Complete Summary

GUIDELINE TITLE

Infliximab for the treatment of adults with psoriasis.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Infliximab for the treatment of adults with psoriasis. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Jan. 25 p. (Technology appraisal guidance; no. 134).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Psoriasis

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Management
Treatment

CLINICAL SPECIALTY

Dermatology
Family Practice
Internal Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To evaluate the clinical effectiveness and cost-effectiveness of infliximab for the treatment of adults with psoriasis

TARGET POPULATION

Adults with severe plaque psoriasis

INTERVENTIONS AND PRACTICES CONSIDERED

Infliximab treatment and duration of treatment

MAJOR OUTCOMES CONSIDERED

- Clinical effectiveness
    - Percentage of patients achieving Psoriasis Area and Severity Index (PASI) scores of 50, 75, and 90 at week 10
    - Physician Global Assessment (PGA) status
    - Quality of life
    - Adverse events
- Cost-effectiveness

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The assessment report for this technology appraisal was prepared by the Southampton Health Technology Assessment Centre (SHTAC), University of Southampton. (See the "Availability of Companion Documents" field.)

Clinical Effectiveness

Critique of Manufacturer's Approach

Description of Manufacturer's Search Strategy

The manufacturer's search contains some omissions, however it is thought unlikely to affect the identification of key studies. Most of the searches have been taken from a previous Technology Assessment Report (TAR) for the NICE appraisal of etanercept and efalizumab.

The manufacturer has adhered to the minimum database search criteria as specified by NICE, (Medline, Embase, Medline in Progress [MEIP] and Cochrane) when undertaking clinical effectiveness searches.

The manufacturer stated that "a search of MEIP was conducted but was not considered applicable since none of the papers in this database fit the inclusion criteria". There is no record of additional searching having been undertaken on other databases, and it is not stated if the searches were restricted to English language.

The date that the clinical searches were undertaken was not recorded in the manufacturer's submission (MS).

The search terms selected by the manufacturer included appropriate descriptor and free text terms (the latter were adequately truncated). The documented strategies were appropriately run on the specified databases. An acceptable randomised controlled trial (RCT) filter was applied to the search strategy. The numbers from each search line have not been recorded in the MS.

The searches for the clinical review included systematic reviews, but in practice the procedure of scanning reference lists was only carried out for a single review, as it was the only relevant systematic review identified.

The ERG re-ran searches in Medline and Ovid with an arbitrary date selection of 1996-2007 and the numbers retrieved were similar to those of the manufacturer.

It is noted in the MS that there are no relevant ongoing RCTs. However the search for ongoing trials was not recorded in the MS. For example, there is no mention of using datasets such as National Research Register or Clinical Trials.gov. There is no record of searching for papers presented at key conferences or symposia.

Statement of the Inclusion/Exclusion Criteria Used in the Study Selection and Comment on Whether They Were Appropriate

The MS specified the following inclusion criteria for the systematic review of the literature:

- RCTs of infliximab efficacy were selected as relevant if they were placebo-controlled, with randomised and double-blinded allocation to study arms. Baseline matching of key patient characteristics was also required: namely

age, sex, as well as treatment and disease history. It was necessary that patients in all studies had active psoriasis at time of study entry, to be relevant to infliximab's licensed indication.
- It was also required that the studies had as their primary, or co-primary, endpoint a relevant psoriasis severity score such as the Psoriasis Area and Severity Index (PASI).

The specified inclusion/exclusion criteria were appropriate and largely reflect the information given in the decision problem. However:

- The MS does not report any inclusion criteria relating to the comparator treatments etanercept and efalizumab.
- The MS does not specify dose as an inclusion criteria and may therefore include patients not reflective of United Kingdom (UK) clinical practice.
- The MS provides no criteria for the rating of severity of psoriasis to ensure patients were moderate-to-severe.
- There was no description of what would constitute a failure to respond, or intolerance/contraindication, to prior systemic treatments, as per the NICE scope. The ERG clinical advisor suggests that most patients entering trials for biologics will have failed other treatments in a clinical setting or been contraindicated according to what co-morbidities they had.
- Baseline matching on certain patient demographics was an additional requirement for inclusion.
- The MS does not state clearly whether conference abstracts would be included or excluded. The ERG requested clarification from the manufacturer about the inclusion/exclusion of these types of publications. The manufacturer noted in their response that these were not eligible for inclusion. However, one conference proceeding was included for the comparator interventions (refer to Table 2 in the ERG Report [See the "Availability of Companion Documents" field].)
- The MS state that they applied the same criteria to the selection of RCTs of competitor products etanercept and efalizumab. A flow chart of included and excluded studies of these comparator interventions was not provided.

Refer to sections 3.1.1 and 3.1.2 of the ERG Report (see the "Availability of Companion Documents" field) for more information on clinical effectiveness searches.

Cost-Effectiveness

Critique of Manufacturer's Approach

Cost-Effectiveness Searches

The cost-effectiveness searches of the manufacturer exceed the minimum database criteria set by NICE (Medline, Embase, MEIP, National Health Service Economic Evaluation Database [NHS EED] and Health Economic Evaluations Database [HEED]). The manufacturer has additionally searched Biosis, Derwent Drug file, Current Content/clinical medicine, and Pubmed. MEIP per se is not documented as being searched although Pubmed would have been a good substitute. It is unusual to select Biosis and Derwent Drug File for cost

effectiveness searches. However, this is unlikely to have impacted in a negative way on the searches.

The date for the economic searches is recorded in the MS as taking place on April 26th 2007 spanning 2004-2007 which is a limited period. It was not stated that this was an update search.

The cost effectiveness search strategy is presented primarily as a list of terms. There is no syntax to indicate which items are descriptors and which items were applied to the strategy in free text. The MS also only provides one listing for all the databases searched. However, the descriptor terms would differ in the various databases. Consequently each database strategy should have been displayed separately as per the clinical effectiveness search strategy. There is no evidence of using exploded terms for descriptors nor for using truncation for free text.

The ERG requested further clarification over the cost effectiveness search strategy and this can be found in Appendix 1 of the ERG Report (see the "Availability of Companion Documents" field). This "revised" strategy is appropriately documented and contains a cost filter. For the sake of consistency, the term psoriasis/ could have been exploded (exp psoriasis/) to match with the search strategy in the clinical effectiveness searches.

Refer to section 3.1.1.2 of the ERG Report (see the "Availability of Companion Documents" field) for more information on cost-effectiveness searches.

NUMBER OF SOURCE DOCUMENTS

Clinical Effectiveness

- Four randomised controlled trials (RCTs) comparing infliximab with placebo were included.
- No RCTs comparing infliximab with comparator drugs were identified.
- Four RCTs comparing etanercept with placebo, and four RCTs comparing efalizumab with placebo for indirect comparisons were included.

Cost-Effectiveness

- One systematic review was identified.
- A report of the economic evaluation undertaken by the manufacturer for the National Institute for Health and Clinical Excellence (NICE) Single Technology Appraisal (STA) process.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis of Randomized Controlled Trials
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The assessment report for this technology appraisal was prepared by the Southampton Health Technology Assessment Centre (SHTAC), University of Southampton. (See the "Availability of Companion Documents" field.)

The Appraisal Committee considered evidence submitted by the manufacturer of infliximab and a review of this submission by the Evidence Review Group (ERG).

Clinical Effectiveness

Description and Critique of Manufacturer's Approach to Validity Assessment

The manufacturer's submission (MS) does not provide a formal appraisal of the validity of the included infliximab trials using the quality assessment criteria developed by NICE. The MS presents information on key criteria relating to randomisation, statistics, follow-up, cross-over and centres and geography. No details are provided of how the quality criteria are applied in the MS. Also, no formal quality assessment is undertaken on the comparator trials. The Evidence Review Group (ERG) assessment of the four infliximab trials can be seen in section 3.1.3 of the ERG Report (see the "Availability of Companion Documents" field).

Description and Critique of the Statistical Approach Used

Meta-Analysis

The MS pooled data on Psoriasis Area and Severity Index (PASI) outcomes from the included infliximab trials. The meta-analysis presents relative differences, although the data in Table 11 of the MS reports relative risks for the individual trials but the table suggests the pooled estimate is odds ratios. The ERG has checked these figures and this is an error in the MS as the pooled estimate is relative risks (RR's).

The manufacturer undertook a fixed effects model for the meta-analysis but found statistically significant heterogeneity. The MS states that the indirect comparison with comparator trials therefore used a random effects model as a fixed effects model would have been inappropriate. The MS does not make any comment about the appropriateness or not of using a fixed-effects model, or the appropriateness of pooling the data generally, for the primary meta-analysis of the infliximab data and continues to present data based on a fixed-effects model.

The MS uses a statistical test to measure heterogeneity but does not provide an explanation of what threshold was used to constitute statistical significance. On observation of the data in the MS the ERG notes that two analyses have p-values less than 0.05 (PASI 50, 75) and the PASI 90 analysis has a p-value of 0.839. The ERG would therefore suggest that this latter analysis does not show statistically significant heterogeneity. The ERG have re-run the data through the Revman software and this shows that (taking a p-value of 0.10 as the cut-off for heterogeneity) there is statistically significant heterogeneity in PASI 50 and PASI 75 (p values same as presented by MS) analyses but no statistically significant heterogeneity in PASI 90 (p-value slightly different, p=0.70).

Refer to sections 3.1.5 and 3.2 of the ERG Report (see the "Availability of Companion Documents" field) for more information.

Cost-Effectiveness

Cost-Effectiveness Analysis Methods

The cost-effectiveness analysis estimates the mean length of time that an individual would be expected to be on infliximab, etanercept, or efalizumab through a Markov type process. These values are combined with estimates of progression to PASI response states, quality-adjusted life year (QALY) data, and costs of being a responder or non responder to estimate the cost-effectiveness of the alternatives. This model is referred to as the York model.

Sensitivity Analyses

The results of one-way sensitivity analyses for selected variables are given in the MS for the base case model. All base case results are for infliximab compared to continuous etanercept and only apply to 4th quartile Dermatology Life Quality Index (DLQI) individuals. The results of the base-case probabilistic sensitivity analysis (PSA) are given in section 6.3.2.6 of the MS. Appendix C of the MS gives the results of deterministic and probabilistic analysis for all patients.

Model Validation

The MS states that the primary method of model validation was by comparing the results with the results obtained from the York model.

Critical appraisal of the manufacturer's submitted economic evaluation and modelling methods are presented in sections 4.3 and 4.4 of the ERG Report (see the "Availability of Companion Documents" field).

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

Technology Appraisal Process

The National Institute for Health and Clinical Excellence (NICE) invites 'consultee' and 'commentator' organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service (NHS) Quality Improvement Scotland and research groups working in the area. They can comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an 'assessment report'. Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the 'appraisal consultation document' (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE website. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the 'final appraisal determination' (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals, patients, carers, manufacturers and government, its advice is independent of any vested interests.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The manufacturer based its cost-effectiveness analysis on the York model. This was a two-state Markov model (the two states were on-treatment and off-treatment); alterations were made to include the new data from the infliximab studies. The rates of transitions between states in the model were informed by response and withdrawal rates from the randomised controlled trials (RCTs). The economic analysis included comparisons with etanercept 25 mg, both intermittent and continuous, efalizumab and supportive care. There were no trials identified for continuous etanercept so the manufacturer used the relative risk (RR) for intermittent etanercept in subsequent analyses. The model had a 10-year time horizon and included a trial period after which treatment could be switched to efalizumab or supportive care if the patient's condition had not responded to initial therapy (defined as achieving Psoriasis Area and Severity Index [PASI] 75).

The manufacturer's base-case analysis (using 4th-quartile Dermatology Life Quality Index [DLQI] utilities) against continuous etanercept resulted in a cost of 26,095 pounds sterling per quality-adjusted life year (QALY) gained. The incremental cost-effectiveness ratio (ICER) for infliximab compared with supportive care was 22,240 pounds sterling per QALY gained. The manufacturer carried out one-way sensitivity analyses. These demonstrated that changes in response rates and patients' weight (the dose of infliximab is dependent on a patient's weight) had the greatest impact on the ICER. The probabilistic sensitivity analysis gives probabilities of being cost effective at 20,000 pounds sterling and 30,000 pounds sterling thresholds of 10% and 73%, respectively.

The manufacturer presented an ICER for infliximab compared with supportive care, using the all-patient utilities, of 41,351 pounds sterling per QALY gained. The probabilistic sensitivity analysis gives a probability of being cost effective at the 30,000 pounds sterling threshold of 0%.

The Evidence Review Group (ERG) had three main areas of concern over the modelling.

- The ERG expressed concern regarding the reasoning behind the exclusive use of the 4th-quartile DLQI utility values.
- The assumed annual drop-out rate in the model was considered by the ERG to be an underestimate because it was based on 6-month rather than annual data.
- The ERG considered that the cost of an inpatient stay might have been overestimated because it was based on an elective inpatient code rather than elective and non-elective codes with excess bed days incorporated.

At the request of the Committee the manufacturer undertook additional analyses.

The Committee considered the cost-effectiveness estimates for the all-patient group (PASI of 10 or more and DLQI of more than 10). The Committee was persuaded that under all scenarios presented the ICERs compared with best supportive care, etanercept and efalizumab were greater than 35,000 pounds sterling. Therefore the Committee concluded that in this all-patient group

infliximab could not be considered a cost-effective use of National Health Service (NHS) resources.

The Committee considered that the approach adopted by the manufacturer for the economic modelling was appropriate because it captured the main aspects of the presentation and course of the disease. However, the Committee expressed concerns over the validity of main input parameters in the model and subsequent analyses.

The Committee also discussed the range of alternatives presented by the manufacturer for the costs of administering infliximab. The Committee considered that it would be difficult to estimate with any certainty the precise infusion costs given the variations within the NHS in clinical practice, local circumstances and interpretation of costing codes. The Committee therefore concluded that, given the methods behind the calculation of reference costs, the base-case figure of 65.02 pounds sterling and the figure of 124 pounds sterling used in sensitivity analysis represented a plausible range for these costs.

The ICERs provided by the manufacturer of infliximab compared with intermittent etanercept in the subgroup of patients identified by the manufacturer as those in the 4th quartile of baseline DLQI values among those with a PASI of 12 or more ranged from 33,000 to 44,000 pounds sterling, whereas the ICERs compared with continuous etanercept ranged from 26,000 to 35,000 pounds sterling for the various utilities and costs presented. The Committee was persuaded by the clinical experts' view that for people with very severe disease the appropriate alternative to infliximab is more likely to be etanercept given continuously, even though this is not recommended by the previous Technology Assessment Report (TAR) for the NICE appraisal of etanercept and efalizumab. The Committee was therefore persuaded that the use of infliximab in the subgroup of patients with very severe disease was a cost-effective use of NHS resources.

Refer to Sections 3 and 4 of the original guideline document for more information on cost analysis.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Consultee organizations from the following groups were invited to comment on the draft scope, Assessment Report and the Appraisal Consultation Document (ACD) and were provided with the opportunity to appeal against the Final Appraisal Determination.

- Manufacturer/sponsors
- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Infliximab, within its licensed indications, is recommended as a treatment option for adults with plaque psoriasis only when the following criteria are met.

- The disease is very severe as defined by a total Psoriasis Area Severity Index (PASI) of 20 or more **and** a Dermatology Life Quality Index (DLQI) of more than 18.
- The psoriasis has failed to respond to standard systemic therapies such as ciclosporin, methotrexate **or** PUVA (psoralen and long-wave ultraviolet radiation), **or** the person is intolerant to or has a contraindication to these treatments.

Infliximab treatment should be continued beyond 10 weeks only in people whose psoriasis has shown an adequate response to treatment within 10 weeks. An adequate response is defined as either:

- A 75% reduction in the PASI score from when treatment started (PASI 75) **or**
- A 50% reduction in the PASI score (PASI 50) and a five-point reduction in the DLQI from when treatment started.

When using the DLQI healthcare professionals should take care to ensure that they take account of a patient's disabilities (such as physical impairments) or linguistic or other communication difficulties, in reaching conclusions on the severity of plaque psoriasis. In such cases healthcare professionals should ensure that their use of the DLQI continues to be a sufficiently accurate measure. The same approach should apply in the context of a decision about whether to continue the use of the drug in accordance with the previous paragraph.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate use of infliximab for the treatment of psoriasis in adults
- Improved quality of life for patients with severe psoriasis

POTENTIAL HARMS

- The most common adverse events reported during infliximab therapy include acute infusion-related reactions, infections and delayed hypersensitivity reactions.
- Before treatment is initiated, people must be screened for both active and inactive tuberculosis. The summary of product characteristics (SPC) lists a number of uncommon but serious adverse events related to the immunomodulatory activity of infliximab.

For full details of side effects and contraindications, see the SPC available at http://emc.medicines.org.uk/.

CONTRAINDICATIONS

CONTRAINDICATIONS

Infliximab is contraindicated in people with moderate or severe heart failure and active infections. Before treatment is initiated, people must be screened for both active and inactive tuberculosis.

For full details of side effects and contraindications, see the SPC available at http://emc.medicines.org.uk/.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guidance represents the view of the Institute, which was arrived at after careful consideration of the available evidence. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Key Issues Surrounding Manufacturer's Submission

- The trials of infliximab efficacy presented by the manufacturer's submission (MS) were placebo-controlled trials. No head-to-head studies were identified that directly compared infliximab to etanercept or efalizumab, the comparators stated in the scope. The manufacturer carried out an indirect comparison, but the Evidence Review Group (ERG) had reservations about the comparison regarding a lack of information presented and areas of uncertainty in relation to the included data. In addition, the ERG questioned the appropriateness of pooling data that is statistically heterogenous.

- The incremental cost-effectiveness ratio (ICER) was highly sensitive to assumptions about the costs and frequency of inpatient stays for non responders of infliximab.
- It was unclear what severity of psoriasis was represented by the utility values presented in the MS. It was also unclear to what extent moderate psoriasis would be represented in the analysis presented in the MS.

Refer to the Evidence Review Group (ERG) Report (see the "Availability of Companion Documents" field) for additional information on weaknesses and areas of uncertainty in the MS.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

- The Healthcare Commission assesses the performance of National Health Service (NHS) organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health' issued in July 2004. The Secretary of State has directed that the NHS provides funding and resources for medicines and treatments that have been recommended by National Institute for Health and Clinical Excellence (NICE) technology appraisals normally within 3 months from the date that NICE publishes the guidance. Core standard C5 states that healthcare organisations should ensure they conform to NICE technology appraisals.
- 'Healthcare standards for Wales' was issued by the Welsh Assembly Government in May 2005 and provides a framework both for self-assessment by healthcare organisations and for external review and investigation by Healthcare Inspectorate Wales. Standard 12a requires healthcare organisations to ensure that patients and service users are provided with effective treatment and care that conforms to NICE technology appraisal guidance. The Assembly Minister for Health and Social Services issued a Direction in October 2003 which requires Local Health Boards and NHS Trusts to make funding available to enable the implementation of NICE technology appraisal guidance, normally within 3 months.
- NICE has developed tools to help organisations implement this guidance (listed below). These are available on NICE website (www.nice.org.uk/TA134). See also the "Availability of Companion Documents" field.
    - Costing report and costing template to estimate the savings and costs associated with implementation
    - Audit criteria to monitor local practice.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Patient Resources
Quick Reference Guides/Physician Guides
Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Infliximab for the treatment of adults with psoriasis. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Jan. 25 p. (Technology appraisal guidance; no. 134).

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Jan

GUIDELINE DEVELOPER(S)

National Institute for Health and Clinical Excellence (NICE) - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Appraisal Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Professor Keith Abrams, Professor of Medical Statistics, University of Leicester; Dr Jeff Aronson, Reader in Clinical Pharmacology, Radcliffe Infirmary; Dr Darren Ashcroft, Senior Clinical Lecturer, School of Pharmacy and Pharmaceutical Sciences, University of Manchester; Professor David Barnett

(Chair), Professor of Clinical Pharmacology, University of Leicester; Dr Peter Barry, Consultant in Paediatric Intensive Care, Leicester Royal Infirmary; Professor Stirling Bryan, Director of the Health Economics Facility, University of Birmingham; Professor John Cairns, Public Health and Policy, London School of Hygiene and Tropical Medicine; Dr Mark Charkravarty, Head of Government Affairs and NHS Policy, Procter and Gamble Pharmaceuticals (UK); Professor Jack Dowie, Health Economist, London School of Hygiene and Tropical Medicine; Ms Lynn Field, Nurse Director, Pan Birmingham Cancer Network; Professor Christopher Fowler, Professor of Surgical Education, University of London; Dr Fergus Gleeson, Consultant Radiologist, Churchill Hospital, Oxford; Ms Sally Gooch, Former Director of Nursing and Workforce Development, Mid Essex Hospital Services NHS Trust; Mrs Barbara Greggains, Lay Member; Mr Sanjay Gupta, Former Service Manager in Stroke, gastroenterology, Diabetes and Endocrinology, Basildon and Thurrock University Hospitals Foundation NHS Trust; Dr Mike Laker, Medical Director, Newcastle Hospitals NHS Trust; Mr Terence Lewis, Mental Health Consultant, National Institute for Mental Health in England; Professor Gary McVeigh, Professor of Cardiovascular Medicine, Queens University, Belfast; Dr Ruairidh Milne, Senior Lecturer in Health Technology Assessment, National Coordinating Centre for Health Technology; Dr Neil Milner, General Medical Practitioner, Tramways Medical Centre, Sheffield; Dr Rubin Minhas, General Practitioner, CHD Clinical Lead, Medway PCT; Dr John Pounsford; Consultant Physician, North Bristol NHS Trust; Dr Rosalind Ramsay, Consultant Psychiatrist, Adult Mental Health Services, Maudsley Hospital; Dr Christa Roberts, UK Country Manager, Abbott Vascular; Dr Stephen Saltissi, Consultant Cardiologist, Royal Liverpool University Hospital; Dr Lindsay Smith, General Practitioner, East Somerset Research Consortium; Mr Roderick Smith, Director of Finance, West Kent Primary Care Trust; Mr Cliff Snelling, Lay Member; Professor Ken Stein, Professor of Public Health, Peninsula Technology Assessment Group (PenTAG), University of Exeter; Professor Andrew Stevens, Professor of Public Health, University of Birmingham; Dr Rod Taylor, Associate Professor in Health Services Research, Peninsula Medical School, Universities of Exeter and Plymouth

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

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

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Infliximab for the treatment of adults with psoriasis. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Jan. 2 p. (Technology appraisal 134) Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Infliximab for the treatment of adults with psoriasis. Costing template. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008. Various p. (Technology appraisal 134). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Infliximab for the treatment of adults with psoriasis. Audit criteria. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008. Various p. (Technology appraisal 134). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Infliximab for the treatment of adults with psoriasis: Evidence review group report. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Sept. Various p. (Technology appraisal 134). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1090. 11 Strand, London, WC2N 5HR.

PATIENT RESOURCES

The following is available:

- Infliximab for psoriasis. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Jan. 4 p. (Technology appraisal 134).

Electronic copies: Available in Portable Document Format (PDF) from National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the NHS Response Line 0870 1555 455. ref: N1091. 11 Strand, London, WC2N 5HR.

NGC STATUS

This NGC summary was completed by ECRI Institute on March 18, 2008.

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