Scottish Medicines Consortium
Providing advice about the status of all newly licensed medicines
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NHS SCOTLAND

empagliflozin 10mg and 25mg tablet (Jardiance®) SMC No. (993/14)

Boehringer Ingelheim / Eli Lilly

05 September 2014

The Scottish Medicines Consortium (SMC) has completed its assessment of the above product and advises NHS Boards and Area Drug and Therapeutic Committees (ADTCs) on its use in Scotland. The advice is summarised as follows:

ADVICE: following a full submission

empagliflozin (Jardiance®) is accepted for restricted use within NHS Scotland.

Indication under review: Treatment of type 2 diabetes to improve glycaemic control in adults as add-on combination therapy: in combination with other glucose–lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control.

SMC restriction: to use in the following situations:

- dual therapy in combination with metformin, when a sulphonylurea is inappropriate
- triple therapy in combination with metformin plus standard of care
- add-on to insulin therapy in combination with insulin plus standard of care

Empagliflozin was superior to placebo for glycaemic control in combination with various anti-diabetic medicines (metformin; metformin plus sulphonylurea; thiazolidinedione ± metformin; and insulin) and it was non-inferior to a sulphonylurea in combination with metformin.

Empagliflozin is also indicated as monotherapy in patients who cannot tolerate metformin. SMC cannot recommend the use of empagliflozin as monotherapy as the company's submission did not include evidence of cost-effectiveness in this setting.

Overleaf is the detailed advice on this product.

Chairman,
Scottish Medicines Consortium

Indication

Treatment of type 2 diabetes to improve glycaemic control in adults as add-on combination therapy: in combination with other glucose–lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control.

As monotherapy, when diet and exercise alone do not provide adequate glycaemic control in patients for whom use of metformin is considered inappropriate due to intolerance.

Dosing Information

Initially 10mg once daily. This may be increased to 25mg once daily in patients tolerating 10mg once daily who have an eGFR ≥60 ml/min/1.73 m^2 and need tighter glycaemic control.

Product availability date

17 June 2014

Summary of evidence on comparative efficacy

Empagliflozin is the third sodium-dependent glucose co-transporter-2 (SGLT-2) inhibitor for type 2 diabetes licensed in the UK. It is indicated for use in combination with other anti-diabetic medicines and, in patients not able to tolerate metformin as monotherapy.[1] The monotherapy indication is not reviewed here.

Five phase III double-blind studies recruited adults with type 2 diabetes inadequately controlled (glycosylated haemoglobin (HbA1c) ≥7% (≥7.5% in study 49) and ≤10%) on a stable dose for at least 12 weeks of anti-diabetic medication that varied across the studies: metformin in study 28[2-5] and study 23-A[2,7,8]; metformin plus sulphonylurea in study 23-B[2,6-8]; pioglitazone ± metformin in study 19[2,9-11]; basal insulin ± metformin ± sulphonylurea in study 33[2,12-14]; and basal plus prandial insulin ± metformin in study 49.[2,15,16]

Randomisation was stratified for baseline HbA1c (<8.5% or ≥8.5%), estimated glomerular filtration rate (eGFR) (<90 or ≥90 ml/min/1.73m^2 in study 28 and 49; eGFR 30-59, 60-89 and ≥90 ml/min/1.73m^2 in studies 19 and 23), region (Europe/South Africa; Asia; North America; Latin America in study 23, 28 and 49), (centre in study 33) and metformin background therapy (no or yes in studies 19 and 49). In study 28, patients were randomised equally to empagliflozin 25mg once daily or glimepiride 1mg to 4mg once daily for two years. In the other studies, patients were randomised equally to placebo, empagliflozin 25mg or 10mg once daily for 24 weeks in studies 19 and 23, and for 78 and 52 weeks in studies 33 and 49, respectively.[2-16]

The primary outcome was change from baseline in HbA1c at 24 weeks in studies 19 and 23; at 104 weeks in study 28, with an interim analysis at 52 weeks; and at 18 weeks in studies 33 and 49. All studies were designed to investigate superiority relative to placebo, except study 28, which was designed to demonstrate non-inferiority using a pre-specified margin of 0.3% at 104 weeks. The primary analyses were performed in the full analysis set (FAS), which comprised all randomised patients who received at least one dose of study drug, except for study 33, where the primary analysis was performed in FAS18-week completers. This included patients in the FAS who had a baseline HbA1c value, did not prematurely discontinue prior to Week 18, completed the minimum treatment duration, and had an on treatment HbA1c at week 18.[2-16]

In study 28 adjusted mean change from baseline in HbA1c at week 104 with empagliflozin was -0.66% and with glimepiride was -0.55%. The between treatment difference was -0.11% (97.5% confidence interval (CI): -0.20% to -0.01%) and non-inferiority of empagliflozin to glimepiride was demonstrated. Superiority of empagliflozin was demonstrated too (p=0.0153). In studies 23, 19, 33 and 49 empagliflozin 10mg and 25mg were associated with significant reductions in HbA1c compared with placebo, as detailed in the table. [2-16]

Table: Adjusted mean changes from baseline in HbA1c, body weight and systolic blood pressure (SBP) and between treatment differences at primary endpoint timepoints. [2-16]

	HbA1c (%)		Body weight (kg)		SBP (mmHg)	
	Mean	**Difference**	**Mean**	**Difference**	**Mean**	**Difference**
In combination with metformin (study 28 at 104 weeks and study 23-A at 24 weeks)						
Empa 25	-0.66	-0.11 (-0.20; -0.01)	-3.12	-4.46 (-4.87; -4.05)	-3.1	-5.6 (-7.0; -4.2)
Glimepiride	-0.55		1.34		2.5	
Empa 25	-0.77	-0.64 (-0.79; -0.48)	-2.46	-2.01 (-2.56; -1.46)	-5.2	-4.8 (-6.9; -2.7)
Empa 10	-0.70	-0.57 (-0.72; -0.42)	-2.08	-1.63 (-2.17; -1.08)	-4.5	-4.1 (-6.2; -2.1)
Placebo	-0.13		-0.45		-0.4	
In combination with metformin and sulphonylurea (study 23-B at 24 weeks)						
Empa 25	-0.77	-0.59 (-0.74; -0.44)	-2.39	-1.99 (-2.48; -1.50)	-3.5	-2.1 (-4.0; -0.2)
Empa 10	-0.82	-0.64 (-0.79; -0.49)	-2.16	-1.76 (-2.25; -1.28)	-4.1	-2.7 (-4.6; -0.8)
Placebo	-0.17		-0.39		-1.4	
In combination with pioglitzone ± metformin (study 19 at 24 weeks)						
Empa 25	-0.72	-0.61 (-0.82; -0.40)	-1.47	-1.81 (-2.49; -1.13)	-4.0	-4.7 (-7.1; -2.4)
Empa 10	-0.59	-0.48 (-0.69; -0.27)	-1.62	-1.95 (-2.64; -1.27)	-3.1	-3.9 (-6.2; -1.5)
Placebo	-0.11		0.34		0.7	
In combination with basal insulin (study 33 at 18 weeks)						
Empa 25	-0.71	-0.70 (-0.93; -0.47)				
Empa 10	-0.57	-0.56 (-0.78; -0.33)				
Placebo	-0.1					
In combination with basal and prandial insulin (study 49 at 18 weeks)						
Empa 25	-1.02	-0.52 (-0.69; -0.35)				
Empa 10	-0.94	-0.44 (-0.61; -0.27)				
Placebo	-0.50					

Empa 25 = empagliflozin 25mg; Empa 10 = empagliflozin 10mg; SBP = systolic blood pressure. Difference is adjusted mean (95.7% confidence interval (CI)), except for SBP in studies 23-A and –B, 19, 33 and 49 and body weight in study 33, where CI are 95%.

In studies 19 and 23, patients could continue randomised treatment after 24-weeks for a further year in an extension (study 31). Studies 33 and 49 continued to 78 and 52 weeks, respectively. Results at these later time-points are consistent with those detailed in the table.[2,13-18]

In a double-blind phase III study (study 36) that recruited adults with renal impairment and inadequate glycaemic control, change from baseline to week 24 in HbA1c, was significantly greater for empagliflozin 25mg compared with placebo in patients with mild or moderate renal impairment: difference -0.51% (95% CI: -0.62, -0.39). It was also significantly greater for empagliflozin 10mg compared with placebo in patients with mild renal impairment: difference -0.52% (95% CI: -0.72, -0.32).[2,19-21]

In a double-blind phase III study (study 48) that recruited adults with type 2 diabetes and hypertension (systolic blood pressure (SBP) 130 to 159 mmHg and diastolic blood pressure (DBP) 80 to 99 mmHg and receiving antihypertensive medication) the co-primary outcomes, change from baseline to week 12 in HbA1c and in mean 24-hour SBP, were significantly greater with empagliflozin 10mg and 25 mg versus placebo.[2,22,23]

*Other data were also assessed but remain commercially confidential.**

Summary of evidence on comparative safety

The adverse effect profile of empagliflozin is typical of an SGLT-2 inhibitor. It did not lead to an increase in the incidence of hypoglycaemia in most studies, although in those where metformin plus sulphonylurea was background therapy, empagliflozin 10mg and 25mg were associated with increased rates of hypoglycaemia compared with placebo; in study 23-B, rates were 16% and 12% versus 8.4%, and in the relevant subgroup of study 31, rates were 20% and 15% versus 12%, respectively. In study 33, which had insulin-containing regimens as background therapy, a higher rate of hypoglycaemia was observed at 18 weeks in the empagliflozin 25mg (but not the 10mg group) compared with placebo: 28% (and 20%) versus 21%, respectively. Frequencies of other adverse events of special interest (including urinary infections and volume depletion) were similar across the treatment groups, except for genital infections. Across the pivotal phase III studies, these were reported by 1.0%, 4.4% and 4.7% of patients in the placebo, empagliflozin 10mg and 25mg groups, respectively.[2]

A pre-specified meta-analysis of pooled data from phase III studies indicated no increased risk of major adverse cardiovascular events (MACE) with empagliflozin versus placebo with a hazard ratio (95% CI) of 0.48 (0.27, 0.85). The number of patients with serious elevations of liver enzymes was greater with empagliflozin compared to placebo; however, all but one of these were considered to be unrelated to treatment.[2]

Summary of clinical effectiveness issues

Empagliflozin is the third SGLT-2 inhibitor marketed in the UK for type 2 diabetes. The other two, dapagliflozin and canagliflozin, have been accepted by SMC for restricted use within NHS Scotland.

Empagliflozin, compared with placebo, was associated with significant reductions in HbA1c, body weight and SBP. The placebo-corrected reductions in HbA1c were in general about 0.5% to 0.65%; in body weight were approximately 1kg to 2kg; and for SBP varied between 1.7mmHg and 4.8mmHg.[2-16] The European Medicines Agency (EMA) considered the reductions in HbA1c to be clinically relevant, but noted that the reductions in weight were small. It concluded that the clinical relevance of the effects on body weight and blood pressure was unknown.[2]

In study 28, non-inferiority of empagliflozin to glimepiride, on metformin background therapy, was demonstrated. In this study, 60% of patients were taking less than the maximum 4mg dose of glimepiride, whereas all patients treated with empagliflozin received the maximum 25mg dose. Therefore, the relative treatment effect of empagliflozin to glimepiride may be overestimated. However, in practice it may not be possible for all patients to achieve the maximum dose of glimepiride.[2-5]

In study 33, within the FAS-18 week completer population there were differences in baseline HbA1c between the treatment groups. It was noted that this could lead to an overestimation of treatment effect of empagliflozin relative to placebo.[2,12-14]

There are no direct comparative data with other SGLT-2 inhibitors or with dipeptidyl peptidase-4 (DPP-4) inhibitors. Four network meta-analyses (NMA) were performed to support the economic analyses and these varied with respect to the background anti-diabetic medicines. Two NMA underpin assumptions of equivalence for empagliflozin versus dapagliflozin. These were on background therapy of (1) metformin alone and (2) insulin-containing regimens. Both NMA contained substantial amounts of data from irrelevant or inappropriate studies. Upon request a more focused NMA with metformin as background therapy was provided and this supports the equivalence assumption. The NMA on a background of insulin has weaknesses, including differences in time-points of outcomes, e.g. 18 versus 24 weeks with empagliflozin and dapagliflozin for HbA1c, weight and SBP, and for hypoglycaemia time-points varied between 52 and 78 weeks. There was an imbalance in baseline HbA1c within the empagliflozin study that may have resulted in overestimation of its treatment effect. There was also variation across the studies in definitions of hypoglycaemia and in study design, with respect to modifying background insulin therapy, that may have influenced rates of hypoglycaemia. There were a number of inaccuracies and unconfirmed data in the tables detailing data input to the NMA.

The other two NMA provided data on empagliflozin 10mg and 25mg, canagliflozin 100mg and 300mg and sitagliptin 100mg for input to economic analyses. These were on background of (1) metformin plus sulphonylurea; and (2) metformin plus thiazolidinedione (TDZ). These indicated that empagliflozin, canagliflozin and sitagliptin are superior to placebo for HbA1c reduction and the SGLT-2 inhibitors are superior to placebo for weight and SBP reduction. Within the NMA on a background of metformin plus sulphonylurea, there are possibly some errors in analyses of HbA1c, SBP and weight that may compromise the results, although this is unclear. There are important limitations with the non-severe hypoglycaemia and urinary tract infection (UTI) data that limit its validity. The NMA on a background of metformin plus TDZ contains a substantial amount of data for medicines not relevant to the economic analysis, with only 3 of the 9 studies relevant. Much of the input data is unconfirmed from the available references and this limits, to varying extents, the analyses of SBP, weight, UTI and overall hypoglycaemia. There also appear to be some errors in input of results from the NMA to the economic analyses.

Clinical experts consulted by SMC considered that the SGLT-2 inhibitor class is a therapeutic advancement due to a novel mechanism of action. However, as the third drug in this class, empagliflozin is not regarded as an advance over other SGLT-2 inhibitors. Clinical experts consulted by SMC considered that the place in therapy of empagliflozin is as an alternative to other SGLT-2 inhibitors, dapagliflozin and canagliflozin, and possibly as an alternative to DPP-4 inhibitors.

*Other data were also assessed but remain commercially confidential.**

Summary of comparative health economic evidence

The company submitted a cost-minimisation analysis and a cost-utility analysis for the evaluation of type 2 diabetes patients, comparing empagliflozin 10mg and 25mg to an SGLT-2 inhibitor and DPP4 inhibitors in the following treatment options:

- For dual therapy, empagliflozin 10mg and 25mg was compared to dapagliflozin in combination with metformin and in combination with insulin. Expert responses have confirmed that dapagliflozin is the appropriate comparator.

- For triple therapy, empagliflozin 10mg and 25mg was compared to DPP4 inhibitors in combination with metformin + sulphonylurea and in combination with metformin +TZD. It should be noted that dapagliflozin is a relevant comparator for this indication, but as SMC advice has only been recently published, the comparison with DPP4 inhibitors is reasonable.

A de novo cost-effectiveness model was submitted by the company. The model simulated a cohort of patients and estimated the efficacy, safety, discontinuation, costs and utilities associated with each treatment arm. Based on the United Kingdom Prospective Diabetes Study (UKPDS) risk equations, patients progress through the model in 6 month cycles until death or the end of the time horizon and their profiles are updated according to time varying risk factors, adverse events experienced and complications.

The clinical evidence used to support the economic evaluations came from four NMAs. For dual therapy, the primary outcome was mean change from baseline in HbA1c. The results showed that there were no significant differences between dapagliflozin 10mg and empagliflozin 10mg or 25mg for the primary outcome. It should be noted that the results of the economic evaluation are reliant upon the conclusion of comparable efficacy. For triple therapy, the company provided two NMAs to support the use of empagliflozin in combination with metformin + sulphonylurea and metformin + TZD. The results for these analyses showed that both empagliflozin 10mg and 25mg, were superior to metformin + sulphonyurea in combination with DPP-4 inhibitors with respect to reduction in weight and SBP reduction.

Drug acquisition costs were included for both analyses. For the triple therapy analyses, the company estimated the cost of managing long term complications in both the first year and subsequent years. Long term complications included ischemic heart disease, chronic heart failure (CHF), stroke, blindness in one eye, amputation of one leg and renal failure. Resource use estimates were taken from the UKPDS. The cost of treating adverse events was also included in the analysis and incorporated severe hypoglycaemic events as well as UTIs and genital infections (GIs).

Most of the utility values were taken from a published study derived from the UKPDS. The value for weight change was taken from a separate published study and adjusted to reflect the disutility per increased unit of BMI, resulting in a value of -0.0159. The study has been used as the source of weight gain disutility in previous submissions to SMC and does not appear to overestimate the impact of empagliflozin in relation to weight gain disutility.

For dual therapy, the base case analysis showed that empagliflozin 10mg and 25mg are cost neutral versus dapagliflozin 10mg with an annual cost per patient of £477.30. For triple therapy, the base case analysis for empagliflozin 10mg and 25mg in combination with metformin + sulphonylurea resulted in incremental cost-effectiveness ratios (ICERs) of £806 and £8,306 respectively, based on incremental quality-adjusted life-year (QALY) gains of 0.036 and 0.018, and incremental costs of £29 and £150 respectively. For empagliflozin 10mg and 25mg in combination with metformin + TZD, the base case analysis resulted in ICERs of £12,798 and £8,947 respectively, based on incremental QALY gains of 0.04 and 0.031, and incremental costs of £516 and £276 respectively. It should be noted that the base case analysis included non-statistically significant results.

One-way sensitivity analysis was provided, which varied a number of key parameters. For empagliflozin 10mg (in the metfomin plus sulphonylurea background therapy analysis), results were most sensitive to changes in body mass index (BMI), discontinuation rates and duration of the treatment effect. The variable which had the largest impact on the ICER was a change in the duration of treatment effect (from one year to two years), which increased the ICER to £5,974 versus sitagliptin 100mg. For empagliflozin 25mg (in the metformin plus TZD analysis), results were most sensitive to

changes in BMI, duration of treatment effect and discount rate. When BMI was assumed not to impact on the incidence of CHF or disutility of patients due to weight changes, the ICER increased to £23,438 versus sitagliptin 100mg.

As the assumption of comparable efficacy between empagliflozin 10mg and 25mg is supported by the NMA and as both doses are priced at parity with dapagliflozin, the economic case for empagliflozin for use in dual therapy has been demonstrated.

However, for the triple therapy analysis, some weaknesses were noted:

- Non-significant differences were included in the base case analysis which favoured sitagliptin in relation to reduction in HbA1c from baseline and probability of experiencing adverse events. When the non-significant differences were removed, empagliflozin 10mg and 25mg dominated sitagliptin for the metformin + sulphonylurea background therapy. For the metformin + TZD background therapy empagliflozin 10mg resulted in an ICER of £2,427 versus sitagliptin based on an incremental cost of £73 and an incremental QALY gain of 0.030. Empagliflozin 25mg resulted in an ICER of £4,700 based on an incremental cost of £89 and a QALY gain of 0.019. The revised results indicate that both doses of empagliflozin remain cost effective when non-significant differences are removed.
- The sensitivity analysis reveals that results are relatively sensitive to assumptions surrounding BMI for both background therapies. When BMI was assumed not to impact on the incidence of CHF or disutility of patients due to weight changes, the ICER increases to £2,809 and £23,438 for empagliflozin 10mg and 25mg, in the metformin plus sulphonylurea and metformin plus TZD arms respectively. However, it should be noted that this is considered to be a conservative assumption, as BMI is likely to impact on long term complications. In order to test the assumption of earlier weight convergence on the ICER, the company was asked to provide additional analysis in which non-significant differences were removed and which assumed weight convergence at year 8.5 (instead of 13.5). Based on this analysis, empagliflozin 25mg remained cost effective versus sitagliptin resulting in an ICER of £9,187, based on an incremental cost of £206 and an incremental QALY gain of 0.030.
- As noted above, some available data relating to hypoglycaemic events have not been included in the analysis which may not be appropriate. However, the company has tested the rate of adverse events in the sensitivity analysis where the lowest number of adverse events for non-severe hypoglycaemia, severe hypoglycaemia, UTIs and GIs were applied to all treatments. For both background therapies, results are not overly sensitive to this assumption.

When the non-significant differences were removed and more conservative assumptions were included around weight convergence, the ICER was still within acceptable limits. Despite the limitations outlined above, the economic case for empagliflozin 10mg and 25mg for use in both dual and triple therapy has been demonstrated.

Summary of patient and public involvement

The following information reflects the views of the specific patient group.

- A submission was received from Diabetes UK Scotland, which is a registered charity.

- Diabetes UK Scotland has received funding from several pharmaceutical companies in the past two years, but not from the submitting company.

- Diabetes is a complex and progressive condition which impacts not only on people living with diabetes quality of life but those of their families and carers. Those living with and affected by

diabetes are more likely to have depression, diabetes related distress and are worried by the risk of hypoglycaemia.

- Compared to existing medicines, empagliflozin achieves a comparable reduction of HBA1c which may improve quality of life and flexible and easy to follow regimes may help to improve compliance/adherence.

- Introduction of another anti-diabetic medication is welcome and provides additional 'armoury' to achieve effective blood glucose control and in combination with Structured Education may support effective self-management for to all those living with and affected by diabetes.

Additional information: guidelines and protocols

The Scottish Intercollegiate Guidelines Network (SIGN) published updated guidance on the Management of diabetes in March 2010. The treatment algorithm notes several options for second and third-line treatment of type 2 diabetes mellitus to be added in combination with metformin and/or sulfonylurea; additional oral anti-diabetic drugs, pioglitazone or DPP-4 inhibitors; or injections of GLP-1 analogues or commencement of insulin. Treatment should be continued if an individualised target is reached or the HbA1c falls at least 0.5% in 3 to 6 months. With respect to using insulin in patients with type 2 diabetes, oral sulphonylurea and metformin therapy should be continued when insulin is initiated to maintain or improve glycaemic control. Once daily, neutral protamine Hagedorn insulin is the first choice of insulin to be used, but basal insulin analogues can be considered if there are concerns regarding the risk of hypoglycaemia. The bedtime basal insulin should be titrated against the morning or fasting glucose and if HbA1c targets are not reached then the addition of prandial insulin should be considered.[26]

The National Institute for Health and Care Excellence published NICE Clinical Guideline 87 – Type 2 diabetes - newer agents in May 2009. The guideline considered sulfonylurea, DPP-4 inhibitors or pioglitazone as suitable second-line options to be used in combination with metformin and advised on cost effective use of exenatide as a third-line agent. The guideline recommended that patients using basal insulin regimens (e.g. neutral protamine Hagedorn or long-acting analogues) be monitored for the need to increase the dose and/or intensify the regimen using short-acting insulin before meals, or pre-mixed insulin. Patients using pre-mixed insulin should be monitored to determine if they need further injections of short-acting insulin before meals or conversion to a basal-bolus regimen. Combination of pioglitazone and insulin was considered appropriate for patients; who have inadequate glycaemic control despite high-dose insulin therapy, or who have had a significant response to TDZ therapy in the past.[27]

The American Diabetes Association (ADA) and European Association for the Study of Diabetes (EASD) published a position statement "Management of Hyperglycaemia in type 2 diabetes: a patient-centered approach" in June 2012. A patient-centered approach is advocated with individualisation of treatment. Beyond lifestyle advice and initial drug therapy with metformin a number of treatment options are recommended with no specific preference: choice is based on patient and drug characteristics.[28]

Additional information: comparators

A variety of anti-diabetic medicines can be used in combination with metformin as dual- or triple-therapy and as add-on to insulin. These include sulphonylureas, dipeptidyl-peptidase-4 (DPP-4) inhibitors, TDZ, SGLT-2 inhibitors and glucagon-like peptide-1 (GLP-1) agonists.

Cost of relevant comparators

Drug	Dose Regimen	Cost per year (£)
Empagliflozin	**10mg to 25mg daily**	**476**
Canagliflozin	100mg to 300mg daily	476 to 607
Dapagliflozin	10mg daily	476
Linagliptin	5mg daily	433
Sitagliptin	100mg daily	433
Vildagliptin	100mg daily (DD)	413
Saxagliptin	5mg daily	411
Glipizide	2.5mg to 20mg daily (higher DD)	18 to 146
Gliclazide	40mg to 320mg daily (higher DD)	44 to 53
Glibenclamide	5mg to 15mg daily	12 to 37
Glimepiride	1mg to 4mg daily	14 to 18

DD = dose divided. Doses are for general comparison and do not imply therapeutic equivalence. Costs from eVadis on 19 June 2014.

Additional information: budget impact

The submitting company estimated the population eligible to be treated with empagliflozin was 1,805 in year 1 rising to 6,064 in year 5, based on market share estimates of 13% in year 1 rising to 26% in year 5.

The gross medicines budget impact was estimated to be £861k in year 1 and £2.9m in year 5. As other medicines were assumed to be displaced, the net medicines budget impact was estimated to be £5k in year 1 and £17k in year 5.

References

The undernoted references were supplied with the submission. Those shaded in grey are additional to those supplied with the submission.

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This assessment is based on data submitted by the applicant company up to and including 14 July 2014.

*Agreement between the Association of the British Pharmaceutical Industry (ABPI) and the SMC on guidelines for the release of company data into the public domain during a health technology appraisal: http://www.scottishmedicines.org.uk/About_SMC/Policy_Statements/Policy_Statements

Drug prices are those available at the time the papers were issued to SMC for consideration. SMC is aware that for some hospital-only products national or local contracts may be in place for comparator products that can significantly reduce the acquisition cost to Health Boards. These contract prices are commercial in confidence and cannot be put in the public domain, including via the SMC Detailed Advice Document. Area Drug and Therapeutics Committees and NHS Boards are therefore asked to consider contract pricing when reviewing advice on medicines accepted by SMC.

Advice context:

No part of this advice may be used without the whole of the advice being quoted in full.

This advice represents the view of the Scottish Medicines Consortium and was arrived at after careful consideration and evaluation of the available evidence. It is provided to inform the considerations of Area Drug & Therapeutics Committees and NHS Boards in Scotland in determining medicines for local use or local formulary inclusion. This advice does not override the individual responsibility of health professionals to make decisions in the exercise of their clinical judgement in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.