NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health Technology Evaluation

Belumosudil for treating chronic graft versus host disease after 2 or more therapies

Draft scope

Draft remit/evaluation objective

To appraise the clinical and cost effectiveness of belumosudil within its marketing authorisation for treating chronic graft versus host disease after 2 or more therapies.

Background

Graft versus host disease (GVHD) usually occurs after an allogeneic haematopoietic stem cell transplant (HSCT) when donated white T-cells attack the body's own cells. Chronic GVHD (cGVHD) results in fibrotic skin disease, bronchiolitis, salivary and lacrimal gland disease, and eosinophilic fasciitis, and typically occurs more than 100 days after a HSCT (whereas acute GVHD usually occurs within 100 days of a HSCT).[1] NHS England's clinical commissioning policy states that cGVHD is staged as limited or extensive, and should be graded as mild, moderate or severe.[2] cGvHD causes severe morbidity and mortality mainly because of infections resulting from immunodeficiency, as well as damage to organs such as the lungs and liver.

In 2020 there were 1,387 first allogeneic transplants in adults in the UK.[3] Between 30% and 40% of adult allograft recipients developed cGVHD in the 2007 to 2012 cohort.[2] 6% of adult allograft recipients will have extensive cGvHD that requires subsequent lines of therapy. Between 2007 and 2012, 241 people were living with extensive cGvHD in England.[2]

NHS England's clinical commissioning policy includes combination therapy of systemic corticosteroids and calcineurin inhibitors (tacrolimus or cyclosporine) as options for the first-line treatment of cGVHD. Sirolimus, extracorporeal photopheresis, pentostatin, rituximab and imatinib are routinely commissioned as second-line options, depending on the specific indication. In people whose condition does not respond to two different second-line treatments, third-line options include mycophenolate mofetil, methotrexate and pulsed corticosteroids[1] (high daily doses of steroids over a short period of time). Topical treatments and organ-specific supportive agents, including antibiotics and vaccinations, also have an important role in the effective management of cGVHD.[4]

The technology

Belumosudil (REZUROCK, Sanofi) is indicated in the UK for treatment of people aged 12 years and older with chronic graft-versus-host disease who have received at least two prior lines of systemic therapy. It is being studied in clinical trials in people aged 12 and over who have cGVHD and have had at least 2 prior lines of systemic therapy.

Intervention(s)	Belumosudil with established clinical management
Population(s)	People aged 12 and over with chronic graft versus host disease after 2 or more therapies
Subgroups	If the evidence allows the following subgroups will be considered. These include: • Number and type of previous treatments
Comparators	Established clinical management without belumosudil, including: • mycophenolate mofetil • methotrexate • pulsed corticosteroids
Outcomes	The outcome measures to be considered include: • response to treatment (including complete response and overall response) • corticosteroid sparing • mortality • adverse effects of treatment • health-related quality of life
Economic analysis	The reference case stipulates that the cost effectiveness of treatments should be expressed in terms of incremental cost per quality-adjusted life year. The reference case stipulates that the time horizon for estimating clinical and cost effectiveness should be sufficiently long to reflect any differences in costs or outcomes between the technologies being compared. Costs will be considered from an NHS and Personal Social Services perspective. The availability of any commercial arrangements for the intervention, comparator and subsequent treatment technologies will be taken into account. The availability of any managed access arrangement for the intervention will be taken into account. The availability and cost of biosimilar and generic products should be taken into account.

Other considerations	Guidance will only be issued in accordance with the marketing authorisation. Where the wording of the therapeutic indication does not include specific treatment combinations, guidance will be issued only in the context of the evidence that has underpinned the marketing authorisation granted by the regulator.
Related NICE recommendations	**Related appraisals in development:** Ruxolitinib for treating chronic graft versus host disease refractory to corticosteroids in people aged 12 and over [ID2716]. Suspended.
Related National Policy	The NHS Long Term Plan, 2019. NHS Long Term Plan NHS England (2018) Manual for prescribed specialised services 2018/19 Chapters 29 and 138 NHS England (2017) Clinical Commissioning Policy: Treatments for Graft versus Host Disease (GvHD) following Haematopoietic Stem Cell Transplantation. 16069/P NHS England (2017) Commissioning Policy: Second allogeneic haematopoietic stem cell transplant for relapsed disease (all ages) NHS England (2013) B04/S/a 2013/14 NHS standard contract for haematopoietic stem cell transplantation (adult) NHS England (2013) B04/S/b 2013/14 NHS standard contract for haematopoietic stem cell transplantation (children) Department of Health and Social Care, NHS Outcomes Framework 2016-2017: Domains 1, 2 and 3 https://www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017

Questions for consultation

Where do you consider belumosudil will fit into the existing care pathway for chronic graft versus host disease?

Have all relevant comparators for belumosudil been included in the scope? Which treatments are considered to be established clinical practice in the NHS for cGVHD?

Would belumosudil be used in people who have had more than 5 previous systemic therapies in NHS practice?

Would belumosudil always be given in combination with other treatments such as but not limited to corticosteroids?

Would belumosudil be given in practice to those whose weight was under 40kg?

Would chronic graft-versus-host disease be more likely to occur in people for whom tissue-type matched donors may be more difficult to identify, for example people from a Black, Asian or minority ethnic family background?

Are the outcomes listed appropriate?

Are there any subgroups of people in whom belumosudil is expected to be more clinically effective and cost effective or other groups that should be examined separately?

Would belumosudil be a candidate for managed access?

Do you consider belumosudil 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 belumosudil can result in any potential 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 committee to take account of these benefits.

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. 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 belumosudil 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.

NICE intends to evaluate this technology through its Single Technology Appraisal process. We welcome comments on the appropriateness of appraising this topic through this process. (Information on NICE's health technology evaluation processes is available at https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance/changes-to-health-technology-evaluation).

References

1. Cancer Research UK (2022) Types and Grades of GvHD. Accessed August 2022

2. NHS England (2017) Clinical Commissioning Policy: Treatments for Graft versus Host Disease (GvHD) following Haematopoietic Stem Cell Transplantation. 16069/P. Accessed May 2022.

3. BSBMTCT (2020) BSBMT Registry. Accessed May 2022.

4. Dignan FL et al. (2012) Organ-specific management and supportive care in chronic graft-versus-host disease. British Journal of Haematology 158(1):62-78. Accessed May 2022.