**Appendix B**

**NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE**

**Health Technology Evaluation**

# Relugolix for treating hormone-sensitive prostate cancer

**Draft scope**

## Draft remit/evaluation objective

To appraise the clinical and cost effectiveness of relugolix within its marketing authorisation for treating hormone-sensitive prostate cancer.

## Background

Prostate cancer is a condition in which tumours develop in the prostate, a gland in the male reproductive system. The exact cause is unknown but environmental and genetic factors are associated with an increased risk of developing prostate cancer.[1,2] Prostate cancer can be classified into localised, locally-advanced and metastatic, depending on whether, and how far the cancer has spread. Localised and locally-advanced prostate cancer can be further classified as being at low, intermediate or high risk of progression based on prostate-specific antigen concentration, Gleason score (based on a biopsy) and clinical stage. The description 'hormone-sensitive prostate cancer' refers to a population that includes people with prostate cancer who have not had androgen deprivation therapy, or whose disease is continuing to respond to androgen deprivation therapy.

The incidence of prostate cancer increases with age and is higher in people of black African-Caribbean family origin and people with a family history of the condition.[1] In England, between 2020 and 2021, 30,741 people were diagnosed with prostate cancer. The age standardised mortality rate for prostate cancer in 2020 was 44.8 for every 100,000 persons.[3]

For people with intermediate or high-risk localised or locally advanced prostate cancer, NICE clinical guideline 131 (NG131) recommends androgen deprivation therapy (also called hormone therapy) as part of their treatment.

For newly diagnosed metastatic prostate cancer, NG131 recommends starting docetaxel chemotherapy within 12 weeks of starting androgen deprivation therapy. The guideline recommends offering bilateral orchidectomy as an alternative to continuous luteinising hormone-releasing hormone agonist therapy (a type of androgen deprivation therapy). For people who are willing to accept the adverse impact on overall survival and gynaecomastia (breast swelling) in the hope of retaining sexual function, the guideline recommends offering anti-androgen monotherapy with bicalutamide. NICE technology appraisal 404 recommends degarelix, a gonadotrophin-releasing hormone antagonist, for treating advanced hormone-dependent (hormone-sensitive) prostate cancer in people with spinal metastases. Additional options for treating hormone-sensitive metastatic prostate cancer in adults, in combination with androgen deprivation therapy, include enzalutamide (NICE technology appraisal 712), apalutamide (NICE technology appraisal 741; if docetaxel is not suitable), and darolutamide (NICE technology appraisal 904; with docetaxel).

## The technology

Relugolix (Orgovyx, Accord Healthcare Limited and Myovant Sciences) is indicated for "the treatment of adult patients with advanced hormone sensitive prostate cancer."

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| **Intervention(s)** | Relugolix |
| **Population(s)** | People with hormone-sensitive prostate cancer |
| **Comparators** | • Androgen deprivation therapy alone (including orchidectomy, luteinising hormone-releasing hormone agonist therapy such as leuprorelin acetate, degarelix)<br>• Monotherapy with bicalutamide<br>• Docetaxel with androgen deprivation therapy<br>• Apalutamide with androgen deprivation therapy<br>• Enzalutamide with androgen deprivation therapy<br>• Darolutamide with androgen deprivation therapy and docetaxel |
| **Outcomes** | The outcome measures to be considered include:<br>• overall survival<br>• progression-free survival<br>• response rate<br>• prostate-specific antigen response<br>• time to prostate-specific antigen progression<br>• adverse effects of treatment<br>• 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.<br>If the technology is likely to provide similar or greater health benefits at similar or lower cost than technologies recommended in published NICE technology appraisal guidance for the same indication, a cost comparison may be carried out.<br>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.<br>Costs will be considered from an NHS and Personal Social Services perspective.<br>The availability of any commercial arrangements for the intervention, comparator and subsequent treatment technologies will be taken into account. |

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| | 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 technology appraisals:**<br>Darolutamide with androgen deprivation therapy and docetaxel for treating hormone-sensitive metastatic prostate cancer (2023) NICE technology appraisal guidance [TA903]<br><br>Apalutamide with androgen deprivation therapy for treating hormone-sensitive metastatic prostate cancer (2021). NICE technology appraisal guidance [TA741]. Review date 2024.<br><br>Abiraterone for treating newly diagnosed high-risk hormone-sensitive metastatic prostate cancer (2021). NICE technology appraisal guidance [TA721]. Review date 2024.<br><br>Enzalutamide for treating hormone-sensitive metastatic prostate cancer (2021). NICE technology appraisal guidance [TA712]. Review date 2024.<br>**Related NICE guidelines:**<br>Prostate cancer: diagnosis and management (2021). [NG131].<br>**Related interventional procedures:**<br>Biodegradable spacer insertion to reduce rectal toxicity during radiotherapy for prostate cancer (2023). NICE interventional procedures guidance [IPG752].<br><br>Focal therapy using high-intensity focused ultrasound for localised prostate cancer (2023). NICE interventional procedures guidance [IPG756].<br><br>Irreversible electroporation for treating prostate cancer (2023). NICE interventional procedures guidance [IPG768].<br><br>**Related diagnostic guidance:**<br>MRI fusion biopsy in people with suspected prostate cancer (2023). NICE diagnostic guidance [DG53].<br><br>**Related quality standards:**<br>Prostate cancer (2015) NICE quality standard [QS91]. |

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| **Related National Policy** | The NHS Long Term Plan (2019) NHS Long Term Plan<br>NHS England (2018) NHS manual for prescribed specialist services (2018/2019)<br>NHS England (2021) Clinical Commissioning Policy: External beam radiotherapy for patients presenting with hormone sensitive, low volume metastatic prostate cancer at the time of diagnosis<br>NHS England (2016) Clinical Commissioning Policy Statement: Docetaxel in combination with androgen deprivation therapy for the treatment of hormone naïve metastatic prostate cancer<br>NHS England (2013) 2013/14 NHS standard contract for cancer: chemotherapy (adult) |

**Questions for consultation**

Where do you consider relugolix will fit into the existing care pathway for hormone-sensitive prostate cancer?

Do you expect relugolix to be used as an alternative to other androgen deprivation therapies? Would it also be used in combination with nonsteroidal androgen receptor antagonist such as apalutamide, enzalutamide and/or darolutamide?

Have all relevant comparators been included in the scope? Should abiraterone, apalutamide and enzalutamide (all in combination with androgen deprivation therapy) be considered relevant comparators?

Are the outcomes listed in the scope appropriate?

Do you consider relugolix 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 relugolix 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 the treatment 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. (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).

NICE's health technology evaluations: the manual 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?
- 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?

**References**

1. Cancer Research UK (2022) Prostate cancer risks and causes. Accessed April 2023.
2. Macmillan Cancer Support (2021) Potential causes of prostate cancer. Accessed April 2023.
3. NHS Digital (2023). Cancer registration statistics, England 2020. Accessed April 2023