11.03 TAFAMIDIS, Capsule 61 mg, Vyndamax®, PFIZER AUSTRALIA PTY LTD

1 Purpose of Submission

1.1 The Category 3 submission requested PBAC to consider revised financial estimates for tafamidis (Vyndamax®) for the treatment of transthyretin amyloid cardiomyopathy (ATTR-CM) and a corresponding increase to the subsidisation caps for the current Risk Sharing Arrangement (RSA) to account for higher utilisation than expected since tafamidis was first listed on the Pharmaceutical Benefits Scheme (PBS) on 1 May 2024.

1.2 The submission has proposed:

- Increased RSA subsidisation caps, effective from 1 May 2026 (Deed Year 3), intended to account for the higher utilisation of tafamidis.
- A [redacted]% price reduction (effective ex-manufacturer) to apply from 1 May 2026.
- A [redacted]% price reduction (published ex-manufacturer) to apply from 1 May 2026.

2 Background

2.1 Tafamidis is currently listed as an Authority Required listing for the treatment of ATTR-CM.

Previous PBAC considerations

2.2 Tafamidis has been previously considered for the treatment of ATTR-CM by the PBAC at its July 2020, March 2021, September 2021, July 2023 and September 2023 meetings.

2.3 At its July 2020, March 2021 and September 2021 meetings the PBAC did not recommend tafamidis, noting that the financial estimates were highly uncertain and highly likely to be underestimated.

July 2023 PBAC consideration

2.4 At its July 2023 meeting the PBAC recommended tafamidis for the treatment of ATTR-CM, with NYHA class I-II heart failure. The PBAC stated an RSA was required to mitigate the high risk of utilisation outside of the proposed restriction and to address the uncertainty around the overall financial impact (paragraph 7.1, Tafamidis, Public Summary Document (PSD), July 2023 PBAC meeting). Specifically, the PBAC reiterated that the RSA would manage the risk associated with use in a broader population and potential continuation in patients progressing to NYHA class III heart failure, in which

cost-effectiveness is unknown (paragraph 7.10, Tafamidis, PSD, July 2023 PBAC meeting).

2.5 The PBAC considered that tafamidis would be acceptably cost-effective based on an ICER of approximately $95,000 to < $115,000/QALY (paragraph 7.8 Tafamidis, PSD, July 2023 PBAC meeting). The PBAC considered this high ICER was acceptable within the context of a high unmet clinical need in a relatively small patient population, with RSA caps to mitigate the risk to Commonwealth of use in a broader population (paragraph 7.8, Tafamidis, PSD, July 2023 PBAC meeting).

2.6 The PBAC considered that there remained considerable uncertainty regarding the rate of diagnosis, uptake and continuation of tafamidis, noting that high level of awareness of tafamidis for clinicians and consumers, which was likely to drive rapid uptake if listed on the PBS (paragraph 7.9, Tafamidis, PSD, July 2023 PBAC meeting). The PBAC recommended an RSA to provide more certainty around the total Commonwealth expenditure for tafamidis and to manage the risk associated with use in a broader population and potential continuation in patients progressing to NYHA class III heart failure, in which cost-effectiveness is unknown (paragraph 7.10, Tafamidis, PSD, July 2023 PBAC meeting).

September 2023 PBAC consideration

2.7 At its September 2023 meeting, the PBAC provided advice to the Department regarding the sponsor's pricing proposal following the July 2023 PBAC recommendation. The sponsor proposed an effective price for Years 1 and 2 ($[redacted]) which resulted in a higher ICER, where treatment initiation occurs at time of listing, than that recommended in July 2023 ($95,000 to < $115,000/QALY vs $95,000 to < $115,000/QALY) (Tafamidis, Ratified Minutes, September 2023 PBAC meeting). For treatment initiation from Year 3, the effective price proposed for Year 3 onwards ($[redacted]), would achieve an ICER within the July 2023 recommended threshold ($95,000 to < $115,000/QALY) (Tafamidis, Ratified Minutes, September 2023 PBAC meeting).

2.8 The PBAC noted that the revised financial impact over 6 years, appeared similar to that using the price based on the July 2023 recommendation, and that the listing was to be subject to a Risk Sharing Arrangement with a [redacted]% reimbursement for use beyond the financial estimates. This provided confidence that a similar average patient cost across the six years would be achieved and that the overall budget impact would be managed (Tafamidis, Ratified Minutes, September 2023 PBAC meeting).

2.9 In September 2023, the PBAC advised that the proposal was acceptable, in the context of the high clinical need for the treatment, where the Department and sponsor could ensure these arrangements be implemented appropriately (Tafamidis, Ratified Minutes, September 2023 PBAC meeting).

3 Current Situation

3.1

3.2

3.3 Table 1 outlines the current subsidisation caps for tafamidis and Commonwealth payment over the term of the RSA. A [redacted]% rebate applies for use exceeding the caps.

Table 1: Current RSA caps and Commonwealth expenditure since listing

	Y1 (May 2024- Apr 2025)	Y2 (May 2025-Apr 2026)	Y3 (May 2026-Apr 2027)	Y4 (May 2027-Apr 2028)	Y5 (May 2028-Apr 2029)	Y6 (May 2029-Apr 2030)
Current caps[1]	$[redacted]	$[redacted][3]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Commonwealth payment	$[redacted][2]	$[redacted][3]	NA	NA	NA	NA
Percentage of RSA cap reached	[redacted]%	[redacted]%[3]	NA	NA	NA	NA

[1] Based off the revised financial estimates which were redistributed over a 6-year period
[2] Current estimate
[3] Projection based on 4 months available data (May – August 2025)

3.4 The RSA cap for tafamidis was breached in Year 1 and expected to be exceeded in Year 2. The submission claimed that this is due to increased prevalence and diagnosis of ATTR-CM in Australia. The submission stated that the utilisation was expected to continue to significantly exceed the estimates for all remaining years of the Deed.

3.5 The submission proposed to increase the RSA caps to account for the unexpectedly high utilisation. Table 2 outlines the proposed subsidisation caps for the remainder of the Deed period (Deed Year 3 onwards).

Table 2: Summary of the proposed subsidisation caps

	Y3 (May 2026-Apr 2027)	Y4 (May 2027-Apr 2028)	Y5 (May 2028-Apr 2029)	Y6 (May 2029-Apr 2030)
Current RSA caps	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Sponsor proposed caps (with revised effective price)	$[redacted]	$[redacted]	$[redacted]	$[redacted]

Source: Extract of Table 2 (row titled: Pfizer redistribution of annual expenditure - agreed RSA subsidisation caps), page 16 of the submission and Table 9, page 23 of the submission

3.6 The submission has proposed a reduction to the effective (and published) ex-manufacturer prices to apply from 1 May 2026. The proposed price has been factored into the RSA cap proposal outlined in Table 2.

3.7 The proposed RSA caps from Year 3 of the Deed reflect an increase of $[redacted] over the 4-year period. At Year 6, the proposed RSA cap is approximately [redacted] times higher than that in the current Deed.

4 Consideration of the evidence

Pricing considerations

4.1 The submission proposed a lower effective ex-manufacturer price of $[redacted] to apply from 1 May 2026.

4.2 Based on the sponsor's pricing proposal considered in September 2023, the effective ex-manufacturer price of tafamidis is to be reduced to $[redacted] from 1 May 2026. The sponsor's proposal of $[redacted] represents a further [redacted]% reduction on the effective ex-manufacturer price for tafamidis.

4.3 Table 3 shows the difference between the estimated Commonwealth expenditure at the current effective ex-manufacturer price and proposed effective ex-manufacturer price based on the submission's revised estimates.

Table 3: Commonwealth payment with 1 May 2026 effective price vs proposed effective price

	Y3 (May 2026-Apr 2027)	Y4 (May 2027-Apr 2028)	Y5 (May 2028-Apr 2029)	Y6 (May 2029-Apr 2030)	Total over 4 years
Commonwealth Payment with effective price which will be applied from 1 May 2026	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Commonwealth Payment with revised effective price	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Difference	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]

Source: Submission Table 13, page 24

4.4 After factoring in the proposed price reduction, the increase to the RSA caps is still expected to significantly increase the Commonwealth expenditure for tafamidis each year compared to the previously agreed financial estimates (refer to Table 2).

4.5 In the pre-PBAC response the sponsor stated that the existing [redacted]% rebate for expenditure above the caps meant that the risk was not balanced. The pre-PBAC response proposed a [redacted]% rebate above the subsidisation caps and considered that the rebate should not exceed [redacted]%.

4.6 In the pre-PBAC response the sponsor stated that the lower proposed effective ex-manufacturer price resulted in an ICER of $55,000 to < $75,000per QALY gained.

4.7 While not a matter for PBAC, the submission also proposed a reduction in the published ex-manufacturer price from $[redacted] to $[redacted].

Estimated PBS usage and financial implications

4.8 The submission used PBS utilisation data for the period May 2024 to August 2025 (provided by the Department), and the findings from a meta-analysis of the estimated ATTR-CM prevalence in patients with HFpEF to estimate the future use of tafamidis.

4.9 Table 4 provides PBS utilisation data (patient numbers) for tafamidis, for the period May 2024 to December 2025.

Table 4: PBS utilisation data for tafamidis - patient numbers

	Year 1 (May 2024- Apr 2025)	*Year 2 (May 2025-Dec 2025)*
Patient counts by list year	[redacted][1]	[redacted]*[1]
Total number of patients	[redacted][1]	

*The initiating patient count for the period May 2025 to December 2025 was [redacted].Source: DUSC Secretariat data sourced from Services Australia and provided to the Department on 27 January 2026. Data is for the period May 2024 to December 2025, inclusive.
The redacted values correspond to the following ranges:
[1] 500 to < 5,000

4.10 In the first year of listing (1 May 2024 to 30 April 2025) there was a higher number of patients treated with tafamidis than expected (500 to < 5,000treated compared to the estimated 500 to < 5,000 patients). The submission stated that a proportion of this increase in Year 1 is due to patients moving from their patient access program, but also that there is a much higher prevalence of ATTR-CM than proposed in the July 2023 PBAC submission.

4.11 The submission states that greater patient numbers than originally assumed in the July 2023 submission are anticipated for the remaining years of the Deed.

4.12 As of December 2025, there were 500 to < 5,000unique patients that had used tafamidis (refer to

4.13 Table 4). For Year 2 at time of analysis (i.e. from 1 May 2025 up to 31 Dec 2025) there were 500 to < 5,000 patients in total, 500 to < 5,000 of these were initiating patients. The submission's estimated number of tafamidis-treated patients (all patients treated in a year) in Year 2 was 500 to < 5,000 (see Table 5).

4.14 Table 5 shows the sponsor's estimate of the number of patients eligible for treatment with tafamidis from 1 May 2026 to 1 April 2030. The percentage of patients treated with tafamidis in years 2 to 6 was extrapolated from the actual patient number in year 1, which was 500 to < 5,000(representing [redacted]% of patients with NYHA class I and II).

Table 5: November 2025 submission estimated ATTR-CM prevalence and tafamidis utilisation estimates

	1 May 24 - 30 Apr 25	1 May 25 - 30 Apr 26	1 May 26 - 30 Apr 27	1 May 27 - 30 Apr 28	1 May 28 - 30 Apr 29	1 May 29 - 30 Apr 30
Patients with ATTR-CM	[redacted][3]	[redacted][3]	[redacted][3]	[redacted][3]	[redacted][3]	[redacted][3]
% patients with NYHA class I and II HFpEF	[redacted]%	[redacted]%	[redacted]%	[redacted]%	[redacted]%	[redacted]%
Number of patients with NYHA class I and II HFpEF	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][3]	[redacted][3]
Percentage of tafamidis-treated patients	[redacted]%	[redacted]%	[redacted]%	[redacted]%	[redacted]%	[redacted]%
Number of tafamidis-treated patients (all patients treated in year)	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]

Source: Extract of submission Table 5 (Nov25 PBAC Submission), page 21

The redacted values correspond to the following ranges:

[1] *500 to < 5,000*

[2] *5,000 to < 10,000*

[3] *10,000 to < 20,000*

4.15 The submission estimated that a total of 10,000 to < 20,000patients would be supplied tafamidis over the first six years of listing (500 to < 5,000 in Year 1 to 500 to < 5,000 in Year 6).

4.16 The higher utilisation of tafamidis presented in the submission was informed by the estimated prevalence of ATTR-CM provided by a sponsor conducted meta-analysis of epidemiological studies in patients with heart failure with preserved ejection fraction (HFpEF). The meta-analysis provided suggested a [redacted]% prevalence of ATTR-CM in HFpEF, with an increasing trend over time. The submission stated that this estimated prevalence is higher than the previous estimates, which ranged from [redacted]% to [redacted]% depending on age and sex, and that increased prevalence is due to both increased awareness of ATTR-CM among cardiologists and development of non-invasive diagnostic techniques. The submission stated that while none of the studies included Australian patients, the disease characteristics of the patients are generalisable to the Australian population.

4.17 The sponsor conducted meta-analysis included 7 studies. The years over which the studies were conducted ranged from 2014 to 2023. The included studies varied in patient setting (outpatient verses inpatient setting) and study design. The starting age

of patients across studies ranged from ≥50 years to 84-85 years. Three of the 7 studies included patients with a moderately reduced left ventricular ejection fraction (LVEF ≥40%) or HFmrEF. The remaining studies only included patients with HFpEF with LVEF ≥50%. The eligibility criteria for left ventricular wall thickness (LVWT) varied between the included studies. The sample sizes of the studies comprising the meta-analysis varied (lowest was 59 and highest 422). A total of 1692 patients (pooled across all studies) were included in the meta-analysis. The I^2 value specified in the meta-analysis was 67% (CI 28%-85%) indicating moderate heterogeneity. Pooling of the studies may therefore not be appropriate. No independent attempt to reproduce these results or to perform an independent meta-analysis has been undertaken.

4.18 The submission states that the usage pattern is expected to be different compared to utilisation in the July 2023 PBAC submission. The July 2023 submission assumed that usage would increase from 2025 to 2027 and decrease from 2028 to 2029. The revised estimates have now assumed that the number of patients treated with tafamidis will continue to grow from 2026 to 2029. The submission stated that the pattern of usage considered in July 2023 was due to an assumption that there was a pool of prevalent patients awaiting treatment that would be treated in the early years and that new incident patients would not replace this prevalent pool. Additionally, it was assumed discontinuation and mortality rates would be relatively high. Utilisation of tafamidis in other countries, including those where the product has already been available for several years, has shown that this is not the case.

4.19 The submission stated that the expected growth is due to the heightened awareness and understanding of ATTR-CM amongst cardiologists, increasing recognition of the clinical red flags for the condition and availability of advanced, non-invasive diagnostic tools to enable accurate and more accessible diagnoses. Table 6 compares the prevalence estimates compared to the July 2023 PBAC submission.

Table 6: Comparison of ATTR-CM prevalence estimates from July 2023 PBAC submission and November 2025 submission

	1 May 24 - 30 Apr 25	1 May 25 - 30 Apr 26	1 May 26 - 30 Apr 27	1 May 27 - 30 Apr 28	1 May 28 - 30 Apr 29	1 May 29 - 30 Apr 30
ATTR-CM prevalence estimate – Jul 23 PBAC	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][2]	[redacted][2]	[redacted][2]
ATTR-CM prevalence estimate – Nov 25 submission	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]

Source: Submission Table 4, page 19

The redacted values correspond to the following ranges:

[1] *500 to < 5,000*

[2] *5,000 to < 10,000*

4.20 The submission provided an updated financial model for the 6-year period from May 2024 to April 2030, which incorporated the revised utilisation estimates.

4.21 The revised utilisation and net financial implications are summarised in Table 7. The financial impact to Services Australia will be determined by that agency as part of the post PBAC process.

Table 7: Sponsor estimated use and financial implications

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Estimated extent of use						
Number of patients treated	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]
Number of scripts dispensed[1]	[redacted][2]	[redacted][3]	[redacted][3]	[redacted][4]	[redacted][5]	[redacted][5]
Net financial implications						
Net cost to PBS/RPBS[2]	$[redacted][6]	$[redacted][7]	$[redacted][7]	$[redacted][8]	$[redacted][9]	$[redacted][10]

[1] Assuming 10.06 scripts per patient per year as estimated by the submission.
[2] There are no costs associated with the changed listing, so the proposed impact is the same as the net impact
Abbreviations: MBS = Medical Benefits Scheme; PBS = Pharmaceutical Benefits Scheme; RPBS = Repatriation Pharmaceutical Benefits Scheme.
Source: Appendix 7 - Section 4 UCM workbook (Sheet 2b and Sheet 5)
The redacted values correspond to the following ranges:
[1] 500 to < 5,000
[2] 10,000 to < 20,000
[3] 20,000 to < 30,000
[4] 30,000 to < 40,000
[5] 40,000 to < 50,000
[6] $30 million to < $40 million
[7] $60 million to < $70 million
[8] $70 million to < $80 million
[9] $80 million to < $90 million
[10] $100 million to < $200 million

4.22 The submission stated that the estimated net financial impact to the PBS/RPBS for the listing of tafamidis is $300 million to < $400 million over the remaining four years (Year 3 $60 million to < $70 million to Year 6 $100 million to < $200 million). As the proposed amendents to the RSA caps affect only from Year 3 onwards, this compares to the agreed caps under the current RSA of $100 million to < $200 million over the remaining four years (Year 3 $30 million to < $40 million to Year 6 $20 million to < $30 million).

Sponsor hearing

4.23 There was no hearing for this item.

Consumer inputs

4.24 The PBAC noted and welcomed the input from health care professionals (6) and organisations (3) via the Office of Health Technology Assessment Consultation Hub. The inputs described a range of benefits of treatment with tafamidis including the ability of patients to maintain physical function, experience fewer symptoms and remain more independent. The health care professionals acknowledged that tafamidis is the only disease-modifying therapy for ATTR-CM and noted that there is high adherence to treatment. One health care professional stated that the prevalence of ATTR-CM is underestimated. Input expressed concern about current PBS eligibility criteria being too strict and may unfairly exclude certain groups.

4.25 Input received from Cardiomyopathy Australia New Zealand (CMANZ), stated that the uncertainty of the prevalence of ATTR-CM in clinical practice reflect that historical challenges of recognising and diagnosing the condition. Input from CMANZ presented

anecdotal evidence of patients who were treated with heart failure or diagnosed with cardiomyopathy for several years which are only now being tested for cardiac amyloid. The CMANZ noted the importance of ongoing access to tafamidis, especially with improved diagnostic pathways and disease understanding.

4.26 Input received from Hearts4heart described the life-changing benefits that tafamidis has had for people living with ATTR-CM and their families. Hearts4heart noted the importance of continued public subsidy of tafamidis, due to the high cost of the treatment. The input referenced a cardiologist who treats 45 patients with tafamidis, who stated that the higher-than-expected use of tafamidis reflects improved awareness and diagnosis of ATTR-CM rather than overuse. The cardiologist identified that both increased awareness among clinicians and the non-invasive nuclear scintigraphy (bone scan) diagnosis has enabled earlier diagnosis and appropriate treatment for more patients.

4.27 Input received from the Australian Amyloidosis Network re-affirmed support for equitable access to effective ATTR-CM treatments.

5 PBAC Outcome

5.1 The PBAC did not recommend amending the financial estimates and the RSA expenditure caps for tafamidis for the treatment of ATTR-CM. The PBAC agreed that the current RSA very likely underestimates the eligible population of patients with ATTR-CM and that revision to the subsidisation caps may be appropriate, although not to the magnitude the submission proposed.

5.2 The PBAC noted that the prevalence of [redacted]% estimated using a meta-analysis, and used to inform the utilisation of tafamidis, was significantly higher than the previous prevalence estimates (which ranged from [redacted]% to [redacted]% depending on age and sex). The PBAC noted that the higher prevalence estimate was due to increased awareness of ATTR-CM among cardiologists and increased utilisation of non-invasive diagnostic techniques.

5.3 The PBAC noted and welcomed input from consumers describing the benefits of treatment with tafamidis and supporting equitable access. The PBAC notes some input stated that the prevalence of ATTR-CM is underestimated.

5.4 The PBAC noted the financial estimates presented, based on the higher prevalence estimate, showed an increasing trend in patient numbers across all years, and that this differed from the utilisation estimates accepted in September 2023, where the patient numbers declined in years 5 and 6. The PBAC noted that in previous utilisation estimates, it was assumed there would be a reduction in the prevalent eligible population and that discontinuation and mortality rates would be relatively high.

5.5 The PBAC advised that given the magnitude of the difference in the prevalence and financial estimates compared to previous considerations and the uncertainty in the patient population outlined in paragraph 5.8 below, further evaluation is required.

5.6 The PBAC recalled from its July 2020 and July 2023 considerations of tafamidis that it had considered that there was considerable uncertainty in the financial estimates (paragraph 7.1 paragraph 7.8 Tafamidis public summary document, July 2020 and July 2023 PBAC meetings respectively). The PBAC further recalled the RSA was established to mitigate the uncertainty in the financial estimates. The PBAC recalled an ICER of $95,000 to < $115,000 per QALY gained was accepted in September 2023, in the context of a smaller patient population and the proposed total budget impact.

5.7 The PBAC noted that the ICER accepted in the September 2023 submission was based on a population derived from the ATTR-ACT study, which required diagnosis of ATTR by tissue biopsy and further supplemented by evidence of cardiac involvement (by echocardiography) and with a history of heart failure and elevated naturetic peptides. The PBAC also noted that the ATTR-ACT Study was performed before widespread adoption of SGLT2 inhibitors in HFpEF and that the benefit of tafamidis on top of these agents was uncertain. These potential issues raised concern by the PBAC that the population presented in the updated prevalence figures may not reflect the population that had been considered previously and that the clinical outcomes may be lower in a broader HFpEF population that was also treated with SGLT2 inhibitors. The PBAC noted the pre-PBAC response which stated that the lower proposed effective ex-manufacturer price results in an ICER of $55,000 to < $75,000 per QALY gained. However, the PBAC advised that the model needed to be reviewed to confirm the effect on the ICER. The PBAC advised that the ICER must be lower to maintain cost-effectiveness, as the model assumes the magnitude of benefit is the same as that in the original population.

5.8 The PBAC advised that a resubmission was required and should include the following:

- Evidence supporting equivalence between diagnosis of ATTR-CM as used in the ATTR-ACT Study and the current diagnostic requirements, in terms of whether the natural course of the disease and patient outcomes is the same.
- Any evidence to support that the magnitude of benefit for all patients diagnosed with ATTR-CM (regardless of the method of diagnosis) and treated with tafamidis is the same.
- A formal literature review to ensure that all relevant studies assessing the prevalence of ATTR-CM in HFpEF have been identified and reviewed. The literature review should also seek to identify any studies on concomitant usage of tafamidis and SGLT2 inhibitors in this population.
- Revised cost-effectiveness model for tafamidis taking into account the above.

5.9 The PBAC noted that this submission was not eligible for an Independent Review. Independent Review is only available to submissions seeking a change to the listing criteria (such as a request for a new indication, an objectively different subtype of disease or a new treatment population).

Outcome:

Not recommended

6 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.

7 Sponsor's Comment

The sponsor had no comment.