Thank you for your reply. However, there are a number of unaddressed questions to which I would like a response:

* There is widespread consensus that this decision is wrong. Lord Lansley called it a “failure of government” on national radio and Jeremy Hunt agreed. An interim Minister made this decision with longstanding consequences that have been decried by senior members of the Conservative Party.
* Since Evusheld was given authorisation by the MHRA on the 17th March, there have been numerous real world studies that demonstrate efficacy as below. The recent Israel paper showed a 92% drop in hospitalisations too: <https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciac625/6651663> Please also see appendix for further studies.
* There is very little transparency in this whole process. It is unclear which data were considered and who on the panel was consulted. Certainly, many clinicians with whom we have spoken are extremely shocked by this decision.
* I would like to know what the perceived risks are, in relation to the statement “the risks of proceeding to patient access are considered to outweigh the risks of not providing this treatment in the current pandemic context”. I am not entirely sure they have an actual grasp on what the risks are to this group. Not only is there a risk of death or admission to ICU but the ongoing risks our group are facing are that many cannot work. This, coupled with the fuel crisis, mean that many people are at breaking point financially and mentally. The effects from a mental health point of view alone will be seen for years to come if nothing is done, as some people have been shielding for 2.5 years already. Add to this the fact that only 13.2% of immunocompromised people referred to CDMUs were given access to antivirals. So the current system is failing. If the “risks” here are supposedly that immunocompromised people will behave in riskier fashions while garnering only partial protection from Evusheld, then this is extremely patronising. The general population gathers only partial protection from vaccines but has been given the freedom to decide for themselves what risks they will accept. We are only asking for the same freedom. That said. immunocompromised people are 26 x more likely to die from covid. So I would love to know what risks outweigh these?
* The advised withdrawal of sotrovimab by the WHO and the US FDA leaves immunocompromised people with ever-fewer options for post-exposure treatment. Evusheld would assist with this risk.
* I would question why every other covid medication has bypassed the NICE route. In fact it appears that a process designed for rapid procurement of an unlicensed product has been applied to a drug that uniquely already had full, rather than conditional MHRA approval. We need to know why.
* Whilst we are aware that evidence shows that different patient groups have different levels of vaccine response, the patient cohorts for Evusheld have already been identified as per document <https://www.gov.uk/government/publications/higher-risk-patients-eligible-for-covid-19-treatments-independent-advisory-group-report/defining-the-highest-risk-clinical-subgroups-upon-community-infection-with-sars-cov-2-when-considering-the-use-of-neutralising-monoclonal-antibodies>
* There has already been a pilot test study carried out on immunosuppressed patient called the Melody Study. There is a whole debate though in the clinical world around antibody testing and a widespread agreement amongst clinicians that it is of little use, as there is still no clear idea how to interpret the results. For this reason the American CDC has scrapped their use, and are purely prescribing on a cohort basis, as per the document previously enclosed. So I think that statement is actually a smokescreen in all honesty and another delaying tactic.
* With regards to the statement regarding further clinical evidence, there has already been a trial which has been ongoing from 2021 called the PROVENT Trial. This trial found that there was a 77% reduced risk of developing symptomatic covid in people who had treatment. The trial involved over 5000 people. More than 75% of the participants had health conditions that put them at higher risk of covid, including people who were immunosuppressed due to disease or medical treatment.

I think that with the anticipated winter covid wave and the expectation of a 1 in 15 infection rate, the rollout of Evusheld is something that could ease this pressure on the NHS. We already know that 1/3 of ICU beds with covid are taken up by the immunocompromised. It seems very short sighted of the government not to provide it. The cost of an ICU bed for just 1 day is in the region of £2500, against the cost of Evusheld at £450 per dose. So the cost argument does not stack up, without even adding in the moral/psychological/clinical and financial burden to the immunocompromised people aspects.

Best wishes

XXXXXXXXXXX



**APPENDIX**

*Please note, the studies marked \* are real-world evaluations of Evusheld, with control arms. These have been conducted in the United States, France, and Israel during the Omicron waves.*

\*Al Jurdi, A., et al. (2022) ‘Tixagevimab/cilgavimab pre-exposure prophylaxis is associated with lower breakthrough infection risk in vaccinated solid organ transplant recipients during the Omicron wave’ American Journal of Transplantation 00, pp.1-7.

\*Bertrand, D., et al. (2022) ‘Efficacy of anti-SARS-CoV-2 monoclonal antibody prophylaxis and vaccination on the Omicron variant of COVID-19 in kidney transplant recipients’ Kidney Int. 102(2), pp.440-442.

Bruel, T., et al. (2022) ‘Serum neutralization of SARS-CoV-2 Omicron sublineages BA.1 and BA.2 in patients receiving monoclonal antibodies’ Nature Medicine 28(6), pp.1297-1302.

\*Kaminski, H., et al. (2022) ‘COVID-19 morbidity decreases with tixagevimab-cilgavimab preexposure prophylaxis in kidney transplant recipient nonresponders/low-vaccine responders’ Kidney Int. in press.

\*Kertes, J., et al. (2022) ‘Association between AZD7442 (tixagevimab-cilgavimab) administration of SARS-CoV-2 infection, hospitalization and mortality’ Clinical Infectious Diseases. in press.

Levin, M, J., et al. (2022) ‘Intramuscular AZD7442 (Tixagevimab-Cilgavimab) for Prevention of Covid-19’ The New England Journal of Medicine 386, pp.2188-2200.

Nguyen, Y., et al. (2022) ‘Pre-exposure prophylaxis with tixagevimab and cilgavimab (Evusheld) for COVID-19 among 1112 severely immunocompromised patients’ Clinical Microbiology and Infection. in press.

\*Young-Xu, Y., et al. (forthcoming) ‘Tixagevimab/Cilgavimab for Prevention of COVID-19 during the Omicron Surge: Retrospective Analysis of National VA Electronic Data’ medRxiv.