considered life expectancy for people with relapsed and refractory multiple myeloma. In the ERG's analysis, the mean undiscounted total life years with pomalidomide with dexamethasone was 1.49 years. The committee was satisfied that the life expectancy in this population was less than 24 months. It was also satisfied that introducing daratumumab to the treatment pathway at this point offers at least a 3-month life extension, because despite the uncertainty around the clinical efficacy of this treatment, there was no scenario by either the company or the ERG in which this criterion was not met. The minimum extension to life modelled in any scenario was 5.5 months. The committee concluded that daratumumab after 3 previous

lines of treatment met the criteria to be considered a life-extending, end of life treatment.

Cost-effectiveness results

The cost-effectiveness estimates are uncertain, but the ERG's preferred ICER is likely the highest plausible ICER

3.15 The committee considered the company's and the ERG's cost-effectiveness results, including confidential discounts for daratumumab and all of the comparator technologies and subsequent treatments. The cost-effectiveness results are commercial in confidence and cannot be reported here. The committee noted that the incremental cost-effectiveness ratios (ICERs) for daratumumab compared with pomalidomide plus dexamethasone varied widely. This reflected the high degree of uncertainty in daratumumab's relative clinical effectiveness. Although the degree of uncertainty in the evidence was high, the committee noted that the naive comparison of clinical trial and real world data would underestimate the benefits of daratumumab, so it believed that the ERG's preferred ICER likely represented the upper end of plausible values.

The most likely ICER is within what NICE considers an acceptable use of NHS resources

3.16 Taking into account all the confidential patient access schemes for all of the comparator technologies and subsequent treatments, all the resulting ICERs were lower than £50,000 per quality-adjusted life year (QALY) gained. However, these were all associated with uncertainty. The committee would have preferred alternative methods to have been used to estimate the relative treatment efficacy of daratumumab compared with pomalidomide plus dexamethasone, specifically obtaining data on pomalidomide plus dexamethasone from the SACT database or an adjusted comparison of SACT data with trial data. The committee was aware that both of these methods would likely be challenging at this

stage, but may be of value in future appraisals when considering what data to request when recommending a treatment for the Cancer Drugs Fund. However, because the committee viewed the ERG's preferred ICER as the very upper end of the plausible values, it considered that the true ICER likely fell below this. Taking all of this into account, the committee concluded that daratumumab was an acceptable use of NHS resources.

Other factors

Equalities

3.17 No equality issues were identified.

Innovation

3.18 The company did not highlight any additional benefits that had not been captured in the QALY calculations.

Conclusion

Daratumumab is recommended for routine use

3.19 The committee concluded that the most plausible cost-effectiveness estimates are within what NICE considers an acceptable use of NHS resources. Therefore, daratumumab is recommended for treating relapsed and refractory multiple myeloma in adults whose previous therapy included a proteasome inhibitor and an immunomodulator, and whose disease progressed on the last therapy, if they have daratumumab after 3 previous therapies.

4 Implementation

4.1 Section 7 of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 requires clinical commissioning groups, NHS England and, with respect to their public health functions,

local authorities to comply with the recommendations in this appraisal within 3 months of its date of publication.

4.2 Chapter 2 of Appraisal and funding of cancer drugs from July 2016 (including the new Cancer Drugs Fund) – A new deal for patients, taxpayers, and industry states that for those drugs with a draft recommendation for routine commissioning, interim funding will be available (from the overall Cancer Drugs Fund budget) from the point of marketing authorisation, or from release of positive draft guidance, whichever is later. Interim funding will end 90 days after positive final guidance is published (or 30 days in the case of drugs with an Early Access to Medicines Scheme designation or fast track appraisal), at which point funding will switch to routine commissioning budgets. The NHS England and NHS Improvement Cancer Drugs Fund list provides up-to-date information on all cancer treatments recommended by NICE since 2016. This includes whether they have received a marketing authorisation and been launched in the UK.

4.3 The Welsh ministers have issued directions to the NHS in Wales on implementing NICE technology appraisal guidance. When a NICE technology appraisal recommends the use of a drug or treatment, or other technology, the NHS in Wales must usually provide funding and resources for it within 2 months of the first publication of the final appraisal document.

4.4 When NICE recommends a treatment 'as an option', the NHS must make sure it is available within the period set out in the paragraphs above. This means that, if a patient has relapsed and refractory multiple myeloma and the doctor responsible for their care thinks that daratumumab is the right treatment, it should be available for use, in line with NICE's recommendations.

5 Review of guidance

5.1 The guidance on this technology will be considered for review 3 years after publication. NICE will decide whether the technology should be reviewed based on information gathered by NICE, and in consultation with consultees and commentators.

Charles Crawley
Chair, appraisal committee
January 2022

6 Appraisal committee members and NICE project team

Appraisal committee members

The 4 technology appraisal committees are standing advisory committees of NICE. This topic was considered by committee B.

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.

The minutes of each appraisal committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

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.

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