NHS Devon

NICE Update Bulletin: February 2026

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Technology Appraisals (TAs)

Canagliflozin for treating type 2 diabetes in people 10 to 17 years (terminated appraisal) TA1137

NICE is **unable to make a recommendation** on canagliflozin for treating type 2 diabetes in children and young people 10 to 17 years. This is because the company did not provide an evidence submission.

Bevacizumab (originator and biosimilars) with fluoropyrimidine-based chemotherapy for metastatic colorectal cancer TA1136

This guidance updates and replaces NICE technology appraisal guidance on bevacizumab in combination with oxaliplatin and either fluorouracil plus folinic acid or capecitabine for the treatment of metastatic colorectal cancer (TA212). It also partially updates TA242 on cetuximab, bevacizumab and panitumumab for the treatment of metastatic colorectal cancer after first-line chemotherapy and TA118 on bevacizumab and cetuximab for the treatment of metastatic colorectal cancer.

Recommendation

Bevacizumab (originator and biosimilars) with fluoropyrimidine-based chemotherapy **can be used** as an option to treat metastatic colorectal carcinoma in adults:

- as first- and second-line treatment only, when
- targeted treatments or immunotherapy are unsuitable, and
- chemotherapy would otherwise be offered.

Bevacizumab with fluoropyrimidine-based chemotherapy can only be used if the companies have an agreed price within the Medicines Procurement and Supply Chain.

This recommendation is not intended to affect treatment with bevacizumab with fluoropyrimidine-based chemotherapy that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

Metastatic colorectal cancer (mCRC) is a tumour arising from the lining of the large intestine (colon and rectum) that has spread beyond the large intestine, most often to the liver, lungs or peritoneum. The aim of treatment for mCRC is to prolong survival and improve quality of life.

Bevacizumab (originator and biosimilars) with fluoropyrimidine-based chemotherapy is indicated for the treatment of adult patients with metastatic carcinoma of the colon or rectum.

Usual first- and second-line treatment for metastatic colorectal cancer when targeted treatments or immunotherapy are not suitable is fluoropyrimidine-based chemotherapy alone. Bevacizumab would be used as well as chemotherapy.

The recommended dose of bevacizumab is either 5 mg or 10 mg per kilogram of body weight given once every 2 weeks, or 7.5 mg or 15 mg per kilogram of body weight given once every 3 weeks.

Bevacizumab will be added to existing intravenous chemotherapy regimens; therefore, people will receive one extra infusion. The extra infusion is given over 30 minutes (after good tolerance of the first dose which is given over 90 minutes).

Financial Factors

This technology is commissioned by NHS England.

Nationally available price reductions for bevacizumab (originator and biosimilars) have been agreed with the Medicines Procurement and Supply Chain. The prices agreed through the framework are commercial in confidence.

The payment mechanism for the technology is determined by the responsible commissioner and depends on the technology being classified as high cost.

Evidence shows that bevacizumab plus chemotherapy increases how long people have before their cancer gets worse and how long they live compared with placebo plus chemotherapy.

NICE estimate that in year 3, 158 people in Devon will be eligible for first line treatment, and 144 eligible for second line treatment.

Baloxavir marboxil for treating and preventing influenza in children 1 to 11 years (terminated appraisal) TA1135

NICE is **unable to make a recommendation** on baloxavir marboxil for treating and preventing influenza in children 1 to 11 years. This is because the company did not provide an evidence submission.

Dupilumab for treating severe chronic rhinosinusitis with nasal polyps TA1134

This guidance updates and replaces NICE technology appraisal guidance on dupilumab for treating chronic rhinosinusitis with nasal polyps (terminated appraisal; TA648).

Recommendation

Dupilumab, as an add-on to intranasal corticosteroids, **can be used** as an option to treat severe chronic rhinosinusitis with nasal polyps in adults if:

- the condition is not controlled well enough by systemic corticosteroids or sinus surgery, and
- they have had at least 1 sinus surgery, and
- the 22-item sinonasal outcomes test (SNOT-22) score is at least 50, and
- the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with dupilumab that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

Chronic rhinosinusitis is a condition in which the lining of the sinuses (air-filled spaces behind the nose, eyes and cheeks) becomes inflamed. It is characterised by symptoms including nasal congestion, discharge, decreased or lost sense of smell, facial pain and headache, which may last many years. Rhinosinusitis is considered chronic when symptoms persist for more than 12 weeks. People with the condition may have nasal polyps, which is also referred to as nasal polyposis. If nasal polyps are also present, the condition is referred to as chronic rhinosinusitis with nasal polyps (CRSwNP). These are growths inside the nasal passages and sinuses, which usually only cause problems if they are large or grow in clusters, causing an obstruction. Additional symptoms of nasal polyps include a blocked nose, snoring and obstructive sleep apnoea (which can disturb sleep).

The cause of chronic rhinosinusitis with nasal polyposis is unknown, but multiple factors including allergies and fungal infection, are known to be contributory factors. Chronic rhinosinusitis is common, affecting around 10% of the UK population. Among all people with chronic rhinosinusitis, around 25% to 30% have CRSwNP. It is estimated that there were 476 cases of CRSwNP per 100,000 people in England in 2018, with prevalence highest in men aged 65 to 84 years.

The goal of treatment is to control inflammation and reduce the size of polyps or eliminate them. CRSwNP may present as a distinct entity or alongside comorbidities such as asthma, non-steroidal anti-inflammatory drug-exacerbated respiratory disease and fungal allergy. Each case may have a slightly different treatment pathway but generally treatments can include saline irrigation as well as intranasal, oral or injectable corticosteroids. Surgery is frequently needed, but it does not always provide a permanent solution because polyps tend to recur.

Dupilumab is indicated as an add-on therapy with intranasal corticosteroids for the treatment of adults with severe CRSwNP (chronic rhinosinusitis with nasal polyposis) for whom therapy with systemic corticosteroids and/or surgery do not provide adequate disease control.

Financial Factors

This technology is commissioned by NHS England.

The company has a commercial arrangement. This makes dupilumab available to the NHS with a discount. The size of the discount is commercial in confidence.

The payment mechanism for the technology is determined by the responsible commissioner and depends on the technology being classified as high cost.

Usual treatment for severe chronic rhinosinusitis with nasal polyps that is not controlled well enough by systemic corticosteroids or sinus surgery, or both, includes further corticosteroids (intranasal and systemic) and further sinus surgery.

Clinical trial evidence suggests that dupilumab plus usual treatment reduces symptoms and nasal polyp size compared with placebo plus usual treatment.

Dupilumab is intended for long-term treatment. It is administered subcutaneously and is assumed to be administered at home via a homecare service.

Standard care costs have been excluded because the costs are minimal. It is also expected that their use will be similar before and after the introduction of dupilumab because dupilumab is an add-on to intranasal corticosteroids, which is the current standard care treatment.

As people start treatment with dupilumab there will be a reduction in endoscopic sinonasal surgeries due to the condition being controlled in more people.

NICE estimate that in year 3, 173 people in Devon will be eligible for treatment, with a 50% uptake.

Belantamab mafodotin with pomalidomide and dexamethasone for previously treated multiple myeloma TA1133

Recommendation

Belantamab mafodotin plus pomalidomide and dexamethasone **can be used** as an option to treat multiple myeloma in adults, if:

- they have only had 1 line of treatment and that contained lenalidomide
- lenalidomide is not tolerated or the condition is refractory to it

Belantamab mafodotin can only be used if the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with belantamab mafodotin plus pomalidomide and dexamethasone that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

Multiple myeloma is a form of cancer that arises from plasma cells (a type of white blood cell) in the bone marrow. Myeloma cells produce large quantities of an abnormal antibody, known as paraprotein. Unlike normal antibodies, paraprotein has no useful function and lacks the capacity to fight infection. Myeloma cells suppress the development of normal blood cells that are responsible for fighting infection (white blood cells), carrying oxygen around the body (red blood cells) and blood clotting (platelets). The term multiple myeloma refers to the presence of more than one site of affected bone at the time of diagnosis. People with multiple myeloma can experience bone pain, bone fractures, tiredness (due to anaemia), infections, hypercalcaemia (too much calcium in the blood) and kidney problems.

Approximately 5,000 people are diagnosed with multiple myeloma in England each year (2016 to 2018 data). Five-year prevalence of multiple myeloma in the UK is estimated to be 26 per 100,000. It is most frequently diagnosed in older people, with about 43% of new cases of multiple myeloma in England in people aged 75 years or older. The 10-year survival rate for people with multiple myeloma in England is estimated to be 29%.3 The incidence rates are reported to be lower in the Asian ethnic group, higher in the Black ethnic group, and similar in people of mixed or multiple ethnicity, compared with the White ethnic group, in England (2013-2017 data).

The main aims of therapy are to prolong survival and maintain a good quality of life by controlling the condition and relieving symptoms. If the condition progresses after initial treatment, the choice of subsequent therapy is influenced by previous treatment and response to it, duration of remission, comorbidities and patient preference.

Belantamab mafodotin is indicated in combination with pomalidomide and dexamethasone for the treatment of adults with multiple myeloma who have had at least one prior therapy including lenalidomide.

Financial Factors

This technology is commissioned by NHS England.

The company has a commercial arrangement (simple discount patient access scheme) for belantamab mafodotin. This makes it available to the NHS with a discount. The size of the discount is commercial in confidence.

The payment mechanism for the technology is determined by the responsible commissioner and depends on the technology being classified as high cost.

There are nationally available price reductions for pomalidomide with the Medicines Procurement and Supply Chain. The prices agreed through the framework are commercial in confidence.

Indirect comparisons suggest that belantamab mafodotin plus pomalidomide and dexamethasone increases how long people have before their condition gets worse compared with:

- carfilzomib plus dexamethasone

- daratumumab plus bortezomib and dexamethasone
- selinexor plus bortezomib and dexamethasone.

There will be additional capacity needs because the Cancer Drugs Fund clinical lead highlighted that everyone must have:

- an ophthalmic eye exam before each of the first 4 doses of belantamab mafodotin
- subsequent monitoring in the event of eye-related adverse events.

There may be a capacity savings because fewer administrations are needed for belantamab mafodotin plus pomalidomide and dexamethasone than with daratumumab plus bortezomib and dexamethasone in year 1.

NICE estimate that in year 3, 37 people in Devon will be eligible for treatment, with 18 having belantamab mafodotin with pomalidomide and dexamethasone each year.

Ruxolitinib for treating moderate to severe chronic graft versus host disease after an allogeneic stem cell transplant in people 28 days to 17 years (terminated appraisal) TA1132

NICE is **unable to make a recommendation** on ruxolitinib for treating moderate to severe chronic graft-versus-host disease after an allogeneic stem cell transplant in people 28 days to 17 years. This is because the company did not provide an evidence submission.

Obinutuzumab with mycophenolate mofetil for treating lupus nephritis TA1131

Recommendation

Obinutuzumab plus mycophenolate mofetil **can be used**, within its marketing authorisation, as an option to treat active class 3 or 4 (with or without class 5) lupus nephritis in adults. It can only be used if the company provides obinutuzumab according to the commercial arrangement.

The Technology

Systemic lupus erythematosus (SLE) is a chronic autoimmune condition that causes inflammation in the body's tissues. The manifestations of SLE vary greatly between people and can affect the whole body including the skin, joints, internal organs and serous membranes.

In some people with SLE, the body’s immune system targets kidney cells, particularly the filtering units called glomeruli, resulting in inflammation. This complication is called lupus nephritis. Lupus nephritis is divided into classes (1 to 6), based on glomerular pathology, following a kidney biopsy. Common signs and symptoms of lupus nephritis include blood or foam in urine, swelling in extremities, and high blood pressure. Untreated lupus nephritis can permanently damage kidneys. People with lupus nephritis are at increased risk of developing end-stage renal disease, which requires lifelong dialysis or kidney transplantation. Lupus nephritis has an increased mortality risk compared with SLE without lupus nephritis.

There are currently around 60,000 people with SLE in England and Wales and around 3,000 people are diagnosed with SLE each year. Up to 60% of people with SLE develop lupus nephritis. Compared with people who are described as white, the prevalence of lupus nephritis is around 4, 18 and 19 times higher, respectively, among those with Indo-Asian, Afro-Caribbean and Chinese family backgrounds. People from ethnic minority groups may also have more severe disease that is less likely to respond to some treatment. Lupus nephritis is also more prevalent in women than in men, but men may be more likely to present with more severe disease.

There is no cure for lupus nephritis. The aim of current treatments for lupus nephritis is to preserve renal function, prevent disease flares, improve quality of life, and improve survival. Because lupus nephritis has a relapsing and remitting pattern, treatments are used to either induce or maintain remission. Most people will have hydroxychloroquine and corticosteroids alongside an immunosuppressive. The choice of immunosuppressive agent varies. The immunosuppressives used to induce remission include mycophenolate, cyclophosphamide, rituximab with mycophenolate, and tacrolimus with or without mycophenolate. NICE TA882 (2023) also recommends voclosporin, a calcineurin inhibitor, with mycophenolate mofetil for treating active class 3 to 5 (including mixed class 3 and 5, and 4 and 5) lupus nephritis in adults. Maintenance treatments include mycophenolate, azathioprine or tacrolimus monotherapy. However, despite treatment, many people do not have sustained kidney remission so remain at risk of developing progressive chronic kidney disease, and end stage kidney disease.

Obinutuzumab, in combination with mycophenolate mofetil (MMF) is indicated for the treatment of adult patients with active Class III or IV, with or without concomitant Class V, lupus nephritis (LN).

First treatment for lupus nephritis is usually mycophenolate mofetil (MMF) with corticosteroids (referred to as MMF alone from now). If MMF alone is insufficient to induce remission, another treatment is added. The comparator treatments for the eligible population are MMF alone or in combination with rituximab, belimumab or voclosporin. Rituximab is the main comparator, and the resource impact template assumes that obinutuzumab will displace use of rituximab.

Obinutuzumab and rituximab are intravenous treatments. Belimumab can be administered intravenously or via subcutaneous injection. MMF and voclosporin are oral treatments.

Financial Factors

This technology is commissioned by NHS England.

The company has a commercial arrangement. This makes obinutuzumab available to the NHS at a discount.

The payment mechanism for the technology is determined by the responsible commissioner and depends on whether the technology is classified as high cost.

The key drivers of resource impact are that:

- Obinutuzumab is an intravenous treatment. It is assumed that it will displace the use of rituximab, which is also administered intravenously. Obinutuzumab however requires 2 more administrations than rituximab in the initial year of treatment. If any oral treatments are displaced there will be a greater capacity impact.
- The infusion time for obinutuzumab is longer than rituximab.
- Effective treatment options for people with lupus nephritis would result in them being less likely to require dialysis or renal transplant.

NICE estimate that in year 3, 261 people in Devon will be eligible for treatment, with 105 having obinutuzumab each year.

Talazoparib with enzalutamide for untreated hormone-relapsed metastatic prostate cancer TA1130

Recommendation

Talazoparib with enzalutamide **can be used** as an option for untreated hormone-relapsed metastatic prostate cancer in adults, only when:

- chemotherapy is not clinically indicated and
- abiraterone plus prednisolone is not tolerated, or
- there are clinical conditions that preclude the use of abiraterone plus prednisolone, and
- the companies provide talazoparib and enzalutamide according to their commercial arrangements.

This recommendation is not intended to affect treatment with talazoparib with enzalutamide that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

Prostate cancer is a condition in which tumours develop in the prostate, a gland in the male reproductive system. The exact cause is unknown but environmental and genetic factors are associated with an increased risk of developing prostate cancer.

Prostate cancer is the most common cancer in men, and the incidence increases with age. It is more common in those who have a family history of prostate cancer, in black African men compared to white men, and is least common in Asian men.

In England and Wales, around 45,885 people were newly diagnosed with prostate cancer between 2019 and 2020. Of this, 13% had metastatic disease, that is, disease that has spread to other parts of the body. In 2019, around 12,000 people died from prostate cancer.

Talazoparib is indicated in combination with enzalutamide for the treatment of adult patients with metastatic castration-resistant prostate cancer (mCRPC) in whom chemotherapy is not clinically indicated.

Usual treatment for untreated hormone-relapsed metastatic prostate cancer is abiraterone plus prednisolone, enzalutamide alone, or olaparib plus abiraterone and prednisolone.

Talazoparib with enzalutamide will be prescribed in secondary care with routine follow-up in secondary care. They are both administered orally as once daily tablets.

Financial Factors

This technology is commissioned by NHS England.

Pfizer has a commercial arrangement for talazoparib. This makes talazoparib available to the NHS with a discount. The size of the discount is commercial in confidence.

Astellas has a commercial arrangement for enzalutamide. This makes enzalutamide available to the NHS with a discount. The size of the discount is commercial in confidence.

The payment mechanism for the technology is determined by the responsible commissioner and depends on the technology being classified as high cost.

Clinical trial evidence shows that talazoparib plus enzalutamide increases how long people have before their condition gets worse and how long people live compared with placebo plus enzalutamide.

NICE estimate that in year 3, 54 people in Devon will be eligible for treatment, with 8 receiving talazoparib plus enzalutamide.

Niraparib for maintenance treatment of advanced ovarian, fallopian tube and peritoneal cancer after response to first-line platinum-based chemotherapy TA1129

Recommendation

Niraparib **can be used** as an option for the maintenance treatment of advanced epithelial (FIGO stages 3 and 4) high-grade ovarian, fallopian tube or primary peritoneal cancer after a response to first-line platinum-based chemotherapy in adults, only if:

- they did not have or could not tolerate bevacizumab as part of first-line induction chemotherapy
- the company provides niraparib according to the commercial arrangement.

This recommendation is not intended to affect maintenance treatment with niraparib for advanced (FIGO stages 3 and 4) high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer after response to first-line platinum-based chemotherapy that was started in the Cancer Drugs

Fund before this guidance was published and that is not covered by the recommendation. For those people, niraparib will be funded by the company until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

Ovarian cancer is a cancerous growth that occurs in different parts of the ovary or fallopian tubes. The most common type of ovarian cancer, high-grade serous carcinoma, is thought to arise from the fallopian tube and presents after it has spread to the ovary. Ovarian cancer is classified from stage 1 to stage 4. Advanced ovarian cancer falls within stages 2 and 4; in stage 2 the disease has grown outside the ovaries but is still within the pelvic area, stage 3 denotes disease that has spread outside the pelvis into the abdominal cavity, and stage 4 denotes that distant metastasis to other body organs such as the liver and the pleura (two thin layers of tissue that protect and cushion the lungs) has occurred. Most people are diagnosed with advanced stage disease. Some people have gene mutations that may increase the risk of ovarian cancer. Mutated inherited genes that increase the risk of ovarian cancer include BRCA 1 and 2.

Ovarian cancer rates in the UK have remained stable since the early 1990s. The incidence of ovarian cancer increases with age, with incidence rates being highest in females aged 75 to 79. In 2022, 7,078 people were diagnosed with ovarian cancer in England. There were 3,564 deaths due to ovarian cancer in 2020. The 5-year survival for women diagnosed with ovarian cancer between 2016 and 2020, in England was 45%. NICE guideline NG241 states that the rate of familial ovarian cancer is higher in people from Ashkenazi Jewish backgrounds.

Niraparib is indicated as a monotherapy for the maintenance treatment of adult patients with advanced epithelial (FIGO Stages III and IV) high-grade ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy.

The treatment options for the eligible population are niraparib, rucaparib and olaparib. Bevacizumab-based regimens (bevacizumab monotherapy, olaparib with bevacizumab) are options for people who have had bevacizumab as part of their first-line chemotherapy, but as the recommendation is for people for whom bevacizumab is not an option, these regimens are excluded from the template.

Niraparib is currently available in the CDF, and the uptake of the treatment options is not expected to change as niraparib becomes available in routine commissioning.

All the relevant treatments in this eligible population are oral.

Financial Factors

This technology is commissioned by NHS England.

The company has a commercial arrangement. This makes niraparib available to the NHS at a discount.

The payment mechanism for the technology is determined by the responsible commissioner and depends on whether the technology is classified as high cost.

As niraparib is available currently in the cancer drugs fund (CDF) and has been in use for some time, there is not expected to be a capacity impact as the use of niraparib is not expected to change.

NICE estimate that in year 3, 25 people in Devon will be eligible for treatment, with 11 having niraparib.

Targeted-release budesonide for treating primary IgA nephropathy TA1128

This guidance updates and replaces NICE technology appraisal guidance on targeted-release budesonide for treating primary IgA nephropathy (TA937).

Recommendation

Targeted-release budesonide **can be used** as an option to treat primary immunoglobulin A nephropathy (IgAN) in adults when:

- they have:
    - a urine protein-to-creatinine ratio (UPCR) of 90 mg/mmol or more or
    - a protein excretion of 1.0 g/day or more, and
- it is used as an add-on to optimised standard care that includes, unless contraindicated:
    - the highest tolerated licensed dose of renin-angiotensin system inhibitors (RASi) or
    - a dual endothelin angiotensin-receptor antagonist (DEARA), and
- the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with targeted-release budesonide that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

IgA nephropathy (also known as Berger's disease) is a chronic autoimmune kidney disease. It causes a build-up of IgA containing immune complexes in the glomeruli of the kidneys. This causes inflammation and damage in the glomeruli and reduces their function, eventually leading to scarring of the whole kidney. In IgA nephropathy, both kidneys are affected equally. The condition is commonly classified as primary or secondary, with secondary disease associated with comorbidities such as IgA vasculitis and chronic liver disease. The presentation of IgA nephropathy varies considerably and, in its early stages, may have no symptoms. The most

common symptoms are blood or protein in the urine (haematuria or proteinuria). IgA nephropathy is also associated with complications from reduced kidney function including high blood pressure, high cholesterol and cardiovascular problems. The rate of progression is variable, although ongoing decline in glomerular function may eventually lead to kidney failure, requiring transplant or life-long dialysis. A particularly severe form, known as rapidly progressive IgA nephropathy, has been reported in a small proportion of people who are at higher risk of progressive kidney function loss.

It is estimated that around 4 in 10,000 people have primary IgA nephropathy in Europe. Most people progress to ESRD within 10 to 15 years of diagnosis with all at risk of ESRD within their expected lifetime unless an eGFR rate loss ≤1 ml/min per 1.73 m^2 per year can be maintained from diagnosis.

There is no cure for IgA nephropathy. The aim of current treatment is to prevent or delay kidney failure and associated complications. Initial treatment focuses on reducing protein levels in the urine and blood pressure.

Targeted-release budesonide is indicated for the treatment of adults with primary immunoglobulin A nephropathy (IgAN) with a urine protein excretion ≥1.0 g/day (or urine protein-to-creatinine ratio ≥0.8 g/gram).

Financial Factors

This technology is commissioned by ICBs.

The company has a commercial arrangement. This makes budesonide available to the NHS at a discount.

Based on the company's economic modelling, the use of budesonide is associated with more adverse events (reported as mild to moderate in intensity) relative to standard care.

Any potential costs are additional because budesonide is prescribed alongside optimised standard care.

There may be cost savings through reduced downstream expenditure on dialysis and potential kidney transplantation. Evidence indicates that targeted-release budesonide reduces chronic kidney disease progression to stages, for which dialysis and, in some cases, transplantation is required. However, the amount and timing of these savings are uncertain. It is anticipated that any dialysis would occur beyond the timeframe of the resource impact model.

The resource impact template excludes standard care costs. As both standard care and budesonide are oral treatments, the use of budesonide has no overall impact on NHS capacity.

NICE estimate that in year 3, 138 people in Devon will be eligible for treatment, with 21 receiving targeted-release budesonide.

Nivolumab with chemotherapy for neoadjuvant treatment then alone for adjuvant treatment of resectable non-small-cell lung cancer TA1127

Recommendation

Nivolumab **can be used** as an option for neoadjuvant treatment with platinum-based chemotherapy, then alone as adjuvant treatment, for non-small-cell lung cancer (NSCLC) with a high risk of recurrence in adults whose tumours:

- are resectable (4 cm or more or node positive) and
- have no epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) rearrangements.

Nivolumab can only be used if the company provides it according to the commercial arrangement.

Use the least expensive option of the suitable treatments (including nivolumab, pembrolizumab and durvalumab), having discussed the advantages and disadvantages of the available treatments with the person with the condition. Take account of administration costs, dosages, price per dose and commercial arrangements.

This recommendation is not intended to affect treatment with nivolumab that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

Lung cancer is the third most common cancer and the most common cause of cancer death in the UK, accounting for 13% of all new cancer cases and 21% of all cancer deaths between 2017 and 2019. Most lung cancers are diagnosed at an advanced stage when the cancer has spread to lymph nodes and other organs in the chest (locally advanced disease; stage 3) or to other parts of the body (metastatic disease; stage 4). Around 30% of lung cancers are diagnosed at an early stage (stage 1 or 2).

In 2022, 90% (around 33,000) of people diagnosed with lung cancer in England had NSCLC. Of these people, 18% (around 6,600) had surgical treatment for their cancer. Despite the curative intent of treatment for early-stage lung cancer, survival is poor, with only about 57% people with stage 1, 34% with stage 2 and 13% with stage 3 surviving for 5 years after diagnosis. It is estimated that over half of all NSCLCs express the programmed cell death ligand-1 (PD-L1) biomarker. Cancer cells expressing PD-L1 are believed to suppress certain immune responses which results in a weaker anti-tumour response.

The treatment pathway for NSCLC can be divided into interconnected decision points based on the number staging system and line of therapy. Treatment choices are influenced by the presence of biological markers (including programmed cell death 1 ligand PD-L1 status), oncogenic driver genetic alterations, histology (squamous or non-squamous) and previous treatment. NICE's

Technology Appraisal Pathway Pilot scope for treatments for non-small-cell lung cancer outlines in more detail the NSCLC treatment pathway.

Nivolumab with platinum-based chemotherapy as neoadjuvant treatment then alone as adjuvant treatment after surgical resection is indicated for the treatment of adults with resectable (tumours ≥4 cm or node positive) non-small cell lung cancer and no known EGFR mutations or ALK rearrangements.

The comparator treatments for the eligible population are pembrolizumab with chemotherapy and durvalumab with chemotherapy in the neoadjuvant setting. It is assumed that a proportion of people who had neoadjuvant treatments will go on to have the same respective treatment option as a monotherapy in the adjuvant setting. Previously nivolumab was only recommended in the neoadjuvant setting.

Financial Factors

This technology is commissioned by NHS England.

The company has a commercial arrangement. This makes nivolumab available to the NHS at a discount.

The payment mechanism for the technology is determined by the responsible commissioner and depends on whether the technology is classified as high cost.

The key drivers of resource impact are that:

- The adjuvant treatment duration of nivolumab is longer than for pembrolizumab but similar to that of durvalumab.
- Adjuvant nivolumab can be administered intravenously or subcutaneously. The intravenous administration time for nivolumab is shorter than for durvalumab but similar to that for pembrolizumab. Subcutaneous nivolumab administration time is less than for treatments administered intravenously.

NICE expect that the resource impact of implementing the recommendations in England will be less than £5 million per year (or about £8,700 per 100,000 people in the population, based on a population in England of 57.7 million people). This is because the technology is an additional treatment option, and a cost comparison suggests the costs for nivolumab are similar to or lower than the costs for pembrolizumab. The recommendation is to use the least expensive option of the suitable treatments, taking account of administration costs, dosages, price per dose and commercial arrangements.

Molnupiravir for treating COVID-19 TA1056 (UPDATE)

Update February 2026: NICE removed sotrovimab from recommendation 1.1. This is because GlaxoSmithKline has discontinued manufacturing, supply, distribution and marketing of sotrovimab in the UK. The 'why the committee made these recommendations'

section and committee discussion section have also been amended to reflect the updated recommendation.

Recommendation

Molnupiravir is **recommended** as an option for treating mild to moderate COVID-19 in adults who have a positive SARS-CoV-2 test, only if:

- they have 1 or more risk factors for progression to severe COVID-19 (as defined in section 5 of NICE's technology appraisal guidance on nirmatrelvir plus ritonavir and tocilizumab for treating COVID-19) and
- nirmatrelvir plus ritonavir is contraindicated or unsuitable.

The Technology

COVID-19 is the acute respiratory illness caused by the SARS-CoV-2 virus. It can range from mild or moderate to severe. If the disease is not adequately controlled, excessive immune response can lead to more severe complications such as hospitalisation and death. Some people are at a higher risk of severe COVID-19 outcomes because of underlying risk factors.

Usual treatment for mild to moderate COVID-19 in people at risk of developing severe COVID-19 includes nirmatrelvir plus ritonavir, or sotrovimab when nirmatrelvir plus ritonavir is unsuitable. There are no other treatment options when these medicines cannot be used.

Molnupiravir is indicated for the treatment of mild to moderate coronavirus disease 2019 (COVID-19) in adults with a positive SARS-CoV-2 diagnostic test and who have at least one risk factor for developing severe illness.

The comparator treatment for the eligible population is nirmatrelvir plus ritonavir.

Molnupiravir and nirmatrelvir plus ritonavir are both administered orally.

Financial Factors

This technology is commissioned by ICBs.

The payment mechanism for the technology is determined by the responsible commissioner and depends on the technology being classified as high cost.

NICE expect the resource impact of implementing the recommendations in England will be less than £5 million per year (or approximately £8,800 per 100,000 population, based on a population for England of 57.16 million people).This is because the technology is a further treatment option, the overall cost of treatment will be similar for this population and they do not think practice will change substantially as a result of this guidance.

Nirmatrelvir plus ritonavir and tocilizumab for treating COVID-19 TA878 (UPDATE)

Update February 2026: NICE removed the recommendation on sotrovimab. This is because GlaxoSmithKline has discontinued manufacturing, supply, distribution and marketing of sotrovimab in the UK. The 'why the committee made these recommendations' section and committee discussion section have also been amended to reflect the updated recommendation.

NICE also included information in section 1 explaining why the recommendation on casirivimab plus imdevimab was removed in March 2024.

Recommendation

Nirmatrelvir plus ritonavir is **recommended** as an option for treating COVID-19 in adults, only if they:

- do not need supplemental oxygen for COVID-19 and
- have an increased risk for progression to severe COVID-19, as defined in section 5.

This recommendation has been deleted because the company has discontinued manufacturing, supply, distribution and marketing of sotrovimab in the UK.

Tocilizumab is **recommended**, within its marketing authorisation, as an option for treating COVID-19 in adults who:

- are having systemic corticosteroids and
- need supplemental oxygen or mechanical ventilation.

Tocilizumab (branded or biosimilar) is only recommended if the companies provide it according to the commercial arrangement.

The Technology

Nirmatrelvir plus ritonavir is indicated for the treatment of COVID-19 in adults who do not require supplemental oxygen and who are at increased risk for progression to severe COVID-19.

Tocilizumab is indicated for the treatment of coronavirus disease 2019 (COVID-19) in adults who are receiving systemic corticosteroids and require supplemental oxygen or mechanical ventilation.

Financial Factors

This technology is commissioned by ICBs.

Highly Specialised Technology Guidance (HSTs)

Cerliponase alfa for treating neuronal ceroid lipofuscinosis type 2 HST34

Recommendation

Cerliponase alfa is **not recommended**, within its marketing authorisation, for treating neuronal ceroid lipofuscinosis type 2 (CLN2; also known as tripeptidyl peptidase 1 deficiency).

This recommendation is not intended to affect treatment with cerliponase alfa that was funded with managed access before final guidance was published. People already having cerliponase alfa for treating CLN2, or who start cerliponase alfa before the end of the managed access period, can continue with treatment until they and their NHS healthcare professional consider it appropriate to stop. This decision should be made jointly by the healthcare professional, the child or young person, and their parents or carers.

The Technology

Cerliponase alfa is a recombinant human tripeptidyl peptidase 1 which is an enzyme replacement therapy. It is administered by intracerebroventricular infusion every 2 weeks.

Cerliponase alfa has a marketing authorisation in the UK for the treatment of neuronal ceroid lipofuscinosis type 2 (CLN2) disease, also known as tripeptidyl peptidase 1 (TPP1) deficiency. It has been studied in patients with a confirmed diagnosis of CLN2, with a 2-domain score of 3 to 6 on motor and language domains of the Hamburg Scale and a score of at least 1 in each of these domains.

This guidance updates and replaces NICE's highly specialised technologies guidance 12 on cerliponase alfa for treating neuronal ceroid lipofuscinosis type 2, which was available with managed access. People already taking it will be able to continue until they and their healthcare professional decide when best to stop.

Cerliponase alfa is indicated for the treatment of neuronal ceroid lipofuscinosis type 2 (CLN2) disease, also known as tripeptidyl peptidase 1 (TPP1) deficiency.

Financial Factors

This guidance updates and replaces NICE's highly specialised technologies guidance 12 on cerliponase alfa for treating neuronal ceroid lipofuscinosis type 2, which was available with managed access. People already taking it will be able to continue until they and their healthcare professional decide when best to stop.

The evidence from clinical trials and from people having treatment in the NHSE suggested that cerliponase alfa slows disease progression. But, although it is an effective treatment, there is uncertainty about how effective it will be after long-term use. Based on the proposed price of the medicine, the preferred cost-effectiveness estimates were substantially above the range NICE

considers an acceptable use of NHS resources for highly specialised technologies. So, cerliponase alfa is not recommended for treating CLN2.

NICE Guidelines (NGs)

Hypertension in adults: diagnosis and management NG136 (UPDATE)

Update February 2026: NICE have added recommendation 1.2.11 to offer advice on healthy living to people who have raised blood pressure but have not been diagnosed with hypertension.

This guideline covers identifying and treating primary hypertension (high blood pressure) in people aged 18 and over, including people with type 2 diabetes. It aims to reduce the risk of cardiovascular problems such as heart attacks and strokes by helping healthcare professionals to diagnose hypertension accurately and treat it effectively.

Type 2 diabetes in adults: management NG28 (UPDATE)

Update February 2026: NICE have reviewed evidence on medicines for type 2 diabetes, for people with no relevant comorbidities as well as for people with common comorbidities.

This guideline covers care and management for adults (aged 18 and over) with type 2 diabetes. It focuses on education, dietary advice, managing cardiovascular risk, managing blood glucose levels, and identifying and managing long-term complications.

Blood transfusion NG24 (UPDATE)

Update February 2026: NICE have reviewed the evidence and made new recommendations on using tranexamic acid during surgery.

This guideline covers assessing for, and managing, blood transfusions in adults, young people and children aged 1 year and over. It covers the general principles of blood transfusion, but does not make recommendations relating to specific conditions.

Public Health Guidelines

None published this month.

Antimicrobial Prescribing Guidelines

None published this month.

Social Care Guidelines

None published this month.

HealthTech guidance (HTGs)

Transcatheter tricuspid valve implantation for symptomatic severe tricuspid regurgitation HTG771

Recommendations

When open-heart surgery is high risk, and transcatheter valve repair is unsuitable:

Transcatheter tricuspid valve implantation can be used in the NHS during the evidence generation period as an option to treat symptomatic severe tricuspid regurgitation when open surgical tricuspid valve repair or replacement is high risk, and transcatheter tricuspid valve repair is unsuitable. There must be enhanced informed consent and auditing of outcomes.

When open-heart surgery is not high risk, or transcatheter valve repair is suitable:

More research is needed on transcatheter tricuspid valve implantation to treat symptomatic severe tricuspid regurgitation before it can be used in the NHS when open surgical tricuspid valve repair or replacement is not high risk, or transcatheter tricuspid valve repair is suitable.

This procedure should only be done as part of formal research and a research ethics committee needs to have approved its use.

The Condition

Tricuspid regurgitation is when blood flows backwards through the tricuspid valve because it does not close properly during systole (when the heart contracts). It can be caused by a problem with the valve itself, but more commonly is a result of an underlying cardiac problem or pulmonary hypertension that has caused the heart to become dilated. This stretches the annulus that supports the valve leaflets so they do not meet and regurgitation of blood happens. Mild tricuspid regurgitation does not usually cause symptoms. Severe regurgitation may cause fatigue, weakness, active pulsing in the neck veins, liver enlargement, ascites, peripheral oedema and renal impairment. Medicines may not effectively control the symptoms.

The Procedure

Transcatheter tricuspid valve implantation is designed to replace the native tricuspid valve in people with symptomatic severe tricuspid valve regurgitation, without the need for open-heart surgery. The procedure is usually done under local or general anaesthesia. An artificial valve is implanted into the existing tricuspid valve. Transfemoral or internal jugular venous access can be used, or the delivery system can be inserted into the right atrium with access through a right anterior lateral thoracotomy in the intercostal space. The valve is positioned within the native

tricuspid valve under real-time transoesophageal echocardiography visualisation and fluoroscopy.

Different transcatheter tricuspid valve implantation systems are available. They differ in terms of valve design, size, stent frame, anchoring mechanism and delivery systems. The devices also differ by access route.

Leadless cardiac pacemaker implantation for bradyarrhythmias HTG770

Recommendations

Right ventricular pacing alone

Leadless cardiac pacemaker implantation can be used as an option for right ventricular pacing alone for bradyarrhythmias.

Dual-chamber pacing or right atrial pacing alone when transvenous pacing is unsuitable

When transvenous pacing is unsuitable, leadless cardiac pacemaker implantation can be used during the evidence generation period for dual-chamber pacing or right atrial pacing alone for bradyarrhythmias. There must be enhanced informed consent and auditing of outcomes.

Dual-chamber pacing or right atrial pacing alone when transvenous pacing is suitable

When transvenous pacing is suitable, more research is needed on leadless cardiac pacemaker implantation for dual-chamber pacing or right atrial pacing alone for bradyarrhythmias.

This procedure should only be done as part of formal research and a research ethics committee needs to have approved its use.

The Condition

Bradyarrhythmias are abnormal heart rhythms associated with a slow heart rate (bradycardia), usually defined as less than 60 beats per minute. There are a range of causes including diseases such as sick sinus syndrome or atrioventricular block. The most common causes are age, ischaemic heart disease, heart valve disorders and heart failure. If untreated, bradyarrhythmias may lead to fatigue, fainting, palpitations, dizziness, heart failure and an increased risk of death.

The Procedure

The aim of implanting a leadless cardiac pacemaker is to detect cardiac bradyarrhythmias and deliver electric pulses to help regulate the heartbeat. Most leadless cardiac pacemakers deliver single-chamber right ventricular pacing (with or without atrial sensing), but dual-chamber systems that deliver atrial or atrioventricular pacing using 2 devices are also available. Right atrial leadless cardiac pacemakers are a recent advancement and are suitable for people needing right atrial pacing only.

The procedure is usually done under local anaesthesia in a cardiac catheterisation laboratory. Fluoroscopic guidance is needed, and intracardiac echocardiography or contrast may be needed to guide implantation in the desired location in the heart chamber (right ventricle or atrium). For right ventricular leadless cardiac pacemakers, the proximal end of the leadless cardiac pacemaker is attached to a deflectable delivery catheter system. It is usually inserted percutaneously through the femoral vein or a vein in the neck (jugular access) using an introducer sheath. It is then moved into the right atrium, through the tricuspid valve into the right ventricle, and positioned near the apex or lower septum. An atrial device does not cross the tricuspid valve into the right ventricle. Once in place, the leadless cardiac pacemaker is securely implanted into the endocardial wall using a fixation mechanism. Electrical measurements are taken and, if satisfactory, the leadless cardiac pacemaker is released from the catheter and the catheter is removed. If the position is suboptimal, the leadless cardiac pacemaker can be detached from the endocardium and repositioned before the catheter is released.

The cardiac pacemaker delivers electrical impulses that pace the heart through an electrode at the distal end of the device. It is adjusted using an external programming system. A catheter retrieval system is used for removal and replacement of the leadless cardiac pacemaker when needed.

A dual-chamber leadless cardiac pacemaker system consists of 2 devices implanted percutaneously, either in a single procedure or over multiple procedures, into the target chambers: one in the right atrium and another in the right ventricle.

Several different devices are available for leadless cardiac pacemaker implantation for bradyarrhythmias.

Pulmonary artery pressure technologies for remote monitoring of chronic heart failure HTG769

Recommendations

Can be used

CardioMEMS HF System can be used as an option for remote monitoring of New York Heart Association (NYHA) class 3 chronic heart failure in adults at risk of hospitalisation who are:

- able to use the technology (with the help of a carer if necessary) and
- willing to adjust medication as directed.

More research is needed

More research is needed on the Cordella Pulmonary Artery Sensor System and the Cordella Heart Failure System for remote monitoring of NYHA class 3 chronic heart failure in adults before it can be funded by the NHS.

The Technologies

Pulmonary artery pressure (PAP) monitoring systems use implantable sensors to collect data on PAP to remotely monitor chronic heart failure. The aim of PAP technologies is to detect increases in PAP at an early stage. PAP increases mean that fluid is beginning to accumulate because of worsening heart failure. So, early detection increases the possibility of optimising medication, and avoiding decompensation of heart failure and hospitalisation.

A PAP sensor is implanted into a pulmonary artery using a right heart catheterisation procedure. NICE's HealthTech guidance on percutaneous implantation of PAP sensors for monitoring treatment of chronic heart failure recommends that the evidence on safety and efficacy is adequate to support this procedure.

People take daily PAP measurements at home. Data, including on pressure trends and waveforms, is collected and transmitted to an external monitor in the home. The monitor securely forwards this information to a remote database that can be accessed by the person's healthcare team. The aim of PAP technologies is to supplement usual monitoring for chronic heart failure. The decision to use the technology should be discussed with the person, who should be able and willing to use the technology, and to adjust their medication dose as requested by their care team. The technologies can replace some aspects of usual care for monitoring but not all, for example, regular check-ups will still be needed. The technologies do not make or confirm diagnosis of heart failure.

Financial Factors

This technology is commissioned by NHS England.

The CardioMEMS HF system is intended to supplement standard care monitoring for chronic heart failure. The data from the system is sent wirelessly to a secure database for healthcare professionals to review.

CardioMEMS costs £11,400 (including VAT) plus £1,631 per person for implantation, with additional ongoing remote-monitoring costs. A one-off £10,000 per-site payment is also needed for the calibration system used during implantation.

Evidence suggest that CardioMEMS supports proactive pulmonary artery pressure management, leading to fewer hospitalisations and mitigating incremental costs. The external assessment group (EAG) report estimates a reduction in annual hospitalisations from 1.52 to around 1.00 per person. This decrease translates into an estimated saving of approximately £2,300 per individual, based on avoided admission cost of around £4,400. When these savings are compared with the upfront device and implantation costs, it suggests an overall payback period of around 5.7 years.

Because CardioMEMS is used alongside standard care, clinical teams may require additional time to review and interpret the transmitted data. But, clinical experts advised that monitoring requirements tend to decrease after the initial implantation. Appropriate monitoring frequency will vary according to an individual's clinical status, and the system can be configured with

person-specific parameters to alert both users and healthcare professionals when readings fall outside the expected range.

Local health systems may need to consider how the frequency of monitoring and alert responses will influence staffing, scheduling, and ongoing operational costs.

Potential benefits of using the CardioMEMS HF system include:

- Early detection of rising pulmonary artery pressure (PAP) may reduce the risk of heart failure worsening and the need for hospital admission.
- Optimising medication based on real-time data may improve symptom control and quality of life.
- Remote monitoring can offer greater convenience for people who prefer to manage their condition from home.
- It supports people who face barriers to attending in-person appointments, such as mobility limitations, travel distance, or work commitments.
- The system may provide people with reassurance by enabling closer oversight of their condition between routine clinic visits.

NICE estimate that in year 3, 1,575 people in Devon will be eligible for CardioMEMS.

Digital technologies to support self-management of COPD: early value assessment HTG736 (UPDATE)

February 2026: NICE removed COPDPredict from recommendation 1.1 because it is no longer available to the NHS. This is because the company for the technology, NEPeSMO, is no longer trading.

This early value assessment (EVA) guidance is on digital technologies to support self-management of COPD.

NICE Quality Standards

Rare diseases QS214

This quality standard covers diagnosing, managing and treating rare diseases in children, young people and adults. It describes high-quality care in priority areas for improvement.

Blood transfusion QS138 (UPDATE)

February 2026: Changes have been made to align this quality standard with the updated NICE guideline on blood transfusion. The population in statement 2 has been amended to align with the updated guideline. Outcome measures have been removed throughout as they do not have a data source.

This quality standard covers blood transfusion and reducing the requirements for blood transfusion in adults, young people and children aged 1 year and over. It describes high-quality care in priority areas for improvement. It does not cover use of tranexamic acid for surgery during pregnancy or labour or blood transfusion during pregnancy or labour.

Current NICE Consultations

Title/link	End date of consultation
Neonatal infection: antibiotics for prevention and treatment - update	04/03/2026
Polihexanide 0.8 mg/ml eye drops for treating acanthamoeba keratitis in people 12 years and over [ID6497]	06/032026
Trastuzumab deruxtecan for treating HER2-positive advanced gastric or gastro-oesophageal junction adenocarcinoma after trastuzumab-based treatment (review of TA879) [ID6680]	16/03/2026
Acalabrutinib with bendamustine and rituximab for untreated mantle cell lymphoma [ID6155]	18/03/2026
Dapagliflozin in combination therapy for treating type 2 diabetes	18/03/2026
Canagliflozin in combination therapy for treating type 2 diabetes	18/03/2026
Dapagliflozin for treating chronic heart failure with reduced ejection fraction	18/03/2026
Canagliflozin, dapagliflozin and empagliflozin as monotherapies for treating type 2 diabetes	18/03/2026
Dapagliflozin in triple therapy for treating type 2 diabetes	18/03/2026
Ertugliflozin as monotherapy or with metformin for treating type 2 diabetes	18/03/2026
Empagliflozin in combination therapy for treating type 2 diabetes	18/03/2026
Tirzepatide for treating type 2 diabetes	18/03/2026
Empagliflozin for treating chronic heart failure with reduced ejection fraction	18/03/2026
Sacubitril valsartan for treating symptomatic chronic heart failure with reduced ejection fraction	18/03/2026
Ertugliflozin with metformin and a dipeptidyl peptidase-4 inhibitor for treating type 2 diabetes	18/03/2026