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
Avacopan (reassessment of an orphan drug after exceeding the EUR 30 million limit; granulomatosis with polyangiitis or microscopic polyangiitis, combination with rituximab or cyclophosphamide)

From 5 March 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. requirements 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 decide 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

Avacopan (Tavneos) was listed for the first time on 15 February 2022 in the "LAUER-TAXE®", the extensive German registry of available drugs and their prices. Tavneos indicated for the treatment of adults with severe, active granulomatosis with polyangiitis or microscopic polyangiitis is approved as a medicinal product for the treatment of rare diseases under Regulation (EC) No. 141/2000 of the European Parliament and the Council of 16 December 1999.

At their session on 4 August 2022, the G-BA decided on the benefit assessment of avacopan in the therapeutic indication "Tavneos, in combination with a rituximab or cyclophosphamide dosage regimen, is indicated for the treatment of adult patients with severe, active

granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)" in accordance with Section 35a SGB V.

If the sales of the orphan drug through the statutory health insurance at pharmacy sales prices and outside the scope of SHI-accredited medical care, including value-added tax, exceed an amount of € 30 million in the last twelve calendar months, the pharmaceutical company must submit evidence in accordance with Chapter 5 Section 5, paragraphs 1 to 6 Rules of Procedure (VerfO) within three months of being requested to do so by the Federal Joint Committee, and in this evidence, must demonstrate the additional benefit compared to the appropriate comparator therapy.

By letter dated 3 June 2025, the pharmaceutical company was requested to submit a dossier for the benefit assessment according to Section 35a SGB V by 15 September 2025, due to exceeding the EUR 30 million turnover limit within the period from March 2024 until the end of February 2025. Pursuant to Section 4, paragraph 3, No. 4 of the Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV) in conjunction with Chapter 5 Section 8, paragraph 1, No. 6 Rules of Procedure, the pharmaceutical company submitted the final dossier to the G-BA in due time on 2 September 2025.

The G-BA commissioned the IQWiG to carry out the assessment of the dossier. The benefit assessment was published on 15 December 2025 on the G-BA website at (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 avacopan 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, the statements submitted in the written statement and oral hearing procedure, and the addendum to the benefit assessment prepared by IQWiG. 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 avacopan.

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 Avacopan (Tavneos) in accordance with the product information

Tavneos, in combination with a rituximab or cyclophosphamide regimen, is indicated for the treatment of adult patients with severe, active granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA).

Therapeutic indication of the resolution (resolution of 05.03.2026):

See the approved therapeutic indication

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

2.1.2 Appropriate comparator therapy

The appropriate comparator therapy was determined as follows:

Adults with severe, active granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)

Appropriate comparator therapy for avacopan in combination with a rituximab or cyclophosphamide treatment regimen:

- Cyclophosphamide (induction phase) followed by rituximab (maintenance phase), each in combination with glucocorticoids (only for patients with GPA)

or

- Rituximab (induction and maintenance phase) in combination with glucocorticoids

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 according to 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 the active ingredient avacopan to be assessed, the active ingredient rituximab is approved for the present therapeutic indication. In addition, the glucocorticoids methylprednisolone, prednisolone and prednisone are indicated for use in this therapeutic indication. The active ingredient cyclophosphamide is approved for granulomatosis with polyangiitis.

On 2. Plasmapheresis is considered as a non-medicinal treatment option in the present therapeutic indication.

On 3: In the present therapeutic indication, only the resolution on the benefit assessment of medicinal products with new active ingredients according to Section 35a SGB V for the active ingredient avacopan dated 4 August 2022 is available, this resolution being replaced by the present resolution.

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 therapeutic indication.

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 therapeutic indication according to Section 35a, paragraph 7 SGB V.

Determination of the appropriate comparator therapy is particularly based on the recommendations of the S3 guideline "Diagnosis and Treatment of ANCA-Associated Vasculitides" (2024)[2] and the "EULAR recommendations for the management of ANCA-associated vasculitis" (update 2022)[3].

[2] German Society for Rheumatology and Clinical Immunology (DGRh). Diagnosis and treatment of ANCA-associated vasculitides; S3 guideline, long version, version 1.1 [online]. AWMF registry number 060-012. Berlin (GER): Association of the Scientific-Medical Societies (AWMF); 2024. [accessed: 23.01.2026]. URL: https://register.awmf.org/assets/guidelines/060-012l_S3_Diagnostik-Therapie-ANCAassoziierten_Vaskulitiden_2024-08_2_01.pdf.

[3] Hellmich B, Sanchez-Alamo B, Schirmer JH, Berti A, Blockmans D, Cid MC, et al. EULAR recommendations for the management of ANCA-associated vasculitis: 2022 update. Ann Rheum Dis 2024;83(1):30-47.

As a rule, the treatment of MPA and GPA is divided into two treatment phases: initial treatment for remission induction and subsequent therapy for remission maintenance. The guidelines recommend cyclophosphamide or rituximab, each in combination with glucocorticoids, for remission induction in patients with organ-threatening and life-threatening symptoms of MPA and GPA. The glucocorticoid dose should be reduced gradually.

Rituximab is recommended as the first-line therapeutic agent for remission maintenance.

As part of remission induction, plasma exchange (PLEX) may also be a treatment option in addition to medicinal treatment. However, as PLEX should only be considered for select patients, this non-medicinal treatment is not considered as the appropriate comparator therapy.

In the overall assessment, given that cyclophosphamide is only approved for the treatment of subjects with GPA, the following therapies are determined as the appropriate comparator therapy:

Cyclophosphamide (induction phase) followed by rituximab (maintenance phase), each in combination with glucocorticoids (only for patients with GPA)

or

Rituximab (induction and maintenance phase) in combination with glucocorticoids.

The appropriate comparator therapy thus includes several therapeutic alternatives. In this context, individual therapy options only represent a comparator therapy for the part of the patient population that has the specified patient and disease characteristics. The therapeutic alternatives are only to be considered equally appropriate in the therapeutic indication, where the patient populations have the same characteristics.

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

Any change to the appropriate comparator therapy requires a decision by the G-BA based on a prior review of the criteria set out in Chapter 5 Section 6, paragraph 3 VerfO.

2.1.3 Extent and probability of the additional benefit

In summary, the additional benefit of avacopan in combination with a rituximab or cyclophosphamide treatment regimen is assessed as follows:

An additional benefit is not proven for adults with severe, active granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA).

Justification:

For the present benefit assessment, the pharmaceutical company submitted data from the ADVOCATE study at week 26.

The ADVOCATE study is a randomised, double-blind phase 3 study comparing avacopan with prednisone, each in combination with a rituximab or cyclophosphamide treatment regimen.

Patients aged 12 years and older who had newly diagnosed or recurrent GPA or MPA requiring treatment with rituximab or cyclophosphamide were enrolled. For enrolment in the study,

patients also had to have ≥ 1 severe item or ≥ 3 less severe items or at least 2 kidney-related items in the Birmingham Vasculitis Activity Score (BVAS).

The estimated glomerular filtration rate (eGFR) must not have been less than 15 ml/min/1.73 m² at the start of the study, without dialysis-dependence, meaning that no data is available for these patients for the present benefit assessment. In addition, patients with alveolar haemorrhage requiring invasive ventilation were excluded from participation in the study.

In the intervention arm, avacopan was administered orally over 52 weeks in accordance with the requirements in the product information. In the comparator arm, orally administered prednisone was completely tapered off within 20 weeks according to a defined regimen. To maintain blinding, patients in the intervention arm and comparator arm received a placebo for avacopan (52 weeks) and prednisone (20 weeks), respectively.

In both study arms, study participants received background therapy: either rituximab weekly for the first 4 weeks or cyclophosphamide (intravenous or oral) for the first 13 or 14 weeks, followed by maintenance treatment with azathioprine or, if applicable, mycophenolate mofetil until the end of the study.

Glucocorticoids not used in the study had to be avoided as far as possible during the course of the study. However, the use of glucocorticoids was allowed due to a comorbidity requiring treatment (such as adrenal insufficiency) or in the event of deterioration, lack of improvement, or recurrence of the disease.

A total of 328 adults and 3 adolescents were enrolled in the study (avacopan arm: N = 166 or prednisone arm: N = 165).

The primary endpoints of the ADVOCATE study were remission at week 26 and sustained remission from week 26 to week 52. Secondary endpoints include endpoints in the categories of morbidity, health-related quality of life and side effects. The 52-week treatment duration was followed by an 8-week observation phase.

On the evaluation time point

In the case of antineutrophil cytoplasmic antibody (ANCA)-associated vasculitis, the treatment concept basically consists of two phases of therapy: remission induction and remission maintenance.

The pharmaceutical company submitted data on week 26 both in the dossier and as part of the written statement procedure and, based on these results, derived an additional benefit of avacopan only for remission induction.

Successful remission induction is an essential therapeutic goal in the treatment of severe GPA and MPA, given the life-threatening or organ-threatening condition. The relevance of remission induction was also emphasised by clinical experts during the written statement procedure.

According to the data subsequently submitted for the sub-population of patients treated with rituximab, there were no statistically significant differences between the treatment arms in terms of remission at week 26. Remission was defined in the ADVOCATE study as having a BVAS = 0 without intake of steroids for treatment of MPA or GPA within 4 weeks prior to week 26 and no BVAS > 0 within 4 weeks prior to week 26 if an unscheduled assessment was performed. In the avacopan arm, 77.5% of patients achieved remission according to this definition, compared with 75.7% in the prednisone arm. Without taking steroid avoidance into

account, remission (BVAS = 0) occurred in 88.8% of patients in the avacopan arm and 86.0% in the comparator arm.

However, the results on remission induction represent only a subaspect of the relevant research question for the benefit assessment. Once remission has been achieved in the present therapeutic indication, maintenance treatment is usually continued for at least 36 to 48 months to prevent recurrence. However, results on remission maintenance (e.g. sustained remission at week 52) were not presented or are unsuitable for the present benefit assessment (see "Implementation of the appropriate comparator therapy" section).

Avacopan is not exclusively approved for remission induction, but generally for the treatment of severe, active GPA and MPA, and continues to be used in medical treatment practice even after achievement of remission. The assessment of the overall therapeutic concept, which includes both remission induction and remission maintenance, is therefore significant for the assessment of the additional benefit of avacopan.

On the implementation of the appropriate comparator therapy

In the dossier, the pharmaceutical company compiled data on the total population of the ADVOCATE study. However, regardless of the chosen evaluation time point, these are unsuitable for the benefit assessment, as a relevant percentage of the study participants received a cyclophosphamide regimen that does not correspond to the determined appropriate comparator therapy. On the one hand, patients received maintenance treatment with azathioprine or, if applicable, mycophenolate mofetil from week 15 onwards, and on the other, they were assigned to the cyclophosphamide treatment regimen, regardless of the presence of GPA.

As part of the written statement procedure, the pharmaceutical company therefore subsequently submitted evaluations of the sub-population of patients, who received rituximab for remission induction in the comparator or intervention arm, at week 26.

The data for this sub-population at the end of treatment (week 52) are unsuitable for benefit assessment, as no maintenance treatment corresponding to the appropriate comparator therapy was administered following remission induction. In accordance with the information provided in the S3 guideline[4] and the statements made by medical experts during the written statement procedure, maintenance treatment with rituximab following remission induction with rituximab generally begins 6 months after the last infusion. However, according to the product information, maintenance treatment can be initiated as early as week 16 after the last infusion.

This means that, at week 26, it is unclear whether some of these study participants would have been eligible for rituximab maintenance treatment at an earlier stage.

Apart from the lack of maintenance treatment with rituximab, the study participants in the comparator arm also no longer received glucocorticoids after week 20. Only in the event of deterioration of the disease or a relapse could the study participants receive glucocorticoids or other immunosuppressants.

[4] **German Society for Rheumatology and Clinical Immunology (DGRh).** Diagnosis and treatment of ANCA-associated vasculitides; S3 guideline, long version, version 1.1 [online]. AWMF registry number 060-012. Berlin (GER): Association of the Scientific-Medical Societies (AWMF); 2024. [accessed: 23.01.2026]. URL: https://register.awmf.org/assets/guidelines/060-012l_S3_Diagnostik-Therapie-ANCAassoziierten_Vaskulitiden_2024-08_2_01.pdf.

In contrast, according to the dosage recommendations in the S3 guideline, glucocorticoids should be gradually reduced to a daily dose of 5 mg/day, which should then be continued until at least week 52. Thus, the available data at week 26, in which rituximab was used largely adequately for remission induction, are also subject to uncertainty, as a comparison of avacopan versus placebo was performed from week 21 to week 26.

Conclusion

The data from the ADVOCATE study are unsuitable for derivation of an additional benefit, as not only the achievement of remission but also the maintenance of remission must be considered for the present benefit assessment. However, with regard to maintenance treatment, the appropriate comparator therapy has not been implemented. That being said, the data on remission induction at week 26 are subject to uncertainty due to the non-treatment in the comparator arm after week 20.

In the overall assessment, an additional benefit of avacopan in combination with a cyclophosphamide or rituximab treatment regimen for adults with severe, active GPA or MPA is therefore not proven.

2.1.4 Summary of the assessment

The present assessment is the new benefit assessment of the active ingredient avacopan due to the exceeding of the € 30 million turnover limit. Tavneos was approved as an orphan drug. Avacopan, in combination with a rituximab or cyclophosphamide dosage regimen, is indicated for the treatment of adult patients with severe, active granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA).

The G-BA determined the following appropriate comparator therapy: In combination with glucocorticoids, either rituximab for the induction and maintenance phases or (only for patients with GPA) cyclophosphamide for the induction phase followed by rituximab for the maintenance phase.

The pharmaceutical company submitted data from the randomised controlled ADVOCATE study at week 26. The ADVOCATE study compared the safety and efficacy of avacopan with prednisone over 52 weeks in subjects with severe MPA and GPA. In both study arms, the study participants also received a rituximab or cyclophosphamide treatment regimen.

Successful remission induction is a key therapeutic goal in the treatment of severe GPA and MPA. For the endpoint of remission (i.e. BVAS = 0 without the intake of steroids within the last 4 weeks), there were no statistically significant differences between the treatment arms for the sub-population of patients treated with rituximab at week 26 in the ADVOCATE study.

Regardless of this, the results on remission induction only represent a subaspect of the relevant research question for the benefit assessment. In accordance with the approved therapeutic indication for avacopan, the overall therapeutic concept, which includes both remission induction and remission maintenance, is significant for the assessment of the additional benefit.

However, with regard to maintenance treatment, the appropriate comparator therapy has not been implemented. That being said, the data on remission induction at week 26 are subject to uncertainty due to the non-treatment in the comparator arm after week 20.

In the overall assessment, no suitable data are available to derive the additional benefit of avacopan compared with the appropriate comparator therapy for the treatment of adults with severe, active GPA and MPA. An additional benefit of avacopan 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 provided by the pharmaceutical company in the benefit assessment dossier.

Overall, the specified number of patients in the SHI target population is subject to uncertainty.

Significant reasons for this include the chosen operationalisation of a severe, active form of the disease and the lack of adjustment in the routine data analysis and estimation of a general percentage range of ± 10%. Despite the application of this general percentage value, the available patient numbers nevertheless represent a better and more up-to-date estimate compared with the previous procedure for avacopan (resolution of 4 August 2022).

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 Tavneos (active ingredient: avacopan) at the following publicly accessible link (last access: 4 December 2025):

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

Treatment with avacopan should only be initiated and monitored by specialists experienced in treating patients with GPA or MPA.

Avacopan has not been investigated in patients with severe disease, manifesting as alveolar haemorrhage requiring invasive ventilation and in patients with an estimated glomerular filtration rate (eGFR) below 15 ml/min/1.73m^2 who are dialysis-dependent or are in need of dialysis or plasma exchange treatment.

In order to further characterise the safety profile of avacopan with respect to e.g. liver injury, severe infections, malignancies and cardiovascular events, a PASS study was requested by the EMA upon marketing authorisation.

2.4 Treatment costs

The treatment costs are based on the requirements in the product information and the information listed in the LAUER-TAXE® (last revised: 1 January 2026). The calculation of treatment costs is generally based on the last revised LAUER-TAXE® version following the publication of the benefit assessment.

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.

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

As it is not always possible to achieve the exact calculated 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.

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)[5]. This results in a body surface area of 1.91 m² (calculated according to Du Bois 1916).

The dosage of oral glucocorticoids is different from patient to patient. As part of the appropriate comparator therapy, oral glucocorticoids are initially administered in high doses and then gradually reduced to the lowest possible patient-individual dosage. In combination with avacopan, glucocorticoids should be used as clinically indicated in accordance with the product information. For economic reasons, prednisolone in potencies of 5 mg and 20 mg is shown as an example for the group of oral glucocorticoids. There are also packs with a potency of 10 mg and 50 mg.

As the product information does not contain any specific information on the cyclophosphamide treatment cycle for the induction phase, treatment with cyclophosphamide for remission induction is presented in the appropriate comparator therapy as recommended by the S3 guideline[6]. The cost of intravenous treatment with cyclophosphamide is calculated on the basis of 6 infusions (3 x every 14 days and 3 x every 21 days; 15 mg/kg body weight per infusion), as these are usually sufficient to achieve remission[4]. For peroral administration, a duration of 3 months with a daily intake of 2 mg/kg body weight/day is assumed accordingly.

According to the requirements in the product information, subsequent maintenance treatment with rituximab should be initiated within 4 weeks after disease remission. For the calculation of costs, a duration of 3 months until disease remission is assumed based on the results of the CYCLOPS study[4]. For example, 14 days after achievement of disease remission are calculated until the first infusion of maintenance treatment with rituximab is administered.

For the start of maintenance treatment with rituximab after prior remission induction with rituximab, only the earliest possible start is specified in the product information. According to the information provided in the S3 guideline and the statements made by medical experts

[5] Federal Health Reporting. Average body measurements of the population (2021, both sexes, 15 years and older), www.gbe-bund.de

[6] German Society for Rheumatology and Clinical Immunology (DGRh). Diagnosis and treatment of ANCA-associated vasculitides; S3 guideline, long version, version 1.1 [online]. AWMF registry number 060-012. Berlin (GER): Association of the Scientific-Medical Societies (AWMF); 2024. [accessed: 23.01.2026]. URL: https://register.awmf.org/assets/guidelines/060-012l_S3_Diagnostik-Therapie-ANCAassoziierten_Vaskulitiden_2024-08_2_01.pdf.

during the written statement procedure, maintenance treatment usually begins 6 months[4,7] after the last infusion.

Since MPA and GPA are chronic diseases requiring long-term treatment[8], both the first year of treatment with induction therapy followed by maintenance treatment and the subsequent year are presented.

Adults with severe, active granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)

Treatment period:

Designation of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
Medicinal product to be assessed				
Avacopan in combination with rituximab and, if applicable, glucocorticoids				
Avacopan	Continuously, 2 x daily	365.0	1	365.0
Rituximab	1 x every 7 days	1st year: 4 Subsequent year: 0	1	1st year: 4 Subsequent year: 0
Prednisolone	1 x daily	Different from patient to patient	1	Different from patient to patient
Avacopan in combination with (intravenous) cyclophosphamide administration followed by azathioprine or mycophenolate mofetil and, if applicable, glucocorticoids				
Avacopan	Continuously, 2 x daily	365.0	1	365.0
Cyclophosphamide	Every 14 – 21 days	1st year: 5 – 7[9] Subsequent year: 0	1	1st year: 5 – 7[9] Subsequent year: 0
Azathioprine	Continuously, 1 x daily	1st year: 267[10]	1	1st year: 267[10]

[7] S3 guideline: *"For remission maintenance after remission induction with RTX [...], RTX 500 mg should be administered intravenously every 6 months."*
[8] S3 guideline: *"The duration of remission-maintaining therapy with RTX should generally be at least 36 months, [...]".*
[9] A duration of 13 weeks = 91 days is used.
[10] From week 15

Designation of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
		Subsequent year: 365.0		Subsequent year: 365.0
Mycophenolate mofetil	Continuously, 1 x daily	1st year: 267[10] Subsequent year: 365.0	1	1st year: 267[10] Subsequent year: 365.0
Prednisolone	1 x daily	Different from patient to patient	1	Different from patient to patient
Avacopan in combination with (peroral) cyclophosphamide administration followed by azathioprine or mycophenolate mofetil and, if applicable, glucocorticoids				
Avacopan	Continuously, 2 x daily	365.0	1	365.0
Cyclophosphamide	1 x daily	1st year: 98[11] Subsequent year: 0	1	1st year: 98[11] Subsequent year: 0
Azathioprine	Continuously, 1 x daily	1st year: 267[10] Subsequent year: 365.0	1	1st year: 267[10] Subsequent year: 365.0
Mycophenolate mofetil	Continuously, 1 x daily	1st year: 267[10] Subsequent year: 365.0	1	1st year: 267[10] Subsequent year: 365.0
Prednisolone	1 x daily	Different from patient to patient	1	Different from patient to patient
Appropriate comparator therapy				
(Intravenous) cyclophosphamide administration followed by rituximab, each in combination with glucocorticoids				
Cyclophosphamide *Induction phase*	3 x every 14 days,	1st year: 6	1	1st year: 6

[11] A duration of 14 weeks = 98 days is used.

Designation of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
	followed by 3 x every 21 days	Subsequent year: 0		Subsequent year: 0
Rituximab *Maintenance phase*	2 x every 14 days, followed by 1 x every 6 months	1st year: 2.7 Subsequent year: 2	1	1st year: 2.7 Subsequent year: 2
Prednisolone	1 x daily	Different from patient to patient	1	Different from patient to patient
(Peroral) cyclophosphamide administration followed by rituximab, each in combination with glucocorticoids				
Cyclophosphamide *Induction phase*	1 x daily	1st year: 91 Subsequent year: 0	1	1st year: 91 Subsequent year: 0
Rituximab *Maintenance phase*	2 x every 14 days, followed by 1 x every 6 months	1st year: 2.7 Subsequent year: 2	1	1st year: 2.7 Subsequent year: 2
Prednisolone	1 x daily	Different from patient to patient	1	Different from patient to patient
Rituximab in combination with glucocorticoids				
Rituximab *Induction phase*	1 x every 7 days	1st year: 4 Subsequent year: 0	1	1st year: 4 Subsequent year: 0
Rituximab *Maintenance phase*	2 x every 14 days, followed by 1 x every 6 months	1st year: 2.9[12] Subsequent year: 2	1	1st year: 2.9[12] Subsequent year: 2

[12] Start of maintenance treatment from the 6th month after remission induction

Designation of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
Prednisolone	1 x daily	Different from patient to patient	1	Different from patient to patient

Consumption:

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
Medicinal product to be assessed					
Avacopan in combination with rituximab and, if applicable, glucocorticoids					
Avacopan	30 mg	60 mg	6 x 10 mg	365.0	2,190 x 10 mg
Rituximab	375 mg/m² = 716.3 mg	716.3 mg	1 x 500 mg + 3 x 100 mg	4	4 x 500 mg + 12 x 100 mg
Prednisolone	Different from patient to patient				
Avacopan in combination with (intravenous) cyclophosphamide administration followed by azathioprine or mycophenolate mofetil and, if applicable, glucocorticoids					
Avacopan	30 mg	60 mg	6 x 10 mg	365.0	2,190 x 10 mg
Cyclophosphamide	15 mg/kg BW = 1,165.5 mg	1,165.5 mg	1 x 1,000 mg + 1 x 200 mg	1st year: 5 – 7 Subsequent year: 0	1st year: 5 x 1,000 mg + 5 x 200 mg – 7 x 1,000 mg + 7 x 200 mg Subsequent year: 0
Azathioprine	77.7 mg	77.7 mg	1 x 75 mg	1st year: 267 Subsequent year: 365.0	1st year: 267 x 75 mg Subsequent year: 365 x 75 mg
Mycophenolate mofetil	2 g	2 g	4 x 500 mg	1st year: 267	1st year: 1,068 x 500 mg

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
				Subsequent year: 365.0	Subsequent year: 1,460 x 500 mg
Prednisolone	Different from patient to patient				
Avacopan in combination with (peroral) cyclophosphamide administration followed by azathioprine or mycophenolate mofetil and, if applicable, glucocorticoids					
Avacopan	30 mg	60 mg	6 x 10 mg	365.0	2,190 x 10 mg
Cyclophosphamide	2 mg/kg BW = 155.4 mg	155.4 mg	3 x 50 mg	1st year: 98 Subsequent year: 0	1st year: 294 x 50 mg Subsequent year: 0
Azathioprine	77.7 mg	77.7 mg	1 x 75 mg	1st year: 267.0 Subsequent year: 365.0	1st year: 267 x 75 mg Subsequent year: 365 x 75 mg
Mycophenolate mofetil	2 g	2 g	4 x 500 mg	1st year: 267.0 Subsequent year: 365.0	1st year: 1,068 x 500 mg Subsequent year: 1,460 x 500 mg
Prednisolone	Different from patient to patient				
Appropriate comparator therapy					
(Intravenous) cyclophosphamide administration followed by rituximab, each in combination with glucocorticoids					
Cyclophosphamide	15 mg/kg BW = 1,165.5 mg	1,165.5 mg	1 x 1,000 mg + 1 x 200 mg	1st year: 6 Subsequent year: 0	1st year: 6 x 1,000 mg + 6 x 200 mg Subsequent year: 0
Rituximab	500 mg	500 mg	1 x 500 mg	1st year: 2.7 Subsequent year:	1st year: 2.7 x 500 mg Subsequent year:

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
				2	2 x 500 mg
Prednisolone	Different from patient to patient				
(Peroral) cyclophosphamide administration followed by rituximab, each in combination with glucocorticoids					
Cyclophosphamide	2 mg/kg BW = 155.4 mg	155.4 mg	3 x 50 mg	91	273 x 50 mg
Rituximab	500 mg	500 mg	1 x 500 mg	1st year: 2.7 Subsequent year: 2	1st year: 2.7 x 500 mg Subsequent year: 2 x 500 mg
Prednisolone	Different from patient to patient				
Rituximab in combination with glucocorticoids					
Rituximab *Induction phase*	375 mg/m² = 716.3 mg	716.3 mg	1 x 500 mg + 3 x 100 mg	4	4 x 500 mg + 12 x 100 mg
Rituximab *Maintenance phase*	500 mg	500 mg	1 x 500 mg	1st year: 2.9 Subsequent year: 2	1st year: 2.9 x 500 mg Subsequent year: 2 x 500 mg
Prednisolone	Different from patient to patient				

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:

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					
Avacopan 10 mg	540 HC	€ 19,324.65	€ 1.77	€ 1,100.34	€ 18,222.54
Azathioprine 75 mg[13]	100 FCT	€ 49.83	€ 1.77	€ 3.05	€ 45.01
Cyclophosphamide 1,000 mg	6 PSI	€ 145.55	€ 1.77	€ 7.43	€ 136.35
Cyclophosphamide 1,000 mg	1 PSI	€ 33.69	€ 1.77	€ 1.24	€ 30.68
Cyclophosphamide 200 mg	10 PSI	€ 70.83	€ 1.77	€ 3.29	€ 65.77
Cyclophosphamide 50 mg	100 CTA	€ 242.68	€ 1.77	€ 147.46	€ 93.45
Mycophenolate mofetil 500 mg[13]	250 FCT	€ 409.94	€ 1.77	€ 31.53	€ 376.64
Prednisolone 5 mg[13]	100 TAB	€ 15.43	€ 1.77	€ 0.33	€ 13.33
Prednisolone 20 mg[13]	100 TAB	€ 21.62	€ 1.77	€ 0.81	€ 19.04
Rituximab 500 mg	1 CIS	€ 1,777.34	€ 1.77	€ 98.21	€ 1,677.36
Rituximab 100 mg	2 CIS	€ 717.21	€ 1.77	€ 39.08	€ 676.36
Appropriate comparator therapy					
Cyclophosphamide 1,000 mg	6 PSI	€ 145.55	€ 1.77	€ 7.43	€ 136.35
Cyclophosphamide 200 mg	10 PSI	€ 70.83	€ 1.77	€ 3.29	€ 65.77
Cyclophosphamide 50 mg	100 CTA	€ 242.68	€ 1.77	€ 147.46	€ 93.45
Prednisolone 5 mg[13]	100 TAB	€ 15.43	€ 1.77	€ 0.33	€ 13.33
Prednisolone 10 mg[13]	50 TAB	€ 14.85	€ 1.77	€ 0.28	€ 12.80
Prednisolone 10 mg[13]	20 TAB	€ 12.95	€ 1.77	€ 0.13	€ 11.05
Prednisolone 20 mg[13]	100 TAB	€ 21.62	€ 1.77	€ 0.81	€ 19.04
Prednisolone 20 mg[13]	50 TAB	€ 16.92	€ 1.77	€ 0.44	€ 14.71
Prednisolone 20 mg[13]	20 TAB	€ 13.84	€ 1.77	€ 0.20	€ 11.87
Prednisolone 50 mg[13]	10 TAB	€ 15.20	€ 1.77	€ 0.31	€ 13.12
Rituximab 500 mg	1 CIS	€ 1,777.34	€ 1.77	€ 98.21	€ 1,677.36
Rituximab 100 mg	2 CIS	€ 717.21	€ 1.77	€ 39.08	€ 676.36
Abbreviations: FCT = film-coated tablets; HC = hard capsules; CIS = concentrate for the preparation of an infusion solution; PSI = powder for solution for injection; TAB = tablets; CTA = coated tablets					

LAUER-TAXE® last revised: 1 January 2026

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

[13] Fixed reimbursement rate

expenditure in the course of the treatment are not shown.

Diagnosis of hepatitis B infection

Patients should be tested for HBV infection before starting treatment with rituximab.

Diagnostics to rule out chronic hepatitis B require 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 ruled out. In certain case constellations, further steps may be necessary in accordance with current guideline recommendations[14].

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).

Premedication for prevention

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.

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							
Not applicable							
Rituximab in combination therapy with avacopan							
Hepatitis B surface antigen status (FSI 32781)	-	-	-	-	€ 5.06	1.0	€ 5.06
Anti-HBc antibody (FSI 32614)	-	-	-	-	€ 5.43	1.0	€ 5.43
Dimetindene (1 mg/ 10 kg, IV)	5 SFI each 4 mg	€ 26.24	€ 1.77	€ 6.92	€ 17.55	4.0	€ 35.10
Paracetamol (1,000 mg, PO)[13]	10 TAB each 1,000 mg	€ 3.32	€ 0.17	€ 0.14	€ 3.01	4.0	€ 3.01

[14] 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

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
Appropriate comparator therapy:							
Rituximab as maintenance treatment following remission induction with cyclophosphamide							
Hepatitis B surface antigen status (FSI 32781)	-	-	-	-	€ 5.06	1.0	€ 5.06
Anti-HBc antibody (FSI 32614)	-	-	-	-	€ 5.43	1.0	€ 5.43
Dimetindene (1 mg/ 10 kg, IV)	5 SFI each 4 mg	€ 26.24	€ 1.77	€ 6.92	€ 17.55	4.7	€ 36.50[15]
Paracetamol (1,000 mg, PO)[13]	10 TAB each 1,000 mg	€ 3.32	€ 0.17	€ 0.14	€ 3.01	4.7	€ 3.01[15]
Rituximab for remission induction and maintenance treatment							
Hepatitis B surface antigen status (FSI 32781)	-	-	-	-	€ 5.06	1.0	€ 5.06
Anti-HBc antibody (FSI 32614)	-	-	-	-	€ 5.43	1.0	€ 5.43
Dimetindene (1 mg/ 10 kg, IV)	5 SFI each 4 mg	€ 26.24	€ 1.77	€ 6.92	€ 17.55	8.9	€ 65.99[15]
Paracetamol (1,000 mg, PO)[13]	10 TAB each 1,000 mg	€ 3.32	€ 0.17	€ 0.14	€ 3.01	8.9	€ 3.01[15]
Abbreviations: SFI = solution for injection; PII = powder and solvent for solution for injection; TAB = tablets							

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-apply 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

[15] Total costs for the 1st year and the subsequent year

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 data from the product 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 statutory 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 severe, active granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)

No medicinal product with new active ingredients for use in combination therapy in compliance with the requirements of Section 35a, paragraph 3, sentence 4 SGB V.

References:
Product information for avacopan (Tavneos); Tavneos 10 mg hard capsules; last revised: 15 January 2025

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 6 October 2020, the Subcommittee on Medicinal Products determined the appropriate comparator therapy.

A review of the appropriate comparator therapy took place. The Subcommittee on Medicinal Products newly determined the appropriate comparator therapy at their session on 26 August 2025.

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

By letter dated 4 September 2025 in conjunction with the resolution of the G-BA of 1 August 2011 concerning the commissioning of the IQWiG to assess the benefit 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 avacopan.

The dossier assessment by the IQWiG was submitted to the G-BA on 10 December 2025, and the written statement procedure was initiated with publication on the G-BA website on 15 December 2025. The deadline for submitting statements was 5 January 2026.

The oral hearing was held on 26 January 2026.

By letter dated 27 January 2026, the IQWiG was commissioned with a supplementary assessment. The addendum prepared by IQWiG was submitted to the G-BA on 12 February 2026.

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 subcommittee session on 24 February 2026, and the draft resolution was approved.

At their session on 5 March 2026, the plenum adopted a resolution to amend the Pharmaceuticals Directive.

Chronological course of consultation

Session	Date	Subject of consultation
Subcommittee on Medicinal Products	6 October 2020	Determination of the appropriate comparator therapy
Subcommittee on Medicinal Products	26 August 2025	New determination of the appropriate comparator therapy
Working group Section 35a	20 January 2026	Information on written statements received; preparation of the oral hearing
Subcommittee on Medicinal Products	26 January 2026	Conduct of the oral hearing, commissioning of the IQWiG with the supplementary assessment of documents
Working group Section 35a	3 February 2026 17 February 2026	Consultation on the dossier evaluation by the IQWiG and evaluation of the written statement procedure
Subcommittee on Medicinal Products	24 February 2026	Concluding discussion of the draft resolution
Plenum	5 March 2026	Adoption of the resolution on the amendment of the Pharmaceuticals Directive

Berlin, 5 March 2026

Federal Joint Committee
in accordance with Section 91 SGB V
The Chair

Prof. Hecken