HSCB Service Notification for the managed entry of new medicines and technologies

Health and Social Care Board

1	**Treatment & Condition** Prasugrel with percutaneous coronary intervention for treating acute coronary syndromes
2	**Associated appraisal body *&* Summary of ruling** NICE Technology Appraisal Guidance 317 (July 2014) - review of technology appraisal guidance 182 Prasugrel 10 mg in combination with aspirin is recommended as an option within its marketing authorisation, that is, for preventing atherothrombotic events in adults with acute coronary syndrome (unstable angina [UA], non-ST segment elevation myocardial infarction [NSTEMI] or ST segment elevation myocardial infarction [STEMI]) having primary or delayed percutaneous coronary intervention. NICE had previously issued two TAs which addressed use of Prasugrel and Ticagrelor for some of these patient subgroups. TA182 recommended prasugrel in combination with aspirin as an option for preventing atherothrombotic events in people with acute coronary syndromes having percutaneous coronary intervention, only when: immediate primary percutaneous intervention for STEMI is necessary; stent thrombosis has occurred during clopidogrel treatment; or the person has diabetes. NICE also recommended ticagrelor in combination with low-dose aspirin for up to 12 months as an option for people with STEMI who are to be treated with percutaneous coronary intervention, NSTEMI or unstable angina (NICE TA 236). NICE noted that in England • options for people with STEMI are prasugrel with aspirin, ticagrelor with low-dose aspirin, or clopidogrel with low-dose aspirin, along with PCI followed by dual antiplatelet treatment. • people with NSTEMI at higher risk of future adverse CV events are offered PCI along with either ticagrelor, or clopidogrel and subsequent dual antiplatelet therapy with clopidogrel and aspirin. • In patients with NSTEMI and diabetes, prasugrel is an alternative to clopidogrel or ticagrelor. • There is variation in opinion among clinicians as to which of prasugrel, ticagrelor or clopidogrel should be considered the standard treatment for all patients with STEMI who have a PCI, because of the chance of increased bleeding with these treatments.
3	**Number of people in Northern Ireland expected to take up service/therapy** *(including new cases per year)* Prasugrel is already an option in Northern Ireland for the treatment of people undergoing pPCI for STEMI and patients with NSTEMI and diabetes. It is it not used widely in the STEMI population. Clinical advice in NI would indicate that this is not likely to be the preferred drug of choice for the STEMI cohort moving forward. There is no local preference as yet regarding its use for NSTEMI.

	NICE estimated that of the 75,217 people in England who had percutaneous coronary intervention in 2012, approximately 1,200 would have high risk NSTEMI or high risk unstable angina without diabetes (i.e. the patient group not already included in TA 182). In 2012, 4200 people in NI had percutaneous intervention. Based on NICE estimates applied to NI, an additional 67 patients in NI will therefore be affected by this decision each year. NICE assumed these patients previously received clopidogrel (50%) or ticagrelor (50%) but in future would receive prasugrel (33%), ticagrelor (33%) or clopidogrel (34%).
4	**Patient Access Scheme availability** Not applicable
5	**Costs** *(before PAS if applicable)*
5.1	**Drug cost per patient per annum (for new and prevalent cases)** Prasugrel costs £628 per patient per year. This is less than ticagrelor but more than clopidogrel. The net additional drug cost indicated in the NICE costing statement, applied to 67 patients, is £82 per patient per annum
5.2	**Infrastructure costs per patient per annum** Not applicable
5.3	**Current in year costs** Assuming 12 months prescription per patient as per NICE guidance in year costs are in the region of £2,000
5.4	**Recurrent overall costs per annum** *(including additional costs)* The additional recurrent cost for N. Ireland is estimated to be £5,500 per annum
5.5	**Opportunities for cost savings and how these will be secured** Not applicable
6	**Expected implementation period** There is no impediment to immediate implementation.
7	**Commissioning arrangements** To be formally commissioned via HSCB
8	**Monitoring arrangements** The drug will be initiated in secondary care and continued in primary care. As per all drugs the primary care expenditure will be monitored through the prescribing data on a monthly basis.

9	**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.