Gemeinsamer Bundesausschuss

# Justification

to the Resolution of the Federal Joint Committee (G-BA) on an Amendment of the Pharmaceuticals Directive:
Annex XII – Benefit Assessment of Medicinal Products with New Active Ingredients according to Section 35a SGB V
Odronextamab (follicular lymphoma, after ≥ 2 prior therapies)

of 22 January 2026

**Contents**

## 1. Legal basis

According to Section 35a paragraph 1 German Social Code, Book Five (SGB V), the Federal Joint Committee (G-BA) assess the benefit of all reimbursable medicinal products with new active ingredients. This includes in particular the assessment of the additional benefit and its therapeutic significance. The benefit assessment is carried out on the basis of evidence provided by the pharmaceutical company, which must be submitted to the G-BA electronically, including all clinical studies the pharmaceutical company have conducted or commissioned, at the latest at the time of the first placing on the market as well as the marketing authorisation of new therapeutic indications of the medicinal product, and which must contain the following information in particular:

1. approved therapeutic indications,
2. medical benefit,
3. additional medical benefit in relation to the appropriate comparator therapy,
4. number of patients and patient groups for whom there is a therapeutically significant additional benefit,
5. treatment costs for the statutory health insurance funds,
6. requirement for a quality-assured application.
7. number of study participants who participated in the clinical studies at study sites within the scope of SGB V, and total number of study participants.

The G-BA may commission the Institute for Quality and Efficiency in Health Care (IQWiG) to carry out the benefit assessment. According to Section 35a, paragraph 2 SGB V, the assessment must be completed within three months of the relevant date for submission of the evidence and published on the internet.

According to Section 35a paragraph 3 SGB V, the G-BA pass a resolution on the benefit assessment within three months of its publication. The resolution is to be published on the internet and is part of the Pharmaceuticals Directive.

## 2. Key points of the resolution

The relevant date for the start of the benefit assessment procedure was the first placing on the (German) market of the active ingredient odronextamab on 1 August 2025 in accordance with Chapter 5 Section 8, paragraph 1, number 1, sentence 2 of the Rules of Procedure (VerfO) of the G-BA. The pharmaceutical company submitted the final dossier to the G-BA in accordance with Section 4, paragraph 3, number 1 of the Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV) in conjunction with Chapter 5 Section 8, paragraph 1, number 1 VerfO on 31 July 2025.

The G-BA commissioned the IQWiG to carry out the assessment of the dossier. The benefit assessment was published on 3 November 2025 on the G-BA website (www.g-ba.de), thus initiating the written statement procedure. In addition, an oral hearing was held.

The G-BA came to a resolution on whether an additional benefit of odronextamab compared with the appropriate comparator therapy could be determined on the basis of the dossier of the pharmaceutical company, the dossier assessment prepared by the IQWiG, and the statements submitted in the written statement and oral hearing procedure. In order to determine the extent of the additional benefit, the G-BA have evaluated the data justifying the finding of an additional benefit on the basis of their therapeutic relevance (qualitative), in accordance with the criteria laid down in Chapter 5 Section 5, paragraph 7 VerfO. The methodology proposed by the IQWiG in accordance with the General Methods [1] was not used in the benefit assessment of odronextamab.

In the light of the above, and taking into account the statements received and the oral hearing, the G-BA have made the following assessment:

## 2.1 Additional benefit of the medicinal product in relation to the appropriate comparator therapy

### 2.1.1 Approved therapeutic indication of Odronextamab (Ordspono) in accordance with the product information

Ordspono as monotherapy is indicated for the treatment of adult patients with relapsed or refractory follicular lymphoma (r/r FL) after two or more lines of systemic therapy.

**Therapeutic indication of the resolution (resolution of 22 January 2026):**

See the approved therapeutic indication

### 2.1.2 Appropriate comparator therapy

The appropriate comparator therapy was determined as follows:

Adults with relapsed or refractory follicular lymphoma (r/r FL) after two or more lines of systemic therapy

**Appropriate comparator therapy for odronextamab as monotherapy:**

Individualised therapy with selection of

- bendamustine + obinutuzumab followed by obinutuzumab maintenance treatment in accordance with the marketing authorisation,
- lenalidomide + rituximab,
- rituximab monotherapy,
- mosunetuzumab,
- tisagenlecleucel and
- zanubrutinib in combination with obinutuzumab

[1] General Methods, version 8.0 from 19.12.2025. Institute for Quality and Efficiency in Health Care (IQWiG), Cologne.

Criteria according to Chapter 5 Section 6 of the Rules of Procedure of the G-BA and Section 6 paragraph 2 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV):

The appropriate comparator therapy must be an appropriate therapy in the therapeutic indication in accordance with the generally recognised state of medical knowledge (Section 12 SGB V), preferably a therapy for which endpoint studies are available and which has proven its worth in practical application unless contradicted by the guidelines under Section 92, paragraph 1 SGB V or the principle of economic efficiency.

In determining the appropriate comparator therapy, the following criteria, in particular, must be taken into account as specified in Chapter 5 Section 6, paragraph 3 VerfO:

1. To be considered as a comparator therapy, the medicinal product must, principally, have a marketing authorisation for the therapeutic indication.
2. If a non-medicinal treatment is considered as a comparator therapy, this must be available within the framework of the SHI system.
3. As comparator therapy, medicinal products or non-medicinal treatments for which the patient-relevant benefit has already been determined by the G-BA shall be preferred.
4. According to the generally recognised state of medical knowledge, the comparator therapy should be part of the appropriate therapy in the therapeutic indication.

According to Section 6, paragraph 2, sentence 2 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV), the determination of the appropriate comparator therapy must be based on the actual medical treatment situation as it would be without the medicinal product to be assessed. According to Section 6, paragraph 2, sentence 3 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV), the G-BA may exceptionally determine the off-label use of medicinal products as an appropriate comparator therapy or as part of the appropriate comparator therapy if they determine by resolution on the benefit assessment according to Section 7, paragraph 4 that, according to the generally recognised state of medical knowledge, this is considered a therapy standard in the therapeutic indication to be assessed or as part of the therapy standard in the medical treatment situation to be taken into account according to sentence 2, and

1. for the first time, a medicinal product approved in the therapeutic indication is available with the medicinal product to be assessed,
2. according to the generally recognised state of medical knowledge, the off-label use is generally preferable to the medicinal products previously approved in the therapeutic indication, or
3. according to the generally recognised state of medical knowledge, the off-label use for relevant patient groups or indication areas is generally preferable to the medicinal products previously approved in the therapeutic indication.

An appropriate comparator therapy may also be non-medicinal therapy, the best possible add-on therapy including symptomatic or palliative treatment, or monitoring wait-and-see approach.

Justification based on the criteria set out in Chapter 5 Section 6, paragraph 3 VerfO and Section 6, paragraph 2 AM-NutzenV:

On 1. In addition to odronextamab, the antineoplastic active ingredients bendamustine, bleomycin, carmustine, chlorambucil, cyclophosphamide, cytarabine, doxorubicin, etoposide, methotrexate, mitoxantrone, trofosfamide, vinblastine and vincristine as well as the glucocorticoids prednisolone and prednisone have been approved for the treatment of non-Hodgkin lymphoma in the present therapeutic indication. The glucocorticoids dexamethasone and methylprednisolone are also approved.

The PI3K inhibitors idelalisib and duvelisib, the immunomodulator lenalidomide, the antibodies epcoritamab, mosunetuzumab, obinutuzumab, rituximab and tafasitamab, the Bruton tyrosine kinase inhibitor zanubrutinib and the CAR-T cell therapies lisocabtagene maraleucel and tisagenlecleucel have a specific marketing authorisation for the treatment of follicular lymphoma. The CAR-T cell therapy axicabtagene ciloleucel is only approved for the treatment of patients after three or more systemic therapies.

The marketing authorisation for duvelisib has however been revoked upon application by the pharmaceutical company with effect from 16 February 2026.

On 2. In the present therapeutic indication, radiotherapy as well as allogeneic or autologous stem cell transplantation can be considered as non-medicinal treatments. However, it is assumed that neither radiotherapy nor autologous or allogeneic stem cell transplantation is indicated at the time of therapy with odronextamab for the present treatment setting.

On 3. Resolutions on the benefit assessment of medicinal products with new active ingredients according to Section 35a SGB V:

- Lisocabtagene maraleucel (resolution of 2 October 2025)
- Epcoritamab (resolution of 6 March 2025)
- Zanubrutinib (resolution of 6 June 2024)
- Axicabtagene ciloleucel (resolution of 21 December 2023)
- Mosunetuzumab (resolution of 15 December 2022)
- Tisagenlecleucel (resolution of 1 December 2022)
- Duvelisib (resolution of 21 July 2022)
- Obinutuzumab (resolutions of 4 November 2021)
- Idelalisib (resolution of 19 March 2015)

Annex VI to Section K of the Pharmaceuticals Directive – Prescribability of approved medicinal products in non-approved therapeutic indications (last revised: 28 October 2022):

- Off-label indications for fludarabine:

  Fludarabine in combination with cyclophosphamide, mitoxantrone, and rituximab (FCM-R) in eligible patients with lowly or moderately malign non-Hodgkin lymphomas of the B-cell series (CD20 positive NHL, including lymphocytic, lympho-plasmocytic, lymphoplasmacytoid, follicular grade 1 or 2, mantle cell, marginal zone, non-multiple myeloma, non-hair cell leukaemia) and resistance to CHOP (with or without rituximab).

On 4. The generally recognised state of medical knowledge was illustrated by a systematic search for guidelines as well as systematic reviews of clinical studies in the present

indication and is presented in the "Research and synopsis of the evidence to determine the appropriate comparator therapy according to Section 35a SGB V".

The scientific-medical societies and the Drugs Commission of the German Medical Association (AkdÄ) were also involved in writing on questions relating to the comparator therapy in the present indication according to Section 35a paragraph 7 SGB V (see “Information on Appropriate Comparator Therapy”). No written opinions were received.

Among the approved active ingredients listed under 1.), only certain active ingredients named below will be included in the appropriate comparator therapy, taking into account the evidence on therapeutic benefit, the guideline recommendations and the reality of care.

Firstly, it should be noted that, irrespective of the fact that grade 3b follicular lymphoma is formally covered by the currently planned therapeutic indication, the present determination of the appropriate comparator therapy relates to relapsed or refractory grade 1 to 3a follicular lymphoma. This is due to the fact that grade 3b follicular lymphoma is not classified as indolent non-Hodgkin lymphoma according to the generally recognised state of medical knowledge and is treated in the same way as diffuse large B-cell lymphoma (DLBCL). Odronextamab has a separate marketing authorisation for the treatment of patients with relapsed or refractory DLBCL after two or more lines of systemic therapy. This approach is also supported by the new WHO classification 2022[2] of lymphoid tumours, which uses the new term "follicular large cell lymphoma" to distinguish the entity formerly known as "grade 3b follicular lymphoma" from the classic (grades 1 to 3a) follicular lymphomas.

In addition, it is assumed that the patients in the present treatment setting have an indication for systemic antineoplastic therapy due to a correspondingly extensive-stage of the disease, in particular with regard to a symptomatic course (e.g. according to the GELF criteria), and therefore, among other things, a watch-and-wait strategy is not considered.

For the treatment of patients with relapsed or refractory follicular lymphoma, no uniform treatment standard can be derived from the available evidence. The S3 guideline refers to an individualised therapy, which is influenced by various factors, whereby the previous therapy, the course of the disease and the general condition play a special role in the choice of therapy.

According to the S3 guideline, patients with relapse or progression of the disease longer than 2 years after chemoimmunotherapy should be given chemoimmunotherapy again. The guideline also states that obinutuzumab-containing induction therapy and maintenance treatment should be used in patients with rituximab-refractory follicular lymphoma. Obinutuzumab in combination with bendamustine, followed by obinutuzumab maintenance treatment, is the only approved chemoimmunotherapy in this therapeutic indication. Against this background, obinutuzumab in combination

[2] Allaggio R., Amador C., Anagnostopoulos I., The 5th edition of the World Health Organization Classification of Haematolyphoid Tumours: Lymphoid Neoplasms; Leukaemia (2022)

with bendamustine, followed by obinutuzumab maintenance treatment in accordance with the marketing authorisation, is determined as a therapy option for individualised therapy.

According to the S3 guideline, monotherapy with rituximab can also be carried out in the relapsed treatment setting, particularly in older or co-morbid patients, if chemoimmunotherapy is unsuitable.

According to the S3 guideline, combination therapy with lenalidomide and rituximab can be used primarily in patients who are refractory or only briefly in remission after chemoimmunotherapy.

According to the joint written statement of the German Society for Haematology and Medical Oncology (DGHO) and German Lymphoma Alliance (GLA), treatments with CAR-T cell therapies and with the bispecific antibody mosunetuzumab are relevant treatment options in the treatment of relapsed or refractory follicular lymphoma. For the CAR-T cell therapy tisagenlecleucel (resolution of 1 December 2022) and for the bispecific antibody mosunetuzumab (resolution of 15 December 2022), a hint for a non-quantifiable additional benefit was identified in each case in the benefit assessment of orphan drugs because the scientific data did not allow quantification. The period of validity of the resolution on tisagenlecleucel is limited to 1 September 2028. In view of the entire body of evidence, mosunetuzumab and tisagenlecleucel are determined to be suitable comparators in the context of an individualised therapy.

The CAR-T cell therapy lisocabtagene maraleucel is a new treatment option in the present therapeutic indication. It was only recently approved. No additional benefit could be identified as part of the benefit assessment by resolution of 2 October 2025, as no suitable data were available. Based on the generally accepted state of medical knowledge, lisocabtagene maraleucel is not determined to be an appropriate comparator therapy for the present resolution.

The CAR-T cell therapy axicabtagene ciloleucel is another treatment option approved for patients with at least three prior therapies. By resolution of 21 December 2023, it was determined that an additional benefit of axicabtagene ciloleucel for patients with at least three prior therapies was not proven, as no suitable data were available to enable an assessment of the additional benefit. Also in view of the fact that tisagenlecleucel is already available as a CAR-T cell therapy with specific marketing authorisation for the therapeutic indication in question, axicabtagene ciloleucel is not included in the appropriate comparator therapy.

In addition, the S3 guideline recommends the chemotherapy regimens CHOP (cyclophosphamide + doxorubicin + vincristine + prednisone), CVP (cyclophosphamide + vincristine + prednisone) and MCP (mitoxantrone, chlorambucil, prednisone), each in combination with rituximab, or in the event of a relapse, during or within 6 months of rituximab therapy in combination with obinutuzumab. However, these chemotherapy regimens are not approved in combination with rituximab or obinutuzumab. In the benefit assessment procedure on axicabtagene ciloleucel, the statements of the scientific-medical societies indicate that chemoimmunotherapies containing rituximab generally play a subordinate role particularly for patients who have already relapsed

several times as they have already been used in previous lines of treatment for relapse[3]. These chemotherapies or chemoimmunotherapies are therefore not determined as therapy options in the context of individualised therapy as appropriate comparator therapy.

Furthermore, the antineoplastic active ingredients bendamustine, chlorambucil and cyclophosphamide, each as monotherapy, are generally considered in accordance with their authorisation status. However, no recommendation can be derived from the available evidence for these monotherapies, which is why they are unsuitable comparators in the context of an individualised therapy.

The PI3K inhibitor idelalisib is also approved for this therapeutic indication. For idelalisib, it was determined by the G-BA's resolution of 15 March 2015 that an additional benefit over the appropriate comparator therapy was not proven, as the necessary evidence had not been submitted. In relation to the significance of the other therapy options, idelalisib cannot be considered as an appropriate comparator therapy based on the current state of medical knowledge.

No additional benefit of zanubrutinib in combination with obinutuzumab (resolution of 6 June 2024) compared with obinutuzumab was identified in the benefit assessment. The written statement of the scientific-medical societies states that zanubrutinib in combination with obinutuzumab is another relevant treatment option in the treatment of relapsed or refractory follicular lymphoma. The G-BA therefore determined zanubrutinib in combination with obinutuzumab as a further suitable comparator in the context of individualised therapy.

Furthermore, epcoritamab as monotherapy has been approved for the treatment of adult patients with refractory or relapsed follicular lymphoma. It was determined in the benefit assessment of epcoritamab that an additional benefit thereof was not proven, as no suitable data were available to enable an assessment of the additional benefit (resolution of 6 March 2025). The therapeutic significance of epcoritamab cannot be conclusively assessed at present. The therapy option is therefore not included in the appropriate comparator therapy.

The active ingredient tafasitamab is a new treatment option in the present therapeutic indication. The active ingredient in combination with lenalidomide and rituximab was only recently approved (marketing authorisation on 15 December 2025). The therapeutic significance of this treatment option cannot yet be conclusively assessed, so that tafasitamab is not determined as an appropriate comparator therapy for the present resolution.

In summary, an individualised therapy with selection of bendamustine in combination with obinutuzumab followed by obinutuzumab maintenance treatment according to the marketing authorisation, lenalidomide in combination with rituximab, rituximab monotherapy, mosunetuzumab, tisagenlecleucel and zanubrutinib in combination with

[3] Summary documentation of the benefit assessment procedure for D-953 axicabtagene ciloleucel, resolution of 21 December 2023

obinutuzumab is determined as the appropriate comparator therapy, taking into account the previous therapy, the course of the disease and the general condition.

Individualised therapy is based on the assumption that several treatment options, which allow an individualised medical treatment decision, are available.

When making the treatment decision, in particular the previous therapy, the course of the disease and the patient's general condition must be considered, taking into account the available evidence.

The findings in Annex XII do not restrict the scope of treatment required to fulfil the medical treatment mandate.

A change in the appropriate comparator therapy requires a resolution by the G-BA linked to the prior review of the criteria according to Chapter 5 Section 6, paragraph 3 Rules of Procedure.

### 2.1.3 Extent and probability of the additional benefit

In summary, the additional benefit of odronextamab is assessed as follows:

Adults with relapsed or refractory follicular lymphoma after two or more lines of systemic therapy

An additional benefit is not proven.

Justification:

In the absence of direct comparator studies on odronextamab versus the appropriate comparator therapy, the pharmaceutical company demonstrated the additional benefit using the phase II ELM-2 study. The pharmaceutical company states that an indirect comparison of the treatment arm of the ELM-2 study with individual arms from studies with active ingredients of the appropriate comparator therapy was not conducted due to the challenges of full confounder adjustment and the high heterogeneity of intensely pretreated study populations.

ELM-2 study

Patients with different tumour entities (follicular lymphoma, diffuse large B-cell lymphoma, mantle cell lymphoma, marginal zone lymphoma) were enrolled In the ongoing, single-arm study, and treated in cohorts with different dosage regimens. The primary endpoint of the study is tumour response according to the Lugano classification of malignant lymphomas according to the assessment by an independent review committee.

The ELM-2 study has been ongoing since November 2019 in 92 study sites in Asia, Australia, North America and Europe. In the dossier, the pharmaceutical company submitted the data cut-offs from 31 January 2023 and 20 October 2023. At the last data cut-off, 140 patients who received a dosage in line with the product information were enrolled.

Conclusion:

Due to its single-arm study design, the ELM-2 study does not allow a comparison with the appropriate comparator therapy and is therefore unsuitable for the assessment of an additional benefit of odronextamab. An additional benefit of odronextamab for the treatment

of adults with relapsed or refractory follicular lymphoma after at least two lines of systemic therapy is therefore not proven.

### 2.1.4 Summary of the assessment

The present assessment concerns the benefit assessment of the new medicinal product Ordspono with the active ingredient odronextamab.

This medicinal product received a conditional marketing authorisation in the following therapeutic indication: for the treatment of adult patients with relapsed or refractory follicular lymphoma (r/r FL) after two or more lines of systemic therapy.

The G-BA defined the appropriate comparator therapy to be an individualised therapy with selection of bendamustine in combination with obinutuzumab followed by obinutuzumab maintenance treatment according to the marketing authorisation, lenalidomide in combination with rituximab, rituximab monotherapy, mosunetuzumab, tisagenlecleucel and zanubrutinib in combination with obinutuzumab.

For the benefit assessment, the pharmaceutical company submitted the results of the single-arm ELM-2 study. Due to its single-arm study design, the ELM-2 study does not allow a comparison with the appropriate comparator therapy and is therefore unsuitable for the assessment of an additional benefit of odronextamab. The pharmaceutical company states that an indirect comparison of the treatment arms of the ELM-2 study with individual arms from studies with active ingredients of the appropriate comparator therapy did not appear expedient on the basis of the available data basis and was therefore not conducted. An additional benefit of odronextamab for the treatment of adults with relapsed or refractory follicular lymphoma after at least two lines of systemic therapy is therefore not proven.

## 2.2 Number of patients or demarcation of patient groups eligible for treatment

The information on the number of patients is based on the target population in statutory health insurance (SHI).

The resolution is based on the information from the resolution on the benefit assessment of zanubrutinib in the same therapeutic indication (resolution of 6 June 2024).

The estimated number of patients is subject to uncertainties resulting, for example, from the length of the observation period, ambiguities in the definition of specific follicular lymphoma therapies and a lack of information on the frequency of individual therapies.

## 2.3 Requirements for a quality-assured application

The requirements in the product information are to be taken into account. The European Medicines Agency (EMA) provides the contents of the product information (summary of product characteristics, SmPC) for Ordspono (active ingredient: odronextamab) at the following publicly accessible link (last access: 16 September 2025):

https://www.ema.europa.eu/en/documents/product-information/ordspono-epar-product-information_en.pdf

Treatment with odronextamab should only be initiated and monitored by specialists in internal medicine, haematology and oncology experienced in the treatment of patients with follicular lymphoma.

This medicinal product received a conditional marketing authorisation. This means that further evidence of the benefit of the medicinal product is anticipated. The European Medicines Agency will evaluate new information on this medicinal product at a minimum once per year and update the product information where necessary.

In accordance with the European Medicines Agency (EMA) requirements regarding additional risk minimisation measures, the pharmaceutical company must provide training material that contains information for medical professionals and patients (incl. patient identification card).

In particular, the training material contains information and warnings on cytokine release syndrome (CRS) and neurological toxicity, including immune effector cell-associated neurotoxicity syndrome (ICANS).

## 2.4 Treatment costs

The treatment costs are based on the contents of the product information and the information listed in the LAUER-TAXE® (last revised: 15 November 2025). The calculation of treatment costs is generally based on the last revised LAUER-TAXE® version following the publication of the benefit assessment.

For the cost representation, one year is assumed for all medicinal products.

The (daily) doses recommended in the product information were used as the calculation basis.

If no maximum treatment duration is specified in the product information, the treatment duration is assumed to be one year (365 days), even if the actual treatment duration is different from patient to patient and/or is shorter on average. The time unit "days" is used to

calculate the "number of treatments/ patient/ year", time intervals between individual treatments and for the maximum treatment duration, if specified in the product information.

For the cost representation, only the dosages of the general case are considered. Patient-individual dose adjustments (e.g. because of side effects or co-morbidities) are not taken into account when calculating the annual treatment costs.

As it is not always possible to achieve the exact target dose per day with the commercially available dosage strengths, in these cases rounding up or down to the next higher or lower available dose that can be achieved with the commercially available dosage strengths as well as the scalability of the respective dosage form.

According to the product information, maintenance treatment with the active ingredient odronextamab is carried out in a 14-day cycle after completion of the first 4 cycles and a one-week break. According to the product information, maintenance treatment is switched to a 28-day cycle if a complete response (CR) has been achieved for 9 months. This results in a range in the cost representation, as the time at which a complete response is achieved is different from patient to patient. As an example, the calculation is based on the assumption that a CR was achieved after completion of the 4th cycle.

In the present therapeutic indication, the product information for obinutuzumab specifies an induction regimen in combination with bendamustine over 6 cycles of 28 days each. Section 5.1 of the product information for obinutuzumab specifies the dose for bendamustine (in combination with obinutuzumab) as 90 mg/m$^2$. The induction phase is followed by obinutuzumab monotherapy as maintenance treatment once every 2 months for a period of 2 years or until disease progression.

The product information for mosunetuzumab for this therapeutic indication provides for a therapy over 8 cycles of 21 days each, whereby no further treatment cycles are required for patients who show a complete response (CR) after the 8 cycles. Patients who show a partial response (PR) after the 8 cycles are additionally given 9 cycles of treatment (17 cycles in total).

*CAR-T cell therapies*

Tisagenlecleucel concerns genetically modified, patient's own (autologous) T cells, which are usually obtained by leukapheresis. Since leukapheresis is part of the manufacture of the medicinal product according to Section 4, paragraph 14 Medicinal Products Act, no further costs are incurred in this respect for these active ingredients.

Tisagenlecleucel is listed on LAUER-TAXE®, but is only dispensed to appropriate qualified inpatient treatment centres, and administered there. Accordingly, the active ingredient is not subject to the Pharmaceutical Price Ordinance (Arzneimittelpreisverordnung) and no rebates according to Section 130 or Section 130a SGB V apply. The calculation is based on the purchase price of the respective clinic pack, in deviation from the LAUER-TAXE® data usually taken into account.

Tisagenlecleucel is administered as a single intravenous infusion according to the requirements in the underlying product information.

Treatment period:

Adults with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy

| Designation of the therapy | Treatment mode | Number of treatments/ patient/ year | Treatment duration/ treatment (days) | Treatment days/ patient/ year |
|---|---|---|---|---|
| Medicinal product to be assessed | | | | |
| *Odronextamab monotherapy* | | | | |
| Odronextamab | Cycle 1:<br>Day 1, 2, 8, 9, 15 and 16 of a 21-day cycle<br><br>Cycle 2 to 4:<br>Day 1, 8 and 15 of a 21-day cycle | 4 | Cycle 1:<br>6<br><br>Cycle 2 to 4:<br>3 | 15 |
| | Maintenance treatment:<br>1 x every 14 days<br>or<br>1 x every 14 days (CR until the 9th month), then<br>1 x every 28 days | 19.3 – 19.6 | 1 | 19.3 – 19.6 |
| Appropriate comparator therapy | | | | |
| *Individualised therapy with selection of* | | | | |
| *Bendamustine + obinutuzumab* | | | | |
| Bendamustine | Induction therapy:<br>Day 1 and 2 of a 28-day cycle | 6 | 2 | 12 |
| Obinutuzumab | Induction therapy:<br>28-day cycles;<br>Cycle 1:<br>Day 1, 8 and 15<br>Cycles 2 to 6:<br>Day 1 | 6 | Cycle 1:<br>3<br><br>Cycle 2 - 6:<br>1 | 8 |
| | Maintenance treatment:<br>every 2 months | 3.2 | 1 | 3.2 |
| *Lenalidomide + rituximab* | | | | |
| Lenalidomide | Day 1 - 21 of a 28-day cycle | 12 | 21 | 252 |
| Rituximab | Induction therapy:<br>Day 1, 8, 15 and 22 of a 28-day cycle | 1 | 4 | 4 |

| | | | | |
|---|---|---|---|---|
| | Maintenance treatment:<br>Day 1 of a 28-day cycle | 4 | 1 | 4 |
| *Rituximab monotherapy* | | | | |
| Rituximab | 1 x weekly for 4 weeks | 4 | 1 | 4 |
| *Mosunetuzumab* | | | | |
| Mosunetuzumab | Cycle 1:<br>Day 1, 8 and 15 of a 21-day cycle<br>Cycle 2 – 8 or 17:<br>Day 1 of a 21-day cycle | 8 - 17 | Cycle 1:<br>3<br>Cycle 2 – 8 or 17:<br>1 | 10 - 19 |
| *Tisagenlecleucel* | | | | |
| Tisagenlecleucel | Single dose | 1 | 1 | 1 |
| *Zanubrutinib + obinutuzumab* | | | | |
| Zanubrutinib | Continuously, 1 x or 2 x daily | 365 | 1 | 365 |
| Obinutuzumab | Induction therapy:<br>28-day cycles;<br>Cycle 1:<br>Day 1, 8 and 15<br>Cycles 2 to 6:<br>Day 1 | 6 | Cycle 1:<br>3<br><br>Cycle 2 - 6:<br>1 | 8 |
| | Maintenance treatment:<br>every 2 months | 3.2 | 1 | 3.2 |

Consumption:

Adults with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy

For dosages depending on body weight (BW) or body surface area (BSA), the average body measurements from the official representative statistics "Microcensus 2021 – body measurements of the population" were applied (average body height: 1.72 m; average body weight: 77.7 kg). This results in a body surface area of 1.91 m² (calculated according to Du Bois 1916).[4]

The consumption of vials and infusion bags is presented for tisagenlecleucel according to the requirements in the product information. These are administered to the patient in a single infusion depending on the number of cells per vial or infusion bag. The annual treatment costs of tisagenlecleucel are independent of the specific number of vials or infusion bags used.

[4] Federal health reporting. Average body measurements of the population (2021, both sexes, 15 years and older: http://www.gbe-bund.de/

| Designation of the therapy | Dosage/ application | Dose/ patient/ treatment day | Consumption by potency/ treatment day | Treatment days/ patient/ year | Average annual consumption by potency |
|---|---|---|---|---|---|
| Medicinal product to be assessed | | | | | |
| *Odronextamab monotherapy* | | | | | |
| Odronextamab | <u>Cycle 1:</u><br>Day 1 and 2: 0.2 mg<br>Day 8 and 9: 2 mg<br>Day 15 and 16: 10 mg | <u>Cycle 1:</u><br>Day 1 and 2: 0.2 mg<br>Day 8 and 9: 2 mg<br>Day 15 and 16: 10 mg | <u>Cycle 1:</u><br>Day 1 and 2: 1 x 2 mg<br>Day 8 and 9: 1 x 2 mg<br>Day 15 and 16: 5 x 2 mg | 15 | 14 x 2 mg + 9 x 80 mg |
| | <u>Cycle 2 - 4:</u><br>Day 1, 8 and 15: 80 mg | <u>Cycle 2 - 4:</u><br>Day 1, 8 and 15: 80 mg | <u>Cycle 2 - 4:</u><br>Day 1, 8 and 15: 1 x 80 mg | | |
| | 160 mg | 160 mg | 2 x 80 mg | 19.3 – 19.6 | 38.6 x 80 mg – 39.2 x 80 mg |
| Appropriate comparator therapy | | | | | |
| *Individualised therapy with selection of* | | | | | |
| *Bendamustine + obinutuzumab* | | | | | |
| Bendamustine | 90 mg/m² = 171.9 mg | 171.9 mg | 1 x 100 mg + 3 x 25 mg | 12.0 | 12 x 100 mg + 36 x 25 mg |
| Obinutuzumab | 1,000 mg | 1,000 mg | 1 x 1,000 mg | 11.2 | 11.2 x 1,000 mg |
| *Lenalidomide + rituximab* | | | | | |
| Lenalidomide | 20 mg | 20 mg | 1 x 20 mg | 252.0 | 252 x 20 mg |
| Rituximab | 375 mg/m² = 716.3 mg | 716.3 mg | 1 x 500 mg + 3 x 100 mg | 8.0 | 8 x 500 mg + 24 x 100 mg |
| *Rituximab monotherapy* | | | | | |
| Rituximab | 375 mg/m² = 716.3 mg | 716.3 mg | 1 x 500 mg + 3 x 100 mg | 4.0 | 4 x 500 mg + 12 x 100 mg |
| *Tisagenlecleucel* | | | | | |
| Tisagenlecleucel | 0.6 - 6 x $10^8$ viable CAR+ T cells (regardless of body weight) | 0.6 - 6 x $10^8$ CAR+ T cells | 1 single infusion bag | 1.0 | 1 single infusion bag |
| *Mosunetuzumab* | | | | | |
| Mosunetuzumab | <u>Cycle 1:</u><br>Day 1: 1 mg<br>Day 8: 2 mg<br>Day 15: 60 mg | <u>Cycle 1:</u><br>Day 1: 1 mg<br>Day 8: 2 mg<br>Day 15: 60 mg | <u>Cycle 1:</u><br>Day 1: 1 mg<br>Day 8: 2 x 1 mg<br>Day 15: 2 x 30 mg | 10.0 (8 cycles) – 19.0 (17 cycles) | 3 x 1 mg + 10 x 30 mg – 3 x 1 mg + 19 x 30 mg |

| | | | | | |
|---|---|---|---|---|---|
| | Cycle 2:<br>Day 1: 60 mg | Cycle 2:<br>Day 1: 60 mg | Cycle 2:<br>Day 1: 2 x 30 mg | | |
| | Cycle 3 – 8 or 17:<br>Day 1: 30 mg | Cycle 3 – 8 or 17:<br>Day 1: 30 mg | Cycle 3 – 8 or 17:<br>Day 1: 1 x 30 mg | | |
| *Zanubrutinib + obinutuzumab* | | | | | |
| Zanubrutinib | 160 mg – 320 mg | 320 mg | 4 x 80 mg<br>or<br>2 x 160 mg | 365.0 | 1,460 x 80 mg<br>or<br>730 x 160 mg |
| Obinutuzumab | 1,000 mg | 1,000 mg | 1 x 1,000 mg | 11.2 | 11.2 x 1,000 mg |

Costs:

In order to improve comparability, the costs of the medicinal products were approximated both on the basis of the pharmacy sales price level and also deducting the statutory rebates in accordance with Section 130 and Section 130a SGB V. To calculate the annual treatment costs, the required number of packs of a particular potency was first determined on the basis of consumption. Having determined the number of packs of a particular potency, the costs of the medicinal products were then calculated on the basis of the costs per pack after deduction of the statutory rebates. Any reference prices shown in the cost representation may not represent the cheapest available alternative.

**Costs of the medicinal products:**

Adults with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy

| Designation of the therapy | Packaging size | Costs (pharmacy sales price) | Rebate Section 130 SGB V | Rebate Section 130a SGB V | Costs after deduction of statutory rebates |
|---|---|---|---|---|---|
| Medicinal product to be assessed | | | | | |
| Odronextamab 2 mg | 1 CIS | € 113.41 | € 1.77 | € 5.65 | € 105.99 |
| Odronextamab 80 mg | 1 CIS | € 4,016.67 | € 1.77 | € 226.10 | € 3,788.80 |
| Appropriate comparator therapy | | | | | |
| Designation of the therapy | Packaging size | Costs (pharmacy sales price) | Rebate Section 130 SGB V | Rebate Section 130a SGB V | Costs after deduction of statutory rebates |
| Bendamustine 100 mg | 5 PIC | € 1,653.78 | € 1.77 | € 208.35 | € 1,443.66 |
| Bendamustine 100 mg | 1 PIC | € 337.73 | € 1.77 | € 41.31 | € 294.65 |
| Bendamustine 25 mg | 5 PIC | € 422.90 | € 1.77 | € 52.08 | € 369.05 |
| Bendamustine 25 mg | 1 PIC | € 101.23 | € 1.77 | € 11.38 | € 88.08 |

| | | | | | |
|---|---|---|---|---|---|
| Lenalidomide 20 mg[5] | 63 HC | € 117.32 | € 1.77 | € 8.38 | € 107.17 |
| Mosunetuzumab 1 mg | 1 CIS | € 275.87 | € 1.77 | € 14.65 | € 259.45 |
| Mosunetuzumab 30 mg | 1 CIS | € 7,751.61 | € 1.77 | € 439.40 | € 7,310.44 |
| Obinutuzumab 1,000 mg | 1 CIS | € 2,649.25 | € 1.77 | € 148.01 | € 2,499.47 |
| Rituximab 500 mg[5] | 1 CIS | € 1,777.34 | € 1.77 | € 98.21 | € 1,677.36 |
| Rituximab 100 mg[5] | 2 CIS | € 717.21 | € 1.77 | € 39.08 | € 676.36 |
| Zanubrutinib 80 mg | 120 HC | € 5,479.32 | € 1.77 | € 0.00 | € 5,477.55 |
| Zanubrutinib 160 mg | 60 FCT | € 5,479.32 | € 1.77 | € 0.00 | € 5,477.55 |
| *CAR-T cell therapeutic* | | | | | |
| Designation of the therapy | Packaging size | Costs (purchase price clinic pack plus value added tax) | Value added tax (19%) | Costs of the medicinal product | |
| Tisagenlecleucel | 1 single infusion bag | € 239,000.00 | € 0 [6] | € 239,000.00 | |
| Abbreviations: FCT = film-coated tablets; HC = hard capsules; CIS = concentrate for the preparation of an infusion solution; PIC = powder for the preparation of an infusion solution concentrate | | | | | |

LAUER-TAXE® last revised: 15 November 2025

Costs for additionally required SHI services:

Only costs directly related to the use of the medicinal product are taken into account. If there are regular differences in the necessary use of medical treatment or in the prescription of other services in the use of the medicinal product to be evaluated and the appropriate comparator therapy in accordance with the product information, the costs incurred for this must be taken into account as costs for additionally required SHI services.

Medical treatment costs, medical fee services, and costs incurred for routine examinations (e.g. regular laboratory services such as blood count tests) that do not exceed the standard expenditure in the course of the treatment are not shown.

Non-prescription medicinal products that are reimbursable at the expense of the statutory health insurance according to Annex I of the Pharmaceuticals Directive (so-called OTC exception list) are not subject to the current medicinal products price regulation. Instead, in accordance with Section 129 paragraph 5aSGB V, when a non-prescription medicinal product is dispensed and invoiced in accordance with Section 300, a medicinal product dispensing price in the amount of the dispensing price of the pharmaceutical company plus the surcharges in accordance with Sections 2 and 3 of the Pharmaceutical Price Ordinance in the version valid on 31 December 2003 applies to the insured.

The calculation of the additionally required SHI services is based on packs in distribution with the LAUER-TAXE® last revised on 15 September 2025 and fee structure items (FSI) - last revised in the 3rd quarter of 2025 - of the uniform value scale (UVS 2025/Q3).

[5] Fixed reimbursement rate
[6] The medicinal product is exempt from value added tax at the applied LAUER-TAXE® last revised.

*CAR-T cell therapy*

Antipyretic and antihistamine premedication is only recommended in the product information of tisagenlecleucel.

*Conditioning chemotherapy for lymphocyte depletion prior to CAR-T cell therapy*

Tisagenlecleucel concerns autologous cell products produced from the patient's own T cells. Therefore, a leukapheresis is usually necessary to obtain the cell material. Since leukapheresis is part of the manufacture of the medicinal product pursuant to Section 4, paragraph 14 Medicinal Products Act, no further costs are incurred in this respect for the medicinal product to be assessed and the mentioned active ingredients of the appropriate comparator therapy.

For tisagenlecleucel, provided the white blood cell count is not below ≤ 1000 cells/µl one week prior to infusion, a treatment regimen for lymphocyte depletion, consisting of intravenous administration of cyclophosphamide (250 mg/m$^2$ = 477.5 mg) and fludarabine (25 mg/m$^2$ = 47.8 mg) is given daily for 3 days, with infusion administered for follicular lymphoma 5 to 9 days after the start of lymphocyte depletion.

*Screening for hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV)*

Patients should be tested for hepatitis B, hepatitis C and HIV infection prior to starting treatment with tisagenlecleucel. Patients receiving therapy with lenalidomide, obinutuzumab, rituximab and zanubrutinib should be tested for the presence of HBV infection before initiating the respective treatment.

Diagnostics to rule out chronic hepatitis B requires sensibly coordinated steps. A step-by-step serological diagnosis initially consists of the examination of HBs antigen and anti-HBc antibodies. If both are negative, a past HBV infection can be excluded. In certain case constellations, further steps may be necessary in accordance with current guideline recommendations[7].

Diagnostics to rule out hepatitis C requires sensibly coordinated steps. HCV screening is based on the determination of anti-HCV antibodies. In certain case constellations, it may be necessary to verify the positive anti-HCV antibody findings in parallel or subsequently by HCV-RNA detection to confirm the diagnosis of an HCV infection.[8]

These examinations are not required for all therapy options of the appropriate comparator therapy. Since there is a regular difference between the medicinal product to be assessed and the appropriate comparator therapy with regard to the tests for hepatitis B, hepatitis C and HIV, the costs of additionally required SHI services are presented in the resolution.

[7] S3 guideline on prevention, diagnosis and therapy of hepatitis B virus infection; AWMF registry no.: 021/011 https://register.awmf.org/assets/guidelines/021-011l_S3_Prophylaxe-Diagnostik-Therapie-der-Hepatitis-B-Virusinfektion_2021-07.pdf

[8] S3 guideline on prevention, diagnosis and therapy of hepatitis C virus (HCV) infection; AWMF registry no.: 021/012 https://register.awmf.org/assets/guidelines/021-012l_S3_Hepatitis-C-Virus_HCV-Infektion_2018-07.pdf

| Designation of the therapy | Packaging size | Costs (pharmacy sales price) | Rebate Section 130 SGB V | Rebate Section 130a SGB V | Costs after deduction of statutory rebates | Treatment days/ year | Costs/ patient/ year |
|---|---|---|---|---|---|---|---|
| Medicinal product to be assessed | | | | | | | |
| Odronextamab | | | | | | | |
| Pre and post-medication | | | | | | | |
| Dexamethasone[5] 10 mg oral | 100 TAB each 2 mg | € 32.94 | € 1.77 | € 0.00 | € 31.17 | 8 | € 31.17 |
| Dexamethasone[5] 20 mg, IV | 10 AMP each 4 mg | € 16.92 | € 1.77 | € 0.44 | € 14.71 | 7 | € 58.84 |
| Dexamethasone[5] 10 mg, IV | 10 SFI 4 mg each | € 16.92 | € 1.77 | € 0.44 | € 14.71 | 1 | € 14.71 |
| Dimetindene IV (1 mg/10 kg BW = 7.8 mg, IV) | 5 SFI each 4 mg | € 26.24 | € 1.77 | € 6.92 | € 17.55 | 8 | € 70.20 |
| Paracetamol[5] 500 mg[9] – 1,000 mg | 10 TAB each 500 mg – 10 TAB each 1,000 mg | € 2.96 - € 3.32 | € 0.15 - € 0.17 | € 0.13 - € 0.14 | € 2.68 - € 3.01 | 8.0 | € 2.68 - € 3.01 |
| Appropriate comparator therapy | | | | | | | |
| *Tisagenlecleucel* | | | | | | | |
| *Conditioning chemotherapy for lymphocyte depletion* | | | | | | | |
| Cyclophosphamide 250 mg/m² = 477.5 mg | 1 PSI each 500 mg | € 23.76 | € 1.77 | € 1.57 | € 20.42 | 3.0 | € 61.26 |
| Fludarabine 25 mg/m² = 47.8 mg | 1 CIS each 50 mg | € 118.54 | € 1.77 | € 5.09 | € 111.68 | 3.0 | € 335.04 |
| Hepatitis B surface antigen status (FSI 32781) | - | - | - | - | € 5.06 | 1.0 | € 5.06 |
| Anti-HBc antibody (FSI 32614) | - | - | - | - | € 5.43 | 1.0 | € 5.43 |
| Hepatitis C HCV antibody status (FSI 32618) | - | - | - | - | € 9.02 | 1.0 | € 9.02 |
| HIV | - | - | - | - | € 4.09 | 1.0 | € 4.09 |

[9] The dosage of 650 mg paracetamol in premedication stated in the product information cannot be achieved by tablets. Because of this, a dosage of 500 mg – 1,000 mg is used.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HIV-1 and HIV-2 antibody status (FSI 32575) | | | | | | | |
| *Rituximab* | | | | | | | |
| *Premedication for rituximab monotherapy* | | | | | | | |
| Dimetindene (1 mg/10 kg, IV) | 5 SFI each 4 mg | € 26.24 | € 1.77 | € 6.92 | € 17.55 | 4.0 | € 35.10 |
| Paracetamol[5] (500 mg – 1,000 mg, PO)[9] | 10 TAB each 500 mg – 10 TAB each 1,000 mg | € 2.96 - € 3.32 | € 0.15 - € 0.17 | € 0.13 - € 0.14 | € 2.68 - € 3.01 | 4.0 | € 2.68 - € 3.01 |
| Hepatitis B surface antigen status (FSI 32781) | - | - | - | - | € 5.06 | 1.0 | € 5.06 |
| Anti-HBc antibody (FSI 32614) | - | - | - | - | € 5.43 | 1.0 | € 5.43 |
| *Premedication for rituximab + lenalidomide* | | | | | | | |
| Dimetindene (1 mg/10 kg, IV) | 5 SFI each 4 mg | € 26.24 | € 1.77 | € 6.92 | € 17.55 | 8.0 | € 70.20 |
| Paracetamol[5] (500 mg – 1,000 mg, PO)[9] | 10 TAB each 500 mg – 10 TAB each 1,000 mg | € 2.96 - € 3.32 | € 0.15 - € 0.17 | € 0.13 - € 0.14 | € 2.68 - € 3.01 | 8.0 | € 2.68 - € 3.01 |
| Hepatitis B surface antigen status (FSI 32781) | - | - | - | - | € 5.06 | 1.0 | € 5.06 |
| Anti-HBc antibody (FSI 32614) | - | - | - | - | € 5.43 | 1.0 | € 5.43 |
| *Mosunetuzumab* | | | | | | | |
| *Premedication for the first two cycles* | | | | | | | |
| Dimetindene (1 mg/10 kg, IV) | 5 SFI each 4 mg | € 26.24 | € 1.77 | € 6.92 | € 17.55 | 4.0 | € 35.10 |
| Paracetamol[5] (500 mg – 1,000 mg, PO)[9] | 10 TAB each 500 mg – 10 TAB each 1,000 mg | € 2.96 - € 3.32 | € 0.15 - € 0.17 | € 0.13 - € 0.14 | € 2.68 - € 3.01 | 4.0 | € 2.68 - € 3.01 |
| Dexamethasone[5] (20 mg, IV)**Fehler! Textmarke nicht definiert.** | 10 AMP each 4 mg | € 16.92 | € 1.77 | € 0.44 | € 14.71 | 4.0 | € 29.42 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| *Bendamustine + obinutuzumab* | | | | | | | |
| Hepatitis B surface antigen status (FSI 32781) | - | - | - | - | € 5.06 | 1.0 | € 5.06 |
| Anti-HBc antibody (FSI 32614) | - | - | - | - | € 5.43 | 1.0 | € 5.43 |
| *Zanubrutinib + obinutuzumab* | | | | | | | |
| Hepatitis B surface antigen status (FSI 32781) | - | - | - | - | € 5.06 | 1.0 | € 5.06 |
| Anti-HBc antibody (FSI 32614) | - | - | - | - | € 5.43 | 1.0 | € 5.43 |
| Abbreviations:<br>AMP = ampoules; CIS = concentrate for the preparation of an infusion solution; PSI = powder for solution for injection; TAB = tablets | | | | | | | |

LAUER-TAXE® last revised: 15 September 2025

Other SHI services:

The special agreement on contractual unit costs of retail pharmacist services (Hilfstaxe) (Sections 4 and 5 of the Pharmaceutical Price Ordinance) from 1 October 2009 is not fully used to calculate costs. Alternatively, the pharmacy sales price publicly accessible in the directory services according to Section 131 paragraph 4 SGB V is a suitable basis for a standardised calculation.

According to the currently valid version of the special agreement on contractual unit costs of retail pharmacist services (Hilfstaxe), surcharges for the production of parenteral preparations containing cytostatic agents a maximum amount of € 100 per ready-to-use preparation, and for the production of parenteral solutions containing monoclonal antibodies a maximum of € 100 per ready-to-use unit are to be payable. These additional other costs are not added to the pharmacy sales price but rather follow the rules for calculating in the Hilfstaxe. The cost representation is based on the pharmacy retail price and the maximum surcharge for the preparation and is only an approximation of the treatment costs. This presentation does not take into account, for example, the rebates on the pharmacy purchase price of the active ingredient, the invoicing of discards, the calculation of application containers, and carrier solutions in accordance with the regulations in Annex 3 of the Hilfstaxe.

## 2.5 Designation of medicinal products with new active ingredients according to Section 35a, paragraph 3, sentence 4 SGB V that can be used in a combination therapy with the assessed medicinal product

According to Section 35a, paragraph 3, sentence 4, the G-BA designate all medicinal products with new active ingredients that can be used in a combination therapy with the assessed medicinal product for the therapeutic indication to be assessed on the basis of the marketing authorisation under Medicinal Products Act.

Basic principles of the assessed medicinal product

A designation in accordance with Section 35a, paragraph 3, sentence 4 SGB V requires that it is examined based on the product information for the assessed medicinal product whether it can be used in a combination therapy with other medicinal products in the assessed

therapeutic indication. In the first step, the examination is carried out on the basis of all sections of the currently valid product information for the assessed medicinal product.

If the assessed medicinal product contains an active ingredient or a fixed combination of active ingredients in the therapeutic indication of the resolution (assessed therapeutic indication) and is approved exclusively for use in monotherapy, a combination therapy is not considered due to the marketing authorisation under Medicinal Products Act, which is why no designation is made.

A designation is also not considered if the G-BA have decided on an exemption as a reserve antibiotic for the assessed medicinal product in accordance with Section 35a, paragraph 1c, sentence 1 SGB V. The additional benefit is deemed to be proven if the G-BA have decided on an exemption for a reserve antibiotic in accordance with Section 35a, paragraph 1c, sentence 1 SGB V; the extent of the additional benefit and its therapeutic significance are not to be assessed by the G-BA. Due to the lack of an assessment mandate by the G-BA following the resolution on an exemption according to Section 35a, paragraph 1c, sentence 1 SGB V with regard to the extent of the additional benefit and the therapeutic significance of the reserve antibiotic to be assessed, there is a limitation due to the procedural privileging of the pharmaceutical companies to the effect that neither the proof of an existing nor an expected at least considerable additional benefit is possible for exempted reserve antibiotics in the procedures according to Section 35a paragraph 1 or 6 SGB V and Section 35a paragraph 1d SGB V. The procedural privileging of the reserve antibiotics exempted according to Section 35a, paragraph 1c, sentence 1 SGB V must therefore also be taken into account at the level of designation according to Section 35a, paragraph 3, sentence 4 SGB V in order to avoid valuation contradictions.

With regard to the further examination steps, a differentiation is made between a "determined" or "undetermined" combination, which may also be the basis for a designation.

A "determined combination" exists if one or more individual active ingredients which can be used in combination with the assessed medicinal product in the assessed therapeutic indication are specifically named.

An "undetermined combination" exists if there is information on a combination therapy, but no specific active ingredients are named. An undetermined combination may be present if the information on a combination therapy:

- names a product class or group from which some active ingredients not specified in detail can be used in combination therapy with the assessed medicinal product, or
- does not name any active ingredients, product classes or groups, but the assessed medicinal product is used in addition to a therapeutic indication described in more detail in the relevant product information, which, however, does not include information on active ingredients within the scope of this therapeutic indication.

Concomitant active ingredient

The concomitant active ingredient is a medicinal product with new active ingredients that can be used in combination therapy with the assessed medicinal product for the therapeutic indication to be assessed.

For a medicinal product to be considered as a concomitant active ingredient, it must be classified as a medicinal product with new active ingredients according to Section 2 paragraph 1 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV) in conjunction with the corresponding regulations in Chapter 5 of the Rules of Procedure of the G-BA as of the

date of the present resolution. In addition, the medicinal product must be approved in the assessed therapeutic indication, whereby a marketing authorisation is sufficient only for a sub-area of the assessed therapeutic indication.

Based on an "undetermined combination", the concomitant active ingredient must be attributable to the information on the product class or group or the therapeutic indication according to the product information of the assessed medicinal product in the assessed therapeutic indication, whereby the definition of a product class or group is based on the corresponding requirements in the product information of the assessed medicinal product.

In addition, there must be no reasons for exclusion of the concomitant active ingredient from a combination therapy with the assessed medicinal product, in particular no exclusive marketing authorisation as monotherapy.

In addition, all sections of the currently valid product information of the eligible concomitant active ingredient are checked to see whether there is any information that excludes its use in combination therapy with the assessed medicinal product in the assessed therapeutic indication under marketing authorisation regulations. Corresponding information can be, for example, dosage information or warnings. In the event that the medicinal product is used as part of a determined or undetermined combination which does not include the assessed medicinal product, a combination with the assessed medicinal product shall be excluded.

Furthermore, the product information of the assessed medicinal product must not contain any specific information that excludes its use in combination therapy with the eligible concomitant active ingredient in the assessed therapeutic indication under marketing authorisation regulations.

Medicinal products with new active ingredients for which the G-BA have decided on an exemption as a reserve antibiotic in accordance with Section 35a, paragraph 1c, sentence 1 SGB V are ineligible as concomitant active ingredients. The procedural privileging of the reserve antibiotics exempted according to Section 35a, paragraph 1c, sentence 1 SGB V also applies accordingly to the medicinal product eligible as a concomitant active ingredient.

Designation

The medicinal products which have been determined as concomitant active ingredients in accordance with the above points of examination are named by indicating the relevant active ingredient and the invented name. The designation may include several active ingredients, provided that several medicinal products with new active ingredients may be used in the same combination therapy with the assessed medicinal product or different combinations with different medicinal products with new active ingredients form the basis of the designation.

If the present resolution on the assessed medicinal product in the assessed therapeutic indication contains several patient groups, the designation of concomitant active ingredients shall be made separately for each of the patient groups.

Exception to the designation

The designation excludes combination therapies for which - patient group-related - a considerable or major additional benefit has been determined by resolution according to Section 35a, paragraph 3, sentence 1 SGB V or it has been determined according to Section 35a, paragraph 1d, sentence 1 SGB V that at least considerable additional benefit of the combination can be expected. In this context, the combination therapy that is excluded from the designation must, as a rule, be identical to the combination therapy on which the

preceding findings were based.

In the case of designations based on undetermined combinations, only those concomitant active ingredients - based on a resolution according to Section 35a, paragraph 3, sentence 1 SGB V on the assessed medicinal product in which a considerable or major additional benefit had been determined - which were approved at the time of this resolution are excluded from the designation.

Legal effects of the designation

The designation of combinations is carried out in accordance with the legal requirements according to Section 35a, paragraph 3, sentence 4 and is used exclusively to implement the combination discount according to Section 130e SGB V between health insurance funds and pharmaceutical companies. The designation is not associated with a statement as to the extent to which a therapy with the assessed medicinal products in combination with the designated medicinal products corresponds to the generally recognised state of medical knowledge. The examination was carried out exclusively on the basis of the possibility under Medicinal Products Act to use the medicinal products in combination therapy in the assessed therapeutic indication based on the product information; the generally recognised state of medical knowledge or the use of the medicinal products in the reality of care were not the subject of the examination due to the lack of an assessment mandate of the G-BA within the framework of Section 35a, paragraph 3, sentence 4 SGB V.

The findings made neither restrict the scope of treatment required to fulfil the medical treatment mandate, nor do they make statements about expediency or economic feasibility.

Justification for the findings on designation in the present resolution:

Adults with relapsed or refractory follicular lymphoma after two or more lines of systemic therapy

No designation of medicinal products with new active ingredients that can be used in combination therapy pursuant to Section 35a, paragraph 3, sentence 4 SGB V, as the active ingredient to be assessed is an active ingredient authorised in monotherapy.

## 2.6 Percentage of study participants at study sites within the scope of SGB V in accordance with Section 35a, paragraph 3, sentence 5 SGB V

The medicinal product odronextamab is a medicinal product placed on the market from 1 January 2025. In accordance with Section 35a, paragraph 3, sentence 5 SGB V, the G-BA must determine whether a relevant percentage of the clinical studies on the medicinal product were conducted within the scope of SGB V. This is the case if the percentage of study participants who have participated in the clinical studies on the medicinal product to be assessed in the therapeutic indication to be assessed at study sites within the scope of SGB V is at least five per cent of the total number of study participants.

The calculation is based on all studies that were submitted as part of the benefit assessment dossier in the therapeutic indication to be assessed in accordance with Section 35a, paragraph 1, sentence 3 SGB V in conjunction with Section 4, paragraph 6 AM-NutzenV.

Approval studies include all studies submitted to the regulatory authority in section 2.7.3 (Summary of Clinical Efficacy) and 2.7.4 (Summary of Clinical Safety) of the authorisation

dossier in the therapeutic indication for which marketing authorisation has been applied for. In addition, studies, which were conducted in whole or in part within the therapeutic indication described in this document, and in which the company was a sponsor or is otherwise financially involved, must also be indicated.

The percentage of study participants in the clinical studies of the medicinal product conducted or commissioned by the pharmaceutical company in the therapeutic indication to be assessed who participated at study sites within the scope of SGB V (German Social Security Code) is ≥ 5 per cent (5.6% or 6.7%) of the total number of study participants according to the information provided by the pharmaceutical company.

The pharmaceutical company uses the ELM-1 and ELM-2 studies to determine two different percentages for study participants at study sites within the scope of SGB V. Of these, one percentage relates to patients with B-cell non-Hodgkin lymphoma (NHL) (5.57%), while the other relates to a part of this study population – patients with follicular lymphoma (FL) or DLBCL (6.68%).

It should be noted that the information on the B-cell NHL cohort must be used for the ELM-1 study, as data from this cohort – instead of only the FL or DLBCL cohort – were submitted for the assessment of the clinical efficacy and safety of the medicinal product, and recruitment for the B-cell NHL cohort has been completed. According to the information provided by the pharmaceutical company, recruitment of the B-cell NHL cohort for the ELM-2 study has not yet been completed, meaning that the FL and DLBCL cohorts, for which recruitment has been completed, should be used instead. Taking this cohort and the B-cell NHL cohort of the ELM-1 study into account, the percentage of study participants at study sites within the scope of SGB V remains above 5%.

The clinical studies of the medicinal product in the therapeutic indication to be assessed were therefore conducted to a relevant extent within the scope of SGB V.

## 3. Bureaucratic costs calculation

The proposed resolution does not create any new or amended information obligations for care providers within the meaning of Annex II to Chapter 1 VerfO and, accordingly, no bureaucratic costs.

## 4. Process sequence

At their session on 26 March 2024, the Subcommittee on Medicinal Products determined the appropriate comparator therapy.

A review of the appropriate comparator therapy took place. The Subcommittee on Medicinal Products determined the appropriate comparator therapy at their session on 12 August 2025.

On 31 July 2025, the pharmaceutical company submitted a dossier for the benefit assessment of odronextamab to the G-BA in due time in accordance with Chapter 5 Section 8, paragraph 1, number 1, sentence 2 VerfO.

By letter dated 31 July 2025 in conjunction with the resolution of the G-BA of 1 August 2011 concerning the commissioning of the IQWiG to assess the benefits of medicinal products with new active ingredients in accordance with Section 35a SGB V, the G-BA commissioned the IQWiG to assess the dossier concerning the active ingredient odronextamab.

The dossier assessment by the IQWiG was submitted to the G-BA on 30 October 2025, and the written statement procedure was initiated with publication on the G-BA website on 3 November 2025. The deadline for submitting statements was 24 November 2025.

The oral hearing was held on 8 December 2025.

In order to prepare a recommendation for a resolution, the Subcommittee on Medicinal Products commissioned a working group (Section 35a) consisting of the members nominated by the leading organisations of the care providers, the members nominated by the SHI umbrella organisation, and representatives of the patient organisations. Representatives of the IQWiG also participate in the sessions.

The evaluation of the written statements received and the oral hearing was discussed at the session of the Subcommittee on 13 January 2026, and the proposed draft resolution was approved.

At their session on 22 January 2026, the plenum adopted a resolution to amend the Pharmaceuticals Directive.

**Chronological course of consultation**

| Session | Date | Subject of consultation |
|---|---|---|
| Subcommittee on Medicinal Products | 26 March 2024 | Determination of the appropriate comparator therapy |
| Subcommittee on Medicinal Products | 12 August 2025 | New determination of the appropriate comparator therapy |
| Working group Section 35a | 3 December 2025 | Information on written statements received; preparation of the oral hearing |
| Subcommittee on Medicinal Products | 8 December 2025 | Conduct of the oral hearing |
| Working group Section 35a | 17 December 2025<br>7 January 2026 | Consultation on the dossier evaluation by the IQWiG and evaluation of the written statement procedure |
| Subcommittee on Medicinal Products | 13 January 2026 | Concluding discussion of the draft resolution |
| Plenum | 22 January 2026 | Adoption of the resolution on the amendment of the Pharmaceuticals Directive |

Berlin, 22 January 2026

Federal Joint Committee (G-BA)
in accordance with Section 91 SGB V
The Chair

Prof. Hecken