NICE National Institute for Health and Care Excellence

NICE guidance

Loncastuximab tesirine for treating relapsed or refractory diffuse large B-cell lymphoma and high-grade B-cell lymphoma after 2 or more systemic treatments

Technology appraisal guidance
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www.nice.org.uk/guidance/ta947

Your responsibility

The recommendations in this guidance represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take this guidance fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this guidance is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Commissioners and/or providers have a responsibility to provide the funding required to enable the guidance to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

1 Recommendations

1.1 Loncastuximab tesirine is recommended as an option for treating relapsed or refractory diffuse large B-cell lymphoma (DLBCL) and high-grade B-cell lymphoma (HGBL) after 2 or more systemic treatments in adults, only if:

- they have previously had polatuzumab vedotin, or if polatuzumab vedotin is contraindicated or not tolerated, and
- the company provides it according to the commercial arrangement.

1.2 This recommendation is not intended to affect treatment with loncastuximab tesirine that was started in the NHS before this guidance was published. People having treatment outside this recommendation 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

Standard treatment for relapsed or refractory DLBCL after 2 or more systemic treatments includes polatuzumab vedotin with rituximab and bendamustine (polatuzumab plus BR), and chemotherapy. There is no standard treatment for HGBL, but people are usually offered the same treatments as for DLBCL. Because a polatuzumab-containing therapy has recently been made available earlier in the treatment pathway, in the future, people are more likely to have chemotherapy if they have already had treatment with polatuzumab vedotin.

Evidence from 1 clinical trial shows that some people with DLBCL and HGBL having loncastuximab tesirine have all signs and symptoms of their cancer disappear (complete remission). But it was not compared with any other treatments in the trial, so it's not known how it directly compares with standard treatment. The results from indirect comparisons of loncastuximab tesirine with other treatments are very uncertain, but suggest it is as effective as polatuzumab plus BR and more effective than chemotherapy.

Because of their similar clinical effectiveness, only the difference in cost between loncastuximab tesirine and polatuzumab plus BR was considered, and loncastuximab

tesirine is more expensive. For loncastuximab tesirine compared with chemotherapy, when considering the condition's severity, and its effect on quality and length of life, the most likely cost-effectiveness estimates are below what NICE normally considers an acceptable use of NHS resources. So, loncastuximab tesirine is recommended, but only for people who have previously had polatuzumab vedotin, or if polatuzumab vedotin is contraindicated or not tolerated.

2 Information about loncastuximab tesirine

Marketing authorisation indication

2.1 Loncastuximab tesirine (Zynlonta, Swedish Orphan Biovitrum) is indicated for 'the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) and high-grade B-cell lymphoma (HGBL), after two or more lines of systemic therapy.'

Dosage in the marketing authorisation

2.2 The dosage schedule is available in the summary of product characteristics for loncastuximab tesirine.

Price

2.3 The list price for loncastuximab tesirine is £15,200 per 10-mg vial (excluding VAT; company submission). An average course of loncastuximab tesirine per person is £85,562.

2.4 The company has a commercial arrangement. This makes loncastuximab tesirine 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.

3 Committee discussion

The evaluation committee considered evidence submitted by Swedish Orphan Biovitrum, a review of this submission by the external assessment group (EAG), and responses from stakeholders. See the committee papers for full details of the evidence.

Clinical need and treatment pathway

A need for new treatment options

3.1 Both relapsed or refractory diffuse large B-cell lymphoma (DLBCL) and high-grade B-cell lymphoma (HGBL) are aggressive types of non-Hodgkin lymphoma. Symptoms and treatment of the disease can have a severe impact, both physically and mentally, for people who have the disease and their carers. The clinical pathway for DLBCL after 2 or more systemic treatments is evolving. There is no standard treatment pathway for HGBL, so it often follows the same treatment pathway as DLBCL. Patient and clinical experts advised that DLBCL and HGBL can be difficult to treat and often needs intensive treatment options, so it is important to have other treatment options available. The committee concluded that there is an unmet need in this population and loncastuximab tesirine offers a new potential treatment option.

Evolving treatment pathway

3.2 At the time of this evaluation, there were several recent changes to the treatment pathway for relapsed or refractory DLBCL after 2 or more systemic treatments. Polatuzumab vedotin with rituximab and bendamustine (polatuzumab plus BR) is recommended for relapsed or refractory DLBCL (NICE technology appraisal 649), and polatuzumab vedotin with rituximab, cyclophosphamide, doxorubicin and prednisolone (polatuzumab R-CHP) was recently recommended for untreated DLBCL (NICE technology appraisal 874). Also, chimeric antigen receptor (CAR) T-cell therapies have been recommended. Axicabtagene ciloleucel is used after 2 or more treatments (NICE technology appraisal 872) and is available in the Cancer

Drugs Fund (CDF) after first-line chemoimmunotherapy (NICE technology appraisal 895). At the time of the evaluation, tisagenlecleucel was available in the CDF after 2 or more treatments (NICE technology appraisal 567). Treatments in the CDF were not considered potential comparators because their availability in the NHS in the future is not guaranteed. The committee concluded that the treatment pathway has changed rapidly and that this would be considered in the decision-making process.

Comparators

3.3 The committee noted that the treatment options for relapsed or refractory DLBCL after 2 previous systemic treatments depend on which treatments the person has had and whether CAR T-cell therapy is suitable. The company highlighted that loncastuximab tesirine would only be used when CAR T-cell therapy is not suitable. This means that the current available treatment options for this population at the time of this evaluation were:

- chemotherapy, including rituximab-based chemotherapy
- polatuzumab plus BR (see NICE's technology appraisal guidance on polatuzumab vedotin with rituximab and bendamustine for treating relapsed or refractory diffuse large B-cell lymphoma)
- pixantrone (see NICE's technology appraisal guidance on pixantrone monotherapy for treating multiply relapsed or refractory aggressive non-Hodgkin B-cell lymphoma).

The company included polatuzumab plus BR and chemotherapy as comparators. The company did not consider pixantrone a relevant comparator because it is rarely used in clinical practice. Both the clinical experts and the NHS England CDF lead agreed that polatuzumab plus BR is a relevant comparator, but its use at this stage in the treatment pathway is decreasing. Its use is also likely to further decrease in the future because polatuzumab has recently been recommended for untreated DLBCL (see section 3.2) and is likely to be used then instead. The clinical experts explained that chemotherapy is currently used less than other options at this stage of the pathway, but it is still a relevant comparator, and may be used

more in the future, as the use of polatuzumab plus BR in this population decreases. The EAG reported that clinical input indicated that loncastuximab tesirine might be used in people for whom CAR T-cell therapy is unsuitable. The committee concluded that although the pathway is quickly changing, the company's positioning is appropriate and both polatuzumab plus BR and chemotherapy are relevant comparators.

Clinical evidence

Indirect comparisons

3.4 Clinical evidence for loncastuximab tesirine came from LOTIS-2, a single-arm, phase 2 trial that collected data on 145 people with relapsed or refractory DLBCL, including HGBL, that had not responded to 2 or more previous systemic treatments. The primary outcome of overall response rate was 48%, and 25% of participants reached complete remission. Median overall survival was 9.5 months and median progression-free survival was 4.9 months. Because there was no evidence directly comparing loncastuximab tesirine with any of the comparator treatments, the company did matched-adjusted indirect treatment comparisons (MAICs) against each of the comparators.

3.5 To compare loncastuximab tesirine with polatuzumab plus BR, the company used data from LOTIS-2 and GO29365, a single-arm extension study, which included 152 people with relapsed or refractory DLBCL after one or more treatments. The company based its matching on 7 baseline characteristics. The baseline characteristics were only available across the whole study population, so included data for people who only had one previous treatment. The company's results showed that loncastuximab tesirine had similar or slightly worse efficacy compared with polatuzumab plus BR. The exact results are considered confidential by the company and cannot be reported here. At technical engagement, the company provided 2 additional sensitivity analyses for the MAIC comparing loncastuximab tesirine and polatuzumab plus BR. One analysis excluded people if their disease response to primary therapy was missing, and the second analysis included matching against all available characteristics, including the International Prognostic Index (IPI). The results of these sensitivity

analyses were similar to the base case analysis, suggesting a hazard ratio for overall survival close to 1 and a hazard ratio for progression-free survival favouring polatuzumab plus BR.

3.6 To compare loncastuximab tesirine with chemotherapy, the company used data from LOTIS-2 and CORAL, an extension study, which included 278 people. It based the matching on 3 baseline characteristics. The company's results showed that loncastuximab tesirine was better than chemotherapy at increasing how long people live, with a hazard ratio of 0.67 for overall survival (95% confidence interval 0.51 to 0.86), and increasing overall disease response, with a hazard ratio of 1.53 (95% confidence interval 0.91 to 2.54). Data on how long people live before their condition gets worse was not available for this comparison.

3.7 The EAG highlighted several concerns with the MAICs. The company based its preferred characteristics for matching on clinical opinion, but these characteristics were not available across all the key studies. Also, the company did not use age, Ann Arbor stage or Eastern Cooperative Oncology Group characteristics for matching in their base case analysis if the IPI stage was available, because these factors are already included in calculating the IPI stage. The EAG considered that all available characteristics should have been used. It also noted that the studies included in the MAICs had different sample sizes, and there were differences across study populations and study definitions. The EAG highlighted that for the comparison with polatuzumab plus BR, the company did not provide an analysis combining both sensitivity analyses, or Kaplan–Meier curves for the MAIC adjustments, and that the results of the sensitivity analyses were not used in the model. It also highlighted that the MAIC analyses results are similar to naive comparisons between the studies, which adds uncertainty to the benefit of using the MAIC analyses. The committee concluded that the results of the MAIC analyses were very uncertain.

Economic model

Company's model

3.8 The company used a partitioned survival model to estimate the cost

effectiveness of loncastuximab tesirine. The model included 3 health states: progression-free, progressed disease and death. The probability of staying in each health state was calculated using overall survival and progression-free survival curves. The committee concluded that the model was suitable for decision-making.

Rates of subsequent autologous stem cell transplant

3.9 For the comparison with chemotherapy, the company used data from the CORAL extension study to inform the rate of subsequent autologous stem cell transplant after chemotherapy. In its original base case, 22% of people had an autologous stem cell transplant after chemotherapy, and 3% after loncastuximab tesirine. The EAG considered that the rate of subsequent autologous stem cell transplant after chemotherapy was likely to be lower in current NHS clinical practice. So, in its base case model, it included a rate of 3% after both chemotherapy and loncastuximab tesirine and provided scenario analyses to explore different rates. Clinical experts agreed that the rates reported by CORAL were higher than they would expect to see in clinical practice. After consultation on the draft guidance, the company updated its base case to include a rate of 3% after chemotherapy. The committee concluded the rate of autologous stem cell transplant after chemotherapy was uncertain, but that 3% would be more plausible in clinical practice.

Overall survival and progression-free survival compared with polatuzumab plus BR

3.10 To estimate long-term overall survival and progression-free survival, the company fitted parametric models to the MAIC results. In its original base case, the company applied a generalised gamma extrapolation for loncastuximab tesirine for both overall survival and progression-free survival because it stated generalised gamma had the best fit to the data. For overall survival, the EAG considered that the log-normal extrapolation had a similar fit to the data, but the long-term predictions of survival were more plausible than with the generalised gamma extrapolation. The clinical experts advised that after 10 years, it was reasonable to assume around 5% of people would still be alive. The company

considers the extrapolated results to be confidential so they cannot be reported here. But the committee noted that the log-normal extrapolation predicted a 10-year overall survival closer to 5% than the generalised gamma extrapolation. It also did not consider it plausible that loncastuximab tesirine would significantly increase 10-year overall survival compared with current practice. For progression-free survival, the EAG noted that the generalised gamma extrapolation was more optimistic in the long-term than most of the other parametric models. Although it appeared similar to the Kaplan—Meier curve from LOTIS-2, there were very few people remaining at risk in LOTIS-2 after 12 months, so it was very uncertain. So, the EAG used the log-normal extrapolation in its base case model. After consultation on the draft guidance, the company updated its base case to use the log-normal distribution to extrapolate progression-free and overall survival for loncastuximab tesirine, when comparing with polatuzumab plus BR. The committee concluded that, for both overall survival and progression-free survival, the log-normal extrapolation was more plausible than the generalised gamma extrapolation.

3.11 To model long-term overall survival and progression-free survival for polatuzumab plus BR after 2 or more systemic treatments, rather than using the hazard ratios estimated by the MAIC analysis, the company extrapolated data from the GO29365 study and adjusted for the effect of including people who had polatuzumab plus BR as second-line treatment. In its original base case, the extrapolated curves showed that loncastuximab tesirine had better overall survival and progression-free survival than polatuzumab plus BR. The EAG considered this implausible because the MAICs showed similar efficacy between loncastuximab tesirine and polatuzumab plus BR. In its base case, the EAG set overall survival and progression-free survival for polatuzumab plus BR equal to that of loncastuximab tesirine. The committee noted that in the company's base case, most of the benefit in progression-free survival for loncastuximab tesirine was shown in the extrapolated period outside of the trial. Clinical experts advised that most of the benefit, and whether the disease would relapse or progress, would likely be seen in the first 2 years of treatment. After consultation on the draft guidance, the company updated its base case to assume equivalence between loncastuximab tesirine and polatuzumab plus BR for both overall and progression-free survival. The committee agreed that, given the MAIC results, assuming equivalence between loncastuximab tesirine and polatuzumab plus BR for both overall survival and progression-free survival was most plausible.

Overall survival compared with chemotherapy

3.12 To model overall survival for loncastuximab tesirine, in its original base case, the company applied a generalised gamma extrapolation to the LOTIS-2 data. The EAG advised that the generalised gamma extrapolation could be implausibly optimistic as it is affected by background mortality restrictions, and preferred to apply a log-normal extrapolation. After consultation on the draft guidance, the company updated its base case to include the log-normal extrapolation for loncastuximab tesirine for overall survival when compared with chemotherapy. The committee concluded that the log-normal extrapolation was the most plausible.

3.13 To model overall survival for chemotherapy, in its original base case, the company applied a hazard ratio of 1.43 from the MAIC analysis to its extrapolation for loncastuximab tesirine, because it considered that there was no evidence to reject the proportional hazards assumption. In response to consultation on the draft guidance, the company stated that changing the rate for autologous stem cell transplant after chemotherapy to match the loncastuximab tesirine arm (see section 3.9) resulted in bias. This was because the costs of chemotherapy were reduced to reflect lower rates of stem cell transplant, but the impact on outcomes was not changed. The company presented an analysis of survival outcomes from the CORAL extension study, split by eventual stem cell transplant status. This showed that people who had a stem cell transplant had better survival outcomes than those who did not. So, it generated overall survival hazard ratios for people who did and did not have a stem cell transplant separately, and then applied a weighted hazard ratio of 1.66 based on the proportion of people who had a stem cell transplant in LOTIS-2 (3% autologous stem cell transplant). The EAG commented that the company's analysis was not described clearly, and that it was not clear whether it was appropriate to use a hazard ratio to measure benefit in either subgroup. It also noted that baseline characteristics were not reported for the subgroups split by eventual stem cell transplant status, and that the company's analysis assumed both subgroups had the same baseline characteristics, which was not plausible. The EAG considered that it was unknown whether the proportional hazards assumption would hold indefinitely, so it preferred to extrapolate the CORAL data directly rather than use a hazard ratio to estimate long-term overall survival for chemotherapy. But after consultation, the EAG also updated its base case to account for the potential difference in

outcomes when adjusting the rate of stem cell transplant. It fitted separate models for people who had and had not had a stem cell transplant, then combined them based on the rate of stem cell transplant. The committee agreed with the EAG that it was not clear the proportional hazards assumption would hold indefinitely, and therefore that it was more appropriate to directly extrapolate from the CORAL data.

Progression-free survival compared with chemotherapy

3.14 To model progression-free survival for loncastuximab tesirine when comparing with chemotherapy, the company fitted models to the LOTIS-2 data and used the generalised gamma extrapolation in its base case. The EAG noted that in the company's model, there were no people in the post-progression health state after around 5 years, which it did not feel was supported by evidence. So, the EAG preferred to use the log-normal model. After consultation, the company accepted the log-normal model for progression-free survival for loncastuximab tesirine in its base case. The committee concluded the log-normal model was appropriate.

3.15 Because there was no evidence to inform the modelling of progression-free survival for chemotherapy, the company assumed that the hazard ratio for comparing with loncastuximab tesirine was identical to that for overall survival. When it updated the hazard ratio for overall survival to 1.66 (see section 3.13), it also updated the hazard ratio for progression-free survival to 1.66. The EAG also used a hazard ratio in its base case because of a lack of robust alternatives. But it considered that it was not appropriate to adjust progression-free survival outcomes to account for changing the rate of stem cell transplant, because it was unclear when stem cell transplant would take place. So, the EAG used the original hazard ratio of 1.43. The committee agreed that it was more appropriate to use the hazard ratio of 1.43 to model progression-free survival for chemotherapy.

Cure point

3.16 At consultation, the company highlighted that in the recent evaluation of glofitamab (NICE technology appraisal 927), the committee had accepted a cure point of 3 years. This was based on real-world data and trial evidence showing

that the risk of mortality begins to plateau after an initial period of 2 to 3 years, and advice from clinical experts that they would consider people cured if their cancer remained in complete remission at 2 years. So, the company presented a scenario analysis with a cure point of 3 years, after which it modelled an increased risk of mortality of 41% compared with the general population, based on the standardised mortality ratio proposed in the evaluation of polatuzumab vedotin with rituximab and bendamustine (NICE technology appraisal 649). The committee noted that the follow-up for progression-free and overall survival in LOTIS-2 was more limited than in the glofitimab trial. It also noted that in TA927, while a lower risk of mortality compared to the general population was modelled (9%), a 10% utility decrement had been modelled, compared with the general population. The committee concluded that a cure point of 3 years was uncertain but plausible based on clinical opinion, and recognised the importance of making consistent decisions between appraisals. It considered that a 41% increased risk of mortality was conservative, while the lack of a modelled utility decrement was less conservative, compared with the way the cure point had been modelled in the glofitamab evaluation. Overall, the committee considered that these factors would balance each other out.

Severity

3.17 The committee considered the severity of the condition (the future health lost by people living with the condition and having standard care in the NHS). The committee may apply a greater weight, called a severity modifier, to quality-adjusted life years (QALYs) if technologies are indicated for conditions with a high degree of severity. The company provided absolute and proportional QALY shortfall estimates in line with NICE's health technology evaluations manual. The company and EAG agreed that for the comparison with chemotherapy, the QALYs should have a higher weighting of 1.2 because of the severity of the condition. The company and EAG agreed that for the comparison with polatuzumab plus BR, the severity weighting did not apply. So, the committee concluded that applying the severity weighting of 1.2 to the QALYs for the comparison with chemotherapy was appropriate.

Cost-effectiveness estimates

Acceptable incremental cost-effectiveness ratio (ICER)

3.18 NICE's manual on health technology evaluation notes that above a most plausible ICER of £20,000 per QALY gained, decisions about the acceptability of a technology as an effective use of NHS resources will take into account the degree of certainty around the ICER. The committee will be more cautious about recommending a technology if it is less certain about the evidence presented, but will also consider other aspects including uncaptured health benefits. The committee agreed that the indirect treatment comparisons showed that loncastuximab tesirine was more effective than chemotherapy and had similar efficacy to polatuzumab plus BR. But there is considerable uncertainty because of the lack of direct evidence and concerns about the MAICs. So, the committee agreed that it would accept an ICER at the lower end of the acceptable range (less than £20,000).

Cost-effectiveness estimates

3.19 There is a confidential commercial arrangement for loncastuximab tesirine and the comparators, so the exact cost-effectiveness estimates are confidential and cannot be reported here. After consultation on the draft guidance, the company updated its base case model to accept most of the assumptions in the EAG base case, except for the method of modelling overall survival for chemotherapy (see section 3.13) and the hazard ratio used for modelling progression-free survival for chemotherapy (see section 3.15). The company also presented a scenario analysis where a cure point was modelled at 3 years for people whose disease had not progressed (see section 3.16). The committee agreed that its preferred assumptions for modelling overall and progression-free survival for chemotherapy were those used in the EAG base case. It also agreed that the cure point at 3 years was plausible. Compared with chemotherapy, the ICER including the severity weighting and a cure point of 3 years was below £20,000 per QALY gained. The committee considered that including a utility decrement after the cure point, as in the glofitamab evaluation (see section 3.16), and using a probabilistic ICER would increase the ICER, but that using an increased risk of mortality of less than 41% compared with the general population, which could be plausible (see section 3.16), would decrease the ICER. So, the committee was

satisfied that the most plausible ICER was likely to be below £20,000 per QALY gained. Compared with polatuzumab plus BR, the committee preferred to assume no QALY difference between loncastuximab tesirine and polatuzumab plus BR, so only considered the difference in costs, and loncastuximab tesirine was more expensive than polatuzumab plus BR. The committee concluded that loncastuximab tesirine was a cost-effective treatment option compared chemotherapy, but not compared with polatuzumab plus BR.

Other factors

Equality

3.20 The committee did not identify any equality issues.

Innovation

3.21 The committee considered if loncastuximab tesirine was innovative. The company highlighted some perceived benefits compared with existing treatments. It stated that loncastuximab tesirine had been well-tolerated in the trial and could be beneficial for frailer people. The company also noted that loncastuximab tesirine was available ready for infusion, and that only a single 30-minute infusion was needed per cycle, which was available in the outpatient setting. The NHS England CDF lead commented that loncastuximab tesirine did need to be reconstituted in aseptic conditions and that it was still associated with some adverse effects. The EAG considered that the reduced administration time of loncastuximab tesirine was already reasonably represented in the model. The committee concluded that all additional benefits of loncastuximab tesirine had already been taken into account.

Conclusion

3.22 Compared with polatuzumab plus BR, there was no QALY difference and loncastuximab tesirine was more expensive than polatuzumab plus BR. Compared

with chemotherapy, the most likely cost-effectiveness estimate for loncastuximab tesirine is below the range that NICE considers an acceptable use of NHS resources. The committee considered that chemotherapy would be used at this point in the pathway when people had previously had polatuzumab vedotin, or when polatuzumab vedotin was contraindicated or not tolerated (see section 3.3). So, the committee decided to recommend loncastuximab tesirine for routine use in the NHS for treating relapsed or refractory DLBCL and HGBL after 2 or more systemic treatments in adults only if they have previously had polatuzumab vedotin, or if polatuzumab vedotin is contraindicated or not tolerated.

4 Implementation

4.1 Section 7 of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 requires integrated care boards, NHS England and, with respect to their public health functions, local authorities to comply with the recommendations in this evaluation within 3 months of its date of publication.

4.2 Chapter 2 of Appraisal and funding of cancer drugs from July 2016 (including the new Cancer Drugs Fund) – A new deal for patients, taxpayers and industry states that for those drugs with a draft recommendation for routine commissioning, interim funding will be available (from the overall Cancer Drugs Fund budget) from the point of marketing authorisation, or from release of positive draft guidance, whichever is later. Interim funding will end 90 days after positive final guidance is published (or 30 days in the case of drugs with an Early Access to Medicines Scheme designation or cost comparison evaluation), at which point funding will switch to routine commissioning budgets. The NHS England Cancer Drugs Fund list provides up-to-date information on all cancer treatments recommended by NICE since 2016. This includes whether they have received a marketing authorisation and been launched in the UK.

4.3 The Welsh ministers have issued directions to the NHS in Wales on implementing NICE technology appraisal guidance. When a NICE technology appraisal guidance recommends the use of a drug or treatment, or other technology, the NHS in Wales must usually provide funding and resources for it within 2 months of the first publication of the final draft guidance.

4.4 When NICE recommends a treatment 'as an option', the NHS must make sure it is available within the period set out in the paragraphs above. This means that, if a patient has relapsed or refractory DLBCL or HGBL and the doctor responsible for their care thinks that loncastuximab tesirine is the right treatment, it should be available for use, in line with NICE's recommendations.

5 Evaluation committee members and NICE project team

Evaluation committee members

The 4 technology appraisal committees are standing advisory committees of NICE. This topic was considered by committee C.

Committee members are asked to declare any interests in the technology being evaluated. If it is considered there is a conflict of interest, the member is excluded from participating further in that evaluation.

The minutes of each evaluation committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

Chair

Stephen O'Brien
Chair, technology appraisal committee C

NICE project team

Each evaluation is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the evaluation), a technical adviser and a project manager.

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Accreditation