7.04 RESPIRATORY SYNCYTIAL VIRUS VACCINE, Powder and suspension for injection (0.5 mL), Arexvy®, GlaxoSmithKline Australia Pty Ltd.

1 Purpose of submission

1.1 The standard re-entry resubmission requested National Immunisation Program (NIP) listing of a recombinant respiratory syncytial virus (RSV) pre-fusion F protein 3 older adult (RSVPreF3 OA; Arexvy®) vaccine for the prevention of RSV-confirmed lower respiratory tract disease (LRTD) among three adult populations. The resubmission noted that RSVPreF3 OA was recommended for NIP listing by the PBAC at the July 2025 meeting in two of these populations, i.e., those aged at least 75 years of age (YOA) and First Nations adults 60-74 YOA. The resubmission requested further consideration of the PBAC's July 2025 positive recommendation for these two populations. The resubmission also requested expansion of the PBAC recommendation to include a third population described as adults 60-74 YOA with medical conditions associated with increased risk of severe RSV disease. The sponsor has now requested NIP listing for all three populations previously recommended by the Australian Technical Advisory Group on Immunisation (ATAGI) as previously discussed at the July PBAC 2024 consideration of RSVPreF3 OA and as described in the Australian Immunisation Handbook (AIH) (ATAGI pre-submission advice, December 2023, p7). The three populations are listed in Table 1 as the 'Target NIP Populations.'

1.2 The resubmission did not provide a definitive list of eligible medical conditions within this population that would place patients at increased risk of severe RSV disease. Instead, the resubmission referenced the AIH, a resource which lists 'risk categories' with 'example medical conditions'.

1.3 The resubmission indicated that the sponsor had not accepted the PBAC's July 2025 advice with regard to the cost-effectiveness evaluation that was necessary to move forward with implementation of the recommended NIP listing. The resubmission proposed some alternative values for use in the cost-effectiveness evaluation, focused on: 1) duration of protection of the vaccine; 2) RSV hospitalisation rate; and 3) RSV hospitalisation costs. The resubmission proposed these alternative values be applied for all three requested populations. However, it should be noted that in parallel, the sponsor submitted a pricing proposal for RSVPreF3 OA in relation to the two previously recommended populations (adults aged at least 75 YOA and First Nations adults 60-74 YOA). The proposal for RSVPreF3 OA was considered by the PBAC at the December 2025 Intracycle meeting and is discussed further in paragraph 2.6.

1.4 Listing was requested based on a cost-utility analysis versus no vaccine. The key components of the clinical issues addressed by the resubmission are presented in Table 1.

Table 1: Key components of the clinical issue addressed by the submission (as stated in the submission)

Component	Description
Target NIP Populations	Adults ≥75 YOA (recommended by the PBAC in July 2025 and December 2025); Aboriginal and Torres Strait Islander adults 60-74 YOA (recommended by the PBAC in July 2025 and December 2025). Adults 60-74 YOA with medical conditions associated with increased risk of severe RSV disease
Intervention	Arexvy (RSVPreF3 OA vaccine), single dose
Comparator	Main comparator: No vaccine Near market: Pfizer RSVpreF
Outcomes	AReSVi-006 (pivotal efficacy and safety trial; NCT04886596) Primary efficacy: Single dose during first season – prevention of RSV-confirmed LRTD Secondary efficacy: Cumulative efficacy of a single dose over 3 RSV seasons - prevention of RSV-confirmed LRTD Secondary safety: Solicited (subset) and Unsolicited AEs, All SAEs and pIMDs
	AReSVi-004 (pivotal immunogenicity trial; NCT04732871) Secondary immunogenicity: Single dose humoral immune persistence [redacted].
Clinical claim	Arexvy (RSVPreF3 OA vaccine), vs No vaccine (Direct comparison): Superior efficacy and acceptable safety profile, despite being more reactogenic than placebo.

Source: Table 1-2, p20 text on p 109 of the submission.
AE = adverse event; AIH = Australian Immunisation Handbook; LRTD = lower respiratory tract disease; pIMD = potential immune mediated disorder; RSV = respiratory syncytial virus; SAE = serious adverse event; YOA = years of age.
Blue shading indicates data previously seen by the PBAC.

2 Background

Registration status

2.1 RSVPreF3 OA was approved by the Therapeutic Goods Administration (TGA) on 14 January 2024 for the active immunisation of individuals 60 years and older for the prevention of lower respiratory tract disease (LRTD) caused by RSV. The TGA granted approval for the use of RSVPreF3 OA in individuals aged 50-59 who are at increased risk of RSV disease in March 2025.[1]

2.2 The approved TGA indication for RSVPreF3 OA is consistent with the indications approved by the Food and Drug Administration (FDA; United States), European Medicines Agency (EMA), Canada and Japan.

2.3 The resubmission did not provide an estimated date for a submission to the TGA for revaccination. The pre-PBAC response reiterated that efficacy data were available over 3 RSV seasons and immunogenicity data [redacted], and that the need for revaccination is yet to be established. It stated that any future regulatory filings for revaccination updates to the Product Information would be informed by longer term

[1] https://www.tga.gov.au/resources/prescription-medicines-registrations/arexvy-glaxosmithkline-australia-pty-ltd-0

clinical and real-world effectiveness data, and National Immunisation Technical Advisory Group (NITAG) recommendations. The pre-PBAC response stated that "based on available data and long-term efficacy modelling, [redacted]". Revaccination is discussed further in paragraph 3.7.

Previous PBAC consideration

2.4 RSVPreF3 OA was initially considered and not recommended by the PBAC at the July 2024 meeting. While the PBAC acknowledged that RSVPreF3 OA was superior in effectiveness against no vaccine, the incremental cost-effectiveness ratio (ICER) was considered (i) unacceptably high and uncertain for the proposed population of adults aged ≥60 YOA (and the proposed alternative population of adults aged ≥75 YOA) and (ii) unknown in Aboriginal and Torres Strait Islander people aged 60-74 years, and high-risk people aged 60-74 years, as these populations were not addressed by the submission (paragraph 7.1, RSVPreF3 OA Public Summary Document [PSD], July 2024). The PBAC noted that lowering the age threshold from 75 to 60 YOA increased the ICER substantially. Further, the PBAC did not agree with the submission's claim that the cost-effectiveness for RSVPreF3 OA demonstrated in adults aged ≥75 years would be applicable to high risk 60-74 year old patients (paragraph 7.18, RSVPreF3 OA PSD, July 2024). The submission requested a price of $[redacted] per dose.

2.5 A resubmission was considered at the July 2025 PBAC meeting, with a positive recommendation made for the use of RSVPreF3 OA in two of the three populations recommended by the ATAGI: adults ≥75 YOA and First Nations adults 60-74 YOA. (paragraph 7.1, RSVPreF3 OA PSD, July 2025). The resubmission proposed a price of $[redacted]. The Pre-Sub-Committee Response (PSCR) and pre-PBAC response offered prices of $[redacted] per vial, and $[redacted] per vial, respectively. The submission did not apply for NIP listing in adults aged 60-74 years with at least one risk factor for severe RSV disease.

2.6 The PBAC reconsidered RSVPreF3 OA at the December 2025 intracycle meeting. The PBAC considered that the revised cost inputs for the economic evaluation were reasonable, and that the vaccine was cost effective at the price proposed ($[redacted]) for adults aged at least 75 YOA and First Nations adults 60-74 YOA. A NIP listing in adults aged 60-74 years with at least one risk factor for severe RSV disease was not requested.

2.7 Additionally, the PBAC considered an application for RSVpreF (Abrysvo®) in older adults, the proposed near market comparator, at its November 2024 PBAC meeting. RSVpreF was recommended for NIP listing for adults aged ≥ 75 years and for Aboriginal and Torres Strait Islander people aged 60–74 years. However, the PBAC did not support a listing for adults aged 60–74 years at high risk of severe RSV disease due to concerns that the economic evaluation lacked a robust estimate of cost-effectiveness, with baseline risks and benefits unclear and likely overestimated (paragraph 7.1, RSVpreF PSD, November 2024). At the July 2025 meeting, the PBAC reconsidered and recommended RSVpreF for NIP listing for adults aged ≥ 75 years and for Aboriginal and Torres Strait Islander people aged 60–74 years (paragraph 15.1, RSVpreF PSD, July

2025). A NIP listing in adults aged 60-74 years with at least one risk factor for severe RSV disease was not requested.

ATAGI advice

2.8 The ATAGI provided pre-submission advice for the PBAC to consider for this resubmission, dated 7 March 2025. The ATAGI provided a response to GSK regarding hospitalisation rates and duration of protection, dated 29 October 2025. The ATAGI previously provided advice for the RSVPreF3 OA submission considered at the July 2024 PBAC meeting, including pre-submission advice dated 21 December 2023, and post-submission advice dated 2 May 2024.

2.9 Since 2023, ATAGI has recommended RSV vaccination for all people aged ≥75 years; Aboriginal and Torres Strait Islander people aged ≥60 years; and people with medical risk factors for severe RSV disease aged ≥60 years. First Nations individuals and those with risk factors for severe RSV disease within this age group have increased RSV disease burden and are recommended for vaccination at an earlier age than the general population, i.e., ≥60 years. ATAGI advises that non-Indigenous adults aged 60–74 years who do not have a medical risk factor for severe RSV disease may also consider vaccination. There are benefits of vaccination in this age group, but the benefits may be less than for those aged ≥75 years, because of a comparatively lower risk of severe RSV disease[2].

For more detail on PBAC's view, see section 7 PBAC outcome.

3 Requested listing

Table 2: Essential elements of the requested listing

MEDICINAL PRODUCT	Requested price per dose	Available brands
Recombinant Respiratory Syncytial Virus (RSV) pre-fusion F protein 3 older adult vaccine, 120 mcg powder vial and suspension vial	$[redacted] (resubmission) $[redacted] (PSCR)	Arexvy
National immunisation program • Adults ≥ 75 YOA • 60-74 YOA First Nations people • Adults 60-74 YOA at increased risk of severe RSV disease (Defined as having at least one condition associated with increased risk of severe RSV disease in adults as defined in the AIH)		

Source: Table 1-10, p35 of the Submission
NIP = national immunisation program; RSV = respiratory syncytial virus; YOA = years of age.
Blue shading indicates data information seen by the PBAC

[2] https://immunisationhandbook.health.gov.au/contents/vaccine-preventable-diseases/respiratory-syncytial-virus-rsv

3.1 The resubmission proposed a price of $[redacted], reduced from the July 2024 submission price of $[redacted] per vial. A price of $[redacted] was requested by the Pre-Sub-Committee Response (PSCR).

3.2 The resubmission stated the proposed NIP listing for adults 60-74 YOA at increased risk of severe RSV disease was consistent with the ATAGI advice (December 2023), and the AIH recommendations for the use of vaccines for prophylaxis of RSV disease in OA. Consistent with ATAGI advice, a definitive list of medical conditions associated with increased risk of RSV disease was not included in the requested listing.

3.3 The conditions associated with increased risk of severe RSV disease in adults as described by the AIH are shown in Table 3.

3.4 The AIH states that adults aged ≥50 years with the medical conditions listed below are at increased risk of severe RSV disease. These examples are not exhaustive, and providers may include people with conditions similar to those listed below based on clinical judgement.

3.5 The ESC noted that the AIH provides a similar list of medical conditions associated with increased risk of severe outcomes due to influenza, and that obesity defined as body mass index (BMI) ≥30 kg per m^2 is included in the list for influenza, however is not NIP funded.[3] The ESC noted the PBAC may wish to consider a similar approach for the proposed NIP listing, i.e. that the BMI criteria would not separately be used to determine eligibility for the vaccine, but many patients in this cohort would qualify for the vaccine due to fulfilling one or more other criteria.

3.6 The pre-PBAC response proposed a revised population for NIP listing, applying an age threshold of 65 years (instead of 60) and excluding obesity as a standalone criterion for NIP eligibility. The PBAC did not support this population, see paragraph 7.7.

3 https://immunisationhandbook.health.gov.au/resources/tables/table-specified-medical-conditions-associated-with-increased-risk-of-influenza-disease-and-severe-outcomes

Table 3: Conditions associated with increased risk of severe RSV disease in adults

Risk category	Example medical conditions
Cardiac disease	• Congenital heart disease • Congestive heart failure • Coronary artery disease
Chronic respiratory conditions	• Suppurative lung disease • Bronchiectasis • Cystic fibrosis • Chronic obstructive pulmonary disease • Chronic emphysema • Severe asthma (requiring frequent medical consultations or the use of multiple medications)
Immunocompromising conditions	• HIV infection • Malignancy • Immunocompromise due to disease or treatment • Asplenia or splenic dysfunction • Solid organ transplant • Haematopoietic stem cell transplant • CAR T-cell therapy
Chronic metabolic disorders	• Type 1 or 2 diabetes • Amino acid disorders • Carbohydrate disorders • Cholesterol biosynthesis disorders • Fatty acid oxidation defects • Lactic acidosis • Mitochondrial disorders • Organic acid disorders • Urea cycle disorders • Vitamin/cofactor disorders • Porphyrias
Chronic kidney disease	• Chronic renal impairment – eGFR < 30mL/min (stage 4 or 5)
Chronic neurological conditions	• Hereditary and degenerative central nervous system diseases • Seizure disorders • Spinal cord injuries • Neuromuscular disorders • Other conditions that increase the risk of severe outcomes from respiratory infection
Chronic liver disease	• Conditions with progressive deterioration of liver function for more than 6 months, including cirrhosis and other advanced liver diseases
Obesity	• Body mass index ≥30 kg per m^2

Source: Table 1-5, pp25-26 of the Submission based on AIH[4]
CAR-T = Chimeric Antigen Receptor T-cell therapy; eGFR = estimated Glomerular Filtration Rate; HIV = human immunodeficiency virus; kg = kilogram; m2 = metre squared.

3.7 The resubmission requested NIP listing of a single dose of RSVPreF3 OA, which was unchanged from previous requests. The submission stated that currently there is not

[4] https://immunisationhandbook.health.gov.au/resources/tables/table-conditions-associated-with-increased-risk-of-severe-rsv-disease-in-adults

enough evidence to determine the need for revaccination. Optimal timing for potential revaccination will be informed by two trials that are ongoing: the pivotal immunogenicity trial, RSV OA=ADJ-004 and a new crossover and revaccination extension study of AReSVi-006 (RSV OA=ADJ-012, NCT06534892). Immune persistence of a single dose of RSVPreF3 OA and alternate revaccination schedules will be assessed up to Month 60 after initial vaccination. As such, a request for NIP listing of a revaccination dose of RSVPreF3 OA is likely should the final results of the RSV OA=ADJ-004 trial and RSV OA=ADJ-012 support the case for revaccination. It is anticipated that if revaccination is required, it will have an impact on the estimated cost-effectiveness and financial estimates. The submission provided updated immunogenicity data from the RSV OA=ADJ-004 trial including data [redacted] post vaccination. The ESC noted that optimal timing for potential revaccination, and the VE associated with revaccination remains unknown. The estimated date for a submission to the TGA for revaccination is not yet available, as discussed in paragraph 2.3.

For more detail on PBAC's view, see section 7 PBAC outcome.

4 Population and disease

4.1 RSV is highly infectious and spreads via respiratory droplets. Most patients develop signs of upper respiratory tract disease (URTD), which in some patients progresses to the lower respiratory tract leading to symptoms such as cough, wheezing, and shortness of breath. Severe RSV may require hospitalisation, including admission into intensive care units (ICU), and/or mechanical ventilation. Aboriginal and Torres Strait Islander people have a greater risk of RSV hospitalisation compared with non-Indigenous Australians. There is growing recognition that the RSV infection can trigger clinically consequential deterioration of underlying co-morbid conditions, particularly cardiopulmonary diseases.

4.2 This resubmission requested the listing of RSVPreF3 OA for adults aged 60–74 years with medical conditions that increase the risk of severe RSV disease. The request for this population was supported by previous ATAGI and PBAC advice (paragraph 7.4, RSVPreF3 OA PSD, July 2025). In July 2024 and July 2025, the PBAC considered there was a high clinical need for an effective vaccine for this population. While the resubmission referred to the AIH list of risk conditions, this resource provides 'risk categories' with 'example medical conditions', which may be open to interpretation without a definitive list of eligible conditions being available. This was noted by the sponsor in their request to the ATAGI to provide advice on the completeness of the list provided in the AIH for the purpose of defining NIP-funded cohorts (ATAGI Pre-Submission Advice, December 2023 p14, Sponsor Question 3). In its advice to the PBAC, the ATAGI stated that the risk factors outlined in the AIH are complete in that they specify all relevant risk factor categories; however, the ATAGI also stated that an exhaustive list of specific at-risk medical conditions is not available and that the list of example conditions in the AIH is intentionally non-exhaustive to allow clinical discretion. The ATAGI considers that this allows providers flexibility in using their

clinical judgement, to identify the presence of risk factors and advise individuals whether they may benefit from an RSV vaccination. It was noted that ATAGI appreciates that providers may include people with conditions similar to the examples of medical conditions listed under each of the specific risk factor categories.

4.3 RSVPreF3 OA is a combination of the RSVPreF3 antigen and the AS01E adjuvant system. RSVPreF3 OA was designed to induce a humoral and cellular immune response, to help protect older adults from RSV infection, including those with underlying co-morbidities.

For more detail on PBAC's view, see section 7 PBAC outcome.

5 Comparator

5.1 The resubmission nominated 'no vaccine' as the main comparator. The PBAC previously considered that 'no vaccine' was appropriate as the main comparator (paragraph 7.11, RSVPreF3 OA PSD, July 2024). The ESC advised that 'no vaccine' is the appropriate comparator for the proposed population of adults 60-74 YOA with medical conditions associated with increased risk of severe RSV disease.

5.2 The resubmission nominated RSVpreF (Abrysvo) as a near market comparator. This was appropriate. RSVpreF is TGA approved for the three target populations for which RSVPreF3 OA listing is being sought. The ESC noted that RSVpreF was recommended for NIP listing for two populations at the July 2025 PBAC meeting including adults aged at least 75 years and First Nations adults aged 60-74 years, and it has not received a positive recommendation for the proposed population of adults 60-74 YOA with medical conditions associated with increased risk of severe RSV disease.

For more detail on PBAC's view, see section 7 PBAC outcome.

6 Consideration of the evidence

Sponsor hearing

6.1 The sponsor requested a hearing for this item. A clinician presented preliminary findings from an observational study of RSV burden in Queensland adults based on cases notified to the Queensland Notifiable Conditions Register (1 March 2024–28 February 2025). It was noted that the presentation was based on a draft manuscript, which has not yet been published. The draft analysis reported hospitalisation rates and costs, and found that as well as being driven by age, health system costs are driven by comorbidities, such as cardiac disease, immune compromise, chronic kidney disease and chronic lung disease. The PBAC found the hearing informative, as it provided an Australian perspective on health system burden associated with RSV in older adults, particularly those with underlying health conditions.

Consumer inputs

6.2 The PBAC noted and welcomed the input from health care professionals (10) and

organisations (16) via the Office of Health Technology Assessment Consultation Hub. The input consistently supported the proposed NIP listing of RSVPreF3 OA for high-risk adults aged 60–74 years. The input stated that the vaccine would be easily delivered through a GP or pharmacist, often alongside other routine immunisations.

6.3 The input from health care professionals emphasised the benefits of vaccination for older adults with chronic health conditions and was reinforced by a wide range of inputs from medical and consumer groups advocating for patient groups with high clinical needs, and potential to benefit significantly from RSV vaccination. The following groups contributed input:

- Asthma Australia
- Australasian Society of Clinical Immunology and Allergy (ASCIA)
- Australian Diabetes Society
- Cystic Fibrosis Australia (X2)
- Cystic Fibrosis Queensland Limited
- Derbarl Yerrigan East Perth
- Heart Support Australia
- Hearts4Heart
- Her Heart
- Immunisation Coalition
- Immunisation Foundation of Australia
- Kidney Health Australia
- Lung Foundation Australia
- Spleen Australia
- Transplant Society of Australia and New Zealand

6.4 A key theme was the need to protect high-risk, vulnerable Australians from preventable infectious diseases. It was stated that adults aged 60–74 with conditions such as cardiopulmonary disease, immunocompromise, diabetes, chronic kidney disease and other comorbidities experience a disproportionate burden of RSV, with hospitalisation, complications, and mortality rates comparable to, or exceeding, those of older adults. Listing RSV vaccination on the NIP for high-risk adults in this age group would improve equity by aligning access with clinical need, reduce preventable hospitalisations, and ease pressure on the health system. It was considered that extending eligibility to medically at-risk adults represents a logical, evidence-based enhancement to the NIP.

6.5 A second key theme focused on the consequences of severe RSV infection and the value of preventing it. While most healthy adults manage RSV at home with rest, hydration, and over-the-counter pain relief, these measures are often inadequate for people aged 60–74 with chronic health conditions. Distressing symptoms such as breathlessness, wheezing, and a persistent cough may require hospital care, and RSV can trigger flare-ups of existing heart or lung disease. Hospital treatment typically centres on stabilisation with oxygen and intravenous fluids, and some individuals may experience a lasting decline in health and independence.

6.6 A third key theme was the need for RSV vaccination to be provided free of charge through NIP listing, as the private cost was inequitable and a significant barrier for many Australians.

6.7 Some respondents highlighted the importance of RSV vaccination for transplant recipients, and other immunocompromising conditions. The PBAC considered that these conditions were adequately captured in the AIH definition of conditions associated with increased risk of severe RSV disease in adults, noting that the example conditions in the AIH are not exhaustive, and immunisation providers may include people with conditions similar to those listed below based on clinical judgement, e.g. in some cases, vaccination may be clinically appropriate prior to initiation of immunocompromising treatment.

6.8 The PBAC recalled it had previously received input supporting NIP listing in adults aged ≥75 years of age and Aboriginal and Torres Strait Islander people aged 60-74 at the July 2025 meeting including individuals (12), health care professionals (17) and organisations (8), and that some of the consumer input at that time also asked the PBAC to consider extending the NIP populations to adults ≥60 years with medical conditions that increase their risk of severe disease (paragraphs 6.4 to 6.10, RSVPreF3 OA PSD July 2025).

Clinical trials

6.9 The resubmission was based on the same trial for RSVPreF3 OA as presented for the previous PBAC considerations, AReSVi-006. This head-to-head randomised trial compared RSVPreF3 OA (N = 12,469) to placebo (N = 12,503). The resubmission did not present an updated data-cut. The July 2025 resubmission presented results up to 30.6 months of follow-up (from 17.8 months at the end of Season 2 presented in the July 2024 resubmission), corresponding to 3 complete RSV seasons in the northern hemisphere (NH) in adults ≥ 60 YOA, across different RSV subtypes, age groups and comorbidity categories.

6.10 A claim of superiority was based on VE using the results from AReSVi-006 for prevention of first occurrence of reverse transcription-polymerase chain reaction (RT-PCR) confirmed RSV-associated LRTD in adults ≥ 60 YOA. At its July 2024 meeting, the PBAC stated that a claim of superior comparative effectiveness was reasonable for the main comparison between RSVPreF3 OA and no vaccination, supported by the estimates of VE in RT-PCR confirmed RSV-LRTD (paragraph 7.13, RSVPreF3 OA PSD, July 2024).

6.11 The resubmission did not present VE evidence across all at-risk groups included in the AIH list, with no data specifically available for people with obesity, neurological disease, or immunocompromised patients (IC). Data for obesity was provided in the PSCR (presented below in Table 7 and Table 9). The PBAC, in their evaluation of Abrysvo, noted a concern around the potential for usage of the RSVpreF vaccine in the 60-74 year age group outside of the intended high risk population, due to the number

and nature of some of the listed conditions (paragraph 7.23, RSVpreF PSD, November 2025).

6.12 The subgroup analyses presented in the resubmission from the AReSVi-006 trial grouped participants with comorbidities of interest into broad categories of ≥1 or ≥2 comorbidities of interest. Approximately 49% of the trial participants with a comorbidity of interest had only 1 comorbidity of interest, and 51% had ≥2 comorbidities of interest, however the resubmission did not provide any efficacy data on the subgroup with only 1 comorbidity of interest. The resubmission also presented LRTD data on the ≥2 comorbidities of interest group at the first interim analysis; these data were too immature to be interpretable. However, additional data on the ≥2 comorbidities of interest group with acute respiratory illness (ARI) at the first interim analysis were identified in a publication,[5] and calculations performed by the evaluation suggested efficacy in the subgroup with 1 comorbidity of interest may not be equivalent to efficacy in the subgroup with ≥2 comorbidities of interest (VE point estimates of 70.62 versus 88.0 respectively), suggesting the efficacy demonstrated in the ≥1 comorbidities of interest group may be primarily driven by participants with ≥2 comorbidities of interest (shown in Table 9 below). A request was made for the sponsor to provide efficacy data in the '1 comorbidity of interest' subgroup across the more mature data cuts of the key trial (for both LRTD and ARI). Some analyses of VE against RSV-LRTD and RSV-ARI by 0, 1 or ≥2 baseline comorbidities were provided with in the pre-PBAC response, which stated that given the post hoc nature of the analyses, the results should be interpreted with caution. Small numbers of events were observed in some analyses, resulting in wide confidence intervals (data not shown).

6.13 The resubmission described the comorbidities of interest in the AReSVi-006 trial as being 'broadly aligned' with the risk categories and example medical conditions outlined in the AIH, except for 'immunocompromising conditions, chronic neurological conditions and obesity', as they were either excluded or not specified as comorbid conditions of interest in AReSVi-006. Patients with obesity (BMI ≥30 kg/m^2) and patients with stable chronic neurological conditions were represented in AReSVi-006. Adults with immunocompromising medical conditions, or who were receiving immunosuppressant or immunomodulatory medications, were excluded from the trial. To support the use of RSVPreF3 OA in immunocompromised patients the resubmission presented evidence from the RSV OA=ADJ-023 immunogenicity study.

6.14 The resubmission argued that although the list of medical conditions with an increased risk of severe RSV disease in the AIH is broader than the comorbid conditions of interest in the AReSVi-006 trial, the VE demonstrated in the trial was consistent, irrespective of the presence or absence of baseline comorbidities.

[5] Robert G Feldman, et al. Respiratory Syncytial Virus Prefusion F Protein Vaccine Is Efficacious in Older Adults With Underlying Medical Conditions, *Clinical Infectious Diseases*, Volume 78, Issue 1, 15 January 2024, Pages 202–209.

6.15 A comparison of the listed AIH at-risk conditions and the participants in the AReSVi-006 study is shown in Table 4.

Table 4: Comparison of the comorbidities at increased risk of severe RSV disease identified in the Australian Immunisation Handbook and the AReSVi-006 trial

AIH Risk Category and example medical conditions	AReSVi-006
Cardiac disease Congenital heart disease Congestive heart failure Coronary artery disease	Participants with medically stable cardiac conditions were eligible for enrolment in AReSVi-006. Chronic heart failure was a comorbid condition of interest. Congestive heart failure (weight = 2) was included in the CCI.
Chronic respiratory conditions Suppurative lung disease Bronchiectasis Cystic fibrosis COPD Chronic emphysema Severe asthma	Participants with medically stable chronic respiratory conditions were eligible for enrolment in AReSVi-006, unless receiving chronic administration (>14 days) of immunosuppressants or immune-modifying drugs during the 90 days prior to vaccine administration[a]. COPD, asthma and chronic respiratory/pulmonary disease were comorbid conditions of interest. Chronic pulmonary disease (weight = 1) was included in the CCI.
Immunocompromising conditions HIV infection Malignancy Immunocompromise due to disease or treatment Asplenia or splenic dysfunction Solid organ transplant Haematopoietic stem cell transplant CAR T-cell therapy	Patients with any confirmed or suspected immunosuppressive or immunodeficient disease resulting from disease or immunosuppressive/cytotoxic therapy were excluded from AReSVi-006.
Chronic metabolic disorders Type 1 or 2 diabetes Other metabolic disorders	Participants with stable metabolic disorders were eligible for enrolment. Diabetes (type 1 and type 2) was a comorbid condition of interest. Diabetes with (weight = 1) or without (weight = 0) chronic complications was included in the CCI.
Chronic kidney disease Chronic renal impairment (stage 4 or 5) – eGFR <30 mL/min	Participants with stable chronic kidney disease were eligible for enrolment. Advanced renal disease was a comorbid condition of interest. Renal disease (weight = 1) was included in the CCI.
Chronic neurological conditions Hereditary and degenerative CNS disorders Seizure disorders Spinal cord injuries Neuromuscular disorders	Participants with medically controlled active or chronic neurological diseases, except conditions that moderately or severely impaired cognition, could be enrolled in the study, provided that their condition would allow them to comply with the requirements of the protocol. No neurological conditions were included in the comorbid conditions of interest.
Chronic liver disease Conditions with progressive deterioration of liver function for >6 months	Participants with stable chronic liver disease were eligible for enrolment, except patients with a history of drug abuse or chronic alcohol consumption who would be unable or unlikely to provide accurate safety reports or comply with study procedures. Advanced liver disease was a comorbid condition of interest. Mild (weight = 2) and moderate to severe (weight = 4) liver disease was included in the CCI.
Obesity BMI ≥30 kg per m^2	Obesity was not included in the comorbid conditions of interest in AReSVi-006 and was not assigned a risk score in the CCI. The median BMI of participants in the Exposed Set was 28.3 (Range: 12.6 - 95.6).

Source: Table 2-7, pp50-51 of the Submission

AIH = Australian Immunisation Handbook; BMI = body mass index; CAR = chimeric antigen receptor; CCI = Charlson comorbidity index; CNS = central nervous system; COPD = chronic obstructive pulmonary disease; eGFR = estimated glomerular filtration rate.

a. Prednisone <20 mg/day and inhaled and topical steroids were permitted.

6.16 The resubmission presented updated immunogenicity and safety results for [redacted] in adults ≥ 60 YOA from one supportive trial, RSV OA=ADJ-004. In its July 2025 consideration, the PBAC had considered immunogenicity data [redacted] post Dose 1 (paragraph 6.41, RSVPreF3 OA PSD, July 2025).

6.17 The resubmission additionally provided 12-month data from the RSV OA=ADJ-023 study to show immune response and safety of RSVPreF3 OA when administered to lung and renal transplant recipients (≥18 YOA; IC adults). The immune response of IC adults receiving 1 or 2 doses of RSVPreF3 OA was also compared to healthy controls (≥50 YOA) receiving 1 dose.

6.18 Details of the trials presented in the resubmission are provided in Table 5.

Table 5: Trials and associated reports presented in the resubmission

Trial ID	Protocol title/ Publication title	Publication citation
Pivotal efficacy trial		
AReSVi-006 (NCT04886596)	A phase 3, randomized, placebo-controlled, observer-blind, multi-country study to demonstrate the efficacy of a single dose and annual revaccination doses of GSK's RSVPreF3 OA investigational vaccine in adults aged 60 years and above Analysis: VE Analysis 1 (Interim Season 1 Analysis) Study report number: 212494 (Attachment 5c) Papi A, Ison, MG, Langley, JM et al. Respiratory Syncytial Virus Prefusion F Protein Vaccine in Older Adults.	Clinical Study Report NEJM 2023, 388: 595-608. DOI: 10.1056/NEJMoa2209604
	A phase 3, randomized, placebo-controlled, observer-blind, multi-country study to demonstrate the efficacy of a single dose and annual revaccination doses of GSK's RSVPreF3 OA investigational vaccine in adults aged 60 years and above Analysis: VE Analysis 3 (End of Season 2 Analysis) Study report number: 212494 Ison MG, Papi A, Athan, E et al. Efficacy and safety of respiratory syncytial virus prefusion F protein vaccine (REVPreF3 OA) in older adults over 2 RSV seasons	Clinical Study Report Clinical Infectious Diseases 2024, ciae010 (Attachment 5f)
	A Phase 3, randomized, placebo-controlled, observer blind, multi-country study to demonstrate the efficacy of a single dose and annual revaccination of GSK's RSVPreF3 OA investigational vaccine in adults aged 60 years and above Analysis: End of Study Analysis (End of Season 3 NH) Study report number: 212494 Ison MG, Papi A, Athan E et al. Efficacy, safety, and immunogenicity of the AS01$_E$-adjuvanted respiratory syncytial virus prefusion F protein vaccine (RSVPreF3 OA) in older adults over three RSV seasons: a multicenter, randomized, observer-blind trial.	Clinical Study Report Lancet Respiratory 2025. DOI: 10.1016/S2213-2600(25)00048-7

Trial ID	Protocol title/ Publication title	Publication citation
Additional analyses of pivotal AReSVi-006 vaccine efficacy trial		
AReSVi-006 (NCT04886596)	Feldman, RG, Antonelli-Incalzi, R, Steenackers, K. et al. Respiratory syncytial virus prefusion F protein vaccine is efficacious in older adults with underlying medical conditions. CID 2024; ciad471. DOI: 10.1093/cid/ciad471	Secondary publication
	Curran D., Matthews S., Cabrera E.S. et al. The respiratory syncytial virus prefusion F protein vaccine attenuates the severity of respiratory syncytial virus-associated disease in breakthrough infections in adults ≥60 years of age.	Secondary publication Influenza and Other Respiratory Viruses 2024; 18(2): e13236. DOI: 10.1111/irv.13236
	Leroux-Roels I, Feldman RG, Antonelli-Incalzi R et al. Robust and Consistent Immune Response of the Adjuvanted Respiratory Syncytial Virus (RSV) Prefusion F Protein Vaccine (RSVPreF3 OA) Across Different Age Ranges and Frailty Status in Older Adults.	Conference Abstract Open Forum Infectious Diseases, Volume 12, S50-51. DOI: 10.1093/ofid/ofae631.077
Immunogenicity and persistence of immune response trials		
RSV OA=ADJ-004 (NCT04732871)	A phase 3, randomized, open-label, multi-country study to evaluate the immunogenicity, safety, reactogenicity and persistence of a single dose of the RSVPreF3 OA investigational vaccine and different revaccination schedules in adults aged 60 years and above Analysis: [redacted]	Data on file
	A phase 3, randomized, open-label, multi-country study to evaluate the immunogenicity, safety, reactogenicity and persistence of a single dose of the RSVPreF3 OA investigational vaccine and different revaccination schedules in adults aged 60 years and above	Clinical Study Report
	Schwarz, TF, Hwang, SJ, Ylisastigui, P. et al. Immunogenicity and safety following one dose of AS01E-adjuvanted respiratory syncytial virus prefusion F protein vaccine in older adults: a phase 3 trial.	Secondary publication Journal of Infectious Diseases 2024; 230(1):e102-e110. DOI: 10.1093/infdis/jiad546
RSV OA=ADJ-023 (NCT05921903)	A Phase 2b, randomized, controlled, open-label study to evaluate the immune response and safety of the RSVPreF3 OA investigational vaccine in adults (≥18 years of age) when administered to lung and renal transplant recipients comparing 1 versus 2 doses and compared to healthy controls (≥50 years of age) receiving 1 dose. Analysis: Final analysis	Clinical Study Report
Near market comparator trials		
RENOIR (NCT05035212)	Walsh EE, Pérez Marc G, Zareba AM, Falsey AR, Jiang Q, Patton M, Polack FP, Llapur C, Doreski PA, Ilangovan K, Rämet M. Efficacy and safety of a bivalent RSV prefusion F vaccine in older adults.	New England Journal of Medicine. 2023 Apr 20;388(16):1465-77
	RSVpreF PBAC Public Summary Document	November 2024 and July 2025.
Study 1006 (NCT05301322)	Athan E, Baber J, Quan K, Scott RJ, Jaques A, Jiang Q, Li W, Cooper D, Cutler MW, Kalinina EV, Anderson AS. Safety and immunogenicity of bivalent RSVpreF vaccine coadministered with seasonal inactivated influenza vaccine in older adults.	Clinical Infectious Diseases. 2024 May 15;78(5):1360-8.
	RSVpreF PBAC Public Summary Document	November 2024 and July 2025.

Source: Table 2-4, pp45-48 of the resubmission and Table 2, p9 of Abrysvo PSD, November 2024 and July 2025
CSR = clinical study report; NIP = National Immunisation Program; RSVPreF3 OA = Arexvy; VE = vaccine efficacy; QoL = quality of life.

Note: References in blue shaded cells have not previously been reviewed by the PBAC

6.19 The key features of the direct randomised trial are summarised in Table 6. AReSVi-006 recruited adults ≥ 60 YOA at the time of first vaccination. Participants aged ≥ 70 YOA formed 44.2% of the full study population (the number of participants ≥ 75 YOA was not reported). The baseline characteristics by age subgroup compared with the full study population were not provided in the resubmission. AReSVi-006 was previously considered to have a low risk of bias (Table 4, RSVPreF3 OA PSD, July 2024). However, the risk of bias in the additional analyses presented by the resubmission is unclear.

6.20 AReSVi-006 was initially designed to assess the efficacy of RSVPreF3 OA against RSV-related LRTD following different dosing schedules; a single dose of vaccine up to the end of Season 3 in the NH or following an annual revaccination schedule at 12- and 24-months post Dose 1 administration. However, the trial protocol was amended on 31 October 2023 to remove the Month 24 revaccination dose schedule because initial analysis of efficacy for the 12-month revaccination dose demonstrated no additional efficacy benefit for the trial population. The July 2025 resubmission noted that 5,742 participants (RSVPreF3 OA: 1,406 participants; placebo: 4,333 participants) from the NH received their second annual revaccination dose at Month 24 (Dose 3) as this occurred before the approval of the protocol amendment. These participants were censored from the VE analysis and included in the updated safety results. The comparative effectiveness results presented below reflect participants who received a single dose of RSVPreF3 OA.

Table 6: Key features of the included evidence

Trial	N	Design/ duration	Risk of bias	Patient population	Outcomes	Use in modelled evaluation
RSVPreF3 OA versus placebo						
AReSVi-006	24,966[a]	Phase 3 R, OB, PC, MC Completed	Low	Adults ≥ 60 YOA[b]	Primary outcome: reduction of the risk of the first occurrence of RT-PCR confirmed RSV-LRTD Key secondary outcomes: safety, PROs	Reduction of the risk of the first occurrence of RT-PCR confirmed RSV-LRTD, safety

Source: Table 26, pp 59-60 of the resubmission.
MC = multi-centre; OB = observer blinded; PC = placebo-controlled; PRO = patient reported outcome; R = randomised; RSV-LRTD = lower respiratory tract disease respiratory syncytial virus; RT-PCR = reverse transcription-polymerase chain reaction.
a Population corresponds to the modified exposed set (mES) which excludes individuals who develop RSV-ARI before Day 15 post first dose (1 in the RSVPreF3 OA arm and 5 in the placebo arm).
b Overall patient population is inclusive of adults 60-74 YOA with medical conditions associated with increased risk of severe RSV disease.
Blue shading indicates information previously seen by the PBAC.

6.21 The resubmission presented an unmatched unanchored ITC of RSVPreF3 OA (pivotal trial; AReSVi-006) with RSVpreF (pivotal trial; RENOIR). This comparison is not discussed further in this document as it does not refer to the main comparator.

Comparative effectiveness

6.22 Efficacy data for the overall trial population of AReSVi-006 over 3 RSV seasons (End of Study Analysis) was presented for the July 2025 PBAC consideration. Both the primary and confirmatory secondary objectives of AReSVi-006 were met, demonstrating that

a single dose of RSVPreF3 OA was efficacious in preventing RSV-LRTD in Season 1 (VE 82.6%; 96.95% CI 57.9, 94.1; LL CI >20%; primary endpoint) and over three complete RSV seasons in adults ≥60 YOA (VE 62.9%; 97.5% CI 46.7, 74.8; LL CI >20%; confirmatory secondary endpoint), with efficacy demonstrated for both RSV-A (69.8%, 97.5% CI lower limit >0%) and RSV-B (58.6%, 97.5% CI lower limit >0%; confirmatory secondary endpoints). Cumulative efficacy of a single dose of RSVPreF3 OA over 3 RSV seasons was also observed across endpoints, including RSV-ARI (51.1%) and severe RSV-LRTD (67.4%) (descriptive secondary endpoints). These results show that, while VE thresholds for both RSV-LRTD and RSV-ARI were met based on cumulative VE results across three seasons, a reduction in efficacy was evident over the period of follow-up.

6.23 The resubmission did not include patient reported outcomes (PRO) for the AReSVi-006 trial. Previously, for the July 2025 PBAC consideration, there were no statistically significant differences observed between the RSVPreF3 OA and placebo groups in terms of physical functioning (SF-12) or health related quality of life (EQ-5D) in participants who developed RSV-ARI. Analysis of the FLU-PRO chest/respiratory item showed no clinically meaningful differences, defined as a difference in item scores of <0.5[6] (RSVPreF3 OA PSD, July 2025 PBAC meeting).

VE in OA at increased risk of severe RSV disease due to comorbid conditions vs placebo

6.24 To support the request for NIP listing for the RSVPreF3 OA vaccine in adults 60-74 YOA with medical conditions that increase the risk of severe RSV disease, the resubmission reported VE against RSV-LRTD, from study AReSVi-006, by baseline comorbidities via 2 different methods: the updated Charlson Comorbidity Index (uCCI) and by baseline comorbidities of interest.

6.25 The uCCI is a method for measuring patient comorbidity with each comorbidity category having an associated weight, based on the adjusted risk of one-year mortality, and the sum of all the weights results in a single comorbidity score for a patient. In addition to comorbidity, the index considers patient age with higher ages being associated with a higher relative risk weighting. The proposed uCCI method applied relative risk weightings to predetermined comorbidities in the context of mortality. The comorbidities used in the uCCI do not directly correlate with the AIH identified comorbidities that are associated with increased risk for developing severe RSV disease, and the uCCI was therefore not representative of the proposed NIP population.

6.26 Analysis of VE against first occurrence of RSV-LRTD by baseline comorbidities of interest according to the age-adjusted uCCI in Season 1 was reported to be 82.4% (95% CI: 48.5, 95.6) for participants with low/medium mortality risk, 82.9% (95% CI: 40.8,

[6] Yu J, et al. Evaluation of Efficacy Endpoints for a Phase IIb Study of a Respiratory Syncytial Virus Vaccine in Older Adults Using Patient-Reported Outcomes With Laboratory Confirmation. Value Health. 2020 Feb;23(2):227-235. doi: 10.1016/j.jval.2019.09.2747. Epub 2019 Nov 21. PMID: 32113628.

96.8) for participants with high mortality risk. For the end of the study analysis (End of Season 3) in the northern hemisphere, the observed cumulative VE of single-dose RSVPreF3 OA was 66.5% (95% CI: 47.5, 79.4) for participants deemed to have a low/medium mortality risk, 58.9% (95% CI: 34.8, 75.0) for participants deemed high risk. The evaluation noted that the lower limit of the 95% confidence interval was >20%, which was the VE threshold defined for the primary VE objective. The VE observed in all of the risk groups was similar (point estimates within 7 percentage points) for the low/medium and high mortality risk groups.

6.27 The resubmission reported a subgroup analysis of AReSVi-006 assessing VE against first occurrence of RSV-LRTD as discussed in paragraph 6.12. This was based on the presence or absence of selected coexisting medical conditions that are known to increase the risk of severe RSV disease, complemented with relevant risk factors for influenza complications, and were collectively referred to as "conditions of interest" by the resubmission (Feldman et al., 2024[7]). These conditions of interest are broadly similar to the AIH list with the exception of individuals with obesity, neurological disease, or immunocompromising conditions which are listed as conditions associated with increased risk of severe RSV disease by the AIH but were not included in the submission's classification of 'conditions of interest' (the PSCR provided VE analyses for participants with obesity, see paragraph 6.33 below).

6.28 The analysis did not include presentation of VE results for individual comorbidities. Instead, VE was presented for the following pre-specified subgroups: ≥1 pre-existing comorbidity of interest, ≥1 pre-existing cardiorespiratory condition, ≥1 pre-existing endocrinometabolic condition, ≥2 pre-existing comorbidities of interest. The analyses were conducted in the overall study population which included participants aged at least 60 years. As such, the analyses were not limited to the age of the proposed population of 60 to 74 years, however the average age of participants in AReSVi-006 was 69.5 years.

6.29 The assessment of VE against RSV-LRTD for participants who reported none or at least one of the comorbidities of interest at baseline was a descriptive secondary outcome. There was no pre-specified efficacy criterion or adjustment for multiplicity and the analysis was not powered for statistical significance. Additional analyses were conducted post-hoc as reported by Feldman (2024).

6.30 The VE against first occurrence of RSV-LRTD by baseline comorbidities of interest in Season 1 was reported to be 72.5% (95% CI: 30.0, 90.9) for participants with no pre-existing comorbidity of interest, 94.6% (95% CI: 65.9, 99.9) for participants with at ≥1 pre-existing comorbidity of interest and 92.0% (95% CI: 46.1, 99.8) for participants with 2 or more pre-existing comorbidities of interest. The point estimates for VEs at

[7] Feldman, R. G. et al, & AReSVi-006 Study Group (2024). Respiratory Syncytial Virus Prefusion F Protein Vaccine Is Efficacious in Older Adults With Underlying Medical Conditions. Clinical infectious diseases : an official publication of the Infectious Diseases Society of America, 78(1), 202–209.

the first data cut were higher in participants with comorbidities of interest compared to those without, however confidence intervals were wide. For the end of the study analysis (End of Season 3) in the northern hemisphere, the observed cumulative VE of single-dose RSVPreF3 OA was 61.5% (95% CI: 38.6, 76.7) for participants with no baseline comorbidity of interest, 64.7% (95% CI: 45.1, 78.1) for participants with at least 1 pre-existing comorbidity of interest, 68.1% (95% CI: 45.7, 82.3) for participants with cardiorespiratory baseline comorbidities, 63.9% (95% CI: 31.4, 82.5) for participants with baseline endocrinometabolic comorbidities. The evaluation noted that in these analyses, the lower limit of the 95% confidence interval was >20%, which was the VE threshold defined for the primary VE objective. Assessment of VE at the end of the Season 3 analysis showed that all groups observed a drop in VE of between approximately 10-30%. However apart from the interim Season 1 analysis, the VE observed in all of the 'comorbidity of interest' groups were similar (point estimates within 7 percentage points) to the VE observed in the 'no comorbidities of interest' subgroup (Table 7).

6.31 RSV-LRTD events in the ≥1 pre-existing cardiorespiratory and ≥1 pre-existing endocrinometabolic condition subgroups had overlapping patients; the sum of patients and events in these subgroups exceeds the total patients and events recorded in the ≥1 pre-existing comorbidity of interest umbrella group. The overlapping patients disproportionately affected the placebo arm, potentially biasing results in favour of apparent efficacy of RSVPreF3 OA. For instance, at VE analysis 1, the sum of events in the ≥1 pre-existing cardiorespiratory and ≥1 pre-existing endocrinometabolic condition placebo groups was 12+13 = 25, however the total number of events recorded in the placebo arm in this time period was only 18 events. This compares to the RSVPreF3 OA group which had no overlapped patients, with only a single event recorded at this time.

6.32 The PSCR commented that subgroup analyses in participants with pre-existing cardiorespiratory or endocrinometabolic conditions were descriptive secondary endpoints, and agreed with the evaluation's observation that these subgroups were not mutually exclusive.

6.33 The PSCR stated that adults with obesity (BMI ≥30 kg/m^2) and stable neurological conditions comprised approximately 38% and 22%, respectively, of participants in AReSVi-006 and were captured in the overall trial population VE analyses, despite not being included in the comorbid conditions of interest subgroup. The PSCR provided results from a post-hoc analysis for obesity (Hulstrom et al 2025). The VE in the obese population was comparable to the overall trial population and participants with ≥1 baseline comorbidity of interest for RSV-LRTD and RSV-ARI (Table 7 and Table 9). The ESC considered it may be plausible to assume similar efficacy across these populations based on the available data, acknowledging the VE data reported is cumulative and not provided for individual season. Further, ESC noted it is unclear how many patients in the 'Obesity (BMI ≥30 kg/m^2)' subgroup had multimorbidity, and to what extent additional comorbidities of interest may confound these results.

Table 7: Cumulative vaccine efficacy of a single dose of RSVPreF3 OA against first occurrence of RSV-LRTD by baseline comorbidities of interest using Poisson Method (mES)

Endpoint	RSVPreF3 OA				Placebo				VE % (95% CI); p-value
	N	n	T (year)	n/T (per 1000)	N	n	T (year)	n/T (per 1000)	
Descriptive secondary endpoints: RSV-LRTD by baseline comorbidities of interest									
VE Analysis 1: Interim S1 (event-driven; median follow-up = 6.7 months)									
Overall trial population[1]	12,466	7	6,865.9	1.0	12,494	40	6,857.3	5.8	**82.6 (57.9, 94.1); <0.0001**
No pre-existing comorbidity of interest	7,529	6	4094.1	1.5	7633	22	4148.1	5.3	**72.5 (30.0, 90.9); 0.0040**
≥1 pre-existing comorbidity of interest	4,937	1	2771.8	0.4	4861	18	2709.1	6.6	**94.6 (65.9, 99.9); <0.0001**
≥1 pre-existing cardiorespiratory condition	2,496	1	1409.5	0.7	2421	12	1352.9	8.9	**92.1 (46.7, 99.8); 0.0025**
≥1 pre-existing endocrinometabolic condition	3,200	0	1795.7	0.0	3234	13	1805.3	7.2	**100.0 (74.0, 100.0); 0.0001**
≥2 pre-existing comorbidities of interest[3]	2,504	1	1418.2	0.7	2431	12	1362.8	8.8	92.0 (46.1, 99.8)
VE Analysis 3: End of S2 NH (median follow-up = 17.8 months)									
Overall trial population[2]	12,469	30	14,662.6	2.0	12,498	139	17,269.0	8.0	**67.2 (48.2, 80.0); <0.0001**
No pre-existing comorbidity of interest	7,486	14	8779.7	1.6	7579	67	10478.1	6.4	**68.3 (42.7, 83.6); <0.0001**
≥1 pre-existing comorbidity of interest	4,983	16	5882.9	2.7	4919	72	6790.9	10.6	**66.7 (41.8, 82.0); <0.0001**
≥1 pre-existing cardiorespiratory condition	2,546	10	2997.5	3.3	2479	56	3411.6	16.4	**73.8 (47.9, 88.2); <0.0001**
≥1 pre-existing endocrinometabolic condition	3,229	8	3822.6	2.1	3255	32	4509.4	7.1	**63.1 (17.4, 85.4); 0.0117**
End of Study Analysis: End of S3 NH (median follow-up = 30.6 months)									
Overall trial population[2]	12,468	48	19,748.8	2.4	12,498	215	27,363.6	7.9	**62.9 (46.7, 74.8); <0.0001**
No pre-existing comorbidity of interest	7454	23	11814.3	1.9	7547	99	16629.0	6.0	**61.5 (38.6, 76.7); <0.0001**
≥1 pre-existing comorbidity of interest	5014	25	7934.5	3.2	4951	116	10734.6	10.8	**64.7 (45.1, 78.1); <0.0001**
≥1 pre-existing cardiorespiratory condition	2577	17	4048.7	4.2	2504	85	5384.8	15.8	**68.1 (45.7, 82.3); <0.0001**
≥1 pre-existing endocrinometabolic condition	3243	12	5152.9	2.3	3274	55	7143.5	7.7	**63.9 (31.4, 82.5); 0.0009**
Post-hoc analysis reported in PSCR (across 3 seasons)									
Obesity (BMI ≥30 kg/m^2)	4716	17	7526.6	2.3	4745	107	10403.0	10.3	74.1 (56.4, 85.5)

Source: Table 2-11, pp 60-61 of the resubmission, Table 2 of PSCR (extracted from Hulstrom et al. Presentation at the European Association for the Study of Diabetes 61st Annual Conference, 15-19 September 2025).

CI = confidence interval; mES = modified exposed set; N = number of participants; n = number of participants with at least one RT-PCR confirmed RSV LRTD; n/T (per 1000) = incidence rate of participants reporting at least one event; NH = northern hemisphere; RSVPreF3 = participants receiving RSVPreF3 OA investigational vaccine (pooled lots); T (year) = sum of follow-up time (from Day 15 post-vaccination

till first occurrence of the event or till the efficacy data lock point or till drop-out date) expressed in years; VE = Vaccine Efficacy (Poisson method – adjusted by age, region and season).
[1] Primary endpoint.
[2] Confirmatory secondary endpoints. All other analyses were descriptive.
[3] Vaccine efficacy was analysed post-hoc in participants with at least 2 conditions of interest.
Notes: For single dose evaluation, participants who received RSVPreF3 OA at Dose 2 (RSV_annual group) are censored at Dose 2
P-value = Two-sided Exact P-value conditional to number of cases comparing incidence rates and testing the null hypothesis VE<=0%;
Comorbidities of interest included COPD, Asthma, Any chronic respiratory/pulmonary disease, Chronic heart failure, Diabetes mellitus Type 1 or Type 2, Advanced liver or renal disease
Cardiorespiratory conditions = COPD, Asthma, Any chronic respiratory/pulmonary disease, Chronic heart failure
Endocrinometabolic conditions = Diabetes mellitus Type 1 or Type 2, Advanced liver or renal disease
VE Analysis 1: Cases reported from Day 15 post-vaccination up to efficacy data lock point = 11APR2022
VE Analysis 3: Cases reported from Day 15 post-Dose 1 up to efficacy data lock point 31 March 2023 if Dose 2 administration or up to efficacy data lock point 30 September 2022 if no Dose 2 administration.
End of Study VE Analysis: Cases reported from Day 15 post-Dose 1 up to efficacy data lock point 30 April 2024, or up to efficacy data lock point 30 September 2022 if no Dose 2 administration.
Blue shading shows results previously seen by the PBAC.

6.34 The resubmission did not present analysis of VE by individual season, however results were extracted from the CSR where possible during the evaluation. ATAGI previously noted in the March 2025 pre-submission advice that VE estimates for the overall population for Season 3 were lower than those measured for Season 1 and Season 2, demonstrating that VE decreases over time (ATAGI pre-submission advice, March 2025, p33). The resubmission's claims for VE are based on results for the cumulative effectiveness across the seasons, which was a secondary confirmatory endpoint, with the AReSVi-006 trial not powered to evaluate season specific efficacy. The overall population VE estimates in each season demonstrate lower efficacy in each season compared with the cumulative results for across the seasons. The evaluation noted that for season 3, the lower limit of the 95% confidence interval was >20% (the VE threshold defined for the primary VE objective) for RSV-ARI but not for RSV-LRTD and severe RSV-LRTD.

6.35 Analysis of VE by baseline comorbidities of interest by individual season is provided in Table 8. Comparison of VE for baseline comorbidities of interest subgroups show lower values in Season 2 (54.35%) and Season 3 (57.82%) analysis when compared to cumulative values at the end of Season 3 (64.7%) in the ≥1 pre-existing comorbidity of interest group. Similarly, the ≥1 pre-existing cardiorespiratory condition had lower values in Season 2 (61.97%) and Season 3 (59.64%) than the cumulative value at the end of Season 3 (68.1%). The CSR reported that the ≥1 pre-existing endocrinometabolic condition group could not be reliably estimated for participants by individual season, which had small numbers per season and wide 95% confidence intervals. The evaluation noted that all of the comorbidity groups demonstrated 95% confidence intervals with lower limits below 20% by Season 3.

Table 8: Season specific vaccine efficacy of a single dose of RSVPreF3 OA against first occurrence of RSV-LRTD by baseline comorbidities of interest using Poisson Method (mES)

Endpoint	RSVPreF3 OA				Placebo				VE % (95% CI); p-value
	N	n	T (year)	n/T (per 1000)	N	n	T (year)	n/T (per 1000)	
Descriptive secondary endpoints: RSV-LRTD by baseline comorbidities of interest									
VE Analysis S1 (Southern Hemisphere)									
Overall trial population[1]	12468	15	11688.4	1.3	12498	58	11649.8	5.0	**74.29 (54.03, 86.47); <0.0001**
No pre-existing comorbidity of interest	7454	6	6936.2	0.9	7547	23	7009.6	3.3	**73.75 (33.68, 91.26); 0.0024**
≥1 pre-existing comorbidity of interest	5014	4	4754.8	0.8	4951	24	4648.7	5.2	**83.78 (52.80, 95.91); 0.0001**
≥1 pre-existing cardiorespiratory condition	2577	3	2448.3	1.2	2504	17	2353.1	7.2	**83.11 (41.59, 96.83); 0.0019**
≥1 pre-existing endocrinometabolic condition	3243	1	3076.4	0.3	3274	14	3076.7	4.6	**92.84 (52.92, 99.83); 0.0010**
VE Analysis S2 (Southern Hemisphere)									
Overall trial population[2]	12468	32	16879.2	1.9	12498	154	21720.6	7.1	**67.67 (52.26, 78.70); <0.0001**
No pre-existing comorbidity of interest	2988	9	2816.0	3.2	6107	51	5726.3	8.9	**64.29 (26.75, 84.54); 0.0027**
≥1 pre-existing comorbidity of interest	2000	13	1879.5	6.9	3924	55	3687.2	14.9	**54.35 (15.35, 77.12); 0.0099**
≥1 pre-existing cardiorespiratory condition	1013	9	947.7	9.5	1976	44	1844.1	23.9	**61.97 (20.96, 83.69); 0.0065**
≥1 pre-existing endocrinometabolic condition	1303	7	1231.2	5.7	2606	22	2462.8	8.9	36.62 (-53.66, 77.14); 0.3918
VE Analysis S3 (Northern Hemisphere)									
Overall trial population[2]	4988	16	2552.9	6.3	10031	60	5081.3	11.8	**47.2 (7.1, 71.6)**
No pre-existing comorbidity of interest	2988	8	1647.8	4.9	6107	24	3322.3	7.2	33.22 (-53.64, 74.07); 0.4236
≥1 pre-existing comorbidity of interest	2000	8	1069.4	7.5	3924	37	2085.1	17.7	**57.82 (7.96, 83.03); 0.0270**
≥1 pre-existing cardiorespiratory condition	1013	5	538.6	9.3	1976	24	1043.0	23.0	59.64 (-8.03, 87.98); 0.0768
≥1 pre-existing endocrinometabolic condition	1303	4	697.1	5.7	2606	19	1386.8	13.7	57.98 (-26.48, 89.61); 0.1504

Source: Table 8.2.1.19, p983 of the CSR, Table 8.2.1.181, pp1209-1210 of the CSR, Table 8.2.1.300, pp2036, 2038 of the CSR and Table 18 p34 of ATAGI pre-submission advice, March 2025.

CI = confidence interval; mES = modified exposed set; N = number of participants; n = number of participants with at least one RT-PCR confirmed RSV LRTD; n/T (per 1000) = incidence rate of participants reporting at least one event; NH = northern hemisphere; RSVPreF3 = participants receiving RSVPreF3 OA investigational vaccine (pooled lots); T (year) = sum of follow-up time (from Day 15 post-vaccination till first occurrence of the event or till the efficacy data lock point or till drop-out date) expressed in years; VE = Vaccine Efficacy (Poisson method – adjusted by age, region and season).

[1] Primary endpoint.

[2] Confirmatory secondary endpoints. All other analyses were descriptive.

Notes: For single dose evaluation, participants who received RSVPreF3 OA at Dose 2 (RSV_annual group) are censored at Dose 2.

VE for S3 was for Northern Hemisphere for both the overall trial population and comorbidities analyses.
P-value = Two-sided Exact P-value conditional to number of cases comparing incidence rates and testing the null hypothesis VE<=0%;
* = denotes lower limit for 95% CI > 20%
Bold = indicates statistically significant results
Comorbidities of interest included COPD, Asthma, Any chronic respiratory/pulmonary disease, Chronic heart failure, Diabetes mellitus Type 1 or Type 2, Advanced liver or renal disease
Cardiorespiratory conditions = COPD, Asthma, Any chronic respiratory/pulmonary disease, Chronic heart failure
Endocrinometabolic conditions = Diabetes mellitus Type 1 or Type 2, Advanced liver or renal disease

6.36 Outcomes for the exploratory endpoint of RSV-ARI are summarised below. The evaluation noted that in these analyses, the lower limit of the 95% confidence interval was >20%, which was the VE threshold defined for the primary VE objective. As with the LRTD outcomes, there was overlapping of patients with ≥1 pre-existing cardiorespiratory and ≥1 pre-existing endocrinometabolic condition. As with LRTD, apart from the interim S1 analysis, VE in the comorbidity groups was approximately similar (point estimate within 7 percentage points, with the exception of ≥1 pre-existing cardiorespiratory condition at VE analysis 3 which had a point estimate 12.5 points higher) compared to the 'no comorbidity of interest' group.

Table 9: Cumulative VE of a single dose of Arexvy against first occurrence of RSV-ARI by baseline comorbidities of interest using Poisson Method (mES)

Endpoint	RSVPreF3 OA				Placebo				VE % (95% CI); p-value
	N	n	T (year)	n/T (per 1000)	N	n	T (year)	n/T (per 1000)	
Exploratory endpoint: RSV-ARI by baseline comorbidities of interest									
VE Analysis 1: Interim S1 (event driven; median follow-up = 6.7 months)									
Overall trial population[a]	12,466	27	6858.7	3.9	12,494	95	6837.8	13.9	**71.7 (56.2, 82.3); <0.0001**
No pre-existing comorbidity of interest	7529	19	4089.9	4.6	7633	54	4136.4	13.1	**64.4 (39.0, 80.1); <0.0001**
1 pre-existing comorbidity of interest calculated during evaluation[b]	2433	5	1351.5	0.8	2430	17	1342.6	2.5	70.62 (20.50, 89.15)
≥1 pre-existing comorbidity of interest	4937	8	2768.8	2.9	4861	41	2701.4	15.2	**81.0 (58.9, 92.3); <0.0001**
≥1 pre-existing cardiorespiratory condition	2496	3	1408.5	2.1	2421	24	1349.0	17.8	**88.1 (60.9, 97.7); <0.0001**
≥1 pre-existing endocrinometabolic condition	3200	6	1793.2	3.3	3234	29	1800.0	16.1	**79.4 (49.4, 93.0); 0.0001**
≥2 pre-existing comorbidities of interest	2504	3	1417.3	2.1	2431	24	1358.8	17.7	88.0 (60.5, 97.7)
VE Analysis 3: End of S2 NH (median follow-up = 17.8 months)									
Overall trial population[1]	12469	94	14626.4	6.4	12498	292	17167.0	17.0	**52.7 (40.0, 63.0); <0.0001**
No pre-existing comorbidity of interest	7486	55	8758.4	6.3	7579	166	10415.2	15.9	**50.5 (32.2, 64.3); <0.0001**
≥1 pre-existing comorbidity of interest	4983	39	5868.1	6.6	4919	126	6751.8	18.7	**55.7 (35.9, 70.0); <0.0001**
≥1 pre-existing cardiorespiratory condition	2546	21	2991.1	7.0	2479	81	3393.2	23.9	**63.0 (39.3; 78.4); <0.0001**

Endpoint	RSVPreF3 OA				Placebo				VE % (95% CI); p-value
	N	n	T (year)	n/T (per 1000)	N	n	T (year)	n/T (per 1000)	
≥1 pre-existing endocrinometabolic condition	3229	24	3811.1	6.3	3255	70	4482.1	15.6	**51.7 (21.7, 71.1); 0.0021**
End of Study Analysis: End of S3 NH (median follow-up = 30.6 months)									
Overall trial population[1]	12468	131	19654.5	6.7	12498	428	27086.0	15.8	**51.1 (40.3, 60.2); <0.0001**
No pre-existing comorbidity of interest	7454	76	11756.4	6.5	7547	237	16451.4	14.4	**48.2 (32.5, 60.7); <0.0001**
≥1 pre-existing comorbidity of interest	5014	55	7898.0	7.0	4951	191	10634.6	18.0	**54.9 (38.7, 67.3); <0.0001**
≥1 pre-existing cardiorespiratory condition	2577	34	4029.5	8.4	2504	119	5338.8	22.3	**55.4 (34.0, 70.6); <0.0001**
≥1 pre-existing endocrinometabolic condition	3243	31	5126.9	6.0	3274	108	7072.7	15.3	**55.2 (32.4, 71.1); <0.0001**
Post-hoc analysis reported in PSCR (across 3 seasons)									
Obesity (BMI ≥30 kg/m^2)	4,716	44	7,494.1	5.9	4,745	183	10,291.9	17.8	62.4 (47.4, 73.7)

Source: Table 2-12, pp 61-62 of the resubmission, Table 2 of PSCR (extracted from Hulstrom et al. Presentation at the European Association for the Study of Diabetes 61st Annual Conference, 15-19 September 2025).

ARI = acute respiratory illness; CI = confidence interval; N = number of participants; n = number of participants with at least 1 RT-PCR confirmed RSV ARI; n/T = incidence rate of participants reporting at least one event; NH = northern hemisphere; RSVPreF3 = Participants receiving RSVPreF3 OA vaccine (Arexvy); T (year) = sum of follow up time expressed in years; VE = vaccine efficacy

[a] Descriptive secondary endpoints. All other analyses were exploratory.

[b] Independent (raw/unadjusted) calculation performed to estimate the VE in the subgroup of patients with only 1 comorbidity of interest, using data extracted data from Table 2-12, pp 61-62 of the Submission and Table 2, p. 207 of Feldman et. al. Respiratory Syncytial Virus Prefusion F Protein Vaccine Is Efficacious in Older Adults With Underlying Medical Conditions. Clin Infect Dis. 2024 Jan 25;78(1):202-209.

Notes: For single dose evaluation, participants who received Arexvy at Dose 2 (RSV_annual group) are censored at Dose 2

P-value = Two-sided Exact P-value conditional to number of cases comparing incidence rates and testing the null hypothesis VE<=0%;

Comorbidities of interest included COPD, Asthma, Any chronic respiratory/pulmonary disease, Chronic heart failure, Diabetes mellitus Type 1 or Type 2, Advanced liver or renal disease

Cardiorespiratory conditions = COPD, Asthma, Any chronic respiratory/pulmonary disease, Chronic heart failure

Endocrinometabolic conditions = Diabetes mellitus Type 1 or Type 2, Advanced liver or renal disease

Bold = indicates statistically significant results

VE Analysis 1: Cases reported from Day 15 post-vaccination up to efficacy data lock point = 11APR2022

VE Analysis 3: Cases reported from Day 15 post-Dose 1 up to efficacy data lock point 31 March 2023 if Dose 2 administration or up to efficacy data lock point 30 September 2022 if no Dose 2 administration.

End of Study VE Analysis: Cases reported from Day 15 post-Dose 1 up to efficacy data lock point 30 April 2024, or up to efficacy data lock point 30 September 2022 if no Dose 2 administration.

Immunogenicity data provided by the resubmission

6.37 Supportive evidence from immunogenicity study RSV OA=ADJ-004 showed an increase in RSV A and B neutralizing titres, measured as the geometric mean titres (GMT), following Dose 1 (initial vaccination). The mean GMT decreased by 6 months and continued to decrease, albeit less markedly by 12 months post vaccination. Beyond 12 months, neutralising titres continue to decline at an apparently slower rate from approximately Month 12, remaining above baseline levels at Month 36. A decline in both RSV-A and RSV-B neutralising titres was observed between Month 30 and Month 36. [redacted] (Table 10).

6.38 The resubmission argued that the updated evidence from RSV OA=ADJ-004 demonstrated persistence of humoral immune responses against RSV-A and RSV-B, and that assuming no residual protection beyond the available VE evidence was 'biologically implausible'. However, ATAGI noted that uncertainty remains regarding clinical protection beyond three years due to a lack of efficacy data or a validated immunological correlate of protection (ATAGI Pre-Submission Advice, October 2025,). [redacted] ATAGI's recommendations remains unchanged that protection for at least 3 seasons in adults aged ≥60 years (based on secondary endpoints) can be assumed until confirmatory efficacy or effectiveness data is presented to support longer protection beyond 3 years (ATAGI Pre-Submission Advice, October 2025). [redacted] (Table 10). The PSCR provided a copy of a publication discussing correlates of protection (Kashihara et al 2026). The study provides preliminary evidence for immune correlates of protection against RSV infection, and does not provide a threshold for assessment of vaccines.

Table 10: RSV-A and RSV-B neutralising titres up to [redacted] following vaccination with single-dose RSVPreF3 OA (GMT (ED60) with 95% CI; PPS, RSV OA=ADJ-004)

Timepoint	n	Geometric Mean Titre (ED_{60}) (95% CI)	
		RSV-A Neutralising Titres	RSV-B Neutralising Titres
Baseline (pre-vaccination)	121	979.8 (827.8, 1159.9)	1333.6 (1142.3, 1557.0)
Day 31	117	10280.2 (8349.6, 12657.2)	9396.6 (7903.6, 11171.6)
Month 6	119	4211.4 (3513.6, 5047.7)	4682.4 (3958.9, 5538.1)
Month 12	116	2943.0 (2420.8, 3577.9)	2997.0 (2498.5, 3594.9)
Month 18	117	2423.1 (1989.4, 2951.3)	2705.4 (2291.5, 3194.0)
Month 24	115[a]	2400.6 (1951.9, 2952.6)	2353.2 (1953.3, 2835.1)
Month 30	114	2407.8 (1988.7, 2915.2)	2418.2 (2006.2, 2914.8)
Month 36	112	1838.6 (1515.6, 2230.4)	2150.3 (1779.5, 2598.2)
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

Source: Table 2-15, p67 of the submission
CI = confidence interval; ED = estimated dilution; GMT = geometric mean titre; n = number of trial participants with evaluable neutralising titre results at each timepoint; PPS = per-protocol set
a = n=115 or 116 for RSV-A or RSV-B neutralising titres, respectively, at Month 24 timepoint.
Blue shading shows results previously seen by the PBAC.

6.39 The resubmission reported an analysis from study RSV OA=ADJ-023, a Phase 2b, randomised, controlled, open-label study that evaluated the immunogenicity, safety, and reactogenicity of RSVPreF3 OA in an immunocompromised (IC) population (lung and renal transplant recipients, ≥ 18 YOA); these data are presented in Table 11 below. The RSV-A and RSV-B neutralising titres declined over time but remained above baseline up to 12 months post-dose. The GMTs of the RSV-A and RSV-B neutralising titres in the immunocompromised cohort didn't reach the same level observed in the 'Healthy Adults' comparator cohort. Neutralising titres reached their peak later in the

immunocompromised group compared to the HA group, suggesting that the induction of the antibody response occurred more slowly in the IC group.

Table 11: GMT of RSV-A and RSV-B neutralising titres (ED_{60}) until end of study for all participants (PPS for HI), RSV OA=ADJ-023

Assay	Timepoint	Result	RSV_IC_1		RSV_HA	
			n	% or value (95% CI)	n	% or value (95% CI)
RSV-A NEUT (ED_{60})	V1	GMT	123	807.0 (700.9, 929.2)	125	889.0 (781.9, 1010.6)
	V2	GMT	36	1775.8 (1201.0, 2625.6)	34	6716.8 (4907.6, 9193.0)
	V3	GMT	123	3990.8 (3219.4, 4947.0)	117	6881.3 (5976.2, 7923.6)
	V4	GMT	116	4184.7 (3360.1, 5211.7)	110	5707.0 (4853.6, 6710.3)
	V5	GMT	119	3220.8 (2637.4, 3933.3)	115	3958.4 (3372.2, 4646.6)
	V6	GMT	116	1773.4 (1486.2, 2116.2)	114	2243.6 (1925.0, 2614.9)
RSV-B NEUT (ED_{60})	V1	GMT	123	864.2 (727.8, 1026.2)	125	1027.3 (889.6, 1186.3)
	V2	GMT	36	2325.3 (1592.9, 3394.5)	34	8113.6 (5699.9, 11549.5)
	V3	GMT	123	5002.9 (3901.7, 6414.8)	117	9125.2 (7781.9, 10700.5)
	V4	GMT	116	4461.7 (3519.0, 5657.0)	110	6281.6 (5377.6, 7337.7)
	V5	GMT	120	2926.9 (2364.0, 3623.8)	115	3584.5 (3093.6, 4153.3)
	V6	GMT	116	2206.7 (1811.3, 2688.5)	114	2665.1 (2310.9, 3073.5)

Source: Data extracted from Table 2-20, p 77 of the submission.
CI = confidence interval; GMT = geometric mean titre; n = number of participants with available results; PPS = per-protocol set; RSV_IC_1 = immunocompromised participants receiving 1 dose of RSVPreF3 OA; RSV_HA = healthy adults participants (≥50 YOA) receiving 1 dose of RSVPreF3 OA; V1 = Pre-vaccination at Visit 1 (Day 1); V2 = Visit 2 (Visit 1 + 7-14 days); V3 = Visit 3 (Visit 1 + 30-60 days); Visit 4 = (Visit 3 + 30-42 days); V5 = Visit 5 (last dose of RSVPreF3 OA + 180-210 days); V6 = Visit 6 (last dose of RSVPreF3 OA + 350-380 days)

Comparative harms

6.40 The safety data for single-dose RSVPreF3 OA for the overall trial population of AReSVi-006 over 1 (VE Analysis 1) or 3 RSV seasons (End of Study Analysis) were previously presented for PBAC consideration. No additional safety data for AReSVi-006 was presented within this resubmission. The PBAC previously considered that the RSVPreF3 OA vaccine had an acceptable safety profile despite being more reactogenic compared to placebo (paragraph 6.42, RSVPreF3 OA PSD, July 2025 PBAC meeting).

6.41 The PBAC previously considered for the ≥75 YOA and First Nations People 60-74 YOA populations that the claim that RSVPreF3 OA vaccine had an acceptable safety profile was reasonable. The PBAC noted there were higher rates of AEs compared with placebo, but overall, the safety was comparable to other adjuvanted vaccines (paragraph 7.14, RSVPreF3 OA PSD, July 2024). This resubmission did not specifically report safety of the RSVPreF3 OA vaccine within the population of interest (at-risk individuals) and instead provided a summary of safety for use within the overall population. The ESC considered that the claim that RSVPreF3 OA vaccine had an acceptable safety profile was reasonable for the population of interest.

6.42 The Periodic Benefit-Risk Evaluation Report (PBRER) reported that [redacted] The sponsor has previously refuted a signal for GBS following notification from the Food and Drug Administration (FDA) at the end of season analysis of the study[8] The TGA advises that given the potential severity of RSV infection and the rarity of GBS, the benefit-risk balance remains strongly in favour of vaccination in the target groups[9].

6.43 Atrial fibrillation (AF) is a specific AE of interest due to an observed numerical imbalance in serious adverse events (SAEs) within 30 days post dose 1 of RSVPPreF3 OA compared to placebo in study AReSVi-006. The FDA requested a post-marketing safety study of AF (included as part of the GBS/ADEM safety study) and expedited reporting of AEs. The resubmission stated that [redacted] The resubmission stated that the sponsor will continue to monitor atrial fibrillation following RSVPReF3 OA via routine pharmacovigilance surveillance activities.

Benefits/harms

6.44 A summary of the comparative benefits and harms for RSVPreF3 OA versus placebo is presented in Table 12.

[8] https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/fda-requires-guillain-barre-syndrome-gbs-warning-prescribing-information-rsv-vaccines-abrysvo-and

[9] https://www.tga.gov.au/news/safety-updates/updated-warnings-respiratory-syncytial-virus-vaccines-arexvy-and-abrysvo

Table 12: Summary of comparative benefits and harms for RSVPreF3 OA and placebo

Benefits				
RT-PCR confirmed RSV-LRTD				
Event	**RSVPreF3 OA**	**Placebo**	**Absolute Difference**	**Cumulative VE% (CI [a])**
End of Study Analysis: End of S3 NH (median follow-up = 30.6 months)				
Overall trial population	48/12468 (0.38%)	215/12498 (1.72%)	167 (1.3%)	62.9 (46.7, 74.8); <0.0001
No pre-existing comorbidity of interest	23/7454 (0.31%)	99/7547 (1.31%)	76 (1.0%)	61.5 (38.6, 76.7); <0.0001
≥1 pre-existing comorbidity of interest	25/5014 (0.50%)	116/4951 (2.34%)	91 (1.8%)	64.7 (45.1, 78.1); <0.0001
≥1 pre-existing cardiorespiratory condition	17/2577 (0.66%)	85/2504 (3.39%)	68 (2.7%)	68.1 (45.7, 82.3); <0.0001
≥1 pre-existing endocrinometabolic condition	12/3243 (0.37%)	55/3274 (1.68%)	43 (1.3%)	63.9 (31.4, 82.5); 0.0009

Harms ≥ 60 YOA						
AReSVi-006	**RSVpreF3 OA n/N**	**Placebo n/N**	**RR (95% CI)**	**Event rate/100 patients**		**RD (95% CI)**
				RSVpreF3 OA	**Comparator/ Placebo**	
Solicited Grade 3 events within 4 days following dose 1						
Any AE	36/879	8/878	4.49 (2.10, 9.62)	4.10	0.91	0.032 (0.02, 0.05)
Admin-site AE	13 [b]		NA	NA	NA	NA
Systemic AE	29/879	8/878	3.62 (1.67, 7.88)	3.30	0.91	0.024 (0.01, 0.04)
Unsolicited AEs within 30 days post vaccination						
Any Grade 3	251/12,469	158/12,503	1.59 (1.31, 1.94)	2.01	1.26	0.007 (0.00, 0.01)
Any Grade 3 related to the intervention	110/12,469	23/12,503	4.79 (3.06, 7.51)	0.88	0.18	0.007 (0.005, 0.009)
Any medically attended	718/12,469	722/12,503	1.00 (0.90, 1.10)	5.76	5.77	0.000 (-0.01, 0.01)
Unsolicited AEs within 6 months post vaccination						
Any SAE	548/12,469	539/12,503	1.02 (0.91, 1.15)	4.39	4.31	0.001 (-0.00, 0.01)
Any SAE related to the intervention	15/12,469	10/12,503	1.50 (0.68, 3.35)	0.12	0.08	0.001 (0.00,0.00)
Any pIMD	46/12,469	38/12,503	1.21 (0.79, 1.86)	0.37	0.30	0.001 (-0.00, 0.00)
Any pIMD related to the intervention	8/12,469	7/12,503	1.15 (0.42, 3.16)	0.03	0.06	0.000 (-0.00, 0.00)
Any fatal SAE	231/12,469	265/12,503	0.87 (0.73, 1.04)	1.85	2.12	-0.003 (-0.00, 0.00)

Source: Table 12, p21 RSVPreF3 OA PSD, July 2025 PBAC meeting

admin = administration; AE = adverse event; CI = confidence interval; ES = exposed set; mES = modified exposed set; N = number of participants; n = number of participants with at least one RT-PCR confirmed RSV-LRTD; LRTD = lower respiratory tract disease; NR = not reported; n/T (per 1000) = incidence rate of participants reporting at least one event; RD = risk difference; RR = relative risk; RSV = respiratory syncytial virus; RSVPreF3 OA= RSV pre-fusion protein 3 older adult; RT-PCR = reverse transcription-polymerase chain reaction; T (year) = sum of follow-up time (from Day 15 post-vaccination till first occurrence of the event or till the efficacy data lock point or till drop-out date) expressed in years; VE = vaccine efficacy.

a ≥ 60 YOA: VE analysis 1 = 96.95% CI; VE analysis 2 = 95% CI; VE analysis 3 = 97.5% CI. ≥ 60 YOA: VE analysis 1, 2 and 3 = 95% CI.
b Due to the small number of events, events are represented across all study arms in order to maintain blinding.
VE analysis 1: median duration of follow up = 6.7 months. VE analysis 1: median duration of follow up = 11.5 months. VE analysis 3: median duration of follow up = 17.8 months
Blue shading reflects data previously seen by the PBAC.
RR and RD were calculated for the evaluation as should be considered as indicative as the study was not powered for comparisons of safety.

6.45 On the basis of direct evidence presented by the resubmission, for every 1,000 individuals ≥ 60 YOA vaccinated with a single dose of RSVPreF3 OA, in comparison with placebo (no vaccine):

- Approximately 13 fewer adults ≥ 60 YOA will have RT-PCR confirmed RSV-LRTD over the first three RSV infection seasons.
- Approximately 18 fewer adults ≥ 60 YOA with ≥1 pre-existing comorbidity of interest will have RT-PCR confirmed RSV-LRTD over the first three RSV infection seasons after vaccination.
- Approximately 27 fewer adults ≥ 60 YOA with ≥1 pre-existing cardiorespiratory condition (COPD, Asthma, Any chronic respiratory/pulmonary disease, Chronic heart failure) will have RT-PCR confirmed RSV-LRTD over the first three RSV infection seasons after vaccination.
- Approximately 13 fewer adults ≥ 60 YOA with ≥1 pre-existing endocrinometabolic condition (Diabetes mellitus Type 1 or Type 2, Advanced liver or renal disease) will have RT-PCR confirmed RSV-LRTD over the first three RSV infection seasons after vaccination.
- Approximately 32 additional adults would experience Grade 3 solicited adverse events within 4 days of vaccination.
- Approximately 7 additional adults would experience any Grade 3 unsolicited adverse events within 30 days of vaccination.

Clinical claim

RSVPreF3 OA versus placebo in adults aged 60–74 years with medical conditions that increase the risk of severe RSV disease

6.46 The resubmission described RSVPreF3 OA as superior in terms of VE compared with no vaccine for the prevention of RSV-confirmed LRTD among adults 60-74 YOA with a comorbidity of interest associated with increased risk of severe RSV disease, and with an acceptable safety profile, despite being more reactogenic than placebo (no vaccination). The ESC and PBAC considered that this claim was adequately supported by the available evidence, noting the issues as discussed in the following paragraphs.

6.47 The resubmission did not present VE evidence across all at-risk groups included in the AIH list of risk conditions, with no data specifically available for people with neurological disease, or immunocompromised patients.

6.48 The strongest evidence provided by the subgroup analysis of VE is in people with a pre-existing cardiorespiratory or endocrinometabolic condition, however these analyses incorporated overlapping patients. Potential differences in VE between participants with 1 comorbidity of interest compared to ≥2 comorbidities of interest could not be ruled out due to wide confidence intervals. The extent to which the results from the trial population, with comorbidities of interest, can be generalised to the proposed eligible population remains uncertain, especially for patients with immunocompromise given that adults with immunocompromising medical conditions, or who were receiving immunosuppressant or immunomodulatory medications, were excluded from AReSVi-006. The results of study RSV OA=ADJ-023 showed that RSV-A and RSV-B neutralising titres in the immunocompromised cohort didn't reach the same levels observed in the healthy adult comparator cohort.

6.49 The cumulative estimate of VE over 3 seasons (64.7%) was lower than those reported at the end of Season 1 (94.6%) and Seasons 1 and 2 (66.7%) in the ≥1 pre-existing comorbidity of interest group in the AReSVi-006 trial. VE estimates in each season demonstrate lower efficacy in each season compared with the cumulative results for across the seasons. Comparison of VE for baseline comorbidities of interest subgroups show lower values in Season 2 (54.35%) and Season 3 (57.82%) compared to cumulative values in the ≥1 pre-existing comorbidity of interest group. Whilst the PBAC has previously described the vaccine as having an acceptable safety profile in the overall population, no safety data were provided for the sub-group analysis of patients with a comorbidity of interest (paragraph 7.14, RSVPreF3 OA PSD, July 2025 PBAC meeting). The PBAC and ESC considered that RSVPreF3 OA has an acceptable safety profile despite being more reactogenic compared to placebo.

6.50 The evaluation noted that the presented VE data suggested RSVPreF3 OA vaccine efficacy was broadly comparable between the overall trial population and participants aged 60–74 years with comorbidities of interest, and considered it may be plausible to assume similar efficacy across these populations based on the available data, acknowledging there was no clinical evidence to determine whether VE data are applicable to patients with immunocompromising conditions and neurological conditions. The PBAC and ESC considered that the subgroup analyses of AReSVi-006 demonstrated VE that was broadly consistent with the overall trial population.

Immunogenicity study to support use of RSVPreF3 OA in overall NIP population (RSV OA=ADJ-004 & RSV OA=ADJ-023)

6.51 The submission presented [redacted] The ATAGI has previously noted, noting that there remains uncertainty of clinical protection beyond 3 years due to a lack of efficacy data or validated immunological correlate of protection (ATAGI Pre-submission advice, October 2025).

6.52 Study RSV OA=ADJ-023 evaluated the immunogenicity, safety, and reactogenicity of RSVPreF3 OA in an IC population (lung and renal transplant recipients, ≥ 18 YOA). The RSV-A and RSV-B neutralising titres in the immunocompromised cohort didn't reach the same level observed in the 'Healthy Adults' comparator cohort. There remains uncertainty of establishment and duration of protection in the immunocompromised group due to a lack of efficacy data or validated immunological correlate of protection.

Economic analysis

6.53 The resubmission presented a modelled economic evaluation comparing a single dose of RSVPreF3 OA with no vaccine based on data from AReSVi-006 for the following groups:

- adults ≥75 YOA
- adults 60-74 YOA at increased risk of severe RSV disease.

6.54 For the 60-74 YOA at increased risk of severe RSV disease population, the resubmission presented two models: one for individuals with at least one at-risk medical condition associated with increased risk of severe RSV disease, as per the AIH list, and another based on each AIH-defined risk category separately. The economic evaluation for adults 60-74 YOA at increased risk of severe RSV disease aimed to address the PBAC's previous advice that the cost-effectiveness of this population cannot be demonstrated with reference to the ≥75 YOA population, as claimed by the sponsor in the July 2024 submission (paragraph 7.18, RSVPreF3 OA PSD, July 2024 PBAC meeting).

6.55 The resubmission did not include Aboriginal and Torres Strait Islander peoples aged 60-74 YOA population, consistent with the PBAC's advice that cost-effectiveness of this relatively small population could be acceptably informed by the cost-effectiveness assessment on the ≥75 YOA population (paragraph 7.15, RSVPreF3 OA PSD, July 2025 PBAC meeting).

6.56 The resubmission stated that the sponsor had not accepted the PBAC's July 2025 advice with regard to the cost-effectiveness evaluation that was necessary to move forward with implementation of the recommended NIP listing. The resubmission proposed alternative values for use in the cost-effectiveness evaluation, focused on: 1) duration of protection of the vaccine; 2) RSV hospitalisation rate; and 3) RSV hospitalisation costs. The resubmission proposed these alternative values be applied for all three requested populations. The resubmission noted that the changes to hospitalisation rates (paragraph 6.62, RSVPreF3 OA PSD, July 2025 PBAC meeting) and the VE duration of protection (paragraph 6.80, RSVPreF3 OA PSD, July 2025 PBAC meeting) were seen by the PBAC at its July 2025 meeting. The PBAC did not accept these inputs at their July 2025 or December 2025 considerations. The ESC noted that the resubmission presented economic analyses with more favourable parameters than were accepted by the PBAC in December 2025 for hospitalisation rates, duration of protection and hospitalisation costs. The ESC agreed with the evaluation that the

resubmission had not adequately justify these revisions, and therefore ESC did not support any change to the economic evaluation compared with that accepted by the PBAC in December 2025 for the ≥75 YOA population. The ESC also advised that the parameters accepted by the PBAC in December 2025 should be the basis of the current consideration for the 60-74 YOA population at increased risk.

6.57 A summary of the model structure, key inputs and rationale is presented in Table 13.

Table 13: Summary of model structure, key inputs and rationale

Component	July 2025 resubmission	March 2026 resubmission
Populations	• ≥ 75 YOA • Aboriginal and Torres Strait Islander people 60-74 YOA	• ≥ 75 YOA • 60-74 YOA at increased risk of severe RSV disease (including a model for at least one at-risk medical condition per the AIH, and a model based on each AIH risk category)
Treatments	RSVPreF3 OA versus no vaccine	Unchanged.
Outcomes	LYs and QALYs	Unchanged.
Time horizon	Lifetime for LYs and QALYs	Unchanged.
Methods used to generate results	Static multi-cohort Markov model	Unchanged.
Health states	No-RSV, post-RSV (participants that survived at least one RSV episode), and death	Unchanged.
Cycle length	1 month	Unchanged.
Vaccine efficacy	Per AReSVi-006 (overall population): 3 years based on linear logarithmic model (median 30.6-month trial data). Waning: 2 years (assuming constant decline rate to 0% at the end of Year 5). Pre-PBAC response: Per AReSVi-006 (overall population): 4 years based on linear logarithmic model (median 30.6-month trial VE data and [redacted] Waning: 1 years (assuming constant decline rate to 0% at the end of Year 5).	Unchanged from its July 2025 pre-PBAC response ([redacted]). The resubmission applied the estimate of VE from the overall population to the economic model, rather than an estimate corresponding to the analysis of ≥1 comorbidities of interest. The VE is uncertain for the population with comorbidities. In July 2025, the PBAC advised it was reasonable to accept VE over a period of three years based on three seasons of data for AreSVi-006, however, the duration of benefit beyond the trial remained uncertain (RSVPreF3 OA July 2025 PSD, paragraph 7.11). The PSCR did not agree with the 3-year VE duration previously advised by the PBAC. Instead, the PSCR maintained that a 5 year VE duration remains appropriate. The PSCR stated that the [redacted]. The pre-PBAC response applied 4-year VE duration in its base case.
Vaccination month	All months, using an annual average	Unchanged.

Component	July 2025 resubmission	March 2026 resubmission
RSV-associated hospitalisation rates	AIHW NHMD 2016-19 data with a multiplier of 2.0 (under-testing correction; ATAGI) and 1.5 (under-ascertainment multiplier for test sensitivity based on 66% sensitivity of RT-PCR of nasopharyngeal swabs; Havers et al., 2024a; Mclaughlin et al., 2022; Onwuchekwa et al., 2023). PSCR: used a 2.0 multiplier only, but applied this to crude hospitalisation rate from AIHW NHMD data from 2018–2019.	≥ 75 YOA: Unchanged from its July 2025 PSCR. In July 2025, the PBAC advised the hospitalisation rate should be reduced from 443 to 384 (RSVPreF3 OA July 2025 PSD, paragraph 7.14). 60-74 YOA at increased risk of severe RSV disease: crude rates from AIHW NHMD data from 2018-2019, adjusted by 2.0 multiplier, and excess hospitalisation multiplier (EHM). The pre-PBAC response applied EHM of 2.29 which was not consistent with ATAGI advice. The PSCR did not agree with the PBAC's previous advice that using crude hospitalisation rates from 2018-19 AIHW data was inappropriate and overestimated the hospitalisation rate. The PSCR stated that use of the 2018-19 AIHW data is justified on the basis that ATAGI selected 2018-19 data for program assessment due to COVID 19 disruption of RSV epidemiology in later years, and that using lower 2016-19 rates would underestimate disease burden and bias the cost effectiveness evaluation. The ESC noted the ATAGI-advised multiplier (i.e. 2.00) was considered suitable only for use with specific AIHW hospitalisation data from 2016-2019. The pre-PBAC response applied AIHW 2016-19 data in its base case consistent with ATAGI advice.
Annual RSV incidence	Unadjusted: 2.61/100 person-years (Korsten et al. 2021; Narejos Pérez et al. 2023). Adjusted: 3.95/100 person-years (2.61 x 1.5 from Havers et al., 2024a; Mclaughlin et al., 2022; Onwuchekwa et al., 2023)	Unchanged.
RSV-related deaths	2012-2019 AIHW NHMD PSCR: changed to a 4.22% RSV-hospital case fatality rate, based on ATAGI advice 2025, consistent with para 7.17, Abrysvo PSD, Nov 2024.	Unchanged.
Background mortality	Age specific mortality rates based on the general population from the ABS lifetable	Unchanged. Appropriate for ≥ 75 YOA, potentially inappropriate for 60-74 YOA at increased risk of severe RSV disease population.
Adverse events	Grade 3 (severe) AE: 2.27% (Grade 3 AE from AreSVi-006 vaccinated arm)	Unchanged.

Component	July 2025 resubmission	March 2026 resubmission
HRQoL	Population norms: Redwood et al., 2024 (0.86 for 60-64 YOA, 0.88 for 65-74 YOA, and 0.86 for ≥75 YOA) Vaccine-related AE: Schmader et al. 2019 (per Grade 3 AE estimated at 0.000677). RSV-LRTD and RSV URTD utility decrements: US TTO study (0.025 for severe RSV-LRTD, 0.018 for RSV-LRTD, and 0.013 RSV-URTD)	Unchanged. Appropriate for ≥ 75 YOA, uncertain for 60-74 YOA at increased risk of severe RSV disease population.
Hospitalisation costs	Hitch et al., 2024 ($20,091, Adjusted mean, 2024 values) PSCR: included scenario analyses which tested other hospitalisation costs including Brusco et al 2022 ($16,693) and expert opinion ($15,525 based on AR-DRG E62A-B, inflated by 50%)	≥75 YOA: $14,171 ($12,807 discharged alive and $1,364 died during stay) In July 2025, the PBAC advised the hospital costs should be reduced from $20,091 to $9,900 and ED costs from $1,565 to $1,457 (RSVPreF3 OA July 2025 PSD, paragraph 7.14). In December 2025, the PBAC accepted RSV hospitalisation cost: $10,045 (vs $9,900 in July 2025); and 60-74 YOA at increased risk of severe RSV: $13,967 ($12,951 discharged alive and $1,016 died during stay). Based on E62A for discharged alive, and E62, E40, and E41 for died during stay The pre-PBAC response applied higher hospitalisation costs than the value accepted by the PBAC in December 2025, which was not consistent with ESC advice.
Emergency department cost	$1,457	$1,478 In December 2025, the PBAC accepted RSV Emergency Department visit cost: $1,478 (vs $1,457 in July 2025). The pre-PBAC response applied higher ED costs than the value accepted by the PBAC in December 2025, which was not consistent with ESC advice.
Administration cost	$9.80 per administration (MBS Item 3, 50% co-vaccination assumption) PSCR: $7.00 consistent with Abrysvo PSD, Nov 2024 (based on marginal administration i.e. 36% of MBS Item 3 which has a fee of $19.60)	Unchanged its July 2025 PSCR ($7.00)

Source: Table 3-4, p115-116 of the March 2026 resubmission. Table 13, RSVPreF3 OA PSD, July 2026 resubmission. 6.80, RSVPreF3 OA PSD, PBAC meeting July 2025

ABS = Australian Bureau of Statistics, AIH = Australian Immunisation Handbook; AIHW = Australian Institute of Health and Welfare; ARI = acute respiratory infection; ATAGI = Australian Technical Advisory Group on Immunisation; EHM = excess hospitalisation multiplier; LRTD = lower respiratory tract disease; LYs = life years; NHMD = National Hospital Morbidity Database; PBAC = Pharmaceutical Benefits Advisory

Committee; PSD = public summary document; QALYs = quality-adjusted life years; OA = older adults; PSCR = Pre-subcommittee response; RSV = respiratory syncytial virus; URTD = upper respiratory tract disease, YOA = years of age.

6.58 The resubmission stated that no specific VE data is available for the population at increased risk of severe RSV disease. The evaluation stated that VE is uncertain for the population with comorbidities. In the previous PBAC consideration of RSVpreF (Abrysvo), ATAGI noted that people with a slightly lower mean age who are considered medically at-risk may have lower immune responses and thus a lower VE following an RSV vaccination. However, ATAGI further considered that, in the absence of detailed evidence, it was reasonable to use the VE values from the evaluable efficacy population of the pivotal of RSVpreF trial (RENOIR) as the base case for at risk population. ATAGI also stated that sensitivity analyses using CIs would provide a potential range of impact for the vaccine in each population (paragraph 6.45, RSVpreF PSD, November 2024).

6.59 The March 2026 resubmission maintained the assumption of a 5-year VE duration, based on a linear model over the first 4 years and convergence to 0% at year 5, as proposed in the pre-PBAC response for the July 2025 resubmission. In July 2025, this assumption was based on [redacted]. The PBAC advised that VE should be limited to 3 years in the model, consistent with available clinical data for RSVPreF3 OA (based on AReSVi-006 results for 3 seasons) (paragraph 6.80, RSVPreF3 OA PSD, July 2025 PBAC meeting). The PSCR did not agree with the 3-year VE duration previously advised by the PBAC and maintained that a 5 year VE duration was appropriate. The pre-PBAC response applied 4-year VE duration in its base case.

6.60 The sponsor sought additional advice from ATAGI on [redacted] (ATAGI Response, 29 October 2025). [redacted]

- [redacted] However, ATAGI noted that there remains uncertainty of clinical protection beyond 3 years due to a lack of efficacy data or validated immunological correlate of protection.
- The uncertainty in VE at later time points, exemplified in modelling of protective efficacy using a linear logarithmic model, which shows the lower confidence interval for protection falling below 20% soon after 3 years.
    - Data on the more clinically important targeted populations of adults aged ≥75 YOA are likely to have even greater uncertainty/imprecision, due to smaller included numbers in clinical trials. ATAGI also referred to its previous consideration that for season-specific VE in season 3, the lower bound of the 95% CI does not exceed 20% for RSV-LRTD (47.2%; 95% CI: 7.1, 71.6), highlighting that significant uncertainty exists around any statements on clinical protection beyond 3 years.

6.61 ATAGI's recommendations remained unchanged that protection for at least 3 seasons in adults aged ≥60 YOA (based on secondary endpoints) can be assumed, noting that it awaits confirmatory efficacy or effectiveness data to be available before being

confident that protection beyond 3 years for the base case can be assumed (ATAGI Response, 29 October 2025).

Adults ≥75 YOA

6.62 A summary of hospitalisation rates for the ≥75 YOA population is presented in Table 14. The resubmission proposed a weighted hospitalisation rate that is higher than the value accepted by the PBAC in December 2025 for the ≥75 YOA population.

Table 14: RSV hospitalisation rates for the ≥75 YOA population (per 100,000 person-year)

Base case	July 2025 PBAC meeting		December 2025 PBAC advice (unchanged from July 2025 advice)	March 2026 resubmission (base case) [a]
	Resubmission - base case	Resubmission - PSCR revised base case		
AIHW NHMD (crude rate)	2016-2019	2018-2019	2016-2019	2018-2019
Under-ascertainment adjustment	2.0 under-testing correction x 1.5 an under-ascertainment multiplier for test sensitivity	2.0 multiplication function	2.0 multiplication function	2.0 multiplication function
Adjusted hospitalisation rates				
75-79 YOA	364	304	384	273
80-84 YOA	750	556	384	599
≥85 YOA	750	556	384	
Weighted [b]	577	443	384	452

Source: Table 3-12, p137 of the March 2026 resubmission; Table 13, and Table 15 RSVPreF3 OA PSD, July 2025 PBAC meeting.
AIHW = Australian Institute of Health and Welfare; ATAGI = Australian Technical Advisory Group on Immunisation; NHMD =National Hospital Morbidity Database, NIP = National Immunisation Program, PBAC = Pharmaceutical Benefits Advisory Committee; PSCR = Pre-subcommittee response; RSV = respiratory syncytial virus, YOA = years of age.
[a] The approach taken in this resubmission was similar to that used in the July 2025 PSCR; however, the hospitalisation rates differ numerically between the two, and the reason for this discrepancy is unclear.
[b] Weighted by population size of each age category from the resubmission i.e. using a population weighting of: 45% 75-79 YOA; and 55% 80+ YOA. This weighted estimate is for comparison purposes, as the resubmission used rates per age band for the economic model.
Blue shading indicates data previously seen by the PBAC.

6.63 The March 2026 resubmission maintained the use of Australian Institute of Health and Welfare National Hospital Morbidity Database (AIHW NHMD) 2018-2019 data for the annual crude rate of RSV-associated hospitalisation, as proposed in the PSCR during the July 2025 resubmission (paragraph 6.62, RSVPreF3 OA PSD, July 2025 PBAC meeting). The PBAC previously noted excluding 2016-2017 data from the estimates was not consistent with the ATAGI pre-submission advice and supported a hospitalisation rate of 384 per 100,000 person-year per the ATAGI (paragraph 7.14 RSVPreF3 OA PSD, July 2025 PBAC meeting). The maintenance of the AIHW NHMD 2018-2019 data in this resubmission was based on:

- The sponsor made an additional request for ATAGI endorsement of age-based crude annual RSV-associated hospitalisation rates derived from 2018–19 AIHW data (ATAGI Response, 29 October 2025). ATAGI acknowledged uncertainty regarding the best method to adjust AIHW data for under-ascertainment of RSV hospitalisation in older adults. After reviewing the data, ATAGI maintained its view

that, for the base case, the preferred method for correcting under-ascertainment is to apply a multiplier of 2.0 to the overall estimated hospitalisation rate for 2016-2019. ATAGI also noted that a multiplier is valid only for the specific data period on which it was derived; applying it to other periods may introduce error (ATAGI Response, 29 October 2025). ATAGI noted that the study by Carlin et al, 2024 was for program assessment purposes and does not imply optimal inputs for PBAC cost-effectiveness assessment. This was discussed previously in the PBAC's consideration in July 2025 (RSVPreF3 OA PSD, paragraph 6.82).

6.64 The ATAGI did not support the resubmission's approach in October 2025. The AIHW 2025[10] report indicates the number of RSV hospitalisations has increased each year between 2008 and 2022, with the exception of 2020 to 2021[11]. The report states that when interpreting these data, it is important to note that changes in notifications over time may not solely reflect changes in disease prevalence or incidence. Depending on the disease, changes in testing policies, screening programs including the preferential testing of high-risk populations, the use of less invasive and more sensitive diagnostic tests, and periodic awareness campaigns may influence the number of notifications that occur each year. The availability of further AIHW data does not supersede ATAGI's October 2025 advice.

6.65 A summary of hospitalisation costs presented in the March 2026 resubmission and previous July 2025 resubmission is presented in Table 15.

[10] Vaccine-preventable diseases in Australia, Summary - Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/immunisation/vaccine-preventable-diseases/contents/summary, accessed 12 Jan 2025.

[11] https://www.aihw.gov.au/reports/immunisation/vaccine-preventable-diseases/contents/data-visualisations

Table 15: RSV related hospitalisation costs in the March 2026 resubmission

	July 2025 PBAC meeting			March 2026 resubmission [a]
	July 2025 resubmission -base case	**July 2025 resubmission PSCR**	**Pre-PBAC response**	
Hospitalisation cost per case	$20,091	$15,525 to $16,693.	$12,510	≥75 YOA: $14,171 ($12,807 discharged alive and $1,364 died during stay) In July 2025, the PBAC advised the hospital costs should be reduced from $20,091 to $9,900 and ED costs from $1,565 to $1,457 (RSVPreF3 OA July 2025 MINS, paragraph 7.14).
				60-74 YOA at increased risk of severe RSV: $13,967 ($12,951 discharged alive and $1,016 died during stay)
Source	Hitch et al. 2024	AR-DRG (NHCDC 2020 – 2021) costs inflated by 50%, Hitch et al 2024 (lower confidence interval, not adjusted for inflation) and Brusco et al 2022	AR-DRG E62A data (NHCDC 2020 – 2021) adjusted to 2025 value	AR-DRG (NHCDC 2020 – 2021) Discharged alive: E62A. Cost of death: E62, E40, and E41

Source: The economic model presented in the March 2026 resubmission; Table 13, 16, RSFPreF3 OA PSD, July 2025 PBAC meeting.
AR-DRG = Australian Refined Diagnosis Related Groups; NHCDC = National Hospital Cost Data Collection; PBAC = Pharmaceutical Benefits Advisory Committee; PSCR = Pre-subcommittee response; RSV = respiratory syncytial virus; YOA = years of age
[a] These numbers were taken from the economic model worksheet, as the figures in the resubmission are inconsistent across the document.
Blue shading indicates data previously seen by the PBAC.

6.66 The resubmission did not agree with the PBAC's advice regarding application of a hospitalisation cost of $9,990, (paragraph 7.14, RSVPreF3 OA PSD, July 2025 PBAC meeting), applying a higher cost of $14,171 for ≥75 YOA (and $13,967 for 60-74 YOA at increased risk of severe RSV). The resubmission argued that the Australian Refined Diagnosis-Related Groups (AR-DRG) E62A/B from the National Hospital Cost Data Collection (NHCDC), used as a basis for the previous PBAC's suggested estimate of the hospitalisation costs, reflects general ward costs only, citing the PBAC's considerations of COVID-19 therapeutics (molnupiravir PSD, July and November 2023 PBAC meeting, and raxtozinameran PSD, May 2025 PBAC meeting). It also noted that additional data from AIHW[12] suggested a longer length of stay (LOS) for RSV hospitalisations (60-64 YOA: 6.2 days, 65-69 YOA: 6.3 days, 6.8 to 7.6 days for ≥75 YOA) compared to the weighted LOS for AR-DRG E62A/B (4.4 days) from the National NHCDC. Given the similarity between the mean LOS for E62A (5.9 days; NHCDC) and that reported by

[12] Referred in the resubmission as the National Centre for Immunisation Research and Surveillance (NCIRS) analysis of AIHW RSV-coded hospitalisations (Dr Jen Kok Webinar. Available at https://ncirs.org.au/ncirs-webinar-series/07032024-rsv-vaccines-protection-older-adults)

AIHW, the resubmission assumed hospitalisation costs should be derived from E62A alone. The evaluation considered this assumption was not reasonable, as it selectively excludes lower-complexity E62B cases and inflates costs. The resubmission further included the cost of death during hospitalisation within the overall hospitalisation cost, arguing this was consistent with the approach taken in the raxtozinameran consideration (E62, E40, and E41). The updated estimates are not consistent with the hospitalisation costs accepted by the PBAC in the context of RSV vaccines. The other economic evaluations cited in the resubmission utilised different model designs (e.g., it had a separate ICU health state; Table 14, raxtozinameran PSD, May 2025 PBAC meeting). In the July 2025 consideration of RSVPreF3 OA, the PBAC advised the hospital costs should be reduced from $20,091 to $9,900 and ED costs from $1,565 to $1,457 (RSVPreF3 OA July 2025 PSD, paragraph 7.14). In December 2025, the PBAC accepted RSV hospitalisation cost: $10,045 (vs $9,900 in July 2025); and ED visit cost: $1,478 (vs $1,457 in July 2025).

6.67 The PSCR did not agree with the evaluation's assessment that using E62A alone inflates hospitalisation costs by excluding lower complexity E62B cases. The PSCR maintained that E62A plus the cost of in hospital death is the most appropriate representation of RSV hospitalisation cost. The PSCR reiterated the sponsor's claim based on LOS discussed in the paragraph above. The ESC noted that costing based on the weighted AR-DRG E62A/B grouping has been considered suitable for representing RSV-related hospitalisations and has been accepted by the PBAC (RSVpreF Nov 2024, RSVPreF3 OA Jul 2024). ICU and ventilation costs are already embedded within the NHCDC cost data, including within E62A/B, and therefore do not require separate inclusion.

6.68 The ESC also noted that the sponsor had previously proposed this method for adjusting RSV hospitalisation costs in its July 2024 (paragraph 6.68, RSVPreF3 OA PSD, July 2024 PBAC meeting) and July 2025 submissions (paragraph 6.69, RSVPreF3 OA PSD, July 2025 PBAC meeting). Consistent with its previous advice the ESC noted that NHCDC cost weights already account for more severe cases and LOS, and therefore the adjustments proposed by the resubmission were not appropriate. The PSCR claimed that the hospital resource use for managing 60-74 YOA adults with RSV has the potential to be greater than for ≥75 YOA based on a recently published Australian RSV national surveillance study (Blyth et al 2026). The ESC considered this was uncertain, noting that the Blyth analysis showed that hospitalised adults aged 18–74 years were more likely admitted to ICU/HDU than those aged 75 years or more (consistent with the PSCR's claim), but also showed that adults aged 75 years or more were more likely to experience prolonged length of stay. The study authors commented that although older adults were at lower risk of ICU or High Dependency Unit (HDU) admission, this is likely to be influenced by referral patterns (p9). The ESC also noted that the sponsor's own estimates resulted in a higher hospitalisation cost for adults aged 75 years or more than for adults 60-74 YOA at increased risk of severe RSV. The ESC advised that using the RSV hospitalisation cost that was accepted by the

PBAC in December 2025 ($10,045, para 12.5, RSVPreF3 OA, December 2025 PBAC meeting) would be reasonable for all of the proposed NIP populations. The pre-PBAC response applied higher hospitalisation costs than the value accepted by the PBAC in December 2025, which was not consistent with ESC advice.

Adults 60-74 YOA at increased risk of severe RSV disease

6.69 The resubmission presented two models for the 60-74 YOA population at increased risk of severe RSV disease: one for individuals with at least one at-risk medical condition associated with increased risk of severe RSV disease in adults, as per AIH recommendations, and another based on each of the eight AIH-defined risk categories separately. The first model provides a broad basis for understanding cost-effectiveness in this population, while the second allows evaluation of differences across risk categories due to heterogeneity. However, several uncertainties affect the reliability of both models.

6.70 The resubmission stated that the magnitude of the VE estimates, and associated confidence intervals (CI), support the statistical robustness of the subgroup analyses, noting that efficacy in the different subgroups were descriptive and not adjusted for multiplicity, and no specific VE data are available for those at increased risk of severe RSV disease. In a previous consideration of RSVpreF, ATAGI noted that people with a slightly lower mean age who are considered medically at-risk may have lower immune responses and thus a lower VE following an RSV vaccination (ATAGI response to PBAC post-submission questions, August 2024). ATAGI further considered that, in the absence of detailed evidence, it was appropriate to use VE values from the evaluable efficacy population of the pivotal RSVpreF (Abrysvo) trial (RENOIR) as the base case for at risk population (paragraph 6.45, RSVpreF PSD, November 2024 PBAC meeting).

6.71 Hospitalisation rates for the 60-74 YOA at increased risk of severe RSV population were derived through a three-step process. First, crude hospitalisation rates from the general population were obtained for the relevant age groups. Second, these rates were adjusted for under-ascertainment to reflect the expected rate in the general population. Finally, an excess hospitalisation multiplier (EHM) was applied to the adjusted rates to account for the increase in hospitalisations observed in at-risk groups compared to the general population of the same age. A summary of the crude hospitalisation rates for 60-74 YOA general population is presented in Table 16.

Table 16: RSV hospitalisation rates in 60-74 YOA general population (per 100,000 person-year)

	March 2026 PBAC resubmission (base case)	ATAGI pre-PBAC submission advice (Table 39, p73, ATAGI Advice, March 2025)
AIHW NHMD (crude rate)	2018-2019	2016-2019
Under-ascertainment adjustment	2.0 multiplication function	2.0 multiplication function
Adjusted hospitalisation rates		
60-64 YOA	90	52
65-69 YOA	118	106
70-74 YOA	182	159

Source: Table 3-12, p137 of the March 2025 resubmission.
AIHW = Australian Institute of Health and Welfare, NHMD = National Hospital Morbidity Database, NIP = National Immunisation Program, RSV = respiratory syncytial virus, YOA = years of age.

6.72 As for the ≥75 YOA population, the resubmission used the AIHW NHMD 2018-2019 data for crude hospitalisation rates for the 60-74 YOA at increased risk of severe RSV population (paragraph 6.63). ATAGI did not support the use of the 2018-2019 dataset (ATAGI Response, 29 October 2025).

6.73 A summary of the EHM used in individuals with at least one at-risk medical condition and by risk category per AIH is presented in Table 17. The bolded figure indicates the selected EHM for use in the base-case analysis.

Table 17: Excess hospitalisation multipliers used in base case and sources

Risk category and conditions	Hutton et al. (2024)		Branche et al. (2021) (Rochester site)		Branche et al. (2021) (NYC site)		Branche et al. (2021) (Weighted mean across NYC and Rochester)		Prasad et al. (2021)	
Country	**USA**								**NZ**	
Age groups (YOA)	**60-74**	**≥75**	**50-64**	**≥65**	**50-64**	**≥65**	**50-64**	**≥65**	**50-64**	**65-80**
Cardiac disease	**Average: 2.35 (base case)**									
Congestive heart failure	**3.18**	1.81	9.03	4.98	5.04	2.24	NA	3.49	5.58	3.77
Coronary artery disease	**2.15**	1.54	2.86	3.74	3.66	2.44	3.28	3.03	3.87	2.00
Stroke/TIA	NA	NA	NA	NA	NA	NA	NA	NA	**1.72**	1.45
Congenital heart disease	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Chronic respiratory conditions	**Average: 2.87 (base case)**									
Chronic obstructive pulmonary disease	**3.17**	2.79	3.81	7.8	4.58	2.33	4.21	4.82	4.92	3.71
Severe asthma (requiring frequent medical consultations/multiple medications)	**2.56**	2.52	1.68	1.89	2.41	1.63	2.06	1.75	3.51	3.29
Suppurative lung disease, bronchiectasis, cystic fibrosis, Chronic emphysema	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Immunocompromising conditions	**Average: 12.25 (base case)**									
Solid organ transplant	**17.3**	6.15	NA	NA	NA	NA	NA	NA	NA	NA
Haematopoietic stem cell transplant (HSCT)	2.9 (auto); **7.2** (allo)	1.03 (auto); 2.57 (allo)	NA	NA	NA	NA	NA	NA	NA	NA

Risk category and conditions	Hutton et al. (2024)		Branche et al. (2021) (Rochester site)		Branche et al. (2021) (NYC site)		Branche et al. (2021) (Weighted mean across NYC and Rochester)		Prasad et al. (2021)	
HIV infection, malignancy, immunocompromise due to disease or treatment, Asplenia or splenic dysfunction, CAR T-cell therapy	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Chronic metabolic disorders	**Average: 1.84 (base case)**									
Type 1 or 2 diabetes	**1.84**	1.36	2.17	3.63	2.47	1.42	2.33	2.43	1.14	1.45
Amino acid disorders, carbohydrate disorders, cholesterol biosynthesis disorders, fatty acid oxidation defects, lactic acidosis, mitochondrial disorders, organic acid disorders, urea cycle disorders, vitamin/cofactor disorders, porphyrias	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Chronic kidney disease	**Average:5.40 (base case)**									
Stage 4 or 5	**4.63**	4.16	NA	NA	NA	NA	NA	NA	NA	NA
ESRD	NA	NA	NA	NA	NA	NA	NA	NA	**6.18**	1.09
Chronic neurological conditions	**Average: 3.92[a] (base case)**									
Hereditary and degenerative central nervous system diseases, seizure disorders, spinal cord injuries, neuromuscular disorders, other conditions that increase the risk of severe outcomes from respiratory infection	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Chronic liver disease	**Average: 5.40[a] (base case)**									
Conditions with progressive deterioration of liver function for more than 6 months including cirrhosis and other advanced liver diseases	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Obesity	**Average: 2.28 (base case)**									
Body mass index ≥30 kg per m^2	**3.23** (BMI≥ 40) **1.33** (BMI= 30-39)	2.80 (BMI≥ 40) 1.06 (BMI= 30-39)	1	1.21	0.83	0.61	0.91	0.88	NA	NA
At least one medical condition	**2.29 (base case)**									
At least one medical condition	1.79	1.62	NA	NA	NA	NA	NA	NA	NA	NA

Source: Table 3.15, p143; and Table 3.16, p144 of the March 2026 resubmission.
Allo: allogeneic; Auto = autologous; BMI = Body mass index; CAR-T = Chimeric Antigen Receptor -T cell therapy; EHM = excess hospitalisation multipliers; ESRD = End Stage Renal Disease; HSCT = Haematopoietic stem cell transplant; NA = No evidence available; NYC = New York City; NZ = New Zealand; TIA = Transient ischemic attack; YOA = Year of Age.
The bold figure indicates the selected EHM for use in the base-case estimate.
[a] Assumption by the resubmission (Not based on hospitalisation rates but using severe disease risk (e.g., intensive care unit; ICU admission) for chronic neurological conditions. Assuming an EHM to chronic kidney disease for chronic liver disease).

6.74 An EHM for the at least one at-risk medical condition model of 2.29 was sourced from Carlin et al., 2024. The authors noted that this EHM was produced based on a community prospective study in the USA (Belongia et al., 2018). Potential issues with the derivation and use of this EHM include:

- Belongia et al. (2018) included a narrower population (chronic obstructive pulmonary disease, congestive heart failure, asthma, diabetes and immunocompromised disorders) than the AIH suggested target population.
- The estimate for the relative risk of hospitalisation for the at-risk cohort was based on a comparison with the not-at-risk cohort. This makes the multiplier less applicable to the model, where the hospitalisation rates are based on general population rates comprising both at-risk and not-at-risk individuals. The EHM from Carlin et al likely inflates the multiplier, as the not-at-risk group is expected to have lower hospitalisation rates than the general population average.
- The evaluators could not verify how the EHM of 2.29 was derived from the cited study (Belongia et al., 2018). The pre-PBAC response provided clarification, see paragraph 6.76.
- Additionally, the 2.29 EHM is higher than that previously proposed by the sponsor to the ATAGI (1.79), which ATAGI did not consider to be conservative (ATAGI Advice, March 2025).

These issues identified during the evaluation and those from the ATAGI collectively indicate that the methodology used for the EHM analysis in the resubmission may not be adequately rigorous and EHM of 2.29 was likely inflated.

6.75 The PSCR did not agree with the evaluation's assessment that the EHM of 2.29 is inflated and based on a narrower population than the AIH at risk cohorts. ATAGI did not endorse the estimate (ATAGI Response, 29 October 2025). The ESC noted that the EHM of 2.29 remained unverified and inappropriately used the 'not at-risk' population' rather than the general population as the reference cohort. The ESC advised that the EHM applied in the economic evaluation should be no higher than 1.79.

6.76 The pre-PBAC response stated that the value of 2.29 was a weighted average relative risk calculated using the raw data reported in Belongia et al 2018, adjusted for the prevalence of each condition in Australia. The pre-PBAC response suggested that an EHM of 2.29 would be appropriate for a population defined as having at least one at-risk medical condition excluding obesity as the report did not provide separate relative risks for patients with obesity. However, the PBAC noted that the relative risk of hospitalisation of 2.29 estimated by Carlin et al was for the at-risk cohort compared to the not-at-risk cohort, and therefore considered it was not appropriate to use this value as a multiplier in the current economic model since the underlying data informing the current model reflected the population average (which is not the same as the "not at risk cohort"). The PBAC agreed with the ESC that the EHM applied in the economic evaluation should be no higher than 1.79.The resubmission differentiated outcomes for each of the eight AIH risk categories using hospitalisation rates derived from specific EHM inputs for each category. Specific EHMs were obtained from an analysis based on five studies previously presented to ATAGI. Several issues regarding the analysis were raised by ATAGI (ATAGI Advice, March 2025), including potential

heterogeneity between sources for EHMs (mostly from the U.S.) and Australian health care systems, and that multipliers for each condition do not factor in co-morbidities within patients. The evaluation noted further issues with the resubmission's approach, including:

- EHMs for each risk category are based on a small number of conditions and do not fully align with conditions suggested in the AIH. For example, there is no direct evidence for RSV hospitalisation rates in chronic neurological conditions or chronic liver disease. The resubmission relied on proxy measures, using severe disease risk (e.g., intensive care unit; ICU admission) for chronic neurological conditions and assuming an EHM to chronic kidney disease for chronic liver disease. Of the eight risk categories, only cardiac disease (congestive heart failure, coronary artery disease) and chronic respiratory conditions (chronic obstructive pulmonary disease; COPD, and severe asthma) had EHMs consistently reported across the sources.
- Most EHMs were sourced from Hutton et al., 2024, which is based on a slide presentation to the United States Centres for Disease Control and Prevention (US CDC) and lacks detailed methodology on how the estimates were derived.
- The statistical method for combining EHMs within categories appears inadequate; for example, the obesity EHM (2.28) was calculated by simply averaging BMI ≥ 40 (3.23) and BMI 30-39 (1.33). This approach likely overestimates EHM as it oversimplifies and does not account for differences in prevalence among the conditions within each category. The ESC considered that the resubmission had overestimated the EHM for the obesity category, as the resubmission had assumed equal proportions of the population would have BMI 30-39 kg per m^2 and ≥40 kg per m^2, which was not supported by evidence. The ESC noted a wide range of values were identified from the literature (from 0.61 to 3.23; Table 21). An estimate based on ABS data[13] assuming 60% BMI 30-39 kg per m^2 and 40% for BMI ≥40 kg per m^2 generates an EHM of 2.09 compared with 2.28 as proposed by the resubmission. Alternatively, it may be appropriate to use a lower EHM reflecting that reported for BMI 30-39 kg per m^2, if it is assumed that the highest risk individuals (BMI ≥40 kg per m^2) would also meet other eligibility criteria, due to the association of obesity with comorbidities for example heart disease, type 2 diabetes and some cancers.
- In the immunocompromised category, the resubmission stated an EHM of 17.3 for solid organ transplantation; however, the source indicates this was based on only lung transplantation. This high value disproportionately influences the category

[13] Australian Bureau of Statistics. National Health Survey 2022. https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/2022

average (12.25), which is based on very few conditions and does not include major conditions such as HIV infection due to lack of data to inform the estimate.

- For each category, it is unclear how results were selected across studies or within study. For instance, alternative sources presented for obesity report lower hospitalisation implications (0.61-1.21) compared to the chosen estimate from Hutton et al. Similarly, for ESRD, the EHM based on 50-64 YOA group (6.18) from Prasad et al., 2021 was selected over the estimate based on 65-80 YOA group (1.09). In addition, the EHM of haematopoietic stem cell transplantation (HSCT) was not derived from a combination of autologous haematopoietic stem cell transplantation (autoHSCT) and allogeneic haematopoietic stem cell transplantation (alloHSCT), despite EHMs being available for both as reported in the study (Hutton et al., 2024). An EHM of 7.2 from alloHSCT was chosen over an EHM of 2.9 from autoHSCT, even though autoHSCT is generally more prevalent than alloHSCT[14]. These selections suggest a potential bias toward higher EHM values.

6.77 The evaluation considered that the methodology used for the EHM analysis in the resubmission may not be adequately rigorous and EHMs were likely inflated.

6.78 The PSCR did not agree with the evaluation's assessment that category specific EHMs rely on limited sources, lack transparency, and EHMs are overestimated. The PSCR maintained that the multiplier approach is appropriate. The PSCR stated this is justified because AIHW data do not report RSV hospitalisations by comorbidity, making multiplier methods standard practice in infectious disease modelling, and because category specific EHMs are aligned with approaches used in US CDC modelling and previous PBAC decisions for COVID-19 therapeutics and vaccines. The ESC noted the various significant concerns raised in the evaluation regarding the EHM estimate, such as the selection of EHM values with a bias towards higher values and the weighting approach that may inflate the EHM.

6.79 Based on the EHM of 2.29 (Carlin et al., 2024), the adjusted hospitalisation rates for the at those 60-74 YOA with least one at-risk medical condition are presented in Table 18. The estimated hospitalisation rates are 206 for 60-64 YOA, 270 for 65-69 YOA, and 417 for 70-74 YOA, equivalent to 289 per 100,000 person-years when weighted by the population distribution across these age groups.

6.80 The resubmission proposed a hospitalisation rate of 289 per 100,000 person-years for the 60-74 YOA HR population. After applying the amendments proposed in the evaluation, the hospitalisation rate corresponds to 181 per 100,000 person-years based on the estimates in Table 16 (60-64 YOA=52, 65-69 YOA= 106, 70-74 YOA=159), the EHM of 1.79, and the proportions indicated in Table 18. The corresponding estimated hospitalisation rate for the all-comers population was 101 per 100,000

[14] Australasian Bone Marrow Transplant Recipient Registry (https://anztct.org.au/registry).

person-years based on the estimates in Table 16 (60-64 YOA=52, 65-69 YOA= 106, 70-74 YOA=159), the EHM of 1, and the proportions indicated in Table 18.

Table 18: RSV hospitalisation rates in 60-74 years with least one at-risk medical condition (per 100,000 person-year)

People with at least one at-risk medical condition		
	Estimate in the resubmission	**Weighted average**
60-64 YOA	206	289 [a]
65-69 YOA	270	
70-74 YOA	417	

Source: Economic model worksheet of the March 2026 resubmission; para 6.53, RSVpreF PSD, November 2024 PBAC meeting
RSV = respiratory syncytial virus, YOA = years of age.
[a] Weighted by population size of each age category from the resubmission i.e. using a population weighting of 37%, 34%, and 29% for 60-64 YOA, 65-69 YOA, and 70-74 YOA respectively. This weighted estimate is for comparison purposes, as the resubmission used rates per age band for the economic model.

6.81 The resubmission applied age-specific background mortalities based on the general population obtained from the Australian Bureau of Statistics (ABS) 2023 data for those the 60-74 YOA population at increased risk of severe RSV disease, for both the model for at least one at-risk medical condition per the AIH, and the model based on each AIH risk category. The resubmission noted that specific to modelling the different at-risk categories, using the general Australian population estimates is considered appropriate given modelling of the different at-risk categories would require different population estimates, which are not readily available. The evaluation considered this was inappropriate and noted that ATAGI recommended using the 1.49 SMR based on Kabir et al., 2022[15] in sensitivity analysis. SMRs of 1.49 and 2.00[16] were tested in sensitivity analyses. The PSCR did not agree with the evaluation's assessment that the model by AIH risk category should incorporate risk specific inputs such as background mortality, stating this would not significantly influence the ICER.

6.82 The pre-PBAC response argued that exclusion of SMR adjustment from the base case was appropriate, on the basis that applying different SMR values was impractical. The PBAC noted that the adjustment of SMR to 1.49 based on based on Kabir et al., 2022 was tested in sensitivity analyses (Table 23).

6.83 The same rate of 4.22% for RSV-related death probability used in the ≥75 YOA population was applied for the 60–74 YOA population at increased risk of severe RSV. ATAGI previously noted that in the absence of more granular data, using the same rate

[15] Kabir A et al. Impact of multimorbidity and complex multimorbidity on mortality among older Australians aged 45 years and over: a large population-based record linkage study. BMJ Open. 2022 Jul 26;12(7):e060001.
[16] An SME of 2.00 has been assumed as the evaluators note that the estimate in Kabir et al. (SMR = 1.49) appears to reflect general multimorbidity in the population (as the study included conditions like depression or anxiety, and allergic rhinitis that might has low association with mortalities), not clinically defined risk groups like the AIH categories. The AIH risk categories are specific high-risk medical conditions, so their mortality risk is expected to be higher than the multimorbidity groups reported by Kabir.

as the ≥75 YOA population allows for a moderate increase in RSV-related death compared to the general population aged 60-74 (ATAGI Advice, March 2025).

6.84 The resubmission applied utility values from the general population (Redwood et al., 2024) to the population at increased risk of severe RSV disease. The evaluation considered this approach inappropriate, as this population is likely to have lower health-related quality of life (HRQoL).

6.85 A summary of the key drivers of the model is presented in Table 19.

Table 19: Key drivers of the model

Description	Method/Value	Impact vs resubmission base case
60-74 YOA at increased risk of severe RSV disease: at least one at-risk medical condition		Base case: $[redacted][1]/QALY gained
Background mortality	Assuming a background mortality equivalent to general population	Moderate, favours RSVPreF3 OA Use of the general population and a multiple of 2 increased the ICER to $[redacted][1]/QALY gained.
Hospitalisation cost	Based on E62A, and include cost of death during hospitalisation (E62, E40, and E41)	Moderate, favours RSVPreF3 OA Use of PBAC-advised hospitalisation cost ($9,900) increased the ICER to $[redacted][2]/QALY gained.
Hospitalisation rates	Based on AIHW NHMD 2018-2019	Moderate, favours RSVPreF3 OA Use of AIHW NHMD 2016-2019 increased the ICER to $[redacted][2]/QALY gained.
EHM	Using 2.29 EHM	Moderate, favours RSVPreF3 OA Use of an EHM previously proposed by the sponsor and noted by ATAGI (1.79) increased the ICER to $[redacted][2]/QALY gained.
VE duration	Using 5-year duration of protection: 4 years based on linear logarithmic model (median 30.6-month trial VE data and [redacted]. Waning: 1 years (assuming constant decline rate to 0% at the end of Year 5).	High, favours RSVPreF3 OA Use of PBAC-accepted and ATAGI-advised duration of protect (3 years) increased the ICER to $[redacted][2]/QALY gained.

Source: Compiled during the evaluation.
AIHW = Australian Institute of Health and Welfare; ATAGI = Australian Technical Advisory Group on Immunisation; EHM = excess hospitalisation multipliers; ICER = incremental cost-effectiveness ratio; NHMD = National Hospital Morbidity Database; PBAC = Pharmaceutical Benefits Advisory Committee; QALY = quality-adjusted life year; RSV= respiratory syncytial virus; UAM = under-ascertainment-multiplier; VE = vaccine efficacy; YOA = years of age.
The redacted values correspond to the following ranges:
[1] *$15,000 to < $25,000*
[2] *$25,000 to < $35,000*

6.86 A summary of the results of the economic evaluation for the ≥75 YOA population from the March 2026 resubmission was presented in the commentary, but is not reproduced in these minutes.

6.87 A summary of the stepped economic evaluation results for 60-74 YOA at increased risk of severe RSV disease, with at least one at-risk medical condition, is presented in Table 20. The PSCR presented revised results applying the revised proposed price of $[redacted]/dose (not shown below).

Table 20: Results of the stepped economic evaluations: at least one at-risk medical condition (price $[redacted]/dose)

Step and component (n = [redacted])	Proposed medicine	Comparator	Increment
Step 1: Crude hospitalisation rate (trial-based outcomes 3-year VE), corrected in ESC Advice			
Costs	$[redacted]	$246,915,612	$[redacted]
QALYs lost	10,345	15,190	-4,845
Incremental cost/extra QALYs gained			$[redacted][1]
Step 2: Adjust crude hospitalisation rates to reflect the general population aged 60-74 years (2.00 UAM)			
Costs	$[redacted]	$370,087,791	$[redacted]
QALYs lost	12,688	18,983	-6,295
Incremental cost/extra QALYs gained			$[redacted][2]
Step 3: Apply EHM (2.29)			
Costs	$[redacted]	$687,811,652	$[redacted]
QALYs lost	18,734	28,768	-10,034
Incremental cost/extra QALYs gained			$[redacted][3]
Step 4: Incorporate updated hospitalisation cost (from $9,900 to $13,967)			
Costs	$[redacted]	$906,268,597	$[redacted]
QALYs lost	18,734	28,768	-10,034
Incremental cost/extra QALYs gained			$[redacted][4]
Step 5: Extend VE from 3 years to 5 years			
Costs	$[redacted]	$906,268,597	$[redacted]
QALYs lost	16,365	28,768	-12,403
Incremental cost/extra QALY gained (base case)			**$[redacted][5]**

Source: Conducted during the evaluation using the economic model presented in the March 2026 resubmission.
EHM = excess hospitalisation multipliers; ICER = incremental cost-effectiveness ratio; QALY = quality-adjusted life year; RSV= respiratory syncytial virus; UAM = under-ascertainment-multiplier; VE = vaccine efficacy; YOA = years of age.

The redacted values correspond to the following ranges:

[1] *$115,000 to < $135,000*
[2] *$75,000 to < $95,000*
[3] *$35,000 to < $45,000*
[4] *$25,000 to < $35,000*
[5] *$15,000 to < $25,000*
[6] *4,000,000 to < 5,000,000*

6.88 A summary of the model's inputs and results for 60-74 YOA at increased risk of severe RSV disease, by each risk category, is presented in Table 21. For comparison, the PBAC-accepted hospitalisation rate for ≥75 was 384 per 100,000 person-year. For several risk categories, the estimated hospitalisation rate is higher than was accepted for ≥75 YOA (includes immunocompromising conditions, chronic liver disease, chronic kidney disease, and chronic neurological conditions), while the remainder have lower rates.

6.89 The PSCR presented revised results applying the revised proposed price of $[redacted]/dose (not shown).

Table 21: Model inputs and results for 60-74 YOA at increased risk of severe RSV disease, by each risk category (ordered by EHM from highest to lowest) and comparison with PBAC-accepted hospitalisation rate for ≥75 YOA

Category	Population size (n)	% of total population	EHM (& hospitalisation rate per 100,000 person-year [a])	EHM range reported	Inc. cost ($) per 100,000 persons	Inc. QALYs per 100,000 persons	ICER ($/QALY)
Immunocompromising conditions	[4]	%	12.25 (1,544)	2.57-17.3	-$	1,143	Dominant (-$)
Chronic liver disease	[4]	%	5.40 (680)	NA	-$	560	Dominant (-$)
Chronic kidney disease	[5]	%	5.40 (680)	1.09-6.18	-$	560	Dominant (-$)
Chronic neurological conditions	[6]	%	3.92 (494)	NA	-$	434	Dominant (-$)
Chronic respiratory conditions	[7]	%	2.87 (362)	1.63-7.80	$	345	$[1]
Cardiac disease	[8]	%	2.35 (296)	1.45-9.03	$	300	$[2]
Obesity	[4]	%	2.28 (287)	0.61-3.23	$	294	$[2]
Chronic metabolic disorders	[8]	%	1.84 (232)	1.14-3.63	$	257	$[3]

Source: Conducted during the evaluation using the economic model presented in the March 2026 resubmission.
BMI = Body mass index; CAR-T = Chimeric Antigen Receptor -T cell therapy; EHM = excess hospitalisation multipliers; ESRD = End Stage Renal Disease; HSCT = Haematopoietic stem cell transplant; ICER = incremental cost-effectiveness ratio; QALY = quality-adjusted life year; RSV= respiratory syncytial virus; TIA = Transient ischemic attack; YOA = Year of Age.
[a] Weighted by population size of each age category from the resubmission i.e. using a population weighting of 37%, 34%, and 29% for 60-64 YOA, 65-69 YOA, and 70-74 YOA respectively.
The redacted values correspond to the following ranges:
[1] $5,000 to < $15,000
[2] $15,000 to < $25,000
[3] $25,000 to < $35,000
[4] 200,000 to < 300,000
[5] 30,000 to < 40,000
[6] 100,000 to < 200,000
[7] 300,000 to < 400,000
[8] 500,000 to < 600,000

6.90 A summary of the economic evaluation results for 60-74 YOA at increased risk of severe RSV disease, by each risk category, is presented in Table 22. These results cannot be combined to reflect the overall proposed population because they are not mutually exclusive categories. The submission did not estimate what proportion of the population would fulfil criteria in more than one risk category, however the sum of persons within the individual risk categories from Table 22 (N=2,000,000 to < 3,000,000) exceeds the estimated size of the total population (N=1,000,000 to < 2,000,000). The evaluation noted that a comparison of results across risk groups should be interpreted with caution, as differences are driven by a single EHM factor, not accounting other factors that may vary. As discussed earlier, the estimated EHMs are undermined by several issues and remain uncertain.

Table 22: Results of the economic evaluations: by each risk category (base case, $[redacted] per dose)

		RSVPreF3 OA	No vaccine	Increment
Cardiac disease (n = [redacted][4], [redacted]%)	Costs	$[redacted]	$113,992,329	$[redacted]
	QALYs lost	2,042	3,594	-[redacted]
	Incremental cost/extra QALYs gained			$[redacted][1]
Chronic respiratory conditions (n = [redacted][5]; [redacted]%)	Costs	$[redacted]	$90,009,134	$[redacted]
	QALYs lost	1,523	2,703	-[redacted]
	Incremental cost/extra QALYs gained			$[redacted][2]
Immunocompromising conditions (n = [redacted][6]; [redacted]%)	Costs	$[redacted]	$250,142,193	-$[redacted]
	QALYs lost	3,266	6,055	-[redacted]
	Incremental cost/extra QALYs gained			**Dominant**
Chronic metabolic disorders (n = [redacted][4]; [redacted]%)	Costs	$[redacted]	$103,321,639	$[redacted]
	QALYs lost	1,999	3,481	-[redacted]
	Incremental cost/extra QALYs gained			$[redacted][3]
Chronic kidney disease (n = 34,034; [redacted]%)	Costs	$[redacted]	$15,944,252	-$[redacted]
	QALYs lost	233	424	-[redacted]
	Incremental cost/extra QALYs gained			**Dominant**
Chronic neurological conditions (n = 177,311; [redacted]%)	Costs	$[redacted]	$61,740,183	-$[redacted]
	QALYs lost	966	1,736	-[redacted]
	Incremental cost/extra QALYs gained			**Dominant**
Chronic liver disease (n = [redacted][6]; [redacted]%)	Costs	$[redacted]	$100,388,730	-$[redacted]
	QALYs lost	1,470	2,670	-[redacted]
	Incremental cost/extra QALYs gained			**Dominant**
Obesity (Body mass index ≥30 kg per m^2) (n = [redacted][6]; 9%)[17]	Costs	$[redacted]	$47,128,839	$[redacted]
	QALYs lost	852	1,498	-[redacted]
	Incremental cost/extra QALYs gained			$[redacted][1]

Source: Conducted during the evaluation using the economic model presented in the March 2026 resubmission.
EHM = excess hospitalisation multipliers; ICER = incremental cost-effectiveness ratio; QALY = quality-adjusted life year; RSV= respiratory syncytial virus; UAM = under-ascertainment-multiplier; VE = vaccine efficacy; YOA = years of age.
The redacted values correspond to the following ranges:
[1] *$15,000 to < $25,000*
[2] *$5,000 to < $15,000*
[3] *$25,000 to < $35,000*
[4] *500,000 to < 600,000*
[5] *300,000 to < 400,000*
[6] *200,000 to < 300,000*

6.91 The results of key sensitivity analyses for 60-74 YOA at increased risk of severe RSV disease, with at least one at-risk medical condition are summarised in Table 23.

6.92 The Evaluation considered that the MSA shown in Table 23 which adjusted hospitalisation rate (change E), background mortality (change G), hospitalisation cost (change J) and VE duration (change K) and resulted in an ICER of $45,000 to < $55,000/QALY was most informative (labelled Evaluation MSA). In addition, the ESC noted the Alternative MSA which applied the adjusted hospitalisation rate (change E),

[17] The prevalence reported here appears to reflect metabolically healthy obesity (obesity without other comorbidities). Evidence suggests a general prevalence of around 5–7%, or roughly 30% among those with obesity. The estimate of 9% in this high-risk group would be lower once non-at-risk individuals are considered and remains within a reasonable range. (Wang, Jiang-Shui, et al. "Trends in the prevalence of metabolically healthy obesity among US adults, 1999-2018." JAMA Network Open 6.3 (2023): e232145-e232145).

hospitalisation cost (change J) and VE duration (change K) and resulted in an ICER of $35,000 to < $45,000/QALY (see paragraph 6.81), and the All-comers analysis which applied an EHM of 1 to generate estimate for the 60-74 years age cohort (all-comers) regardless of medical risk factors and resulted in an ICER of $55,000 to < $75,000 /QALY (using an SMR 1).

6.93 The PSCR noted that the cost-effectiveness of RSVPreF3 OA has a strong age gradient that is largely driven by differences in age-based hospitalisation rates. The PSCR presented results for two cohorts, 1) 65-74 YOA at increased risk of severe RSV disease and 2) 60-74 YOA at increased risk of severe RSV disease. The results for the older cohort had lower ICERs than the younger cohort .

Table 23: Results of sensitivity analyses: RSVPreF3 OA vs no vaccine, 60-74 YOA at increased risk of severe RSV

	Analysis	Incremental Costs (discounted)	Incremental QALYs (discounted)	ICER	ICER changed (%)
	Base-case	$[redacted]	12,403	$[redacted][1]	
A	Discount rate: 0% (base case: 5%)	$[redacted]	18,805	$[redacted][2]	-[redacted]%
B	Discount rate: 3.5% (base case: 5%)	$[redacted]	13,814	$[redacted][1]	-[redacted]%
	Hospitalisation rates (base case: 289 per 100,000 person-year based on AIHW NHMD 2018-2019, 2.00 UAM, and 2.29 EHM)				
C	AIHW NHMD 2016-2019 (with UAM of 2: 60-64=52, 65-69=106, 70-74=159)[a]	$[redacted]	10,832	$[redacted][3]	+[redacted]%
D	EHM previously proposed to ATAGI: 1.79	$[redacted]	10,613	$[redacted][3]	+[redacted]%
E	C + D (weighted rate across age groups of 181 per 100,000 person-year)	$[redacted]	9,385	$[redacted][4]	+[redacted]%
F	197 per 100,000 person-year (paragraph 6.53, RSVpreF PSD, November 2024 PBAC meeting)	$[redacted]	9,768	$[redacted][4]	+[redacted]%
	Background mortalities (base case: general population)				
G	SMR: 1.49 times higher than the general population (previously proposed to ATAGI based on Kabir et al., 2022)	$[redacted]	11,548	$[redacted][1]	+[redacted]%
H	SMR: 2.00 times higher than the general population (arbitrarily assumed)	$[redacted]	10,872	$[redacted][1]	+[redacted]%
	Hospitalisation costs (base case: $13,967)[b]				
I	PBAC-advised value: $9,900 (paragraph 7.14, RSVPreF3 OA, July 2025 PBAC meeting)	$[redacted]	12,403	$[redacted][3]	+[redacted]%
J	PBAC-advised value: $10,045 (paragraph 12.5, RSVPreF3 OA, December 2025 PBAC meeting)	$[redacted]	12,403	$[redacted][3]	+[redacted]%
	VE duration (base case: 5-year duration of protection)				
K	3 years (PBAC-advised VE duration; para 7.14, RSVPreF3 OA, July 2025 PBAC meeting)[c]	$[redacted]	10,034	$[redacted][3]	+[redacted]%
L	4 years (ATAGI-advised for a sensitivity analysis)[d]	$[redacted]	11,754	$[redacted][1]	+[redacted]%
	Multivariate analyses (price $[redacted]/dose)				
M	Evaluation MSA: E G J K	$[redacted]	7,161	$[redacted][5]	+[redacted]%
N	Alternative MSA: E J K (PBAC scenario 2)	$[redacted]	-7,593	$[redacted][4]	+[redacted]%
O	65-74 years at increased risk of severe RSV (E J K and 60-64 years removed)	$[redacted]	-5,579	$[redacted][3]	+[redacted]%
P	All comers 60-74: Apply settings for Alternative MSA except set EHM to 1: C J K and EHM = 1 (PBAC scenario 1)	$[redacted]	-5,740	$[redacted][6]	+[redacted]%

Source: Conducted during the evaluation; Table 3.-42, p255; Table 3-72, p180 of the March 2026 resubmission.

AIHW = Australian Institute of Health and Welfare; ATAGI = Australian Technical Advisory Group on Immunisation; ESC = Economic Sub-Committee; ICER = incremental cost-effectiveness ratio; NHMD = National Hospital Morbidity Database; PBAC = Pharmaceutical

Benefits Advisory Committee; PSCR = Pre-subcommittee response; PSD = public summary document; QALYs = quality-adjusted life years; RSV= respiratory syncytial virus; SMR = standardised mortality ratios; VE = Vaccine Efficacy; YOA = years of age.

[a] Data sourced from Table 39, p 75, ATAGI advice 7 March 2025 under heading "Multiplier method", this reflects mean AIHW NHMD 2016-2019 RSV-coded hospitalisations (any diagnosis fields), multiplied by 2.0 (as shown in Epidemiology sheet of the model cells AD137:AD139)

[b] The March 2026 resubmission acknowledged the PBAC-advised emergency department (ED) cost of $1,457 (Table 20, para 7.14, RSVPreF3 OA PSD, July 2025 PBAC meeting) and updated it to the June 2025 value of $1,478 based on consumer price index.

[c] 3 years of VE reflects PBAC advice. Applied in the model by updating Efficacy sheet of the model, set cells as follows AF8 = 3, AF9 = 3.

[d] Four years of VE was adopted by the evaluators as the assumption for the analysis. ATAGI indicated support for a longer duration of VE than its suggestion (3 years) but did not specify an exact timeframe (p2, ATAGI Response, 29 October 2025).

The redacted values correspond to the following ranges:

[1] *$15,000 to < $25,000*
[2] *$5,000 to < $15,000*
[3] *$25,000 to < $35,000*
[4] *$35,000 to < $45,000*
[5] *$45,000 to < $55,000*
[6] *$55,000 to < $75,000*

6.94 The pre-PBAC response presented alternative analyses including a new base case, which resulted in an ICER of $25,000 to < $35,000/QALY for adults 60-74 years when an EHM of 1.79 was applied, and noted the ICER would reduce to $15,000 to < $25,000/QALY if the youngest five year cohort of this group was excluded, such that the eligible population would be those with increased risk of severe RSV aged 65 to 74 years. The sponsor's analysis applied inputs that were not consistent with previous ESC and PBAC advice, and the results could not be verified. Applying the inputs from the evaluation (E J K), the analysis for the population aged 65-74 years at increased risk of severe RSV using EHM=1.79, and age 65-74 resulted in an ICER of $25,000 to < $35,000/QALY (Table 23).

6.95 The pre-PBAC response also presented an all-comers analysis which resulted in an ICER of $45,000 to < $55,000/QALY for adults aged 60 to 74 years. The sponsor's analysis applied inputs that were not consistent with previous ESC and PBAC advice, and the results could not be verified.

6.96 The PBAC noted that the sponsor presented a revised base case in its pre-PBAC response, however considered it was not suitable for decision making as it applied several inputs that were not consistent with previous PBAC advice, for example in relation to duration of VE, which the PBAC advised should be no more than 3 years based on currently available clinical data.

RSVPreF3 OA cost per person

6.97 The proposed cost of RSVPreF3 OA per administration is $[redacted] based on the price proposed in the PSCR.

Estimated PBS usage & financial implications

6.98 This submission was not considered by DUSC.

6.99 The March 2026 resubmission presented the financial impact of introducing a single dose of RSVPreF3 OA onto the NIP for adults: ≥75 YOA; Aboriginal and Torres Strait Islander people 60-74 YOA; and adults 60-74 YOA at increased risk of severe RSV disease. This was consistent with the requested NIP listing. However, two of the

populations were previously recommended for NIP listing, and therefore the key information for consideration at the March 2026 meeting was the incremental cost of the proposed NIP listing for adults 60-74 YOA at increased risk of severe RSV disease.

6.100 The resubmission used an epidemiological approach to estimate the eligible population. Key inputs used by the resubmission are presented in Table 24.

Table 24: Key inputs for financial estimates

Data	Value applied source		Comment
Prevalent population	60-74 at increased risk of severe RSV disease 1,706,556	• 2027 population based on ABS Population Projections, Australia, 2018 (base). (Series 3222.0). (ABS, 2018) • Aboriginal and Torres Strait Islander peoples taken out.	The evaluation considered this was reasonable
		• Proportion with at least one at-risk condition: 40.22% based on obesity prevalence (ABS National Health Survey 2022)	Underestimate. Lower than ATAGI's previous advice as discussed in paragraph 6.101 (60-64 YOA: 49%; 65-69 YOA: 58%; 70-74 YOA: 67%) (ATAGI Advice, March 2025).
Incident population	60-74 at increased risk of severe RSV disease Yr 1: 24,808 to Yr 6: 26,871	• 2027 population based on ABS Population Projections, Australia, 2018 (base). (Series 3222.0). (ABS, 2018) • Aboriginal and Torres Strait Islander peoples taken out.	The evaluation considered this was reasonable
		• Proportion with at least one at-risk condition: 40.22% based on obesity prevalence (ABS National Health Survey 2022)	Underestimate. Lower than ATAGI's advice regarding prevalence (60-64 YOA: 49%; 65-69 YOA: 58%; 70-74 YOA: 67%) (ATAGI Advice, March 2025).
Uptake rate	60-74 at increased risk of severe RSV disease 60-64 YOA: Yr 1: [redacted]% Yr 2-5: increases by [redacted]% per year, Yr 6: [redacted]% 65-74 YOA: Yr 1: [redacted]%, Yr 2-5: increases by [redacted]% per year, Yr 6: [redacted]%	ATAGI advice, March 2025	The evaluation considered this was reasonable

Source: Table 4.-1, pp184-185; Table 4-2, pp187-188; 4-4, p190; Table 4-8, pp193-194; Table 4-10, p196; Table 4-11, p197; Table 4-12, pp197-198; Table 4-13, p198; Financial model worksheets of the March 2026 resubmission.

ABS = Australian Bureau of Statistics, AIH = Australian Immunisation Handbook; ATAGI = Australian Technical Advisory Group on Immunisation; PBAC = Pharmaceutical Benefits Advisory Committee; PSD = public summary document; OA = older adults; PSCR = Pre-subcommittee response; RSV = respiratory syncytial virus; YOA = years of age.

6.101 The resubmission used obesity prevalence (40.22%, ABS NHS 2022) as a proxy to estimate the eligible population for the 60-74 at increased risk of severe RSV disease population. The following arguments were used to justify this approach:

- The resubmission referred to the July 2024 DUSC advice suggested that "estimates regarding high-risk chronic population for oral antivirals for the treatment of COVID-19 could be used to inform the financial estimates of the subgroup at increased risk (60-74 YOA)".
- The resubmission noted that the estimate from nirmatrelvir plus ritonavir, a treatment for early COVID-19 in high-risk adults (November 2023 PBAC meeting) suggested 35-38% of people in this age group were considered at high risk of requiring hospitalisation for COVID-19 infection. The definition of at-risk/high-risk was consistent with the RSV AIH but excluded obesity. The resubmission stated that this range is also similar to the estimate reported in RSVpreF (i.e., 35%; November 2024 PBAC meeting).

The arguments do not fully reflect what was previously proposed and ATAGI's advice (ATAGI Advice, March 2025). ATAGI noted the DUSC's suggestion regarding the reasonableness of the eligible population estimates based on the high-risk chronic population for oral antivirals for the treatment of COVID-19. Specifically, the ATAGI further advised that using the prevalence of people at increased risk of severe COVID-19, based on Clark et al., 2020 (a global population-based study of people at increased risk of severe COVID-19)[18] as proposed in the pre-submission advice, was reasonable. The ATAGI noted the prevalence from the study ranging from 49% in 60-64 YOA, 58% in 65-69 YOA, and 67% in 70-74 YOA was reasonable and informative for financial estimate for this population. The use of obesity prevalence presented in this resubmission results in lower estimate than that previously proposed.

6.102 The estimated utilisation and cost to NIP considered by the PBAC in December 2025 are presented in Table 25. The cost to the NIP at the price of $[redacted]/dose is $200 million to < $300 million over the first 6 years of listing.

[18] Clark, Andrew, et al. "Global, regional, and national estimates of the population at increased risk of severe COVID-19 due to underlying health conditions in 2020: a modelling study." *The Lancet Global Health* 8.8 (2020): e1003-e1017.

Table 25: Estimated use and financial implications (recommended at December 2025 PBAC meeting)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total Years 1 to 6
Estimated extent of use - adults ≥75 YOA							
Vials	[redacted][1]	[redacted][2]	[redacted][3]	[redacted][3]	[redacted][3]	[redacted][3]	[redacted][4]
Estimated extent of use - Aboriginal and Torres Strait Islander people aged 60-74							
Vials	[redacted][5]	[redacted][6]	[redacted][6]	[redacted][6]	[redacted][6]	[redacted][6]	[redacted][7]
Estimated extent of use - Total							
Vials	[redacted][1]	[redacted][3]	[redacted][3]	[redacted][3]	[redacted][3]	[redacted][3]	[redacted][4]
Estimated financial implications of RSVPreF3 OA							
Cost to the NIP	$[redacted][8]	$[redacted][9]	$[redacted][9]	$[redacted][9]	$[redacted][9]	$[redacted][9]	$[redacted][10]

Source: RSVPreF3 OA PBAC minutes December 2025, Table 28.
NIP = National Immunisation Program; YOA = years of age.
The redacted values correspond to the following ranges:
[1] *800,000 to < 900,000*
[2] *100,000 to < 200,000*
[3] *200,000 to < 300,000*
[4] *1,000,000 to < 2,000,000*
[5] *20,000 to < 30,000*
[6] *5,000 to < 10,000*
[7] *60,000 to < 70,000*
[8] *$90 million to < $100 million*
[9] *$20 million to < $30 million*
[10] *$200 million to < $300 million*

6.103 The estimated use and financial implications for the proposed population of adults 60-74 YOA at increased risk of severe RSV disease are presented in Table 26.

6.104 The resubmission assumed an average vaccine administration cost of $7. The ESC noted that the costs of administration may be underestimated, however were consistent with the economic evaluation.

6.105 Additional analyses are presented in Table 26 including revised estimates from the PSCR. When estimates from Clark 2020 are used for estimating the eligible population, the cost to NIP increases to $100 million to < $200 million over 6 years, compared with $100 million to < $200 million over 6 years in the PSCR base case.

6.106 The ESC advised that a sensitivity analysis would be informative for PBAC consideration that omits obesity to align with the criteria for influenza. The analysis includes the cohort aged 60-74 years with medical risk factors as proposed by the resubmission but with the exception of obesity. A sensitivity analysis where obesity is excluded is shown in Table 26, however the result is uncertain as it relies on an estimate that 9% of the total population would qualify for vaccination based on BMI and not meet other medical criteria (Table 21). The cost to NIP was decreased to $100 million to < $200 million over six years in this analysis, compared with to $100 million to < $200 million over six years in the Clark sensitivity analysis.

6.107 A scenario analysis considering the entire cohort aged 60-74 years is also shown, which increases the estimated cost to NIP to $300 million to < $400 million over 6 years compared with $100 million to < $200 million over 6 years in the PSCR base case.

Table 26: Estimated use and financial implications, including revised PSCR estimates

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Adults 60-74 YOA at increased risk of severe RSV disease						
Estimated extent of use						
Predicted number of vials	[redacted][1]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]
Estimated financial implications of RSVPreF3 OA						
NIP ($[redacted] per dose)	$[redacted][3]	$[redacted][4]	$[redacted][4]	$[redacted][4]	$[redacted][4]	$[redacted][4]
Vaccine administration	$[redacted][5]	$[redacted][5]	$[redacted][5]	$[redacted][5]	$[redacted][5]	$[redacted][5]
PSCR estimates						
Sponsor base case, Prevalence rate of at least one medical condition - 40.22%						
Vials	[redacted][1]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]
NIP ($[redacted] per dose)	$[redacted][6]	$[redacted][4]	$[redacted][4]	$[redacted][4]	$[redacted][4]	$[redacted][4]
Clark 2020 - 49% in 60-64 YOA, 58% in 65-69 YOA, and 67% in 70-74 YOA (sponsor's result could not be verified)						
Vials	[redacted][7]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]
NIP ($[redacted] per dose)	$[redacted][3]	$[redacted][4]	$[redacted][4]	$[redacted][4]	$[redacted][4]	$[redacted][4]
ESC Sensitivity Analyses						
Population excluding obesity (PSCR Clark 2020 estimates minus 9% as per resubmission estimate)						
Vials	[redacted][8]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]
NIP ($[redacted] per dose)	$[redacted][3]	$[redacted][4]	$[redacted][4]	$[redacted][4]	$[redacted][4]	$[redacted][4]
Entire population aged 60-74 assuming no change to uptake rates (all-comers)						
Vials	[redacted][9]	[redacted][10]	[redacted][10]	[redacted][10]	[redacted][10]	[redacted][10]
NIP ($[redacted] per dose)	$[redacted][11]	$[redacted][12]	$[redacted][12]	$[redacted][12]	$[redacted][12]	$[redacted][12]

Source: Table 4-1, pp184-185 of the March 2026 resubmission; Table 23, Table 24, RSVPreF3 OA July 2025 minutes; Table 33, RSVPreF3 OA July 2024 minutes

M = million; NIP = National Immunisation Program; PBS = Pharmaceutical Benefit Scheme; PSCR = Pre-subcommittee response; YOA = years of age.

The redacted values correspond to the following ranges:

[1] *500,000 to < 600,000*
[2] *100,000 to < 200,000*
[3] *$80 million to < $90 million*
[4] *$10 million to < $20 million*
[5] *$0 to < $10 million*
[6] *$60 million to < $70 million*
[7] *800,000 to < 900,000*
[8] *700,000 to < 800,000*
[9] *1,000,000 to < 2,000,000*
[10] *200,000 to < 300,000*
[11] *$100 million to < $200 million*
[12] *$30 million to < $40 million*

6.108 The submission estimated the total cost to the NIP of listing RSVPreF3 OA for adults 60-74 YOA at increased risk of severe RSV disease to be $80 million to < $90 million in Year 1 and $10 million to < $20 million in Year 6, and a total of $100 million to < $200 million in the first 6 years of listing at the price proposed in the resubmission of $[redacted]/dose. The evaluation considered the total cost to the NIP is likely underestimated, due to the substantially underestimated eligible population for adults 60-74 YOA at increased risk of severe RSV disease in the resubmission, compared to the higher estimates accepted by ATAGI.

6.109 The ESC agreed with the commentary that the estimated utilisation in adults 60-74 YOA at increased risk of severe RSV disease was likely underestimated as it had been based on an estimate of obesity alone. As noted in the evaluation, the Clarke 2020 dataset was previously presented by the sponsor to ATAGI and accepted as suitable

for informing policy considerations. A revised analysis applying estimates from Clarke 2020 is provided in Table 26.

6.110 Regarding uptake rates, the ATAGI advice considered it was reasonable to assume that Year 1 uptake for RSVPreF3 OA would be half (i.e., [redacted]%) of expected uptake for influenza, and to assume increased uptake in the following years, that would reach no higher than [redacted]% of estimated influenza vaccine coverage. The ESC noted that vaccine uptake was based on ATAGI advice, but remained uncertain.

6.111 The resubmission requested a price of $[redacted] per dose for RSVPreF3 OA which was revised to $[redacted] in the PSCR, which was the price accepted by the PBAC in December 2025 for two populations (≥75 YOA and Aboriginal and Torres Strait Islander people 60-74 YOA).

6.112 As mentioned in paragraph 3.6, the pre-PBAC response proposed a revised population for NIP listing, applying an age threshold of 65 years (instead of 60) and excluding obesity as a standalone criterion for NIP eligibility. The pre-PBAC response suggested the budget impact associated with this population, based on the Clark 2020 estimates would be $100 million to < $200 million over 6 years, but would be reduced to $70 million to < $80 million over 6 years if it was assumed that only 35% of the population would be eligible, rather than the higher percentages suggested by the Clark study. These results were not verified. The PBAC did not support this population, see paragraph 7.7.

Quality Use of Medicines

6.113 The March 2026 resubmission described the following Quality Use of Medicine activities :

- Medical information responses to address enquiries to reduce prescribing and dispensing errors.
- RSV disease awareness campaigns.
- Multiple educational meetings enabling HCPs to identify older adults suitable for RSVPreF3 OA and counsel them appropriately.
- Disseminating independent clinical guidance (e.g. NCIRS, ATAGI, and TGA documents) on correct administration of RSV immunisation products and incorporation of relevant content.
- A routine, pro-active process for identifying safety signals.
- Ongoing clinical and post-marketing program for RSVPreF3 OA which is designed to provide additional data on immune persistence, revaccination and real-world effectiveness, ensuring continued confidence in the vaccine's value for older adults and those at increased risk for RSV disease.

For more detail on PBAC's view, see section 7 PBAC outcome.

7 PBAC Outcome

7.1 The PBAC recommended a change to the previously recommended National Immunisation Program (NIP) listing for respiratory syncytial virus vaccine (RSVPreF3 OA, Arexvy®). The submission requested NIP listing for adults aged 60-74 years with at least one condition associated with increased risk of severe RSV disease as described in the Australian Immunisation Handbook (AIH). Noting (i) the heterogeneity of the subgroups within the proposed population with respect to the extent of the increased risk of severe RSV, (ii) that it was likely that more than half of the population aged 60-74 years would meet the criteria for increased risk, and (iii) the potential for improved outcomes at the population level with a broader listing, the PBAC recommended expanding the eligible population to include all people aged 60-74 years. As the PBAC previously recommended RSVPreF3 OA for all adults aged 75 years and above, the revised NIP listing would allow a single dose of vaccine for all people aged 60 years and above. Consistent with its previous advice, the PBAC considered that the vaccine was superior to no vaccine in terms of effectiveness with an acceptable safety profile. The PBAC advised that revised inputs were required for the economic evaluation and that the ICER based on the PBAC's recommended inputs resulted in an ICER that was unacceptably high. On this basis, the PBAC considered that a price reduction would be required to demonstrate cost-effectiveness.

7.2 The PBAC acknowledged comments in the pre-PBAC response that suggested the sponsor may be unwilling to proceed with a recommendation for the eligible population to include all people aged 60-74 years, and its proposal to further restrict eligibility to people aged 65-74 years at increased risk of severe RSV. The PBAC did not consider there was a sound clinical basis to restrict the population at increased risk to those aged above 65 years, however accepted that the population with the highest clinical need was those with increased risk. The PBAC therefore recommended, in the event that a listing for all people aged 60-74 years was unable to be progressed, restricting the eligible population to those aged 60-74 years at increased risk of severe RSV disease as defined by ATAGI.

7.3 The PBAC recommended the listing of RSVPreF3 OA on the basis that it should be available through the NIP under the circumstances specified in Section 8 below, noting that two scenarios are presented: Listing Scenario 1 (PBAC preferred scenario), and Listing Scenario 2 (as requested by sponsor).

7.4 The resubmission also requested further consideration of the PBAC's July 2025 positive recommendation for RSVPreF3 OA and presented economic analyses that used more favourable inputs than were accepted by the PBAC in December 2025 for hospitalisation rates, duration of protection and hospitalisation costs. The PBAC advised that the resubmission did not adequately justify these revisions and therefore did not support any change to the economic evaluation accepted by the PBAC in December 2025.

7.5 The PBAC noted and welcomed the advice from the ATAGI that was provided to assist with its consideration of this resubmission. The PBAC noted that ATAGI advice supported NIP listing for people aged 60 to 74 years with increased risk of severe RSV disease due to pre-defined risk conditions. ATAGI also advises that non-Indigenous adults aged 60–74 years who do not have a medical risk factor for severe RSV disease may consider vaccination as there are benefits of vaccination in this age group, however the benefits may be less than for those aged ≥75 years, because of a comparatively lower risk of severe RSV disease.

7.6 The PBAC noted the proposed listing of RSVPreF3 OA vaccine was supported by the consumer comments received for this resubmission. It was noted that 15 different organisations submitted input for PBAC consideration, advocating for RSVPreF3 OA to be made available via the NIP, especially for patients with underlying medical conditions which have a higher clinical need for protection from severe RSV infection.

7.7 Regarding definition of the population for NIP listing, the resubmission requested expansion of the previous PBAC recommendation to include adults 60-74 YOA with medical conditions associated with increased risk of severe RSV disease, based on the definition of risk factors provided by the ATAGI. The AIH provides a list of example conditions indicating adults 'at increased risk of severe RSV disease', leaving some ambiguity about the patients that would meet eligibility requirements. The PBAC considered the proposed approach to listing based on AIH categories was reasonable, and that obesity should be retained as a criterion for NIP eligibility. The PBAC noted that ATAGI supported the threshold of BMI ≥30 mg/m^2 as a risk factor for severe RSV disease in adults 60-74 years, and clinical evidence supporting efficacy of RSVPreF3 OA for individuals with obesity was provided in the PSCR (paragraph 6.11). However, as mentioned above, the PBAC's preferred listing scenario would not be limited to specific medical conditions. The PBAC noted the suggestion in the pre-PBAC response to limit eligibility to those aged at least 65 years at increased risk of severe RSV disease, however the PBAC considered that there was not a strong clinical rationale to increase the age threshold to 65 years. Likewise, the PBAC considered that obesity should not be removed from the eligibility criteria.

7.8 The PBAC advised that 'no vaccine' is the appropriate comparator for the population of adults 60-74 YOA, including for the proposed population with medical conditions associated with increased risk of severe RSV disease.

7.9 Consistent with previous advice, the PBAC considered that the claim of superior comparative effectiveness was reasonable for the comparison with no vaccination, based on the randomised placebo-controlled trial AreSVi-006, albeit with uncertainty regarding the duration of benefit given that VE waned over time (paragraph 7.10, RSVPreF3 OA PSD, July 2025). The PBAC noted that the resubmission presented data from the AReSVi-006 trial corresponding to median follow-up of 30.6 months. The PBAC was satisfied that RSVPreF3 OA provides, for some patients, a significant improvement in efficacy over no vaccine based on the results of AReSVi-006.

7.10 The extent to which the results from the trial population, with comorbidities of interest, can be generalised to the proposed population at increased risk of severe RSV disease remains uncertain, especially for patients with immunocompromise given that adults with immunocompromising medical conditions, or who were receiving immunosuppressant or immunomodulatory medications, were excluded from AReSVi-006. The results of study RSV OA=ADJ-023 showed that RSV-A and RSV-B neutralising titres in the immunocompromised population didn't reach the same level observed in the healthy adult comparator population. However, the PBAC advised that the data did not justify exclusion of these patients from NIP access, in the context of the clinical need in this population.

7.11 The resubmission presented subgroup analyses of AReSVi-006 for participants with comorbidities, including two broad categories namely 'cardiopulmonary' and 'endocrinometabolic'. Additionally, the PSCR presented data for participants with obesity. The resubmission also presented subgroup analyses for individuals with ≥1 or ≥2 comorbidities of interest. The PBAC considered that the subgroup analyses indicated VE that was broadly consistent with that for the overall trial population. The PBAC noted that the subgroup analyses of AReSVi-006 revealed heterogeneity in the incidence of RSV-LRTD for the various subgroups. For example, based on the end of study analysis (with median follow-up of 30.6 months) the incidence of RSV-LRTD in the placebo arm was reported to be 6.0 events per 1,000 person years in participants with no pre-existing comorbidities of interest compared with 10.8 events per 1,000 person years in participants with ≥ 1 pre-existing comorbidity of interest. However the incidence of RSV-LRTD varied for different comorbidities, noting a higher rate of 15.8 per 1000 person years was reported for participants with ≥1 cardiorespiratory condition, and a lower rate of 7.7 per 1,000 person years was reported for participants with ≥1 pre-existing endocrinometabolic condition. The PBAC noted that the resubmission reported a wide range of estimates sourced from the literature, and this varied both within and across risk categories (Table 21). For example, the EHM ranges derived from studies assessing chronic respiratory conditions or cardiac disease were 1.63-7.80 and 1.45-9.03, respectively. The broadest EHM range was reported for immunocompromising conditions, which spanned 2.57 to 17.3. The reported EHM range for obesity was 0.61-3.23.

7.12 The resubmission presented updated immunogenicity results [redacted] that was considered by the PBAC in July 2025. The PBAC noted ATAGI's advice that clinical protection beyond 3 years remains uncertain due to lack of efficacy data or validated immunological correlate of protection.

7.13 The resubmission applied the estimate of VE from the overall population to the economic model. The PBAC considered the VE is uncertain for the population with comorbidities, however advised that it would be reasonable to accept VE over a period of three years based on three seasons of data for AreSVi-006 in the model. The PBAC considered that the duration of benefit remained uncertain, and noted that VE against first occurrence of RSV-LRTD was 81% for Season 1, 61% for Season 2, and 47% for

Season 3. For the Season 3 individual results, the PBAC noted that the lower bound of the 95% CI was below 20% for first occurrence of RSV-LRTD and severe RSV-LRTD. The PBAC noted that ATAGI's recommendations remain unchanged and that ATAGI is awaiting confirmatory efficacy or effectiveness data before being confident of protection beyond 3 years.

7.14 In regard to the economic evaluation provided in the resubmission, the PBAC advised it was reasonable to model VE over a period of three years as discussed in paragraph 7.13 rather than 4 or 5 years as had been proposed by the sponsor. The PBAC considered that key inputs should align with the accepted parameters for RSVpreF3 OA at the December 2025 PBAC meeting which related to the population aged 75 years or above, except for the necessary adjustments to reflect the target population. The corresponding amendments to the resubmission's model included 1) use AIHW data from 2016-2019 for the population aged 60-74 years to estimate hospitalisation rates, consistent with ATAGI advice; 2) reduction of hospital costs from $13,967 to $10,045; and 3) VE of 3 years. For the all-comers population the excess hospital multiplier (EHM) should be removed (i.e. set to 1). For the population aged 60-74 years at increased risk of severe RSV, the EHM should be no more than 1.79 (see below).

7.15 The PBAC noted that the resultant ICER for the all-comers (60-74 years) population was $55,000 to < $75,000 /QALY (PBAC scenario 1, Table 23), and recalled that it had previously considered that an ICER of less than $15,000 to < $25,000/QALY would be required to demonstrate cost-effectiveness for adults aged 75 years and above (paragraph 12.5, RSVPreF3 OA, December 2025 PBAC meeting). The PBAC noted that the increase in the ICER was driven by the reduced incidence of RSV hospitalisation in the younger population (average of 101 versus 384 per 100,000 person years). On this basis the PBAC considered the cost-effective price for RSVpreF3 OA in the younger population would be lower than for the older population. The PBAC advised that RSVpreF3 OA would be cost-effective in the population aged 60-74 years if the ICER was consistent with that for the 75 years and above population.

7.16 For the economic models for each of the eight AIH risk categories, the PBAC noted the EHMs applied in the resubmission varied substantially (from 1.84 for chronic metabolic disorders to 12.25 for immunocompromising conditions, derived from studies of transplant recipients). However, there were limited data to inform the EHM estimates, including the need to use proxy values for some of the categories. Additional concerns with the estimates included omission of comorbidities, lack of methodological transparency, simplistic approaches to combining estimates, and potential bias in the selection of the data. The PBAC considered that some of the EHMs applied in the resubmission were likely overestimated. The PBAC advised that the economic model results for the individual risk categories were not suitable for decision making due to the uncertainty in the applied EHMs. The PBAC noted however, that the analysis demonstrated that the proposed population consisted of heterogenous subgroups with a wide range in terms of their risk of severe RSV.

7.17 For the economic model for the proposed population with at least one at-risk medical condition, the PBAC considered that the EMH applied in the resubmission's base case (2.29) was overestimated. The EHM was sourced from Carlin et al., 2024, which derived its estimate from Belongia et al., 2018. The estimate was based on a narrower population than the AIH target population and inappropriately calculated using the 'not at-risk' population as the reference rather than the general population. This inflates the multiplier, as the model applies the EHM relative to the hospitalisation rates of the general population. Noting the proportion of the population with at least one at-risk medical condition was likely to exceed 50%, the PBAC considered an EHM of more than 2 to be implausible. The PBAC agreed with ATAGI that an EHM of 1.79 was not conservative (ATAGI Advice, March 2025) and advised that the EHM applied in the economic evaluation should be no higher than 1.79.

7.18 The PBAC noted that when using an EHM of 1.79 and not adjusting the background mortality rate, the ICER for the population aged 60-74 years at increased risk of severe RSV was $35,000 to < $45,000/QALY (PBAC scenario 2, Table 23). The PBAC recalled that it had previously considered that an ICER of less than $15,000 to < $25,000/QALY would be required to demonstrate cost-effectiveness for adults aged 75 years and above (paragraph 12.5, RSVPreF3 OA, December 2025 PBAC meeting). The PBAC noted the higher ICER for 60-74 year olds was due to the incidence of RSV hospitalisation in the younger increased risk population being lower than in the population aged 75 years and above (average of 181 versus 384 per 100,000 person years). On this basis the PBAC considered the cost-effective price for RSVpreF3 OA in the younger population at increased risk of severe RSV would be lower than for the all comers population aged 75 years above. The PBAC advised that RSVpreF3 OA would be cost-effective in the population aged 60-74 years at increased risk of severe RSV if the ICER was consistent with that for the above 75 years population.

7.19 On the basis that the cost-effective price for both listing scenarios would require a lower price than the recommended cost-effective price in December 2025 for the population aged at least 75 years and First Nations adults 60-74 years, the PBAC noted a weighted price based on estimated utilisation would be necessary.

7.20 The resubmission estimated that 40.22% of the population aged 60-74 years would meet the proposed eligibility criteria, however the PBAC considered that this proportion was underestimated, and the estimates based on the Clark 2020 study would be more reliable for estimating the population aged 60-74 years who would meet the AIH criteria for risk of severe RSV (49% in 60-64 YOA, 58% in 65-69 YOA, and 67% in 70-74 YOA). The PBAC noted that the assumed vaccine uptake was based on ATAGI advice, and was reasonable although it remained uncertain. The PBAC noted that analyses reflecting the PBAC's preferred listing scenario (all-comers) and the at risk population based on the Clark 2020 estimates are presented in Table 23.

7.21 The PBAC noted the need for revaccination has not been established and that the ATAGI will make recommendations for subsequent doses when this is sought by the sponsor. The PBAC noted that alternate revaccination schedules up to Month 60 after

initial vaccination are being assessed in ongoing clinical studies. The PBAC noted that if revaccination is requested in the future, this would impact cost-effectiveness and financial implications, and a new submission would be required.

7.22 The PBAC noted that this submission is not eligible for an Independent Review because it is only relevant to submissions requesting a listing (or change to a listing) on the PBS.

Outcome:
Recommended

8 Recommended listing

8.1 Amend existing/recommended listing in the Determination. The two listing scenarios described in Section 7 are provided below. New text is added in italics and deletions are crossed out with strikethrough.

Listing Scenario 1 (PBAC preferred scenario)

Vaccine and the circumstances in which vaccine may be provided	Brand	Formulation	Active ingredient and strength	Number and timing of doses
Vaccine respiratory syncytial virus (RSV) stabilised prefusion F protein vaccine ($AS01_E$ adjuvanted)	Arexvy	Injection (0.5mL)	Each 0.5mL dose contains 120 µg of RSVPreF3 antigen adjuvanted with $AS01_E$.	1 dose
Circumstances • A person who is at least *60* ~~75~~ years of age; • ~~A person who is an Aboriginal and/or Torres Strait Islander and aged 60 to 74 years.~~				

Listing Scenario 2 (as requested by sponsor)

Vaccine and the circumstances in which vaccine may be provided	Brand	Formulation	Active ingredient and strength	Number and timing of doses
Vaccine respiratory syncytial virus (RSV) stabilised prefusion F protein vaccine ($AS01_E$ adjuvanted)	Arexvy	Injection (0.5mL)	Each 0.5mL dose contains 120 µg of RSVPreF3 antigen adjuvanted with $AS01_E$.	1 dose
Circumstances • A person who is at least 75 years of age; • A person who is an Aboriginal and/or Torres Strait Islander and aged 60 to 74 years. • *A person who is aged between 60 and 74 years and is at increased risk of severe RSV disease (Defined as having at least one condition associated with increased risk of severe RSV disease in adults as defined in the Australian Immunisation Handbook)*				

This restriction may be subject to further review. Should there be any changes made to the restriction the sponsor will be informed.

9 Context for Decision

The PBAC helps decide whether and, if so, how medicines should be subsidised through the Pharmaceutical Benefits Scheme (PBS) in Australia. It considers

applications regarding the listing of medicines on the PBS and provides advice about other matters relating to the operation of the PBS in this context. A PBAC decision in relation to PBS listings does not necessarily represent a final PBAC view about the merits of the medicine or the circumstances in which it should be made available through the PBS. The PBAC welcomes applications containing new information at any time.

10 Sponsor's Comment

GSK welcomes PBAC's recommendation and we are committed to ensuring all vulnerable older Australians, including those that are at severe risk, are protected against lower respiratory tract illness caused by RSV.