

NICE TA 243: Follicular Lymphoma – Rituximab (Review of TA110)

1	<p>Name of Commissioning Team</p> <p>Specialist Services Commissioning Team</p>
2	<p>Summary of NICE TA 243</p> <p>Rituximab as a first-line treatment for follicular lymphoma was originally licensed in combination with cyclophosphamide, vincristine and prednisolone (CVP). This indication was covered under NICE TA110. The licence for rituximab was changed in January 2008 to allow the use of a wider range of chemotherapy regimens. TA 243 is a review of TA110 to encompass this wider range of regimens.</p> <p>NICE TA243 indicates that rituximab, in combination with:</p> <ul style="list-style-type: none"> • cyclophosphamide, vincristine and prednisolone (CVP), or • cyclophosphamide, doxorubicin, vincristine and prednisolone (CHOP), or • mitoxantrone, chlorambucil and prednisolone (MCP), or • cyclophosphamide, doxorubicin, etoposide, prednisolone and interferon-α (CHVPi) or • chlorambucil is recommended as an option for the treatment of symptomatic stage III and IV follicular lymphoma in previously untreated people.
3	<p>Number of people in Northern Ireland expected to take up service/therapy (new cases per year)</p> <p>From the Northern Ireland Cancer Registry, between 2005 and 2009, there was an average of 293 new cases of NHL every year in Northern Ireland. 22% of these are <u>follicular</u> NHL (64 cases per year). Of these, 85% are stage III or IV = 54 cases.</p> <p>NICE indicates that 94% of these newly diagnosed cases would be eligible for induction chemotherapy = 51 patients; and that 92% of these will go on to have induction chemotherapy = 47 patients</p>
4	<p>Outcomes</p>
4.1	<p>Additional life expectancy gain / progress improvement</p> <p><u>Rituximab plus CVP versus CVP alone</u></p> <p>The median time to treatment failure in the rituximab plus CVP group was 27 months compared with 7 months in the CVP alone group ($p < 0.0001$). Overall survival rate at 4 years was 83% in the rituximab plus CVP group and 77% in the CVP alone</p>

group ($p < 0.0290$). The overall response rate was 81% in the rituximab plus CVP group and 57% in the CVP alone group ($p < 0.0001$).

Rituximab plus CHOP versus CHOP alone

The overall survival rate at 5 years was 90% in the rituximab plus CHOP group and 84% in the CHOP alone group ($p = 0.0493$). The overall response rate was 96% in the rituximab plus CHOP group and 91% in the CHOP alone group ($p = 0.0046$). Complete response in the rituximab plus CHOP group was 19% and 17% in the CHOP alone group.

Rituximab plus MCP versus MCP alone

The overall response rate was 92% in the rituximab plus MCP group and 75% in the MCP alone group ($p < 0.0009$). The overall survival rate at 4 years was 87% for the rituximab plus MCP group and 74% for the MCP alone group ($p = 0.0096$). Complete response in the rituximab plus MCP group was 50% compared with 25% in the MCP alone group ($p = 0.0004$).

Rituximab plus CHVPi versus CHVPi alone

The overall survival rate at 5 years was 84% in the rituximab plus CHVPi group and 79% in the CHVPi alone group (not significant). The overall response rate was 81% in the rituximab plus CHVPi group and 72% in the CHVPi alone group.

Clinical specialists advised the NICE Appraisal panel that the availability of rituximab treatment was considered to have transformed clinical practice.

4.2 Reduction in morbidity

As per section 4.1

4.3 Cost per patient per annum

The recommended dose of rituximab in combination with chemotherapy for induction treatment of previously untreated patients with follicular lymphoma is 375 mg/m^2 body surface area, per cycle, for up to eight cycles, administered on day 1 of the chemotherapy cycle. The cost of one 10-ml (100-mg) vial is £174.63 and one 50-ml (500-mg) vial is £873.15 (excluding VAT).

For a person with a body surface area of 1.85 m^2 and assuming vial wastage, the cost per infusion of rituximab induction treatment is £1222.41 (excluding VAT).

The cost for eight cycles, therefore, would be £9779.28 (excluding VAT) per patient.

Assuming eligible patients are currently initiated on rituximab plus CVP (as recommended in NICE's previous technology appraisal guidance (TA110), a change to other combinations might incur additional costs or savings.

A change in treatment practice from:

	<ul style="list-style-type: none"> • rituximab plus CVP, to rituximab plus CHOP = annual additional cost per patient of £2752. • rituximab plus CVP, to rituximab plus MCP = annual additional cost per patient of £1368 • rituximab plus CVP, to rituximab plus CHVPi = annual saving of £700 per patient • rituximab plus CVP, to rituximab plus chlorambucil = annual saving of £360 per patient <p>In Northern Ireland the standard first line treatment for follicular lymphoma is rituximab plus CVP combination chemotherapy for 6-8 cycles and all elements TA 110 are currently being delivered.</p> <p>The only potential additional resources or savings which could be generated by uptake of this TA relate to the degree to which current clinical practice changes.</p> <p>It is not anticipated that current practice will substantially vary and where this does occur it is not expected that this will result in a significant change in resource use.</p> <p>Uptake of the availability of new combinations will be monitored through the existing oncology/haematology chemotherapy reports. In the event that a significant change in clinical practice occurs with an accompanying requirement for additional resource or generation of savings, a business case or savings plan will be sought. Should this result in a requirement for some additional resource this will be met from the 2012/13 specialist drugs allocation.</p>
<p>4.4</p>	<p>In year cost per patient per annum (for new and prevalent cases)</p> <p>As above.</p>
<p>4.5</p>	<p>Any cost savings and how these will be secured</p> <p>Understood that the use of rituximab in first-line will be offset by a reduction in use in relapsed/refractory disease (particularly where maintenance has been used)</p>
<p>4.6</p>	<p>Recurrent overall cost</p> <p>See 4.3</p>
<p>4.7</p>	<p>Cost per QALY</p> <p>NICE calculated an ICER of:</p> <ul style="list-style-type: none"> • £7720 per QALY gained for rituximab plus CVP, • £10,800 per QALY gained for rituximab plus CHOP, and • £9320 per QALY gained for rituximab plus MCP.

4.8	<p>Other treatments available for this condition</p> <p>Other treatments are available, however with lesser outcomes.</p>
4.9	<p>Readiness to implement</p> <p>The combinations in the TA could be implemented immediately.</p>
5	<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. 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>
6	<p>What will Commissioning Team do to secure funding for the implementation of this TA including any proposals for disinvestment</p> <p>Not expected to be applicable in respect of this TA.</p>
7	<p>Commissioning arrangements</p> <p>Following DHSSPSNI approval, the Board will issue a commissioning statement to the service.</p>
8	<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 regimen and this group of patients.</p> <p>SSCT has a long-established working relationship with NICaD D&T committee, which meets on a bi-monthly basis. Service monitoring including the review of the quarterly monitoring of data returns is a key function of this group.</p>