Briefing Paper for Surrey Heartlands Integrated Care System (ICS) Area Prescribing Committee (APC)

NICE Technology Appraisals: Local implementation

NICE TA Guidance[1]	Risankizumab for treating active psoriatic arthritis after inadequate response to DMARDs Technology appraisal guidance TA803		
Available at	Overview | Risankizumab for treating active psoriatic arthritis after inadequate response to DMARDs | Guidance | NICE		
Date of issue	13th July 2022	**Implementation deadline**	30 days

Medicine details	
Name, brand name	Risankizumab (Skyrizi)
Manufacturer	AbbVie Ltd
Licensed indication[2]	Skyrizi, alone or in combination with methotrexate (MTX), is indicated for the treatment of active psoriatic arthritis in adults who have had an inadequate response or who have been intolerant to one or more disease-modifying antirheumatic drugs (DMARDs) (accessed 21/07/2022)
Formulation	Each pre-filled pen contains 150 mg risankizumab in 1 mL solution. Risankizumab is a humanised immunoglobulin G1 (IgG1) monoclonal antibody selective to the interleukin (IL)-23 protein produced in Chinese Hamster Ovary cells using recombinant DNA technology. (accessed 21/07/2022)
Usual dosage	The recommended dose is 150 mg administered as a subcutaneous injection at week 0, week 4, and every 12 weeks thereafter (either as two 75 mg pre-filled syringe injections or one 150 mg pre-filled pen or pre-filled syringe injection). Consideration should be given to discontinuing treatment in patients who have shown no response after 16 weeks of treatment. (accessed 21/07/2022).
NICE recommended dosage/schedule	The dosage schedule is available in the summary of product characteristics for risankizumab.

Disease and potential patient group	
Brief description of disease[3]	Psoriatic arthritis is a type of arthritis that affects some people with the skin condition psoriasis. It typically causes affected joints to become swollen, stiff and painful. Active psoriatic arthritis is defined as 3 or more tender joints and 3 or more swollen joints. Like psoriasis, psoriatic arthritis is a long-term condition that can get progressively worse. If it's severe, there's a risk of the joints becoming permanently damaged or deformed, and surgery may be needed.

But if psoriatic arthritis is diagnosed and treated early, it's progression can be slowed down and permanent joint damage can be prevented or minimised.

The severity of the condition can vary considerably from person to person. Some people may have severe problems affecting many joints, whereas others may only notice mild symptoms in 1 or 2 joints.

There may be times when symptoms improve (known as remission) and periods when they get worse (known as flare-ups or relapses).

Relapses can be very difficult to predict but can often be managed with medicine when they do occur.

Causes of psoriatic arthritis

Almost 1 in 3 people with psoriasis also have psoriatic arthritis.

It tends to develop 5 to 10 years after psoriasis is diagnosed, although some people may have problems with their joints before they notice any skin-related symptoms.

Like psoriasis, psoriatic arthritis is thought to happen as a result of the immune system mistakenly attacking healthy tissue.

But it's not clear why some people with psoriasis develop psoriatic arthritis and others do not.

The aim of treatment is to control joint and connective tissue inflammation. This prevents joint damage progressing and the associated pain and disability.

Potential patient numbers per 100,000[4]

Recommendation of NICE TA803	% of people	Number of people
Specific population (from cost overtime worksheet e.g. adults)		851,080
Prevalence of active psoriatic arthritis	0.19%	1,617
Proportion of people suitable for a biologic treatment	20.00%	323
Proportion of people who have had 2 conventional DMARDs and at least one biological DMARD	36.00%	116
Proportion of people who have moderate to severe psoriasis	31.00%	36
Number of people eligible for treatment		36

Table 1. NICE resource planner – potential number of patients eligible for Risankizumab as per NICE TA803, for NHS Surrey Heartlands ICS

Potential patient numbers: 4.2/100,000 population

SUMMARY

NICE recommendation

1.1 Risankizumab, alone or with methotrexate, is recommended as an option for treating active psoriatic arthritis in adults whose disease has not responded well enough to disease-modifying antirheumatic drugs (DMARDs) or who cannot tolerate them. It is recommended only if they have:

- peripheral arthritis with 3 or more tender joints and 3 or more swollen joints
- moderate to severe psoriasis (a body surface area of at least 3% affected by plaque psoriasis and a Psoriasis Area and Severity Index [PASI] score greater than 10)
- had 2 conventional DMARDs and at least 1 biological DMARD.

Risankizumab is recommended only if the company provides it according to the commercial arrangement.

1.2 Assess the response to risankizumab from 16 weeks. Stop risankizumab if psoriatic arthritis has not responded adequately using the Psoriatic Arthritis Response Criteria (PsARC; an adequate response is an improvement in at least 2 of the 4 criteria, 1 of which must be joint tenderness or swelling score, with no worsening in any of the 4 criteria). If PsARC response does not support continuing treatment but there is a PASI 75 response, a dermatologist should decide whether continuing treatment is appropriate based on skin response.

1.3 If risankizumab is one of a range of suitable treatments, including guselkumab, choose the least expensive (taking into account administration costs, dosage, price per dose and commercial arrangements).

1.4 Take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the responses to the PsARC, and make any adjustments needed.

1.5 Take into account how skin colour could affect the PASI score and make any adjustments needed.

1.6 These recommendations are not intended to affect treatment with risankizumab 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

People with psoriatic arthritis that is not controlled well enough with 2 conventional DMARDs are usually offered biological DMARDs. People whose disease has not responded to a biological DMARD and who also have moderate to severe psoriasis may be offered guselkumab, an IL-23 modulator already recommended by NICE. Risankizumab is also an IL-23 modulator.

Clinical evidence shows that risankizumab is effective for active psoriatic arthritis compared with placebo. Risankizumab has not been compared directly with other biological DMARDs for psoriatic arthritis. But the results of an indirect comparison suggest that it is as effective as guselkumab, particularly for skin and joint symptoms, and likely has similar safety.

Risankizumab has similar costs to guselkumab for people with moderate to severe psoriasis who have had 2 conventional DMARDs and at least 1 biological DMARD. So, risankizumab is recommended as an option for treating active psoriatic arthritis in this group.

Cost implications*

Cost of product:

The cost of a 150 mg pre-filled disposable injection of risankizumab is £3,326.09 (excluding VAT; BNF online, accessed May 2022).

Annual cost per patient:
The recommended dose is 150 mg administered as a subcutaneous injection at week 0, week 4, and every 12 weeks thereafter (either as two 75 mg pre-filled syringe injections or one 150 mg pre-filled pen or pre-filled syringe injection).

Annual costs	No. of doses	Annual cost
Year 1	6	£19,956
Year 2 onwards	4	£13,304

Has dose escalation been considered as part of the NICE costing template?
Dose escalation / intensification has not been considered as part of the NICE costing template, nor is it currently described in the SPC.

Costing information/100,000 population and per CCG:
NICE does not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year (or £9,000 per 100,000 population, based on a population for England of 56.3 million people).
This is because the technology is a further treatment option and is available at a similar price to the current treatment options.

Availability of PAS and details (if appropriate):
Risankizumab has a commercial arrangement. This makes risankizumab 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): Yes, if provider arranges for contract

**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 and cost per patient (per year / per month as appropriate)

Other NICE recommended products:
Please refer to NHS Surrey Heartlands CCG's 'Psoriatic Arthritis (PsA) Treatment Pathway in Adults' available at:
https://surreyccg.res-systems.net/PAD/Search/DrugConditionProfile/6444 Update of this pathway is included in submission

- Adalimumab, certolizumab pegol, etanercept, golimumab and infliximab are tumour necrosis factor (TNF)-alpha inhibitors.
- Ixekizumab and secukinumab are IL-17A inhibitors.
- Ustekinumab is an IL-12 / IL-23 inhibitor.
- Tofacitinib is a Janus kinase (JAK) inhibitor.
- Apremilast is a PDE 4 inhibitor.
- Guselkumab is an IL-23 inhibitor (same as this drug)

Impact to patients

- Risankizumab has an identical mode of action as guselkumab (already available to patients).
- Risankizumab should be made available under a homecare service so will be delivered directly to the patient.

Impact to primary care prescribers

- Risankizumab is commissioned by integrated care systems and clinical commissioning groups. Providers are NHS hospital trusts. There should be no prescribing in primary

care.

- Primary care prescribers should be aware that their patient is receiving risankizumab 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 also 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.
- Homecare arrangements will be managed by the trust.

Impact to CCGs

- The technology is commissioned by integrated care systems and clinical commissioning groups and they are required to comply with the recommendations of this NICE TA within 30 days of its date of publication – for this NICE TA this was 13th August 2022.
- Providers are NHS hospital trusts.
- No potential savings for out-patient appointments as risankizumab is another treatment option within a large group of existing choices.

Implementation

- NICE TA implementation must be within 30 days of publication.
- Blueteq forms to be developed.
- Trusts to follow internal governance procedures to add to their formulary and initiate. Homecare.
- Pathway to be discussed at Rheumatology Network. Other points for consideration:
    - Risankizumab is now the second monoclonal antibody specifically targeting IL-23 to be considered by NICE for use in psoriatic arthritis.
    - Not for first line biologic use (NICE TA states that patient has had 2 conventional DMARDs and at least 1 biological DMARD).
    - Possibility of continuing treatment when the PsARC response does not justify continuing but there is a PASI 75 response (as with guselkumab patients)
    - Liaison with dermatology colleagues.
    - No comparator data with other bDMARDs or tsDMARDs.
    - The committee concluded that, 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.

Recommendation to APC

PbRe: Yes

Colour classification guidelines

Recommended traffic light status (see attached guidelines):
RED

Additional comments:
See proposed Blueteq forms (below)

Area Prescribing Committee - Decision-making criteria

1	National guidance and priorities	• NICE published this Technology Appraisal (TA803) on 13th July 2022 with a 30-day implementation deadline (as opposed to the usual 90 days). Surrey Heartlands ICB is mandated to fund this treatment.
2	Clinical	• Risankizumab is to be used as per its licensed indication only,

	effectiveness	and as per the NICE guidance recommendations. NICE concluded that this drug was at least as clinically effective as other drugs available. Safety and efficacy in people under the age of 18 years has not been established.
3	Patient safety	• Risankizumab is licensed for this indication in the UK, it is an injectable drug; packaged and marketed with the intention that patients would self-inject. Risk of sharps injury would be mitigated by suitable patient training and waste management. • As with all systemic immunosuppressants, prescribers should be aware of patient risk of reduced immune response to infection, and this should be considered when triaging patient exhibiting symptoms. GP practice records should be maintained accordingly (this should be reiterated in the PAD narrative). • The drug is already widely used in dermatology and no other additional concerns were identified with regards to patient safety.
4	Patient factors	• Risankizumab constitutes an alternative option for those patients who have yet to try an IL23 inhibitor but does not add a further therapeutic line to the current treatment pathway. • Patient education materials, injection technique training and additional support is provided. • Alternative options / products are available to those patients who will not/cannot use injectable products.
5	Environmental impact	• Risankizumab is only available as an injection. It is likely that the product would be delivered to the patient's home via a dedicated homecare service using a refrigerated van - this could be considered as an **additional carbon load** due to extra road traffic. • **Packaging waste** would be additional to usual municipal waste recycling or landfill. • **Medical sharps waste** would be collected and disposed of by the homecare company. • Discharge into the **wastewater** system (post-metabolism) from an individual patient is unlikely to have a significant impact short term, however the long-term impact to the water ecosystem is unknown.
6	Equality & diversity	• **Disabilities** – patients with physical or learning impairment may not be able to access this treatment if they cannot to easily/safely use the pre-filled syringe that the drug is packaged in. Alternative drug / administration options are available for those patients who are not able to self-inject. • **Religion & beliefs** - Risankizumab is produced using mammalian ovary cells, and therefore is considered a "biological" medicine. This NICE TA could be considered to have a negative impact upon patients who follow a vegan lifestyle. Alternative products of a non-biological nature are available for psoriatic arthritis. • **Age** – Risankizumab is only licensed for patients over the age of 18 years – younger patients will not be able to access this treatment under this TA. Alternative products are available for patients under the age of 18 years. IFR policy remains an option if clinicians wish to prescribe off-label (subject to patient numbers). • **Race** – NICE has specified the following – "Take into account how skin colour could affect the PASI score and make any

		adjustments needed." Clinicians should already be aware of this in their day-to-day use of assessment tools, as although rare for NICE to be so explicit in their recommendations, this requirement has been included in national guidance for a while now.
7	Place in therapy relative to available treatments	• This drug does not constitute either a new class of treatment, or an additional line of treatment to those already available on the current treatment pathway. It is an alternative option for patient/clinician choice.
8	Stakeholder views	• Specialist clinicians who sit in the Surrey Rheumatology Network and the wider APC audience have been consulted on this paper. Comments received are displayed below.
9	Cost-effectiveness	• NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year (or £9,000 per 100,000 population, based on a population for England of 56.3 million people). This is because the technology is a further treatment option and is available at a similar price to the current treatment options.
10	Additional funding required	• Not applicable, budget uplift anticipated as per NICE cost calculations from DOHSC. • Anticipated cost is less than £100k/Place/annum financial threshold for APC decisions.
11	Identified implementation issues	• None identified, prescribing, administration and supply will be the same as for other drugs already used in the treatment pathway. Drug should be identified as RED (hospital use only), and extra workload will be minimal as patients will already be known to the clinics involved. GPs should continue to ensure patient practice records are kept up to date.

References:

1. Risankizumab for treating active psoriatic arthritis after inadequate response to DMARDs NICE Technology Appraisal TA803. Available at : https://www.nice.org.uk/guidance/ta803 Accessed 21/07/2022
2. eMC Skyrizi 150mg solution for injection in pre-filled pen. Summary of Product Characteristics. Available at: Skyrizi 150 mg solution for injection in pre-filled pen - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk) Accessed on 21/07/2022
3. Psoriatic arthritis. NHS. Available at: https://www.nhs.uk/conditions/psoriatic-arthritis/ Accessed 21/07/2022
4. NICE Resource impact statement & template Available at: https://www.nice.org.uk/guidance/ta803/resources Accessed 21/07/2022

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Declaration of Interest:

None to declare

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Declaration of Interest:

None to declare

Date: 09/08/2022

Blueteq forms

RISANKIZUMAB - 2nd line treatment of Psoriatic Arthritis - NICE TA803

Please indicate whether patient meets the following NICE criteria:	**Please tick**
1. Patient has not responded well enough or the patient cannot tolerate a biological DMARD? (Please tick Yes if you agree with this statement)	○ Yes ○ No
2. Patient has active psoriatic arthritis and meets ALL of the following criteria: Patient has peripheral arthritis AND Patient has three or more tender joints AND Patient has three or more swollen joints AND Moderate to severe psoriasis AND a Psoriasis Area & Severity Index (PASI) score greater than 10	○ Yes ○ No
3. Please provide most recent PASI score here (Score must be at last 10) PASI score: Date:	
5. Please provide patient's most recent PsARC scores: Patient global self assessment:: Date:: Physician global assessment value: Date:: Tender joint score:: Date:: Swollen joint score:: Date::	
7. FOR INFORMATION ONLY Initial funding will be approved for 16 weeks. Stop risankizumab at 16 weeks if the Psoriatic Arthritis has not responded adequately using the PsARC criteria Funding will only be re-approved for a further 12 months if: The patient has responded adequately to treatment at 16 weeks i.e. improvement in two out of the four PsARC criteria; one has to be joint tenderness or swelling score, with no worsening in any of the four criteria. If PsARC response does not justify continuing treatment but there is a PASI 75 response, a dermatologist should decide whether continuing treatment is appropriate based on skin response.	

Please indicate whether patient meets the following Local policy:	**Please tick**
1. Patient has previously been treated with TWO biological DMARDS. Please provide details below. Biological DMARD 1: ____ Biological DMARD 2: ____	○ Yes ○ No
2. Whilst using biological DMARD 2, the patient has experienced (please check which applies) : ☐ Primary failure (occurs when the response criteria (as defined within the NICE TA) is not fully met when response to treatment is assessed at the time interval defined within the NICE TA i.e. 12 weeks) ☐ Secondary failure (occurs when the response to treatment (as defined within the NICE TA) is no longer met). ☐ Primary intolerance/adverse effects (an occurrence that causes discontinuation of treatment, due to inability to tolerate side-effects of that treatment that occurs during the initial time period defined by the NICE TA). Please provide details: ☐ Secondary intolerance/adverse effect (an occurrence that causes discontinuation of treatment, due to inability to tolerate side effects of that treatment that occurs after the initial time period defined by the NICE TA). Please provide details:	
3. Please provide the current Psoriatic Arthritis Response criteria (PsARC)	
4. FOR INFORMATION	

	Score	Date taken
Patient Global Assessment Score		
Tender Joint Score		
Physician Global Assessment Score		
Swollen Joint Score		

Initial funding will be approved for 16 weeks. Stop risankizumab at 16 weeks if the Psoriatic Arthritis has not responded adequately using the PsARC criteria Funding will only be re-approved for a further 12 months if: The patient has responded adequately to treatment at 16 weeks i.e. improvement in two out of the four PsARC criteria; one has to be joint tenderness or swelling score, with no worsening in any of the four criteria. If PsARC response does not justify continuing treatment but there is a PASI 75 response, a dermatologist should decide whether continuing treatment is appropriate based on skin response	

Continuation - RISANKIZUMAB treatment in Psoriatic Arthritis

Please indicate whether patient meets the following NICE criteria:	**Please tick**
1. I herewith provide you with the requested information:	
7. Funding will be continued if the patient has responded adequately using the Psoriatic Arthritis Response Criteria (PsARC). If PsARC response does not justify continuing treatment but there is a PASI75 response. then please answer the next question	
8. A dermatologist has determined that it is appropriate that this patient continues treatment based on the skin response.	○ Yes ○ No

PsARC	Most recent scores (no more than 3 months old)	Date scores taken
Patient's global assessment score (on 0-5 Likert Scale)		
Physician's global assessment score (on 0-5 Likert scale)		
Tender Joint Score		
Swollen joint score		
PASI score		

9. FOR INFORMATION ONLY **Funding will be approved at 12 monthly intervals if response to treatment is maintained**	