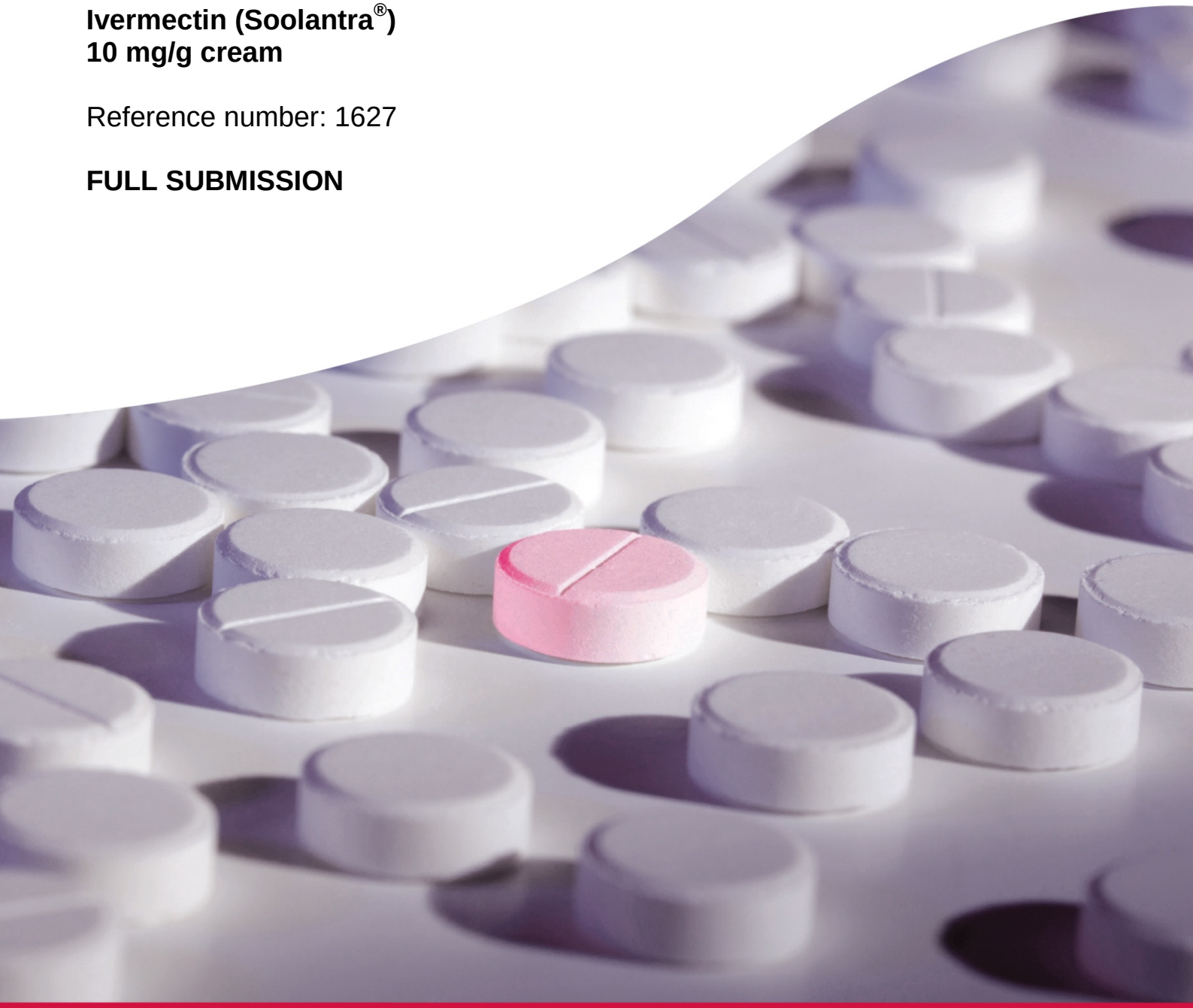
All Wales Therapeutics and Toxicology Centre
Canolfan Therapiwteg a Thocsicoleg Cymru Gyfan

AWMSG SECRETARIAT ASSESSMENT REPORT

Ivermectin (Soolantra®) 10 mg/g cream

Reference number: 1627

FULL SUBMISSION



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AWMSG Secretariat Assessment Report
Ivermectin (Soolantra®) 10 mg/g cream

This assessment report is based on evidence submitted by Galderma Ltd[1].

1.0 PRODUCT DETAILS

Licensed indication under consideration	Ivermectin (Soolantra®) for the topical treatment of inflammatory lesions of rosacea (papulopustular) in adult patients[2].
Dosing	The cream should be applied only to the face, once daily for up to four months. If there is no improvement after three months, the treatment should be discontinued. The treatment course may be repeated. Refer to the Summary of Product Characteristics (SPCs) for further details[2].
Marketing authorisation date	17 April 2015[2]

2.0 DECISION CONTEXT

2.1 Background

Rosacea is a relapsing, chronic inflammatory facial skin disease characterised by flushing episodes, erythema, papules, pustules and telangiectasia[3,4]. Rosacea has a bi-modal prevalence with a peak at 20 to 30 years and a larger peak at 40 to 50 years and it predominately affects those with fair skin and blue eyes[5]. Possible causes of rosacea include altered innate immune response, neurogenic inflammation, neurovascular dysregulation and sun damage[3]. The disease has been classified into four subtypes: erythematotelangiectatic, papulopustular, phymatous and ocular[3]. Papulopustular rosacea (PPR), is characterised by episodic or persistent inflammation in the form of small to medium papules and pustules in a central facial distribution as well as persistent central facial erythema[6].

Based on an estimated prevalence of PPR of 2.7%[7]; the company estimate that there are 50,951 adults in Wales who have PPR[1]. Of those patients who attend health care services and are diagnosed with PPR the company estimate that 8,108 adults will be eligible for treatment with ivermectin in Wales[1].

There is no known cure for rosacea, but there are treatments to control symptoms[8]. The National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summary (CKS) for rosacea states that topical agents including metronidazole 0.75% cream/gel and azelaic acid 15% gel may be used to treat mild to moderate PPR and for the maintenance of more severe disease. Systemic treatment (oral tetracycline or erythromycin) is recommended when there is moderate to severe PPR covering extensive areas that would be difficult to treat topically[9]. The Primary Care Dermatology Society (PCDS) recommends topical agents as first line treatment for mild symptoms and systemic treatment if topical agents fail or if symptoms are more severe[5].

The mechanism of action of ivermectin in treating the inflammatory lesions of rosacea is not known but may be linked to its anti-inflammatory effects as well as causing the death of Demodex mites that have been reported to be a factor in skin inflammation[2].

2.2 Comparators

The comparators included in the company submission were:

- Topical metronidazole 0.75% cream/gel twice daily
- Topical azelaic acid 15% gel twice daily

2.3 Guidance and related advice

- Interventions for rosacea (Review). The Cochrane Collaboration (2015)[10].
- Primary Care Dermatology Society. Rosacea Management (2014)[5].
- Clinical Knowledge Summary. Rosacea. National Institute for Health and Care Excellence (NICE) (2012)[9].

3.0 SUMMARY OF EVIDENCE ON CLINICAL EFFECTIVENESS

The company submitted evidence from a phase III study of ivermectin 1% cream versus metronidazole 0.75% cream (study 40173), two phase III studies of ivermectin versus vehicle (studies 18170 and 18171) and one phase II dose finding study (study 40027). As no evidence for the clinical efficacy of ivermectin versus the active comparators was provided in studies 18170 and 18171[1] and as study 40027 was a dose finding study these will not be discussed further[1]. In the absence of studies providing direct comparison between ivermectin and azelaic acid the company have provided an indirect comparison using a network meta-analysis (NMA)[1].

3.1 Study 40173

This was a multicentre, European, investigator-blind, randomised, parallel group phase III study[1,11]. Patients with moderate to severe PPR were randomised to receive either ivermectin 1% cream once-daily (n = 478) or metronidazole 0.75% cream twice-daily (n = 484). The study consisted of two periods: a 16-week treatment (period A) followed by a 36-week extension (period B). Patients entering the study, assessed using an investigator global assessment (IGA), had a score of 3 (several small or large papules/pustules, moderate erythema) or 4 (numerous small and/or large papules/pustules, severe erythema) and presented with 15–70 facial inflammatory papules and pustules[1,11].

3.1.1 Study 40173 Period A

The primary endpoints in period A were the percentage change in inflammatory lesion count from baseline to week 16 and the time at which a statistically significant difference in the inflammatory lesion count was achieved between the two treatment arms[1,11]. At week 16, ivermectin had a statistically significant greater reduction in inflammatory lesion count compared to metronidazole (see Table 1). This difference was seen as early as week 3, and continued through to week 16 ($p < 0.04$). Secondary endpoints included the success rate at week 16 (the percentage of patients with an IGA score of 0 [no inflammatory lesions present, no erythema] or 1 [very few small papules or pustules, very mild erythema present]) for ivermectin compared to metronidazole and the difference was statistically significant in favour of ivermectin (see Table 1)[1,11].

Patients completed a Dermatology Life Quality Index (DLQI) questionnaire at week 16[1,11]. The questionnaire asked the patients to respond to ten questions regarding symptoms, feelings, daily activities, leisure and personal relationship to measure how much the skin condition affected their quality of life. Patients treated with ivermectin had a greater reduction ($p < 0.01$) in DLQI score relative to baseline compared to those treated with metronidazole indicating a greater improvement in quality of life (see Table 1). The EuroQol 5 dimensional (EQ5D) questionnaire was used to assess patients' perception of global improvement compared to baseline at week 16. At the end of week 16, EQ5D scores were statistically significantly higher (indicating a better health-related quality of life) in the ivermectin arm versus the metronidazole arm (see Table 1)[1,11].

Table 1. Endpoints for ivermectin versus metronidazole at 16 weeks, study 40173, period A[1,11].

	Ivermectin 1% cream (n = 478) once daily	Metronidazole 0.75% cream twice daily (n = 484)	p value
Primary endpoint			
Mean % change from baseline in inflammatory lesion count (± standard deviation)	−83.0 ± 26.0	−73.7 ± 39.7	< 0.001
Secondary endpoint			
IGA success rate*	84.9%	75.4%	< 0.001
Patient reported outcomes			
Mean change in DLQI score between baseline and 16 weeks[†]	−5.18	−3.92	< 0.01
EQ5D score[¶]	0.94	0.91	< 0.05
IGA: investigator global assessment; DLQI: Dermatology Life Quality Index; EQ5D: EuroQol 5 dimensional questionnaire;* success rate defined as the percentage of patients with an IGA score of 0 [no inflammatory lesions present, no erythema] or 1 [very few small papules or pustules, very mild erythema present]; [†]number of patients completing DLQI at week 16 were n = 464 (ivermectin) and n = 469 (metronidazole);[¶]there was no difference in EQ5D score between the two arms at baseline.			

3.1.2 Study 40173 Period B

[commercial in confidence information removed]

Table 2 Endpoints for ivermectin versus metronidazole at 52 weeks, study 40173 period B[1].

[commercial in confidence data removed]

3.2 Network Meta-Analysis

In the absence of direct comparison of the clinical effects of ivermectin versus azelaic acid, the company conducted a literature search to identify randomised controlled studies associated with ivermectin 1% cream once-daily, metronidazole 0.75% cream/gel twice daily and azelaic acid 15% gel twice-daily in the treatment of moderate to severe rosacea[1]. The literature search results were used to create NMAs for the following endpoints: success rate at 12 weeks; success rate at 15 weeks; percentage change in inflammatory lesion count at 12 weeks. Success was associated with IGA scores of 0 or 1 on a five-point scale or 1 or 2 on a seven-point scale. In the NMA for success at 12 weeks, obtained using 12 studies, ivermectin was associated with a statistically significantly higher success rate compared to azelaic acid and compared to metronidazole (see Table 3). Analysis at 15 weeks, based on three studies, indicated statistically significantly higher success rate for ivermectin compared to metronidazole and comparable efficacy for ivermectin and azelaic acid. The NMA for percentage change in inflammatory lesion count at 12 weeks, based on 13 studies indicated a higher change for ivermectin compared to the comparators (see Table 3)[1].

Table 3 Results of Network Meta-Analyses[1].

Success rate at 12 weeks (risk ratio for ivermectin 1% cream once daily versus comparator)		
Comparator	**Risk ratio**	**95% credible interval**
Azelaic acid 15% gel twice daily	1.230	1.111 to 1.371
Metronidazole 0.75% cream twice daily	1.169	1.085 to1.286
Success rate at 15 weeks (risk ratio for ivermectin 1% cream once daily versus comparator)		
Comparator	**Risk ratio**	**95% credible interval**
Azelaic acid 15% gel twice daily	0.998	0.699 to 1.299
Metronidazole 0.75% cream twice daily	1.415	1.187 to 1.708
% change inflammatory lesion count at 12 weeks (ivermectin 1% cream once daily versus comparator)		
Comparator	**Absolute difference**	**95% credible interval**
Azelaic acid 15% gel twice daily	−5.96	−11.31 to −0.58
Metronidazole 0.75% cream twice daily	−9.43	−13.06 to −5.78
Risk ratios > 1 favour ivermectin; absolute difference < 0 favours ivermectin		

3.3 Comparative safety

The safety of ivermectin was assessed in the four clinical studies 40173, 18170, 18171 and 40027[1]. The AEs were typically mild to moderate in severity, and usually decreased when treatment was continued[2]. The most common ivermectin-related adverse events (AEs) were skin irritation, skin burning sensation, pruritus and dry skin which all occurred in ≤ 1% of patients[2,12]. In study 40173 nine patients in the ivermectin arm (1.9%) and 12 in the metronidazole arm (2.5%) experienced treatment-related dermatological AEs[11]. Three patients (0.6%) in the ivermectin arm and ten patients (2.3%) in the metronidazole arm discontinued due to treatment-related AEs[11].

3.4 AWTTC critique

- Ivermectin is licensed for the topical treatment of inflammatory lesions of PPR in adult patients. Study 40173 has been conducted in patients with moderate (83%) to severe (17%) PPR (but not in patients with mild PPR). NICE CKS for rosacea states that topical treatments may be used in patients with mild to moderate PPR and for the maintenance of more severe disease[9]. PCDS guidance advises topical agents as first line treatment for mild symptoms and systemic treatment if topical agents fail or if symptoms are more severe PPR[5]. AWTTC sought clinical expert advice confirmed that mild PPR could be treated with ivermectin but suggested that as disease severity is complicated by rosacea subtype; severity does not necessarily determine treatment options[13].
- Study 40173 directly compared ivermectin with metronidazole. AWTTC sought clinical expert advice, NICE CKS for rosacea and prescribing data suggests that metronidazole is the first-line treatment choice, and the most commonly prescribed topical agent for PPR.
- [commercial in confidence information removed]
- The company did not provide evidence of direct comparison between ivermectin and azelaic acid. NMA suggested ivermectin was more effective than azelaic acid, but this result should be interpreted with caution due to the heterogeneity of studies in the network. In particular methods used to assess treatment success and the PPR status of patients at baseline varied between studies.
- Ivermectin is a once-daily treatment, whilst metronidazole and azelaic acid are applied twice-daily; thus ivermectin may be preferred by patients as a more convenient treatment.

4.0 SUMMARY OF THE EVIDENCE ON COST-EFFECTIVENESS

4.1 Cost-effectiveness evidence

4.1.1 Context

The company submission describes a cost-utility analysis comparing once daily use of ivermectin 1% cream against twice daily use of metronidazole 0.75% gel/cream or azelaic acid 15% gel as first-line treatment for adults with PPR[1].

The analysis is based on a three-year Markov model, in which patients are assigned to one of two health states (HSs) in a 4-weekly cycle according to level of control[1]. The HSs are as defined by Investigator Global Assessment (IGA) scores used in the clinical studies (see Section 3.0): clear to almost clear (IGA scores 0 or 1; HS1), or mild to severe (IGA scores > 2; HS2), which are intended to represent treatment success or treatment failure, respectively. All patients commence treatment in HS2 and are assumed to receive topical treatment for the first 16 weeks (four model cycles). During this initiation phase, patients may experience treatment success in any cycle but remain on topical treatment for the full 16 weeks. Patients who achieve success after 16 weeks of topical treatment are assumed to stop treatment and move to a treatment-free maintenance phase, where they remain until relapse occurs or the end of the model time horizon. Patients experiencing relapse after initial treatment success are assumed to be re-treated with their initial topical treatment. Patients who fail to achieve treatment success after their initial 16 weeks of topical treatment, or those who experience a subsequent relapse after successful topical treatment, are assumed to switch to systemic therapy, and may then achieve success and stop treatment, achieve success and subsequently relapse, or remain on systemic therapy[1].

Efficacy data (transition probabilities) for initial topical treatments are derived from the Bayesian NMA discussed in Section 3.2[1]. In the base case analysis, probabilities of initial topical treatment success/failure over the initial 16 weeks are based on success rates estimated from the NMA using data at 12 weeks, assuming no difference in treatments for the first two four-week cycles but sustained differences for the third and fourth four-week cycles. Probabilities of relapse with ivermectin and metronidazole, and the probabilities of success in the patients who undergo re-treatment with these topical agents, are based on parametric extrapolation of data from part B of study 40173 that directly compared these agents[11]. For azelaic acid, the probability of relapse is assumed to be the same as for metronidazole, and the probability of success in patients undergoing re-treatment is based on the same relative treatment effect as estimated for initial treatment in the NMA, which is applied to the ivermectin probability. Treatment success with systemic antibiotics is assumed to be the same as with topical metronidazole in part B of study 40173 [1,11].

Medication costs are based on Monthly Index of Medical Specialities (MIMS) list prices[14]. The base case analysis assumes metronidazole and ivermectin daily doses based on mean average doses observed in study 40173, with the azelaic acid dose assumed to be the same as for metronidazole[1,11]. As several metronidazole products are available, a weighted average cost based on market share is adopted. Systemic antibiotics costs are based on a weighted average price assuming 50% each for tetracycline and oxytetracycline 1000 mg per day. Other resource use relates to GP and dermatologist visits, which are priced using published unit costs. It is assumed that patients without PPR (HS1) require 0.25 GP visits per four-week cycle, and patients with PPR (HS2) require 0.75 GP visits (based on assumptions employed in a Scottish Medicines Consortium appraisal of brimonidine[15]). Dermatology appointments are based on hospital episode statistics for any skin-related problems in England and Wales, 2006–2007[16], 6.1% of GP visits for PPR are assumed to result in referral to a dermatologist, equivalent to 0.046 dermatology appointments per four-week cycle for those with PPR (HS2). Adverse events are not considered in the analysis[1].

Utility values to reflect health-related quality of life associated with each health state are based on the mean EQ-5D data collected at baseline, week 16, week 32 and week 52 in study 40173 (HS1: 0.93, and HS2: 0.86)[1]. Costs and outcomes beyond one year are discounted to net present values at a rate of 3.5% per annum[1].

4.1.2 Results

The results of the base case analysis are presented for a hypothetical cohort of 1000 patients in Table 4[1]. Over a three-year time horizon of analysis, ivermectin is estimated to be overall marginally less costly and marginally more effective than both metronidazole and azelaic acid. The main driver of the marginal cost differences in favour of ivermectin is the other healthcare costs, and specifically the assumed lower costs arising from fewer GP visits over the three year modelled time horizon (around one GP visit difference), which offsets the greater acquisition costs of ivermectin. The main driver of the QALY gains (and the fewer GP visits) with ivermectin is the greater proportion of patients achieving treatment success, derived from the 12-week data used in the meta analysis[1].

Table 4. Base case cost utility analysis results over a three-year time horizon.

	Ivermectin 1% OD	Metronidazole 0.75% BD	Azelaic acid 15% BD
Medication costs	£152.52	£183.08	£136.95
Other Healthcare costs	£701.04	£743.46	£753.74
Total costs (discounted)	**£854**	**£927**	**£891**
Total QALYs (discounted)	**2.311**	**2.302**	**2.300**
ICER (Cost/QALY gained) Ivermectin - comparator		**Ivermectin dominant***	
BD:twice daily; ICER:incremental cost-effectiveness ratio; QALY:quality-adjusted life years; *ivermectin is both less costly and more effective than the comparators			

A range of one-way scenario and sensitivity analyses was conducted, including: use of 16-week direct comparative study data for the comparison of ivermectin and metronidazole; reducing the dose of azelaic acid to 1 g per day as per its SPC[17]; use of alternative parametric extrapolations of data from part B of study 40173[11]; use of alternative utility values; use of 1- and 5-year time horizons of analysis; and variation in all parameter values in the range +/-15%[1]. Ivermectin remained dominant over the comparators, except when the assumed daily dose of ivermectin was increased to the same daily dose as metronidazole and azelaic acid; in this unlikely scenario, ivermectin was marginally more costly than metronidazole (by £12.60) and azelaic acid (by £48.45), resulting in ICERs of around £1,400 and £4,300 per QALY gained, respectively. Probabilistic sensitivity analyses confirmed the base case results[1].

4.1.3 AWTTC critique

The economic model relates only to patients with moderate to severe PPR. The model categorises patients into health states of ‘success’ or ‘failure’ based on the probabilities of achieving physicians’ subjective improvements in PPR in clinical studies. The model relies on NMAs of heterogeneous study data to determine relative treatment effects for ivermectin compared with metronidazole and azelaic acid. Using these data, the model estimates ivermectin would be more effective than both metronidazole and azelaic acid, and this superior effectiveness would lead to lower health care resource use that would more than off-set any differences in acquisition costs, although the actual differences are small. Direct comparative data indicate ivermectin is superior to metronidazole, but there is a high degree of uncertainty in the assumption that

ivermectin is superior to azelaic acid, and if no material differences exist in their effectiveness, azelaic acid would provide the same benefits at marginally less cost than ivermectin.

Key strengths of the economic evidence include:

- In the absence of direct comparative data for ivermectin and azelaic acid as first-line topical treatments, the company has conducted a systematic literature review and NMAs to inform the estimates of relative treatment effects.
- Utility data for weighting health states by patients' health-related quality of life are derived from the key direct comparative study of ivermectin and metronidazole.

Key limitations and uncertainties in the economic evidence include:

- The base case economic model is reliant on the NMA of 12-week study data, which is subject to several limitations:
    - The NMA of 12-week data estimated statistically significant differences in treatment success in favour of ivermectin compared with both metronidazole and azelaic acid using a fixed effects model; however, this was achieved using an extended network of studies that employed different inclusion criteria, different measures/thresholds of treatment success, and included a wide range of treatment success rates with common comparators (e.g. vehicle gel). Collectively, there would appear to be several sources of heterogeneity in the study data that would not be accounted for in a fixed effects model and would potentially influence the estimates of relative treatment effects.
    - Results of a NMA were also presented using 15-week data from a less extended study network that appropriately included direct comparative data for azelaic acid and metronidazole. Similar sources of heterogeneity exist and in this analysis, success rates were still statistically significantly greater with ivermectin compared with metronidazole, but not compared with azelaic acid.
    - No sensitivity analyses have been provided exploring the possibility of no significant differences between ivermectin and azelaic acid; however if it was to be assumed that no differences exist, azelaic acid would deliver the same benefits at lower cost compared with ivermectin.
- The study data for ivermectin and the comparators in the analyses relate to use in moderate or worse PPR. The economic evidence therefore relates only to moderate or worse PPR, yet the definition of treatment failure in the model includes mild PPR. As a consequence of this lack of granularity in modelling PPR, the impact of mild PPR on health-related quality of life and healthcare resource use is considered to be the same as that of severe PPR, which could potentially overestimate the modelled QALY loss associated with treatment failure.
- The model assumes continued initial use of all topical treatments for a minimum of 16 weeks, irrespective or treatment success during that time; however, the SPCs note that ivermectin should be discontinued after 3 months, and azelaic acid should be discontinued after 2 months, if no improvement is observed. Alternative durations of initial treatment are not considered.
- Based on the assumptions of GP visits, and the model-predicted average treatment durations in those with PPR and those without PPR, the model would indicate there are 15.95 GP visits for those treated initially with ivermectin, 16.85 GP visits for those treated with metronidazole and 17.05 GP visits for those treated with azelaic acid over a three year period. It is unclear if this reflects the number of GP visits likely to be seen in practice for patients with PPR, and in the base case model, equates to ivermectin reducing the number of GP visits by one visit over a three year period, compared with use of metronidazole and azelaic acid.

- As ivermectin is modelled to have lower rates of treatment failure than both comparators, more patients on comparator treatments are assumed to switch to systemic therapy. The relative effectiveness of systemic therapy, which is composed of tetracycline or oxytetracycline, is simply assumed. Doxycycline (Efracea®), which is specifically licensed for PPR[18], and is a more costly product, is not considered as a systemic therapy.

4.2 Review of published evidence on cost-effectiveness

Standard literature searches conducted by AWTTC have not identified any published evidence on the cost-effectiveness of ivermectin of relevance to the UK NHS.

5.0 SUMMARY OF EVIDENCE ON BUDGET IMPACT

5.1 Budget impact evidence

5.1.1 Context and methods

Based on a published estimated prevalence of subtype 2 rosacea (papulopustular rosacea) in Ireland of 2.7%[7], adult (age 18-65 years) population estimates for Wales, and company market research indicating that only 40.7% of sufferers have consulted health care services, of which 39.1% receive treatment, the company estimates 8,108 patients are currently eligible for treatment with ivermectin in Wales[1].

Incidence estimates are derived from a UK observational study[3], and the company anticipates uptake of ivermectin to be 5.2% in Year 1, rising to 12.9% in year 5, mainly as a result of displacement of metronidazole[1]. Medication costs and average treatment durations are derived from the cost effectiveness model, and are applied to the estimated market share of ivermectin, metronidazole and azelaic acid. This relates only to duration of topical treatment; systemic treatments used upon failure of topical treatment are not considered[1].

5.1.2 Results

The company reports the net budget impact in Wales in each of the next five years as in Table 5[1].

Table 5. Company estimates of net cost implications associated with use of ivermectin[1].

	Year 1	Year 2	Year 3	Year 4	Year 5
Number of eligible patients	8,108	8,120	8,132	8,144	8,157
Uptake (%)	5.2	8.6	12.7	12.8	12.9
Treated patients	422	698	1033	1042	1052
Overall net costs	**£2,862**	**£4,740**	**£7,010**	**£7,078**	**£7,139**

No sensitivity and scenario analyses have been provided regarding budget impact estimates.

5.1.3 AWTTC critique

- The company has adopted a pragmatic approach to estimate patient numbers.
- Estimates of uptake are subject to uncertainty as in all budget impact analyses. The company anticipates the vast majority of its predicted uptake of ivermectin will be due to displacement of metronidazole use.
- The estimation of net costs per patient treated is based on the total treatment durations over one year with topical treatments only, estimated from the economic model. As the economic model considers differential treatment efficacy, it predicts patients will remain on ivermectin treatment marginally longer than they would remain on metronidazole or azelaic acid, and this would contribute to the additional costs that are estimated. The net cost estimates do not account for the treatment of patients who experience treatment failure on topical treatments and so appear to be incomplete; however, taking a pragmatic approach based purely on acquisition costs, the magnitude of the net budget impact provided by the company seems to be a reasonable estimate.

5.2 Comparative unit costs

Example comparative costs of topical treatments for PPR, based on British National Formulary (BNF)[19] and MIMS[14] list prices, are included in Table 6, assuming up to four months of successful use. Several alternative metronidazole preparations are available, and for all products the respective SPCs should be consulted for full dosing details[2,17,20]. Brimonidine is a recently licensed topical treatment for erythema in rosacea, rather than PPR, and so is not considered to be an alternative to ivermectin cream[21].

Table 6. Illustrative costs of topical treatments for PPR

Product	Example regimen	Costs
Ivermectin (Soolantra®) cream	Apply once daily (assuming 0.5g daily) for up to 4 months	£37
Metronidazole 0.75% gel (Rozex®)	Apply twice daily (assuming 1g daily) for 3-4 months	£30
Azelaic acid 15% gel (Finacea®)*	Apply twice daily (assuming 1g daily) for e.g. 3-4 months*	£22 to £30
This table does not imply therapeutic equivalence of the drugs or regimens. See respective SPCs for full details[2,17,20]. *Azelaic acid can be used over several months in accordance with the clinical outcome. Assume 3-4 months treatment to be consistent with metronidazole gel and ivermectin example treatment durations		

6.0 ADDITIONAL INFORMATION

6.1 Prescribing and supply

AWTTC is of the opinion that, if recommended, ivermectin (Soolantra®) may be appropriate for prescribing by all prescribers within NHS Wales for the indication under consideration.

The company do not anticipate that ivermectin (Soolantra®) will be supplied by a home healthcare provider.

6.2 Ongoing studies

The company submission states that there are no ongoing studies from which additional evidence is likely to be available within the next 6–12 months.

6.3 AWMSG review

This assessment report will be considered for review three years from the date of the Final Appraisal Recommendation.

6.4 Evidence search

Date of evidence search: 28 September 2015.
Date range of evidence search: No date limits were applied to database searches.

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