xxxxxxxxxxx

Policy and Public Affairs Advisor

Lymphoma Action

3 Cromwell Court

New Street

Aylesbury

Bucks HP20 2PB

Sent by e-mail only: xxxxxxxxxxxxxxxxxxxxxxxxx

26 September 2022

Dear xxxxx

**Re: Final Appraisal Document — Tafasitamab with Lenalidomide for treating relapsed or refractory diffuse large B-cell lymphoma [ID3795]**

Thank you for your letter of 13 September 2022, lodging an appeal against the above Final Appraisal Document (FAD).

Introduction

The Institute's appeal procedures provide for an initial scrutiny of points that an appellant wishes to raise, to provide an initial view on whether they are within the permitted grounds of appeal ("valid") and are at least arguable. The permitted grounds of appeal are:

* 1(a) NICE has failed to act fairly, or
* 1(b) NICE has exceeded powers;
* (2) the recommendation is unreasonable in the light of the evidence submitted to NICE.

This letter sets out my initial view of the points of appeal you have raised: principally whether they fall within any of the grounds of appeal, or whether further clarification is required of any point. Only if I am satisfied that your points contain the necessary information, are arguable, and fall within any one of the grounds will your appeal be referred to the Appeal Panel.

You have the opportunity to comment on this letter in order to elaborate on or clarify any of the points raised before I will make my final decision as to whether each appeal point should be referred on to the Appeal Panel.

Initial View

I assess each of your points in turn.

***Ground 1a: In making the assessment that preceded the recommendation, NICE has failed to act fairly***

**Appeal point 1a.1 NICE has failed to act fairly because “The decision for Tafasitamab with lenalidomide for treating relapsed or refractory diffuse large B-cell lymphoma [ID3795] has not explained why it has not followed the same decision process as the Polatuzumab vedotin R/R DLBCL appraisal for end of life”**

I am not minded to refer this appeal point to the Appeal Panel.

The basis of the appeal point, as I understand it, is that it was unfair for the Committee to “*favour mean survival estimates (over median survival) when applying the end of life criteria*”. You say that this is unfair because “*[p]revious NICE appeals have accepted that using the median average of life expectancy to define “normal” is more appropriate than using the mean average for relapsed or refractory (R/R) diffuse large B-cell lymphoma (DLBCL) (e.g. Polatuzumab vedotin with rituximab and bendamustine for treating relapsed or refractory diffuse large B-cell lymphoma [TA649])*”. You say that the Committee has not sufficiently explained why it differed from previous NICE committee decisions, and that the failure to do so was unfair and did not give consultees (including Lymphoma Action sufficient opportunity to rebut the assumptions, which you consider to be unreasonable.

I am not minded to refer this point because the Committee has made it clear in paragraph 3.8 of the FAD that it had in mind the recent conclusions of the Appeal Panel about the short life expectancy criteria as part of NICE’s technology appraisal guidance on avelumab for maintenance treatment of locally advanced or metastatic urothelial cancer after platinum-based chemotherapy. I note that the avelumab appeal post-dates TA649.

It is helpful to set out those conclusions here:

*83. The NICE end of life criteria is applied when, “The treatment is indicated for patients with a short life expectancy, normally less than 24 months”. The appeal panel note that there is no guidance in the NICE Guide to the Methods of Technology Appraisal or from the NICE Decision Support Unit on how the word “normally” should be interpreted and the appeal panel note that historically both the mean and median have been used.*

*84. The appeal panel note that the NICE end of life criteria are founded on the principles in the NICE guide to the use of Social Value Judgements and the outcomes of the Citizens Council meeting in November 2008.*

*85. Consequently, the panel feel that the paramount consideration should be what the key stakeholders of NICE: the general public, patients, Appeal Panel Decision: Avelumab for maintenance treatment of locally advanced or metastatic urothelial cancer after platinum-based chemotherapy [ID3735] 22 of 24 clinicians, policy makers and industry would consider a reasonable interpretation of the word “normally”.*

*86. The appeal panel, therefore, do not accept the argument advanced by the appraisal committee that the mean survival of 24 months must be used as the threshold for application of end of life criteria to maintain consistency with the methodology used to calculate the incremental cost-effectiveness ratio. The appeal panel note that there are a number of other circumstances when policy consideration and social value judgements are incorporated into the technology appraisal framework.*

*87. The appeal panel felt that the key stakeholders of NICE would consider it unreasonable to state that life-expectancy was not “normally less than 24 months”, even if the mean life expectancy was greater than 24 months, if 65% of patients, the significant majority, in the modelled cohort had died prior to 24 months.*

*88. The appeal panel agreed that a totality of the data and analysis have to be looked at when considering if life expectancy is “normally less than 24 months”. It does not wish to suggest there is a general rule that median is preferable to mean or vice versa. The question is it reasonable to conclude that life expectancy is below 24 months, and the mean, the median, and clinical opinion all inform that judgement. Taken in the round the panel did not feel it would be possible to explain to patients or clinicians why it was said these patients would have a life expectancy in excess of 24 months, and therefore this conclusion was unreasonable.*

Those conclusions are consistent with the approach taken by the Committee in this case, and I note that the Committee explained that it had “*carefully considered the totality of the data and analysis*” before reaching its conclusions.

I also note that the Committee’s substantive conclusions on end of life criterion 2 did not change between the ACD and the FAD, albeit, the reasoning in the FAD is expanded to give further explanation of the data and analysis considered and to highlight the reasoning of the Appeal Panel considering the avelumab technology appraisal. I can see from the published papers that several responses to the ACD commented upon the Committee’s approach to EoL, and the Committee emphasised in response to those comments that it was mindful of the need to consider the totality of the data and analysis regarding the short life expectancy criterion and the interpretation of the work normally.

***Ground 2:******the recommendation is unreasonable in the light of the evidence submitted to NICE***

**Appeal point 2.1: The recommendation is unreasonable because “the Committee’s conclusion that patients eligible for treatment with tafasitamab and lenalidomide do not meet the end of life criteria does not reflect the balance of the available evidence”**

I agree that this is a valid appeal point.

Conclusion

The above sets out above my initial views on all of your appeal points.

In respect of your points which I am not minded to refer on you are entitled to submit further clarification and/or evidence to me within the next 10 working days, **no later than 10 October 2022** and I will then give a final decision on the points to put before an appeal panel. For the points I am already content to refer on, an oral appeal will be held which is likely to be held remotely.

Once I have made my final decision, and where there is more than one appellant, each appellant will receive the valid appeal points of the other appellants and their redacted appeal letter. This is to enable appellants to avoid duplication at the hearing where there are overlapping appeal points. If the appeal letter and/or responses to scrutiny contain confidential information please ensure you have provided a version with this information redacted by **17 October 2022.**

Ordinarily appeals are conducted on the basis of the appellants’ written appeal letters, and the material generated during the appraisal process. Use of additional written material is discouraged, and the panel cannot receive any new evidence. If, exceptionally, you feel there is written material that will not be before the panel that you would wish to rely on you must let the NICE Appeal team know by return of letter, indicating what the material is, why it is desirable to submit it, and when it will be available, by no later than **11 October 2022**. Please note that the appeal panel cannot accept papers that are tabled late or ad hoc, as this affects the preparation of the panel and other parties for the appeal.

Yours sincerely

Dr Mark Chakravarty

Lead Non-Executive Director for Appeals & Vice Chairman

National Institute for Health and Care Excellence