

1	<p><b>Treatment &amp; Condition</b> <i>(Title)</i></p> <p>Apixaban for treating and preventing recurrent deep vein thrombosis or pulmonary embolism</p>
2	<p><b>Associated appraisal body</b> <i>(NICE/SMC/Other)</i> &amp; <b>Summary of ruling</b> <i>(to include indication, restrictions, other relevant information)</i></p> <p>NICE technology appraisal guidance 341.</p> <p>Apixaban is recommended, within its marketing authorisation, as an option for treating and for preventing recurrent deep vein thrombosis and pulmonary embolism in adults.</p>
3	<p><b>Number of people in Northern Ireland expected to take up service/therapy</b> <i>(including new cases per year)</i></p> <ul style="list-style-type: none"> <li>• Estimate 1737 incident cases of DVT/PE per year (using age specific incidents rates applied to NI population)</li> <li>• Based on estimates from NICE TA 327 (another option), 52% of DVT/PE get NOACS (remaining 48% warfarin).</li> <li>• NICE have not estimated the percentage of patients who will get apixaban as a proportion of the population on NOACs</li> </ul> <p>There may also be prevalent cases on life-long warfarin switched to a NOAC.</p>
4	<p><b>Patient Access Scheme availability</b></p> <p>None</p>
5	<p><b>Costs</b> <i>(before PAS if applicable)</i></p>
5.1	<p><b>Drug cost per patient per annum (for new and prevalent cases)</b></p> <p>Drug cost per patient is dependent on the length of treatment. One year’s treatment costs £802, which is similar to other NOACs.</p> <p>Prevalent cases: NICE estimate that between 28 and 50% patients being treated for this indication will go on to receive life long therapy. The cost for each patient will be in the region of £802 irrespective of what NOAC is used.</p>
5.2	<p><b>Infrastructure costs per patient per annum</b></p> <p>Renal function at baseline and at least annual monitoring (U&amp;E blood testing)          Cost of U&amp;E &lt;£10 per test = £20 annually per patient.</p>

5.3	<p><b>Current in year costs</b></p> <p>It is estimated that in year costs will be approximately £38k</p>
5.4	<p><b>Recurrent overall costs per annum</b> <i>(including additional costs)</i></p> <p>The cost of treating new patients depends on the duration of their treatment. For the purposes of this calculation it is estimated that 30% patients will be treated for 6 months or less and that 70% patients will be treated for at least 12 months in their first year.</p> <p>Most of the costs of implementing TA341 and other new oral anti –coagulants (NOACs) fall to Primary Care. Approximately 1/12 (the first month’s supply) of total costs will fall to Secondary Care.</p> <p>Growth in this medication is proceeding faster than expected and may create a pressure in Primary Care and Secondary Care.</p> <p>Expenditure on all NOACs for 2014/15 is approximately £3.5m. Uptake is proceeding faster in some Trust and LCG areas.</p> <p>Funding of £225k has been provided to Secondary Care in 2014/15. Actual spend in Secondary Care is estimated at £300k.</p> <p>Further funding of £175k has been earmarked for Secondary Care for 2015/16.</p> <p>The overall position on uptake by Trust will continue to be reviewed and monitored</p>
5.5	<p><b>Opportunities for cost savings and how these will be secured</b></p> <p><b>Potential savings from no requirement for INR monitoring.</b> The costs of INR monitoring are difficult to quantify as there are several different delivery contexts including GP practice, domiciliary, INR clinic. NICE TA362 (Rivaroxaban for DVT/VTE) estimates the cost of first year of INR monitoring as £302 (Initial visit £22 plus 14 visits) and subsequent annual costs to be up to £240 (12 visits costing £20 per visit). However this must be offset against the need for monitoring of renal function at least twice annually in patients taking NOACs.</p> <p><b>Potential savings from reduction in recurrent VTE.</b> The evidence presented in NICE TA 327 suggests equivalence of warfarin and dabigatran in preventing VTE, so there are unlikely to be significant reductions.</p>
6	<p><b>Expected implementation period</b></p> <p>No barriers to immediate implementation anticipated</p>
7	<p><b>Commissioning arrangements</b></p>

	None
<b>8</b>	<b>Monitoring arrangements</b>  Majority of costs expected to be incurred in Primary Care – spend will be monitored as part of primary care prescribing budget
<b>9</b>	<b>DHSSPS Legislative/Policy Caveats</b>  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.