South African National Department of Health
Rapid Review Report
Component: COVID-19

TITLE: TOCILIZUMAB FOR THE TREATMENT OF COVID-19: EVIDENCE REVIEW OF THE CLINICAL BENEFIT AND HARM

Date: 5 March 2021 (second update of the initial 15 April 2020 rapid review)

Key findings

- We updated the rapid review of clinical evidence for the use of tocilizumab with or without other medicines in the management of hospitalised patients with severe COVID-19 requiring oxygen or ventilatory assistance.
- We identified 9 eligible randomised controlled trials (RCTs), and a systematic review and meta-analysis that combined all 9 RCTs.
- Overall tocilizumab reduced all-cause mortality from 29.1% to 25.9% at 28 days: The absolute risk reduction was 3.2% (95% confidence interval (CI) 0.8% to 5.2%), and the relative risk (RR) 0.89 (95% CI 0.82 to 0.97, 8 RCTs, n = 6 363). The number needed to treat to prevent one additional death was 32 (95% CI 20 to 125).
- Tocilizumab was not associated with an increased risk of adverse events (RR 1.23 [95% CI 0.87 to 1.72]), or serious adverse events (RR 0.89 [95% CI 0.75 to 1.06]).
- We did not identify any reports on the use of tocilizumab in children with COVID-19.

NEMLC THERAPEUTIC GUIDELINES SUB-COMMITTEE RECOMMENDATION:

	We recommend against the option and for the alternative **(strong)**	We suggest not to use the option or to use the alternative **(conditional)**	We suggest using either the option or the alternative **(conditional)**	We suggest using the option **(conditional)**	We recommend the option **(strong)**
Type of recommendation		**X**			

Recommendation: The sub-committee suggests not to use tocilizumab. Despite the reduction in death in the included trials, tocilizumab is not affordable at the current single exit price.

Rationale: A meta-analysis of 9 randomised controlled trials showed that tocilizumab, used in combination with corticosteroids, reduced all-cause mortality at day 28 from 29.1% to 25.9% amongst adult patients with COVID-19 with hypoxia and evidence of systemic inflammation (CRP ≥ 75mg/L), without an increase in clinically significant adverse events. However, the subcommittee expressed concerns regarding the budget impact and national supply of tocilizumab.

Level of Evidence: I High to moderate certainty evidence

Review indicator: **Reduction in price**

Therapeutic Guidelines Sub-Committee for COVID-19: Andy Parrish (chair), Gary Reubenson (vice-chair), Marc Blockman, Karen Cohen, Andy Gray, Tamara Kredo, Renee De Waal, Gary Maartens, Jeremy Nel, Helen Rees.

Note: Due to the continuous emergence of new evidence, the rapid review will be updated if and when more relevant evidence becomes available. It was noted that, as of 5 March 2021, 43 clinical trials investigating the role of tocilizumab in the management of COVID-19 are registered on https://clinicaltrials.gov/.

Version	Date	Reviewer(s)	Recommendation and Rationale
First	15 April 2020	RW, MB	Recommend against using tocilizumab in children or adult patients with COVID-19 as there is currently insufficient evidence to recommend routine use - consider in context of clinical trial setting.
Second	17 November 2020	RW, MB	Recommend against using tocilizumab in children or adult patients with COVID-19 as there is currently insufficient RCT evidence to recommend routine use - consider in context of clinical trial setting.
Third	5 March 2021	RW, MB, RdW, KC	Suggest the use of tocilizumab in hospitalized hypoxic adult patients with COVID-19 and a CRP ≥ 75mg/L, but with concerns about affordability and possible supply constraints.

BACKGROUND

In patients infected with SARS-CoV-2, disease severity and outcomes are related to the characteristics of the immune response. [1-6] The median time from onset of symptoms of COVID-19 to the development of acute respiratory distress syndrome (ARDS) is as short as 8 days[7]. Interleukin (IL)-6 and other components of the inflammatory cascade play an important role in the inflammatory reaction and immune response[8]. However, excessive cytokine production ('cytokine storm') as part of a hyper-inflammatory response has been suggested as a cause of severe COVID-19.[1-3] There has been some controversy as to whether IL-6 constitutes one of the most important cytokines involved in COVID-19-induced cytokine storms and if there is a correlation between elevated IL-6 levels in patients with COVID-19 and the risks of respiratory failure and the requirement for ventilation.[8, 9, 25]

Retrospective case series and individual case reports from China identified that IL-6 blockade therapy may constitute a novel therapeutic strategy in patients with severe SARS-CoV-2 pneumonia. [8, 10-13]

Tocilizumab (TCZ) is a recombinant humanized monoclonal antibody against human IL-6 receptor of immunoglobulin IgG1 subtype. In South Africa, it is the only commercially available IL-6 inhibitor and is registered for use in the management rheumatoid arthritis. Tocilizumab specifically binds soluble and membrane-bound IL-6 receptors (sIL-6R and mIL-6R) and inhibits the associated signal transduction. As a result, there is biological plausibility associated with tocilizumab's importance in the management COVID-19. [14] However, tocilizumab is not currently recommended in the World Health Organization guidelines, but is considered in the Australian and US National Institutes of Health (NIH) guidelines for patients who are within 24 hours of admission to the intensive care unit (ICU) and require invasive or noninvasive mechanical ventilation or high-flow oxygen (Appendix 1).

New RCT data was recently made available as a pre-print, thus warranting an update of this rapid review.

RESEARCH QUESTION:

Should tocilizumab be used for managing severe COVID-19 (with or without elevated IL-6 levels) in patients requiring oxygen or ventilatory assistance?

METHODS

This is the second update of this rapid review. The first review was conducted in April 2020, for which we systematically searched four electronic databases (PubMed as well as the Epistemonikos, Cochrane COVID Study Register and Living mapping and living network meta-analysis of COVID-19 studies databases).

The search strategy for the first update focused on randomised controlled trials and systematic reviews as such data had been published subsequent to the initial review. To this end, the Epistemonikos L*OVE evidence platform (https://app.iloveevidence.com/) was searched for randomised controlled trials and systemic reviews. Relevant records were extracted in a narrative table of results (see update of 26 November 2020).

This second update focused on new studies published after 15 November 2020. The Epistemonikos L*OVE evidence platform (https://app.iloveevidence.com/) was searched for randomised controlled trials and systemic reviews. Relevant records were extracted and summarized in a narrative table of results (see Table 1).

The search strategies for all three reviews are shown in Appendix 2.

Eligibility criteria for review

Population: Patients with confirmed COVID-19 (with or without elevated IL-6 levels), no restriction to age but severe disease requiring oxygen or ventilatory assistance.

Intervention: Tocilizumab in combination with local standard of care at the time. No restriction on dose, frequency, or timing with respect to onset of symptoms/severity of disease.

Comparators: Any (standard of care/placebo or active comparator).

Outcomes: Mortality; duration of ventilatory support including mechanical ventilation; duration of ICU stay; progression to ICU admission, progression to mechanical ventilation, clinical outcome on an ordinal scale at chosen time points, adverse events, adverse reactions.

Study designs: Randomised controlled trials, and systematic reviews of studies in humans.

RESULTS

The previous version of this review included 6 RCTs. The Epistemonikos L*OVE evidence platform (https://app.iloveevidence.com/) was searched on 13 January 2021. Details of the search are provided in Appendix 2. One reviewer screened 8 records (4 RCTs and 4 systematic reviews). One additional RCT[28] was eligible for inclusion in this review; two were formal publications of data included from pre-prints in the first update[21, 22]one was not relevant to the PICO question and thus excluded. Two additional recently published RCTs were shared by a Committee member for consideration[31, 32]. The main characteristics and outcomes of the 9 included RCTs are summarised in Table 2.

The Cochrane supported living meta-analysis (COVID-NMA) included all nine RCTs.[29] Findings of this living meta-analysis for the outcomes of interest are detailed below in Table 1. The associated forest plots are included in Appendix 3.

The other four systematic reviews retrieved did not include the results of the RCTs conducted by Gordon *et al.*, Veiga *et al.*[31] or Horby *et a*l.[32], and were thus not included in this update.

All-cause mortality at day 28

The COVID-NMA meta-analysis showed that tocilizumab 8mg/kg compared with standard of care/placebo for Mild/Moderate/Severe/Critical COVID-19 (eight RCTs, 6 363 participants) reduced mortality: RR 0.89 (95% CI 0.82 to 0.97; I^2=0.0%).

In Horby *et al.* (the Recovery trial) [32] there was some evidence for effect modification by concomitant use of steroids (Chi squared test for interaction p=0.01). In participants that received corticosteroids, day 28 mortality was 27% (457/1644) in the tocilizumab arm and 33% (565/1721) in the usual care arm. Amongst participants that did not receive corticosteroids, day 28 mortality was 39% (139/357) in the tocilizumab arm and 35% (127/367) in the usual care arm.

WHO ordinal progression score level 7 or above at Day 28

Level 7 and above on the WHO ordinal scale for clinical improvement is defined as "hospitalized patients with severe disease requiring mechanical ventilation ± additional organ support (ECMO, vasopressors or dialysis) OR death"[30].
COVID-NMA meta-analysis showed that tocilizumab 8mg/kg compared with standard of care/placebo for mild/moderate/severe/critical COVID-19 (three RCTs, 712 participants) reduced progression to WHO level 7 or above: RR 0.99 (95% CI 0.56 to 1.74; I^2=64.4%).

Adverse events

Tocilizumab 8mg/kg (except for Wang *et. al.* which allowed for a standard 400 mg dose) compared with standard of care/placebo for mild/moderate/severe/critical COVID-19 (seven RCTs, 1 534 participants): the included studies showed no statistically significant difference in adverse events: RR 1.23 (95% CI 0.87 to 1.72; I^2=86.4%).

Serious adverse events

Tocilizumab 8mg/kg (except for Wang *et al.* which allowed for a standard 400 mg dose) compared with standard of care/placebo for mild/moderate/severe/critical COVID-19 (eight RCTs, 2 312 participants): the included studies showed no statistically significant difference in serious adverse events: RR 0.89 (95% CI 0.75 to 1.06; I^2=0.0%).

Table 1: Summary of findings of the Cochrane Living Meta-analysis: Tocilizumab compared to standard care/placebo for mild/moderate/severe/critical COVID-19

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)
	Risk with Standard care/Placebo	Risk with Tocilizumab			
Clinical improvement D28 [b]	515 per 1.000	**545 per 1.000** (515 to 581)	**RR 1.06** (1.00 to 1.13)	5585 (7 RCTs) [c]	⨁⨁⨁◯ MODERATE [d]
WHO progression score (level 7 or above) D28	262 per 1.000	**260 per 1.000** (147 to 457)	**RR 0.99** (0.56 to 1.74)	712 (3 RCTs) [e]	⨁⨁◯◯ LOW [f,g]
All-cause mortality D28	291 per 1.000	**259 per 1.000** (239 to 283)	**RR 0.89** (0.82 to 0.97)	6363 (8 RCTs) [h]	⨁⨁⨁⨁ HIGH [i]
All-cause mortality D60 or above	133 per 1.000	**114 per 1.000** (70 to 186)	**RR 0.86** (0.53 to 1.40)	519 (2 RCTs) [j]	⨁⨁◯◯ LOW [k,l]
Adverse events	457 per 1.000	**562 per 1.000** (397 to 786)	**RR 1.23** (0.87 to 1.72)	1534 (7 RCTs) [m]	⨁◯◯◯ VERY LOW [n,o,p]
Serious adverse events	149 per 1.000	**132 per 1.000** (111 to 157)	**RR 0.89** (0.75 to 1.06)	2312 (8 RCTs) [q]	⨁⨁⨁◯ MODERATE [n]

***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).
CI: Confidence interval; **RR:** Risk ratio; **HR:** Hazard Ratio

GRADE Working Group grades of evidence
High certainty: We are very confident that the true effect lies close to that of the estimate of the effect
Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations
a. Last update: 13 February, 2021
b. Clinical improvement was defined variably as an improvement from baseline in >2 categories on a 7-category ordinal scale (Rosas I, COVACTA, 2020); a decrease of at least 2 points on an ordinal clinical improvement scale (Stone JH, 2020); or hospital discharge or ready to discharge (Hermine O, CORIMUNO-19, 2020; Horby P, RECOVERY (TCZ), 2021; Salvarani C, 2020; Salama C, EMPACTA, 2020; Veiga VC, TOCIBRAS, 2021)
c. Salama C, EMPACTA, 2020; Stone JH, 2020; Hermine O, CORIMUNO-19, 2020; Rosas I, COVACTA, 2020; Horby P, RECOVERY (TCZ), 2021; Veiga VC, TOCIBRAS, 2021; Salvarani C, 2020
d. Risk of bias downgraded by 1 level: some concerns due to deviation from intended interventions and outcome measurement
e. Hermine O, CORIMUNO-19, 2020; Rosas I, COVACTA, 2020; Veiga VC, TOCIBRAS, 2021
f. Risk of bias downgraded by 1 level: some concerns due to deviations from intended interventions
g. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm
h. Salama C, EMPACTA, 2020; Stone JH, 2020; Hermine O, CORIMUNDO-19, 2020; Rosas I, COVACTA, 2020; Horby P, RECOVERY (TCZ), 2021; Veiga VC, TOCIBRAS, 2021; Salvarani C, 2020, Gordon AC, REMAP-CAP, 2021
i. Despite some concerns due to deviation from intended interventions, risk of bias was not downgraded because the studies at risk contributed < 20% weight to the effect estimate.
j. Hermine O, CORIMUNO-19, 2020; Salama C, EMPACTA, 2020
k. Despite some concerns due to deviation from intended intervention in one study, risk of bias was not downgraded because this study contributed only 30% weight to the effect estimate.
l. Imprecision downgraded by 2 levels: due to low number of events and a wide confidence interval consistent with the possibility for benefit and the possibility for harm
m. Salama C, EMPACTA, 2020; Stone JH, 2020; Hermine O, CORIMUNO-19, 2020; Wang D, 2020; Rosas I, COVACTA, 2020; Veiga VC, TOCIBRAS, 2021; Salvarani C, 2020
n. Risk of bias downgraded by 1 level: some concerns regarding randomization, deviations from intended interventions, outcome measurement and selection of reported result
o. Inconsistency downgraded by 1 level: I^2=86.4%
p. Imprecision downgraded by 1 level: due to a wide confidence interval consistent with the possibility for no effect and the possibility for harm
q. Salama C, EMPACTA, 2020; Stone JH, 2020; Hermine O, CORIMUNO-19, 2020; Wang D, 2020; Rosas I, COVACTA, 2020; Veiga VC, TOCIBRAS, 2021; Salvarani C, 2020, Gordon AC, REMAP-CAP, 2021

CONCLUSION

A systematic review of nine RCTs of the use of tocilizumab in hospitalized patients with COVID-19 demonstrated a reduction in all-cause mortality at day 28. The absolute risk reduction was 3.2% (95% CI 0.8% to 5.2%), while the relative risk was 0.89 (95% CI 0.82 to 0.97, 8 RCTs, n = 6 363). The number needed to treat to prevent one additional death due to COVID-19 was calculated as 32 (95% CI 20 to 125). This result is largely driven by the findings of the RECOVERY trial[32] wherein tocilizumab, when used for hypoxic patients with a CRP of >75mg/L, produced a 4% absolute reduction in 28-day mortality compared with standard of care alone (TCZ = 29% vs. SOC = 33%; RR 0.86; 95% CI, 0.77 to 0.96; p=0·007). However, there are concerns regarding the national supply of tocilizumab and that the product is unaffordable. On this basis, it is recommended that tocilizumab, used in combination with corticosteroids, not be included in the COVID-19 treatment guidelines for the management of hospitalized hypoxic SARS-CoV-2 infected patients with CRP levels >75mg/L.

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Additional reviewers: Karen Cohen (Division of Clinical Pharmacology, Department of Medicine, Groote Schuur Hospital, University of Cape Town). Renee De Waal (Centre for Infectious Disease Epidemiology and Research, University of Cape Town).

Declaration of interests: RW, MB, KC and RdW have no interests to declare in respect of tocilizumab.

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Table 2. Characteristics of 9 randomised controlled trials included in the Cochrane living systematic review

Citation	Study design	Population (n)	Treatment	Main findings	Comments
Published, not peer-reviewed Gordon AC, Mouncey PR, Al-Beidh F, et. al. for the REMAP-CAP Investigators.[28] Interleukin-6 Receptor Antagonists in Critically Ill Patients with Covid-19 – Preliminary report: medRxiv 2020. DOI: 10.1101/2021.01.07.21249390	Randomised, placebo controlled multifactorial open-label trial. Study is ongoing. Primary endpoint: composite outcome of mortality or respiratory and CVS organ support-free days up to day 21 in survivors This analysis includes participants enrolled up to 19 November 2020	Multicentre: 113 sites across 6 countries. Participants: Critically ill adult patients with suspected or confirmed Covid-19, admitted to an intensive care unit (ICU) and receiving respiratory or cardiovascular organ support. Patients were randomized receive therapy within 24 hours of commencing organ support in an intensive care unit. Population: 895 were assigned to the immune modulation therapy domain (TCZ 366, sarilumab 48, 69 "other interventions", 412 control). 30 participants withdrew consent, and 11 had missing primary outcome data 803 participants were included at baseline (TCZ = 353, sarilumab = 48, control = 402) Outcomes for participants in the Other treatment arm were not reported on separately. The following participant numbers were included in the mortality analysis:	TCZ was administered intravenously at a dose of 8mg/kg up to a maximum of 800 mg. This dose could be repeated 12 - 24 hours later at the discretion of the treating clinician. 92% of participants received at least one dose of TCZ and 29% received a second dose. 707 participants were enrolled after the dexamethasone result from the RECOVERY trial. Of these participants, 93.3% (610/654) were treated with corticosteroids at enrollment or within the following 48 hours. Of the 158 participants recruited before June 17, 107 were randomized in the previously published Corticosteroid domain within REMAP-CAP, 41 allocated to a seven-day course of hydrocortisone and 39 to shock dependent hydrocortisone. Remdesivir use was recorded in 32.8% of participants.	Primary outcome: Respiratory and cardiovascular organ support-free days up to day 21. In this composite ordinal outcome, all deaths within hospital are assigned the worst outcome (–1). Among survivors, respiratory and cardiovascular organ support-free days are calculated up to day 21, such that a higher number represents faster recovery. Hospital mortality was 28.0% (98/350) for TCZ, 22.2% (10/45) for SRL and 35.8% (142/397) for control. Compared with control, median adjusted odds ratios for hospital survival were 1.64 (95% CrI 1.14, 2.35) for TCZ and 2.01 (95% CrI 1.18, 4.71) for SRL. Median organ support-free days were 10 (IQR -1, 16), 11 (IQR 0, 16) and 0 (IQR -1, 15) for TCZ, SRL and control groups, respectively. Compared with control, median adjusted odds ratios were 1.64 (95% CrI 1.25, 2.14) for TCZ and 1.76 (95% CrI 1.17, 2.91) for SRL.	Risk of bias assessment: MODERATE with some concerns noted. It was an unblinded study. There appears to be missing data regarding the concomitant use of dexamethasone and remdesivir. Although treatment assignment was adjusted for in their model, it's not clear if/how dexamethasone was adjusted for once it became standard of care. It appears that some participants were included in the final analysis despite having missing outcome data. It's not clear how these participants were censored.

Citation	Study design	Population (n)	Treatment	Main findings	Comments
		TCZ = 350 SRL = 45 Control = 397 Median age: 61.4 years (TCZ = 61.5 years; SRL = 63.4 years; placebo = 61.1 years			
Published, peer reviewed Salvarani C, Dolci G, Massari M, et al. [21] JAMA internal medicine. 2020. Effect of Tocilizumab vs Standard Care on Clinical Worsening in Patients Hospitalized With COVID-19 Pneumonia: A Randomized Clinical Trial.	Prospective, open-label, randomized clinical trial 31 March 2020 to 11 June 2020. The primary aim was to evaluate the efficacy of early administration of tocilizumab vs standard therapy in the first 2 weeks following randomization.	Setting: Italy, 24 hospitals Participants: patients with COVID-19 confirmed by positive PCR and the presence of acute respiratory failure with a partial pressure of arterial oxygen to fraction of inspired oxygen (PaO2/FIO2) ratio between 200 and 300 mm/Hg, an inflammatory phenotype defined by a temperature greater than 38°C during the last 2 days, and/or serum CRP ≥ 10mg/dL and/or CRP level increased to at least twice the admission measurement. Sample size: 126 (TCZ = 60, Standard Care = 66) Median age = 60.0 years (range 53.0 to 72.0 years).	The TCZ group received TCZ intravenously within 8 hours from randomization at a dose of 8mg/kg up to a maximum of 800 mg, followed by a second dose after 12 hours. The control arm received supportive care following the treatment protocols of each centre. All drugs were allowed except IL-1 blockers, Jak inhibitors, and tumor necrosis factor inhibitors.	Primary endpoint: clinical worsening within 14 days since randomization, defined by the occurrence of 1 of the following events, whichever occurred first: • Admission to ICU with mechanical ventilation • Death from any cause • PaO2/FIO2 ratio less than 150 mm Hg in 1 of the scheduled arterial blood gas measurements or in an emergency measurement, confirmed within 4 hours by a second examination 17 of 60 participants (28.3%) in the TCZ group and 17 of 63 (27.0%) in the standard care group showed clinical worsening within 14 days following randomization (rate ratio, 1.05; 95% CI, 0.59-1.86; P = .87)	Risk of bias assessment: **MODERATE** with some concerns noted. ITT analysis, but an unblinded study with a cross-over design (21.2% of patients in the SOC arm received study treatment due to clinical worsening).
Published, non-peer reviewed Salama C, Han J, Yau L, et. al. [22] medRxiv 2020.	Randomised, double-blind, placebo controlled, Phase III study	Setting: Multi-centre study across 6 countries Participants: hospitalized patients with COVID-19 pneumonia confirmed by positive PCR test and radiographic imaging.	Participants were randomized (2:1) to intravenous tocilizumab (8 mg/kg, maximum 800 mg) or placebo. If participants worsened or did not improve, an additional infusion could be administered 8 to 24 hours after the first.	Primary endpoint: cumulative proportion of participants requiring mechanical ventilation (mechanical invasive ventilation or extracorporeal membrane oxygen) or who had died by Day 28.	Risk of bias assessment: **LOW** as study was double-blind, placebo-controlled with random allocation sequence and adequate concealment. Data was available for >95% of population and outcomes reported were pre-specified in the protocol.

Tocilizumab in nonventilated patients hospitalized with Covid-19 pneumonia. DOI: 10.1101/2020.10.21.20210203		Sample size: 377 (TCZ = 249, Placebo = 128) Median age (± SD) = TCZ = 56.0 ±14.3 years; placebo = 55.6 ±14.9 years.	Both groups received standard care per local practice which could include antiviral treatment, limited systemic corticosteroids (≤1 mg/kg methylprednisolone or equivalent recommended) and supportive care In the tocilizumab and placebo arms, 55.4% and 67.2% of participants received dexamethasone, respectively, and 52.6% and 58.6% received remdesivir, respectively.	TCZ = 12.0% (95% CI, 8.52% to 16.86%) Placebo = 19.3 % (95% CI, 13.34% to 27.36%) (HR, 0.56 [95% CI, 0.33 to 0.97]; log-rank P=0.036).	
Published, peer reviewed Hermine O, Mariette X, Tharaux PL, et al. for the CORIMUNO-19 Collaborative Group.[19] JAMA internal medicine. 2020. Effect of Tocilizumab vs Usual Care in Adults Hospitalized With COVID-19 and Moderate or Severe Pneumonia: A Randomized Clinical Trial	Randomised, open-labelled, multicenter study. 31 March 2020 to 18 April 2020.	Setting: France, 9 university hospitals Participants: patients with COVID-19 and moderate or severe pneumonia requiring at least 3 L/min of oxygen but without ventilation or ICU admission. Sample size: 130 (TCZ = 63 Usual Care = 67) Median age = TCZ = 64.0 years; UC = 63.3 years.	Participants were randomized on a 1:1 ratio to receive TCZ plus usual care or usual care alone. TCZ was administered at a dose of 8mg/kg IV on Day 1, followed by a fixed dose of 400mg IV on day 3 if the oxygen requirement has not decreased by more than 50%.	Primary outcomes were scores higher than 5 on the World Health Organization 10-point Clinical Progression Scale (WHO-CPS) on day 4 and survival without need of ventilation (including non-invasive ventilation) at day 14. Outcomes amended on 06 April 2020 to include high-flow oxygen in noninvasive ventilation. Primary: 12 participants (19%) had a WHO-CPS score greater than 5 at day 4 vs 19 (28%) in the UC group (median posterior absolute risk difference [ARD] −9.0%; 90% credible interval [CrI], −21.0 to 3.1) At day 14, 12% (95% CI −28%to 4%) fewer participants needed non-invasive ventilation (NIV) or mechanical ventilation (or died in the TCZ group than in the UC group (24%vs 36%, median posterior hazard ratio [HR] 0.58; 90% CrI, 0.33-1.00).	Risk of bias assessment: **MODERATE** as this was an unblinded study.

				The number of participants with mechanical ventilation or death at Day 14 was 11 (17%) and 18 (27%) in the TCZ and UC groups respectively.	
Published, peer reviewed Stone JH, Frigault MJ, Serling-Boyd NJ, et al.[20] New England Journal of Medicine. 2020. Efficacy of Tocilizumab in Patients Hospitalized with Covid-19 https://www.nejm.org/doi/full/10.1056/NEJMoa2028836	Randomised, double-blind, placebo controlled. 20 April 2020 to 15 June 2020.	Setting: USA, 7 hospitals in Boston Participants: patients with COVID-19 confirmed either by PCR or serum IgM antibody assay. Participants had to have at least two of the following signs: fever (body temperature >38°C) within 72 hours before enrollment, pulmonary infiltrates, or a need for supplemental oxygen to maintain an oxygen saturation > 92%. At least one of the following laboratory criteria also had to be fulfilled: a CRP > 50 mg/L, ferritin > 500 ng/ml, D-dimer > 1000 ng/ml, LDH > 250 U/L. Sample size: 242 (TCZ = 161, Placebo = 81) Median age = 59.8 years (range 21.7 to 85.4 years).	Participants were randomised on a 2:1 ratio to receive standard care plus a single dose of either tocilizumab (8 mg per kilogram of body weight administered intravenously, not to exceed 800 mg) or placebo Antiviral therapy, hydroxychloroquine, and glucocorticoids were permitted as concomitant treatment. However, some participants received remdesivir as concomitant treatment due to the release of the ACTT-1 trial during this trial. no participants received dexamethasone as the RECOVERY trial results were announced afterwards.	The primary outcome was intubation (or death, for participants who died before intubation) after administration of tocilizumab or placebo. The secondary endpoints were clinical worsening and discontinuation of supplemental oxygen among participants who had been receiving it at baseline. The hazard ratio for intubation or death for TCZ as compared with the placebo group was 0.83 (95% confidence interval [CI], 0.38 to 1.81; P = 0.64). The hazard ratio for disease worsening was 1.11 (95% CI, 0.59 to 2.10; P = 0.73). At 14 days, 18.0% of the participants in the TCZ group and 14.9% of the participants in the placebo group had demonstrated disease worsening. There was no difference in the median time to discontinuation of supplemental oxygen [TCZ = 5.0 days (95% CI, 3.8 to 7.6) vs placebo = 4.9 days (95% CI, 3.8 to 7.8)] in the placebo group (P = 0.69). At 14 days, 24.6% of the participants in the tocilizumab group and 21.2% of the participants in the placebo group were still receiving supplemental oxygen.	Risk of bias assessment: **LOW** as the study is a randomized, double-blind, placebo-controlled trial with random allocation sequence and adequate concealment. 242/243 patients analyzed (<5% of total sample size).

Non-peer reviewed Wang D, Fu B, Peng Z, et. al.[24] SSRN. 2020. Tocilizumab Ameliorates the Hypoxia in COVID-19 Moderate Patients with Bilateral Pulmonary Lesions: A Randomized, Controlled, Open-Label, Multicenter Trial. DOI: 10.2139/ssrn.3667681	Randomized, controlled, open-label, multicentre trial 13 February 2020 to 13 March 2020.	Setting: China, 6 hospitals in Anhui and Hubei Participants: Patients PCR confirmed COVID-19 between the ages of 18 and 85 years, had elevated plasma IL-6 levels with moderate or severe disease. Moderate disease was defined as fever or other respiratory symptoms as well as bilateral pulmonary lesions confirmed on chest imaging Severe disease was defined as the presence of any of the following: 1) respiratory rate ≥30 breaths per min; 2) SpO2 ≤ 93% while breathing room air; and/or 3) PaO2/FiO2 ≤ 300 mmHg Sample size: 65 (TCZ = 33, Control = 1460) Median age = 63.0 years (IQR = 55.0 to 71.0 years).	Participants were randomly assigned in a 1:1 ratio to receive either tocilizumab in addition to standard care, or standard care alone. If a participant in the control group progressed to severe disease within 3 days after randomization, they were transferred to the tocilizumab group.	Primary endpoint: Cure rate. Cure was defined as 1) fever attenuated for continuously for 7 days, 2) two negative COVD-19 PCR tests, 3) CT scan showing absorption of chest effusion by more than 50% percent on discharge. The cure rate for TCZ was 94.12% vs 87.10% for the control group, but the difference was not statistically significant (P = 0.4133). For the secondary endpoints of recovery rate of hypoxia over 14 days and the worsening rate of hypoxia during hospitalization: Recovery rate of hypoxia: TCZ = 91.67% vs 60.00% (p = 0.0328) in the control group. The difference was evident from day 4 and statistically significant from day 12.	Risk of bias assessment: **HIGH**, as there were concerns regarding the allocation concealment during randomisation. ITT analysis, but small study (n=65). Study unblinded and possible bias with the measurement of the outcome in particular the measurement of adverse events and serious adverse events. Possible bias regarding selection of the reported results, as adverse events were not mentioned in the registry but reported in the paper. The protocol and statistical plans were not available.
Published non-peer reviewed Rosas I, Bräu N, Waters M, et. al.[23] medRxiv 2020 Tocilizumab in Hospitalized Patients With COVID-19 Pneumonia.	Randomized, double-blind, placebo-controlled trial	Setting: 9 Countries - Canada, Denmark, France, Germany, Italy, Netherlands, Spain, UK and USA. Participants: Patients with PCR confirmed COVID-19 and evidenced by bilateral chest infiltrates on chest x-ray or CT. Participants were also required to have blood oxygen saturation ≤93% or partial pressure of	Participants were randomized (2:1) to receive intravenous tocilizumab (8 mg/kg infusion, maximum 800 mg) or placebo plus standard care. If clinical signs or symptoms did not improve or worsened a second infusion could be administered 8 to 24 hours after the first.	Primary endpoint: Clinical status assessed on a 7-category ordinal scale at day 28. Clinical status was measured at baseline and every day during hospitalization. Clinical status at day 28 was not statistically significantly improved for tocilizumab versus placebo (P=0.36). Median (95% CI) ordinal scale values at day 28: TCZ = 1.0 (1.0 to 1.0) for tocilizumab	Risk of bias assessment: **LOW** as blinded study with random allocation sequence and adequate concealment. 452/438 patients analysed (>95% of population), and outcomes reported were pre-specified in the registry.

DOI 10.1101/2020.08.27.20183442		oxygen/fraction of inspired oxygen <300 mmHg. Sample size: 438 (TCZ = 294, Control = 144) Median age = 63.0 years (IQR = 55.0 to 71.0 years).		Placebo 2.0 (1.0 to 4.0) (odds ratio, 1.19 [0.81 to 1.76]). There was no difference in mortality at day 28 between tocilizumab (19.7%) and placebo (19.4%) (difference, 0.3% [95% CI, –7.6 to 8.2]; nominal P=0.94). Median time to hospital discharge was 8 days shorter with tocilizumab than placebo (20.0 and 28.0, respectively; nominal P=0.037; hazard ratio 1.35 [95% CI 1.02 to 1.79]). Median duration of ICU stay was 5.8 days shorter with tocilizumab than placebo (9.8 and 15.5, respectively; nominal P=0.045).	
Published, peer-reviewed Veiga VC, Prats JAGG, Farias DLC et. al.[31] BMJ 2021 Effect of tocilizumab on clinical outcomes at 15 days in patients with severe or critical coronavirus disease 2019: randomised controlled trial. DOI: 10.1136/bmj.n84	Randomised, open-labelled trial 08 May to 17 July 2020.	Setting: Brazil, 9 hospitals Participants: Adult patients with severe PCR-confirmed SARS-CoV-2 infection. Patients were required to have experience symptoms for more than 3 days and present with evidence of pulmonary infiltrates confirmed by chest CT or radiography and were receiving supplemental oxygen or had been receiving mechanical ventilation for less than 24 hours before analysis. Sample size: 129 (TCZ = 65, SOC = 64) Mean age:	Patients were randomised (1:1) to receive either TCZ (single intravenous infusion of 8 mg/kg) plus standard care or standard care alone. Standard of care allowed for the concomitant use of hydroxychloroquine, azithromycin, corticosteroids, and antibiotics as per local institutional guidelines for patients with covid-19. Remdesivir was not available in Brazil at the time of the study.	Primary outcome: clinical status at 15 days evaluated on a seven-level ordinal scale. The trial was prematurely after the first interim analysis owing to an excess number of deaths at 15 days in the tocilizumab group TCZ was not associated with an improvement in mechanical ventilation or death at 15 days (18 of 65 (28%) patients in the TCZ group and 13 of 64 (20%) in the SOC group: odds ratio 1.54, 95% CI 0.66 - 3.66; P=0.32). Death at 15 days, a component of the primary outcome, occurred in 11 (17%) patients in the TCZ group compared with two (3%) in the SOC group (odds ratio 6.42, 1.59 - 43.2).	Risk of bias assessment: **MODERATE** as study was unblinded study and the outcomes could have been influenced by the intervention assignment.

		TCZ = 57.4 years (SD = 15.7 years) SOC = 57.5 years (SD = 13.5years)			
Published, non-peer reviewed Horby PW, Pessoa-Amorim G, Peto L et al. for the RECOVERY Collaborative Group[32] *medRxiv* 2021 Tocilizumab in patients admitted to hospital with COVID-19 (RECOVERY): preliminary results of a randomised, controlled, open-label, platform trial DOI: https://doi.org/10.1101/2021.02.11.21249258	Randomised, controlled, open-label, platform trial (Randomised Evaluation of COVID-19 Therapy [RECOVERY] 23 April 2020 and 24 January 2021	Setting: United Kingdom, 131 sites Participants: Adult hospitalized patients with clinically suspected or laboratory confirmed SARS-CoV-2 infection as well as hypoxia (defined as Sp02 of <92% and a CRP level of ≥75 mg/L). Sample size: 4 116 (TCZ = 2 022, SOC = 2 094) At the time of this publication, follow-up was completed for 1602 (79%) of the 2022 TCZ patients and 1664 (79%) of the 2094 patients SOC Mean age: 63.6 years (SD 13.7)	Patients were randomised (1:1) to receive either TCZ plus standard care or standard care alone. TCZ doses were weight-based (800mg if weight >90kg; 600 mg if weight >65 and ≤90 kg; 400 mg if weight >40 and ≤65 kg; and 8mg/kg if weight ≤40 kg). A second dose could be given 12 to 24 hours later if, at the discretion of the attending clinician, the patient's condition had not improved. Standard of care is not described. At randomisation, 562 (14%) patients were receiving invasive mechanical ventilation, 1686 (41%) were receiving non-invasive respiratory support (including high-flow nasal oxygen, CPAP, and non-invasive ventilation), and 1868 (45%) were receiving no respiratory support other than simple oxygen therapy.	Primary outcome: all-cause mortality at 28 days. Secondary outcomes were time to discharge alive from hospital, and, among patients not receiving invasive mechanical ventilation at randomisation, receipt of invasive mechanical ventilation (including extra-corporeal membrane oxygenation) or death. TCZ was associated with a 4% absolute reduction 28-day mortality compared with SOC alone (596 [29%] of 2022 patients in the tocilizumab group vs. 694 (33%) of 2094 patients in the usual care group; rate ratio 0.86; 95% confidence interval [CI], 0.77 to 0.96; p=0·007). TCZ was associated with a greater probability of discharge from hospital alive within 28 days (54% vs. 47%; rate ratio 1.22, 95% CI 1.12 to 1.34, p<0·0001). Among those not on invasive mechanical ventilation at baseline, TCZ reduced in the risk of progressing to the pre-specified composite secondary outcome of invasive mechanical ventilation or death when compared to SOC (33% vs. 38%, risk ratio 0.85, 95% CI 0.78 to 0.93, p=0·0005).	Risk of bias assessment: **MODERATE** as study was unblinded and there were some concerns with the measurement of the outcome: Clinical improvement (D28), defined as discharge from hospital. Assessment requires clinical judgement and could be affected by knowledge of intervention receipt.

Appendix 1: GUIDELINE CONSIDERATIONS

1. NIH COVID-19 Treatment Guidelines (updated 3 February 2021)[17]

Interleukin-6 Inhibitors

Statement: "….After reviewing the collective evidence from REMAP-CAP and other trials, the Panel has revised the recommendations on the use of tocilizumab and sarilumab in patients with COVID-19:

Recommendations:

- "For patients who are within 24 hours of admission to the intensive care unit (ICU) and require invasive or noninvasive mechanical ventilation or high-flow oxygen (>0.4 FiO2/30 L/min oxygen flow), there are insufficient data to recommend either for or against the use of tocilizumab or sarilumab for the treatment of COVID-19.
  - Although many trials of tocilizumab for the treatment of COVID-19 have included patients who meet the above criteria, the collective data available to date preclude a definitive recommendation for or against the use of the drug.
  - In view of the results from the REMAP-CAP trial, some Panel members would administer a single dose of tocilizumab (8 mg/kg of actual body weight, up to 800 mg) in addition to dexamethasone to patients who meet the above criteria and who are also exhibiting rapid progression of respiratory failure.
  - Too few patients in REMAP-CAP received sarilumab for the Panel to assess its efficacy in the treatment of patients who met the above criteria.
- For patients who do not require ICU-level care or are admitted to the ICU but do not meet the above criteria, the Panel recommends against the use of tocilizumab or sarilumab for the treatment of COVID-19, except in a clinical trial (BIIa).
- Additional results of randomized controlled trials of tocilizumab and sarilumab will further understanding of the role these IL-6 inhibitors play in the treatment of COVID-19. Future updates to the Interleukin-6 Inhibitors section will include discussion of these studies".

2. World Health Organization: Clinical management of severe acute respiratory infection when novel coronavirus (2019-nCoV) infection is suspected. Interim guidance (27 May 2020)[18]:

Antivirals, immunomodulators and other adjunctive therapies for COVID-19

Recommendation: We recommend that the following drugs not be administered as treatment or prophylaxis for COVID-19, outside of the context of clinical trials:

- Chloroquine and hydroxychloroquine (+/- azithromycin)
- Antivirals, including but not limited to:
  - Lopinavir/ritonavir
  - Remdesivir
  - Umifenovir
  - Favipiravir
- Immunomodulators, including but not limited to:
  - Tocilizumab
  - Interferon-β-1a
- Plasma therapy

3. Australian guidelines for the clinical care of people with COVID-19. Version 34.1 (updated 18 February 2021)[27]

6.6.29 Tocilizumab

Recommendation: Consider using tocilizumab for the treatment of COVID-19 in adults who require supplemental oxygen, particularly where there is evidence of systemic inflammation.

In patients hospitalised with COVID-19 who require supplemental oxygen, tocilizumab probably reduces the risk of death. Because of this, the Taskforce gives a conditional recommendation for tocilizumab both within and outside the context of a randomised trial unless contraindicated (e.g. patients with other active, severe infections).

In accordance with the RECOVERY trial, tocilizumab should be administered as a single intravenous infusion over 60 minutes, with the potential for a second dose to be administered either 12 or 24 hours later if the patient's condition has not improved. The suggested dose is dependent on body weight:

- Patients > 90 kg: 800 mg tocilizumab
- Patients > 65 and ≤ 90 kg: 600 mg tocilizumab
- Patients > 40 and ≤ 65 kg: 400 mg tocilizumab
- Patients ≤ 40 kg: 8 mg/kg tocilizumab

In addition, the RECOVERY and REMAP-CAP trials have demonstrated a significant benefit when using corticosteroids in conjunction with tocilizumab. Use of combined tocilizumab and corticosteroids should be considered in patients hospitalised with COVID-19 who require oxygen, however the optimal sequencing of tocilizumab and corticosteroid use is unclear.

As tocilizumab inhibits the production of C-reactive protein (CRP), a reduction in CRP should not be used as a marker of clinical improvement.

Evidence summary: "…. Evidence comes from nine randomised trials that compared tocilizumab with standard care in 6390 adults hospitalised with COVID-19. The majority of data are from the RECOVERY trial, which included 4116 adults hospitalised with moderate to critical COVID-19 [79]. There was variability in disease severity among patients included in the trials….."
"Following publication of the tocilizumab arm of the RECOVERY trial, the Taskforce updated the ICEMAN analysis to determine whether the inclusion of the RECOVERY data affected the appropriateness of subgroup analyses. Results from the updated analysis suggest that it is still likely to be inappropriate to separate data based on disease severity. This is because:

- There remained limited within-trial (COVACTA and RECOVERY) and between-trial publications (REMAP-CAP, COVACTA and RECOVERY) that provide data for the smallest subgroup (patients with critical illness).
- The test for subgroup differences continues to suggest that chance may be a likely explanation, with the P value increasing to 0.78 following inclusion of the RECOVERY trial. Data remains sufficiently homogenous between data points (I^2 = 0%)".

Appendix 2: Search strategy

Search Strategy 1:
Date: 11 April 2020
Period: Prior to 11 April 2020

Epistemonikos

(title:(coronavirus or covid* or 2019-ncov or sars-cov-2) or abstract:(coronavirus or covid* or 2019-ncov or sars-cov-2)) and (title:(tocilizumab or IL-6 inhibitor or interleukin-6 inhibitor) or abstract:(tocilizumab or IL-6 inhibitor or interleukin-6 inhibitor))

Records retrieved: 13 (1 relevant to PICO question)

PubMed

(((coronavirus[title/abstract] or covid*[title/abstract] or 2019-ncov[title/abstract] or sars-cov- 2[title/abstract])) and (tocilizumab[title/abstract] or IL-6 inhibitor[title/abstract] or interleukin-6 inhibitor[title/abstract]) not ((animals[mh] not humans[mh]))) and ("2019/12/01"[date - publication] : "3000"[date - publication])

Records retrieved: 43 (1 relevant to PICO question)

Living mapping and living network meta-analysis of COVID-19 studies (https://covid-nma.com/)

Tocilizumab
Interleukin-6 inhibitor
Interleukine-6 inhibitor

Records retrieved: none

Cochrane COVID Study Register (https://covid-19.cochrane.org/)

Tocilizumab AND interleukin-6 inhibitor

Records retrieved: 12 (none relevant to PICO question)

Search Strategy 2:
Date: 15 November 2020

Epistemonikos L*OVE evidence platform:

Tocilizumab

Records retrieved: 58 (10 RCTs and 48 systematic reviews). 6 RCTs and 1 systematic review were included for review.

Search Strategy 3:

Date: 13 January 2021

Epistemonikos L*OVE evidence platform:

Tocilizumab

Records retrieved: Randomised controlled trials and systematic reviewed published in December 2020 and January 2021. Three RCTs were eligible, however only one pertained to data not previously reviewed and thus was included in this update. No systematic reviews were found published after 15 November 2020 that included the randomized controlled trial described above.

Appendix 3: Forest plots for Cochrane Living Meta-analysis: Tocilizumab compared to Standard of care/Placebo for Mild/Moderate/Severe/Critical COVID-19

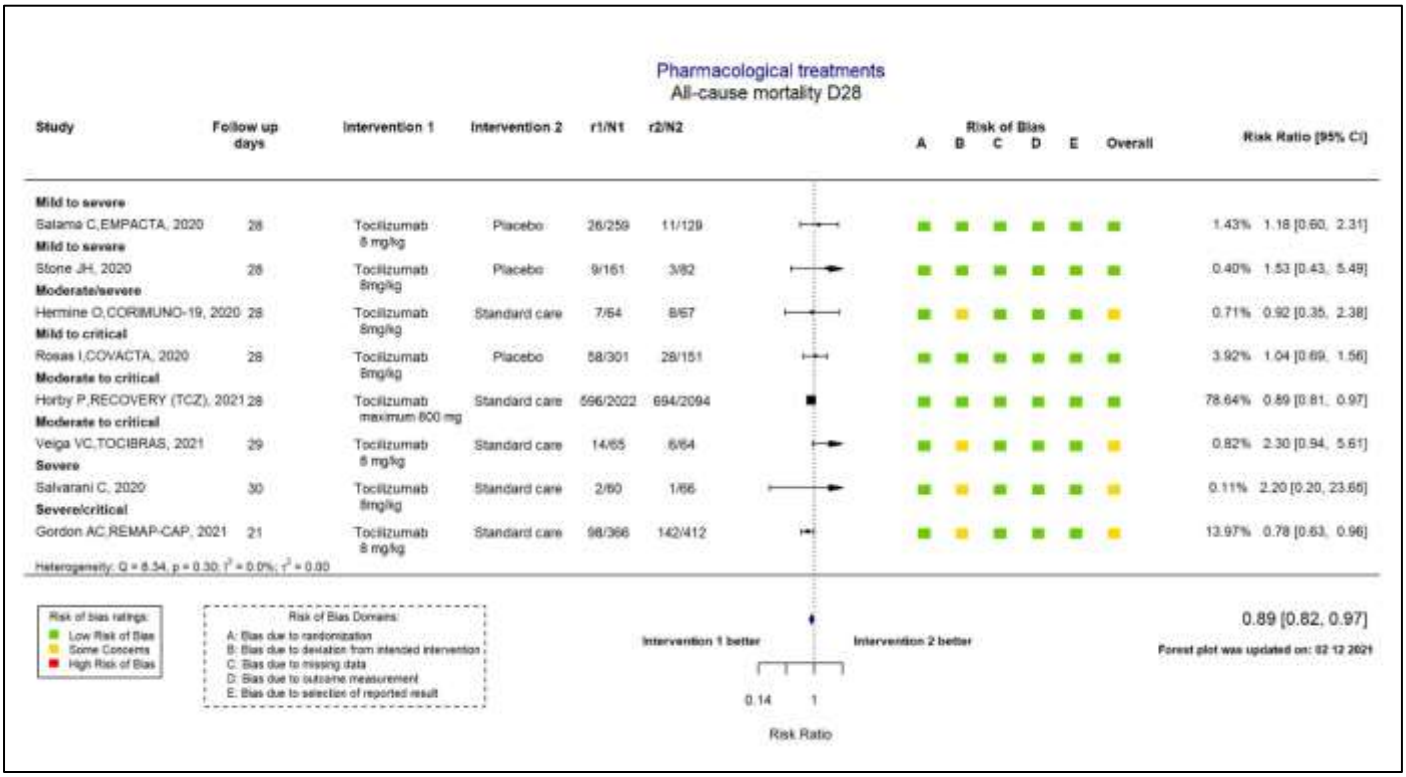

Figure 1: All-cause mortality, D28: Tocilizumab compared to Standard of care/Placebo

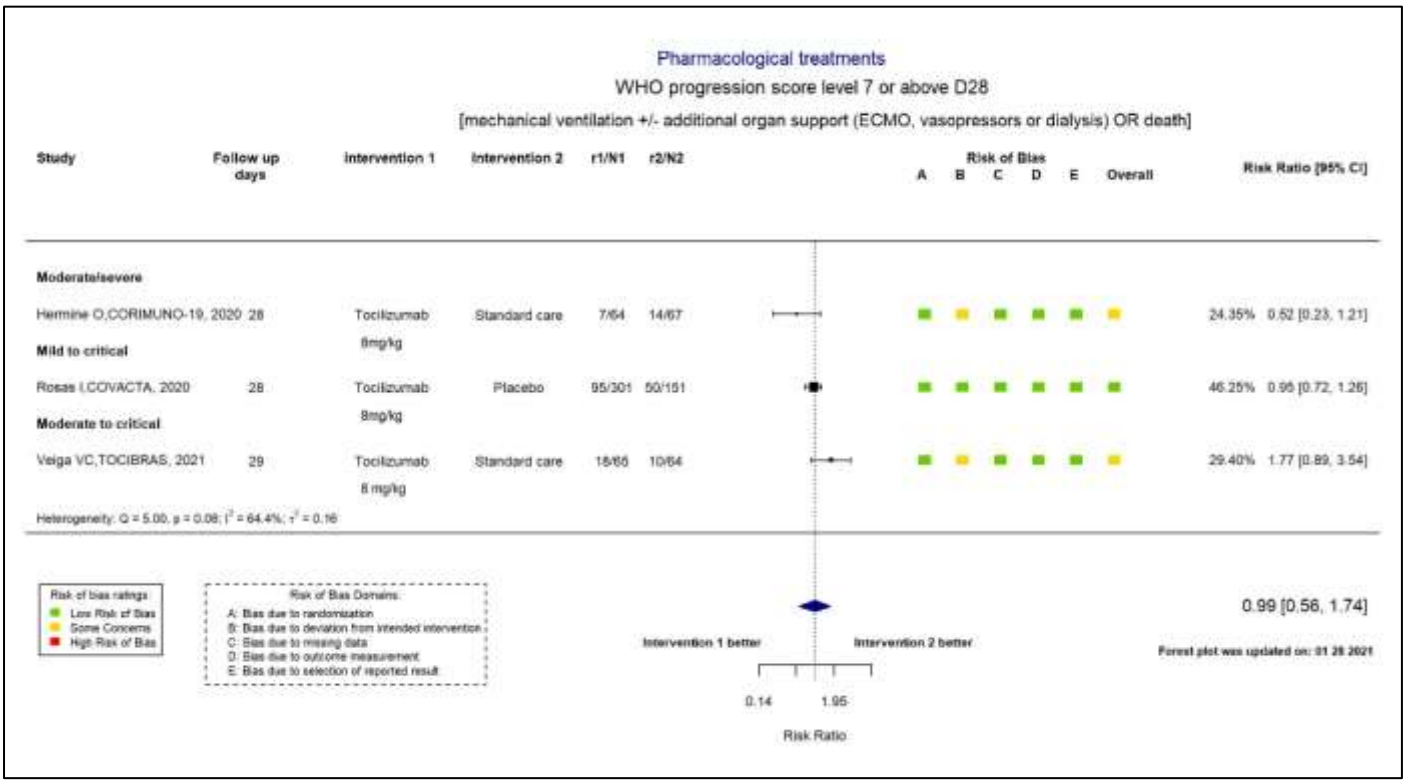

Figure 2: WHO progression score level 7 or above at Day 28 [mechanical ventilation ± additional organ support (ECMO, vasopressors or dialysis) OR death.

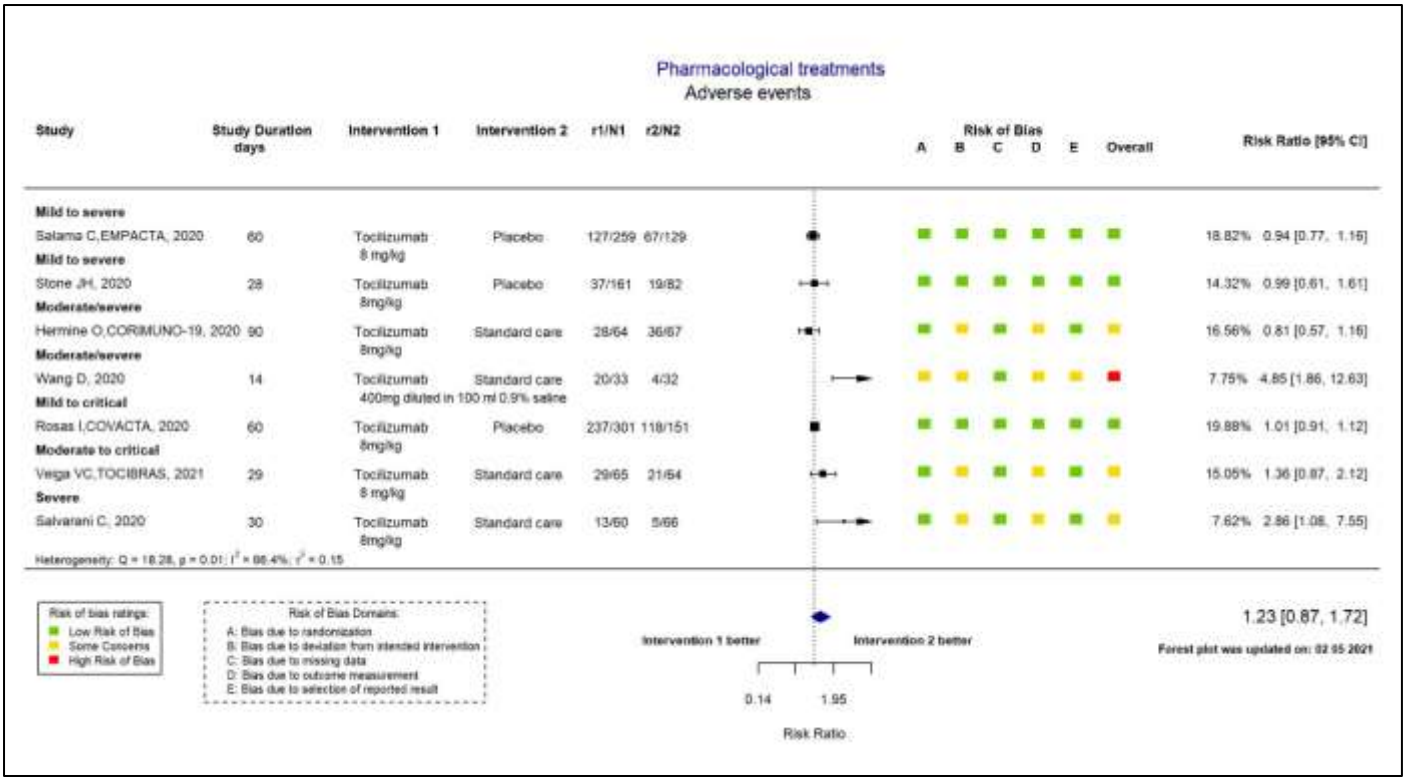

Figure 3: Adverse events: Tocilizumab compared to Standard of care/placebo

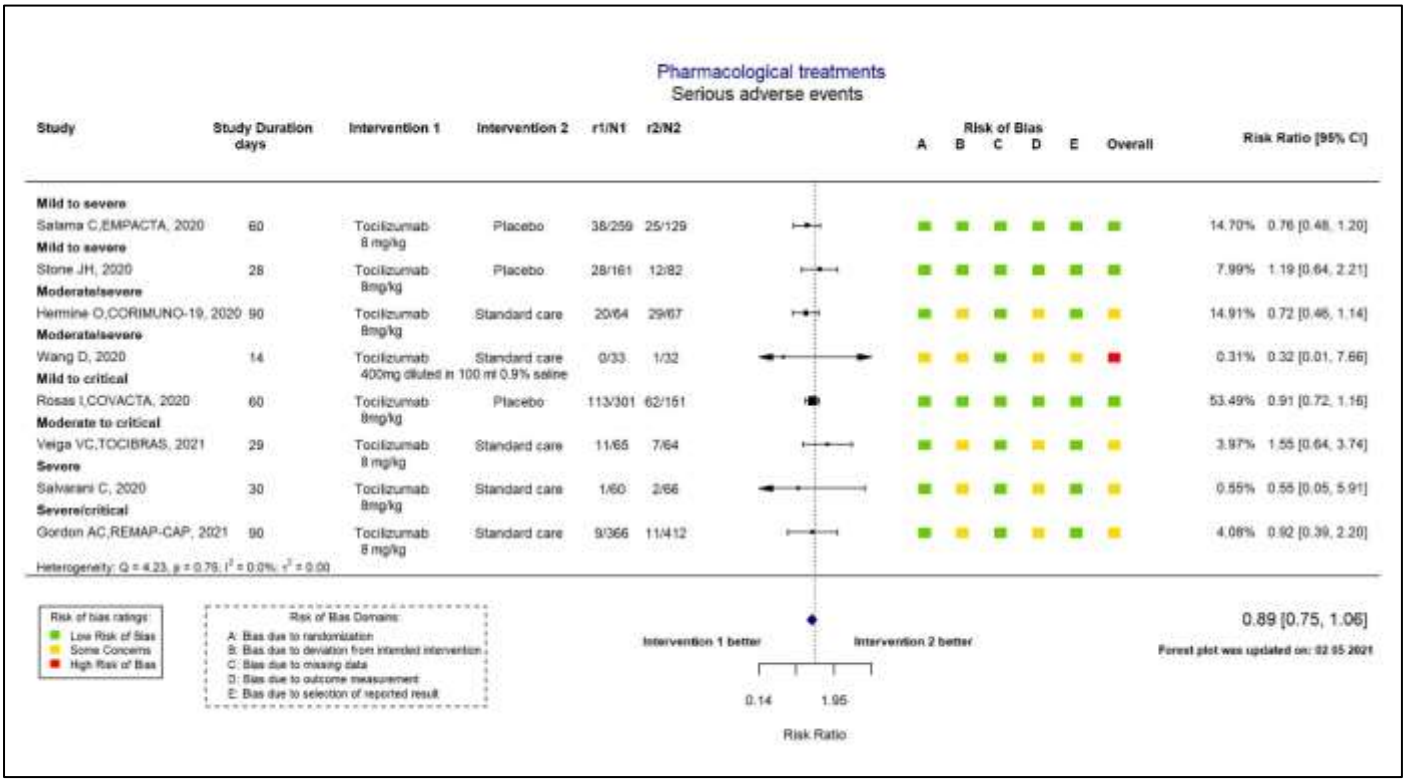

Figure 4: Serious adverse events: Tocilizumab compared to Standard of care/Placebo

Appendix 4: Evidence to decision framework

	JUDGEMENT	EVIDENCE & ADDITIONAL CONSIDERATIONS
EVIDENCE OF BENEFIT	**What is the size of the effect for beneficial outcomes?** Large ☐ Moderate ☒ Small ☐ None ☐ Uncertain ☐	A meta-analysis of 9 RCTs demonstrated that TCZ is associated with an all-cause mortality benefit at 28 days. ARR 3.2% (95% CI 0.8% to 5.2%); RR 0.89 (95% CI 0.82 to 0.97, 8 RCTs, n = 6 363). NNT 32 (95% CI 20 to 125) to prevent 1 death.
EVIDENCE OF HARMS	**What is the size of the effect for harmful outcomes?** Large ☐ Moderate ☐ Small ☐ None ☒ Uncertain ☐	No increased risk of infections or adverse events was observed with tocilizumab use in the RCTs [29]
BENEFITS & HARMS	**Do the desirable effects outweigh the undesirable harms?** Favours intervention ☒ Favours control ☐ Intervention = Control *or* Uncertain ☐	Available evidence shows that TCZ is associated with an all-cause mortality benefit at 28 days, with no reports of associated increased risk of infections or adverse events.
QUALITY OF EVIDENCE	**What is the certainty/quality of evidence?** High ☒ Moderate ☐ Low ☐ Very low ☐ *High quality:* confident in the evidence *Moderate quality:* mostly confident, but further research may change the effect *Low quality:* some confidence, further research likely to change the effect *Very low quality:* findings indicate uncertain effect	The findings are based on the finding of a large RCT and meta-analysis of 9 trials. Assessed per outcome – refer to table 1: • Mortality at D28: high certainty evidence. • WHO progression score (level 7 or above) D28: low certainty evidence • Serious adverse events: moderate certainty evidence
FEASABILITY	**Is implementation of this recommendation feasible?** Yes ☐ No ☐ Uncertain ☒	Tocilizumab is SAHPRA registered and available on the South African market, however price and affordability is a concern.
RESOURCE USE	**How large are the resource requirements?** More intensive ☒ Less intensive ☐ Uncertain ☐	**Price of medicines/dose** (8mg/kg) **Medicine** | **Price - SEP** 60 kg patient: Tocilizumab 480mg | R 7 014.23 75 kg patient: Tocilizumab 600mg | R 8 767.79 Maximum dose: Tocilizumab 800mg | R 11 690.38 **Single exit price (SEP), ex manufacturer (+ VAT + logistics):** 400mg/20ml = R 5 845.19; 200mg/10ml = R 2 922.60; 80mg/4ml = R 1 169.04 *Source*: SEP database, 28 December 2020 **Basic costing analysis:** • *Clinical inputs:* - *Public sector hospitalizations in 1st and 2nd waves:* ≈ **40000 and 60000, respectively (DATCOV survey)** *(Note: Number of public facilities reporting data improved in the second wave; and modelling data for 3rd wave predictions was not available from South African COVID-19 Modelling Consortium, at the time of this report)* - *Incidence of elevated CRP>75 mg/l:* **30-50%** (Western Cape PHDC) ○ >75 mg/l = 7867/26351 = 30% ○ >150 mg/l = 4528/26351 = 20% • *Assumptions:* - DATCOV hospital surveillance data assumed to project total future national COVID-19 hospitalizations. Average for 3rd wave 50000 (lower and upper limit of 40000 and 60000, respectively). *Note: Timing of the effect of COVID-19 vaccine on herd immunity needs consideration*

		- Western Cape data regarding the incidence of raised CRP assumed to be generalisable to the whole country. Average of 40% (upper and lower limit of 30% and 50%, respectively). - Patient with CRP>75mg/l assumed to be severe, requiring supplemental oxygen. • *Estimated forecast:* - Estimated number of patients who will be eligible for tocilizumab treatment: 20000 (lower and upper limit of 12000 and 30000, respectively). • *Estimated budget impact at current SEP:* - SEP treatment cost @R9 000 per patient (75 kg); then total cost estimated as R180 mil (lower and upper limit of R108 mil to R270 mil). • *References* - Data on file, Western Cape NHLS - Data on file, DATCOV reports, NICD - SEP Database, 28 December 2020 - Rapid review of Tocilizumab for CoVID-19 Update, 3 March 2021
VALUES, PREFERENCES, ACCEPTABILITY	**Is there important uncertainty or variability about how much people value the options?** Minor [ ] Major [ ] Uncertain [X] **Is the option acceptable to key stakeholders?** Yes [X] No [ ] Uncertain [ ]	No specific research surveying patients' or healthcare workers' value of this therapeutic agent is currently available. The Committee was of the opinion that the option would be acceptable to key stakeholders.
EQUITY	**Would there be an impact on health inequity?** Yes [ ] No [ ] Uncertain [X]	Tocilizumab currently only available in private sector and is expensive.

Appendix 5: Updating of rapid report

Date	Signal	Rationale
10 January 2021 & 11 February 2021	Preprints of REMAP-CAP and RECOVERY trials	The preliminary study results of the tocilizumab arm of the REMAP-CAP and RECOVERY trials have been published in preprint format