www.scottishmedicines.org.uk

SMC2729

spesolimab concentrate for solution for infusion (Spevigo®)

Boehringer Ingelheim Ltd

07 February 2025

The Scottish Medicines Consortium (SMC) has completed its assessment of the above product and advises NHS Boards and Area Drug and Therapeutic Committees (ADTCs) on its use in NHSScotland. The advice is summarised as follows:

ADVICE: following a full submission assessed under the orphan equivalent medicine process

spesolimab (Spevigo®) is not recommended for use within NHSScotland.

Indication under review: for the treatment of flares in adult patients with generalised pustular psoriasis (GPP) as monotherapy.

In a double-blind, phase II study, spesolimab, compared with placebo, significantly increased the proportion of adults with a moderate-to-severe flare of GPP who achieved pustular clearance.

The submitting company did not present a sufficiently robust clinical and economic analysis to gain acceptance by SMC.

This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting.

Chair
Scottish Medicines Consortium

1. Clinical Context

1.1. Medicine background

Spesolimab is a monoclonal antibody that blocks the interleukin 36 receptor (IL-36R), thereby supressing activation of pro-inflammatory and pro-fibrotic pathways associated with inflammatory skin diseases. Spesolimab is given as a single dose of 900 mg by intravenous (IV) infusion. If flare symptoms persist, an additional 900 mg dose may be administered 1 week after the initial dose. Treatment should be initiated and supervised by physicians experienced in the management of patients with inflammatory skin diseases.[1]

1.2. Disease background

Generalised pustular psoriasis (GPP) is a rare, severe, neutrophilic skin disease characterised by flares of widespread sterile pustules and erythema that can be associated with systemic inflammation. It can be relapsing-remitting or persistent with intermittent flares of increased severity and may be associated with infections, pregnancy, menstruation, stress or corticosteroid use or withdrawal. Cutaneous symptoms such as pustules, pain and itch are often the most troublesome and can impact mental health, with patients suffering anxiety, depression and social isolation. Systemic symptoms include fatigue and pyrexia. Severe flares may lead to sepsis and are associated with increased risks of failure in multiple organ systems, including the lung (acute respiratory distress syndrome), liver, kidney and cardiovascular shock. These may require hospital admission, with the most severe cases treated in intensive care units (ICU). The mortality rate for patients hospitalised with a GPP flare is 2.5% within 4 weeks. The pathology of GPP is not fully understood, but it has been suggested that loss-of-function mutations in the IL-36R antagonist gene, allow hyperactivation of IL-36 signalling leading to accumulation of neutrophils in the skin.[2]

1.3. Treatment pathway and relevant comparators

No other medicines are licensed for treatment of GPP flares. Management of moderate-to-severe episodes is based on off-label immunomodulatory medicines, including non-biologics, such as retinoids, methotrexate, cyclosporin and systemic corticosteroids, and biologics. The latter include tumour necrosis factor (TNF) inhibitors (adalimumab, infliximab and certolizumab pegol), interleukin-17 (IL-17) inhibitors (secukinumab, brodalumab and ixekizumab), and interleukin-23 (IL-23) inhibitors (risankizumab and guselkumab), with some of these licensed for treatment of GPP in other countries. Topical treatments are also used and include emollients, corticosteroids, calcipotriol and tacrolimus. Other treatments include phototherapy and antibiotics.[2,3]

1.4. Category for decision-making process

Eligibility for interim acceptance decision option

Spesolimab has conditional marketing authorisation from the Medicines and Healthcare Products Regulatory Agency (MHRA).

Eligibility for a PACE meeting

Spesolimab meets SMC orphan equivalent criteria.

2. Summary of Clinical Evidence

2.1. Evidence for the licensed indication under review

Clinical evidence is from the Effisayil-1 (1368-0013) study, detailed in Table 2.1.[2,3]

Table 2.1. Overview of relevant study.[2,3]

Criteria	Effisayil-1 (1368-0013) study
Study design	Double-blind, international, phase II study
Eligible patients	Adults (18 to 75 years) with GPP based on ERASPEN criteria with acute flare of moderate-to-severe intensity, defined by experiencing all the following: GPPPGA total score ≥ 3 (moderate); fresh pustules (new or worsening); GPPGA pustulation subscore ≥ 2 (mild); and ≥5% BSA affected by erythema and pustules.
Treatments	Day 1, double-blind, single dose of spesolimab 900 mg IV infusion or placebo. Day 2 to 7, if disease worsens, escape treatment with Investigator's choice. Day 8, all patients (placebo and spesolimab arm) who had not received escape treatment and had a GPPGA total score and GPPGA pustulation subscore of ≥2 could receive a single open-label dose of spesolimab 900 mg IV infusion. Day 8 to Week 12, patients who had achieved clinical response (GPPGA 0 or 1) with spesolimab or placebo at Day 1, or escape medication, or open-label spesolimab at Day 8, if they had recurrence of GPP flare (≥2 increase in GPPGA total score and GPPGA pustulation subscore ≥2) could receive a single rescue treatment with spesolimab 900 mg IV infusion. Systemic and topical therapies for GPP were discontinued prior to randomisation: biologics for ≥6 to 8 weeks; other systemic immunomodulators for ≥30 days; and phototherapy or topical therapy for ≥7 days.
Randomisation	Randomised in 2:1 ratio to spesolimab or placebo on Day 1 with stratification for Japanese versus non-Japanese ethnic group.
Primary outcome	Proportion of patients achieving GPPGA pustulation subscore 0 by Day 8.
Secondary outcome	Key secondary: proportion of patients achieving GPPGA total score 0 or 1 by Day 8.
Statistical analysis	The primary and key secondary outcome were controlled for multiplicity. High rates of crossover (from placebo to spesolimab) at Day 8 prevented the planned inferential analysis of secondary outcomes assessed at Week 4.

BSA = body surface area; ERASPEN = European Rare and Severe Psoriasis Expert Network; GPP = generalised pustular psoriasis; GPPGA = generalised pustular psoriasis physician global assessment; it is the average of three components (pustules, erythema and scaling/crusting), which are each scored separately from 0 to 4, where 0 is clear, 1 is almost clear, 2 is mild, 3 is moderate, and 4 is severe. The score is determined by the mean of the three components; it is 0 for mean of 0; 1 for mean >0 and <1.5; 2 for mean ≥1.5 and <2.5; 3 for mean ≥2.5 and <3.5; and 4 for mean ≥3.5.

Spesolimab, compared with placebo, significantly increased the proportion of patients achieving the primary outcome, generalised pustular psoriasis physician global assessment (GPPGA) pustular subscore of 0, and the key secondary outcome, GPPGA total score of 0 or 1, as detailed in Table 2.2. At Day 8, open-label spesolimab 900 mg was given to 83% (15/18) of the placebo group. This crossover prevented planned inferential analysis of secondary outcomes assessed at Week 4.[2,3]

Table 2.2: Primary and key secondary outcomes of Effisayil-1 study.[2,3]

Day 8	Spesolimab (n=35)	Placebo (n=18)	Difference (95% CI), p-value
GPPGA pustule subscore 0, % (n)	54% (19)	5.6% (1)	49% (22% to 67%), p<0.001
GPPGA total score 0 to 1, % (n)	43% (15)	11% (2)	32% (2.2% to 53%), p=0.012

CI = confidence intervals; GPPGA = generalised pustular psoriasis physician global assessment.

2.2. Health-related quality of life outcomes

Health-related quality of life (QoL) was assessed via pain visual analogue scale (VAS), Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-Fatigue), Dermatology Life Quality Index (DLQI) and Psoriasis Symptom Scale (PSS). These suggested improvements compared with baseline with spesolimab that were sustained to Week 12.[2,4]

2.3. Supportive studies

The ongoing, open-label, Effisayil-ON study included patients who had completed the Effisayil-1 or Effisayil-2 study (that assessed subcutaneous [SC] spesolimab for prevention of GPP flares) if they were without moderate-to-severe flare symptoms. Patients received spesolimab 300 mg SC every 12 weeks, if they did not have spesolimab IV rescue therapy in the preceding study, and every 4 or 6 weeks, if they had. In the event of a flare, patients could receive spesolimab 900 mg IV as rescue. This regimen differs from the current licence, which does not permit SC maintenance. A total of 39 patients from Effisayil-1 enrolled in Effisayil-ON and interim analysis indicate that ten patients were treated for a recurrent GPP flare. Five patients had one flare, four had two flares, and one had four flares (17 flare treatment periods). One week after the first flare treatment with IV spesolimab, five patients (50%) achieved a GPPGA pustulation subscore of 0. A GPPGA pustulation subscore of 0 was achieved in 41% (7/17) of the total flare treatment periods.[2,5]

2.4. Indirect evidence to support clinical and cost-effectiveness comparisons

There was a naïve indirect comparison with retrospective observational data for some of the patients included in the Effisayil-1 study who had previous flares and available data, referred to as the Effisayil-1 historical cohort study.[2,6]

Table 2.3: Summary of indirect treatment comparison.[2,6]

Criteria	Overview
Design	Naïve indirect comparison
Population	Patients recruited to the Effisayil-1 study with available data for previous flares.
Comparators	Undefined
Studies included	Retrospective historical cohort of patients in Effisayil-1 study
Outcomes	Duration of previous flares: typical flares (based on data from 37 patients); most severe flares (31 patients) and longest flares (14 patients); time to pustular resolution.
Results	Duration of a typical previous flare was up to 2 weeks for 43% (15/35) of patients and 57% (17/30) had pustular clearance in this timeframe. Duration of most severe previous flare was up to 2 weeks for 29% (9/31) of patients and 21% (6/28) had pustular clearance in this timeframe.

3. Summary of Safety Evidence

In Effisayil-1, during the first week of double-blind treatment with spesolimab or placebo, adverse events were reported by 66% (23/35) and 56% (10/18) of patients in the respective groups and were considered treatment related in 29% and 28%, with serious adverse events in 5.6% and 0. There were no discontinuations due to adverse events. The types of adverse events were similar across the groups and the safety profile was described as manageable by the regulator.[2,3]

In Effisayil-1, anti-drug antibodies (ADA) formed in 46% (23/50) of patients following IV spesolimab 900 mg, at a median onset of 2.3 weeks, with 24% of patients having maximum ADA titre >4000.

All ADA samples with titres >4000 were positive for neutralising antibodies (NAb). Median time to onset of NAb was 6.7 weeks. Females appeared to have a higher immunogenic response. It is not known if there is a relationship between ADA to spesolimab and maintenance of efficacy or hypersensitivity reactions upon re-treatment.[2]

The regulatory authority noted that the safety database for spesolimab in the treatment of GPP flares is very small, although it has been supplemented with data from studies in other indications. Data on long-term safety with repeated treatment of recurrent GPP flares is not comprehensive, and the regulator has granted a conditional marketing authorisation that requires collection of post-authorisation data on re-treatment of new flares and long-term maintenance of efficacy and safety (for example impact of ADA, hypersensitivity reactions, infections, safety of concomitant treatment). This is to be achieved through the planned open-label 1368-0120 study of spesolimab in the treatment of recurrent flares in adults with GPP. Final results are to be submitted to the regulatory authority by January 2028.[2]

4. Summary of Clinical Effectiveness Considerations

4.1. Key strengths

- In a double-blind, phase II study, spesolimab, compared with placebo, significantly increased the proportion of adults with a moderate-to-severe flare of GPP who achieved pustular clearance (GPPGA pustule subscore 0) by 49% and resolution of the episode to at least mild severity (GPPGA total score 0 or 1) by 32%. This was considered clinically meaningful by the regulator.[2,3]
- It is the first medicine to act by inhibition of IL-36 signalling and it is the first medicine specifically licensed for the treatment of GPP flares.

4.2. Key uncertainties

- Placebo-controlled data are limited as they are available only up to Day 8. On this day, 83% (15/18) of patients in the placebo group crossed over to receive spesolimab and 34% (12/35) in the spesolimab group had an open-label second dose of spesolimab. Therefore, there is a lack of controlled data or inferential analysis beyond this point and subsequent descriptive analysis of secondary outcomes, including health-related QoL, are difficult to interpret as patients who had escape medication or spesolimab open-label at Day 8 or as rescue were considered non-responders in analysis of subsequent binary and continuous outcomes.[2,3]
- The Effisayil-1 study uses placebo as a comparator, which is not representative of practice for the treatment of moderate-to-severe GPP. Defining relevant comparators is challenging as many of the medicines for GPP are used off-label in the UK.
- There are limitations with comparative data versus relevant alternative treatment options. Within the Effisayil-1 historical cohort analyses, which provide data for best available care, the medicines used to treat specific flares are not defined. There is information on all medicines previously used for flares, but this is not linked to a flare with specific outcomes.
- The comparison with best available care is limited because placebo-controlled data from the Effisayil-1 study inform Week 1, and this is not representative of practice, where active

treatment would be initiated at the earliest opportunity. The comparison after Week 1 with the Effisayil-1 historical cohort is naïve and the historical cohort analyses are limited by small sample size and available data (14 to 35 patients); retrospective, observational data collection; and lack of formal methods of assessing severity of disease (mild, moderate and severe) and outcomes (duration of flare and clearance of pustules) with categorisation at the investigator's discretion. Subgroups in the historical cohorts may have different baseline characteristics compared with the Effisayil-1 total study population, which included 7 patients (13%) without previous GPP flares who were not included in the historical cohort. The medicines used to treat the flares (most severe, longest and typical) are not detailed, therefore, comparator(s) are not defined.[2,6]

- Data for a second dose of spesolimab is limited to only 12 (34%) patients in Effisayil-1. Data for treatment of recurrent flares is limited by small patient numbers, that is, only 10 patients (17 flares) in Effisayil-ON, and by use of an unlicensed regimen, that included maintenance therapy. However, this may be addressed by the planned open-label 1368-0120 study designed to meet the requirements of the conditional marketing authorisation.[2]
- In the Effisayil-1 study, most patients at baseline had a moderate GPPGA score (81%) and evidence is limited in patients with more severe flares as less than 20% had a GPPGA score of 4. About 30% (16/53) of the study population were diagnosed with GPP within the preceding year, including 7 patients (13%) who had no previous flares, with the study flare being their diagnosis flare. There is also no evidence in patients with a milder flare or in those with flares that are life-threating or require intensive care as they were excluded from Effisayil-1.[2,3]

4.3. GB/EMA conditional marketing authorisation specific obligations (if applicable)

Spesolimab has a conditional marketing authorisation that requires collection of data on repeated treatment of recurrent flares and long-term maintenance of efficacy and safety through the open-label 1368-0120 study of spesolimab in adults with GPP. Final results are to be submitted to the regulatory authority by January 2028. This study will address the lack of long-term data, especially for treatment of recurrent flares. However, as it is uncontrolled, it may not provide useful comparative data versus relevant comparators.

The EMA specific obligations for ongoing study 1368-01200 may address some of the uncertainties in the clinical evidence presented. SMC can consider the interim acceptance decision option when encountering clinical uncertainty for medicines with a GB conditional marketing authorisation. However, the Committee considered that the ongoing study would be unlikely to address the key uncertainties, and the option of interim acceptance was not appropriate.

4.4. Clinical expert input

Clinical experts consulted by SMC advised that spesolimab would fill an unmet need in the treatment of GPP flares as the first medicine licensed specifically for this use, and is a therapeutic advance due to its novel mechanism of action and that it may be used in place of other systemic therapies.

5. Patient and clinician engagement (PACE)

A patient and clinician engagement (PACE) meeting with patient group representatives and clinical specialists was held to consider the added value of spesolimab, as an orphan equivalent medicine, in the context of treatments currently available in NHSScotland.

The key points expressed by the group were:

- Generalised pustular psoriasis (GPP) is a rare, chronic condition characterised by severe flares with painful, itchy pustule-covered skin and systemic symptoms that may be life-threatening. It has an immense psychological impact, reduces self-esteem, limits social interaction, and creates difficulties in work, education, caring for family, and maintaining relationships. Many patients suffer stress, anxiety, depression and live in chronic fear of the unpredictable flares. They are unable to plan for the future with confidence and many cannot maintain employment.

- The patient's family and friends may be required to help the patient manage the condition, attend appointments and provide emotional support. Family may need to take on some of their family caring or work and financial responsibilities.

- The management of GPP flares often requires a prolonged admission to HDU or ICU as care cannot be provided in general wards. Treatment includes frequent administration of topical creams and ointments that often do not adequately control the condition and can damage clothing and bedding. Non-biologic and biologic systemic medicines are used but require regular administration and monitoring, with some taking a long time to have an effect. None of these medicines are licensed for treatment of GPP flares or act via IL-36, which is believed to be involved in the development of GPP.

- Spesolimab is a targeted therapy that inhibits the effects of IL-36. It is licensed for treatment of flares of GPP and quickly relieves skin and systemic symptoms associated with these.

- Spesolimab's rapid effect may reduce the time the patient spends in hospital or allow them to avoid hospital admission. It would limit the period that they are at risk of complications, such as infection. Spesolimab would give the patient more time to enjoy with family and friends and allow the patient to return to work, education or family caring responsibilities. It may help their self-esteem and mental health, which will be further supported by the knowledge that they have access to a rapidly effective targeted therapy, thereby reducing their fear of future flares and giving confidence that the condition is manageable, and they can make plans or maintain employment.

- Accessing spesolimab may help the patient's family and friends by giving them more time to enjoy together while the patient is well. There may be reduced requirements for them to help the patient manage their condition and mental health. If spesolimab allows the

patient to maintain work or family caring responsibilities, this may provide practical help to their family.

- Clinical experts advise that spesolimab would be used first or second line for treatment of acute flares of GPP. They consider that it would be used when patients are being considered for possible admission to hospital.

Additional Patient and Carer Involvement

We received patient group submissions from the Psoriasis Association and the Psoriasis and Psoriatic Arthritis Alliance (PAPAA). The Psoriasis Association is a charitable incorporated organisation and PAPAA is a registered charity. The Psoriasis Association has received 9.25% pharmaceutical company funding in the past two years, with none from the submitting company. PAPAA has not received any pharmaceutical company funding in the past two years. Representatives from both patient groups participated in the PACE meeting. The key points of their submissions have been included in the full PACE statement considered by SMC.

6. Summary of Comparative Health Economic Evidence

6.1. Economic case

A summary of the economic analysis provided by the submitting company is outlined in table 6.1.

Table 6.1 Description of economic analysis

Criteria	Overview
Analysis type	Cost-utility analysis.
Time horizon	12 weeks.
Population	Adult patients with GPP as monotherapy.
Comparators	Spesolimab was compared against best available care (BAC), which comprised no active treatment in week 1 followed by a mix of TNF inhibitors (infliximab), IL-23 inhibitors (guselkumab),IL-17 inhibitors (secukinumab) and ustekinumab.
Model description	The submitting company presented a de novo Markov model with three health states: • GPP flare (defined as per the Effisayil-1 study: GPPGA score ≥ 3, new or worsening pustules, GPPGA pustulation subscore ≥ 2 and ≥ 5% of body surface area with erythema and the presence of pustules • Resolved flare (GPPGA pustulation subscore 0, 1) • Death Patients entered the model in the GPP flare state. Patients in the BAC arm received no active treatments in the first week of the model. The model had a cycle length of one day.
Clinical data	Clinical data used in the model were taken from the Effisayil-1 study[2,3] for the spesolimab arm and the inclusion of Effisayil-1 historical cohort[2,6] in the BAC arm via a naïve indirect treatment comparison.
Extrapolation	The submitting company selected a time horizon of 12 weeks to align with the length of the Effisayil-1 study. This meant no extrapolation was necessary.
Quality of life	EQ-5D-5L values were collected in the Effisayil-1 study. These values were mapped on to the EQ-5D-3L to estimate the utility values for the active flare and resolved flare health states. The utility value for patients in ICU was assumed to be zero.

Costs and resource use	Medicine costs included were acquisition costs, adverse event and administration costs. Other costs included disease management costs and end-of-life care costs. Hospitalisation rates for the BAC arm were obtained from Wolf et al. with an assumed 50% relative reduction in hospitalisations in the spesolimab arm based on effect of spesolimab on Day 2 responses.[7]
PAS	Patient access scheme (PAS) discounts are in place for guselkumab, secukinumab and ustekinumab and these were included in the results used for decision-making by using estimates of the comparator PAS prices.

6.2. Results

SMC considered results for decision-making that took into account all relevant PAS. SMC is unable to present these results due to competition law issues.

6.3. Sensitivity analyses

A range of sensitivity and scenario analyses were considered and descriptions of these key scenarios are provided in table 6.2 below.

Table 6.2 Sensitivity and Scenario Analysis

	Parameter	**Base case**	**Scenario**
1	BAC efficacy	Effisayil-1 evidence up to day 8	RWE from day 0
2	BAC efficacy	Typical flare from day 0	Typical flare from day 8
3	BAC weightings	55% most severe and 45% typical flares from day 0	100% most severe from day 0
4	BAC inpatient rate	Inpatient rate of 78%	Percentage based on SEE
5	BAC inpatient rate	Inpatient rate of 78%	Percentage (93%) based on literature (proportion of patients treated as inpatients: most severe flare)
6	Length of stay for ICU with MV	Capped	Not capped
7	Hospital costs	Scottish costs (dermatology)	Scottish costs (all specialities)
8	Spesolimab % of inpatients treated in ICU	50% of comparator	Equivalent to comparator
9	Inpatient rates	Relative reduction in inpatient rates with spesolimab 50%	Relative reduction 10%
10			Relative reduction 20%
11			Relative reduction 30%
12	GPP active flare utility values	Derived from EQ-5D data in Effisayil-1	Utility value increased
13			Utility value increased
14	Combined scenario		Relative reduction in inpatient rates 20%, utility value for active flare state increased, using historical data from day 0 in BAC arm
15	ICU utility	Utility of 0	No utility decrement for being in ICU
16	ICU admission rate	Higher ICU admission rate for BAC inpatients and 0% for spesolimab inpatients	ICU admission rate of 5% for both spesolimab and BAC
17	BAC inpatient rate	78%	30%

18	Maximum hospital length of stay	Estimated from SEE	Reduced to 3 days

Abbreviations: BAC = best available care; GPP = generalised pustular psoriasis; ICU = intensive care unit; MV = mechanical ventilation; RWE = real world evidence; SEE = structured expert elicitation.

6.4. Key strengths

- The model type was appropriate.
- The structured expert elicitation (SEE) performed to inform the resource use was well structured and comprehensive. These were based on the methodological approach by Bojke et al, 2021 and the Delphi technique.[8]

6.5. Key uncertainties

- A formal indirect comparison was not conducted. A naïve comparison was performed instead, relying on retrospective observational data. This approach introduces significant limitations and contributes to a high degree of uncertainty in the comparative efficacy estimates for the BAC arm. Consequently, the economic results, which are primarily driven by the assumed efficacy improvements with spesolimab, are subject to substantial uncertainty.
- The rates of hospitalisation in the model, including inpatient and ICU rates, which are key drivers of the results, are uncertain. SMC experts were consulted on this with some responses supporting the company's estimates but others suggested both the inpatient and ICU rates are higher than observed in clinical practice.
- Efficacy inputs for the BAC arm are based on placebo outcomes and no active treatments for week 1 in the model, which does not represent how patients would be treated in practice. This is likely to underestimate efficacy in the BAC arm and bias results in favour of spesolimab. Results were sensitive to applying the RWE estimates from day 0.
- The model time horizon may not be appropriate if patients can be offered additional doses of spesolimab after 12 weeks. Whilst this time horizon models the time from treatment initiation to flare resolution, it does not capture the time from resolution to a potential new flare and the long-term effects are therefore unknown.
- The utility value of an ICU stay is highly uncertain, but sensitivity analysis showed this was not a key driver of the results.
- It is uncertain if the basket of best available care (BAC) is the most relevant comparator.
- Assigning equal resource use and efficacy outcomes for patients with different GPPGA pustulation subscores is not appropriate.

*Other data were also assessed but remain confidential.**

7. Conclusion

The Committee considered the benefits of spesolimab in the context of the SMC decision modifiers that can be applied when encountering high cost-effectiveness ratios and agreed that as spesolimab is an orphan equivalent medicine, SMC can accept greater uncertainty in the economic case.

After considering all the available evidence and the output from the PACE process, the Committee was unable to accept spesolimab for use in NHSScotland.

8. Guidelines and Protocols

No relevant guidelines were identified.

9. Additional Information

9.1. Product availability date

November 2023

Table 9.1 List price of medicine under review

Medicine	Dose regimen	Cost per course (£)
Spesolimab	900 mg IV infusion on Day 1, with optional extra dose on Day 8	**15,000 to 30,000**

Costs from BNF online on 6th November 2024. Costs calculated using the full cost of vials/ampoules assuming wastage. Costs do not take any patient access schemes into consideration.

10. Company Estimate of Eligible Population and Estimated Budget Impact

The submitting company estimated there would be 145 patients eligible for treatment with spesolimab in year 1 and 146 in year 5 estimates.

SMC is unable to publish the budget impact due to commercial in confidence issues.

*Other data were also assessed but remain confidential.**

References

1. Boehringer Ingelheim International GmbH. Summary of Product Characteristics. Spevigo 450 mg concentrate for solution for infusion (SPC). 2023. Available at: https://mhraproducts4853.blob.core.windows.net/docs/a309d0aa2dd806ac31c5ee92f28f67abe63e5a3f. Accessed: 25 June 2024.

2. European Medicines Agency (EMA). European Public Assessment Report: Spevigo 450mg concentrate for solution for infusion. 2022. Available at: https://www.ema.europa.eu/en/documents/assessment-report/spevigo-epar-public- assessment-report_en.pdf. Accessed: 25 June.

3. Bachelez H, Choon SE, Marrakchi S, et al. Trial of Spesolimab for Generalized Pustular Psoriasis. N Engl J Med. 2021; 385(26):2431-40.

4. Navarini AA, Prinz JC, Morita A, et al. Spesolimab improves patient-reported outcomes in patients with generalized pustular psoriasis: Results from the Effisayil 1 study. J Eur Acad Dermatol Venereol. 2023; 37(4):730-6.

5. Navarini AA, Bachelez H, Choon SE, et al. 43008 Effisayil ON, an open-label, longterm extension study of spesolimab treatment in patients with generalized pustular psoriasis: interim results for flare treatment. Journal of the American Academy of Dermatology. 2023; 89(3): AB44

6. Choon SE, Lebwohl MG, Turki H, et al. Clinical Characteristics and Outcomes of Generalized Pustular Psoriasis Flares. Dermatology. 2023; 239(3):345-54.

7. Wolf P, Ceovic R, Conrad C, et al. Characteristics and management of generalized pustular psoriasis (GPP): Experience from the Central and Eastern Europe (CEE) GPP Expert Network. J Eur Acad Dermatol and Venereol 2024; 38(8): 1531-42.

8. Bojke L, Soares M, Claxton K, et al. Developing a reference protocol for structured expert elicitation in health-care decision-making: a mixed-methods study. Health Technol Assess 2021; 25(37): 1-124.

This assessment is based on data submitted by the applicant company up to and including 13 December 2024.

**Agreement between the Association of the British Pharmaceutical Industry (ABPI) and the SMC on guidelines for the release of company data into the public domain during a health technology appraisal:*https://www.scottishmedicines.org.uk/about-us/policies-publications/

Medicine prices are those available at the time the papers were issued to SMC for consideration. SMC is aware that for some hospital-only products national or local contracts may be in place for comparator products that can significantly reduce the acquisition cost to Health Boards. These contract prices are commercial in confidence and cannot be put in the public domain, including via the SMC Detailed Advice Document. Area Drug and Therapeutics Committees and NHS Boards are therefore asked to consider contract pricing when reviewing advice on medicines accepted by SMC.

Patient access schemes: A patient access scheme is a scheme proposed by a pharmaceutical company in order to improve the cost-effectiveness of a medicine and enable patients to receive

access to cost-effective innovative medicines. A Patient Access Scheme Assessment Group (PASAG), established under the auspices of NHS National Services Scotland reviews and advises NHSScotland on the feasibility of proposed schemes for implementation. The PASAG operates separately from SMC in order to maintain the integrity and independence of the assessment process of the SMC. When SMC accepts a medicine for use in NHSScotland on the basis of a patient access scheme that has been considered feasible by PASAG, a set of guidance notes on the operation of the scheme will be circulated to Area Drug and Therapeutics Committees and NHS Boards prior to publication of SMC advice.

Advice context:

No part of this advice may be used without the whole of the advice being quoted in full.

This advice represents the view of the Scottish Medicines Consortium and was arrived at after careful consideration and evaluation of the available evidence. It is provided to inform the considerations of Area Drug & Therapeutics Committees and NHS Boards in Scotland in determining medicines for local use or local formulary inclusion. This advice does not override the individual responsibility of health professionals to make decisions in the exercise of their clinical judgement in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.