## NICE-approved drugs available for use within the Trust

The following drugs have been recommended by NICE as treatment options for the indications noted below. They are listed in the Trust Medicines Formulary but are not routinely stocked in pharmacy. These drugs will be ordered if authorised by the Trust DTC Chairman/High Cost Drugs process for use within the specific criteria set by NICE.

| Drug | NICE-approved use | NICE TA link |
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| **Abatacept** | Abatacept (Orencia), adalimumab (Humira), etanercept (Enbrel) and tocilizumab (RoActemra) are recommended as possible treatments for people with polyarticular juvenile idiopathic arthritis.<br><br>Adalimumab and etanercept are recommended as possible treatments for people with enthesitis-related juvenile idiopathic arthritis.<br><br>Etanercept is recommended as a possible treatment for people with psoriatic juvenile idiopathic arthritis. | http://www.nice.org.uk/guidance/ta373<br><br>***Shared Care on behalf of Specialist Paediatric Rheumatology Centres Only**** |
| **Adalimumab** | Infliximab (also known as Remicade, Inflectra or Remsima), adalimumab (Humira) and golimumab (Simponi) are recommended. They are possible treatments for adults with moderate to severe ulcerative colitis if conventional therapy hasn't worked or isn't suitable.<br><br>Infliximab is also recommended as a possible treatment for children or young people aged 6–17 years with severe ulcerative colitis, if conventional therapy hasn't worked or isn't suitable.<br><br>People should be able to have the treatment for at least 12 months, unless it stops working well enough. Their condition should be assessed at least every 12 months. Their doctor should discuss with them the benefits and risks of continuing or stopping treatment. If treatment is stopped and the ulcerative colitis gets worse, people should be able to start treatment again. | https://www.nice.org.uk/guidance/ta329 |
| **Adalimumab** | Abatacept (Orencia), adalimumab (Humira), etanercept (Enbrel) and tocilizumab (RoActemra) are recommended as possible treatments for people with polyarticular juvenile idiopathic arthritis.<br><br>Adalimumab and etanercept are recommended as possible treatments for people with enthesitis-related juvenile idiopathic arthritis.<br><br>Etanercept is recommended as a possible treatment for people with psoriatic juvenile idiopathic arthritis. | http://www.nice.org.uk/guidance/ta373<br><br>***Shared Care on behalf of Specialist Paediatric Rheumatology Centres Only**** |
| **Atezolizumab** | 1.1 Atezolizumab is recommended as an option for treating locally advanced or metastatic non-small-cell lung cancer (NSCLC) in adults who have had chemotherapy (and targeted treatment if they have an EGFR- or ALK‑positive tumour), only if:<br><br>•atezolizumab is stopped at 2 years of uninterrupted treatment or earlier if the disease progresses and | https://www.nice.org.uk/guidance/ta520 |

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| | •the company provides atezolizumab with the discount agreed in the patient access scheme.<br><br>1.2 This recommendation is not intended to affect treatment with atezolizumab 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 clinician consider it appropriate to stop.<br><br>**Please Note:** this drug would be restricted to Royal Surrey County Hospital Oncology Patients treated at ASPH Only | |
| **Azacitidine** | Azacitidine is recommended as a treatment option for adults who are not eligible for haematopoietic stem cell transplantation and have:<br>intermediate-2 and high-risk myelodysplastic syndromes according to the International Prognostic Scoring System (IPSS)<br>**or**<br>chronic myelomonocytic leukaemia with 10–29% marrow blasts without myeloproliferative disorder<br>**or**<br>acute myeloid leukaemia with 20–30% blasts and multilineage dysplasia, according to the World Health Organization classification<br>**and**<br>if the manufacturer provides azacitidine with the discount agreed as part of the patient access scheme. | http://guidance.nice.org.uk/TA218 |
| **Bivalirudin** | Bivalirudin in combination with aspirin and clopidogrel is recommended for the treatment of adults with ST-segment-elevation myocardial infarction undergoing primary percutaneous coronary intervention. | http://guidance.nice.org.uk/TA230 |
| **Brigatinib** | For Royal Surrey County Hospital Outreach patients only.<br><br>Brigatinib is recommended, within its marketing authorisation, for treating anaplastic lymphoma kinase (ALK)-positive advanced non-small-cell lung cancer (NSCLC) in adults who have already had crizotinib. It is recommended only if the company provides it according to the commercial arrangement. | https://www.nice.org.uk/guidance/ta571 |
| **Canagliflozin** | If a person needs to take 2 antidiabetic drugs, canagliflozin is recommended as a possible treatment for people with type 2 diabetes when taken with a drug called metformin, only if the person:<br><br>•cannot take a type of drug called a sulfonylurea or<br>•is at significant risk of hypoglycaemia or its consequences.<br>If a person needs to take 3 antidiabetic drugs, canagliflozin is recommended as a possible treatment when taken with either metformin and a sulfonylurea, or metformin and a type of drug called a thiazolidinedione.<br><br>Canagliflozin is recommended as a possible treatment | http://www.nice.org.uk/Guidance/TA315 |

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| | taken with insulin, with or without other antidiabetic drugs. | |
| **Canagliflozin** | Canagliflozin, dapagliflozin and empagliflozin as monotherapies are recommended as options for treating type 2 diabetes in adults for whom metformin is contraindicated or not tolerated and when diet and exercise alone do not provide adequate glycaemic control, only if:<br><br>a dipeptidyl peptidase-4 (DPP-4) inhibitor would otherwise be prescribed and a sulfonylurea or pioglitazone is not appropriate.<br><br>Adults whose treatment with canagliflozin, dapagliflozin or empagliflozin as monotherapy is not recommended in this NICE guidance, but was started within the NHS before this guidance was published, should be able to continue treatment until they and their NHS clinician consider it appropriate to stop. | https://www.nice.org.uk/guidance/ta390 |
| **Ceritinib** | Ceritinib is recommended, within its marketing authorisation, as an option for treating advanced anaplastic lymphoma kinase positive non-small-cell lung cancer in adults who have previously had crizotinib. The drug is recommended only if the company provides it with the discount agreed in the patient access scheme.<br><br>**Please Note:** this drug would be restricted to Royal Surrey County Hospital Oncology Patients treated at ASPH Only | https://www.nice.org.uk/guidance/ta395 |
| **Certolizumab pegol** | 1.1 Certolizumab pegol is recommended as an option for treating plaque psoriasis in adults, only if:<br>•the disease is severe, as defined by a total Psoriasis Area and Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10 and<br>•the disease has not responded to other systemic treatments, including ciclosporin, methotrexate and phototherapy, or these options are contraindicated or not tolerated and<br>•the lowest maintenance dosage of certolizumab pegol is used (200 mg every 2 weeks) after the loading dosage and<br>•the company provides the drug according to the commercial arrangement.<br><br>1.2 Stop certolizumab pegol at 16 weeks if the psoriasis has not responded adequately. An adequate response is defined as:<br>•a 75% reduction in the PASI score (PASI 75) from when treatment started or<br>•a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from when treatment started.<br><br>1.3 If patients and their clinicians consider certolizumab pegol to be one of a range of suitable treatments, the least expensive should be chosen (taking into account administration costs, dosage, price per dose and commercial arrangements).<br><br>1.4 When using the PASI, healthcare professionals | https://www.nice.org.uk/guidance/ta574 |

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| | should take into account skin colour and how this could affect the PASI score, and make the clinical adjustments they consider appropriate.<br><br>1.5 When using the DLQI, healthcare professionals should take into account any physical, psychological, sensory or learning disabilities, or communication difficulties that could affect the responses to the DLQI and make any adjustments they consider appropriate.<br><br>1.6 These recommendations are not intended to affect treatment with certolizumab pegol that was started in the NHS before this guidance was published. People having treatment outside these recommendations may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop. | |
| **Ciclosporin** | Ciclosporin (Ikervis) is recommended as a possible treatment for people with dry eye disease that has not improved despite treatment with artificial tears. | http://www.nice.org.uk/guidance/ta369 |
| **Cinacalcet** | Cinacalcet is not recommended for the routine treatment of secondary hyperparathyroidism in patients with end-stage renal disease on maintenance dialysis therapy.<br><br>Cinacalcet is recommended for the treatment of refractory secondary hyperparathyroidism in patients with end-stage renal disease (including those with calciphylaxis) only in those:<br>who have 'very uncontrolled' plasma levels of intact parathyroid hormone (defined as greater than 85 pmol/litre [800 pg/ml]) that are refractory to standard therapy, and a normal or high adjusted serum calcium level<br>**and**<br>in whom surgical parathyroidectomy is contraindicated, in that the risks of surgery are considered to outweigh the benefits.<br><br>Response to treatment should be monitored regularly and treatment should be continued only if a reduction in the plasma levels of intact parathyroid hormone of 30% or more is seen within 4 months of treatment, including dose escalation as appropriate. | http://guidance.nice.org.uk/TA117 |
| **Dronedarone** | Dronedarone is recommended as an option for the treatment of non-permanent atrial fibrillation **only** in people:<br>whose atrial fibrillation is not controlled by first-line therapy (usually including beta-blockers), that is, as a second-line treatment option<br>**and**<br>who have at least one of the following cardiovascular risk factors:<br>hypertension requiring drugs of at least two different classes<br>diabetes mellitus<br>previous transient ischaemic attack, stroke or systemic embolism<br>left atrial diameter of 50 mm or greater<br>left ventricular ejection fraction less than 40% (noting | http://guidance.nice.org.uk/TA197 |

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| | that the summary of product characteristics [SPC] does not recommend dronedarone for people with left ventricular ejection fraction less than 35% because of limited experience of using it in this group)<br>**or**<br>age 70 years or older<br>**and**<br>who do not have unstable New York Heart Association (NYHA) class III or IV heart failure.<br><br>People who do not meet the above criteria who are currently receiving dronedarone should have the option to continue treatment until they and their clinicians consider it appropriate to stop. | |
| **Eluxadoline** | 1.1 Eluxadoline is recommended as an option for treating irritable bowel syndrome with diarrhoea in adults, only if:<br>•the condition has not responded to other pharmacological treatments (for example, antimotility agents, antispasmodics, tricyclic antidepressants) or<br>•pharmacological treatments are contraindicated or not tolerated, and<br>•it is started in secondary care.<br><br>1.2 Stop eluxadoline at 4 weeks if there is inadequate relief of the symptoms of irritable bowel syndrome with diarrhoea.<br><br>1.3 These recommendations are not intended to affect treatment with eluxadoline that was started in the NHS before this guidance was published. Adults having treatment outside these recommendations may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop. | https://www.nice.org.uk/guidance/ta471 |
| **Eptifibatide** | This guidance replaces 'Glycoprotein IIb/IIIa inhibitors in the treatment of acute coronary syndromes' (Technology Appraisal Guidance No 12) issued in September 2000.<br><br>This guidance has been partially updated by 'Unstable angina and NSTEMI' (NICE clinical guideline 94).<br><br>It is recommended that a GP IIb/IIIa inhibitor is considered as an adjunct to PCI for all patients with diabetes undergoing elective PCI, and for those patients undergoing complex procedures (for example, multi-vessel PCI, insertion of multiple stents, vein graft PCI or PCI for bifurcation lesions); currently only abciximab is licensed as an adjunct to PCI. In procedurally uncomplicated, elective PCI, where the risk of adverse sequelae is low, use of a GP IIb/IIIa | http://guidance.nice.org.uk/TA47 |

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| | inhibitor is not recommended unless unexpected immediate complications occur.<br><br>GP IIb/IIIa inhibitors are not currently licensed in the UK for use as an adjunct to thrombolytic therapy in ST-segment-elevation MI. | |
| **Ertugliflozin** | 1.1 Ertugliflozin as monotherapy is recommended as an option for treating type 2 diabetes in adults for whom metformin is contraindicated or not tolerated and when diet and exercise alone do not provide adequate glycaemic control, only if:<br>•a dipeptidyl peptidase 4 (DPP‑4) inhibitor would otherwise be prescribed and<br>•a sulfonylurea or pioglitazone is not appropriate.<br><br>1.2 Ertugliflozin in a dual-therapy regimen in combination with metformin is recommended as an option for treating type 2 diabetes, only if:<br>•a sulfonylurea is contraindicated or not tolerated or<br>•the person is at significant risk of hypoglycaemia or its consequences.<br><br>1.3 If patients and their clinicians consider ertugliflozin to be 1 of a range of suitable treatments including canagliflozin, dapagliflozin and empagliflozin, the least expensive should be chosen.<br><br>1.4 These recommendations are not intended to affect treatment with ertugliflozin that was started in the NHS before this guidance was published. People having treatment outside these recommendations may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop. | https://www.nice.org.uk/guidance/ta572 |
| **Etanercept** | Abatacept (Orencia), adalimumab (Humira), etanercept (Enbrel) and tocilizumab (RoActemra) are recommended as possible treatments for people with polyarticular juvenile idiopathic arthritis.<br><br>Adalimumab and etanercept are recommended as possible treatments for people with enthesitis-related juvenile idiopathic arthritis.<br><br>Etanercept is recommended as a possible treatment for people with psoriatic juvenile idiopathic arthritis. | http://www.nice.org.uk/guidance/ta373<br><br>***Shared Care on behalf of Specialist Paediatric Rheumatology Centres Only**** |
| **Febuxostat** | Febuxostat is recommended as a possible treatment for chronic hyperuricaemia in people with gout only if:<br>they can't take the medicine allopurinol for medical reasons<br>**or**<br>the side effects of allopurinol are so bad that the person either has to stop taking it or can't be given the most effective dose.<br><br>People who were already taking febuxostat when the guidance was issued should be able to carry on taking it until they and their healthcare professional(s) decide that it is the right time to stop treatment. | http://guidance.nice.org.uk/TA164 |

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| **Golimumab** | Infliximab (also known as Remicade, Inflectra or Remsima), adalimumab (Humira) and golimumab (Simponi) are recommended. They are possible treatments for adults with moderate to severe ulcerative colitis if conventional therapy hasn't worked or isn't suitable.<br><br>Infliximab is also recommended as a possible treatment for children or young people aged 6–17 years with severe ulcerative colitis, if conventional therapy hasn't worked or isn't suitable.<br><br>People should be able to have the treatment for at least 12 months, unless it stops working well enough. Their condition should be assessed at least every 12 months. Their doctor should discuss with them the benefits and risks of continuing or stopping treatment. If treatment is stopped and the ulcerative colitis gets worse, people should be able to start treatment again. | https://www.nice.org.uk/guidance/ta329 |
| **Ixekizumab** | 1.1 Ixekizumab alone, or with methotrexate, is recommended as an option for treating active psoriatic arthritis in adults, only if:<br><br>• it is used as described in NICE's technology appraisal guidance on etanercept, infliximab and adalimumab for the treatment of psoriatic arthritis (recommendations 1.1 and 1.2) or<br><br>• the person has had a tumour necrosis factor (TNF)-alpha inhibitor but their disease has not responded within the first 12 weeks or has stopped responding after the first 12 weeks or<br><br>• TNF-alpha inhibitors are contraindicated but would otherwise be considered (as described in NICE's technology appraisal guidance on etanercept, infliximab and adalimumab for the treatment of psoriatic arthritis).<br><br>Ixekizumab is only recommended if the company provides it according to the commercial arrangement.<br><br>1.2 Assess the response to ixekizumab after 16 weeks of treatment. Only continue treatment if there is clear evidence of response, defined as an improvement in at least 2 of the 4 Psoriatic Arthritis Response Criteria (PsARC), 1 of which must be joint tenderness or | https://www.nice.org.uk/guidance/ta537 |

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| | swelling score, with no worsening in any of the 4 criteria. People whose disease has a Psoriasis Area and Severity Index (PASI) 75 response but whose PsARC response does not justify continuing treatment should be assessed by a dermatologist, to determine whether continuing treatment is appropriate based on skin response (as described in NICE's technology appraisal guidance on etanercept, infliximab and adalimumab for the treatment of psoriatic arthritis, recommendation 1.3).<br><br>1.3 When using the PsARC, healthcare professionals should take into account any physical, sensory or learning disabilities or communication difficulties that could affect a person's responses to components of the PsARC and make any adjustments they consider appropriate.<br><br>1.4 When using the PASI, healthcare professionals should take into account skin colour and how this could affect the PASI score, and make the clinical adjustments they consider appropriate.<br><br>1.5 These recommendations are not intended to affect treatment with ixekizumab that was started in the NHS before this guidance was published. People having treatment outside these recommendations may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop. | |
| **Lubiprostone** | Lubiprostone is recommended as a possible treatment for people with chronic idiopathic constipation:<br><br>•who have previously been treated with 2 different types of laxatives at the highest possible recommended dose, for at least 6 months, but these haven't worked well enough, and<br>•when invasive treatment is being considered.<br><br>Review if treatment with lubiprostone has not worked after 2 weeks. Lubiprostone should only be prescribed by a doctor who is experienced in treating chronic idiopathic constipation, after they have carefully | https://www.nice.org.uk/Guidance/TA318 |

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| | considered previous treatments. | |
| **Mannitol** | Mannitol dry powder for inhalation is recommended as an option for treating cystic fibrosis in adults:<br>who cannot use rhDNase because of ineligibility, intolerance or inadequate response to rhDNase<br>and<br>whose lung function is rapidly declining (forced expiratory volume in 1 second [FEV1] decline greater than 2% annually)<br>and<br>for whom other osmotic agents are not considered appropriate.<br><br>People currently receiving mannitol whose cystic fibrosis does not meet the above criteria should be able to continue treatment until they and their clinician consider it<br>appropriate to stop. | http://guidance.nice.org.uk/TA266 |
| **Naloxeogol** | Naloxegol (Moventig) is recommended as a possible treatment for people with opioid induced constipation that has had an inadequate response to laxatives. | http://www.nice.org.uk/guidance/ta345 |
| **Nintedanib** | Nintedanib is recommended as an option for treating idiopathic pulmonary fibrosis, only if:<br>•the person has a forced vital capacity (FVC) between 50% and 80% of predicted<br>•the company provides nintedanib with the discount agreed in the patient access scheme and<br>•treatment is stopped if disease progresses (a confirmed decline in percent predicted FVC of 10% or more) in any 12‑month period. | https://www.nice.org.uk/guidance/ta379 |
| **Obeticholic acid** | 1.1 Obeticholic acid is recommended, within its marketing authorisation, as an option for treating primary biliary cholangitis in combination with ursodeoxycholic acid for people whose disease has responded inadequately to ursodeoxycholic acid or as monotherapy for people who cannot tolerate ursodeoxycholic acid. Obeticholic acid is recommended only if the company provides it with the discount agreed in the patient access scheme.<br><br>1.2 Assess the response to obeticholic acid after 12 months. Only continue if there is evidence of clinical benefit. | https://www.nice.org.uk/guidance/ta443 |
| **Ocrelizumab** | 1.1 Ocrelizumab is recommended as an option for treating relapsing–remitting multiple sclerosis in adults with active disease defined by clinical or imaging features, only if:<br><br>•alemtuzumab is contraindicated or otherwise unsuitable and<br><br>•the company provides ocrelizumab according to the commercial arrangement.<br><br>1.2 This recommendation is not intended to affect treatment with ocrelizumab 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 clinician consider it appropriate to stop. | https://www.nice.org.uk/guidance/ta533 |

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| **Pertuzumab** | For Royal Surrey County Hospital Outreach patients only.<br><br>1.1 Pertuzumab, with intravenous trastuzumab and chemotherapy, is recommended for the adjuvant treatment of human epidermal growth factor receptor 2 (HER2)-positive early stage breast cancer in adults, only if:<br>•they have lymph node-positive disease<br>•the company provides it according to the commercial arrangement.<br><br>1.2 This guidance is not intended to affect adjuvant treatment with pertuzumab 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 clinician consider it appropriate to stop. | https://www.nice.org.uk/guidance/ta569 |
| **Pirfenidone** | 1.1 Pirfenidone is recommended as an option for treating idiopathic pulmonary fibrosis in adults only if:<br>•the person has a forced vital capacity (FVC) between 50% and 80% predicted<br>•the company provides pirfenidone with the discount agreed in the patient access scheme and<br>•treatment is stopped if there is evidence of disease progression (an absolute decline of 10% or more in predicted FVC within any 12‑month period).<br><br>1.2 This recommendation is not intended to affect treatment with pirfenidone 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 clinician consider it appropriate to stop. | https://www.nice.org.uk/guidance/ta504 |
| **Pixantrone** | Pixantrone monotherapy is recommended as a possible treatment for adults with multiply relapsed or refractory aggressive non-Hodgkin's B‑cell lymphoma if:<br><br>•they have previously been treated with rituximab and<br>•they are having third- or fourth-line treatment.<br><br>Patients who have non-Hodgkin's B-cell lymphoma should be able to have Pixantrone on the NHS if their doctor thinks that it is the right treatment<br><br>People currently receiving Pixantrone that is not recommended according to the above criteria should have the option to continue treatment until they and their clinician consider it appropriate to stop. | http://guidance.nice.org.uk/TA306 |
| **Prucalopride** | Prucalopride is recommended as an option for the treatment of chronic constipation only in women for whom treatment with at least two laxatives from different classes, at the highest tolerated recommended doses for at least 6 months, has failed to provide adequate relief and invasive treatment for constipation is being considered. | http://guidance.nice.org.uk/TA211 |

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| | If treatment with prucalopride is not effective after 4 weeks, the woman should be re-examined and the benefit of continuing treatment reconsidered.<br><br>Prucalopride should only be prescribed by a clinician with experience of treating chronic constipation, who has carefully reviewed the woman's previous courses of laxative treatments specified above. | |
| **Pertuzumab with trastuzumab and docetaxel** | For Royal Surrey County Hospital Outreach patients only.<br><br>Pertuzumab, in combination with trastuzumab and docetaxel, is recommended, within its marketing authorisation, for treating HER2‑positive metastatic or locally recurrent unresectable breast cancer, in adults who have not had previous anti‑HER2 therapy or chemotherapy for their metastatic disease, only if the company provides pertuzumab within the agreed commercial access arrangement. | https://www.nice.org.uk/guidance/ta509 |
| **Reteplase** | This guidance provides recommendations on the selection of thrombolytic drugs in patients with acute myocardial infarction (AMI). Recommendations are made in relation to the use of the drugs in hospital and pre-hospital settings. The guidance does not compare hospital and pre-hospital models of delivering thrombolysis.<br><br>It is recommended that, in hospital, the choice of thrombolytic drug (alteplase, reteplase, streptokinase or tenecteplase) should take account of:<br>• the likely balance of benefit and harm (for example, stroke) to which each of the thrombolytic agents would expose the individual patient.<br>• current UK clinical practice, in which it is accepted that patients who have previously received streptokinase should not be treated with it again.<br>• the hospital's arrangements for reducing delays in the administration of thrombolysis.<br><br>Where pre-hospital delivery of thrombolytic drugs is considered a beneficial approach as part of an emergency-care pathway for AMI (for example, because of population geography or the accessibility of acute hospital facilities), the practicalities of administering thrombolytic drugs<br>in pre-hospital settings mean that the bolus drugs (reteplase or tenecteplase) are recommended as the preferred option. | http://www.nice.org.uk/TA52 |
| **Rituximab** | Rituximab taken with glucocorticoids is recommended as a possible treatment for people with anti-neutrophil cytoplasmic antibody-associated vasculitis (that is, severely active granulomatosis with polyangiitis [also known as Wegener's granulomatosis] and microscopic polyangiitis) if:<br><br>•more treatment with cyclophosphamide would exceed the maximum amount of cyclophosphamide they can have or | http://guidance.nice.org.uk/TA308 |

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| | •cyclophosphamide is not suitable for them or they cannot take it or<br>•they want to have children and treatment with cyclophosphamide may affect their fertility or<br>•the disease has stayed active or got worse after a course of cyclophosphamide lasting 3–6 months or<br>•the person has had cancer affecting the lining of the bladder and other parts of the urinary system.<br><br>Patients already receiving Rituximab who do not meet the criteria above should have the option to continue treatment until they and their clinicians consider it appropriate to stop. | |
| **Roflumilast** | Roflumilast is recommended only in the context of research as part of a clinical trial for adults with severe chronic obstructive pulmonary disease (COPD) (for the purposes of this guidance defined as forced expiratory volume in 1 second [$FEV_1$] post-bronchodilator less than 50% predicted) associated with chronic bronchitis with a history of frequent exacerbations as an add-on to bronchodilator treatment.<br><br>Such research should be designed to generate robust evidence about the benefits of roflumilast as an add-on to long-acting muscarinic antagonists (LAMA) plus long-acting $beta_2$ agonists (LABA) plus inhaled corticosteroids (ICS), or LAMA plus LABA for people who are intolerant to ICS.<br><br>Patients receiving Roflumilast should have the option to continue treatment until they and their clinicians consider it appropriate to stop. | http://guidance.nice.org.uk/TA244 |
| **Streptokinase** | This guidance provides recommendations on the selection of thrombolytic drugs in patients with acute myocardial infarction (AMI). Recommendations are made in relation to the use of the drugs in hospital and pre-hospital settings. The guidance does not compare hospital and pre-hospital models of delivering thrombolysis.<br><br>It is recommended that, in hospital, the choice of thrombolytic drug (alteplase, reteplase, streptokinase or tenecteplase) should take account of:<br>• the likely balance of benefit and harm (for example, stroke) to which each of the thrombolytic agents would expose the individual patient.<br>• current UK clinical practice, in which it is accepted that patients who have previously received streptokinase should not be treated with it again.<br>• the hospital's arrangements for reducing delays in the administration of thrombolysis.<br><br>Where pre-hospital delivery of thrombolytic drugs is considered a beneficial approach as part of an emergency-care pathway for AMI (for example, because of population geography or the accessibility of acute hospital facilities), the practicalities of administering thrombolytic drugs<br>in pre-hospital settings mean that the bolus drugs (reteplase or tenecteplase) are recommended as the | http://www.nice.org.uk/TA52 |

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| | preferred option. | |
| **Teriparatide** | This guidance relates only to treatments for the secondary prevention of fragility fractures in postmenopausal women who have osteoporosis and have sustained a clinically apparent osteoporotic fragility fracture. Osteoporosis is defined by a T-score[1] of −2.5 standard deviations (SD) or below on dual-energy X-ray absorptiometry (DXA) scanning. However, the diagnosis may be assumed in women aged 75 years or older if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible.<br><br>This guidance assumes that women who receive treatment have an adequate calcium intake and are vitamin D replete. Unless clinicians are confident that women who receive treatment meet these criteria, calcium and/or vitamin D supplementation should be considered.<br><br>This guidance does **not** cover the following:<br>The use of alendronate, etidronate, risedronate, raloxifene, strontium ranelate or teriparatide for the secondary prevention of osteoporotic fragility fractures in women with normal bone mineral density (BMD) or osteopenia (that is, women with a T-score between −1 and −2.5 SD below peak BMD).<br>The use of these drugs for the secondary prevention of osteoporotic fragility fractures in women who are on long-term systemic corticosteroid treatment.<br><br>Teriparatide is recommended as an alternative treatment option for the secondary prevention of osteoporotic fragility fractures in postmenopausal women:<br>who are unable to take alendronate and either risedronate or etidronate, or have a contraindication to or are intolerant of alendronate and either risedronate or etidronate,<br>**or**<br>who have a contraindication to, or are intolerant of strontium ranelate<br>**or**<br>who have had an unsatisfactory response to treatment with alendronate, risedronate or etidronate<br>**and**<br>who are 65 years or older and have a T-score of –4.0 SD or below, or a T-score of –3.5 SD or below plus more than two fractures, **or** who are aged 55–64 years and have a T-score of –4 SD or below plus more than two fractures.<br><br>Women who are currently receiving treatment with one of the drugs covered by this guidance, but for whom treatment would not have been recommended according to the above, should have the option to continue treatment until they and their clinicians consider it appropriate to stop.<br><br>[1] T-score relates to the measurement of bone mineral density (BMD) using central (hip and/or spine) DXA | http://guidance.nice.org.uk/TA161 |

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| | scanning, and is expressed as the number of standard deviations (SD) from peak BMD. | |
| **Tildrakizumab** | 1.1 Tildrakizumab is recommended as an option for treating plaque psoriasis in adults, only if:<br>•the disease is severe, as defined by a total Psoriasis Area and Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10 and<br>•the disease has not responded to other systemic treatments, including ciclosporin, methotrexate and phototherapy, or these options are contraindicated or not tolerated and<br>•the company provides the drug according to the commercial arrangement.<br><br>1.2 Consider stopping tildrakizumab between 12 weeks and 28 weeks if there has not been at least a 50% reduction in the PASI score from when treatment started.<br><br>1.3 Stop tildrakizumab at 28 weeks if the psoriasis has not responded adequately. An adequate response is defined as:<br>•a 75% reduction in the PASI score (PASI 75) from when treatment started or<br>•a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from when treatment started.<br><br>1.4 If patients and their clinicians consider tildrakizumab to be one of a range of suitable treatments, the least expensive should be chosen (taking into account administration costs, dosage, price per dose and commercial arrangements).<br><br>1.5 When using the PASI, healthcare professionals should take into account skin colour and how this could affect the PASI score, and make the clinical adjustments they consider appropriate.<br><br>1.6 When using the DLQI, healthcare professionals should take into account any physical, psychological, sensory or learning disabilities, or communication difficulties that could affect the responses to the DLQI and make any adjustments they consider appropriate.<br><br>1.7 These recommendations are not intended to affect treatment with tildrakizumab that was started in the NHS before this guidance was published. People having treatment outside these recommendations may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop. | https://www.nice.org.uk/guidance/ta575 |
| **Tocilizumab** | Abatacept (Orencia), adalimumab (Humira), etanercept (Enbrel) and tocilizumab (RoActemra) are recommended as possible treatments for people with polyarticular juvenile idiopathic arthritis.<br><br>Adalimumab and etanercept are recommended as possible treatments for people with enthesitis-related juvenile idiopathic arthritis. | http://www.nice.org.uk/guidance/ta373<br><br>***Shared Care on behalf of Specialist Paediatric Rheumatology Centres Only**** |

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| | Etanercept is recommended as a possible treatment for people with psoriatic juvenile idiopathic arthritis. | |
| **Tofacitinib** | Moderate to severe rheumatoid arthritis | https://www.nice.org.uk/guidance/ta480 |
| **Tofacitinib** | Active psoriatic arthritis after inadequate response to DMARDs | https://www.nice.org.uk/guidance/ta543 |
| **Tolvaptan** | Tolvaptan (Jinarc) is recommended as a possible treatment for people with autosomal dominant polycystic kidney disease if:<br><br>•they have chronic kidney disease stage 2 or 3 at the start of treatment and<br>•there is evidence of rapidly progressing disease. | http://www.nice.org.uk/guidance/ta358 |
| **Varenicline** | Varenicline is recommended within its licensed indications as an option for smokers who have expressed a desire to quit smoking.<br><br>Varenicline should normally be prescribed only as part of a programme of behavioural support. | http://guidance.nice.org.uk/TA123 |