Complete Summary

GUIDELINE TITLE

Ranibizumab and pegaptanib for the treatment of age-related macular degeneration.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Ranibizumab and pegaptanib for the treatment of age-related macular degeneration. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Aug. 43 p. (Technology appraisal guidance; no. 155).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Subfoveal choroidal neovascularisation (CNV) associated with neovascular (wet) age-related macular degeneration (AMD)

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Treatment

CLINICAL SPECIALTY

Ophthalmology

INTENDED USERS

Advanced Practice Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To evaluate the clinical effectiveness and cost-effectiveness of ranibizumab and pegaptanib for the treatment of age-related macular degeneration

TARGET POPULATION

Patients with age-related wet (neovascular) macular degeneration

INTERVENTIONS AND PRACTICES CONSIDERED

1. Ranibizumab
2. Pegaptanib (not recommended)

MAJOR OUTCOMES CONSIDERED

- Clinical effectiveness
    - Visual acuity (loss, maintenance, gain, mean change and deterioration to visual acuity 3/60)
    - Contrast sensitivity
    - Anatomical changes in choroidal neovascularisation (CNV)
    - Adverse effects of treatment
    - Adherence to treatment
    - Health-related quality of life (visual function questionnaire scores)
- 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Searches of Unpublished Data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 a Technology Assessment Report. The Technology Assessment Report for this technology appraisal was prepared by Southampton Health Technology Assessment Centre (SHTAC), University of Southampton (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Search Strategy

A sensitive search strategy was developed, tested and refined by an experienced information scientist. Separate searches were conducted to identify studies of clinical effectiveness, cost-effectiveness, quality of life, resource use/costs and epidemiology/natural history. Sources of information and search terms are provided in Appendix 2 of the Assessment Report (see the "Availability of Companion Documents" field). The most recent search was carried out in September 2006.

Searches for clinical and cost effectiveness were from database inception to the current date. Electronic databases searched included: The Cochrane Database of Systematic Reviews (CDSR); The Cochrane Central Register of Controlled Trials; National Health Service Centre for Reviews and Dissemination (NHS CRD, University of York) Database of Abstracts of Reviews of Effectiveness (DARE), Health Technology Assessment (HTA) database and the NHS Economic Evaluation Database (NHS EED); Medline (Ovid), Medline In-Process (Ovid), Embase (Ovid); National Research Register; Current Controlled Trials; Institute for Scientific Information (ISI) Proceedings; Web of Science ISI Science Citation Index; and BIOSIS. Ophthalmology conferences were searched for recent abstracts (from 2004). The searches were restricted to English language. Bibliographies of related papers were screened for relevant studies, and the manufacturers' submissions to NICE were assessed for any additional studies. Experts were also contacted for advice and peer review, and to identify additional published and unpublished references.

Inclusion Criteria

Titles and abstracts of studies identified by the search strategy were assessed for potential eligibility by two reviewers. The full text of relevant papers was then obtained and inclusion criteria were applied by one reviewer and checked by a second reviewer.

Patients

People with subfoveal choroidal neovascularisation (CNV) associated with wet age-related macular degeneration (AMD).

Interventions

Studies reporting the following interventions were eligible for inclusion:

- Ranibizumab (Lucentis, Genentech/Novartis Pharmaceuticals UK Ltd)
- Pegaptanib sodium (Macugen, Pfizer Ltd)
- Combination of the drugs with photodynamic therapy (PDT) where the licensed indication and evidence allow

Comparators

- Best supportive care
- For the subgroup of individuals with a confirmed diagnosis of classic with no occult subfoveal wet AMD, PDT with verteporfin was also a comparator.
- If insufficient evidence was found using the above comparators, the following comparators were also to be considered:
    - Sham injection
    - PDT with verteporfin for patients with subfoveal wet AMD with predominantly classic lesions

Outcomes

Studies were included if they reported one or more of the following outcome measures:

- Visual acuity
- Contrast sensitivity
- Adverse effects of treatment
- Adherence to treatment
- Health-related quality of life

Types of Studies

Systematic reviews and meta-analyses of randomised controlled trials (RCTs) and RCTs were included. Studies published only as abstracts or conference presentations were considered if sufficient information was presented to allow an appraisal of the methodology and assessment of results. Non-English language studies were excluded.

Full economic evaluations of the specified interventions were also included. A range of designs for studies on quality of life, epidemiology and natural history were considered.

Cost-Effectiveness

Methods for the Systematic Review

A systematic literature search was undertaken to identify economic evaluations comparing pegaptanib and ranibizumab to existing treatments (PDT) or best supportive care in patients with AMD. The details of the search strategy are documented in Appendix 2 of the Assessment Report (see the "Availability of Companion Documents" field). The manufacturers' submissions to NICE were reviewed for additional studies.

Titles and abstracts of studies identified by the search strategy were assessed for potential eligibility by two health economists independently. Economic evaluations were eligible for inclusion if they reported on the cost-effectiveness of pegaptanib and/or ranibizumab versus existing treatments (PDT) or no treatment (best supportive care) in patients with AMD. Studies reporting the economic evaluation of comparator treatments were also identified and reviewed to highlight key methodological issues in economic evaluation of treatment for AMD.

NUMBER OF SOURCE DOCUMENTS

Clinical Effectiveness

- Published literature: 264 citations; 26 documents retrieved
- Ranibizumab: 2 published randomized controlled trials (RCTs) and 2 unpublished RCTs
- Pegaptanib: 2 RCTs (in 3 publications)

Cost-Effectiveness

- Published literature: A total of 421 publications relating to cost-effectiveness in age-related macular degeneration were identified through the literature searches. None of these was a fully published economic evaluation of either drug. Three related conference abstracts reporting evaluations of pegaptanib were identified and are reviewed in outline.
- Two manufacturer's submissions
- Assessment Group economic model

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

Review of Published Meta-Analyses
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 a Technology Assessment Report. The Technology Assessment Report for this technology appraisal was prepared by Southampton Health Technology Assessment Centre (SHTAC), University of Southampton (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Data Extraction Process

Data were extracted by one reviewer using a standard data extraction form and checked by a second reviewer.

Quality Assessment

The quality of included RCTs and systematic reviews was assessed using criteria recommended by National Health Service (NHS) Centre for Reviews and Dissemination (CRD) (refer to Appendix 3 of the Assessment Report [see the "Availability of Companion Documents" field]). Quality criteria were applied by one reviewer and checked by a second reviewer. At each stage, any differences in opinion were resolved through discussion or consultation with a third reviewer.

Data Synthesis

Data were synthesised through a narrative review with tabulation of results of all included studies. Full data extraction forms are presented in Appendix 4 of the Assessment Report (see the "Availability of Companion Documents" field). It was not considered appropriate to combine the included RCTs in a meta-analysis due to heterogeneity in the patient groups and comparator treatments.

Cost-Effectiveness

With no economic evaluations identified in the systematic review of cost-effectiveness, a model was developed to estimate the cost-effectiveness separately of ranibizumab and of pegaptanib, compared to current practice or best supportive care, from the perspective of the NHS and Personal Social Services.

Two time horizons were adopted for each model. The first (short-term analysis) adopted time horizons determined by the available trial data. In this analysis, no attempt was made to extrapolate costs or effects beyond the period of follow-up in clinical trials of ranibizumab and of pegaptanib. The second analysis extrapolated effects of treatment beyond the clinical trials, adopting a time horizon of ten years, the approximate life expectancy for the cohort of age-related macular degeneration (AMD) patients being modelled.

The proportions of patients gaining and losing visual acuity reported in the clinical trials were converted to three-month transition probabilities in the model and combined with published estimates of health state utilities to estimate the quality-adjusted life years (QALYs) associated with each intervention.

Refer to Section 4 of the Assessment Report (see the "Availability of Companion Documents" field) for more information on methods used to analyze cost-effectiveness.

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

Manufacturers' Submissions

Both manufacturers provided cost-utility models. Both models were Markov state transition models, with the states being different levels of visual acuity and death. Both models assumed that only the better-seeing eye is treated.

Ranibizumab

The manufacturer's submission compared the use of ranibizumab with best supportive care for patients with minimally classic or occult no classic lesions, and with both photodynamic therapy (PDT) with verteporfin and best supportive care for patients with predominantly classic lesions. The different types of wet age-related macular degeneration (AMD) were analysed separately based on results from randomised controlled trials (RCTs).

The model had five health states defined by declining visual acuity ranging from 6/15 or better (least severe) to less than 3/60 (most severe), and an additional absorbing state, death. In the base-case analysis for the model, 8 injections in the first year and 6 injections in the second year were used.

The base-case incremental cost-effectiveness ratios (ICERs) for predominantly classic lesions, assuming 1 year of treatment as per the ANCHOR RCT, were 4,489 pounds sterling per quality-adjusted life-year (QALY) gained for ranibizumab versus PDT, and 14,781 pounds sterling per QALY gained for ranibizumab versus best supportive care. For occult no classic lesions, assuming 2 years of treatment, the ICER was 26,454 pounds sterling per QALY gained for ranibizumab versus best supportive care. Likewise, for minimally classic lesions, the ICER was 25,796 pounds sterling per QALY gained. For all lesion types (PIER), assuming 1 year of treatment, the ICER was 12,050 pounds sterling per QALY gained.

Pegaptanib

The manufacturer's model for pegaptanib compared the cost effectiveness of pegaptanib with usual care in the NHS. Usual care was identified as the best supportive care (visual rehabilitation and provision of visual aids) for all patients, with the addition of PDT with verteporfin in patients with predominantly classic lesions. The base-case analysis is based on all lesion types. The analysis was based on patient-level data from the VISION study.

The model had 12 health states, defined by visual acuity ranging from 6/10 or better to less than 3/60, and an additional absorbing state, death. Treatment was assumed to be stopped if visual acuity dropped below 6/96 or by six or more lines from baseline at the end of a year. This is referred to as scenario A. The cost effectiveness of adopting an alternative stopping rule with a higher threshold of visual acuity (6/60) for stopping pegaptanib treatment, labelled scenario B, is also reported in the submission. Cycle length in the model is 6 weeks.

In the base case, the ICER was 15,819 pounds sterling per QALY gained for scenario A and 14,202 pounds sterling per QALY gained for scenario B. Results of sensitivity analyses carried out by the manufacturer showed that the costs and probabilities of receiving visual impairment services and the model time horizon had a significant effect on the ICERs.

The Assessment Group Model

The Assessment Group's model evaluated the cost effectiveness of ranibizumab and pegaptanib compared with current practice (PDT with verteporfin for classic no occult lesions or predominantly classic lesions, and best supportive care for all lesion types).

A six-state Markov model was developed and the rate of disease progression was modelled as the probability of progressing to a different level of visual acuity health state in each model cycle. The model extrapolated the effects of the 2-year trial period (or 1 year for ranibizumab in predominantly classic lesions) to 10 years in both arms of the model. Ranibizumab and pegaptanib treatments are assumed to have stopped at the end of year 2, and thereafter benefits were assumed to decline at the same rate as those for usual care, although from a higher level of visual acuity.

Resources and costs incorporated in the Assessment Group model included those for treatment, administration, monitoring, managing adverse events and blindness.

Ranibizumab

The Assessment Group's base-case ICERs over a 10-year time horizon for predominantly classic lesions assuming 1 year of treatment were 15,638 pounds sterling per QALY gained compared with PDT, and 11,412 pounds sterling per QALY gained compared with best supportive care. For minimally classic lesions and occult no classic lesions, assuming 2 years of treatment, they were 25,098 pounds sterling per QALY gained compared with best supportive care.

The Assessment Group carried out sensitivity analyses of different assumptions used in their model. The results for ranibizumab showed that as the time horizon decreased the ICERs increased.

Pegaptanib

The Assessment Group estimated the base-case ICER for pegaptanib (all lesion types) compared with usual care to be 30,986 pounds sterling per QALY gained over a 10-year time horizon.

The Assessment Group carried out sensitivity analyses of different assumptions used in their model. As with ranibizumab, the results for pegaptanib showed that decreasing the time horizon increased the ICERs. The ICER was also sensitive to the costs of blindness, in particular the uptake of services, estimated as the proportion of patients with visual acuity of less than 6/60 receiving services. Using high uptake and high unit-cost estimates resulted in pegaptanib being

economically dominant (with a lower cost and better outcome) compared with usual care. However, when low costs and medium uptake assumptions were used, the ICER increased from the base case of 30,986 pounds sterling to 37,154 pounds sterling per QALY gained.

Further Analysis by the Assessment Group and the Decision Support Unit

The Committee requested additional analysis from the Assessment Group and the Decision Support Unit. The Assessment Group explored alternative assumptions for the main drivers of the economic model: namely the costs of blindness, the costs of administering the injections, the number of injections of ranibizumab, and the utility values used in the analysis. The Decision Support Unit provided similar analyses using the manufacturer's model for pegaptanib.

The Assessment Group explored the cost of treating the first eye to come to clinical attention rather than treating only the better-seeing eye. The analysis assumed an annual incidence of AMD in the second eye of 10% and explored a number of different scenarios. It found that for ranibizumab the additional cost of treating two eyes ranged from about 9,900 pounds sterling to about 28,600 pounds sterling, depending on the number of injections (9 to 24) over 2 years. For pegaptanib, the additional cost of treating two eyes ranged from about 9,100 pounds sterling to about 15,700 pounds sterling.

In addition to the cumulative assumptions described in sections 4.2.4.5 and 4.2.4.6 of the original guideline document, but instead assuming that only 14 injections would be required over two years to attain the same clinical benefit without reducing the frequency of monitoring costs, the ICER for ranibizumab for predominantly classic lesions further decreased from 37,489 pounds to 13,671 pounds per QALY gained compared with PDT, and from 23,887 pounds to 9,900 pounds per QALY gained compared with best supportive care. For minimally classic or classic no occult lesions the ICER decreased from 38,659 pounds to 19,904 pounds per QALY gained compared with best supportive care.

For pegaptanib, the Decision Support Unit used the manufacturer's model to reproduce the manufacturer's finding that the cost per QALY gained for pegaptanib treatment is lower in subgroups with better baseline visual acuity using all the Committee's preferred assumptions. The lowest cost per QALY gained was obtained in a subgroup of people with visual acuity between 6/12 and 6/24. When the inputs outlined in section 4.2.4.4 of the original guideline document were cumulatively considered in the manufacturer's model, the ICER was 23,124 pounds sterling per QALY gained in the 6/12 to 6/24 subgroup compared with best supportive care, 40,627 pounds sterling per QALY gained for the 6/24 to >6/60 subgroup, 115,244 pounds sterling per QALY gained for the 6/60 to >3/60 subgroup, and 34,602 pounds sterling per QALY gained for the whole cohort. Using the same set of assumptions, the ICER from the Assessment Group model was 44,259 pounds sterling per QALY gained for the whole group irrespective of visual acuity levels.

Consideration of the Evidence

The Committee concluded that treatment with ranibizumab would be cost effective if the manufacturer pays for the drug cost of ranibizumab beyond 14 injections in

the treated eye. The Committee further concluded that treatment with pegaptanib for wet AMD is not a cost-effective use of national health Service (NHS) resources.

Refer to Sections 4.2 and 4.3 of the original guideline document for details of the economic analyses provided by the manufacturer, the Assessment Group 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

Ranibizumab, within its marketing authorisation, is recommended as an option for the treatment of wet age-related macular degeneration if:

- All of the following circumstances apply in the eye to be treated:
    - The best-corrected visual acuity is between 6/12 and 6/96
    - There is no permanent structural damage to the central fovea
    - The lesion size is less than or equal to 12 disc areas in greatest linear dimension
    - There is evidence of recent presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, or recent visual acuity changes)

and

- The cost of ranibizumab beyond 14 injections in the treated eye is met by the manufacturer.

It is recommended that treatment with ranibizumab should be continued only in people who maintain adequate response to therapy. Criteria for discontinuation should include persistent deterioration in visual acuity and identification of

anatomical changes in the retina that indicate inadequate response to therapy. It is recommended that a national protocol specifying criteria for discontinuation is developed.

Pegaptanib is not recommended for the treatment of wet age-related macular degeneration.

People who are currently receiving pegaptanib for any lesion type should have the option to continue therapy until they and their clinicians consider it appropriate to stop.

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 ranibizumab and pegaptanib in the treatment of age-related macular degeneration

POTENTIAL HARMS

- The summary of product characteristics (SPC) states that adverse events commonly associated with ranibizumab include conjunctival haemorrhage, eye pain, vitreous floaters, retinal haemorrhage, increased intraocular pressure, vitreous detachment, intraocular inflammation, eye irritation, cataract, foreign body sensation in the eyes, visual disturbance, blepharitis, subretinal fibrosis, ocular hyperaemia, blurred/decreased visual acuity, dry eye and vitreitis.
- The SPC states that adverse events commonly associated with pegaptanib are anterior chamber inflammation, eye pain, increased intraocular pressure, punctate keratitis, vitreous floaters and vitreous opacities.

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 (http://www.nice.org.uk/TA155) [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). Ranibizumab and pegaptanib for the treatment of age-related macular degeneration. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Aug. 43 p. (Technology appraisal guidance; no. 155).

ADAPTATION

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

DATE RELEASED

2008 Aug

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 David Barnett (*Vice-Chair)* Professor of Clinical Pharmacology, University of Leicester; Dr David W Black, Director of Public Health, Chesterfield PCT; Mr Brian Buckley, Chair, Incontact; Dr Carol Campbell, Senior Lecturer, University of Teesside; Professor Mike Campbell, Professor of

Medical Statistics, University of Sheffield; Ms Jude Cohen, Special Projects Consultant, UK Council for Psychotherapy; Dr Christine Davey, Senior Researcher, North Yorkshire Alliance R & D Unit; Dr Mike Davies, Consultant Physician, Manchester Royal Infirmary; Mr Richard Devereaux-Phillips, Public Affairs Manager, Medtronic Ltd; Dr Rachel A Elliott, Lord Trent Professor of Medicines and Health, Nottingham University; Mrs Eleanor Grey, Lay representative; Dr Catherine Jackson, Clinical Lecturer in Primary Care Medicine, Alyth Health Centre; Dr Peter Jackson, Clinical Pharmacologist, Sheffield Teaching Hospitals NHS Foundation Trust; Ms Rachel Lewis, Nurse Adviser to the Department of Health; Dr Damien Longson, Consultant in Liaison Psychiatry, Manchester Mental Health & Social Care Trust; Professor Jonathan Michaels, Professor of Vascular Surgery, University of Sheffield; Dr Eugene Milne, Deputy Medical Director, North East Strategic Health Authority; Dr Richard Alexander Nakielny, Consultant Radiologist, Royal Hallamshire Hospital, Sheffield; Dr Katherine Payne, Health Economics Research Fellow, The University of Manchester; Dr Martin J Price, Head of Outcomes Research, Janssen-Cilag Ltd; Professor Andrew Stevens (*Chair*) Professor of Public Health, University of Birmingham; Dr Cathryn Thomas, Senior Lecturer, Department of Primary Care and General Practice, University of Birmingham

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:

- Ranibizumab and pegaptanib for the treatment of age-related macular degeneration. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Aug. 2 p. (Technology appraisal 155). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Ranibizumab and pegaptanib for age-related macular degeneration. Costing template. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Aug. Various p. (Technology appraisal 155). Available in Portable Document Format (PDF) from the NICE Web site.
- Ranibizumab and pegaptanib for age-related macular degeneration. Audit support. London (UK): National Institute for Health and Clinical Excellence

(NICE); 2008. 5 p. (Technology appraisal 155). Available in Portable Document Format (PDF) from the NICE Web site.

- Ranibizumab and pegaptanib for the treatment of age-related macular degeneration: a systematic review and economic evaluation. Technology Assessment Report. Southampton Health Technology Assessments Centre (SHTAC); 2006 Nov. 278 p. (Technology appraisal 155). 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: N1664. 11 Strand, London, WC2N 5HR.

PATIENT RESOURCES

The following is available:

- Ranibizumab and pegaptanib for wet age-related macular degeneration. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Aug. 4 p. (Technology appraisal 155). 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: N1665. 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 December 19, 2008.

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Date Modified: 1/12/2009