National Institute for Health and Care Excellence

Health Technology Evaluation

Targeted-release budesonide for treating primary IgA nephropathy (ID1434)

Response to stakeholder organisation comments on the draft remit and draft scope

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.

Comment 1: the draft remit and proposed process

Section	Stakeholder	Comments [sic]	Action
Appropriateness of an evaluation and proposed evaluation route	Novartis Pharmaceuticals	Overall, Novartis considers the topic and evaluation route (STA) to be appropriate. Although IgA nephropathy is a rare disease, the number of prevalent patients (and the likely number of eligible patients in England) is too high for treatments for this condition to meet Highly Specialised Technology (HST) criteria. However, within the STA process, it should nevertheless be considered that IgA nephropathy is a rare disease. As acknowledged in the latest NICE health technology evaluations manual, evidence generation is challenging in rare diseases and as a result, the level of evidence for technologies indicated for rare diseases might not be as high as for other technologies.	Thank you for your comment. Targeted-release budesonide will be appraised in line with the latest technology evaluations manual. No changes to the scope required.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	This topic is appropriate to refer to NICE for evaluation. Evaluation of Targeted-release budesonide for IgAN via a single technology appraisal (STA) is the most appropriate route, as it is anticipated that this therapy will provide a cost-effective treatment for IgAN.	Thank you for your comment. No action required.

Section	Stakeholder	Comments [sic]	Action
Wording	Novartis Pharmaceuticals	**1.** Novartis suggests to add “primary” [immunoglobulin A (IgA) nephropathy] to the wording of the remit in order to define the condition appropriately.	Thank you for your comment. The remit and title of the scope has been updated to specify “primary” IgA nephropathy.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	The wording of the remit is largely appropriate; however, please note that the marketing authorisation in Europe will be for the treatment of primary IgAN in adults at risk of rapid disease progression with a urine protein-to-creatinine ratio (UPCR) ≥1.5 g/gram. The UK marketing authorisation is expected to be the same.	Thank you for your comment. The remit and title of the scope has been updated to specify “primary” IgA nephropathy, further details on the specific indication covered by the marketing authorisation can be added to the company submission.
Timing issues	Novartis Pharmaceuticals	IgA nephropathy is a rare disease with a high unmet need. Additionally, there are currently no treatments specifically licensed for IgA nephropathy. These aspects should be considered when assessing the urgency of this evaluation. However, Novartis would suggest that a scoping workshop could be of value, given that this would be the first appraisal of a treatment for IgA nephropathy, and due to the evolving treatment landscape.	Thank you for your comment. NICE aims to provide draft guidance to the NHS within 6 months from the date when the marketing authorisation for a technology is granted. NICE has scheduled this topic into its work programme. For more

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			information please see https://www.nice.org.uk/guidance/indevelopment/gid-ta11028/documents A scoping workshop is scheduled for this topic.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	As an orphan disease, there is significant unmet need for new treatments for IgAN. IgAN first presents with symptoms, including proteinuria, haematuria, tiredness, fatigue and pain, which can restrict peoples' ability to perform daily activities.[1-3] Without adequate disease control, kidney damage accumulates and 20 – 40% of people with IgAN develop kidney failure within 10 to 20 years of diagnosis, leading to end stage renal disease (ESRD) in 15–50% of people through their time.[4, 5] Once people progress to ESRD and require dialysis, they experience significantly impaired quality of life and significantly greater cost of care, requiring burdensome treatments such as dialysis or transplantation.[6, 7] A Swedish study of 2432 patients with chronic kidney disease (CKD) found that patients with ESRD requiring dialysis accrued 9.4 times greater costs than those with CKD stage 4–5 who did not require dialysis.[6] Currently, there are no treatments that have been developed to specifically target IgAN. Patients are treated with RAS-blockade as first-line therapies, to reduce patient hypertension associated with kidney dysfunction and to exert a renoprotective effect.[8, 9] Patients at high risk of progressive CKD despite maximal supportive care with RAS blockade are considered for immunosuppressive therapy.[9] However, the KDIGO international guidelines for IgAN highlight the uncertainty regarding the safety and efficacy of existing immunosuppressive options, and recommend that all patients who	Thank you for your comment. NICE aims to provide draft guidance to the NHS within 6 months from the date when the marketing authorisation for a technology is granted. NICE has scheduled this topic into its work programme. For more information please see https://www.nice.org.uk/guidance/indevelopment/gid-ta11028/documents

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		remain at high risk of progressive CKD despite maximal supportive care should be offered the opportunity to take part in a clinical trial.[9] Kinpeygo® (targeted release budesonide) is the first treatment specifically developed to treat patients with IgAN. The targeted release formulation releases budesonide at the Peyer's patches, a primary site of the IgA implicated in the disease pathology. In the Nefigard clinical trial, Kinpeygo® plus RAS blockade significantly reduced UPCR, relative to RAS blockade alone, and stabilised the eGFR over a 9-month treatment course. The 9-month treatment effect was sustained over 12 months. Kinpeygo is expected to provide the first therapy for patients with IgAN at risk of rapidly progressing disease, which can delay or prevent progression to advanced CKD stages. Therefore, there is a high degree of urgency for this evaluation.	
Additional comments on the draft remit	Novartis Pharmaceuticals	No comments	No action required.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	No comments	No action required.

Comment 2: the draft scope

Section	Consultee/ Commentator	Comments [sic]	Action
Background information	Novartis Pharmaceuticals	Novartis would like to suggest the following revisions to the background section to improve clarity and accuracy:	Thank you for your comments. NICE recognises the

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		• For an accurate description of disease pathophysiology, Novartis suggests in the first paragraph to replace “abnormal IgA antibody” with “IgA containing immune complexes” (2nd sentence) and “The abnormal IgA deposits” with “Accumulation of these immune complexes results in local complement activation which causes” [inflammation and damage in glomeruli ...] (3rd sentence).[10-12] • Novartis proposes to remove “and Henoch-Schönlein purpura, a condition affecting the blood vessels that presents as a rash.” Henoch-Schönlein purpura is now referred to as IgA vasculitis (which is already mentioned earlier in the paragraph) and considered a distinct pathology rather than a complication of IgA nephropathy.[13] • Regarding the rate of progression, Novartis suggests to remove “but is usually slow”. This could be seen as a value judgment and bears the risk of underestimating the debilitating nature of this condition which, given the young age at incidence, commonly results in people in their 30s–50s requiring a kidney transplant or maintenance dialysis for the remainder of their lives. • When describing the prevalence of IgA nephropathy, Novartis would ask to state explicitly that this is therefore a rare disease (given the condition affects <5 in 10,000 people), for the benefit of readers less familiar with these definitions, and to ensure that the implications for the appraisal are considered. • The Kidney Disease: Improving Global Outcomes (KDIGO) guidelines define high risk of progression as proteinuria >0.75–1 g/d despite ≥90 days of optimised supportive care (practice point 2.3.1.1).[9] Therefore, Novartis would ask to revise the wording in the scope from currently “above 0.75 grams” to “above 0.75–1 grams”. • The summary of current treatment options omits important concerns regarding their safety and efficacy in IgA nephropathy, which should be added for a balanced presentation. Specifically, for glucocorticoids, the KDIGO guidelines highlight an “important risk of treatment-emergent	importance of accurate and clear information. However, the scope is intended to provide a general overview of the condition. We have amended the disease pathophysiology description to reflect the suggested wording. We have removed reference to Henoch-Schönlein purpura. We have removed the wording “but is usually slow”. We have added a note about the safety concerns with glucocorticoids. We have removed discussion of anticoagulants, fish oil, tonsillectomy, hydroxychloroquine and mycophenolate mofetil based on feedback from

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		toxicity" (recommendation 2.3.1.1) and that the "clinical benefit of glucocorticoids in IgAN is not established and should be given with extreme caution" (practice point 2.3.1.3). For all the other treatments listed in the background section of the draft scope as also having been evaluated in trials (anticoagulants, fish oil, etc.), the information should be added that these are explicitly not recommended in the KDIGO guidelines, with the exception of some of these treatments for patients of Chinese or Japanese ethnicity only (practice points 2.3.1.5 and 2.3.1.6). When discussing ACE inhibitor/ARB treatment, Novartis would propose to specify "at the maximum tolerated or allowed dose", as per KDIGO guidelines and the clinical trial evidence for targeted-release budesonide.[9, 14]	clinical experts during the scoping workshop. We have added wording to explain that ACE inhibitors and ARBs are recommended at the maximum tolerated licensed doses. We have not amended the proteinurea criteria for high-risk of progression based on KDIGO guidelines as we heard in the workshop that an alternative criterion (>1g/d) is used in clinical practice. The scope was amended to reflect clinical experts' views in the workshop.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	In explaining the pathology of the disease, we would further indicate that Peyer's patches in the gut are a primary site of IgAN production, with the gut comprising at least 80% of all immunoglobulin-producing cells in the body.[15] This is an important component in understanding the gut-kidney axis, the disease pathology and the mechanism of action for targeted-release budesonide.	Thank you for your comments. We have not added the description for the Peyer's patches as this is deemed a level of detail not required at

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		It is also important to highlight that, although immunosuppressants can be used to treat patients with IgAN at risk of rapidly progressing disease, KDIGO guidelines recommend that patients at risk of progressive CKD should be considered for clinical trials, due to the uncertainty regarding the safety and efficacy of existing immunosuppressive treatments. This is reflected in UK clinical practice. It is further important to clarify that cyclophosphamide is also only used in patients with rapidly progressive glomerulonephritis.	scoping stage. We have added a note about the safety concerns with glucocorticoids and their limited use due to this. Clinical trials have been added as a potential second-line option. Cyclophosphamide has been removed as during the scoping workshop experts explained that it would only be used in people with rapidly deteriorating renal function.
Population	Novartis Pharmaceuticals	The population included in the clinical trials of targeted-release budesonide was narrower than currently specified in the “Population” section, as reflected in the “The technology” section.	Thank you for your comment. Targeted-release budesonide will be appraised within its marketing authorisation. No action required.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	As described above, the marketing authorisation is now expected to be adults with IgAN at risk of rapid disease progression with a UPCR ≥1.5 g/gram.	Thank you for your comment. Targeted-release budesonide will be appraised within its

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			marketing authorisation. No action required.
Subgroups	Novartis Pharmaceuticals	No comments	No action required.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	This relevant subgroup is no longer relevant, given that the marketing authorisation is specifically for the population of IgAN IgAN at risk of rapid disease progression with a UPCR ≥1.5 g/g. There are no further relevant subgroups	Thank you for your comment. The scope has been updated to remove this subgroup.
Comparators	Novartis Pharmaceuticals	Novartis agrees with the inclusion of ACE inhibitor/ARB treatment (at the maximum tolerated licensed dose) as the key component of established clinical management in IgA nephropathy, in line with the KDIGO guidelines and feedback from UK nephrologists.[9] Insights gained by Novartis from several UK clinicians also point to an existing and increasing usage of sodium-glucose cotransporter-2 (SGLT2) inhibitors in IgA nephropathy in the UK, as an add-on therapy to an ACE inhibitor or ARB. The marketing authorisation of dapagliflozin, an SGLT2 inhibitor, covers treatment of chronic kidney disease (CKD) and dapagliflozin was recently recommended by NICE for this indication [TA775]. Subgroup data from the dapagliflozin CKD trial in patients with IgA nephropathy were published in April 2021.[16] Based on insights from UK clinicians, glucocorticoids are used only very cautiously, given their side effects. Novartis would like to note that the KDIGO guidelines specify that patients with rapidly progressive IgA nephropathy should be offered treatment with cyclophosphamide *and glucocorticoids* (practice point 2.4.3)[9], and this was also described as the preferred treatment approach by UK nephrologists in an advisory board.	Thank you for your comments. The comparators have been updated to reflect discussions at the scoping workshop. Established clinical management is with lifestyle modifications and ACE inhibitors / ARBs at the maximum tolerated licensed dose. If proteinurea ≥1g/d second-line treatments such as glucocorticoids (albeit rare or limited use due to safety concerns associated with systemic steroid

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			use), SGLT2 inhibitors or entry into a clinical trial may be considered. Clinical experts explained that cyclophosphamide is only used in people with rapidly deteriorating renal function. This population would be those in whom budesonide wouldn't be used.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	The comparators are not currently considered standard treatments in the NHS with which the current technology should be compared. As described above, there are no treatments that have been developed to specifically target IgAN – in KDIGO guidelines and UK clinical practice, it is recommended that patients at risk of progressive CKD should be considered for clinical trials, due to the uncertainty regarding the safety and efficacy of existing immunosuppressive treatments. The uncertainty regarding the uncertainty associated with the efficacy and safety of existing immunosuppressive options is demonstrated by the results of the TESTING and STOP-IGAN trials. The TESTING trial, which assessed methylprednisolone versus placebo, was terminated early due to excess severe adverse events, particularly severe infections.[17] On the other hand, the STOP-IGAN trial, which assessed standard care versus standard care plus an immunosuppressive protocol of cyclophosphamide, azathioprine and, oral prednisolone over three years, demonstrated that, although significantly more patients receiving this immunosuppression regimen achieved clinical	Thank you for your comments. The comparators have been updated to reflect discussions at the scoping workshop. Established clinical management is with lifestyle modifications and ACE inhibitors / ARBs at the maximum tolerated licensed dose. If proteinurea 1g/d second-line treatments such as glucocorticoids (albeit rare or limited use due to safety

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		remission based on proteinuria, there was no significant difference in eGFR between the standard care plus the immunosuppressive protocol.[18] Reflecting this uncertainty, UK clinicians use corticosteroids sparingly, in order to avoid the severe adverse events associated with high dose corticosteroids. Cyclophosphamide is also not an appropriate comparator, because this treatment is used in patients with rapidly progressive glomerulonephritis. This is an advanced stage of CKD, which is not appropriate for treatment with Kinpeygo®.	concerns associated with systemic steroid use), SGLT2 inhibitors or entry into a clinical trial may be considered. Clinical experts explained that cyclophosphamide is only used in people with rapidly deteriorating renal function. This population would be those in whom budesonide wouldn't be used.
Outcomes	Novartis Pharmaceuticals	Novartis would suggest revising "change from baseline in urine protein creatinine ratio" to "proteinuria (for example, change from baseline in urine protein creatine ratio)", to match the top-line description of other outcomes. Overall, the listed outcomes are appropriate, with changes in proteinuria (urine protein creatine ratio) and kidney function (estimated glomerular filtration rate [eGFR]) playing a key role in determining long-term outcomes such as kidney failure in IgA nephropathy.	Thank you for your comment, the wording of this outcome has been revised.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	These outcomes are all appropriate and relevant to the disease progression of patients with IgAN.	Thank you for your comment. No action required.

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Equality	Novartis Pharmaceuticals	No comments	No action required.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	The proposed scope is not expected to exclude any people protected by equality legislation, nor lead to recommendations with differential impacts on people protected by equality legislation relative to the broader population. It is also not expected that this technology assessment will lead to recommendations with any adverse impact on individuals with particular disability or disabilities.	Thank you for your comment. No action required.
Other considerations	Novartis Pharmaceuticals	No comments	No action required.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	No comments	No action required.
Questions for consultation	Novartis Pharmaceuticals	***How is IgA nephropathy currently treated in the NHS?*** Based on insights from engagement with various UK nephrologists, Novartis understands that patients with IgA nephropathy are predominantly treated with ACE inhibitors or ARBs, with additional treatments considered if patients continue to be at high risk of disease progression despite treatment with the maximum tolerated licensed dose. SGLT2 inhibitors are increasingly being used in the UK for treatment of IgA nephropathy. Use of glucocorticoids varies between patients and clinicians, but in general appears to be much more limited in the UK than in other countries, which aligns with the latest KDIGO guidelines advising extreme caution (practice point 2.3.1.3).[9] A recent advisory board highlighted widespread treatment variation for patients who	Thank you for your comments. The scope has been amended to clarify that all second-line treatments would be add-on treatments to the maximum tolerated licensed doses of ACE inhibitors and ARBs. SGLT2 inhibitors have been added to the scope, other

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		continue to be at high risk of disease progression despite optimised first-line treatment with an ACE inhibitor or ARB. ***Where do you consider targeted-release budesonide will fit into the existing treatment pathway for IgA nephropathy?*** There is considerable variation in the current treatment of IgA nephropathy and no established treatment pathway exists. UK clinicians commented in an advisory board on the lack of standardisation, with the care that patients receive very much dependent on the clinician they see and not all patients receiving evidence-based care. Novartis anticipates that targeted-release budesonide, if recommended by NICE, would be used in line with the available clinical trial evidence (see response to questions further below). ***Would the following treatments be considered established clinical practice for the treatment of IgA nephropathy:*** • ***Immunosuppressants other than glucocorticoids and cyclophosphamide*** • ***Anticoagulants*** • ***Fish oil*** • ***Surgical tonsillectomy?*** These treatments are not recommended by the KDIGO guidelines (practice points 2.3.1.5 and 2.3.1.6), other than mycophenolate mofetil and hydroxychloroquine for Chinese patients and tonsillectomy for Japanese patients.[9] No widespread use was reported by UK clinicians in advisory boards held by Novartis.	immunosuppressants, anticoagulants, fish oil and surgical tonsillectomy have been removed as feedback suggested not used in the NHS.

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		Would targeted-release budesonide always be used in people who are taking stable doses of ACE inhibitors or ARBs? Novartis anticipates that targeted-release budesonide, if recommended, would be used in line with the available clinical trial evidence, where it was added to a stable maximum allowed or tolerated dose of an ACE inhibitor or ARB, for patients who continue to have a urine protein creatinine ratio ≥1 g/24hr.[14] ***Would targeted-release budesonide only be used in people who are at risk of progressing to kidney failure? How is this population defined in clinical practice?*** Again, Novartis would expect that targeted-release budesonide, if recommended, would be used in line with the available clinical trial evidence, which specified a urine protein creatinine ratio ≥1 g/24hr for inclusion in the trial.[14]The KDIGO guidelines define high risk of progression in IgA nephropathy as proteinuria >0.75–1 g/d despite ≥90 days of optimised supportive care (practice point 2.3.1.1).[9] ***Have all relevant comparators for targeted-release budesonide been included in the scope?*** Please refer to our response to the comparators section of the draft scope.	
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	***Question: How is IgA nephropathy currently treated in the NHS?*** Response: IgAN is currently treated as per KDIGO guidelines in the UK. Patients are first treated with RAS blockade and lifestyle advice, in terms of on dietary sodium restriction, smoking cessation, weight control, and exercise. All patients who remain at risk of rapidly progressing disease, despite this treatment, are considered for inclusion in clinical trials, due to the uncertainty regarding the	Thank you for your comments. The comparators have been amended following discussions at the scoping workshop. Clinical experts explained that

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		safety and efficacy of current immunosuppressive therapies. Immunosuppressive drugs (particularly corticosteroids) are considered for sparing use, in patients with IgAN who remain at high risk of progressive CKD despite maximal supportive care who are not appropriate for clinical trials. ***Question: Where do you consider targeted-release budesonide will fit into the existing treatment pathway for IgA nephropathy?*** Response: Kinpeygo ® (targeted-release budesonide) expected to be used as a second-line therapy for patients in patients with IgAN who remain at high risk of progressive CKD despite maximal supportive care with RAS blockade. ***Question: Would the following treatments be considered established clinical practice for the treatment of IgA nephropathy:*** • ***Immunosuppressants other than glucocorticoids and cyclophosphamide*** • ***Anticoagulants*** • ***Fish oil*** • ***Surgical tonsillectomy?*** Response: Further immunosuppressants, anticoagulants and tonsillectomy are not used as part of regular clinical practice. Fish oil may be recommended as a supplement, but is unlikely to be prescribed.	glucocorticoids are rarely used due to safety concerns (estimated to be <10% people). SGLT2 inhibitors have been included as a comparator based on feedback from experts. We have added a note in the background section that clinical trials could be considered as a second-line option. Other immunosuppressants, anticoagulants, fish oil and surgical tonsillectomy have been removed as clinical advice indicated these treatments are not used in the NHS.

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		Question: Would targeted-release budesonide always be used in people who are taking stable doses of ACE inhibitors or ARBs? Response: Yes, in line with the clinical trial, Kinpeygo® would be expected to be used in patients who were at risk of rapidly progressing IgAN, despite stable doses of RAS blockers. ***Question: Would targeted-release budesonide only be used in people who are at risk of progressing to kidney failure? How is this population defined in clinical practice?*** Response: In line with the latest anticipated marketing authorisation, the targeted release formulation of budesonide will be indicated for adults with IgAN adults at risk of rapid disease progression with a UPCR ≥1.5 g/gram. The patient population has been defined based on UPCR, because UPCR is an indicator of proteinuria – patients with proteinuria are at greater risk of progression to ESRD.[19] While proteinuria requires 24-hour urine collection, UPCR can be tested in a single spot test that can easily be assayed as part of clinical practice.[19] ***Question: Would targeted-release budesonide be used in people with rapidly progressive IgA nephropathy?*** Response: Please see the above response ***Question: Have all relevant comparators for targeted-release budesonide been included in the scope?*** Response: Yes	

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		Question: Would targeted-release budesonide be a candidate for managed access? Response: No ***Question: Do you consider targeted-release budesonide 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)?*** Response: Yes, KDIGO international guidelines for IgAN highlight the uncertainty regarding the safety and efficacy of existing immunosuppressive options and recommend that all patients who remain at high risk of progressive CKD despite maximal supportive care should be offered the opportunity to take part in a clinical trial (KDIGO, 2021). The uncertainty associated with the efficacy and safety of existing immunosuppressive options is demonstrated by the results of the TESTING and STOP-IGAN trials. The TESTING trial assessed methylprednisolone versus placebo – this trial was terminated early due to excess severe adverse events and severe infections.[17] By contrast, the STOP-IGAN trial, which assessed standard care versus standard care plus an immunosuppressive protocol of cyclophosphamide, azathioprine and, oral prednisolone over three years, demonstrated that, although significantly more patients receiving this immunosuppression regimen achieved clinical remission based on proteinuria, there was no significant difference in eGFR between the standard care plus the immunosuppressive protocol.[18] As described above, Kinpeygo plus RAS blockade significantly improved both UPCR and eGFR, relative to RAS alone. The majority of adverse events were mild to moderate and no severe infections were observed. Thus, Kinpeygo provides patients with the first approved therapy specifically targeting IgAN, which can delay or prevent progression to advanced CKD stages. Because	

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		patients experience quality of life impairments as CKD progresses, due worsening symptoms and the need for dialysis or transplant.[7, 20] Kinpeygo provides significant health benefits to patients that will be a step-change in patient management. ***Question: Do you consider that the use of targeted-release budesonide can result in any potential substantial health-related benefits that are unlikely to be included in the QALY calculation?*** Response: Yes, Kinpeygo® would be expected to provide significant patient benefits that will not be captured in the QALY calculation. Firstly, patients experience symptoms and treatments that can lead patients to substantial lifestyle changes. For example, haematuria can be distressing to patients at the time that it occurs and lead them to avoid certain activities such as sports[3]; however, the episodic nature of this symptom may not be captured by generic measures that typically inform the QALY. Furthermore, the fatigue associated with the disease can cause significant lifestyle changes, which generic measures may not capture.[3]The impact of these symptoms is demonstrated by patient testimonies recorded by Tyagi *et al.,* 2019: - *"My daughter LOVES sport and she misses her sport activities… every time she even jumps around for a bit, there is gross haematuria"* - *"The opportunity to walk the beach without getting winded on family vacations, to drink more than one beer without nearly collapsing. All of these things were normal for him just months ago, before he found out he was in kidney failure from IgA nephropathy"* Secondly, patients who progress to ESRD and require dialysis. This is a significant patient burden, not only for the impacts captured in the QALY, but	

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		also because of the time and stress associated with going for dialysis not captured by the QALY. For example, patients may need to miss or give-up their jobs[3, 21], while the need for permanent venous catheters may result in impaired sexual function and drive.[22] Finally, IgAN and ESRD have significant caregiver impacts that would not be captured by the QALY. Close persons may find living with patients with ESRD requiring dialysis stressful, experiencing fatigue, and the effect of caring for a patient with ESRD may lead caregivers to neglect their own health.[23] By improving patient outcomes and preventing progression to late stage CKD, Kinpeygo® may provide significant patient benefits that will not be captured in the QALY calculation.	
Additional comments on the draft scope	Novartis Pharmaceuticals	If dapagliflozin, an SGLT2 inhibitor, is included as a comparator to be considered, Novartis would suggest adding the relevant NICE guidance [TA775] to the **Related NICE recommendations** section.	Thank you for your comment. SGLT2 inhibitors have been added as a comparator following discussions at the scoping workshop and dapagliflozin added in the related NICE guidance section.
	Calliditas Therapeutics AB / Britannia Pharmaceuticals (STADA)	No comments	No action required.

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

Kidney Care UK

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