Complete Summary

GUIDELINE TITLE

Adalimumab for the treatment of adults with psoriasis.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Adalimumab for the treatment of adults with psoriasis. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Jun. 25 p. (Technology appraisal guidance; no. 146).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Psoriasis

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Treatment

CLINICAL SPECIALTY

Dermatology
Family Practice

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To evaluate the clinical effectiveness and cost-effectiveness of adalimumab for the treatment of psoriasis

TARGET POPULATION

Adult patients with plaque psoriasis

INTERVENTIONS AND PRACTICES CONSIDERED

Adalimumab treatment

MAJOR OUTCOMES CONSIDERED

- Clinical Effectiveness
    - Psoriasis area and severity index (PASI) 50, 75, 90, and 100
    - Physician's global assessment (PGA)
    - Quality of life: dermatology life quality index (DLQI), Euro quality of life questionnaire (EQ-5D), and short form (version) 36 (SF-36)
    - Adverse events
- Cost-effectiveness

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

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Searches of Unpublished Data

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 Evidence Review Group (ERG) report. The ERG report for this technology appraisal was prepared by Southampton Health Technology Assessment Centre, University of Southampton (see the "Availability of Companion Documents" field).

Clinical-Effectiveness Searches

The minimum database search criteria that are specified by NICE (Medline, Embase, Medline in Progress [MEIP] and Cochrane) for undertaking clinical-effectiveness searches have been fully adhered to by the manufacturer. The manufacturer has exceeded the remit by undertaking searches on additional databases. The three key dermatology conference proceedings (American Academy of Dermatology [AAD], European Academy of Dermatology and Venerology [EADV], British Association of Dermatology [BAD]) are recorded as having been searched. The manufacturer also records additional searching having been undertaken on their in-house database ("PRLIT" – product literature).

Clinical-effectiveness searches for the systematic review were undertaken on the 8th August 2007. Databases were searched from 1996 to the search date. The manufacturer's submission (MS) states that it was not deemed necessary to search older databases as the clinical phase of adalimumab began in 1997. No start date is given for searches of conference abstracts but results are presented for AAD 2004-2007, for EADV 2005-2007, and for BAD 2006-2007. No start date or end date is given for the in house database search.

The search terms selected by the manufacturer include appropriate descriptor and free text terms (the latter were adequately truncated) for the disease area. The terms selected to identify clinical trials represent an adequate filter for the search. The documented strategies are appropriately run on the specified databases. All steps of the search strategy have been carefully recorded and the numbers from each search line have been recorded. The publication type (PT) has been applied in Medline to randomised controlled trials (RCTs) and controlled trials, which has good retrieval potential of relevant studies. The search could possibly have been extended to include follow up, cross over and meta analysis.

Cochrane was searched and a simple strategy is recorded in the MS. The ERG re-ran the first two lines of the search strategy and obtained the same number of results in Cochrane Central.

Ongoing Trials

The manufacturer has manually searched the conference abstracts for three major dermatology meetings: AAD, EADV and BAD and records the number of hits for each conference year searched. The manufacturer's in-house data and database (PRLIT) were also searched, which should comprehensively retrieve all ongoing trials that the manufacturer is undertaking pertaining to adalimumab. Biosis is charted as having been searched which contains conference and meeting abstracts which might present interim data before the studies are fully published in journals.

Cost-Effectiveness Searches

The cost-effectiveness searches run by the manufacturer meet the minimum database criteria set by NICE (Medline, Embase, MEIP, National Health Service Economic Evaluations Database [NHS EED] and the Health Economic Evaluations Database [HEED]). No additional searches were made in the company database PRLIT. The searches are recorded as undertaken on the 4th September 2007. The databases Medline (PubMed), Medline (R) InProcess, and Embase were searched from 1996 to the search date. No start date is given for the databases HEED and

NHS EED and the ERG assumes that these were searched from inception to the search date of 4th September 2007.

The manufacturer clearly states that scoping searches revealed a paucity of literature on cost studies for the drugs and hence it seems sensible to extend this to the disease area of psoriasis. However the search strategy contains only a few search terms: the free text terms "cost" and "effectiveness" and "Psoriasis"; the search string "cost adj effectiveness"; and finally cost or effectiveness appearing anywhere in the indexing or abstract. Cost-effectiveness could have been truncated to cost$ effective$. There are no free text synonyms used such as price, pricing, economic$ pharmacoeconomic$ fee$ charges, budget$, expenditure$, resources, utility, utilities. For the sake of being systematic a full cost filter could have been applied using the mix of index and free text terms for the drugs and then for the disease area in order to overtly spell out the absence or paucity of relevant results. The full economic filters always produce a large amount of irrelevant hits but the ERG feels the process should have been recorded. There is no strategy recorded for HEED and NHS EED (N/A is recorded for these two databases, however the number of retrieved items is recorded).

The ERG re-ran the manufacturer's search strategy on Medline and obtained similar numbers of hits.

Refer to Section 3.1.2 of the ERG report (see the "Availability of Companion Documents" field) for statement of the inclusion/exclusion criteria used in the study selection and comment on whether they were appropriate.

NUMBER OF SOURCE DOCUMENTS

Clinical Effectiveness

Seven randomized controlled trials (RCTs) were identified (the main evidence was derived from 3 RCTs).

Cost-Effectiveness

Six studies were identified and a manufacturer's model was submitted.

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

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 Evidence Review Group (ERG) report. The ERG report for this technology appraisal was prepared by the Southampton Health Technology Assessment Centre, University of Southampton (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Manufacturer's Approach to Validity Assessment

The manufacturer's submission (MS) provides a formal appraisal of the validity of the included trials using the quality assessment criteria developed by NICE. The process of applying quality criteria was not reported in the MS so the ERG requested further information from the manufacturer about the process used. The manufacturer responded stating that the quality of trials was assessed by one researcher. The ERG assessment of the four trials can be found in the ERG report (see "Availability of Companion Documents" field) and differs from the MS for some of the trials but is generally in agreement.

Description and Critique of the Statistical Approach Used

The MS presents results from each trial independently, little narrative summary or tabulation of the overall effect of treatment from the trials is reported. In general the data presented in the MS reflects the data reported in the trial publications. In the MS the achievement of psoriasis area and severity index (PASI) 50, 75 and 90 are reported as proportions of patients (numbers and proportion in REVEAL) with p-values reported for comparisons between groups in most cases (in some, p-values were only presented in the confidential clinical study reports [CSRs]). Quality of life outcomes (dermatology life quality index [DLQI], Euro quality of life questionnaire [EQ-5D], short form version 36 [SF-36]) were presented as change from baseline scores. For the CHAMPION trial the p-values alone for quality of life outcomes were presented in the MS. The variance around point estimates was not presented in many cases (see Tables 3 to 9 in the ERG report [see the "Availability of Companion Documents" field]). There is no discussion in the MS of whether or not it was necessary or appropriate to make adjustments to the level of statistical significance in order to correct for multiple comparisons in the analyses, but this was not discussed in the trial publications either.

Meta-Analysis

There was no meta-analysis undertaken on the data from the included trials for any of the outcomes.

Indirect Comparison/Mixed Treatment Comparison

Evidence was collected for a mixed treatment comparison from the results of a different systematic literature search to the one which informed the systematic literature review (ERG report section 3.1.1.1 [see the "Availability of Companion Documents" field]). Although a publication is referenced in which a mixed

treatment comparison is described, full methodological details were not supplied in the MS. It was not clear what the processes were for determining which studies would be included and for performing the data extractions so the ERG requested clarification from the manufacturer. The manufacturer responded by providing some additional information about how data abstraction and quality assessment were carried out (refer to Appendix 1, section A6 of the ERG report [see the "Availability of Companion Documents" field]).

Refer to Sections 3.1.3 to 3.1.5 of the ERG report (see the "Availability of Companion Documents" field) for more information.

Cost-Effectiveness

Cost-Effectiveness Analysis Methods

The model assumes individuals have a short period of therapy during which their response to treatment is assessed, this is referred to in the report as the trial period. Individuals will continue treatment if they have a sufficiently good response at the end of this trial period. Those who respond adequately progress to treatment for a maximum of ten years. The expected length of time that individuals would spend receiving treatment after the trial period was stated as having been estimated through a Markov type process using a discount rate of 3.5%. Treatment effectiveness is defined in terms of the number of individuals who achieve defined responses from baseline PASI score. These changes were combined with estimates of the quality of life improvements associated with a reduction in PASI score. The direct costs associated with each therapy and also costs associated with being a non-responder to treatment are included in the model. The analysis is based closely upon the York Model.

Sensitivity Analyses

A series of one-way sensitivity analyses were carried out and these are presented in the MS. Also presented in the MS are the results of a probabilistic sensitivity analysis and an expected value of perfect information analysis.

Model Validation

The model was validated by comparison to the York model. In addition, models were developed using two computer packages and results were compared.

Refer to Section 4.2 of the ERG report (see the "Availability of Companion Documents" field) for more information.

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 used in 'Etanercept and efalizumab for the treatment of adults with psoriasis' (NICE technology appraisal guidance 103 [TA 103]).

In the manufacturer's base-case analysis, the incremental cost per quality-adjusted life year (QALY) gained for adalimumab compared with supportive care was 30,500 pounds sterling. Etanercept given continuously was dominated by adalimumab (that is, adalimumab had greater effectiveness and lower costs than etanercept), and etanercept given intermittently (assumed to be 88% of the cost of continuous etanercept) and efalizumab were ruled out on the grounds of extended domination (that is, the incremental costs per QALY gained were higher than for adalimumab even though either the cost or effectiveness was more favourable).

The manufacturer's base-case analysis included only people whose psoriasis had a substantial effect on their quality of life, as indicated by a baseline dermatology life quality index (DLQI) score greater than 10. The manufacturer conducted a sensitivity analysis for people with milder forms of psoriasis (baseline DLQI less than or equal to 10) and this increased the incremental cost per QALY gained for adalimumab compared with supportive care from 30,500 pounds sterling (baseline DLQI greater than 10) to 80,100 pounds sterling (baseline DLQI less than or equal to 10).

The manufacturer carried out further sensitivity analyses to test key assumptions in the model. Changing the number of hospital inpatient days assumed to be avoided by using a biological therapy instead of supportive care had a large impact on the results. Changing the assumption used in the base-case analysis (21 hospital inpatient days avoided per year) to 0 days and 39 days was associated with incremental costs per QALY gained of 60,600 pounds sterling and 4800 pounds sterling, respectively, compared with supportive care.

Changing the assumption regarding the cost of intermittent etanercept from 88% of the cost of continuous etanercept to 74% (the figure used in the York model) reduced the incremental cost per QALY gained for intermittent etanercept compared with supportive care from 37,300 pounds sterling to 27,600 pounds sterling.

The Evidence Review Group (ERG) ran the manufacturer's model, changing the assumption for the cost of intermittent etanercept to the value used in the York model (74% of the continuous etanercept cost); this resulted in 27,300 pounds sterling per QALY gained for intermittent etanercept compared with supportive care and 36,700 pounds sterling per QALY gained for adalimumab compared with intermittent etanercept. Changing the assumption for the cost of intermittent etanercept did not alter the cost effectiveness results for adalimumab compared with continuous etanercept; adalimumab continued to have greater effectiveness and lower costs than etanercept.

The ERG performed a probabilistic sensitivity analysis, re-running the manufacturer's model using different assumptions for treatment with intermittent etanercept (74% of the continuous etanercept dose used to calculate costs rather than 88%) and infliximab (three infusions in the trial period rather than four). The ERG found that adalimumab had a 16% probability of being cost effective at a threshold of 30,000 pounds sterling per QALY, compared with 46% estimated by the manufacturer.

The Committee noted that in the manufacturer's base-case analysis using indirect comparisons, etanercept given continuously was dominated by adalimumab (that is, adalimumab had greater effectiveness and lower costs) and etanercept given intermittently (assumed to be 88% of the cost of continuous etanercept) was ruled out on the grounds of extended domination (that is, the incremental cost per QALY gained was higher even though either the cost or effectiveness was more favourable).

The Committee noted that the manufacturer's base-case analysis included an estimate of utility for the use of intermittent etanercept that assumed a disutility related to the associated 'gaps' in therapy. The Committee was concerned, however, that the dose of intermittent therapy used to calculate costs (88% of the continuous etanercept dose) was estimated from US data and was inconsistent with the dose assumed in TA103 (74%).The Committee noted that assumptions regarding the yearly dose for etanercept based on an intermittent dosing schedule had a large impact on the results, and it agreed that the assumptions used should be consistent with those applied in TA103. It also noted the manufacturer's sensitivity analysis, where the assumption regarding the cost of intermittent etanercept was changed to 74% of the cost of continuous etanercept (as in TA103); the resulting incremental cost per QALY gained for intermittent etanercept compared with supportive care (27,600 pounds sterling) was consistent with the value calculated by the ERG (27,300 pounds sterling) in its re-analysis of the manufacturer's model. In addition, the Committee noted that the ERG had also estimated the incremental cost per QALY gained for adalimumab compared with intermittent etanercept, which was 36,700 pounds sterling.

The Committee concluded that adalimumab should be recommended as a treatment option only for people with severe plaque psoriasis when standard systemic therapies have failed.

Refer to Sections 3 and 4 of the original guideline document for details of the economic analyses provided by the manufacturer, the ERG comments, and the Appraisal Committee considerations.

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

Adalimumab is recommended as a treatment option for adults with plaque psoriasis for whom anti-tumour necrosis factor (TNF) treatment is being considered and when the following criteria are both met.

- The disease is severe as defined by a total Psoriasis Area Severity Index (PASI) of 10 or more **and** a Dermatology Life Quality Index (DLQI) of more than 10.
- The psoriasis has not responded to standard systemic therapies including ciclosporin, methotrexate **and** PUVA (psoralen and long-wave ultraviolet radiation); **or** the person is intolerant of, **or** has a contraindication to, these treatments.

Adalimumab should be discontinued in people whose psoriasis has not responded adequately at 16 weeks. An adequate response is defined as either:

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

When using the DLQI, healthcare professionals should ensure that when reaching conclusions on the severity of plaque psoriasis they take into account a person's disabilities (such as physical impairments) and linguistic or other communication difficulties. 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 adalimumab in accordance with the above section.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are supported primarily by randomized controlled trials, supplemented by extension and open-label studies, as well as an economic model for cost-effectiveness.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate use of adalimumab for the treatment of psoriasis in adults

POTENTIAL HARMS

Common adverse events associated with adalimumab, as reported in the summary of product characteristics (SPC), include injection-site reactions, infections, dizziness, headache, diarrhoea, abdominal pain, stomatitis and mouth ulceration, nausea, increased hepatic enzymes, musculoskeletal pain and fatigue.

For full details of side effects and contraindications, see the SPC.

CONTRAINDICATIONS

CONTRAINDICATIONS

Contraindications listed in the summary of product characteristics (SPC) include active tuberculosis or other severe infections such as sepsis, opportunistic infections and moderate to severe heart failure.

For full details of side effects and contraindications, see the SPC.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. 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 decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

- The Healthcare Commission assesses the performance of National Health Service (NHS) organizations 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 the 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 the NICE website (www.nice.org.uk//TA146 [see also the "Availability of Companion Documents" field]).
    - Costing report and costing template to estimate the savings and costs associated with implementation
    - Audit support for monitoring local practice

IMPLEMENTATION TOOLS

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

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). Adalimumab for the treatment of adults with psoriasis. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Jun. 25 p. (Technology appraisal guidance; no. 146).

ADAPTATION

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

DATE RELEASED

2008 Jun

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 Ray Armstrong, Consultant Rheumatologist, Southampton General Hospital; Dr Jeff Aronson, Reader in Clinical Pharmacology, University Department of Primary Health Care, University of Oxford; Dr Darren Ashcroft, Reader in Medicines Usage and Safety, School of Pharmacy and Pharmaceutical Sciences, University of Manchester; Professor David Barnett (*Chair*) Professor of Clinical Pharmacology, University of Leicester; Professor Stirling Bryan, Head, Department of Health Economics, University of Birmingham; Professor John Cairns, Professor of Health Economics, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine; Dr Mark Charkravarty, Director, External Relations, Procter and Gamble Health Care, Europe; 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, Barts and The London School of Medicine and Dentistry, Queen Mary, University of London;

Dr Fergus Gleeson, Consultant Radiologist, Churchill Hospital, Oxford; Ms Sally Gooch, Independent Nursing and Healthcare Consultant; 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; Mr Terence Lewis, Lay member; Professor Gary McVeigh, Professor of Cardiovascular Medicine, Queens University, Belfast; Dr Ruairidh Milne, Senior Lecturer in Public Health, National Coordinating Centre for Health Technology, University of Southampton; Dr Neil Milner, General Medical Practitioner, Tramways Medical Centre, Sheffield; Dr Rubin Minhas, General Practitioner, Coronary Heart Disease Clinical Lead, Medway PCT; Dr John Pounsford, Consultant Physician, Frenchay Hospital, Bristol; Dr Rosalind Ramsay, Consultant Psychiatrist, Adult Mental Health Services, Maudsley Hospital, London; Dr Stephen Saltissi, Consultant Cardiologist, Royal Liverpool University Hospital; Dr Lindsay Smith, General Practitioner, East Somerset Research Consortium; Mr Roderick Smith, Finance Director, West Kent PCT; Mr Cliff Snelling, Lay member; Professor Ken Stein, Professor of Public Health, Peninsula College of Medicine and Dentistry, University of Exeter; Professor Andrew Stevens, Professor of Public Health, Department of Public Health and Epidemiology, 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:

- Adalimumab for the treatment of adults with psoriasis. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Jun. 2 p. (Technology appraisal 146). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Adalimumab for the treatment of adults with psoriasis. Costing template and report. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Jun. Various p. (Technology appraisal 146). Available in Portable Document Format (PDF) from the NICE Web site.
- Adalimumab for the treatment of adults with psoriasis. Audit support. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008. 6 p.

(Technology appraisal 146). Available in Portable Document Format (PDF) from the NICE Web site.

- Adalimumab for the treatment of psoriasis. Evidence review group report. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Nov. 102 p. (Technology appraisal 146). Available in Portable Document Format (PDF) from the NICE Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1610. 11 Strand, London, WC2N 5HR.

PATIENT RESOURCES

The following is available:

- Adalimumab for psoriasis. Understanding NICE guidance - Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Jun. 4 p. (Technology appraisal 146).

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

Print copies: Available from the NHS Response Line 0870 1555 455. ref: N1611. 11 Strand, London, WC2N 5HR.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI Institute on September 16, 2008.

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