POSTER
352

The Benefits and Challenges of Streamlined NICE Cost Comparisons

Authors: Rupniewska E[1], Guerra Primo L[2], Behr C[2], Gladwell D[3], Matthijsse S[2]

Affiliations: [1] Lumanity, London, UK; [2] Lumanity, Utrecht, the Netherlands; [3] Lumanity, Sheffield, UK

INTRODUCTION

- In 2022, the National Institute for Health and Care Excellence (NICE) introduced a proportionate approach to technology appraisals. This strategy employed expedited evaluations for straightforward, low-risk decisions, such as streamlined cost-comparison appraisals (sCCAs), to facilitate rapid guidance on specific topics[1,2]

OBJECTIVES

- This study aimed to identify the key benefits and issues associated with published sCCAs

METHODS

- We reviewed all NICE sCCAs published between January 2023–September 2024. Data were extracted for each identified sCCA, including recommendations, timing of guidance publication, and key information related to the decision problem, clinical effectiveness, and cost-comparison model

RESULTS

- Out of 126 published technology appraisals (excluding terminations), 15 were sCCAs (12%): five in autoimmune diseases, two in oncology and eight in other disease types (Table 1)
- **Timeliness of publication:** The mean duration from invitation to participate to final guidance publication was 32 weeks (median, 29 weeks; range, 18–60; Figure 1) and the mean time from marketing authorization to final guidance publication was 29 weeks (median, 22 weeks; range 0–72; excluding sCCAs that were reviews of prior NICE TAs). Notably, one sCCA was published on the same day as the Medicines and Healthcare products Regulatory Agency (MHRA) marketing authorization, while two were published within 6 weeks of the authorization.
- **Appraisal outcome:** All sCCAs received positive recommendations; although seven had optimized recommendations (Table 1), which were generally aligned with narrower decision problems presented in company submissions. This restricted their target population to later lines of therapy than the marketing authorization, primarily due to the 1) anticipated positioning within the National Health Service (NHS) and 2) alignment with the comparator's reimbursed population
- **Comparator selection:** Eleven sCCAs involved a narrower comparator selection than listed in the NICE final scope (between one and three selected versus up to 15 listed). Selection of comparator was mainly justified by the company by the proposed positioning, widespread usage of the selected comparator(s) in clinical practice, and similar expected efficacy and safety. Both the External Assessment Group (EAG) and NICE accepted the selected decision problem and comparators
- **Costing:** All sCCAs included acquisition costs (the sole cost category in five; Table 2), with nine including administration costs (generally where the mode or frequency of administration differed), four including adverse event costs, and eight including resource use/other costs. None included wastage costs in the base case. The EAG's primary concerns related to dosage calculations (e.g. dose calculations for weight-based dosing, dose adjustments, and accounting for wastage), response rates, long-term treatment adherence, discontinuation, and choice of subsequent treatments. The time horizon varied from 1 to 10 years in most sCCAs, with a lifetime horizon only applied in four sCCAs. Although NICE's sCCA methods do not require discounting of costs or outcomes in sCCAs, they were applied in three sCCAs
- **Costing interpretation:** In three sCCAs, the cost of the new intervention was lower than the cost of one comparator, but similar or higher than another. NICE accepted this in accordance with its sCCA methods, which state that the new intervention needs to cost less than one relevant comparator already established in the NHS to be recommended as a treatment option

CONCLUSIONS

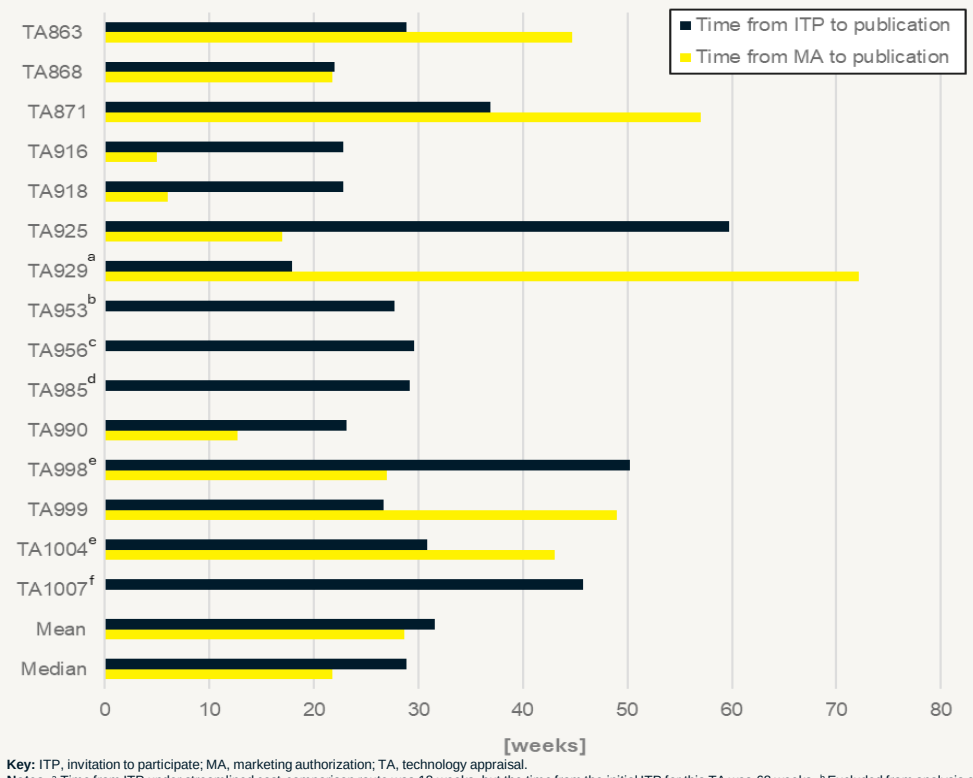
Our research confirmed several benefits sCCA, including:

- Timeliness of guidance publication
- Requirement to demonstrate cost saving against one key comparator only
- Simplified economic model

The main issues in sCCAs were related to:

- Demonstrating efficacy equivalence (see ISPOR Poster HTA120)
- Accurately estimating acquisition costs for the new intervention and comparators

Figure 1. Time from ITP and MA to final guidance publication in sCCAs



Key: ITP, invitation to participate; MA, marketing authorization; TA, technology appraisal.
Notes: [a] Time from ITP under streamlined cost-comparison route was 18 weeks, but the time from the initial ITP for this TA was 68 weeks. [b] Excluded from analysis of time from MA to final guidance publication: review of TA613 (MA in May 2012); [c] TA published on the same day as MA; [d] Excluded from analysis of time from MA to final guidance publication: part review of TA688 (CE mark in April 2015) [e] Used EMA MA date (UK MA date not found); [f] Excluded from analysis of time from MA to final guidance publication: review of TA611 (CDF exit; MA in January 2019).

Table 2. Time horizon and cost types included in identified NICE's sCCAs

TA	Time horizon	Discounting	Acquisition costs	Administration costs	Adverse events costs	Resource use and other costs
TA863	1 year	No	Yes	No	No[a]	No
TA868	5 years	No	Yes	Yes	No[b]	Yes: premedication
TA871	Lifetime (82 yrs)	No	Yes	Yes	No[b]	Yes: monitoring, concomitant therapy
TA916	10 years	No	Yes	No[b]	No[b]	No[b]
TA918	10 years	No	Yes	No[b]	No[b]	No[b]
TA925	10 years	No	Yes	Yes	No[b]	No[b]
TA929	1 year	No	Yes	No[b]	No[b]	No[b]
TA953	6 years	Yes, 3.5%	Yes	Yes	Yes	Yes: routine disease management, complications
TA956	5 years	No	Yes	Yes	No[a]	Yes: pre-initiation ECG and concomitant therapy
TA985	Lifetime (10 yrs)	No	Yes	Yes: procedure cost	Yes: same for all treatments	Yes: e.g. workup costs
TA990	72 hours	No	Yes	Yes	Yes	Yes
TA998	10 years	No	Yes	Yes	No[a]	No
TA999	1 year	No	Yes	No[c]	No[b]	No[b]
TA1004	Lifetime (25 yrs)	Yes, 3.5%	Yes	Yes	No[b]	Yes: OCT and monitoring costs
TA1007	Lifetime (30 yrs)	Yes, 3.5%	Yes	No[c]	Yes	Yes: resource use subsequent treatment, one-off cost of death

Key: AE, adverse event; ECG, electrocardiogram; ITC, indirect treatment comparison; OCT, optical coherence tomography; TA, technology appraisal.
Notes: [a] No significant differences in AEs showed in a RCT or ITC; [b] Expected to be the same/equivalent between intervention and comparators; [c] None expected; both drugs are oral.

Table 1: Overview of identified NICE's streamlined cost-comparison appraisals

TA	Title	Publication date	Outcome	Disease area	Comparators in company submission	Comparators narrower than in NICE final scope?
TA863	Somatrogon for treating growth disturbance in children and young people aged 3 years and over	1/2/2023	Aligned with MA	Endocrinology	Somatropin (seven different preparations)	Yes
TA868	Vutrisiran for treating hereditary transthyretin-related amyloidosis	15/2/2023	Aligned with MA	Neurology	Patisiran	Yes
TA871	Eptinezumab for preventing migraine	1/3/2023	Optimized	Neurology	Erenumab, fremanezumab and galcanezumab	Yes
TA916	Bimekizumab for treating active psoriatic arthritis	4/10/2023	Optimized	Autoimmune/rheumatology	Ixekizumab	Yes
TA918	Bimekizumab for treating axial spondyloarthritis	11/10/2023	Optimized	Autoimmune/rheumatology	Ixekizumab and secukinumab	Yes
TA925	Mirikizumab for treating moderately to severely active ulcerative colitis	25/10/2023	Optimized	Autoimmune/gastroenterology	Vedolizumab and ustekinumab	Yes
TA929	Empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction	1/11/2023	Aligned with MA[a]	Cardiology	Dapagliflozin	Yes
TA953	Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema	13/3/2024	Aligned with MA[b]	Ophthalmology/endocrinology	Dexamethasone intravitreal implant	No
TA956	Etrasimod for treating moderately to severely active ulcerative colitis in people aged 16 and over	11/3/2024	Aligned with MA	Autoimmune/gastroenterology	Adalimumab, infliximab and vedolizumab	Yes
TA985	Selective internal radiation therapy with QuiremSpheres for treating unresectable advanced hepatocellular carcinoma	3/7/2024	Optimized	Oncology	SIR-Spheres and TheraSphere	No
TA990	Tenecteplase for treating acute ischaemic stroke	24/7/2024	Aligned with MA	Neurology	Established clinical management without tenecteplase including: alteplase	No
TA998	Risankizumab for treating moderately to severely active ulcerative colitis	22/8/2024	Optimized	Autoimmune/gastroenterology	Ustekinumab	Yes
TA999	Vibegron for treating symptoms of overactive bladder syndrome	4/9/2024	Optimized	Urology	Mirabegron	Yes
TA1004	Faricimab for treating visual impairment caused by macular oedema after retinal vein occlusion	11/9/2024	Aligned with MA	Ophthalmology	Ranibizumab and aflibercept	Yes
TA1007	Rucaparib for maintenance treatment of relapsed platinum-sensitive ovarian, fallopian tube or peritoneal cancer	17/9/2024	Aligned with MA	Oncology	Olaparib and niraparib	No

Key: MA, marketing authorization; TA, technology appraisal.
Notes: [a] TA929 'complements' TA773 to achieve positive recommendation in the full marketing authorization population. The company's decision problem in TA929 focuses only on a population with preserved or mildly reduced ejection fraction. [b] TA953 is a part review of T613, and merges with recommendation from TA301 to cover full MA

LIMITATIONS

The main limitation of our study is that it may not capture any 'negative' sCCAs – which could be paused for further discussion and/or commercial negotiations (or in theory, re-routed as standard STA) – as our research only included published sCCA appraisals.

REFERENCES

1. NICE. www.nice.org.uk/about/what-we-do/proportionate-approach-to-technology-appraisals. Accessed: 19 September 2024. 2. NICE. 2023. (Updated: April 2023). www.nice.org.uk/Media/Default/About/what-we-do/PATT/PATT-final-report-2022-23.pdf. Accessed: 19 September 2024.

An electronic version of the poster can be viewed by scanning the QR code.

Poster presented at the 2024 ISPOR Europe; 17-20 November 2024; Barcelona, Spain.