East Surrey CCG, Guildford & Waverley CCG, North West Surrey CCG, Surrey Downs CCG, Surrey Heath CCG, Crawley CCG, Horsham & Mid-Sussex CCG

Briefing Paper for Surrey & North West Sussex Area Prescribing Committee (APC) on NICE Technology Appraisals: Local implementation

NICE TA Guidance	Certolizumab pegol (Cimzia) for treating moderate to severe plaque psoriasis (TA 574)		
Available at	https://www.nice.org.uk/guidance/ta574/resources/certolizumab-pegol-for-treating-moderate-to-severe-plaque-psoriasis-pdf-82607142805189		
Date of issue	17th April 2019	**Implementation deadline**	CCGs are required to comply with the recommendations within 3 months. (17th July 2019)

Medicine details[1,2]	
Name, brand name	Certolizumab pegol (Cimzia) Mechanism of action – TNF alpha inhibitor
Manufacturer	UCB Pharma Limited
Licensed indication	Cimzia is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy
Formulation	Pre-filled syringe/pen contains 200mg/1mL solution for injection
Usual dosage	**Plaque psoriasis** After the starting dose, the maintenance dose of Cimzia for adult patients with plaque psoriasis is 200 mg every 2 weeks. A dose of 400 mg every 2 weeks can be considered in patients with insufficient response Available data in adults with plaque psoriasis suggest that a clinical response is usually achieved within 16 weeks of treatment. Continued therapy should be carefully reconsidered in patients who show no evidence of therapeutic benefit within the first 16 weeks of treatment. Some patients with an initial partial response may subsequently improve with continued treatment beyond 16 weeks. **Medicines management team comments:** **NICE concluded that 'it is not cost effective to increase**

	the dose of certolizumab pegol to 400mg if response to the 200mg dose is inadequate'. **But it is considered to be clinically effective see below (consideration of evidence by NICE).**
NICE recommended dosage/schedule	As above

Disease and potential patient group	
Brief description of disease[3]	**https://patient.info/skin-conditions/psoriasis-leaflet** Psoriasis is a common condition where there is inflammation of the skin. It typically develops as patches (plaques) of red, scaly skin. Once it develops psoriasis it tends to come and go throughout life. A flare-up can occur at any time. The frequency of flare-ups varies. There may be times when psoriasis clears for long spells. However, in some people the flare-ups occur often. Psoriasis is not due to an infection. It cannot be passed on to other people and it does not turn into cancer. The severity of psoriasis varies greatly. In some people it is mild with a few small patches that develop and are barely noticeable. In others, there are many patches of varying size. In many people the severity is somewhere between these two extremes. However, with an early diagnosis and appropriate treatment, it's possible to slow down the progression of the condition and minimise or prevent permanent damage to the joints.
Potential patient numbers per 100,000	**www.nice.org.uk** Resource impact template

Population	**NICE assumption (%)**	**Number of people**
Adult population per 100,000		78,666
Prevalence of psoriasis	1.75	1,377
Proportion with plaque psoriasis	90	1,239
People eligible for biologic treatments	2.55	32

Certolizumab pegol will be another treatment option for Psoriasis.

Currently there are 3 lines of treatment (after standard systemic treatments) available in the psoriasis pathway in line with national guidance.

Choices are from 10 drugs with 7 different mechanisms of action. Specialists should choose a drug with a different mode of action with each line of treatment.

SUMMARY

NICE recommendation www.nice.org.uk

1. Recommendations
   1.1. Certolizumab pegol is recommended as an option for treating plaque psoriasis in adults, only if:
      - the disease is severe, as defined by a total Psoriasis Area and Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10 and
      - the disease has not responded to other systemic treatments, including ciclosporin, methotrexate and phototherapy, or these options are contraindicated or not tolerated
      - and the lowest maintenance dosage of certolizumab pegol is used (200 mg every 2 weeks) after the loading dosage
      - and the company provides the drug according to the commercial arrangement.

   1.2. Stop certolizumab pegol at 16 weeks if the psoriasis has not responded adequately. An adequate response is defined as:
      - a 75% reduction in the PASI score (PASI 75) from when treatment started or
      - a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from when treatment started.

   1.3. If patients and their clinicians consider certolizumab pegol to be one of a range of suitable treatments, the least expensive should be chosen (taking into account administration costs, dosage, price per dose and commercial arrangements).

   1.4. When using the PASI, healthcare professionals should take into account skin colour and how this could affect the PASI score, and make the clinical adjustments they consider appropriate.

   1.5. When using the DLQI, healthcare professionals should take into account any physical, psychological, sensory or learning disabilities, or communication difficulties that could affect the responses to the DLQI and make any adjustments they consider appropriate.

   1.6. These recommendations are not intended to affect treatment with certolizumab pegol that was started in the NHS before this guidance was published. People having treatment outside these recommendations may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop.

Why the committee made these recommendations

Certolizumab pegol is proposed as an alternative to other biological treatments already recommended by NICE for treating severe plaque psoriasis in adults. It is also proposed as an alternative to systemic non-biological treatments such as

methotrexate, ciclosporin and acitretin in adults who have not had systemic treatment. Clinical trial results show that certolizumab pegol improves severe plaque psoriasis more than either placebo or etanercept. When compared indirectly, it appears to be as effective as other biological treatments for the condition, and also appears to be more effective than non-biological treatments.

When there is a partial response to the 200 mg certolizumab pegol dose, there may be an improved response to an increased dose

The committee noted that increasing the maintenance dose from 200 mg every 2 weeks to 400 mg every 2 weeks is within certolizumab pegol's marketing authorisation. The company stated that people whose disease had a partial response (defined as a PASI 50 to PASI 74) after 16 weeks of treatment with certolizumab pegol at a maintenance dose of 200 mg were the most likely group for whom this would be considered. It presented evidence from CIMPACT showing that most patients in this group had a PASI 75 response after a further 16 weeks of treatment with certolizumab pegol at the increased maintenance dose of 400 mg. The company stated that there were no prognostic factors identified in the trial that indicated whether a person whose disease had a partial response would be likely to have a PASI 75 response after increasing the dose. The committee noted that the trials did not compare the efficacy of increasing the dose of certolizumab pegol with either placebo or another active treatment. Also, the results for patients whose disease had a partial response were based on a small number of patients. It noted that the company's definition of partial response may have included people with a PASI 50 response and a 5-point reduction in the DLQI, which is recommended by NICE as an alternative to the PASI 75 to assess response to treatment. The committee would have preferred to see efficacy results that excluded this group, although it recognised that this exclusion would have further reduced the number of patients whose disease was defined as having a partial response and increased the uncertainty of the clinical effectiveness of increasing the dose. The committee noted that people whose disease had a partial response to certolizumab pegol and no, or manageable, adverse events may prefer to continue on a higher dose of certolizumab pegol than to switch to an alternative treatment, which could be less well tolerated. It also noted that psoriasis is a lifelong condition and that people with psoriasis would be likely to try several treatments over their lifetime, so may wish to continue with their current treatment at a higher dose and reserve other biological treatments for future use. The committee concluded that it was appropriate to consider the cost effectiveness of increasing the dosage to 400 mg every 2 weeks in people whose disease had a partial response to certolizumab pegol 200 mg every 2 weeks.

Medicines management team comments:

Note that the number of people that would meet NICE recommendation to continue treatment with standard dosing (1.2 from NICE guidance), would have been included in the group of patients that would be considered for dose escalation?

Cost implications*

Cost of product:

£357.50 per 200 mg pre-filled pen or syringe (excluding VAT, British national formulary online; accessed February 2019). The company has a **commercial arrangement.**

Annual cost per patient:

Year 1:

Injections (400mg) at 0, 2 & 4 weeks (induction) and then every 2 weeks thereafter (30 injections) = £10,725 (if provided via homecare then VAT not applicable
Year 2:
8 weekly injections (total 6 injections) = £9,295

Dose escalation (for consideration by APC) – see below under recommendations

Availability of PAS and details (if appropriate): www.nice.org.uk
The company has a commercial arrangement. This makes certolizumab pegol available to the NHS with a discount. The size of the discount is commercial in confidence. It is the company's responsibility to let relevant NHS organisations know details of the discount.

Availability of homecare service (if appropriate):
Home care service is available

**NICE funding requirements are based on Quality Adjusted Life Years (QALY) threshold. If there is evidence that the incremental cost rises above this threshold in the future, the APC may reconsider the commissioning status.*

Alternative treatments available with the psoriasis pathway

TNF-Alpha inhibitors
- adalimumab, etanercept & infliximab **(& certolizumab)**

Fumaric Acid Ester
- dimethyl fumarate

Phosphodiesterase (PDE4) inhibitor
- apremilast

Interleukin 17RA inhibitor
- brodalumab

Interleukin 17 inhibitor
- secukinumab & izekizumab

Interleukin (IL)23 protein
- guselkumab (**& tildrakizumab)**

Interleukin (IL)12/23 inhibitor
- ustekinumab

Clinical effectiveness: **www.nice.org.uk**
NICE concluded that certolizumab pegol was more clinically effective than placebo and etanercept.

Impact to patients

- An additional treatment option for plaque psoriasis would be valued by patients.
- Suitable for women planning a pregnancy in near future (low placental transfer)
- Minimal transfer of certolizumab pegol from plasma to breast milk

Impact to primary care prescribers

- This is a PbRe drug and is commissioned by CCGs for use in secondary care. There should be no prescribing in primary care.
- Primary care prescribers should be aware that their patient is receiving certolizumab pegol and ensure that this is recorded in the patient's notes in order to be alert to potential side-effects and interactions with other medicines

prescribed in primary care. This will ensure that GP records, which are accessed by other healthcare providers, are a true and accurate reflection of the patient's medication.
Impact to secondary care
• The initiation, administration and on-going treatment is managed by secondary care. • Conception –if conception plans or pregnancy indicate a change of drug is advisable, it is agreed that this does not constitute a change in line of treatment. (in line with use in Rheumatology) • Homecare arrangements will be managed by the trust. • An additional treatment option for plaque psoriasis would be valued by clinicians. • Blueteq forms for initiation and continuation will need to be completed by dermatology specialists.
Impact to CCGs
• The technology is commissioned by clinical commissioning groups (CCGs). • Providers are NHS hospital trusts. • Certolizumab pegol is PbRe and if a patient meets NICE criteria, treatment can be initiated and invoiced to the commissioner (if Blueteq forms have been completed). • Revision of the psoriasis pathway discussed with dermatology specialist teams prior to APC discussion
Implementation
• NICE TA implementation must be within 90 days of publication – 17th July 2019 • Blueteq forms to be developed
Recommendation to PCN
APC to consider • **RED TRAFFIC LIGHT STATUS –** Blueteq forms for initiation and continuation will be developed for specialists to complete. • Would dose escalation (to 400mg bi weekly) be supported (where a patient has an insufficient response) given the information presented to NICE from the clinical trials (see page 4)

References:

1. www.medicines.org
2. NICE www.nice.org.uk
3. What is psoriasis? Patient Platform Ltd. Available at: https://patient.info/health/psoriasis-leaflet
4. Resource impact statement & template www.nice.org.uk
5. NHS choices www.nhs.uk

Prepared by:

Name: **Clare Johns (Lead Commissioning Technician – Pharmaceutical Commissioning (Surrey Downs CCG – Hosted Service)**

Declaration of Interest:

None

Date: 16/07/2018

Reviewed by:

Name:

Declaration of Interest:

Date:

VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
v.1		*Clare Johns*	*Draft*	*For peer review prior to consultation with specialist teams and APC*