Gemeinsamer
Bundesausschuss

Justification

for 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
Nipocalimab (myasthenia gravis, anti-AChR antibody positive, anti-MuSK antibody positive, ≥ 12 years)

From 18 June 2026

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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

The relevant date for the start of the benefit assessment procedure was the first placing on the (German) market of the active ingredient nipocalimab on 1 January 2026 in accordance with Chapter 5, Section 8, paragraph 1, number 1, sentence 2 of the Rules of Procedure of the G-BA (VerfO). Pursuant to 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 of the Rules of Procedure (VerfO), the pharmaceutical company submitted the final dossier to the G-BA on 17 December 2025.

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The G-BA commissioned the IQWiG to carry out the assessment of the dossier. The benefit assessment was published on 1 April 2026 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 nipocalimab 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 the 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 nipocalimab.

In the light of the above, and taking into account the statements received and the oral hearing, the G-BA have come to 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 Nipocalimab (Imaavy) in accordance with the product information

Imaavy is indicated as an add-on to standard therapy for the treatment of generalised myasthenia gravis (gMG) in adult and adolescent patients aged 12 years of age and older who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.

Therapeutic indication of the resolution (resolution of 18.06.2026):

see the approved therapeutic indication

2.1.2 Appropriate comparator therapy

The appropriate comparator therapy was determined as follows:

a) Adults with anti-acetylcholine receptor antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy

Appropriate comparator therapy for nipocalimab as an add-on to standard therapy:

- Eculizumab (only refractory patients are eligible) or efgartigimod alfa or ravulizumab or rozanolixizumab or zilucoplan

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

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b) Adults with anti-muscle-specific tyrosine kinase antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy

Appropriate comparator therapy for nipocalimab as an add-on to standard therapy:

- Rozanolixizumab

c) Adolescents with anti-acetylcholine receptor antibody positive refractory generalised myasthenia gravis who are eligible for an add-on to standard therapy

Appropriate comparator therapy for nipocalimab as an add-on to standard therapy:

- Eculizumab

d) Adolescents with anti-acetylcholine receptor antibody positive non-refractory generalised myasthenia gravis, or with anti-muscle-specific tyrosine kinase antibody positive generalised myasthenia gravis, who are eligible for an add-on to standard therapy

Appropriate comparator therapy for nipocalimab as an add-on to standard therapy:

- Best supportive care

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

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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.

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

On 1. The active ingredients azathioprine, distigmine bromide, neostigmine methylsulphate and pyridostigmine bromide, as well as the glucocorticoids prednisolone and prednisone are generally approved for the treatment of generalised myasthenia gravis (gMG).

The active ingredients efgartigimod alfa, ravulizumab, rozanolixizumab and zilucoplan are approved as an add-on to standard therapy in adults with anti-acetylcholine receptor (AChR) antibody positive gMG. Furthermore, eculizumab is approved for the treatment of AChR-positive refractory gMG in patients aged 6 years and older. The active ingredient rozanolixizumab has been approved for the adjunctive treatment of anti-muscle-specific tyrosine kinase (MuSK) antibody positive gMG. Furthermore, normal human immunoglobulin (IVIg) has been granted the marketing authorisation for the treatment of severe acute exacerbations of myasthenia gravis.

On 2. In the therapeutic indication of gMG, thymectomy and plasmapheresis/ immunoadsorption are considered as non-medicinal treatments.

On 3. For the indication as an add-on to standard therapy in adults with gMG, there are benefit assessments pursuant to Section 35a SGB V on efgartigimod alfa (resolutions of 17 February 2023 and 19 September 2024), ravulizumab (resolution of 20 April 2023), rozanolixizumab (resolution of 15 August 2024) and zilucoplan (resolution of 15 August 2024).

In addition, for the therapeutic indication "generalised myasthenia gravis", there are resolutions on the off-label use (Annex VI to Section K of the Pharmaceuticals Directive, Part A) of mycophenolate mofetil for the "long-term therapy of generalised myasthenia gravis in the case of therapy resistance under treatment with the approved substances or in the case of azathioprine intolerance" and of intravenous immunoglobulins in "myasthenic crises/ severe exacerbations".

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

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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").

Overall, the identified evidence in the therapeutic indication is very limited. This body of evidence includes a systematic review and two additionally presented guidelines "International Consensus Guidance for Management of Myasthenia Gravis: 2020 Update" and the recently fully revised German S2k guideline "Diagnosis and Treatment of Myasthenic Syndromes".

According to the German S2k guideline, treatment decisions are made, in particular, depending on disease activity and disease severity. The appropriate classification into mild/ moderate versus (highly) active generalised myasthenia gravis should be based on the severity of clinical symptomatology, duration of the symptoms and tendency to regress, as well as clinical residuals and the presence or number of crisis-like exacerbations/ crises. Generalised myasthenia gravis refractory to therapy falls under (highly) active disease. Furthermore, the treatment of generalised myasthenia gravis is based on the antibody status, subdivided into, amongst others, anti-AChR, anti-MuSK and anti-low-density lipoprotein receptor-related protein 4 (LRP4) antibody positive, as well as seronegative myasthenia gravis.

Recommendations of the above guidelines for patients with generalised myasthenia gravis include acetylcholinesterase inhibitors, immunosuppressants (glucocorticoids, azathioprine, mycophenolate mofetil, ciclosporin A, methotrexate and tacrolimus), thymectomy, complement inhibitors (eculizumab, ravulizumab and zilucoplan), a neonatal Fc receptor inhibitor (efgartigimod alfa and rozanolixizumab) and CD-20 antibody (rituximab).

Mycophenolate mofetil, ciclosporin A, methotrexate, tacrolimus and rituximab are not approved for the present therapeutic indication. However, according to Annex VI of the Pharmaceuticals Directive, mycophenolate mofetil is reimbursable in the case of treatment resistance.

Furthermore, according to the guideline, intravenous immunoglobulins, as well as plasmapheresis or immunoabsorption may be used if the previously mentioned options fail, or are recommended as a treatment for a myasthenic crisis. However, these options therefore represent a treatment setting different from the therapeutic indication of nipocalimab and are not considered the appropriate comparator therapy in this context.

The G-BA define "standard therapy" – as referred to in the therapeutic indication of nipocalimab – as a treatment comprising acetylcholinesterase inhibitors and a basic immunosuppressive therapy (glucocorticoids and/or non-steroidal immunosuppressants). According to the guideline, patients with mild or moderate disease activity/ severity are eligible for this standard therapy, which does not differ significantly in terms of antibody status or between adults and adolescents.

An add-on to standard therapy is recommended for active or highly active generalised myasthenia gravis. This adjunctive treatment is used in particular as escalation therapy after failure to respond to standard therapy, but can also be an early treatment option in highly active courses of the disease.

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Given that the guideline recommendations on add-on to standard therapy are based on antibody status, and that individual active ingredients are specifically approved only for certain patient groups, it is considered appropriate to categorise patient populations not only by age (adolescents and adults) but also antibody status, as follows:

a) Adults with anti-AChR antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy

b) Adults with anti-MuSK antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy

c) Adolescents with anti-AChR antibody positive refractory generalised myasthenia gravis who are eligible for an add-on to standard therapy

d) Adolescents with anti-AChR antibody positive non-refractory generalised myasthenia gravis, or with anti-MuSK antibody positive generalised myasthenia gravis, who are eligible for an add-on to standard therapy

For all patient groups, it is assumed that patients receive guideline-compliant treatment with acetylcholinesterase inhibitors, as well as basic immunosuppressive therapy alongside the adjunctive treatment.

Patient group a)

The approved first-line treatment options of eculizumab, efgartigimod alfa, ravulizumab, rozanolixizumab and zilucoplan are equally recommended as an add-on to basic therapy for adults with anti-AChR antibody positive generalised myasthenia gravis. The marketing authorisation of eculizumab is nevertheless limited to the treatment of patients refractory to therapy and therefore only applies as an appropriate comparator therapy to a sub-population of the therapeutic indication.

Furthermore, thymectomy also assumes high significance in the treatment of anti-AChR antibody positive generalised myasthenia gravis. However, it is assumed that patients for whom treatment with nipocalimab is indicated are either ineligible for thymectomy or have already undergone this.

In the overall assessment, the appropriate comparator therapy for nipocalimab as an add-on to standard therapy for adults with anti-AChR antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy is determined to be eculizumab (for refractory patients) or efgartigimod alfa or ravulizumab or rozanolixizumab or zilucoplan.

The appropriate comparator therapy determined here includes several therapeutic alternatives. These therapeutic alternatives are equally appropriate for the comparator therapy.

The additional benefit can be demonstrated compared to one of the therapeutic alternatives mentioned.

Patient group b)

Rozanolixizumab, whose use is also recommended in the current S2k guideline on myasthenia gravis, is an approved active ingredient for the treatment of adults with

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generalised myasthenia gravis, who are anti-MuSK antibody positive and are eligible for an add-on to standard therapy.

Consequently, the approved active ingredient rozanolixizumab is determined as the appropriate comparator therapy for this patient population.

Patient groups c) and d)

The German guideline recommends the first-line use of IVIG/ plasmapheresis for juvenile myasthenia gravis with (highly) active disease progression, and the second-line use of rituximab and eculizumab as an add-on to standard therapy. Efgartigimod alfa and ravulizumab may also be considered as second-line therapies.

Furthermore, thymectomy also assumes high significance in the treatment of anti-AChR antibody positive generalised myasthenia gravis in adolescents. However, as with adults, it is assumed that patients for whom treatment with nipocalimab is indicated are either ineligible for thymectomy or have already undergone this.

Only the active ingredient eculizumab is approved for adolescents with generalised myasthenia gravis who are eligible for an add-on to standard therapy. However, the approved indication is limited to the sub-population of anti-AChR antibody positive, refractory subjects. For the other treatment options mentioned, the available evidence for adolescents with generalised myasthenia gravis is considered to be insufficient overall to determine them as the appropriate comparator therapy.

In the overall assessment, eculizumab is therefore determined as the appropriate comparator therapy for nipocalimab as an adjunctive treatment for adolescents with anti-AChR antibody positive refractory generalised myasthenia gravis who are eligible for an add-on to standard therapy.

Given that no active ingredients are approved for use as adjunctive treatment for adolescents with anti-AChR antibody positive non-refractory generalised myasthenia gravis, or with anti-MuSK antibody positive generalised myasthenia gravis, best supportive care is determined as the appropriate comparator therapy for nipocalimab as an adjunctive treatment for this patient group.

"Best Supportive Care" (BSC) is defined as the therapy that provides the best possible, patient-individually optimised, supportive treatment to alleviate symptoms and improve quality of life. In the present therapeutic indication, amongst others, non-medicinal measures according to the catalogue of remedies can help to alleviate symptoms.

The 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 nipocalimab is assessed as follows:

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a) The additional benefit of nipocalimab over the appropriate comparator therapy is not proven for adults with anti-AChR antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy.

b) The additional benefit of nipocalimab over the appropriate comparator therapy is not proven for adults with anti-MuSK antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy.

c) The additional benefit of nipocalimab over the appropriate comparator therapy is not proven for adolescents with anti-AChR antibody positive refractory generalised myasthenia gravis who are eligible for an add-on to standard therapy.

d) The additional benefit of nipocalimab over the appropriate comparator therapy is not proven for adolescents with anti-AChR antibody positive non-refractory generalised myasthenia gravis, or with anti-MuSK antibody positive generalised myasthenia gravis, who are eligible for an add-on to standard therapy.

Justification:

Patient groups a) and b)

For adults with generalised myasthenia gravis who have antibodies against AChR (patient group a) or MuSK (patient group b) and who are eligible for an add-on to standard therapy, no data are available for comparison with the appropriate comparator therapy.

The double-blind, randomised, controlled, pivotal phase III VIVACITY-MG3 study compared nipocalimab with placebo in terms of efficacy and safety. The study therefore does not allow for a comparison with the appropriate comparator therapy determined in each case.

Consequently, an additional benefit of nipocalimab over the appropriate comparator therapy is not proven for either patient group.

Patient group c)

For adolescents with anti-AChR antibody positive refractory generalised myasthenia gravis who are eligible for an add-on to standard therapy, no data are available for comparison with the appropriate comparator therapy. The single-arm VIBRANCE-MG study (see below), in which adolescents with generalised myasthenia were enrolled, is unsuitable for the benefit assessment due to the missing comparison.

An additional benefit of nipocalimab over the appropriate comparator therapy is therefore not proven for this patient group.

Patient group d)

No direct comparator studies are available for adolescents with anti-AChR antibody positive non-refractory generalised myasthenia gravis, or with anti-MuSK antibody positive generalised myasthenia gravis, who are eligible for an add-on to standard therapy.

For the present benefit assessment, the pharmaceutical company therefore transferred the results for a sub-population of the VIVACITY-MG3 study, which compared nipocalimab with

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placebo in adults with generalised myasthenia gravis, to the patient group d). As part of the evidence transfer, they additionally presented the results for this sub-population of adolescents 12 years of age and older from the single-arm VIBRANCE-MG study.

The VIVACITY-MG3 study in adults

The VIVACITY-MG3 study is an ongoing, double-blind, randomised controlled trial comparing treatment with nipocalimab against placebo over 24 weeks, in each case in addition to an ongoing stable standard therapy. Adults with generalised myasthenia gravis, who have a Myasthenia Gravis Foundation of America (MGFA) classification of II to IV and also exhibited disease-specific symptoms (Myasthenia Gravis – Activities of Daily Living (MG-ADL) score ≥ 6), were enrolled in the study. In addition, study participants should have shown a suboptimal response to the current stable standard therapy, or should have discontinued the standard therapy at least 4 weeks prior to screening due to intolerance or lack of efficacy. If patients were receiving treatment with acetylcholinesterase inhibitors and/or non-steroidal immunosuppressants and/or glucocorticoids prior to the start of the study, they were required to continue taking these as concomitant medication during the study, maintaining a stable regimen and a stable dose. In this context, requirements specific to the active ingredient regarding the duration of pretreatment and the duration of stable dosing of the prior therapy before study start had to be met. Where medically necessary, dosage adjustments were permitted only for acetylcholinesterase inhibitors during the study. Non-medicinal measures in place prior to enrolment in the study, such as exercise therapy, may be continued during the study.

A total of 199 patients were enrolled in the study (nipocalimab N = 100; placebo N = 99).

The primary endpoint of the study is the mean change in the total MG-ADL score over weeks 22, 23 and 24 of the double-blind treatment phase, compared to baseline. Other patient-relevant endpoints were assessed in the categories of morbidity, health-related quality of life and side effects.

In the present assessment, the pharmaceutical company has limited the study population to adults with anti-AChR antibody positive non-refractory myasthenia gravis, or anti-MuSK antibody positive generalised myasthenia gravis, in line with patient population d) of adolescents. To exclude patients with refractory disease, they define refractoriness as a persistent impairment of activities of daily living despite immunosuppressants (glucocorticoids and non-steroidal immunosuppressants), operationalised as treatment with ≥ 2 immunosuppressive therapies (monotherapy or combination therapy) or as treatment with ≥ 1 immunosuppressive therapy and at least 2 treatments with plasmapheresis/ plasma exchange or intravenous immunoglobulins.

As part of the written statement procedure, the pharmaceutical company has also submitted further data from the VIVACITY-MG3 study. These include, in particular, details of subgroup analyses, prior therapies and adjustments to concomitant therapies during the course of the study.

The VIBRANCE-MG study

The VIBRANCE-MG study is an ongoing, single-arm study of nipocalimab as an add-on to ongoing stable standard therapy. Children and adolescents aged between 2 and < 18 years with anti-AChR or anti-MuSK antibody positive generalised myasthenia gravis, who have an MGFA classification of II to IV, were enrolled in the study. Furthermore, patients should have shown a suboptimal response to the current stable standard therapy, or should have discontinued the standard therapy at least 4 weeks prior to screening due to intolerance or

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lack of efficacy. To date, 9 adolescents have been enrolled in the relevant age cohort (12 to < 18 years) for the present benefit assessment.

The requirements for concomitant standard therapy largely correspond to those of the VIVACITY-MG3 study.

The primary endpoints of the study are the effect on total serum immunoglobulin G, adverse events and the pharmacokinetics of nipocalimab. Other patient-relevant endpoints were assessed in the categories of morbidity and health-related quality of life.

Evidence transfer

Even taking into account the data submitted subsequently during the written statement procedure, the VIVACITY-MG3 study in adults is unsuitable for transferring an additional benefit. This is due, in particular, to the fact that the adults in the comparator arm of the VIVACITY-MG3 study received inadequate treatment. In the present treatment setting, it is assumed that patients are receiving guideline-compliant treatment with acetylcholinesterase inhibitors and basic immunosuppressive therapy. Any available options for therapy optimisation should be implemented.

In the intervention arm of the VIVACITY-MG3 study, patients received nipocalimab as part of a therapy escalation regimen in addition to their existing stable therapy, whilst those in the comparator arm received only a placebo in addition to their existing therapy. With the exception of adjustments to the dosage of acetylcholinesterase inhibitors where medically necessary, no changes to concomitant medication were permitted during the study. In the event of clinical deterioration, plasmapheresis or intravenous immunoglobulins were permitted as emergency therapies at the discretion of the principal investigator, but resulted in the discontinuation of the study medication during the double-blind phase of the study. Other emergency therapies, such as increasing the dose of concomitant medication or administering oral or intravenous glucocorticoids, were not permitted.

Based on the information provided, it can be assumed that no therapy optimisation took place prior to the start of the study. However, based on the provided information on prior therapies and concomitant medication, it can be inferred that, in principle, there were still options for therapy optimisation in the relevant study sub-population for the benefit assessment. This is also due to the fact that 76.5% of patients in the nipocalimab arm and 90% of patients in the placebo arm are those with non-refractory (anti-AChR antibody positive) disease, for whom options for therapy optimisation can generally still be expected.

The data on stable concomitant medication show that the majority of patients were not receiving guideline-compliant therapy with acetylcholinesterase inhibitors and immunosuppressive therapy comprising glucocorticoids and/or non-steroidal immunosuppressants at the start of the study. Thus, only 20% of patients in the comparator arm of the relevant sub-population received combination therapy comprising acetylcholinesterase inhibitors, glucocorticoids and non-steroidal immunosuppressants, and only 7.5% of patients in the comparator arm received combination therapy comprising acetylcholinesterase inhibitors and a non-steroidal immunosuppressant. 17.5% of patients in the comparator arm of the relevant sub-population of the study received only symptomatic therapy with acetylcholinesterase inhibitors and therefore no immunosuppressive therapy.

The data presented also show that no patient in the relevant sub-population of the study received an adjusted dose of acetylcholinesterase inhibitors. In accordance with the study protocol, treatment with glucocorticoids and non-steroidal immunosuppressants had to be

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maintained at a stable dose during the randomised treatment phase; no adjustments were permitted.

Conclusion:

Consequently, based on the available information, it can be assumed that there were still options for therapy optimisation at the start of the study and that patients in the comparator arm of the VIVACITY-MG3 study were inadequately treated. Adjustments to concomitant medication during the course of the study were not permitted, with the exception of symptomatic therapy with acetylcholinesterase inhibitors, and were not carried out in the relevant sub-population either.

Another critical point to note is that the pharmaceutical company did not gather any information on the appropriate comparator therapy of best supportive care for adolescents according to patient group d). For evidence transfer, comparator data must, in principle, be provided for both the baseline population (adults) and the target population (adolescents), meaning not only for the intervention but also for the comparator therapy.

In the overall assessment, the data presented for a sub-population of the VIVACITY-MG3 study, which compared nipocalimab with placebo in adults with generalised myasthenia gravis, are unsuitable for the benefit assessment. Consequently, these data cannot be used for evidence transfer to the adolescent population. Furthermore, insufficient information was provided for carrying out an evidence transfer.

An additional benefit of nipocalimab over the appropriate comparator therapy for adolescents with anti-AChR antibody positive non-refractory generalised myasthenia gravis, or with anti-MuSK antibody positive generalised myasthenia gravis, who are eligible for an add-on to standard therapy, is therefore not proven.

2.1.4 Summary of the assessment

The present assessment concerns the benefit assessment of the new medicinal product Imaavy with the active ingredient nipocalimab. Nipocalimab is approved as an add-on to standard therapy for the treatment of generalised myasthenia gravis (gMG) in adults and adolescents 12 years of age and older who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.

In the therapeutic indication to be considered, 4 patient groups were distinguished as follows:

a) Adults with anti-AChR antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy

b) Adults with anti-MuSK antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy

c) Adolescents with anti-AChR antibody positive refractory generalised myasthenia gravis who are eligible for an add-on to standard therapy

d) Adolescents with anti-AChR antibody positive non-refractory generalised myasthenia gravis, or with anti-MuSK antibody positive generalised myasthenia gravis, who are eligible for an add-on to standard therapy

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Patient group a)

The G-BA determined the appropriate comparator therapy to be eculizumab (only refractory patients are eligible) or efgartigimod alfa or ravulizumab or rozanolixizumab or zilucoplan.

For adults with generalised myasthenia gravis who have anti-AChR antibodies and are eligible for an add-on to standard therapy, no data are available for comparison with the appropriate comparator therapy.

The double-blind, randomised, controlled, pivotal phase III VIVACITY-MG3 study compared nipocalimab with placebo in terms of efficacy and safety. The study therefore does not allow for a comparison with the determined appropriate comparator therapy.

Consequently, an additional benefit of nipocalimab over the appropriate comparator therapy is not proven for this patient group.

Patient group b)

The G-BA determined rozanolixizumab as the appropriate comparator therapy.

For adults with generalised myasthenia gravis who have anti-MuSK antibodies and are eligible for an add-on to standard therapy, no data are available for comparison with the appropriate comparator therapy.

The double-blind, randomised, controlled, pivotal phase III VIVACITY-MG3 study compared nipocalimab with placebo in terms of efficacy and safety. The study therefore does not allow for a comparison with the determined appropriate comparator therapy.

Consequently, an additional benefit of nipocalimab over the appropriate comparator therapy is not proven for this patient group.

Patient group c)

The G-BA determined eculizumab as the appropriate comparator therapy.

For adolescents with anti-AChR antibody positive refractory generalised myasthenia gravis who are eligible for an add-on to standard therapy, no data are available for comparison with the appropriate comparator therapy. The single-arm VIBRANCE-MG study, in which adolescents with generalised myasthenia were enrolled, is unsuitable for the benefit assessment due to the missing comparison.

An additional benefit of nipocalimab over the appropriate comparator therapy is therefore not proven for this patient group.

Patient group d)

The G-BA determined best supportive care as the appropriate comparator therapy.

No direct comparator studies are available for adolescents with anti-AChR antibody positive non-refractory generalised myasthenia gravis, or with anti-MuSK antibody positive generalised myasthenia gravis, who are eligible for an add-on to standard therapy.

For the present benefit assessment, the pharmaceutical company therefore transferred the results for a sub-population of the VIVACITY-MG3 study, which compared nipocalimab with placebo in adults with generalised myasthenia gravis, to the population of adolescents.

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However, the VIVACITY-MG3 study in adults is unsuitable for transferring an additional benefit. This is due, in particular, to the fact that the adults in the comparator arm of the VIVACITY-MG3 study received inadequate treatment. Based on the available information, it can be assumed that patients in the comparator arm still had options for therapy optimisation at the start of the study. Adjustments to the standard therapy during the course of the study were not permitted, with the exception of symptomatic therapy with acetylcholinesterase inhibitors, and were not carried out in the relevant sub-population either.

In the overall assessment, the data presented for a sub-population of the VIVACITY-MG3 study, which compared nipocalimab with placebo in adults with generalised myasthenia gravis, are unsuitable for the benefit assessment. Consequently, these data cannot be used for evidence transfer to the adolescent population. Furthermore, insufficient information was provided for carrying out an evidence transfer.

An additional benefit of nipocalimab over the appropriate comparator therapy for adolescents with anti-AChR antibody positive non-refractory generalised myasthenia gravis, or with anti-MuSK antibody positive generalised myasthenia gravis, who are eligible for an add-on to standard 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).

There are methodological limitations and uncertainties in several steps when the pharmaceutical company determined the number of patients in the SHI target population.

Overall, the lower limit of the pharmaceutical company's estimate of the number of adults with anti-AChR antibody positive and anti-MuSK antibody positive generalised myasthenia gravis in the SHI target population is uncertain. The upper limit, by contrast, is overestimated, particularly because of the operationalisation of high disease activity/ disease severity solely by taking into account MGFA classes II to IV.

With regard to adults with anti-AChR antibody positive generalised myasthenia gravis (patient group a), the number of patients stated in this dossier falls within the range specified in previous resolutions in the therapeutic indication, with a slight deviation from the upper limit (resolution of 19 September 2024 on efgartigimod alfa, resolutions of 15 August 2024 on rozanolixizumab and zilucoplan). In the benefit assessment of efgartigimod alfa, to which the figures in all previous resolutions refers, the upper limit of approximately 19,000 patients was deemed to be an overestimate, and the lower limit of approximately 6,300 was deemed to be uncertain. In order to take greater account of the uncertainty in the figures provided by the pharmaceutical company on nipocalimab, the lower limit specified in previous resolutions in the therapeutic indication will be used for the present resolution. As both upper limits have been overestimated, the lower of the two upper limits set out in the previous resolutions will be taken into account.

With regard to adults with anti-MuSK antibody positive generalised myasthenia gravis (patient group b), the figures in this dossier exceed those set out in the previous resolution on rozanolixizumab dated 15 August 2024 in the therapeutic indication. Although the method used in this dossier to determine patient numbers is considered more appropriate than the method used for rozanolixizumab, operationalisation of high disease activity/ disease severity

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solely on the basis of MGFA classes leads to an overestimation of the patient numbers. In order to take greater account of the uncertainty, a wide range is established based on the patient numbers given in the previous procedure for rozanolixizumab (lower limit) and the figures provided by the pharmaceutical company in the present procedure (upper limit).

For the two patient groups comprising adolescents with generalised myasthenia gravis (patient groups c and d), the figures provided by the pharmaceutical company in this dossier are used as the basis. The derivation of the figures for patients is essentially the same as for adults. Accordingly, corresponding uncertainties regarding the lower limit and overestimation of the upper limit must be assumed. In addition, in the case of adolescents, there is the added uncertainty arising from the chosen operationalisation used to distinguish between refractory and non-refractory patients. Furthermore, the transferability of percentages from adults to adolescents is unclear. Overall, the figures given for the adolescents in patient groups c and d are therefore uncertain.

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 Imaavy (active ingredient: nipocalimab) at the following publicly accessible link (last access: 4 March 2026):

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

Treatment with nipocalimab should only be initiated and monitored by specialists who are experienced in the treatment of patients with neuromuscular diseases.

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 April 2026). 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, only the dosages of the general case are considered. Patient-individual dose adjustments, e.g. because of side effects or comorbidities, are not taken into account when calculating the annual treatment costs.

In general, initial induction regimens are not taken into account for the cost representation, since the present indication is a chronic disease with a continuous need for therapy and, as a rule, no new titration or dose adjustment is required after initial titration.

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.

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For dosages depending on body weight (BW), the average body measurements from the official representative statistics "2017 Microcensus – body measurements of the population[2]" (average body weight of those aged ≥ 12 years: 47.1 kg) and "2021 Microcensus – body measurements of the population[3]" (average body weight of those under 18 years: 67.2 kg and aged ≥ 18 years: 77.7 kg) were used as the basis.

The dosage recommended in the product information was used as the calculation basis for efgartigimod alfa. One treatment cycle of efgartigimod alfa spans 4 weeks. Further treatment cycles are administered on a patient-individual basis according to the clinical assessment and at the earliest 7 weeks after the first infusion.

According to the product information, a treatment cycle of rozanolixizumab spans 6 weeks. A new treatment cycle is initiated on a patient-individual basis according to the clinical assessment. In the clinical development programme, most study participants had treatment-free intervals of 4 – 13 weeks. This range is used for the cost calculation.

a) Adults with anti-acetylcholine receptor antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy

Treatment period:

Name of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
Medicinal product to be assessed				
Nipocalimab	Continuously, 1 x every 14 days	26.1	1	26.1
Appropriate comparator therapy				
Eculizumab (for refractory patients) or efgartigimod alfa or ravulizumab or rozanolixizumab or zilucoplan				
Eculizumab	Continuously, 1 x every 12-16 days	22.8 - 30.4	1	22.8 - 30.4
Efgartigimod alfa	1 x every 7 days per 4-week cycle	1 – 7.4	4	4 - 29.6
Ravulizumab	Continuously, 1 x every 56 days	6.5	1	6.5
Rozanolixizumab	1 x every 7 days per 6-week cycle	2.7 – 5.2	6	16.2 – 31.2
Zilucoplan	Continuously,	365.0	1	365.0

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

[3] Federal Health Reporting. Average body measurements of the population (2017, both sexes, 1 year and older), www.gbe-bund.de

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Name of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
	1 x daily			

Consumption:

Name 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					
Nipocalimab	15 mg/kg BW 1,165.5 mg	1,165.5 mg	1 x 1,200 mg	26.1	26.1 x 1,200 mg
Appropriate comparator therapy					
Eculizumab (for refractory patients) or efgartigimod alfa or ravulizumab or rozanolixizumab or zilucoplan					
Eculizumab	1,200 mg	1,200 mg	4 x 300 mg	22.8 - 30.4	91.2 x 300 mg – 121.6 x 300 mg
Efgartigimod alfa	1,000 mg	1,000 mg	1 x 1,000 mg	4.0 - 29.6	4.0 x 1,000 mg – 29.6 x 1,000 mg
Ravulizumab	3,300 mg	3,300 mg	3 x 1,100 mg	6.5	19.5 x 1,100 mg
Rozanolixizumab	≥ 70 to < 100 kg BW 560 mg	560 mg	1 x 560 mg	16.2 – 31.2	16.2 x 560 mg – 31.2 x 560 mg
Zilucoplan	32.4 mg	32.4 mg	1 x 32.4 mg	365.0	365 x 32.4 mg

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b) Adults with anti-muscle-specific tyrosine kinase antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy

Treatment period:

Name of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
Medicinal product to be assessed				
Nipocalimab	Continuously, 1 x every 14 days	26.1	1	26.1
Appropriate comparator therapy				
Rozanolixizumab				
Rozanolixizumab	1 x every 7 days per 6-week cycle	2.7 – 5.2	6	16.2 – 31.2

Consumption:

Name of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Annual average consumption by potency
Medicinal product to be assessed					
Nipocalimab	15 mg/kg BW 1,165.5 mg	1,165.5 mg	1 x 1,200 mg	26.1	26.1 x 1,200 mg
Appropriate comparator therapy					
Rozanolixizumab					
Rozanolixizumab	≥ 70 to < 100 kg BW 560 mg	560 mg	1 x 560 mg	16.2 – 31.2	16.2 x 560 mg – 31.2 x 560 mg

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c) Adolescents with anti-acetylcholine receptor antibody positive refractory generalised myasthenia gravis who are eligible for an add-on to standard therapy

Treatment period:

Name of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
Medicinal product to be assessed				
Nipocalimab	Continuously, 1 x every 14 days	26.1	1	26.1
Appropriate comparator therapy				
Eculizumab				
Eculizumab	Continuously, 1 x every 12-16 days	22.8 - 30.4	1	22.8 - 30.4

Consumption:

Name 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					
Nipocalimab	15 mg/kg BW 706.3 mg – 1,008 mg	706.5 mg – 1,008 mg	3 x 300 mg – 1 x 1,200 mg	26.1	78.3 x 300 mg – 26.1 x 1,200 mg
Appropriate comparator therapy					
Eculizumab					
Eculizumab	1,200 mg	1,200 mg	4 x 300 mg	22.8 - 30.4	91.2 x 300 mg – 121.6 x 300 mg

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d) Adolescents with anti-acetylcholine receptor antibody positive non-refractory generalised myasthenia gravis, or with anti-muscle-specific tyrosine kinase antibody positive generalised myasthenia gravis, who are eligible for an add-on to standard therapy

Treatment period:

The treatment costs for best supportive care are different from patient to patient. Because best supportive care has been determined as an appropriate comparator therapy, this is also reflected in the medicinal product to be assessed. The type and scope of best supportive care can vary depending on the medicinal product to be assessed and the comparator therapy.

Name of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
Medicinal product to be assessed				
Nipocalimab	Continuously, 1 x every 14 days	26.1	1	26.1
Best supportive care		Different from patient to patient		
Appropriate comparator therapy				
Best supportive care				
Best supportive care		Different from patient to patient		

Consumption:

Name 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					
Nipocalimab	15 mg/kg BW 706.5 mg – 1,008 mg	706.5 mg – 1,008 mg	3 x 300 mg – 1 x 1,200 mg	26.1	78.3 x 300 mg – 26.1 x 1,200 mg
Best supportive care		Different from patient to patient			
Appropriate comparator therapy					
Best supportive care					
Best supportive care		Different from patient to patient			

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Patient groups a) to d)

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:

Name 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					
Nipocalimab 300 mg	1 CIS	€ 5,356.80	€ 1.77	€ 302.64	€ 5,052.39
Nipocalimab 1,200 mg	1 CIS	€ 21,254.22	€ 1.77	€ 1,210.54	€ 20,041.91
Appropriate comparator therapy					
Eculizumab 300 mg	1 CIS	€ 5,586.75	€ 1.77	€ 318.47	€ 5,266.51
Efgartigimod alfa 1,000 mg	1 IPFS	€ 14,816.64	€ 1.77	€ 842.89	€ 13,971.98
Ravulizumab 1,100 mg	1 CIS	€ 16,418.81	€ 1.77	€ 937.09	€ 15,479.95
Rozanolixizumab 560 mg	1 SFI	€ 17,201.94	€ 1.77	€ 979.11	€ 16,221.06
Zilucoplan 32.4 mg	28 SFI	€ 22,941.65	€ 1.77	€ 1,309.61	€ 21,630.27
Abbreviations: IPFS = solution for injection in a pre-filled syringe; CIS = concentrate for the preparation of an infusion solution; SFI = solution for injection					

LAUER-TAXE® last revised: 15 April 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 expenditure in the course of the treatment are not shown.

Because there are no 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, no costs for additionally required SHI services had to be taken into account.

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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 01.10.2009 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 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

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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

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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

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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:

a) Adults with anti-acetylcholine receptor antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy

– 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.

b) Adults with anti-muscle-specific tyrosine kinase antibody positive generalised myasthenia gravis who are eligible for an add-on to standard therapy

– 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.

c) Adolescents with anti-acetylcholine receptor antibody positive refractory generalised myasthenia gravis who are eligible for an add-on to standard therapy

– 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.

d) Adolescents with anti-acetylcholine receptor antibody positive non-refractory generalised myasthenia gravis, or with anti-muscle-specific tyrosine kinase antibody positive generalised myasthenia gravis, who are eligible for an add-on to standard therapy

– 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.

Product information for nipocalimab (Imaavy®); Imaavy 185 mg/ml infusion solution concentrate; last revised: November 2025

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 Imaavy 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.

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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% (8.0%) of the total number of study participants according to the information provided by the pharmaceutical company.

The pharmaceutical company calculated this percentage on the basis of 16 studies. Discrepancies in the figures for the number of study participants have been identified in two studies. Furthermore, the MOM-M281-006 study cannot be used, as it is still in the recruitment phase.

Overall, it can however be concluded that the percentage of study participants at study sites within the scope of SGB V exceeds 5%.

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 27 February 2024, the Subcommittee on Medicinal Products determined the appropriate comparator therapy.

A review of the appropriate comparator therapy took place once the positive opinion was granted. At their session on 25 November 2025, the Subcommittee on Medicinal Products newly determined the appropriate comparator therapy.

On 17 December 2025, the pharmaceutical company submitted a dossier for the benefit assessment of nipocalimab to the G-BA in due time in accordance with Chapter 5, Section 8, paragraph 1, number 1, sentence 2 VerfO.

By letter dated 23 December 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 nipocalimab.

The dossier assessment by the IQWiG was submitted to the G-BA on 25 March 2026, and the written statement procedure was initiated with publication on the G-BA website on 1 April 2026. The deadline for submitting written statements was 22 April 2026.

The oral hearing was held on 11 May 2026.

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By letter of 12 May 2026, the IQWiG was commissioned with a supplementary assessment of data submitted in the written statement procedure. The addendum prepared by the IQWiG was submitted to the G-BA on 28 May 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 were discussed at the Subcommittee's session on 9 June 2026 and the draft resolution was approved.

At their session on 18 June 2026, the plenum adopted a resolution to amend the Pharmaceuticals Directive.

Chronological course of consultation

Session	Date	Subject of consultation
Subcommittee on Medicinal Products	27 February 2024	Determination of the appropriate comparator therapy
Subcommittee on Medicinal Products	25 November 2025	New determination of the appropriate comparator therapy
Working group Section 35a	5 May 2026	Information on written statements received; preparation of the oral hearing
Subcommittee on Medicinal Products	11 May 2026	Conduct of the oral hearing, commissioning of the IQWiG with the supplementary assessment of documents
Working group Section 35a	19 May 2026 2 June 2026	Consultation on the dossier assessment by the IQWiG and evaluation of the written statement procedure
Subcommittee on Medicinal Products	9 June 2026	Concluding discussion of the draft resolution
Plenum	18 June 2026	Adoption of the resolution on the amendment of the Pharmaceuticals Directive

Berlin, 18 June 2026

Courtesy translation – only the German version is legally binding.

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

Prof. Hecken

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