Gemeinsamer Bundesausschuss

Justification

of 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
Tebentafusp (uveal melanoma, HLA-A*02:01-positive)

of 20 October 2022

Contents

1. Legal basis

According to Section 35a paragraph 1 German Social Code, Book Five (SGB V), the Federal Joint Committee (G-BA) assesses the benefit of reimbursable medicinal products with new active ingredients.

For medicinal products for the treatment of rare diseases (orphan drugs) that are approved according to Regulation (EC) No. 141/2000 of the European Parliament and the Council of 16 December 1999, the additional medical benefit is considered to be proven through the grant of the marketing authorisation according to Section 35a, paragraph 1, sentence 11, 1st half of the sentence German Social Code, Book Five (SGB V). Evidence of the medical benefit and the additional medical benefit in relation to the appropriate comparator therapy do not have to be submitted (Section 35a, paragraph 1, sentence 11, 2nd half of the sentence SGB V). Section 35a, paragraph 1, sentence 11, 1st half of the sentence SGB V thus guarantees an additional benefit for an approved orphan drug, although an assessment of the orphan drug in accordance with the principles laid down in Section 35a paragraph 1, sentence 3, No. 2 and 3 SGB V in conjunction with Chapter 5 Sections 5 et seq. of the Rules of Procedure (VerfO) of the G-BA has not been carried out. In accordance with Section 5, paragraph 8 AM-NutzenV, only the extent of the additional benefit is to be quantified indicating the significance of the evidence.

However, the restrictions on the benefit assessment of orphan drugs resulting from the statutory obligation to the marketing authorisation do not apply if the turnover of the medicinal product with the SHI at pharmacy sales prices and outside the scope of SHI-accredited medical care, including VAT exceeds € 50 million in the last 12 calendar months. According to Section 35a, paragraph 1, sentence 12 SGB V, the pharmaceutical company must then, within three months of being requested to do so by the G-BA, submit evidence according to Chapter 5, Section 5, subsection 1–6 VerfO, in particular regarding the additional medical benefit in relation to the appropriate comparator therapy as defined by the G-BA according to Chapter 5 Section 6 VerfO and prove the additional benefit in comparison with the appropriate comparator therapy.

In accordance with Section 35a paragraph 2 SGB V, the G-BA decides whether to carry out the benefit assessment itself or to commission the Institute for Quality and Efficiency in Health Care (IQWiG). Based on the legal requirement in Section 35a paragraph 1 sentence 11 SGB V that the additional benefit of an orphan drug is considered to be proven through the grant of the marketing authorisation the G-BA modified the procedure for the benefit assessment of orphan drugs at its session on 15 March 2012 to the effect that, for orphan drugs, the G-BA initially no longer independently determines an appropriate comparator therapy as the basis for the solely legally permissible assessment of the extent of an additional benefit to be assumed by law. Rather, the extent of the additional benefit is assessed exclusively on the basis of the approval studies by the G-BA indicating the significance of the evidence.

Accordingly, at its session on 15 March 2012, the G-BA amended the mandate issued to the IQWiG by the resolution of 1 August 2011 for the benefit assessment of medicinal products with new active ingredients in accordance with Section 35a paragraph 2 SGB V to that effect that, in the case of orphan drugs, the IQWiG is only commissioned to carry out a benefit assessment in the case of a previously defined comparator therapy when the sales volume of the medicinal product concerned has exceeded the legal limit of € 50 million and is therefore subject to an unrestricted benefit assessment (cf. Section 35a paragraph 1, sentence 12 SGB V). According to Section 35a paragraph 2 SGB V, the assessment by the G-BA 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 decides 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 first placing on the (German) market of the active ingredient tebentafusp in accordance with Chapter 5, Section 8, paragraph 1, number 1, sentence 2 of the Rules of Procedure of the G-BA (VerfO) is 1 May 2022. The pharmaceutical company submitted the final dossier to the G-BA in accordance with Section 4, paragraph 3, number 1 of the Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV) in conjunction with Chapter 5, Section 8, paragraph 1, number 1 VerfO on 20 April 2022.

Tebentafusp in the treatment of human leukocyte antigen (HLA)-A*02:01-positive adult patients with unresectable or metastatic uveal melanoma is approved as a medicinal product for the treatment of rare diseases under Regulation (EC) No. 141/2000 of the European Parliament and of the Council of 16 December 1999.

In accordance with Section 35a, paragraph 1, sentence 11, 1st half of the sentence SGB V, the additional benefit is considered to be proven through the grant of the marketing authorisation. The extent of the additional benefit and the significance of the evidence are assessed on the basis of the marketing authorisation studies by the G-BA.

The G-BA carried out the benefit assessment and commissioned the IQWiG to evaluate the information provided by the pharmaceutical company in Module 3 of the dossier on treatment costs and patient numbers. The benefit assessment was published on 1 August 2022 together with the IQWiG assessment on the website of the G-BA (www.g-ba.de), thus initiating the written statement procedure. In addition, an oral hearing was held.

The G-BA has adopted its resolution on the basis of the dossier of the pharmaceutical company, the dossier evaluation carried out by the G-BA, the assessment of treatment costs and patient numbers (IQWiG G22-015) prepared by the IQWiG, and the statements submitted in the written statement and oral hearing procedure.

In order to determine the extent of the additional benefit, the G-BA has assessed the studies relevant for the marketing authorisation considering their therapeutic relevance (qualitative) in accordance with the criteria laid down in Chapter 5, Section 5, paragraph 7, sentence 1, numbers 1 – 4 VerfO. The methodology proposed by the IQWiG in accordance with the General Methods [1] was not used in the benefit assessment of tebentafusp.

2.1 Additional benefit of the medicinal product

2.1.1 Approved therapeutic indication of Tebentafusp (Kimmtrak) in accordance with the product information

Kimmtrak is indicated as monotherapy for the treatment of human leukocyte antigen (HLA)-A*02:01-positive adult patients with unresectable or metastatic uveal melanoma.

Therapeutic indication of the resolution (resolution of 20 October 2022):

see the approved therapeutic indication

[1] General Methods, version 6.1 from 24.01.2022. Institute for Quality and Efficiency in Health Care (IQWiG), Cologne.

2.1.2 Extent of the additional benefit and significance of the evidence

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

Hint of a considerable additional benefit

Justification:

For the assessment of the additional benefit of tebentafusp, the pharmaceutical company presented data from the IMCgp100-202 pivotal study and supplementary data from the IMCgp100-102 study in the dossier. The IMCgp100-202 study exclusively includes previously untreated patients in the metastatic stage and the IMCgp100-102 study exclusively includes pretreated patients in the metastatic stage. The patients with unresectable but non-metastatic uveal melanoma included in the therapeutic indication are not part of the study population in each case.

IMCgp100-202 study

The IMCgp100-202 pivotal study, hereafter referred to as 202 study, is an ongoing, randomised, multicentre, controlled, unblinded phase II study to evaluate the efficacy and safety of tebentafusp versus a therapy at the doctor's discretion (dacarbazine, ipilimumab or pembrolizumab) in HLA-A*02:01-positive patients with untreated advanced or metastatic uveal melanoma. The study will be conducted in 58 study sites and 14 countries (North America, Europe, Australia, Ukraine and Russia) from October 2017 to an estimated March 2023. For the present benefit assessment, the primary data cut-off (pre-specified interim analysis) from 13 October 2020 is used for all patient-relevant endpoints. The data cut-off from 12 August 2021 required by the EMA was not submitted for the benefit assessment. According to the EPAR, this contains later data on overall survival. It is noted that patients were able to switch from the control arm to the treatment arm following the primary data cut-off. According to the EPAR, this could affect the assessment of the further results of the overall survival endpoint.

The total of 378 included HLA-A*02:01-positive patients with metastatic uveal melanoma will be stratified by LDH status and randomised in a 2:1 ratio to the two study arms. During the treatment phase, they will receive either weekly tebentafusp or a therapy at the doctor's discretion (dacarbazine, ipilimumab or pembrolizumab) every three weeks. The median treatment duration was 163 days in the tebentafusp arm and was significantly shorter in the comparator arm at 65 days.

Patients will be observed as part of a safety follow-up after the last dose with the study medication over a period of 90 days. In addition, progression and survival will be followed up.

The primary study endpoint is overall survival. In addition, data on morbidity (symptomatology (EORTC QLQ-C30) and health status (EQ-5D-5L VAS)), quality of life (EORTC QLQ-C30) and side effects are collected.

102 study

The ongoing 102 study is a single-arm phase I/II study to investigate the efficacy and safety of tebentafusp in patients with advanced uveal melanoma. Phase I of the study included dose escalation in 19 patients, 13 of whom did not receive a dose in accordance with the product information from day 15 onwards. The phase II of the study aims to estimate the overall response rate in previously treated HLA-A*02:01-positive patients with uveal melanoma based on the dosing scheme of tebentafusp monotherapy derived from the phase I study. The median duration of exposure to tebentafusp was 169 days.

Phase II of the study will be conducted in 26 study sites and 5 countries (Canada, USA, Germany, Spain, UK) from January 2017 to an anticipated March 2024. For the present benefit assessment, the pharmaceutical company submits the primary data cut-off (pre-specified interim analysis) from 20 March 2020 for all patient-relevant endpoints.

The primary endpoint of the study is the overall response rate. In addition, data on the secondary endpoint of overall survival, morbidity (symptomatology and health status), quality of life and side effects are presented.

The data of the 102 study were presented additionally by the pharmaceutical company in the dossier. Due to the single-arm study design, there is no evidence from the 102 study that is relevant for the benefit assessment beyond the pivotal 202 study. Therefore, only the pivotal 202 study is used for the present assessment.

Mortality

The overall survival is defined in the 202 study as the time between the first day of randomisation and death from any cause.

For the endpoint of overall survival, there is a statistically significant difference in favour of tebentafusp compared to therapy at the doctor's discretion (dacarbazine, ipilimumab or pembrolizumab).

The extent of the prolongation achieved in overall survival is assessed as a significant improvement.

In the subgroup analyses for the endpoint of overall survival, there is an interaction between treatment and the stratification characteristic LDH (≤ ULN vs > ULN; p = 0.04). For the LDH ≤ ULN subgroup, there is a statistically significant difference to the advantage of tebentafusp. There is no statistically significant difference for the LDH > ULN subgroup. This result of the subgroup analysis for the characteristic LDH is considered relevant, but does not lead to correspondingly differentiated statements in the quantification of the additional benefit in the present assessment in the overall assessment.

Morbidity

Symptomatology (EORTC QLQ-C30)

Disease symptomatology was assessed using the cancer-specific questionnaire EORTC QLQ-C30.

The pharmaceutical company submitted responder analyses in the dossier for the percentage of patients with a change of 6.7 points. In addition, sensitivity analyses were presented with 10 points or 15% of the scale range.

In the 202 study, the return rates in the comparator arm were already below 70% at baseline and the difference in return rates between the treatment arms was more than 15%. Therefore, the results are not used further for the benefit assessment.

Health status (EQ-5D, visual analogue scale)

The health status was assessed in the 202 study using the visual analogue scale (VAS) of the EQ-5D questionnaire.

The results of the questionnaire were not used because the return rates were already low at baseline and differed greatly between the groups.

For the reasons mentioned above, the results of the measurement instruments in the endpoint category of morbidity are not used.

Quality of life

Health-related quality of life (EORTC QLQ-C30)

Health-related quality of life was assessed in the 202 study using the functional scales and the global scale of general health status of the EORTC QLQ-C30 questionnaire.

Due to the low return rates of the EORTC QLQ-C30, the results on health-related quality of life are not used for the benefit assessment.

Side effects

Treatment-emergent AEs (TEAEs) were evaluated from the day of the first study medication until 90 days after the last dose or start of subsequent anti-tumour therapy.

In the 202 study, the median treatment duration was 163 days in the tebentafusp arm and 65 days in the comparator arm. For the 202 study, the effect estimators of relative risk, odds ratio or risk difference were calculated post hoc by the pharmaceutical company and presented in the dossier. However, the differences in the duration of observation were not taken into account, which is why the results were not used in the dossier assessment.

As part of the written statement procedure, the pharmaceutical company submits subgroup analyses and time-to-event analyses for adverse events of special interest as well as time-to-event analyses for the adverse events and the serious adverse events. However, some of the subsequently submitted data is non-comparator data.

There was no statistically significant difference in serious adverse events (SAEs).

Even with the subsequently submitted data, time-to-event analyses and corresponding effect estimators are not available for all endpoints in the side effects category. The evaluations presented therefore do not allow a sufficiently reliable assessment and are therefore not suitable for quantifying the extent of the additional benefit of tebentafusp.

Overall assessment

For the assessment of the additional benefit of tebentafusp for the treatment of HLA (human leukocyte antigen)-A*02:01-positive adults with unresectable or metastatic uveal melanoma, the results of the 202 study are available for the endpoint categories of mortality, morbidity, quality of life and side effects. The 202 study was compared to a therapy at the doctor's discretion (dacarbazine, ipilimumab or pembrolizumab).

There was a statistically significant difference in overall survival in favour of tebentafusp versus a therapy at the doctor's discretion (dacarbazine, ipilimumab or pembrolizumab). The magnitude of the effect is assessed as a significant improvement.

In the endpoint categories of morbidity and quality of life, the return rates of the EORTC QLQ-C30 and EQ-5D VAS measurement instruments were already low at baseline and differed greatly between the groups. The results presented are therefore not usable. Statements on morbidity and, in particular, on quality of life are given a high priority, especially in the palliative treatment setting presented here.

With regard to side effects, corresponding evaluations with effect estimators are not available for all endpoints. There is no statistically significant difference in the SAEs. However, the evaluations presented do not allow a sufficiently reliable assessment overall and are therefore not suitable for quantifying the extent of the additional benefit of tebentafusp.

In the overall assessment, the G-BA comes to the conclusion that due to the clear advantage in overall survival, there is an overall improvement in the therapy-relevant benefit in the therapeutic indication for tebentafusp.

The G-BA identifies a considerable additional benefit of tebentafusp compared to a therapy at the doctor's discretion (dacarbazine, ipilimumab or pembrolizumab) in the treatment of human leukocyte antigen (HLA)-A*02:01-positive adults with unresectable or metastatic uveal melanoma.

Significance of the evidence

The present benefit assessment is based on the results of the ongoing, randomised, multicentre phase III 202 study.

For the 202 study, a high risk of bias can be assumed due to the open-label study design.

The results on the patient-reported endpoints of morbidity and health-related quality of life are not usable due to large differences in return rates. The submitted evaluations of the side effects do not allow a sufficiently reliable assessment. Furthermore, there are clear differences in treatment and observation times between the treatment arms.

In summary, the G-BA derives a hint for the identified additional benefit with regard to the significance.

2.1.3 Summary of the assessment

The present assessment concerns the benefit assessment of the new medicinal product Kimmtrak with the active ingredient tebentafusp. Tebentafusp was approved as an orphan drug.

Tebentafusp is approved for the treatment of human leukocyte antigen (HLA)-A*02:01-positive adults with unresectable or metastatic uveal melanoma.

For the assessment, the pharmaceutical company submits the results of the still ongoing, randomised, multicentre, controlled phase II 202 study comparing tebentafusp to a therapy at the doctor's discretion (dacarbazine, ipilimumab or pembrolizumab).

For overall survival, there is a statistically significant difference. The magnitude of the effect is assessed as a significant improvement.

In the endpoint category of morbidity and quality of life, the return rates of the EORTC QLQ-C30 and EQ-5D VAS measurement instruments were already low at baseline and differed greatly between the groups. The results presented are therefore not usable.

With regard to side effects, corresponding evaluations with effect estimators are not available for all endpoints. The evaluations presented do not allow a sufficiently reliable assessment and are therefore not suitable for quantifying the extent of the additional benefit of tebentafusp.

In the overall assessment, the G-BA comes to the conclusion that due to the clear advantage in overall survival, there is an overall improvement in the therapy-relevant benefit in the therapeutic indication for tebentafusp.

The G-BA identifies a considerable additional benefit of tebentafusp compared to a therapy at the doctor's discretion (dacarbazine, ipilimumab or pembrolizumab) in the treatment of HLA-A*02:01-positive adults with unresectable or metastatic uveal melanoma.

The significance is rated as hint.

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 G-BA takes into account the patient numbers stated in the pharmaceutical company's dossier, which are, however, fraught with uncertainties due to the incomprehensible incidences regarding newly diseased patients (diagnosis ICD-10 C69.-) and the considered range of patients with metastasised uveal melanoma. Furthermore, there is a possible overestimation of the percentage of the HLA-A*02:01 subtype.

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 Kimmtrak (active ingredient: tebentafusp) at the following publicly accessible link (last access: 17 August 2022):

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

Treatment with tebentafusp should only be initiated and monitored by specialists in internal medicine, haematology and oncology experienced in the treatment of patients with uveal melanoma as well as specialists in dermatology, specialists in ophthalmology and other specialists participating in the Oncology Agreement.

In accordance with the European Medicines Agency (EMA) requirements regarding additional risk minimisation measures, the pharmaceutical company must provide training material that contains information for medical professionals and patients. This aims to promote the prompt diagnosis and treatment of cytokine release syndrome (CRS), thereby reducing its severity.

Patients treated with Kimmtrak must have an HLA-A*02:01 genotype detected by a validated genotyping assay.

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: 1 October 2022).

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 patient-individual 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 annual treatment costs shown refer to the first year of treatment.

According to the product information, it is recommended that the first three treatments with tebentafusp be administered in an inpatient setting. In subsequent treatment cycles, tebentafusp may be administered during an inpatient stay or in an appropriate outpatient care centre where full resuscitation equipment is immediately available to treat cytokine release syndrome.

For the cost calculation, the case scenarios a) purely inpatient administration and b) inpatient administration in the first three treatments and subsequent outpatient treatment are considered.

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				
Tebentafusp	Once on day 1[2]	1	1	1
	Once on day 8	1	1	1
	1 x every 7 days from day 15	50.1	1	50.1

Consumption:

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment day	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
Medicinal product to be assessed					
Tebentafusp	20 µg	20 µg	1 x 100 µg	1	1 x 100 µg
	30 µg	30 µg	1 x 100 µg	1	1 x 100 µg
	68 µg	68 µg	1 x 100 µg	50.1	50.1 x 100 µg

Costs:

In the inpatient setting:

Tebentafusp does not currently meet the criteria of the NUB agreement for 2022 according to the list of information pursuant to Section 6 para. 2 KHEntgG (Act on Charges for Fully and Partially Inpatient Hospital Services). As an approximation, the manufacturer's sales price plus 19% value added tax is used to calculate the inpatient costs for the medicinal product. The actual costs incurred may vary from hospital to hospital.

Costs of the medicinal products:

Designation of the therapy	Packaging size	Cost (manufacturer sales price)	Value added tax (19%)	Costs of the medicinal product
Medicinal product to be assessed				
Tebentafusp	1 CIS	€ 13,264.00	€ 2,520.16	€ 15,784.16
Abbreviations: CIS = concentrate for the preparation of an infusion solution				

LAUER-TAXE® last revised: 1 October 2022

[2] KIMMTRAK must only be administered under the direction and supervision of a physician experienced in the application of anticancer drugs and capable of treating cytokine release syndrome in a setting where full resuscitation equipment is immediately available. It is recommended that at least the first three KIMMTRAK infusions be given in an inpatient setting.

In the outpatient setting:

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.

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					
Tebentafusp	1 CIS	€ 16,315.30	€ 1.77	€ 928.48	€ 15,385.05
Abbreviations: CIS = concentrate for the preparation of an infusion solution					

LAUER-TAXE® last revised: 1 October 2022

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.

Premedication

To minimise the risk of hypotension associated with cytokine release syndrome (CRS), the patient may have to be administered intravenous fluids before starting the tebentafusp infusion. In the inpatient treatment setting, the costs for premedication are included in the per case flat rate. The additional costs for premedication incurred in the outpatient treatment setting cannot be precisely quantified due to the largely lacking dosage data for premedication.

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 drugs a maximum amount of € 81 per ready-to-use unit, and for the production of parenteral solutions containing monoclonal antibodies a maximum of € 71 per ready-to-use unit are to be payable. These additional other costs are not added to the

pharmacy sales price but rather follow the rules for calculating in the Hilfstaxe. The cost representation is based on the pharmacy retail price and the maximum surcharge for the preparation and is only an approximation of the treatment costs. This presentation does not take into account, for example, the rebates on the pharmacy purchase price of the active ingredient, the invoicing of discards, the calculation of application containers, and carrier solutions in accordance with the regulations in Annex 3 of the Hilfstaxe.

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

On 20 April 2022, the pharmaceutical company submitted a dossier for the benefit assessment of tebentafusp to the G-BA in due time in accordance with Chapter 5, Section 8, paragraph 1, number 1, sentence 2 VerfO.

The benefit assessment of the G-BA was published on 1 August 2022 together with the IQWiG assessment of treatment costs and patient numbers on the website of the G-BA (www.g-ba.de), thus initiating the written statement procedure. The deadline for submitting written statements was 22 August 2022.

The oral hearing was held on 5 September 2022.

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

The evaluation of the written statements received and the oral hearing was discussed at the session of the subcommittee on 11 October 2022, and the proposed resolution was approved.

At its session on 20 October 2022, the plenum adopted a resolution to amend the Pharmaceuticals Directive.

Chronological course of consultation

Session	Date	Subject of consultation
Subcommittee Medicinal products	26 July 2022	Information of the benefit assessment of the G-BA
Working group Section 35a	30 August 2022	Information on written statements received; preparation of the oral hearing
Subcommittee Medicinal products	5 September 2022	Conduct of the oral hearing
Working group Section 35a	13 September 2022 20 September 2022 4 October 2022	Consultation on the dossier assessment by the G-BA, the assessment of treatment costs and patient numbers by the IQWiG, and the evaluation of the written statement procedure
Subcommittee Medicinal products	11 October 2022	Concluding discussion of the draft resolution
Plenum	20 October 2022	Adoption of the resolution on the amendment of Annex XII AM-RL

Berlin, 20 October 2022

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

Prof. Hecken