Complete Summary

GUIDELINE TITLE

Abatacept for the treatment of rheumatoid arthritis.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Abatacept for the treatment of rheumatoid arthritis. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Apr. 29 p. (Technology appraisal guidance; no. 141).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
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SCOPE

DISEASE/CONDITION(S)

Rheumatoid arthritis

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Rheumatology

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To evaluate the clinical effectiveness and cost-effectiveness of abatacept for the treatment of rheumatoid arthritis

TARGET POPULATION

Patients with rheumatoid arthritis

INTERVENTIONS AND PRACTICES CONSIDERED

The use of abatacept for the treatment of rheumatoid arthritis was considered but not recommended.

MAJOR OUTCOMES CONSIDERED

- Clinical effectiveness
    - Disease activity
    - Physical function
    - Joint damage
    - Pain
    - Mortality
    - Fatigue
    - Health-related quality of life (HRQoL)
    - Adverse effects of treatment
- 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Searches of Unpublished Data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 Liverpool Reviews

and Implementation Group, University of Liverpool (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Critique of Manufacturer's Approach

Description of Manufacturers Search Strategy and Comment on whether the Search Strategy Was Appropriate

Two electronic databases were searched (Medline and EMBASE) covering the period 01/01/1990 to 22/08/2006. Internal manufacturer databases of clinical studies were also searched. In March 2007, an additional search of ongoing clinical trials databases was conducted.

The search strategies employed were comprehensively reported enabling replication. The ERG is confident that all relevant published clinical trials were identified by the manufacturer.

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

Details of inclusion and exclusion criteria are provided below and are considered appropriate and complete.

<u>Scope of the Literature Review</u>

Inclusion Criteria

- Randomised controlled trials (RCTs) published since 1990 where the full paper can be obtained.
- Patients in at least one arm of the trial must receive abatacept as in the proposed indication. Comparators included any other disease-modifying anti-rheumatic drug (DMARD) agent or placebo (including the 'do nothing' option) or standard care.
- Head-to-head trials were included.
- The patients of interest are adults with moderate to severe rheumatoid arthritis (RA).
- Long-term extension studies of observational design were included.
- Non-English (French, Spanish, Italian or German) publications were included.

Exclusion Criteria

- Non-randomised or uncontrolled studies (unless these are long-term extensions of RCTs), observational studies, case series, letters to editor, studies with no abstracts, conference abstracts only.
- Reviews were ordered for the purpose of checking the bibliographies but were excluded from the list of included studies.
- Trials in diseases other than RA.

- Patients with early RA were excluded as abatacept is not indicated for treatment of early RA and the scope of this submission focuses on more severe disease.
- Studies reporting solely on laboratory measures aimed at investigating disease or treatment mechanisms, and which do not report relevant clinical outcomes.

Economic Evaluation

Summary of Published Cost-Effectiveness Analyses Identified in the Manufacturer's Submission

A systematic review (SR) was conducted by the manufacturer to identify published economic models, information on costs, cost effectiveness and quality of life impact of biologic DMARDs, specifically abatacept, adalimumab, anakinra, etanercept, infliximab and rituximab.

The results of the SR were presented for (1) review of economic analyses and (2) review of quality of life studies.

Identification and Description of Studies

The manufacturer's submission (MS) included full details of the electronic search strategy used in the review. The ERG could therefore replicate the electronic searching undertaken by the manufacturer. The total number of papers initially found and the number of papers excluded from the review were reported. Reasons for excluding papers were also provided.

Stated inclusion criteria were:

- **Study type**

Cost-consequence analysis, cost-benefit analysis, cost-effectiveness analysis, cost-utility analysis, cost study, quality of life (QoL) study (for QoL review)

- **Condition**

Rheumatoid arthritis only. Other types of arthritis and autoimmune disease were excluded

- **Treatment**

Etanercept, infliximab, adalimumab, anakinra, abatacept, biologic DMARDs, tumour necrosis factor (TNF) blockers

- **Populations**

Adults with RA. Studies on children and adolescents were excluded

- **Outcomes**

Cost estimates (including unit costs, resource utilization), cost effectiveness/utility measures, QoL, utility measures (the last two for the QoL review)

- **Time horizon**

Unlimited

- **Language**

Only English language publications were considered

NUMBER OF SOURCE DOCUMENTS

Clinical Effectiveness

- The search strategy resulted in the identification of 10 articles reporting six randomised controlled trials (RCTs). The search strategy was then restricted to within-licence studies resulting in the inclusion of one trial (ATTAIN).
- The manufacturer's submission also included non-RCT evidence from 3 trials ATTAIN, ARRIVE, and BSRBR

Cost-effectiveness

- Only two of the 21 identified studies included abatacept as a comparator; neither of the two studies could be critically appraised due to lack of data.
- The manufacturer of abatacept submitted a cost-effectiveness 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

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 Liverpool Reviews and Implementation Group, University of Liverpool (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Critique of Manufacturer's Approach

The manufacturer's submission (MS) includes a systematic review (SR) of the clinical evidence available to assess the efficacy and safety of abatacept for the treatment of patients with moderate to severe rheumatoid arthritis (RA) who have failed a tumour necrosis factor alpha inhibitor (TNFi).

Key aspects of the methodological quality of the manufacturer's review of the clinical literature were assessed based on an accepted quality assessment tool and the results are summarised in Table 4-1 of the ERG report (see the "Availability of Companion Documents" field).

Description and Critique of Manufacturers Approach to Validity Assessment

The MS includes a completed validity assessment and a JADAD score of five for the ATTAIN trial, the only randomised controlled trial (RCT) that met the review inclusion criteria. The validity assessment tool used is not referenced but the questions are appropriate and complete.

The ERG agrees that the validity assessment tool used in the MS was appropriate and that all trials were of a good quality. The completed validity assessment tool for ATTAIN as reported in the MS is reproduced in Table 4-5 of the ERG report (see the "Availability of Companion Documents" field).

Describe and Critique the Statistical Approach Used

The ATTAIN trial was powered to 96% to detect a 20% change for the primary outcome of American College of Rheumatology (ACR)20 and 87% to detect an 18% change in Health Assessment Questionnaire (HAQ) scores. For binary measures, Cochran-Mantel-Haenszel chi-square tests with stratification based on baseline history of TNFi treatment (current or prior use) were used. For continuous measures, an analysis of covariance was used, with treatment as the main factor and baseline measures as the covariate. All statistical tests and confidence intervals were two sided. Subgroup analyses were not sufficiently powered to detect a difference. All statistical methods were fully reported for each of the trials.

Refer to Sections 4.1 and 4.2 of the ERG report (see the "Availability of Companion Documents" field) for more information.

Economic Evaluation

Data Extraction

The manufacturer presented summary details of the cost-effectiveness studies (n=10) which described (1) abatacept in any country context or (2) any other biologic used in the UK setting. All of the economic analyses and quality of life

studies are also summarised (including details of study, aims, methods, results and comments/relevance) in MS.

Data were extracted into pre-specified tables by one reviewer. A second reviewer conducted independent data abstraction and any discrepancies were discussed.

Quality Assessment

The results of each of the studies were discussed in light of the critical appraisal of its methodology. The specific critical appraisal tool employed was not stated.

Overview of Manufacturer's Economic Evaluation

In the absence of UK-based economic evaluations of abatacept, the manufacturer conducted a de novo economic evaluation. The principal analysis compares abatacept + methotrexate (MTX) versus MTX. An additional analysis compares abatacept versus a cycled TNFi. An economic model was developed to estimate the costs and outcomes of typical RA patients from the beginning of a specific treatment, after having failed a TNFi, until death. The model structure reflects the clinical outcomes of a phase III RCT of abatacept (ATTAIN), published economic evaluations, and expert opinion from clinicians, statisticians and health economists.

The manufacturer constructed a patient-level state simulation model which focuses on a hypothetical cohort of 10,000 patients. Patient disability is simulated over time using six-monthly cycles. Each patient in the hypothetical cohort is "run through" the model, one at a time, to estimate outcomes for the cohort as a whole. The nature of RA is modelled at the patient level in terms of changes in HAQ scores over time. The model estimates the worsening of HAQ scores due to underlying disease progression and treatment discontinuation. The model can be run for different durations up to lifetime duration.

Sensitivity Analyses (SA)

Univariate SA and probabilistic sensitivity analysis (PSA) were conducted by the manufacturer. Univariate SA was performed on a range of key parameters and the results are presented in the MS. In the base-case and additional analyses, the cost-effectiveness results appear to be most sensitive to the following parameters: time horizon, discount rate, annual treatment cost of abatacept and assumption on rebound following treatment discontinuation. In addition, the cost-effectiveness results in the abatacept + MTX versus MTX comparison appear to be sensitive to the annual rate of HAQ progression on MTX.

Refer to Section 5 of the ERG report (see the "Availability of Companion Documents" field) for additional 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 economic model provided by the manufacturer was a patient-level simulation that estimated the cost effectiveness of abatacept in combination with methotrexate in two scenarios: the first where the comparator was methotrexate alone, and the second where the comparator was a second tumour necrosis factor (TNF)-alpha inhibitor. In the model, patients starting abatacept moved to methotrexate either if there was an insufficient response to abatacept in the first 6 months or if they experienced an adverse event. Patients receiving methotrexate remained on methotrexate for the remainder of the 20-year time horizon of the model. The submitted model did not examine the optimal sequencing of abatacept in a strategy containing a range of anti-rheumatic drugs.

The economic comparison with methotrexate was based on short-term efficacy data from the ATTAIN trial. The comparison with TNF-alpha inhibitors used data for abatacept from the ATTAIN trial and data from the BSRBR for the second TNF-alpha inhibitor. Because of limitations in the data, the manufacturer described the comparisons with TNF-alpha inhibitors as speculative. A comparison with rituximab was not completed principally on the basis that rituximab was not considered to be current standard practice at the time of submission.

The manufacturer estimated the incremental cost effectiveness of abatacept compared with methotrexate to be 25,395 pounds sterling per quality-adjusted life year (QALY) gained. The corresponding estimate in comparison with a second TNF-alpha inhibitor was 22,628 pounds sterling per QALY gained. One-way sensitivity analyses suggested that the model was sensitive to assumptions about the time horizon, discounting, rate of underlying disease progression, and the cost of abatacept. The manufacturer's probabilistic sensitivity analyses suggested that there was a high probability that abatacept was cost effective if the acceptable amount to pay for an additional QALY is 30,000 pounds sterling. However, at a threshold of 20,000 pounds sterling, methotrexate had a higher probability of being cost effective.

At the request of NICE, the manufacturer completed further analyses for the comparison of abatacept with methotrexate exploring the impact on the incremental cost-effectiveness ratio (ICER) of using different underlying rates of disease progression (measured as increases in health assessment questionnaire [HAQ] score) that have been used in other National Institute for Health and Clinical Excellence (NICE) technology appraisals of treatments for rheumatoid arthritis. In a scenario where the rates of disease progression were 0.03 per year for patients on abatacept and 0.045 per year for patients on methotrexate, the estimated ICER was 33,567 pounds sterling per QALY. Using an estimate of 0.03 per year for abatacept, and an estimate of 0.06 per year for methotrexate, led to an estimated ICER of 28,445 pounds sterling per QALY.

The Evidence Review Group (ERG) highlighted a number of issues with the submitted model including errors in the model logic. The ERG suggested alternative estimates of parameter values for treatment costs, disease-related costs, rates of abatacept discontinuation, choice of HAQ mortality multiplier, and the estimated benefit of abatacept therapy on HAQ score. The ERG also constructed an overall mixed gender cohort for the comparisons, as opposed to the female cohort used in the manufacturer's base case. The ERG used an alternative model for deriving utility values from HAQ scores and investigated the impact of different values for HAQ progression rate. For the comparison with TNF-alpha inhibitors, the ERG incorporated new parameter values to represent the clinical effectiveness of a second TNF-alpha inhibitor on HAQ scores, as well as the appropriate treatment costs. The ERG estimated that the cumulative impact of these amendments would increase the ICER in both scenarios (using methotrexate or using further TNF-alpha inhibitors as comparators) to approximately 50,000 pounds sterling per QALY.

In addition, the ERG examined in detail the evidence relating to underlying disease progression because this was identified as a key driver in the cost-effectiveness modelling. The ERG noted that both the rate of disease progression while on abatacept and the magnitude of the difference in the rate of progression between abatacept and the comparator are important factors in estimating the cost effectiveness of abatacept. The ERG identified a number of limitations in the studies that have been used to calculate underlying disease progression rates, and it reanalysed the available data. The ERG concluded that the rates of progression while on conventional disease-modifying anti-rheumatic drugs (DMARDs) or on palliative care could be as low as 0.012 per year, and that a reasonable assumption for the relative progression rate while on biologic treatments such as abatacept would be around 75% of the rate while on conventional DMARDs (0.009). Using these values in the model suggested an estimate of cost effectiveness for abatacept of around 70,000 pounds sterling per incremental QALY gained when the comparator was either methotrexate or a TNF-alpha inhibitor.

The ERG also carried out analyses that included all the amendments it had made to the manufacturer's model as well as the values for underlying disease progression that were consistent with other technology appraisals of treatments for rheumatoid arthritis. Modelling underlying disease progression using increases in HAQ score of 0.03 and 0.045 per year for abatacept and methotrexate respectively, the estimated ICER was approximately 63,000 pounds sterling per QALY gained. Using values of 0.03 per year for abatacept and 0.06 per year for methotrexate, the estimated ICER was approximately 55,000 pounds sterling per QALY gained.

The Committee considered the cumulative impact of the issues raised by the ERG and the manufacturer. The Committee considered that the changes to the costs of abatacept treatment were not enough to significantly change the base-case ICER of 25,000 pounds sterling included in the manufacturer's submission. It noted that the addition of the increased annual rate of discontinuation raised the ICER to approximately 28,000 pounds sterling, but that this would be slightly reduced by a lower HAQ mortality multiplier. The Committee considered that with the HAQ progression rates used in the appraisal of rituximab the ICER would be further increased by about 3000 pounds sterling, and that the cumulative impact would

be greater than 30,000 pounds sterling. The use of a different HAQ mapping algorithm could increase the ICER by as much as a further 5000 pounds sterling which, with the revised estimates of disease-related costs, the small reduction in the effectiveness of abatacept, and the use of average mortality data from both men and women would generate an ICER in the region of 37,000 pounds sterling to 43,000 pounds sterling. The Committee, while recognising the innovative nature of the drug, the severity of the disease and the limitations around the use of HAQ in the economic modelling, concluded that abatacept would not be a cost-effective use of National Health Service (NHS) resources for patients for whom rituximab failed or in whom rituximab was contraindicated or not tolerated.

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

Abatacept is not recommended (within its marketing authorisation) for the treatment of people with rheumatoid arthritis.

Patients currently receiving abatacept for the treatment of rheumatoid arthritis 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 recommendation regarding the use of abatacept for the treatment of rheumatoid arthritis

POTENTIAL HARMS

Abatacept affects the immune system and may be associated with an increased risk of infections and malignancies. Because abatacept is administered by intravenous infusion, infusion-related reactions may also occur, including dizziness, headache and hypertension. The summary of product characteristics (SPC) does not recommend abatacept in combination with tumor necrosis factor (TNF)-alpha inhibitors, and while patients are making the transition to abatacept from TNF-alpha inhibitors they should be monitored for signs of infection.

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//TA141) [see also the "Availability of Companion Documents" field]).
    - Audit support for monitoring local practice.
    - A costing statement explaining the resource impact of this guidance.

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

Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Abatacept for the treatment of rheumatoid arthritis. London (UK): National Institute for Health and

Clinical Excellence (NICE); 2008 Apr. 29 p. (Technology appraisal guidance; no. 141).

ADAPTATION

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

DATE RELEASED

2008 Apr

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: Mr Brian Buckley, Chairman, Incontact; Professor Mike Campbell, Professor of Medical Statistics, University of Sheffield; Dr Carol Campbell; Senior Lecturer, University of Teesside; Professor David Chadwick, Professor of Neurology, Liverpool University; 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 Peter Jackson, Clinical Pharmacologist, the University of Sheffield; Professor Peter Jones, Pro Vice Chancellor for Research & Enterprise, Keele University; Ms Rachel Lewis, Nurse Advisor to the Department of Health; Dr Damien Longson, Consultant in Liaison Psychiatry, North Manchester General Hospital; Professor Jonathan Michaels, Professor of Vascular Surgery, University of Sheffield; Dr Eugene Milne, Deputy Medical Director, North East Strategic Health Authority; Dr Simon Mitchell, Consultant Neonatal Paediatrician, St Mary's Hospital, Manchester; Dr Richard Alexander Nakielny, Consultant Radiologist, Royal Hallamshire Hospital, Sheffield; Professor Andrew Stevens, Chair of Appraisal Committee C

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:

- Abatacept for the treatment of rheumatoid arthritis. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Apr. 2 p. (Technology appraisal 141). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Abatacept for the treatment of rheumatoid arthritis. Costing statement. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Apr. 1 p. (Technology appraisal 141). Available in Portable Document Format (PDF) from the NICE Web site.
- Abatacept for the treatment of rheumatoid arthritis. Audit support. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008. 4 p. (Technology appraisal 141). Available in Portable Document Format (PDF) from the NICE Web site.
- Abatacept for the treatment of rheumatoid arthritis. Evidence Review Group report. Liverpool Reviews and Implementation Group; 2007 May 31. 100 p. (Technology appraisal 141). 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: N1561. 11 Strand, London, WC2N 5HR.

PATIENT RESOURCES

The following is available:

- Abatacept for the treatment of rheumatoid arthritis. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Apr. 4 p. (Technology appraisal 141). 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: N1562. 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

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