

NICE TA 268 – Ipilimumab for previously treated advanced (resectable or metastatic) melanoma

<p>1</p>	<p>Summary of NICE TA 268</p> <p>NICE recommends ipilimumab as a possible treatment for people with previously treated advanced (unresectable or metastatic) melanoma, only if the manufacturer provides ipilimumab with the discount agreed in the patient access scheme.</p>
<p>2</p>	<p>Number of people in Northern Ireland expected to take up service/therapy (new cases per year)</p> <p>The NICE costing statement accompanying TA 268 indicates that 5 patients per year would be expected to take up treatment with ipilimumab for previously treated advanced (unresectable or metastatic) melanoma.</p> <p>A business case from the NICAN Drugs and Therapeutic Committee has indicated that approximately 18-22 patients each year would be eligible for treatment with ipilimumab.</p> <p>Coincidentally, another regime for treatment of malignant melanoma has also been recommended by NICE in the same timescale. This is for TA 269 – Vermurafinib.</p> <p>As part of the engagement process with local clinicians when exploring the delivery of new NICE recommended Technical Appraisals, the HSCB/PHA has considered submissions from the Northern Ireland Cancer Network, Drug and Therapeutic Committee.</p> <p>The volume of patients projected to benefit by NICaN from these regimes in Northern Ireland is considerably higher than that projected in the NICE costing templates for both of these regimes.</p> <p>The submissions made by NICaN D&T in respect of both TA 268 and TA 269 identified a cohort of 86 patients per annum with this condition. The NICaN submissions were forwarded as two individual, separate business cases for each of the two TA's but did not provide any information as to whether treatment for this cohort of patients would be potentially sequential between the two regimes or exclusive to one subset of eligible patients.</p> <p>In addition there is a difference in the number of treatment cycles proposed under TA 268 and the NICaN estimate of same.</p> <p>Therefore, HSCB/PHA sought additional clarification from the NICaN D&T Committee specifically on:</p> <ul style="list-style-type: none"> • Rationale for significantly higher volume of patients with this specific condition than projected by NICE • Relationship between the two regimes identified through a care pathway or confirmation that the 2 regimes are exclusive to specific patient subsets

- Rationale for the difference in treatment cycles

Clinical advice indicates that there may be higher incidence of advanced / unresectable melanoma in the Northern Ireland population, some of which may be among patients diagnosed some years ago but among whom the disease has progressed. The NICaN D&T Committee has advised that they are planning an audit on the first year of Cost Per Case use of these drugs and the results of this audit will be taken into account in service planning.

Regarding the relationship between these 2 drugs clinical advice is that when a patient develops irresectable metastatic melanoma they will be considered for systemic therapy. If the tumour carries a mutation of the BRAF gene then it is suitable for Vemurafenib and this would be offered. If not then the patient is offered first-line chemotherapy (dacarbazine or temozolomide).

When disease progression occurs then the patient will be considered for second line therapy which would be Ipilimumab if they are fit for that therapy. If not suitable for Ipilimumab then they would be considered for a second-line treatment with chemotherapy (particularly if they are taking steroids or have an auto-immune disease, which renders them unsuitable for Ipilimumab).

Metastatic Disease

First line BRAF +ve = vemurafenib
 BRAF -ve = DTIC/Temozolomide

Second line Ipilimumab or second-line chemotherapy

The NICAN D&T has advised that based on clinical trial and expanded access programme experience only 60% of patients (14) receive all four doses of drug (either due to disease progression or toxicity) and the average number of cycles actually received was 3.3 per patient trial.

HSCB/PHA has reserved a level of funding adequate to address the demand for this regime in line with the NICaN D&T estimate to ensure that the higher estimate of projected demand can be resourced if required and the NICE TA introduced in line with Circular HSC (SQSD) 04/11. The regime is currently available on a cost per case basis and no patient will be delayed from commencing treatment pending finalisation of the business case.

From October, 2012 to date, 9 requests for Ipilimumab have been approved by HSCB on a Cost Per Case basis.

The final position will be closely monitored via a formal review of the cost per case applications by the specialist services commissioning team on a quarterly basis.

3	Costs
3.1	<p>Cost per patient per annum</p> <p>The average cost per dose of ipilimumab is £19,565. This costing is based on an average patient weight of 81.7kg (derived from the weight of UK patients enrolled in the pivotal trial and the expanded access programme) and a unit cost of £3,750 per 50mg vial of ipilimumab (NICE).</p> <p>The NICAN D&T business cases estimates that based on clinical trial and expanded access programme experience only 60% of patients (14) receive all four doses of drug (either due to disease progression or toxicity) and the average number of cycles actually received was 3.3 per patient trial, hence the anticipated drug costs per patient are £64,565 (in comparison to £78,260 for 4 doses).</p> <p>For 14 patients on 3.3 cycles, NICAN estimated cost before PAS is £904k</p>
3.2	<p>In year cost per patient per annum</p> <p>In year costs will be met through a cost per case arrangement and monitored pending finalisation of the recurrent business case.</p> <p>Estimated in year costs will depend on patient numbers approved.</p>
3.3	<p>Cost savings and how these will be secured</p> <p>Not applicable</p>
3.4	<p>Recurrent overall cost</p> <p>The estimated recurrent cost for drugs is £904k. Some additional administration costs (see below) have yet to be agreed.</p> <p>The HSCB/PHA recognise that there will also be non drug costs arising from the introduction of this regime such as pharmacy and nursing time and additional pre-chemotherapy blood tests. There will also be additional costs arising from management of drug toxicity including supportive treatment such as steroids and potentially 7 bed days per year.</p> <p>The manufacturer of ipilimumab has agreed a patient access (PAS) with the Department of Health, in which a discount on the list price of ipilimumab is offered. The size of the discount is commercial in confidence. Belfast Trust will be expected to avail of this scheme.</p>
4	<p>Expected implementation period</p> <p>There is no impediment to immediate implementation for new patients. Patients are already commencing on treatment through a cost per case arrangement.</p>

<p>5</p>	<p>Commissioning arrangements</p> <p>This treatment will be delivered only in the Cancer Centre. Treatment for advanced melanoma is delivered in the Cancer Centre for all patients across the region.</p> <p>For monitoring purposes, commissioning arrangements for this regime will be via the Cost Per Case arrangement for a 12 month period and will be consolidated thereafter in line with the cost per case audit data.</p>
<p>6</p>	<p>Monitoring arrangements</p> <p>HSCB currently reviews quarterly monitoring information in relation to the usage of all recurrently funded specialist cancer drugs across both the Cancer Centre and other Units.</p> <p>The monitoring pro forma will be adapted to capture information in respect of this regime and this group of patients. This monitoring report is submitted to the Specialist Services Commissioning Team for formal review and comment by the Team.</p> <p>The HSCB IFR process will generate quarterly reports on the number of Cost Per Case applications which will be reviewed formally by the Specialist Services Commissioning Team on a quarterly basis.</p> <p>SSCT has a long established relationship with NICaN D&T and will continue regular interface with the committee to discuss the quarterly review of the cost per case applications and identify any necessary action.</p>
<p>7</p>	<p>DHSSPS Legislative / Policy Caveats</p> <p>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.</p> <p>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.</p>