APPENDIX 1 STAKEHOLDER RESPONSES TO MO00X01 COMMISSIONING MEDICINES IN CHILDREN DRAFT POLICY PROPOSITION

Responder	Response	Recommended action
Royal College of Physicians	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our Young Adults and Adolescents Steering Group and would like to make the following comments. Our experts welcome this policy proposition but note that it should be made clear within the document that commissioning of medicines should not create a gap between adolescence and young adulthood (up to 25). Unless there are clear safety concerns, medicines that can be prescribed in adulthood should be eligible for adolescents if the benefit is thought to be equivalent. The other way around is also an issue, medicines prescribed in childhood should be equally available in young adulthood to support seamless care up to the age at least of 25. There are numerous examples (biologics, hearing aid provision) when the patient has been on medication/technology as a child but is not eligible for the same/funding as an adult. Our experts note that in some cases commissioning seems to be dictated by whether funding is requested by children's or adult services.	Noted That is not the purpose of the policy which specifically relates to those <18 who may not be covered by a current MA and therefore cannot access treatments recommended by NICE As above
British Pain Society	COMMENTS: Both the RCPCH and the BPS have current advice on the prescribing of medicines outside of their UK marketing authorisation. a) THE USE OF UNLICENSED MEDICINES OR LICENSED MEDICINES FOR UNLICENSED APPLICATIONS IN PAEDIATRIC PRACTICE. RCPCH 2013. b) Use of medicines outside of their UK marketing authorisation in pain management and palliative medicine. British Pain Society, in consultation with the Association of Palliative Medicine of Great Britain and Ireland 2012. COMMENTS: Not entirely. I am presuming that	Noted Noted – it will be

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	the current pathway is that presented in section 3 (Background). Commissioning stances do vary between CCGs across the country and there is sometimes confusion between what are "specialist" and "specialised" services and what these services are able to provide. I strongly suspect that not all off-license prescribing of NICE TA approved medicines results in an IFR.	made clear that the policy only pertains to specialised services only and not those commissioned by CCGs
	COMMENTS: It is not entirely clear to me exactly how the commissioning arrangements will work. Section 9 states "It is proposed that decisions about the commencement, monitoring and stopping of a treatment approved under this policy will be made by a specialist children's service": Section 11 states "NHS England will be responsible for commissioning treatments prescribed in line with this policy on behalf of the population of England. The medicine will be funded through local specialised commissioning teams." My understanding is that "Specialist" children's services are funded by CCGs and "Specialised" services by NHS England. As this policy is written, there does not appear to be a route for funding "specialised children's services", unless "specialist" in section 9 should be "specialised" in which case there is clear inequality between specialist and specialised services.	Noted - as above
	I presume the intention is that both "specialist" and "specialised" services should be able to prescribe, both funded by NHS England through local specialised commissioning teams. In the case of a "specialist" service, the medicine to be funded by NHS England and other aspects of care by CCGs.	Noted – as above
	COMMENTS: See section on health inequalities. However, apart from this, I highly commend the approach taken by the policy, particularly the removal of post-pubescent adolescents from the proposed use of the FDA methodology.	Noted
Healthcare Industry	The EMA draft paper on extrapolating of adult patient data for paediatric indications also supports the proposals in this policy. (April 2016)	Noted
	As the policy states, in lieu of a commissioning policy for children, the only option for funding treatments is to apply for treatment via the NHS England Individual Funding Request (IFR) process. This is not an appropriate route for	Noted

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	funding as often these patients represent a cohort and are not exceptional so are screened out of the process. This can lead to children being unintentionally penalised, resulting in them not having the same access to medicines as over 18 years old, despite the similarities between adult and paediatric patients.	
	This policy will reduce inequities associated with the IFR process. As the policy states, IFRs may or may not be screened out by the four regional teams, (usually due to lack of exceptionality) which can result in inconsistencies in funding across England. A national policy supporting the commissioning of medicines in children where they meet the NICE TA/NHS policy criteria that apply to adults is clinically appropriate and will reduce inequities in access to medicine across England.	Noted
	Children are unintentionally penalised under the current system. The number of children which can be subjected to studying a medicine is often restricted due to rarity of paediatric disease, heterogeneity of the paediatric population and issues around consent to enter clinical trials. Therefore it is not always possible to generate the full data set possible as is the case for the adult population. This leads to less available clinical data by age which is often used to support technology appraisals leading to routine commissioning. This proposed policy will help address this.	Noted
	Extrapolation from adult population clinical data can reduce paediatric data requirements to make decisions on the use of medicines in the paediatric population. This reduction in requirements is of benefit for ethical reasons as it minimises exposure of children to clinical trials and because the available paediatric population for study may be limited in number. Therefore the use of information from adult clinical trials (used to inform NICE TA) should be maximised, and this implementation of this policy is welcomed.	Noted
	How involved were NICE with the development of this proposal? Is NICE aligned to this policy? Will the publication of this policy mean that NICE will no longer topic select paediatric medicine	NICE are aware of the policy and will be able to comment during consultation That will be a NICE

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	where it already has a license for use in adults? What is the process if there is a variation between the license for adults and children? Section 7 regarding evidence base outlines "fundamental assumptions" derived from the FDA – is this set of assumptions to be used in each case – and what does "similar" mean in reality?	decision If the license is significantly different then a NICE TA or NHS England policy will be required That will be for the relevant PWG to determine
Healthcare Industry	Given the vulnerable populations covered by this policy, it is critical that treatments with specific licensed paediatric indications in which efficacy and safety have been established should be given priority over unlicensed treatments. This is also relevant in the context of biosimilar medicines whereby biosimilar versions may not be granted the same paediatric licensed indications as the originators, as has been seen with recent introduction of Benepali, without low dose formulations (1). In the event that a biosimilar is considered an appropriate option for a patient (if licensed or if no licensed treatments available), then NHSE's guidance provided in 'What is a Biosimilar Medicine?' (2) is relevant, and in particular the points below: • The decision to prescribe a biological medicine for an individual patient, whether an originator or biosimilar medicine, rests with the responsible clinician in consultation with the patient.* • At the time of dispensing, a biosimilar medicine should not be automatically substituted for the originator by the pharmacist. • In line with MHRA guidelines, biological medicines, including biosimilar medicines must be prescribed by brand name to support on-going pharmacovigilance of the individual products. *Clearly in the context of this policy, parent consent will be relevant. In these vulnerable populations, it may be inappropriate to consider switching a patient from an originator medicine to a biosimilar or between	Noted – this will be strengthened within the policy We would treat biosimilar medicines on the basis of their licensed indications Noted

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	biosimilars, even if both are licensed. In the event of a switch, a high degree of patient monitoring may be necessary. 1. Benepali Summary of Product Characteristics https://www.medicines.org.uk/emc/medicine/31511 [Accessed Aug-16] 2. 'What is a Biosimilar Medicine?' NHS England 2015. https://www.england.nhs.uk/wp-content/uploads/2015/09/biosimilar-guide.pdf [Accessed Aug-16] The Policy should make clear that unlicensed treatments should only be considered in the event that a patient is unsuitable for available licensed treatments due to contraindication. This should be made explicit in the Proposed Criteria for Commissioning. Given the vulnerable populations covered by this policy, it is critical that treatments with specific licensed paediatric indications in which efficacy and safety have been established should be given priority over unlicensed treatments. In addition, guidance should be included on the use of biosimilar medicines in these vulnerable populations.	Noted – as above
Specialised service provider/NHS Trust	As far as I am aware, rituximab is approved for treatment of paed nephrotic syndrome, however, this is not the same in adult nephrotic patients. Therefore, will paediatric patients still have funding approved from NHS England if this guidance is approved?	Yes
Faculty of Pain Medicine of the Royal College of Anaesthetists. (Professional Body)	COMMENTS: 1. A key issue will be having medications agreed by an 'appropriately constructed MDT'. The document indicates that this would not be for each individual patient, but more for each unit to decide what drugs they will use via some sort of consensus MDT meeting. This point could be clarified further. Having to agree drug use via an MDT for individual patients would potentially slow things down a lot. 2. Further clarification is required relating to the requirement for medication to be prescribed by "a specialist service" (section 9). It would be helpful to have clarification if this is "Paediatrics" or e.g " Paediatric Pain services" in the case of pain. Some DGHs do not have dedicated paediatric/ adolescent pain services.	NHS England feels that such an off label use of a medicine should go through an appropriately constructed MDT This policy relates to specialised services only

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	3. In section 8 the term '**specialised paediatric centre'** is used but in section 9 the term '**specialist children's service'** is used instead. From a commissioning service 'specialist' and 'specialised' are different types of pain services. Thus some confusion regarding this. The potential Elephant in the Room here is that every single medication off-license will have to go through Trust internal systems before they can be used by clinicians. The next question is what constitutes a Trust internal system....an MDT team (but what constitutes an acceptable MDT team for decision making) or is it D+T approval. Is DGH approval sufficient or do DGH's have to submit to a specialised unit etc. Surely having a central decision making framework within NHS England for agreeing all paediatric off-license usage would be a more sensible and efficient proposition rather than leaving it to individual hospitals. This could then feed into the commissioning process and only some additional IFR needed in exceptional situations.	Noted – it will be made clear that the policy only pertains to specialised services only and not those commissioned by CCGs NHS England would expect all off label use of drugs (not just those used in paediatrics) to go through a properly constructed governance process Noted – this is the key reason for the development of the policy but note point above re governance
Devices Manufacturer	We request that the scope of this policy be expanded to include medical devices where a medical device is approved for use by NICE TA or NHS England policy in the adult population but not in the paediatric population and the device is clinically appropriate for use in a child. Cutting-edge research and has to the development of countless innovative medical devices, allowing patients to live longer, healthier lives however, as with medicines, the paediatric population is often not included when a medical technology is being developed for a disease or condition in adults, and children are at risk of being left behind. The FDA have just recently (June 2016) finalised set of rules for the extrapolation if existing clinical data to paediatric uses of medical devices similar to the one for medicines that is referenced in this draft policy. See attached	This is not the scope for this policy. A separate policy for devices will be considered by the Clinical Panel based on this feedback.
Chief Pharmacist	The background section should acknowledge the introduction of the EU paediatric regulation in	The EU regulation will be added to the

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	2007, which seeks to drive licensing of medicines for children through an incentive/reward system of patent extension. Companies seeking a license for their product in the EU/UK are obliged to develop a Paediatric Investigation Plan or obtain a waiver excluding them from developing a PIP. It is misleading to suggest that it is "not often the case that paediatric patients are considered" when a product is being developed.	background section As these are not formal recommendations this will not be included
	Reference to the NICE ESUOM (Evidence summaries for unlicensed off-label medicines) process might also be valuable in the background; although these are not formal recommendations they provide support when considering the evidence base for IFRs.	Noted
	This will improve the current situation with regard to paediatric access to medicines, it will reduce clinician time spent on administrative tasks trying to gain access to medicines and will positively support the transition pathway from childhood to adult services for chronic illnesses.	Policy updated
	Section 4: The definition of off-label could be expanded to assist understanding. " Off-label- a term used to describe the use of a licensed medicine outside the terms of its marketing authorisation e.g. on the basis of age, dose, route, indication."	Policy updated
	Section 4: Pharmacokinetics is the study of absorption distribution metabolism and excretion. I agree bioavailability is relevant within the context of absorption but it is a reflection of the properties of the drug rather than the kinetic processes and is captured within absorption/distribution. It is not usually described as a pharmacokinetic process- I would suggest removing the term bioavailability.	Policy updated
	Section 6: Epidemiology and Needs assessment: For completion and accuracy please describe age in terms of years i.e. below the age of "18 years". Unlike adults, the units of age in paediatric also include days, weeks, months. Apologies if this sounds pedantic.	Policy updated
	Section 6: Epidemiology and Needs assessment: There is an **incorrect statement** in this section. An unlicensed medicine is a medicine that has not	

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	been approved by the regulatory authorities (typically an imported medicine, an extemporaneously prepared medicine, a medicine prepared under a specials manufacturing licence, or a manipulated medicine). A medicine which is not specifically licensed for use in children, but is licensed in adults and used to treat children is an off-label medicine. The term unlicensed medicine has been incorrectly applied.	
	Section 6: Epidemiology and Needs assessment: throughout the document the term "medicine" and "drug" are used interchangeably- use one term to be consistent.	Policy updated and term medicine used where appropriate
	Section 7 : Evidence base. I am sure most readers will know who the FDA are - but term should be expanded in full the first time it is used and it may be helpful to include it in the Definitions section.	Policy updated
	Section 7: Evidence base. The word" categorization" (5th paragraph) should be corrected to the anglicised spelling "categorisation"	Policy updated
	Section 7: Evidence base. Grammatical correction " The pharmacokinetic **processes** in adolescent patients **are** often similar to the pharmacokinetic **processes** in adults.	Policy updated
	Section 8: Proposed Criteria for Commissioning**.** Consider re-wording the first bullet point to read: **The medicine has a license for use in children and both the indication for use and the age of the child fall within those specified in the license**	Policy updated

PWG recommendations:

1. That the CLM approve updates to the policy as highlighted in the feedback
2. That the CLM agrees to a 30 day consultation of the policy

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