North Central London Integrated Care System

NHS
North Central London
Joint Formulary Committee

Principles for commissioning high-cost drug pathways for ICB commissioned indications

Purpose

High-cost drug pathways agreed across NCL support our patients to equitably receive the most cost-effective treatment for the management of their chronic disease.

The purpose of this document is to propose, with justification, a set of principles against which the ICS should develop and commission high-cost drug pathways for ICB commissioned medicines.

Summary of recommendations

1) High-cost drug pathways should be updated by the NCL High Cost Drugs team within 90 days of publication of a positive NICE TA (or 30 days if MHRA Early Assess to Medicines Scheme or NICE Fast Track appraisal):
   a) All pathways should permit:
      i) 1 drug per mechanism of action, PLUS
      ii) A second biosimilar anti-TNF for patients who experienced secondary loss-of-response to the first anti-TNF (assuming the originator is recommended by NICE, and the biosimilar is available at a significant discount)

All drugs with a NICE TA will be made available, however the expectation (supported by a traffic light system; see

b) Appendix 1) is that
   i) Lower cost drug classes are used preferentially to higher cost classes
   ii) Where two or more drugs have the same mechanism of action, the drug with the lowest acquisition cost is used preferentially
c) Where there is a claim of superiority of a given drug (vs. biosimilar or a lower cost drug) the NCL JFC will evaluate whether the more expensive drug is cost-effective. For the avoidance of doubt, NCL JFC will not make an assessment on affordability.
d) Where there is a claim that more than one drug per mechanism of action should be made available the NCL JFC will evaluate whether this is cost-effective.
e) For patients who experience an immediate ADR [within 1 month] or have responded to treatment but experience an ADR within 6 months of treatment initiation, another treatment option within the same mechanism of action (if available and appropriate) can be accessed. Where the ADR is likely to be a drug class effect, an alternative mechanism of action is preferable.

2) Drug costs should include drug acquisition price plus any fee associated with drug administration e.g. infusion costs, homecare costs.
3) High-cost drug pathways are to be approved clinically by NCL Joint Formulary Committee and NCL Integrated Medicines Optimisation Committee, and financially by [*to be confirmed*], within the implementation period.
4) Contracting and finance arrangements between ICBs and Trusts should not delay the provision of NICE TA treatments.
5) Where an updated high-cost drug pathway is clinically but not financially approved within the NICE TA implementation period, the new drug can be used in line with the wording of the TA (i.e. any patient who meets eligibility criteria, regardless of locally optimised place in therapy or prior mechanisms of action).
6) **Dual biologic therapy for the same disease** is not routinely commissioned; for individual cases, please consider RMOC advisory statement, discuss at MDT and contact Trust formulary teams for advice re IFR submission.
   Concurrent biologic treatment for different co-morbidities, is permissible provided NICE eligibility criteria for both treatments are met and there is MDT agreement across both specialities that dual therapy is appropriate and a single drug which is active against both co-morbidities is not available.

1. Scope

The purpose of this paper is to support NCL ICS in agreeing a set of principles, against which a consistent, timely and equitable suite of high-cost drug pathways can be agreed, updated and commissioned.

There remains uncertainty as to who needs to approve pathways in NCL, however this is out of scope of this paper.

2. Background

2.1. Historical arrangement

CCGs were responsible for commissioning high-cost drugs for indications, including and not limited to:

- Rheumatoid arthritis
- Ulcerative colitis
- Crohn's disease
- Psoriasis
- Psoriatic arthritis
- Ankylosing spondylitis and Non-radiographic axial spondyloarthritis
- Juvenile Idiopathic Arthritis (adults only)
- Wet age related macular degeneration
- Diabetic macular oedema
- Branch retinal vein occlusion
- Central retinal vein occlusion
- Atopic dermatitis
- Immune thrombocytopenic purpura
- Auto-immune haemolytic anaemia

Within NCL, the responsibility for managing high-cost drugs was outsourced to London Shared Services (formerly NEL CSU and NEL). When NCL ICB was formed in July 2022, the responsibility for high-cost drug management was brought in-house, however the resource is no longer available.

High-cost drug pathways are considered valuable where a number of high-cost drugs with positive NICE Technology Appraisals are available for a given place in therapy. Pathway development was led by 'task and finish groups' with membership drawn from NCL Provider clinicians and pharmacists, London Shared Services (representing the commissioner) and the NCL Joint Formulary Committee (JFC). These groups informally negotiated a balance between expanded access (cost-pressures) and pathway efficiency. The pathways were reviewed and approved by the NCL JFC to confirm appropriateness and cost-effectiveness, then by NCL CCG to confirm affordability.

NCL ICB inherited 10 pathways from NCL CCG which inform current clinical practice:

- Rheumatology [£9.3 million][i]
  - Rheumatoid arthritis
  - Psoriatic arthritis
  - Ankylosing spondylitis and Non-radiographic axial spondyloarthritis
- Gastroenterology [£6.9 million]
  - Ulcerative colitis
  - Crohn's disease
- Dermatology [£4.0 million]
  - Psoriasis
- Ophthalmology [£10.2 million]
  - Wet age related macular degeneration
  - Diabetic macular oedema
  - Branch retinal vein occlusion

- Central retinal vein occlusion

Many of these pathways are due, or overdue, review. If the system is unable to review and (where appropriate) approve updated pathways and associated budget impacts, indecision will leave patients untreated, create inequity of access (a proportion of patients will seek treatment outside of NCL e.g. SEL and Herts), create stress in the system (dissatisfaction amongst clinical team which medicines management colleagues cannot resolve) and risk legal challenge (as NICE TAs should be made available).

2.2. High-cost drugs

The term high-cost drug refers to a medicine which is specified in Annex A (14b) of the National Tariff Payment System (NTPS)[ii]. This list is nationally set and updated annually.

2.3. NICE Technology Appraisal

Technology appraisals (TAs) are recommendations on the use of new and existing medicines and treatments within the NHS.[iii] They usually, but not exclusively relate to high-cost drugs.

NICE usually issue one of two decisions for ICB commissioned drugs; 'recommended', 'not recommended'.

Where a drug is recommended it can be used 'as an option' at a given place in therapy. The place in therapy may include a disease score threshold (e.g. DAS28 >5.1 for rheumatoid arthritis) or a minimum degree of pre-treatment (e.g. after failure or unsuitability for tumour necrosis factor-alpha inhibitor).

2.4. NICE and the NHS Constitution

The NHS is legally obliged to fund and resource medicines and treatments recommended by a NICE TA.[iii]

The NHS Constitution states that patients have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if their doctor believes they are clinically appropriate.[iii]

When NICE recommends a treatment 'as an option', the NHS must make sure it is available within 3 months (unless otherwise specified) of its date of publication. This means that, if a patient has a disease or condition and the doctor responsible for their care thinks that the technology is the right treatment, it should be available for use, in line with NICE's recommendations.[iii]

2.5. ICB statutory duties

Balanced with the statutory obligation to provide high-cost drugs which are recommended by a NICE TA, is the ICB statutory responsibility to ensure the annual budget (revenue and capital limits and running costs allowances) are not exceeded.[iv]

2.6. Regional Medicines Optimisation Committee (RMOC) Advisory Statement

Prescribing choices should be made on grounds of clinical and cost-effectiveness, and ensuring that the most appropriate and safe treatment option is selected through shared decision-making.

Where patients have received a number of the available NICE approved treatments, the following position is based on advice from the NHS England and NHS Improvement Governance and Legal Team:

- *A policy adopted by a commissioner that would serve to limit patients' access to appropriate treatments based on a number of prior treatments being attempted would be counter to the provisions of the NHS Constitution.*
- *The NHS Constitution pledges that patients have the right to drugs and treatments that have been recommended by NICE subject to being clinically appropriate, and patients have the right to expect*

local decisions on the funding of drugs and treatments to be made rationally and following the proper consideration of evidence.

- *Clinical assessment of the appropriateness of treatments should be the overriding factor rather than the implementation of policies for costs saving reasons.*

When a treatment fails, guidance from specialist bodies suggests switching to a biologic with a new mechanism of action is more effective than switching within class, although it should be noted that this is based on low quality evidence. The exception to this is secondary failure of anti-TNF treatment due to formation of anti-drug-antibodies, in which case switching within class may be a valid treatment option.[v]

2.7. Evidence base underpinning NICE TAs

NICE TAs assess the incremental benefits, harms and costs for a given drug compared to its real-world comparator(s). These comparisons are informed by one or more pivotal/licensing studies. Licensing studies (to the authors knowledge) do not include patients who have received prior treatment with the same mechanism of action.

For example, recent NICE TAs for ulcerative colitis were underpinned by pivotal studies, all of which excluded prior treatment with the same mechanism of action (Appendix 2).

In the case of JAK inhibitors for ulcerative colitis, NICE recommend tofacitinib (November 2018), filgotinib (June 2022) and upadacitinib (January 2023) however, no evidence was reviewed which supports the use of a second JAK inhibitor after failure of a first.

It is reasonable (in the authors opinion) to conclude that NICE only consider the effectiveness of each drug for a specific condition, when it is the first of that mechanism of action to be given to a cohort. ICS pathways might reasonably reflect this.

2.8. NCL JFC advice

The NCL JFC consider that the following approach strikes a pragmatic balance between the legal requirement to make available drugs with a positive NICE TA, the evidence base (see 2.7) and subsequently cost-effectiveness, and affordability:

- One drug per mechanism of action, PLUS
- A second biosimilar anti-TNF for patients who experienced secondary loss-of-response to the first anti-TNF

3. Assessment

There are broadly three approaches to commissioning high-cost drug pathways for patients who meet NICE TA criteria:

1) Cap the number of ‘lines of therapy’ available below ‘one drug per mechanism of action’
2) No cap
3) Provide one drug per mechanism of action +/- one additional line

The advantages and disadvantages of each approach are discussed in the following sections. In the authors opinion, Option 3 is pragmatic.

Cap the number of 'lines of therapy' available below 'one drug per mechanism of action'

Advantages	Disadvantages
- Lowest cost	- Untreated patients live with a high disease burden, despite nationally approved drugs being available which may benefit their condition - Inconsistent with the NHS Constitution - Directly contravenes advice from NHSE/I Governance and Legal team - Subject to legal challenge - Patients who can 'vote with their feet' may seek treatment outside of NCL in regions which do not adopt such a cap, creating inequity of access.

No cap

Advantages	Disadvantages
- Maximal patient access - Fully complies with the NHS Constitution - No risk of legal review	- Highest cost - Could be argued as being inconsistent with the evidence-base (as such a position effectively permits/commissions cycling within a class, which is not explored in pivotal studies) though there may be exceptions to this - May result in patients from other regions being referred to NCL Providers for extended access to treatment

Provide one drug per mechanism of action +/- one additional line

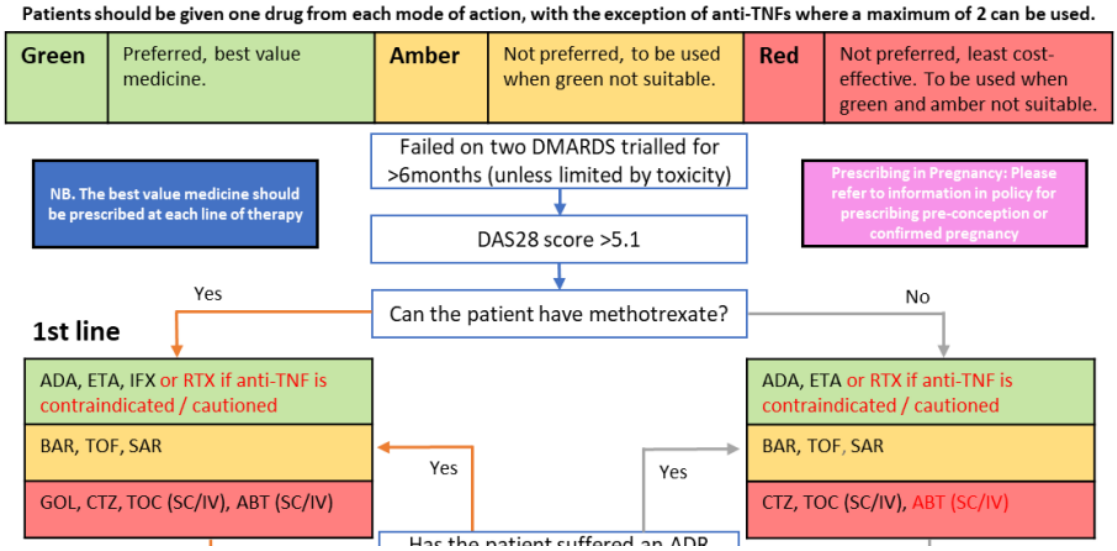
Advantages	Disadvantages
- Medium cost option - Patients have a good access to treatment - Established practice in rheumatology, dermatology, and to an extent gastroenterology (though until JAKi they have not had more than one mechanism for mechanisms other than anti-TNF) - Could be argued as being consistent with the evidence-base (as such a position effectively prevents cycling within a class, which is not explored in pivotal studies) though there may be exceptions to this - SPS advisory statement appears to make room for this position	- Might be considered inconsistent with the NHS Constitution - Non-zero risk of legal challenge

4. Conclusion

Refer to Summary of recommendations at the top of this document.

Appendix 1: Traffic light approach to indicating which drugs are preferred at a given place in therapy

https://www.ncl-mon.nhs.uk/wp-content/uploads/Guidelines/10_RA_biologics_pathway.pdf



Appendix 2: Recent NICE TAs for ulcerative colitis

Drug	MoA	TA	Pivotal study exclusion criteria
Mirikizumab	Anti IL-23	ID3973	LUCENT 1 Prior exposure to anti-IL-12 antibodies or anti-IL-23 antibodies [link]
Etrasimod	S1P receptor modulator	ID5091	ELEVATE UC 12 Prior treatment with S1P receptor modulators [link]
Upadacitinib	JAK inhibitor	ID3953	U-ACHIEVE and U-ACCOMPLISH Participant with previous exposure JAK inhibitor [link]
Tofacitinib	JAK inhibitor	TA547	OCTAVE Prior JAK inhibitor was not excluded [link], however no other JAK inhibitors were licensed for UC at the time of the clinical trial therefore highly unlikely that patients will have received prior AK inhibitors
Filgotinib	JAK inhibitor	TA792	SELECTION Patients who had previously received any JAK inhibitor were not eligible for either induction study, following an amendment to the protocol [link]

References

[i] NCL ICB High Cost Drug Reports; Topline Summary 2021 / 2022. Adenike Fakoya (email received 14/12/2022)
[ii] https://www.england.nhs.uk/publication/national-tariff-payment-system-documents-annexes-and-supporting-documents/
[iii] https://www.nice.org.uk/About/What-we-do/Our-Programmes/NICE-guidance/NICE-technology-appraisal-guidance
[iv] https://www.hfma.org.uk/docs/default-source/publications/guides/intro-to-nhs-finance/chapter-6---hfma-introductory-guide-to-nhs-finance.pdf?sfvrsn=70dd76e7_2#:~:text=%E2%80%A2-,ICBs%20are%20accountable%20to%20NHS%20England%20for%20improving%20outcomes%20to,to%20the%20public%20and%20patients.&text=ICBs%20receive%20funding%20for%20commissioning%20NHS%20services%20from%20NHS%20England.
[v] https://www.sps.nhs.uk/articles/rmoc-advisory-statement-sequential-use-of-biologic-medicines/ [date accessed 15/01/2023; removed from website as of 20/02/2023]; https://nras.org.uk/wp-content/uploads/sites/2/2021/04/Sequential-use-of-biologic-medicines-RMOC-v-2.0-1.pdf

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