NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health Technology Evaluation

Risankizumab for previously treated moderately to severely active ulcerative colitis in people aged 16 and over

Draft scope

Draft remit/evaluation objective

To appraise the clinical and cost effectiveness of risankizumab within its marketing authorisation for treating moderately to severely active ulcerative colitis in people who have had an inadequate response, lost response, or were intolerant to conventional therapy, one or more biologic therapies, or a JAK inhibitor.

Background

Ulcerative colitis is the most common inflammatory bowel disease. The cause of ulcerative colitis is unknown. Hereditary, infectious and immunological factors have been proposed as possible causes. It can develop at any age, but peak incidence is between the ages of 15 and 25 years, with a second, smaller peak between 55 and 65 years. It has been estimated that between 1 in 200 and 1 in 420 people in England have ulcerative colitis, of whom about 52% have moderate to severe disease.[1,2]

Ulcerative colitis can cause inflammation in the inner lining of the large intestine. This is usually restricted to the mucosal surface. The symptoms of ulcerative colitis include bloody diarrhoea, pain, urgency, ulceration, tenesmus, fatigue, and anaemia. Up to 50% of people will experience extra-intestinal manifestations involving joints, eyes, the skin, and liver.[3] Ulcerative colitis is associated with significant morbidity; symptoms can have a debilitating impact on quality of life and daily life, including physical, social, and mental well-being. It is a lifelong disease, and symptoms can recur, or the disease can go into remission for months or even years. Ulcerative colitis can be defined as mild or moderate to severe. Around 50% of people with ulcerative colitis will have at least one relapse per year.[4] About 80% of these are mild to moderate and about 20% are severe.[4] 15-25% of people with ulcerative colitis will require hospitalisation due to acute severe colitis.[5] Complications of ulcerative colitis may include haemorrhage, bowel perforation, stricture formation, abscess formation and anorectal disease. Some people may also develop primary sclerosing cholangitis, osteoporosis, and toxic megacolon. People with long-standing disease have an increased risk of bowel cancer.

The aim of treatment in active disease is to address symptoms of bloody diarrhoea, urgent need to defecate and abdominal pain, and thereafter to maintain remission. Initial management depends on clinical severity, extent of disease and the person's preference, and may include aminosalicylates (sulfasalazine, mesalazine, balsalazide or olsalazine), corticosteroids (beclometasone, budesonide, hydrocortisone or prednisolone) and immunomodulators (thiopurines). Options for people whose disease has responded inadequately to conventional therapy or who cannot tolerate or have medical contraindications for such therapies include:

- infliximab, adalimumab and golimumab (NICE technology appraisal 329)
- vedolizumab (NICE technology appraisal 342)

- tofacitinib (NICE technology appraisal 547)
- ustekinumab (only if a tumour necrosis factor-alpha inhibitor has failed, cannot be tolerated or is not suitable; NICE technology appraisal 633)
- filgotinib (NICE technology appraisal 792)
- ozanimod (only if infliximab is not suitable, or biological treatment is not tolerated or not working well enough; NICE technology appraisal 828)
- upadacitinib (NICE technology appraisal 865).

For people admitted to hospital with acute severe ulcerative colitis NICE guideline 130 recommends offering intravenous corticosteroids to induce remission and assessing the need for surgery. Surgery may be considered as emergency treatment for severe ulcerative colitis that does not respond to drug treatment. People may also choose to have elective surgery for unresponsive or frequently relapsing disease that is affecting their quality of life. The scope of this appraisal does not include severe ulcerative colitis that is a medical emergency requiring intensive inpatient treatment.

The technology

Risankizumab (Skyrizi, AbbVie) does not currently have a marketing authorisation in the UK for moderately to severely active ulcerative colitis. It has been studied in clinical trials compared with placebo in people with moderately to severely active ulcerative colitis who have had an inadequate response, lost response, or were intolerant to conventional therapy, one or more biologic therapies, or tofacitinib.

Intervention(s)	Risankizumab
Population(s)	People aged 16 years and older with moderately to severely active ulcerative colitis who have had an inadequate response to or were intolerant to conventional therapy, one or more biologic therapies, or a JAK inhibitor.
Subgroups	If the evidence allows the following subgroups will be considered: • people who have been previously treated with 1 or more biologic therapies • people who have been previously treated with a JAK inhibitor • people who have not received a prior biologic therapy or a JAK inhibitor.

Comparators	At least 1 of the following treatments, according to NICE guidance: • conventional therapies (including aminosalicylates, oral corticosteroids and/or immunomodulators), without biologic therapies • TNF-alpha inhibitors (such as infliximab, adalimumab or golimumab) • JAK inhibitors (such as tofacitinib, filgotinib or upadacitinib) • ustekinumab • vedolizumab • ozanimod • etrasimod (subject to ongoing NICE evaluation) • mirikizumab (subject to ongoing NICE evaluation).
Outcomes	The outcome measures to be considered include: • rate of and duration of response, relapse and remission • corticosteroid-free remission • rate of endoscopic improvement • rate of hospitalisation • rate of surgical intervention • mortality • adverse effects of treatment, including nephrotoxicity • 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. 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. 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 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:** Upadacitinib for treating moderately to severely active ulcerative colitis (2023) NICE technology appraisal guidance 856. Ozanimod for treating moderately to severely active ulcerative colitis (2022) NICE technology appraisal guidance 828. Filgotinib for treating moderately to severely active ulcerative colitis (2022) NICE technology appraisal guidance 792. Ustekinumab for treating moderately to severely active ulcerative colitis (2020) NICE technology appraisal guidance 633. Tofacitinib for moderately to severely active ulcerative colitis (2018) NICE technology appraisal guidance 547. Vedolizumab for treating moderately to severely active ulcerative colitis (2015) NICE technology appraisal guidance 342. Infliximab, adalimumab and golimumab for treating moderately to severely active ulcerative colitis after the failure

	of conventional therapy (2015) NICE technology appraisal guidance 329. Infliximab for acute exacerbations of ulcerative colitis (2008) NICE technology appraisal guidance 163. **Related technology appraisals in development:** Etrasimod for treating moderately to severely active ulcerative colitis. NICE technology appraisal [ID5091]. Publication date to be confirmed Mirikizumab for treating moderately to severely active ulcerative colitis. NICE technology appraisal [ID3979]. Publication date to be confirmed **Related NICE guidelines:** Ulcerative colitis: management (2019) NICE guideline NG130. Colorectal cancer prevention: colonoscopic surveillance in adults with ulcerative colitis, Crohn's disease or adenomas (2011) NICE guideline 118. **Related Interventional Procedures:** Leukapheresis for inflammatory bowel disease (2005). NICE interventional procedures guidance 126. **Related quality standards:** Inflammatory bowel disease (2015) NICE quality standard 81.
Related National Policy	British Society of Gastroenterology (2019) Consensus guidelines on the management of inflammatory bowel disease in adults British Society of Gastroenterology (2017) UK guideline on transition of adolescent and young persons with chronic digestive diseases from paediatric to adult care The NHS Long Term Plan (2019) NHS Long Term Plan NHS England (2013) 2013/14 NHS Standard Contract for Colorectal: Complex Inflammatory Bowel Disease (Adult) A08/S/c

Questions for consultation

Where do you consider risankizumab will fit into the existing care pathway for ulcerative colitis?

Is there a preferred treatment sequence with biologics and/or other advanced therapies (e.g. JAK inhibitors or ozanimod) after an inadequate response or intolerance to conventional therapy?

Are there specific sub-groups that would particularly benefit from treatment with risankizumab?

Should conventional therapy with aminosalicylates, oral corticosteroids and/or immunomodulators be considered a comparator in the evaluation?

The trial included people who had intolerance or an inadequate response to tofacitinib. Would risankizumab be used after other JAK inhibitors or ozanimod?

Would risankizumab be a candidate for managed access?

Do you consider that the use of risankizumab 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 risankizumab 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 is considering evaluating this technology through its cost comparison evaluation process.
Please provide 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).

Technologies can be evaluated through the cost-comparison process if they are expected to provide similar or greater health benefits, at a similar or lower cost, compared with technologies that have been previously recommended (as an option) in published NICE guidance for the same indication. Companies can propose cost-comparison topics to NICE at any stage during topic selection and scoping. NICE will route technologies for evaluation through the cost-comparison process if it is agreed during scoping that the process is an appropriate route to establish the clinical and cost effectiveness of the technology.

NICE's health technology evaluations: the manual states the methods to be used where a cost comparison case is made.

- Is the technology likely to be similar in its clinical effectiveness and resource use to any of the comparators? Or in what way is it different to the comparators?

- Will the intervention be used in the same place in the treatment pathway as the comparator(s)? Have there been any major changes to the treatment pathway recently? If so, please describe.
- Will the intervention be used to treat the same population as the comparator(s)?
- Overall is the technology likely to offer similar or improved health benefits compared with the comparators?
- Would it be appropriate to use the cost-comparison methodology for this topic?

References

1. Hamilton B, Green H, Heerasing N, et al. Incidence and prevalence of inflammatory bowel disease in Devon, UK Frontline Gastroenterology 2021;12:461-470. Accessed April 2023.
2. Crohn's and Colitis UK (2017) Ulcerative Colitis. Accessed April 2023.
3. IBD UK (2021) Crohn's and Colitis Care in the UK: The Hidden Cost and a Vision for Change. Accessed April 2023.
4. National Institute for Health and Care Excellence (2014) Quality standards and indicators Briefing Paper. Accessed April 2023.
5. IBD UK (2023) Management of acute severe colitis. Accessed April 2023.