Service Notification in response to DHSSPS endorsed NICE Technology Appraisals

Health and Social Care Board

NICE TA 248: Exenatide Prolonged-Release suspension for injection in combination with oral antidiabetic therapy for the treatment of type 2 diabetes.

1	**Name of Commissioning Team** Long Term Conditions Commissioning Team
2	**Summary of NICE TA 248** Prolonged release exenatide is a once weekly subcutaneous injection. Prolonged-release exenatide in triple therapy regimens (that is in combination with metformin and a sulphonylurea, or metformin and a thiazolidinedione) is recommended as a treatment option for people with Type 2 diabetes as described in 'Type 2 diabetes: the management of type 2 diabetes' (NICE clinical guideline 87); that is, when control of blood glucose remains or becomes inadequate (HbA1c≥7.5% [59mmol/mol] or other higher level agreed with the individual), and the person has: • A body mass index (BMI)≥35kg/m^2 in those of European family origin (with appropriate adjustment for other ethnic groups) and specific psychological or medical problems associated with high body weight or • A BMI <35kg/m^2, and therapy with insulin would have significant occupational implications or weight loss would benefit other significant obesity-related comorbidities. Treatment with prolonged-release exenatide in a triple therapy regimen should only be continued as described in 'Type 2 diabetes: the management of type 2 diabetes' (NICE clinical guideline 87); that is, if a beneficial metabolic response has been shown (defined as a reduction of at least 1 percentage point in HbA1c [11mmol/mol] and a weight loss of at least 3% of initial body weight at 6 months). Prolonged-release exenatide in dual therapy regimens (that is, in combination with metformin or a sulphonylurea) is recommended as a treatment option for people with type 2 diabetes as described in 'Liraglutide for the treatment of type 2 diabetes(NICE TA 203); that is, only if: • The person is intolerant of either metformin or a sulphonylurea, or a treatment with metformin or a sulphonylurea is contraindicated, and • The person is intolerant of thiazolidinediones and DPP-4 inhibitors is contraindicated. Treatment with prolonged-release exenatide in a dual therapy regimen should only be continued as described in 'Liraglutide for the treatment of type 2 diabetes mellitus' (NICE TA 203); that is, if a beneficial metabolic response has been shown (defined as a reduction of at least 1 percentage point in HbA1C [11mmol]mol] at 6 months).

3	**Number of people in Northern Ireland expected to take up service/therapy (new cases per year)** Prolonged-release exenatide is recommended for the same people as the existing glucagon-like peptide -1 (GLP-1) receptor agonists in NICE clinical guideline 87 and technology appraisal guidance 203.
4	**Outcomes**
4.1	**Additional life expectancy gain / progress improvement** Manufacturer's results showed that weekly prolonged-release exenatide was associated with greater life expectancy and more QALYs than pioglitazone, sitagliptin and insulin glargine.
4.2	**Reduction in morbidity** The main benefit of weekly prolonged-release exenatide to patients is the need for fewer injections (weekly versus daily), which reduces the impact of managing type 2 diabetes on the daily lives of patients and carers.
4.3	**Cost per patient per annum** Total estimated cost per patient £1005 based on annual drug cost of £953.68 and self monitoring of blood glucose of £51.09 (Drug costs taken from British National Formulary (BNF 62)
4.4	**In year cost per patient per annum (for new and prevalent cases)** Based on NICE costing statement it is estimated that 1262* patients would be eligible to receive prolonged-release exenatide, exenatide twice daily or liraglutide 1.2mg. *Figure based on NICE TA 248 Costing statement Table 1 using Northern Ireland population.
4.5	**Any cost savings and how these will be secured** It is unlikely that the implementation of this technology appraisal will result in a significant resource impact because the cost of prolonged-release exenatide is comparable to the cost of alternative GLP-1 receptor agonists recommended by NICE.
4.6	**Recurrent overall cost** Information is available on current usage of GLP-1 receptor agonists although these drugs are still relatively new and establishing this place in therapy. In the first 2 months of 2012 there were 10301 individual items costing £405K. Extrapolating this would give annual figure of 25,000 prescriptions costing £2.4 million for GLP-1 receptor agonists including prolonged release exenatide however this figure may

	rise if usage increases.
4.7	**Cost per QALY** According to the manufacturer at a threshold of £20,000 per QALY, weekly prolonged-release exenatide had a 99-100% probability of being cost effective when compared with pioglitazone, sitagliptin, exenatide twice daily and insulin glargine and a 87.4% probability of being cost effective compared with liraglutide 1.2 mg.
4.8	**Other treatments available for this condition** Exenatide twice daily Liraglutide Pioglitazone Sitagliptin Insulin glargine
4.9	**Readiness to implement** It is anticipated that this TA will be implemented within 3 months of issue to Trusts.
5	**DHSSPS Legislative / policy caveats** This advice does not override or replace the individual responsibility of health professionals to make appropriate decisions in the circumstances of their individual patients, in consultation with the patient and/or guardian or carer. This would, for example, include situations where individual patients have other conditions or complications that need to be taken into account in determining whether the NICE guidance is fully appropriate in their case.
6	**What will Commissioning Team do to secure funding for the implementation of this TA including any proposals for disinvestment** As prolonged-release exenatide is recommended as an alternative treatment and has comparable costs to the other GLP-1receptor agonists recommended by NICE, this implementation is a minor change to treatment and should be cost neutral and can be monitored through existing arrangements for this group of therapies.
7	**Commissioning arrangements** This treatment would usually be initiated by diabetes specialists in secondary care and prescribed in primary care.
8	**Monitoring arrangements** Monitoring will be undertaken by Medicines Management in line with arrangements for other GLP-1 agonists. HSC Trusts will be asked for regular updates regarding the actual uptake of this technology versus the expected uptake.