AWTTC
All Wales Therapeutics & Toxicology Centre
Canolfan Therapiwteg a Thocsicoleg Cymru Gyfan

One Wales Medicines Assessment Group (OWMAG)
Minutes of the Teams meeting held Monday, 3 November 2025

Members in attendance
Andrew Champion, Program Director, AWTTC, Interim OWMAG Chair
Anthony Cadogan, Deputy Chief Pharmacist, representative Velindre
Stuart Wyn Evans, Clinical Effectiveness Pharmacist, representative Swansea Bay
Laurence Gray, Clinical Pharmacologist
Kathryn Howard, Head of Pharmacy, Royal Glamorgan Hospital, representative Cwm Taf Morgannwg
William King, Consultant in Public Health, representative Powys
Malcolm Latham, Lay representative
Anghard Lawson, Advanced Pharmacist, NHS Wales Joint Commissioning Committee
Eilir Hughes, Assistant Medical Director, representative Betsi Cadwaladr
Susan Myles, Director, Health Technology Wales
Ryan Miller, Senior Health Economist, Health Technology Wales
Joe Castle, Head of External Affairs and Operations, ABPI Cymru Wales
Leo P Pinto, Consultant Physician & Assistant Medical Director, representative Aneurin Bevan
Chris Commins, Assistant Finance Director, Aneurin Bevan
Michael Thomas, Consultant in Public Health, representative Hywel Dda

AWTTC
Gail Woodland, Senior Appraisal Pharmacist
Rosie Spears, Senior Appraisal Scientist
Laura Phillips, Admin Manager
Thomas Winfield, Senior Health Economist
Rachel Vickery, Medical Writer

Observers
Margaret Clark, alternate ABPI representative
Aled Richards, deputy Hywel Dda panel representative

Clinical expert
Professor Steven Knapper, Clinical Haematologist

List of abbreviations:

ABPI	Association of the British Pharmaceutical Industry
AWMSG	All Wales Medicines Strategy Group
AWTTC	All Wales Therapeutics and Toxicology Centre
ESR	Evidence status report
FLAG-IDA	Fludarabine, Ara-C (cytarabine), Granulocyte colony-stimulating factor (G-CSF), and Idarubicin
HSCT	Hematopoietic Stem Cell Transplantation
IPFR	Individual Patient Funding Request

NICE National Institute for Health and Care Excellence
OWMAG One Wales Medicines Assessment Group

Welcome and introduction
The Chair opened the meeting and welcomed members.

Apologies

- Tim Banner, Clinical Director Pharmacy & Medicines Management, representative Cardiff and Vale
- Will Hardy, Research Fellow, Bangor University, Health Economist
- Hazel Jones, Lay representative

Welcome
The Chair welcomed Ryan Miller, Senior Health Economist at Health Technology Wales, as the new alternate (deputy) health economic representative. The Chair also welcomed new observers to the meeting, including Margaret Clark as the alternate ABPI representative and Aled Richards as the deputy Hywel Dda panel representative. The Chair noted that Sue Beach, a long-standing member and deputy, has retired and stepped down from the panel. A letter of thanks and best wishes has been sent on behalf of the committee and AWTTC. Since the last meeting, the OWMAG recommendation for infliximab in treating immune checkpoint inhibitor-induced grade 3 myocarditis (unresponsive to first-line corticosteroids) has been endorsed by AWMSG and ratified by Welsh Government.

Declarations of interests/confidentiality
The Chair reminded members that all OWMAG proceedings are confidential and should not be disclosed outside of the meeting. Members were reminded that declarations of interest and confidentiality statements are signed by each member on an annual basis. The Chair invited any declarations of interest relating to the medicine being assessed today; there were none.

Assessment
venetoclax (Venclyxto®) with azacitidine for the treatment of relapsed/refractory acute myeloid leukaemia in adults following at least one line of intensive chemotherapy before or following allogenic haematopoietic stem cell transplant (HSCT) as an alternative to intensive chemotherapy

The Chair introduced the medicine to be assessed: venetoclax (Venclyxto®) with azacitidine, and welcomed Professor Steven Knapper, Clinical Haematologist, to the meeting. The Chair described the role of the clinical expert as an invited observer of the OWMAG meeting to answer questions and input into discussions to enable members to gain a better understanding of the clinical context. The Chair highlighted that clinical experts were nominated by their specialist group or network and should not express their personal opinion or promote the use of a medicine. The Chair invited any declarations of interest from Professor Knapper who disclosed a previous honorary speaking engagement with the manufacturer, which took place more than

12 months ago and therefore does not impact his ability to provide clinical input during this meeting.

The Chair invited Rosie Spears to present the assessment of venetoclax with azacitidine.

Rosie Spears presented the clinical evidence to the group for consideration, including data from the Woods et al. study supporting venetoclax with azacitidine therapy, and the Doma et al. study, which provided data for the comparator FLAG-IDA.

Professor Knapper was invited by the Chair to provide an overview of real-world clinical use, with the Chair guiding the discussion towards key considerations: defining the target patient cohort, evaluating the suitability of comparators, and establishing the medicine's position within the treatment pathway.

Evidence largely relates to newly diagnosed patients, originally approved by NICE under a fast-track process during COVID. There is now greater clinical experience, and an increased appetite for effective options in patients with unmet need, particularly those with relapsed or refractory AML. Intensive regimens remain standard for younger, fit patients, but toxicity is a major concern for older patients. The venetoclax with azacitidine regimen offer a less intensive alternative with better tolerability and quality-of-life benefits. The Wood study was a UK study and included the Cardiff and Vale UHB site, it is a reasonable study to use as is reflective of the practice in the UK and patient population. It demonstrated good response rates, especially for bridging to HSCT.
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The group discussed comparators. It was agreed there is no perfect comparator due to heterogeneity in the population. FLAG-Ida is appropriate where a curative strategy and transplant are pursued. Gilteritinib was raised as an alternative; it is NICE-approved and available in the UK but only for patients with FLT3 mutations (20–25% of relapsed cases), so not applicable to the broader cohort. Gail Woodland clarified that patients eligible for gilteritinib would fall outside of the population under consideration here. Other treatment options would include palliative care. A question was raised about when to treat, Professor Knapper confirmed that treatment tends to happen at molecular relapse. For those not suitable for FLAG-Ida then venetoclax and azacitidine would be a suitable option.

Patient numbers were considered. Based on Wood, approximately 50% achieved significant response, with 60% of those proceeding to transplant. For venetoclax with azacitidine , roughly 30–40% may reach transplant, though, for patients who had previously received a stem cell transplant donor lymphocyte infusion may be considered.

Practical experience was discussed. FLAG-Ida requires prolonged inpatient admission (4–6 weeks) and is associated with severe toxicity, including neutropenia, infections, and increased mortality risk. Venetoclax with azacitidine is not toxicity-free but generally involves shorter admissions and offers improved quality of life, particularly for older patients.

Access issues were highlighted. Use via IPFR is widespread, reflecting unmet need, but access remains inconsistent across the UK. No devolved nations have approved the treatment routinely. NICE has scheduled a technology appraisal; however, the specific indication is still in scoping, and there is no confirmation that the company intends to pursue a licence for this indication.

The Chair thanked Professor Knapper, who then left the meeting at 9.55am.

Rosie Spears continued presenting the clinical evidence, providing an overview of the smaller supplementary clinical studies included in the report, which supported the broader context of the main evidence base. An overview of the available safety data was also provided, highlighting key adverse events and tolerability profiles associated with venetoclax with azacitidine therapy and FLAG-Ida.

Tom Winfield presented a health economic analysis comparing venetoclax with azacitidine therapy with FLAG-Ida using a cost-consequence approach. This method was selected due to uncertainties in the clinical evidence and differences between the study populations.. Tom included a modified cost utility analysis indicating that venetoclax with azacitidine is likely to be both cost saving and less effective than FLAG-Ida indicating that it would sit within the southwest quadrant of the cost effectiveness plane. A 1.7 severity modifier was applied to the resulting incremental cost effectiveness ratio (ICER). Both analyses required assumptions for key cost drivers, such as HSCT, in the absence of published cost-effectiveness studies. Results should therefore be interpreted with caution. No questions were raised by members following the presentation.

Rosie Spears presented budget impact and patient factors. Based on an estimate of 10 eligible patients per year, the treatment is expected to generate modest annual savings compared to FLAG-Ida, mainly due to reduced inpatient costs. IPFR data indicate current use in NHS Wales is comparable to the estimated patient population. Relapsed/refractory AML has a poor prognosis, particularly in older patients; the treatment may delay progression, improve quality of life, and offer hope of extended survival. No equality concerns were identified, and members had no questions.

Malcolm Latham, as the lay member of the group, was invited by the Chair to provide an overview of the patient and public perspective. Malcolm highlighted the costs associated with this treatment are not excessive and may be considered cost-effective given the limited treatment options and associated quality-of-life benefits. Travel costs to tertiary centres were highlighted as a significant burden for some patients and their families.

The Chair summarised the main points of the assessment and asked the Group if there were any outstanding issues that required discussion before the vote was opened for the venetoclax with azacitidine assessment. The Chair confirmed the OWMAG recommendation to go to the All Wales Medicines Strategy Group (AWMSG) for endorsement was agreed.

Date of advice: Monday 3 November 2025

Using the agreed starting and stopping criteria venetoclax (Venclyxto®) with azacitidine can be made available within NHS Wales for the treatment of relapsed/refractory acute myeloid leukaemia in adults following at least one line of intensive chemotherapy before or following allogenic haematopoietic stem cell transplant (HSCT) as an alternative to intensive chemotherapy.

Venetoclax and azacitidine should be prescribed on the basis of lowest acquisition cost.

The risks and benefits of the off-label use of venetoclax and azacitidine for this indication should be clearly stated and discussed with the patient to allow informed consent.

Providers should consult the relevant guidelines on prescribing unlicensed medicines before any off-label medicines are prescribed.

This advice will be reviewed after 12 months or earlier if new evidence becomes available.

The Group then discussed the wording for the decision rationale document which accompanies the recommendation when it is presented to AWMSG for endorsement. The Group acknowledged that the review of the recommendation after 12 months will provide more evidence on the effectiveness of venetoclax with azacitidine and its associated costs for this intervention in NHS Wales. A draft was agreed which will be circulated to members after the meeting for comment before final sign-off.

The Chair thanked members for attending the meeting. Members were informed they will receive information regarding a review of rituximab for the treatment of myasthenia gravis. This treatment was initially assessed for fourth-line use and later reassessed for first-line use. Details will be circulated via email, including a voting slip, with responses requested by Monday 10 November. The next OWMAG meeting is scheduled for Monday 8 December and will be held via Microsoft Teams. One assessment will be discussed, infliximab for ICI-induced pneumonitis.

A note of thanks was extended to Joe Castle for her longstanding contributions to AWTTC committees. Joe is leaving at the end of the month to take up a new role, and her input and advocacy were warmly acknowledged by the team.

The Chair closed the meeting.