FOR PUBLIC CONSULTATION ONLY

SPECIALISED COMMISSIONING - CLINICAL EVIDENCE EVALUATION CRITERIA FOR A PROPOSITION FOR A CLINICAL COMMISSIONING POLICY FOR ROUTINE COMMISSIONING

URN: E09X03
TITLE: Sodium oxybate for symptom control of narcolepsy with cataplexy (children)

CRG: Paediatric neurosciences
NPOC: Women and Children
Lead: Anthony Prudhoe

Date: 17th February 2016

The panel were presented a policy proposal for routine commissioning.

Question	**Conclusion of the panel**	**If there is a difference between the evidence review and the policy please give a commentary**
<u>The population</u> 1. Are the eligible and ineligible populations defined in the policy consistent with the evidence of effectiveness, and evidence of lack of effectiveness; and where evidence is not available for the populations considered in the evidence review?	The eligible population(s) defined in the policy are the same or similar to the population(s) for which there is evidence of effectiveness considered in the evidence review	The panel considered the application of adult evidence to post-pubescent children, weighing >40kg (the defined sub-group).
<u>Population subgroups</u> 2. Are any population subgroups defined in the policy and if so do they match the subgroups considered by the evidence review?	The population subgroups defined in the policy are the same or similar as those for which there is evidence in the evidence review	Inclusion criteria specifically defined the sub-group. The panel noted that the criteria for commissioning are based on clinical consensus rather than available evidence base.
<u>Outcomes - benefits</u> 3. Are the clinical benefits demonstrated in the	The clinical benefits demonstrated in the	The evidence identified shows benefits in reducing

evidence review consistent with the eligible population and/or subgroups presented in the policy?	evidence review support the eligible population and/or subgroups presented in the policy	cataplexy attacks for adults. Overall, the panel noted that the evidence in the adult population was strong. The panel therefore agreed that the clinical benefits can be extrapolated to the eligible population.
<u>Outcomes – harms</u> 4. Are the clinical harms demonstrated in the evidence review reflected in the eligible and / or ineligible population and/or subgroups presented in the policy?	The clinical harms demonstrated in the evidence review are not reflected in the eligible population and/or subgroups presented in the policy	The panel noted that there is evidence of harms included in the evidence base, including the risk of suicidal ideation. The panel noted that the harms are not sufficiently reflected in the criteria for commissioning and requested that these be changed to include psychological input before drug is administered.
<u>The intervention</u> 5. Is the intervention described in the policy the same or similar as the intervention for which evidence is presented in the evidence review?	The intervention described in the policy the same or similar as in the evidence review	
<u>The comparator</u> 6. Is the comparator in the policy the same as that in the evidence review? 7. Are the comparators in the evidence review the most plausible	The comparator in the policy is not the same as that in the evidence review. The comparators in the evidence review do not include plausible comparators for	The comparator in the evidence review is placebo.

comparators for patients in the English NHS and are they suitable for informing policy development.	patients in the English NHS and are not suitable for informing policy development.	
Advice The Panel should provide advice on matters relating to the evidence base and policy development and prioritisation. Advice may cover: • Uncertainty in the evidence base • Challenges in the clinical interpretation and applicability of policy in clinical practice • Challenges in ensuring policy is applied appropriately • Issues with regard to value for money • Likely changes in the pathway of care and therapeutic advances that may result in the need for policy review.		The panel noted that the policy can proceed as a routinely commissioned policy proposition, provided that: 1. Harms are clearly identified in the patient population; 2. That criteria for commissioning include psychological input; and 3. It is understood that Clinical Panel accepted the use of adult evidence can be extrapolated to post-pubescent children (the defined population).

Overall conclusions of the panel

The policy can proceed as a routine commissioning policy.

Report approved by:
James Palmer
Clinical panel Chair
17/2/16

Post meeting note:
The following changes have been addressed:

- Changed age range to ≤ 18 years
- Clearly identified the risk of harms
- Clearly identified the role of psychologist, incl. CAHMS