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, 9 February 2026

**Members in attendance**
Andrew Champion, Program Director, AWTTC, Interim OWMAG Chair
Tim Banner, Clinical Director Pharmacy & Medicines Management, representative Cardiff and Vale
Maggie Clark, Head of Access & Adoption Policy (Devolved Nations), ABPI
Stuart Wyn Evans, Clinical Effectiveness Pharmacist, representative Swansea Bay
James Coulson, Clinical Director of AWTTC
Will Hardy, Research Fellow, Bangor University, Health Economist
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
Chris Commins, Assistant Finance Director, Aneurin Bevan
Michael Thomas, Consultant in Public Health, representative Hywel Dda
Craig Roberts, Assistant Director of Allied Health Professions & Health Science, representative Aneurin Bevan

**AWTTC**
Gail Woodland, Senior Pharmacist
Eleri Burd, Advanced Pharmacist
Rosie Spears, Senior Scientist
Laura Phillips, Admin Manager

**Clinical experts**
Professor Ricky Frazer, Consultant Medical Oncologist and Clinical Lead for the South East Wales Immunotherapy Toxicity Service
Dr Samah Massalha, Consultant in Medical Oncology, Betsi Cadwaladr
Dr Sarah Hemington-Gorse, Consultant in Burns and Plastics, Swansea Bay

**Patient Organisation representative**
Susanna Daniels, Melanoma Focus

**List of abbreviations:**

| | |
|---|---|
| ABPI | The Association of the British Pharmaceutical Industry |
| AWMSG | All Wales Medicines Strategy Group |
| AWTTC | All Wales Therapeutics and Toxicology Centre |
| ESR | Evidence status report |
| EFS | Event free survival |
| NICE | National Institute for Health and Care Excellence |
| OWMAG | One Wales Medicines Assessment Group |
| RFS | Recurrence-free survival |
| SOC | Standard of care |

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

**Apologies**
- Hazel Jones, Lay representative
- Leo Pinto, Consultant Physician & Assistant Medical Director, representative Aneurin Bevan
- Laurence Gray, Clinical Pharmacologist
- Susan Myles, Director, Health Technology Wales
- Eilir Hughes, Assistant Medical Director, representative Betsi Cadwaladr
- Anthony Cadogan, Deputy Chief Pharmacist, representative Velindre (non-voting member, joined 10:50 until the end of the meeting (11:00)

**Welcome**
Dr Andrew Champion welcomed the Group.

**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**
**Nivolumab plus ipilimumab (OPDIVO® plus YERVOY®) for the neoadjuvant treatment of patients with resectable macroscopic stage III melanoma with ≥1 pathologically proven lymph node metastasis and up to 3 in-transit metastases.**

The Chair introduced the medicine to be assessed: nivolumab plus ipilimumab, and welcomed Professor Ricky Frazer, Consultant Medical Oncologist and Clinical Lead for the South East Wales Immunotherapy Toxicity Service, Dr Samah Massalha, Consultant in Medical Oncology, Betsi Cadwaladr, and Dr Sarah Hemington-Gorse, Consultant in Burns and Plastics, Swansea Bay, 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 Frazer, Dr Massalha, and Dr Hemington-Gorse; there were none.

The Chair invited Eleri Burd to present key aspects of the clinical effectiveness section of the evidence status report (ESR). Eleri briefly explained the background to the assessment, and the current treatment options and guidelines for treating stage III melanoma.

Eleri presented the clinical evidence to the Group, including data from the NADINA study by Blank et al., which provides the primary evidence in support of the treatment. Eleri also referred to the PRADO study by Reijers et al., which provides evidence for the potential surgery-sparing effects of the treatment. Eleri highlighted key clinical effectiveness and safety considerations before concluding that the favourable pathological response, event-free survival (EFS), and recurrence-free survival (RFS) rates reported in the NADINA and supporting studies suggests that the treatment under consideration is clinically effective and tolerable.

The Chair invited the clinical experts to share their views and experiences pertinent to the assessment, with the Chair guiding the discussion towards unmet need, current treatment options, positioning within the treatment pathway, and the benefits of treatment. The Chair invited Professor Frazer to share his views first.

Professor Frazer explained that the treatment would be prescribed to patients with the most aggressive form of stage III melanoma (approximately 20% of patients), who experience relapse rates of 50% and above at 5 years and many of whom die as a result of melanoma. He explained that the immune system can attack cancer cells more effectively when the tumour is present, as opposed to residual cancer cells. He concluded that the proposed treatment pathway aims to provide patients with less treatment in a timelier manner.

Professor Frazer noted that patients who achieve a major pathological response to neoadjuvant treatment are likely to experience improved quality of life and fewer drug-related toxicities as 12 months of adjuvant treatment is not required. He highlighted that the treatment enables the identification of patients with immune systems that respond to neoadjuvant treatment, who can subsequently avoid adjuvant treatment. However, Professor Frazer noted that the pathway will also benefit patients who do not respond to treatment, by facilitating the identification of individuals that require adjuvant immunotherapy, or an alternative adjuvant treatment. Professor Frazer noted that the treatment under consideration is used across the world and aligns with the gold standard treatment pathway for metastatic disease, but with a superior toxicity profile.

The Chair thanked Professor Frazer for their input and invited Dr Massalha to share her views. Dr Massalha reiterated that the treatment would result in a lower treatment burden for some patients. She acknowledged that, although the toxicity profile is less favourable to NHS Wales standard of care (SOC), the proposed dose of ipilimumab is lower than what the dose used for metastatic disease, rendering the treatment less toxic than the nivolumab plus ipilimumab combination used in the metastatic setting. Dr Massalha considered the risk of patients not undergoing surgery due to treatment-induced toxicity and acknowledged that a small number of patients did not progress to surgery due to neoadjuvant treatment-induced toxicities in the NADINA study. She highlighted the importance of considering the referral pathway for patients residing in north Wales, as surgery takes places in England.

Professor Frazer confirmed that, in the NADINA study, only 3 patients in the neoadjuvant treatment group did not progress to surgery due to treatment-related

toxicity. He noted that some patients in the NADINA study were unable to progress to surgery due to primary progression. He explained that this is important to establish, as surgery may not be suitable for these patients.

Professor Frazer explained that the treatment under consideration allows for treatment personalisation, by identifying which patients are likely to benefit from immunotherapy. He also referred to the surgery-sparing potential of the treatment as reported in the PRADO trial. He explained that omitting surgery would be beneficial for patients as lymphadenectomies can cause long-term neurological nerve problems and ongoing lymphoedema, which can significantly affect quality of life.

The Chair invited Dr Hemington-Gorse to share their views, who stated that post-lymphadenectomy lymphoedema affects approximately 30% of patients. She noted that they have treated some unresectable patients with neoadjuvant treatment, which has proven to be beneficial. She stated that alignment between surgical and oncology multi-disciplinary teams would be essential to ensure that surgery is performed in a timely manner.

The Chair invited questions from the committee members. A member of the Group asked whether delayed surgery could adversely impact patients who do not achieve a pathological response to neoadjuvant treatment. Professor Frazer explained that, in the cohort of patients that do not achieve a pathological response, a proportion will be found to have progressive disease, rendering surgery non-curative. In the event of delayed surgery due to treatment-induced toxicity, Professor Frazer highlighted that treatment-induced toxicity is a surrogate marker for a positive patient outcome. Therefore, he does not anticipate any detrimental effects from delayed surgery in these patient groups.

A member of the Group asked whether intelligence around the treatment's clinical efficacy has been gathered from colleagues in Scotland. Eleri confirmed that AWTTC hasn't gathered intelligence from Scotland.

The Chair asked whether the age and performance status of the NADINA study's population is comparable to the eligible patients in NHS Wales. Both Dr Massalha and Professor Frazer confirmed that the trial's population is largely representative of NHS Wales. The Chair raised that the NADINA trial only included nivolumab as a comparator, and asked the clinicians whether nivolumab, pembrolizumab and dabrafenib plus trametinib share comparable efficacy and side effect profiles. Professor Frazer informed the Group that the efficacy is comparable, and that nivolumab and pembrolizumab have shown comparable efficacy across 17 different tumour types, including melanoma. He explained that pembrolizumab is often preferred due to its lower frequency of administration, however efficacy and tolerability are comparable.

The Chair concluded the clinical effectiveness discussion and asked Eleri to present the budget impact to the Group. Eleri explained that, in the absence of cost effectiveness data and analysis, a comprehensive budget impact and comparison of costs was undertaken which considered medicine acquisition, medicine

administration, healthcare resource, and adverse event costs. Based on an estimated uptake of 41 patients per year, the treatment is expected to generate significant annual savings compared to NHS Wales SOC treatment, mainly due to reduced medicine acquisition, administration, and healthcare resource costs. Eleri highlighted the estimations and assumptions made to inform the budget impact.

The Chair invited questions from committee members. A member of the Group raised that potential long term treatment costs are not accounted for, in the scenario that adjuvant treatment would be required after year 1. The committee member noted that the adverse event costs of the neoadjuvant treatment have likely been underestimated, relative to SOC, as a fixed cost has been applied regardless of the adverse event or grade. Additionally, only the most common adverse events have been captured in the analysis, and rare adverse events can be costly.

Gail Woodland clarified that the costs of the treatment under consideration and SOC were compared to outline the costs associated with the treatments and support the budget impact. Gail explained that the costs used in the adverse event calculation were felt to be reasonable and in line with the rates of adverse events but acknowledged the committee member's view.

Professor Frazer responded to the committee member's concern that adjuvant treatment may be required after year 1 and the associated cost of this. He shared updated data from the NADINA study, where the neoadjuvant group's EFS rate was 20% higher than the adjuvant group's EFS, suggesting that the additional benefit of neoadjuvant treatment has been maintained. Professor Frazer also referred to the PRADO study, noting that the overall survival rate in this patient group at 5 years is 86%, higher than the anticipated survival of 60%. He concluded that the data provides reassuring data on relapse rates and mortality, which suggests that patients achieving a major pathological response will not require adjuvant treatment in the future.

Another member of the Group discussed the treatment's impact on diagnostic and support services, such as pathology, both in terms of the financial cost, and the human resource demand. The Chair thanked the committee member for their comment and highlighted the beneficial service impacts of the treatment, such as reduced outpatient appointments. Gail concluded that the treatment may be associated with additional service requirements initially, including a greater demand on pathology services, however in the future, the wider service will likely benefit from fewer outpatient appointments.

The Chair asked Eleri to provide an overview of the patient and societal factors related to the treatment under consideration. Eleri relayed the key factors, many of which had already been discussed by the Group, including the potential for a lower treatment burden resulting in fewer side effects for patients and less clinic appointments. She concluded that the equality and health impact assessment did not find any potential negative or an unequal impact on people based on their protected characteristics and they would expect a potential positive impact on people with stage III melanoma and their families and carers.

The Chair invited questions from the Group. Professor Frazer raised that the assessment of pathological response is a key biomarker in the pathway under consideration, for patients who do achieve a pathological response, and for the patients who do not. He concluded that, in patients who do not achieve a pathological response, the proposed pathway will enable clinicians to consider alternative treatments in a timelier manner.

The Chair invited Susanna Daniels, representative of Melanoma Focus, to give the views of patients with stage III melanoma. Susanna stated that melanoma is one of the most common cancers in young adults, a population that is economically active. She raised that patients receive 12 months of adjuvant treatment without knowing whether it's effective. She highlighted the importance of offering more personalised care for melanoma patients, which the treatment under consideration can offer. Susanna concluded that brain metastases is a significant concern of patients with melanoma, which is often a driver for patients to receive adjuvant treatment.

The Group's lay member was invited to provide comment on the patient and public perspective. The lay member highlighted that inequity of access is a major concern for patients and noted that the treatment is available in Scotland and internationally. The lay member stated that reducing the financial burden of cancer is becoming increasingly important for patients, who wish to contribute to their families and communities. The lay member acknowledged the benefits of the proposed pathway, including fewer appointments and timely alternative treatments for patients who do not respond to immunotherapy. The lay member noted that 41 patients is a considerable number of patients to be treated annually. The lay member acknowledged uncertainty around the budget impact but did not feel that this should be a barrier to making the treatment available for patients in Wales.

The Chair invited the clinicians to provide final thoughts and reflections. Professor Frazer highlighted that Wales is in a strong position with regards to managing immunotherapy-induced toxicities due to robust toxicity services. Dr Massalha noted that the medicines under consideration, and the management of their toxicities, are familiar to the clinicians. Dr Hemington-Gorse concluded that the majority of surgery would occur in Swansea Bay, which would be beneficial. Dr Massalha reminded the Group that in north Wales, scheduling surgery could be more challenging as it occurs in England. The Group discussed the potential for inequity of access to treatment between for patients residing in England and Wales. The Group discussed the neoadjuvant treatment options that are under consideration in England which could impact prescribing practices in England. Susanna Daniels informed the Group that the treatment under consideration is also approved for use in Northern Ireland.

The Chair thanked Professor Frazer, Dr Massalha, Dr Hemington-Gorse, and Susanna Daniels, who then left the meeting.

The Chair asked the Group if there were any outstanding issues that required discussion before the vote was opened for the nivolumab plus ipilimumab assessment.

The OWMAG recommendation to go to the All Wales Medicines Strategy Group (AWMSG) for endorsement was agreed.

**Date of advice: Monday 9 December 2026**

Using the agreed starting and stopping criteria nivolumab plus ipilimumab (OPDIVO® plus YERVOY®) can be made available within NHS Wales for the neoadjuvant treatment of patients with resectable macroscopic stage III melanoma with ≥1 pathologically proven lymph node metastasis and up to 3 in-transit metastases.

There is a simple discount patient access scheme (PAS) for both nivolumab (OPDIVO®) and ipilimumab (YERVOY®).

The risks and benefits of the off-label use of nivolumab plus ipilimumab (OPDIVO® plus YERVOY®) 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 recommendation will be reviewed after 12 months or earlier if new evidence becomes available.

The Chair thanked members for attending the meeting. Members were informed that they will receive information regarding reviews of infliximab and vedolizumab, both to treat ICI induced colitis. Details will be circulated via email, including a voting slip, with responses requested by Monday 16 February. The Group were informed that the next OWMAG meeting is scheduled for Monday 16 March. There are no new assessments but there are 2 reviews so this will be an email vote, rather than a meeting. The reviews are of bendamustine and rituximab for treatment of previously untreated and relapsed mantle cell lymphoma and bendamustine and rituximab for the treatment of previously untreated and relapsed indolent lymphomas.

The Chair closed the meeting.