5.10 TECLISTAMAB, Solution for subcutaneous injection, 30 mg in 3 mL, Solution for subcutaneous injection, 153 mg in 1.7 mL, Tecvayli®, Janssen Cilag Pty Ltd

1 Purpose of submission

1.1 The Category 2 submission requested an Authority Required listing for teclistamab for the treatment of adult patients with relapsed or refractory multiple myeloma (RRMM) who have received at least 3 prior lines of therapy, including a proteasome inhibitor (PI), an immunomodulatory agent (IMiD) and an anti-CD38 monoclonal antibody.

1.2 Listing was requested on the basis of a cost-minimisation approach (CMA) versus elranatamab. The key components of the clinical issues addressed by this submission are outlined in Table 1.

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

Component	Description
Population	Patients with RRMM who have received at least 3 prior lines of therapy, including a PI, an immunomodulatory agent, and an anti-CD38 monoclonal antibody. Patients must not have previously received treatment with another BCMA directed therapy for this condition.
Intervention	Teclistamab is administered by subcutaneous injection, with step-up doses of 0.06 mg/kg and 0.3 mg/kg followed by 1.5 mg/kg once weekly. Patients who have a CR or better for a minimum of 6 months are eligible for a reduced dosing frequency of 1.5 mg/kg every two weeks until disease progression or unacceptable toxicity.
Comparator	Elranatamab administered by subcutaneous injection, with step-up doses of 12 mg on Day 1 and 32 mg on Day 4, followed by the full treatment dose of 76 mg once a week from Week 2 to Week 24. Patients who have achieved and maintained a response are recommended to transition to 76 mg every two weeks from Week 24 with a further dose frequency reduction to 76 mg every 4 weeks if maintaining a response after at least 24 weeks of treatment with 76 mg every 2 weeks. Treatment with elranatamab should be continued until disease progression or unacceptable toxicity.
Outcomes	PFS, OS, ORR, CRR, MRD negativity, depth of response, duration of response, time to response, time to subsequent therapy, adverse events, and health-related quality of life.
Clinical claim	Teclistamab is non-inferior in terms of efficacy compared to elranatamab. Teclistamab has a similar safety profile compared with elranatamab.

Source: Table 1.1, p17 of the submission.
Abbreviations: BCMA = b-cell maturation antigen; CR = complete response; CRR = complete response rate; MRD = minimal residual disease; ORR = overall response rate; OS = overall survival; PFS = progression-free survival; PI = proteasome inhibitor; RRMM = relapsed or refractory multiple myeloma.

2 Background

Registration status

2.1 Teclistamab was provisionally approved by the Therapeutic Goods Administration (TGA) in June 2023 for the treatment of adult patients with relapsed or refractory multiple myeloma (RRMM) who have received at least 3 prior therapies, including a proteasome inhibitor (PI), an immunomodulatory agent (IMiD) and an anti-CD38

monoclonal antibody on the basis of the overall response rate in the MajesTEC-1 single arm study.

2.2 Elranatamab has provisional TGA approval for the same indication.

Previous PBAC consideration

2.3 In March 2025, the PBAC recommended elranatamab for PBS listing for the same patient population as that proposed in the submission.[1] According to the Medicines Status Website, at the time of PBAC consideration, the sponsor for elranatamab had agreed to listing arrangements and Government processes had commenced.

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

3 Requested listing

3.1 The requested restriction is presented below. Secretariat suggested additions are in italics and deletions in strikethrough.

Initial/induction doses:

MEDICINAL PRODUCT **medicinal product pack**	**PBS item code**	**Max. qty packs**	**Max. qty units**	**№.of Rpts**	**Available brands**
TECLISTAMAB					
Teclistamab~~, subcutaneous vial,~~ 30 mg*/3 mL injection, vial*	NEW (CT)	~~2~~ *1*	~~2~~ *1*	1	Tecvayli
Teclistamab~~, subcutaneous vial,~~ 30 mg*/3 mL injection, vial*	NEW (GE)	~~2~~ *1*	~~2~~ *1*	1	Tecvayli
Category / Program: ☒ GENERAL – General Schedule (Code GE) ☒ Section 100 – Efficient Funding of Chemotherapy – Related Benefits (Code CT)					
Prescriber type: ☒Medical Practitioners					
Restriction type: ☒Authority Required (Telephone/Online)					
Authority type: ☒ Non-complex Authority Required (non-CAR)					
Restrictions Summary [New1] / Treatment of Concept [New 1A]					
Episodicity: [Blank]					
Severity: Relapsed or refractory					
Condition: Multiple myeloma					
Indication: Relapsed or refractory multiple myeloma					
Treatment Phase: Induction treatment (step-up dosing)					
Clinical criteria:					
The condition must be confirmed by a histological diagnosis					
AND					
Clinical criteria:					
Patient must have had progressive disease after receiving at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, and (iii) an anti-CD38 monoclonal antibody; or					
Patient must have been refractory to, at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, (iii) an anti-CD38 monoclonal antibody					
AND					
Clinical criteria:					
Patient must have a WHO performance status of 2 or less					

[1] Pharmaceutical Benefits Scheme (PBS) | Elranatamab; Solution for subcutaneous injection 44 mg in 1.1 mL (40 mg per mL), Solution for subcutaneous injection 76 mg in 1.9 mL (40 mg per mL); Elrexfio®

AND
Clinical criteria:
Patient must not have previously received treatment with another B-cell maturation antigen (BCMA) directed therapy for this condition
AND
Clinical criteria:
The treatment must be the sole PBS-subsidised systemic anti-cancer therapy for this condition
Prescribing instruction: According to the TGA-approved Product Information, patients should be instructed to remain within proximity of a healthcare facility for 48 hours after all doses within the induction treatment phase.
Prescribing instruction: Patients who require restarting therapy due to dose delays may access step-up dosing through this induction treatment restriction.
Prescribing instruction: *This drug is not PBS-subsidised if it is administered to an in-patient in a public hospital setting.*
Prescriber Instructions: *Progressive disease is defined as at least 1 of the following:* *(a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or* *(b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or* *(c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase in the difference between involved free light chain and uninvolved free light chain; or* *(d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or* *(e) an increase in the size or number of lytic bone lesions (not including compression fractures); or* *(f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or* *(g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).* *Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein. Details of: the histological diagnosis of multiple myeloma; prior treatments including name(s) of drug(s) and date of most recent treatment cycle; the basis of the diagnosis of progressive disease or failure to respond; and which disease activity parameters will be used to assess response, must be documented in the patient's medical records.* *Confirmation of eligibility for treatment with current diagnostic reports of at least one of the following must be documented in the patient's medical records:* *(a) the level of serum monoclonal protein; or* *(b) Bence-Jones proteinuria - the results of 24-hour urinary light chain M protein excretion; or* *(c) the serum level of free kappa and lambda light chains; or* *(d) bone marrow aspirate or trephine; or* *(e) if present, the size and location of lytic bone lesions (not including compression fractures); or* *(f) if present, the size and location of all soft tissue plasmacytomas by clinical or radiographic examination i.e. MRI or CT-scan; or* *(g) if present, the level of hypercalcaemia, corrected for albumin concentration.* *As these parameters must be used to determine response, results for either (a) or (b) or (c) should be documented for all patients. Where the patient has oligo-secretory or non-secretory multiple myeloma, either (c) or (d) or if relevant (e), (f) or (g) must be documented in the patient's medical records. Where the prescriber plans to assess response in patients with oligo-secretory or non-secretory multiple myeloma with free light chain assays, evidence of the oligo-secretory or non-secretory nature of the multiple myeloma (current serum M protein less than 10 g per L) must be documented in the patient's medical records.* *Refractory disease is defined as less than or equal to a 25% response to therapy, or progression during or within 60 days after completion of therapy*
Administrative advice: *No increase in the maximum number of repeats may be authorised*
Administrative advice: Special pricing arrangements apply
Administrative Advice: *Applications for authorisation under this restriction may be made in real time using the Online PBS Authorities system (see www.servicesaustralia.gov.au/HPOS) or by telephone by contacting Services Australia on 1800 888 333.*

Continuing treatment:

MEDICINAL PRODUCT medicinal product pack	PBS item code	Max. qty packs	Max. qty units	№.of Rpts	Available brands
ELRANATAMAB					
Teclistamab~~, subcutaneous vial,~~ 153 mg*/1.7 mL injection, vial*	NEW (CT)	2	2	5	Tecvayli
Teclistamab~~, subcutaneous vial,~~ 153 mg*/1.7 mL injection, vial*	NEW (GE)	2	2	5	Tecvayli

Category / Program: ☒ GENERAL – General Schedule (Code GE) ☒ Section 100 – Efficient Funding of Chemotherapy – Related Benefits (Code CT)
Prescriber type: ☒Medical Practitioners
Restriction type: ☒Authority Required (Telephone/Online) – Immediate Assessment
Authority type: ☒ Non-complex Authority Required (non-CAR)
Episodicity: [Blank]
Severity: Relapsed or refractory
Condition: Multiple myeloma
Indication: Relapsed or refractory multiple myeloma
Treatment Phase: Continuing treatment
Clinical criteria:
Patient must have previously received treatment with this drug for this condition
AND
Clinical criteria:
Patient must have had progressive disease after receiving at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, and (iii) an anti-CD38 monoclonal antibody; or
Patient must have been refractory to, at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, (iii) an anti-CD38 monoclonal antibody
AND
Clinical criteria:
Patient must not have previously received treatment with another B-cell maturation antigen (BCMA) directed therapy for this condition
AND
Clinical criteria:
Patient must have a WHO performance status of 2 or less prior to initiating treatment with this drug for this condition
AND
Clinical criteria:
Patient must not have developed disease progression while receiving treatment with this drug for this condition
AND
Clinical criteria:
The treatment must be the sole PBS-subsidised systemic anti-cancer therapy for this condition
Prescribing Instructions: According to the TGA-approved Product Information, patients should be instructed to remain within proximity of a healthcare facility for 48 hours after the first full treatment dose in the continuing treatment phase.
Prescribing Instructions: Prescribers may request the number of vials in line with the dosing requirement for each stage of treatment with the intention of providing the number of vials for each 4-weeks of treatment (24-weeks of treatment including repeats). Up to a maximum of 8 vials for each 4-weeks of treatment, with 5 repeats, may be requested for a patient undergoing treatment.

Prescribing Instructions: *Progressive disease is defined as at least 1 of the following:* *(a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or* *(b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or* *(c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase in the difference between involved free light chain and uninvolved free light chain; or* *(d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or* *(e) an increase in the size or number of lytic bone lesions (not including compression fractures); or* *(f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or* *(g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).*
Prescribing instruction: *This drug is not PBS-subsidised if it is administered to an in-patient in a public hospital setting.*
Administrative advice: *No increase in the maximum number of repeats may be authorised*
Administrative advice: Special pricing arrangements apply
Administrative Advice: *Applications for authorisation under this restriction may be made in real time using the Online PBS Authorities system (see www.servicesaustralia.gov.au/HPOS) or by telephone by contacting Services Australia on 1800 888 333.*

3.2 The submission requested a dual Section 85 and Section 100 Efficient Funding of Chemotherapy (EFC) – Related Benefits listing for teclistamab. This was consistent with the recommended listing for elranatamab (paragraph 7.6, elranatamab public summary document [PSD], March 2025 PBAC meeting).

3.3 The submission requested a special pricing arrangement (SPA). It was proposed that teclistamab be listed at an effective approved ex-manufacturer price (AEMP) per vial that reflects the agreed equi-effective doses for teclistamab and elranatamab for the treatment of RRMM (i.e., teclistamab reimbursed at the cost-minimised price to elranatamab).

3.4 The submission proposed restricting teclistamab to patients with a WHO performance status ≤ 2. While this mirrors the recommended restriction for elranatamab, this criterion does not reflect the inclusion criteria for patients in the teclistamab study MajesTEC-1, which enrolled patients with an WHO ECOG Performance Status of 0–1. The ESC considered that the proposed restriction criterion was reasonable.

3.5 Due to the risk of cytokine release syndrome (CRS), the proposed restriction stated that initiation of teclistamab required patients to remain in proximity to a healthcare facility during the step-up dosing schedule. This restriction is consistent with the approved TGA Product Information, but does not align with the key evidence, the MajesTEC-1 study, in which all patients were hospitalised for safety monitoring for at least 48 hours after each step-up dose and the first treatment dose.

3.6 The submission proposed a grandfathering restriction; however, the Secretariat noted it was not necessary as the proposed restriction criteria allows for patients to transition to PBS-funded teclistamab.

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

4 Population and disease

4.1 Multiple myeloma (MM) is a plasma cell malignancy characterised by the abnormal growth of clonal B-cells in the bone marrow leading to bone destruction and bone marrow failure. Patients experience hypercalcaemia, renal impairment, anaemia, pain, bone fractures, and are susceptible to infections. According to the Australian Institute of Health and Welfare (AIHW), an estimated 2,755 new cases of MM were diagnosed in Australia in 2025. The median age of a patient with MM in Australia is 68 years and the 5-year survival is 57%.

4.2 As noted above, the requested listing is for patients who have been treated with a PI, an IMiD, and an anti-CD38 monoclonal antibody, i.e. triple class exposed (TCE). In MajesTEC-1, the pivotal study presented in the submission, all patients were TCE, and 68.1% had received 5 prior lines of therapy.

4.3 The proposed clinical algorithm placed elranatamab and teclistamab as the only alternative therapies in the 4L+ line. However, there are other therapies that are PBS listed for treatment of RRMM in 4L+ (i.e., carfilzomib + dexamethasone (Cd), pomalidomide + dexamethasone (Pd) and selinexor + dexamethasone (Sd)). These therapies were not included in the proposed clinical management algorithm. Further, as noted at the clinician and consumer Multiple Myeloma Stakeholder meeting (July 2025) the current treatment algorithm does not accommodate flexibility as the categorisation of medicines by line of therapy reduces clinical discretion and may delay access to optimal regimens. At the Stakeholder meeting clinicians agreed that treatment sequencing could be improved if determined by prior drug exposure, rather than lines of therapy.[2]

4.4 Teclistamab and elranatamab have a similar mechanism of action, as both are bispecific T-cell engager antibodies engaging B-cell maturation antigen (BCMA), thereby redirecting T-cell–mediated cytotoxicity against malignant cells. Both treatments are included in the NCCN guidelines[3] as preferred treatment options for patients with RRMM following 3 prior lines of therapy and at least 4 prior therapies.

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

5 Comparator

5.1 The submission nominated elranatamab as the main comparator. The main arguments provided in support of this nomination were:

- Elranatamab was recommended in March 2025 by the PBAC for the same population as targeted in the submission.
- Once PBS listed, BCMA targeting bi-specific therapies such as elranatamab are expected to be the standard of care in 4L+ MM given their superior benefits in PFS and OS over currently available therapies in this setting (i.e. Cd, Pd and Sd).

[2] Multiple-Myeloma-Meeting-Outcome-Statement.pdf
[3] NCCN Guidelines Version 5.2026, November 26, 2025. Multiple Myeloma.

5.2 Elranatamab was recommended by the PBAC at the March 2025 meeting based on a cost-effectiveness analysis versus standard of care, represented by Cd (51.0%), Pd (46.5%) and Sd (2.5%) (paragraph 7.7, elranatamab PSD, March 2025 PBAC meeting).

5.3 Cd, Pd and Sd are current standard of care and may also be considered relevant comparators; however, the submission did not provide any additional comparative evidence for teclistamab relative to the current standard of care.

5.4 Overall, noting that elranatamab was likely progressing to PBS listing (see paragraph 2.3), the ESC considered that it was a reasonable comparator.

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

6 Consideration of the evidence

Sponsor hearing

6.1 There was no hearing for this item.

Consumer input

6.2 The PBAC noted and welcomed the input from individuals (257), health care professionals (11) and organisations (6) via the Office of Health Technology Assessment Consultation Hub. The inputs from individuals who have received the drug described a range of benefits of treatment with teclistamab including rapid and profound reductions in myeloma markers and restored disease control. The comments described the ability to return to work, fewer and manageable side effects, and improved quality of life. A number of individuals who have received teclistamab through clinical trials described the rapid and dramatic improvements in their day-to-day wellbeing. Patients also highlighted concerns regarding equitable access to teclistamab, noting the high cost of treatment. Individuals who would like access to teclistamab described the need for new RRMM drugs, stating that new drugs like teclistamab represented hope, reassurance and the possibility of more time with loved ones.

6.3 The comments from health professionals described teclistamab as a highly effective therapy that offers clinical benefits for patients with RRMM. Health professionals reported higher response rates and more durable outcomes than currently available options for patients that are triple class exposed. The health professionals also stated that the side effects associated with teclistamab were known and manageable and highlighted that quality of life improvements experienced by patients.

6.4 The PBAC noted the advice received from Myeloma Australia and its Medical and Scientific Advisory Group (MSAG) which strongly supported the submission, but noted that, as per their recently updated guidelines, treatment should no longer be based on lines of therapy, instead it should focus on drug class refractory criteria. The Myeloma & Related Diseases Registry (MRDR), Rare Cancers Australia and the Leukaemia Foundation also supported the submission, stating that teclistamab is a potentially effective therapy with a novel mechanism of action which could provide substantial benefits for patients with limited treatment options. These organisations also highlighted the high cost of RRMM treatments that are not subsidised on the PBS.

6.5 The PBAC noted the advice from the Integrated Clinical Oncology Network (ICON) and Licensed Sterile Compounders of Australia who highlighted that the proposed dual listing would mean that patients who accessed teclistamab via the General Schedule and Section 100 Efficient Funding of Chemotherapy (Related Benefits) would be required to pay additional co-payments. Patients would not be required to pay additional co-payments if teclistamab was listed on Section 100 – Efficient Funding of Chemotherapy (Public and Private Hospital). Further, these organisations noted that a Section 100 – Efficient Funding of Chemotherapy (Public and Private Hospital) listing would provide specific fees to pharmacies for preparing and dispensing drugs such as teclistamab based on the most efficient combination of vials to maximise efficiency and minimise wastage.

Clinical trials

6.6 The submission was based on one phase 1/2, single-arm, open label, multicentre clinical study evaluating teclistamab (MajesTEC-1). The study included a number of cohorts, two of which were presented in the submission. The 'Recommended Phase 2 Dose (RP2D) population (n=165[4]) and the China Cohort (n=26) included patients with RRMM after at least 3 therapy lines, including triple-class exposure to a PI, an IMiD, and an anti-CD38 antibody and no prior exposure to a BCMA-targeted therapy.

6.7 One single arm, open label, multicentre clinical study evaluated elranatamab (MagnetisMM-3), which included one population relevant to the submission: Cohort A, n= 123. Cohort A of the MagnetisMM-3 was considered by PBAC in March 2025.

6.8 The efficacy claim in the submission was based on an unanchored, matched adjusted indirect comparison (MAIC) between results from the MajesTEC-1 and MagnetisMM-3 studies. The claim for safety was based on an unanchored, unadjusted indirect treatment comparison (ITC) of adverse events from MajesTEC-1 and MagnetisMM-3.

<u>China Cohort</u>

6.9 The submission pooled the RP2D population from MajesTEC-1 with those enrolled in the China Cohort. However, the China Cohort patients had different baseline characteristics compared to those enrolled in the RP2D:

- Aggressive disease features: High-risk cytogenetics: 57.7% in the China cohort versus 25.7% in the RP2D.
- Extramedullary plasmacytomas: 34.6% in the China Cohort versus 17.0% in the RP2D.
- ISS stage III disease: 26.9% in the China Cohort versus 12.3% in the RP2D.
- Penta class exposed: 26.9% in the China Cohort compared to 20.6% the in RP2D.

6.10 Although the above differences might suggest lower response rates in this population compared to RP2D, the results for the China Cohort study, reported in Cai 2025, showed an overall response rate (ORR) and median PFS that were better compared to RP2D population. The authors of the China Cohort study (Cai 2025) stated that while the ORR was above the upper limit of the RP2D cohort's confidence interval, the overall efficacy profile was consistent with the pivotal cohort. However, the authors cautioned

[4] Includes 125 patients from Part 3, Cohort A and 40 patients from Part 1 and Part 2 of the study.

that the improved response rates observed in the poorer-performing subgroups should be interpreted with care due to the small sample size of the China cohort. The ESC noted that the small sample size of the China Cohort (N=26) also increased susceptibility to confounding and limits the reliability and generalisability of the findings.

6.11 The ESC considered that differences in clinical practice, treatment availability, use of post-progression therapies and healthcare settings in China may also limit the comparability of the China Cohort with the MajesTEC-1 RP2D population and reduce the validity of pooling these populations in the analysis. Moreover, unlike the RP2D analysis, response assessments for the China Cohort were conducted by unblinded investigators rather than an independent blinded review committee, increasing the risk of selection and assessment bias. Collectively, these factors, suggest the two cohorts represent distinct patient populations and clinical environments, reducing the reliability of the China Cohort as evidence to support comparative effectiveness. Therefore, comparative results from the MAIC that included/excluded the China Cohort are presented. The Pre-Sub-Committee Response (PSCR) and pre-PBAC response disagreed with this approach, stating that patients in the China cohort followed the same study protocol, were subject to the same eligibility criteria and had a similar duration of follow-up as the RP2D population. Furthermore, the responses stated that the clinical management and treatment pathways could also be considered similar and both populations consisted of patients with late line MM who had previous exposure to the same classes of MM therapies, and both populations had the same median number of prior lines of therapies (n=5). Thus, the RP2D population and China Cohort should not be considered different populations.

Published MAIC

6.12 A published unanchored MAIC, initially reported in 2024 (Mol 2024[5]) and updated in 2025 (Mol 2025[6]), was identified during the evaluation. The unanchored MAIC compared elranatamab and teclistamab in the target population. The methodology utilised individual patient data from the elranatamab MagnetisMM-3 study Cohort A (BCMA-naïve, n = 123), which was re-weighted to match the aggregated baseline characteristics reported in the teclistamab MajesTEC-1 study (RP2D population, n = 165). The China Cohort was not included in Mol 2024-2025. The PSCR stated that the Mol 2024-2025 paper was excluded as the MAICs presented did not include all the relevant teclistamab data to inform the comparisons (i.e. the China cohort) and did not adjust for COVID-19 deaths in the MajesTEC-1 study.

6.13 Details of the studies presented in the submission are provided in Table 2.

[5] Mol I, Hu Y, LeBlanc TW, Cappelleri JC, Chu H, Nador G, Aydin D, Schepart A, Hlavacek P. A matching-adjusted indirect comparison of the efficacy of elranatamab versus teclistamab in patients with triple-class exposed/refractory multiple myeloma. Leuk Lymphoma. 2024 May;65(5):660-668. doi: 10.1080/10428194.2024.2313628.

[6] Mol I, Hu Y, LeBlanc TW, Cappelleri JC, Chu H, Nador G, Aydin D, Perez Cruz I, Hlavacek P. Matching-Adjusted Indirect Comparison of Elranatamab versus Teclistamab in Patients with Triple-Class Exposed/Refractory Multiple Myeloma: Updated Results. J Blood Med. 2025 May 14;16:233-239. doi: 10.2147/JBM.S507550

Table 2: Studies and associated reports presented in the submission

Study name / NCT ID	Protocol title/ Publication title	Publication citation
MajesTEC-1 (NCT03145181; NCT04557098)	Primary Analysis Clinical Study Report. Data Cutoff Date 07 September 2021.A Phase 1/2, First-in-Human, Open-Label, Dose Escalation Study of Teclistamab, a Humanized BCMA x CD3 Bispecific Antibody, in Subjects with Relapsed or Refractory Multiple Myeloma. MajesTEC-1.	6 December 2021
	Ad Hoc Analysis for Publication. Data Cutoff Date 16 March 2022. TECVAYLI ®. JNJ-64007957 (teclistamab)	7 July 2022
	Clinical Study Report (2-year Follow-up Analysis for the Pivotal RP2D Population). Data Cutoff Date 22 August 2023. A Phase 1/2, First-in-Human, Open-Label, Dose Escalation Study of Teclistamab, a Humanized BCMA x CD3 Bispecific Antibody, in Subjects with Relapsed or Refractory Multiple Myeloma. MajesTEC-1.	29 January 2024
	Primary Analysis Clinical Study Report for China Cohort. Data Cutoff Date 27 March 2023. A Phase 1/2, First-in-Human, Open-Label, Dose Escalation Study of Teclistamab, a Humanized BCMA x CD3 Bispecific Antibody, in Subjects with Relapsed or Refractory Multiple Myeloma. MajesTEC-1.	25 July 2023
	Final Clinical Study Report for China Cohort (2-year follow-up analysis for China Cohort). Data Cutoff Date 27 September 2024. A Phase 1/2, First-in-Human, Open-Label, Dose Escalation Study of Teclistamab, a Humanized BCMA x CD3 Bispecific Antibody, in Subjects with Relapsed or Refractory Multiple Myeloma. MajesTEC-1.	23 April 2025
	Moreau, P., Garfall A.L, et al. Teclistamab in Relapsed or Refractory Multiple Myeloma.	The New England Journal of Medicine. 2022; 387:495-505
	Cai Z., Xia Z., He A.-L., et al Efficacy, safety, and pharmacokinetics of teclistamab in Chinese patients with relapsed/refractory multiple myeloma from the China cohort of MajesTEC-1.	Cancer 2025;131(1):no pagination. doi:10.1002/cncr.35665
	Nooka A.K., Rodriguez C., Mateos M.V., et al Incidence, timing, and management of infections in patients receiving teclistamab for the treatment of relapsed/refractory multiple myeloma in the MajesTEC-1 study.	Cancer 2024;130(6):886-900. doi:10.1002/cncr.35107
	van de Donk N.W.C.J., Bahlis N., Costa L.J., et al Impact of COVID-19 on outcomes with teclistamab in patients with relapsed/refractory multiple myeloma in the phase 1/2 MajesTEC-1 study.	Blood Cancer J. 2024;14(1):no pagination. doi:10.1038/s41408-024-01160-1
	Van De Donk N.W.C.J., Bahlis N., Costa L.J., et al Impact of COVID-19 on outcomes with teclistamab in the Phase 1/2 MajesTEC-1 study in patients with relapsed/refractory multiple melanoma.	Haematologica 2024;109(Supplement 2):31.
	Garfall A.L., Nooka A.K., Van De Donk N.W.C.J., et al Long-term follow-up from the phase 1/2 MajesTEC-1 trial of teclistamab in patients with relapsed/refractory multiple myeloma.	J. Clin. Oncol. 2024;42(16 Supplement):no pagination.
MagnetisMM-3 (NCT04649359)	Lesokhin A.M., Tomasson M.H., Arnulf B., et al Elranatamab in relapsed or refractory multiple myeloma: phase 2 MagnetisMM-3 trial results.	Nat. Med. 2023;29(9):2259-2267. doi:10.1038/s41591-023-02528-9
	Prince H.M., Bahlis N.J., Rodriguez-Otero P., et al MagnetisMM-3: Long-Term Update and Efficacy and Safety of Less Frequent Dosing of Elranatamab in Patients with Relapsed or Refractory Multiple Myeloma.	Blood 2024;144(Supplement 1):4738. doi:10.1182/blood-2024-208192
	Tomasson M.H., Iida S., Niesvizky R., et al Long-term survival and safety of elranatamab in patients with relapsed or refractory multiple myeloma: Update from the MagnetisMM-3 study.	HemaSphere 2024;8(7):no pagination. doi:10.1002/hem3.136
	Raab M., Mohty M., Iida S., et al Long-term survival after elranatamab (ELRA) monotherapy in patients (pts) with relapsed or refractory multiple myeloma (RRMM): MagnetisMM-3.	Oncol. Res. Treat. 2024;47(Supplement 2):242. doi:10.1159/000540557
	Mohty M., Bahlis N.J., Nooka A.K., DiBonaventura M., Ren J., Conte U. Impact of elranatamab on quality of life: Patient-reported outcomes from MagnetisMM-3.	Br. J. Haematol. 2024;204(5):1801-1810. doi:10.1111/bjh.19346

Source: Table 2.7, p64 of the submission.

6.14 The overall risk of bias in both MajesTEC-1 and MagnetisMM-3 was high due to the study designs (open-label, single-arm).

6.15 The submission presented results from MajesTEC-1 from the final analysis for both the RP2D population (clinical cut-off [CCO] 22 August 2023, median follow-up 30.4 months) and the China Cohort (CCO 27 September 2024, median follow-up 27.2 months). These data were included in the submission's MAIC versus elranatamab.

6.16 For MagnetisMM-3, the efficacy results used in the unanchored MAIC were informed by Prince 2024 (data cut-off September 10, 2024, median follow-up of 33.9 months). These results were presented only in an abstract with limited information. Safety results for elranatamab were sourced from an earlier CCO, Lesokhin 2023 with a shorter follow-up time (median follow-up of 14.7 months). A short median follow-up limits the ability to fully characterise the safety profile, as late-onset, cumulative, and rare adverse events may be under-reported.

6.17 The key features of the single arm studies are summarised in Table 3.

Table 3: Key features of the included evidence

Study	N	Design/ duration	Risk of bias	Patient population	Outcome(s)
Teclistamab					
MajesTEC-1	RP2D: 165 China Cohort: 26	Phase II, single arm, OL RP2D: 30.4 months FU China Cohort: 27.2 months FU	High	TCE RRMM	ORR, PFS, OS, DoR; QoL
Elranatamab					
MagnetisMM-3	Cohort A: 123	Phase II, single arm, OL 33.9 months follow-up	High	Refractory to at least one IMiD, one PI, and one anti-CD38 antibody	ORR, PFS, DoR; OS.

Source: Table 2.10, p74, of the submission.
CMA = cost-minimisation approach; DoR = duration of response; FU = follow-up; II = phase 2; IMiD = immunomodulatory drug; OL = open-label; ORR = overall response rate; OS = overall survival; PFS = progression-free survival; PI = proteasome inhibitor; QoL = quality of life; RDI = relative dose intensity; RP2D = recommended phase 2 dose; RRMM = relapsed or refractory multiple myeloma; TCE = triple-class exposed; TTD = time to treatment discontinuation

Indirect treatment comparison

6.18 The submission stated that overall, the study enrolment criteria between MajesTEC-1 and MagnetisMM-3 were similar and thus, did not prevent the inclusion of these studies in a MAIC. There were differences in baseline characteristics between MajesTEC-1 and MagnetisMM-3 relating to patient fitness, disease risk, previous lines of therapies and age demographics. Overall, MajesTEC-1 included a younger and clinically fitter patient population compared with MagnetisMM-3, which could bias outcomes in favour of teclistamab.

6.19 The base-case for the unanchored MAIC excluded the 19 patients in MajesTEC-1 RP2D who died due to COVID-19 for all outcomes that were compared. The submission acknowledged that the MAIC did not account for the 2 patients (1.6%) in MagnetisMM-3 who also died due to COVID-19. The PSCR stated that patients who died due to COVID-19 in MajesTEC-1 were excluded from the MAIC as MajesTEC-1 commenced enrolment in March 2020 at the start of the global pandemic; whereas the comparator MagnetisMM-3 study commenced enrolment in February 2021 when vaccinations had become more routinely available. The PSCR stated that patients in the MajesTEC-1 study were therefore at a higher risk of death due to COVID-19, as

reflected by 19 (11.5%) of MajesTEC-1 RP2D population dying due to COVID-19 as compared to 2 (1.6%) of the MagnetisMM-3 study.

6.20 The submission selected refractory status, number of prior lines of therapy, presence of extramedullary disease, ISS/r-ISS stage, and cytogenetic risk as primary adjustment variables. Other covariates identified through clinical expert ranking were arbitrarily considered by the submission to be of lower clinical relevance and were only incorporated in sensitivity analyses (referred to as the 'full matching set' in the submission). The submission did not provide justification for this prioritisation.

6.21 The unanchored MAIC by Mol 2024-2025 matched and adjusted for an additional 9 prognostic variables and effect modifiers: age, sex (for OS endpoint only), median time since diagnosis, ISS stage, high-risk cytogenetics, extramedullary disease, number of prior lines of therapy, ECOG performance status, and penta-drug exposed and penta-drug refractory status. Notably, the MAIC presented in the submission did not include ECOG status among the variables.

6.22 After matching using the 5 variables mentioned in paragraph 6.20, the effective sample size (ESS)[7] was reduced to 123 patients, representing a 35.6% (123/191[8]) reduction in sample size. A sensitivity analysis that excluded the China Cohort but including RP2D patients who died due to COVID-19 had an ESS of 115/165 (30.3% reduction in sample size*).* The extra number of covariates used in Mol 2024-2025 reduced the ESS for MajesTEC-1 from 165 (the RP2D population) to 75 for ORR, 76 for PFS and DoR and 74 for OS compared to 123 in the submission. The ESS for the full matching set (17 variables) was 97.

6.23 Excluding COVID-19 deaths from the analyses is likely to inflate survival estimates and bias the evidence in favour of teclistamab, thereby overestimating treatment benefit. Accordingly, the evaluation focussed on the unadjusted results including COVID-19 deaths as the primary source of evidence.

6.24 A propensity score model was conducted using the identified covariates to generate weights for patients in MajesTEC-1, enabling their covariates profile to more closely match the aggregated baseline characteristics reported in MagnetisMM-3. A similar methodology was used by Mol 2024-2025.

6.25 The submission did not provide non-inferiority margins. Without clearly defined non-inferiority thresholds, it is challenging to interpret the clinical significance of the observed differences from the unanchored MAIC. Mol 2024-2025 did not discuss the use of non-inferiority margins.

[7] Based on Phillippo 2018: ESS=$(\sum w_i)^2/(\sum w_i^2)$, where w_i, i=1, …, N, are the patient weights. A low ESS compared to the original sample size N indicates extreme patient weights due to large imbalances in patient populations prior to reweighting. While guidance on what constitutes a minimally acceptable ESS is not currently available, a review of published MAIC studies showed reductions in ESS ranging from 57% to 98% (Phillippo 2016), suggesting that there are circumstances where a large reduction in ESS is required to adjust for covariate bias.

[8] 191 = RP2D population (n=165) plus China Cohort (n=26)

Comparative effectiveness

Primary analysis: ORR

6.26 The MajesTEC-1 RP2D population had an ORR, as assessed by IRC, of 104/165 (63.0%; 95% CI: 55.2, 70.4), (Table 4). Of these 104 patients, 76 (46.1%) patients achieved a complete response (CR) or better and 64 (38.8%) patients achieved a stringent complete response (sCR). A sCR was defined as achieving a CR plus a normalisation of the kappa and lambda serum free light chain (sFLC) ratio plus the absence of clonal plasma cells in bone marrow. The ORR assessed by BICR in MagnetissMM-3, was 61.0%. The overall rate of patients achieving CR or better was 37.4%.

Table 4: Results of ORR for MajesTEC-1 (mFU: 30.4 months) and MagnetisMM-3 (mFU: 33.9 months)

	MajesTEEC-1, RP2D population (N=165)		MagnetisMM-3, Cohort A (n=123)
	n (%)	95% CI	n (%)
ORR	104 (63.0%)	55.2% - 70.4%	61.0%
≥VGPR (sCR + CR + VGPR)	98 (59.4%)	51.5% - 67.0%	NR
≥CR (sCR + CR)	76 (46.1%)	38.3% - 54.0%	37.4%
sCR	64 (38.8%)	31.3% - 46.7%	16.3%
CR	12 (7.3%)	3.8% - 12.4%	21.1%
VGPR	22 (13.3%)	8.5% - 19.5%	18.7%
PR	6 (3.6%)	1.3% - 7.7%	4.9%
MR	2 (1.2%)	0.1% - 4.3%	NR
SD	28 (17.0%)	11.6% - 23.6%	NR
PD	23 (13.9%)	9.0% - 20.2%	NR
Not evaluable	8 (4.8%)	2.1% - 9.3%	NR

Source: Table 2.32, p138, Table 2.54, p175 of the submission and Prince 2024.

Abbreviations: CR = complete response; MR = minimal response; IRC = independent central review; NR = not reported; ORR = overall response rate; PD = progressive disease; PR = partial response; RP2D = recommended phase 2 population; sCR = stringent complete response; SD = stable disease; sFLC = serum free light chain; VGPR = very good partial response.

a Outcomes assessed by independent central review.

b sCR = achieving a complete response (CR) plus a normalisation of the kappa and lambda serum free light chain (sFLC) ratio plus the absence of clonal plasma cells in bone marrow.

MajesTEC-1 PFS and OS

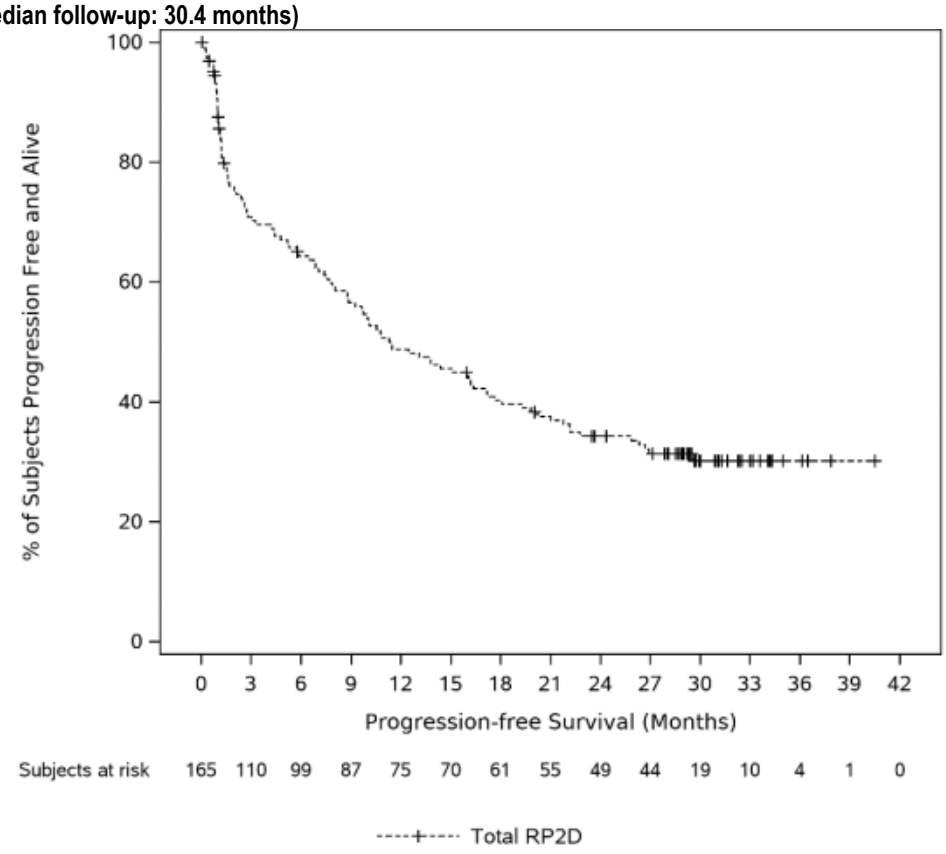
6.27 Median PFS in the MajesTEC-1 RP2D population was 11.4 months (95% CI: 8.8, 16.4) (Table 5 and Figure 1). Median OS was 22.2 months (95% CI: 15.1, 29.9; Table 5 and Figure 2).

Table 5: PFS and OS in the MajesTEC-1 study (all-treated analysis sets, unadjusted analysis; median follow-up: 30.4 months)

PFS	**RP2D population (N=165)**
Number of events (%)	107 (64.8%)
Number of censored (%)	58 (35.2%)
Kaplan-Meier estimate (months)	
25% percentile (95% CI)	2.1 (1.2, 4.3)
Median (95% CI)	11.4 (8.8, 16.4)
75% percentile (95% CI)	NE (26.7, NE)
6-month progression-free survival rate % (95% CI)	64.4 56.4, 71.3)
12-month progression-free survival rate % (95% CI)	48.8 (40.7, 56.4)
24-month progression-free survival rate % (95% CI)	34.2 (26.8, 41.8)
30-month progression-free survival rate % (95% CI)	30.1 (22.9)
OS	
Number of events (%)	94 (57.0%)
Number of censored (%)	71 (43.0%)
Kaplan-Meier estimate (months)	
25% percentile (95% CI)	8.8 (4.2, 10.8)
Median (95% CI)	22.2 (15.1, 29.9)
75% percentile (95% CI)	NE (35.5, NE)
6-month overall survival rate % (95% CI)	77.8 (70.6, 83.4)
12-month overall survival rate % (95% CI)	64.0 (56.0, 70.9)
24-month overall survival rate % (95% CI)	48.9 (40.9, 56.3)
30-month overall survival rate % (95% CI)	41.9 (33.9, 49.6)

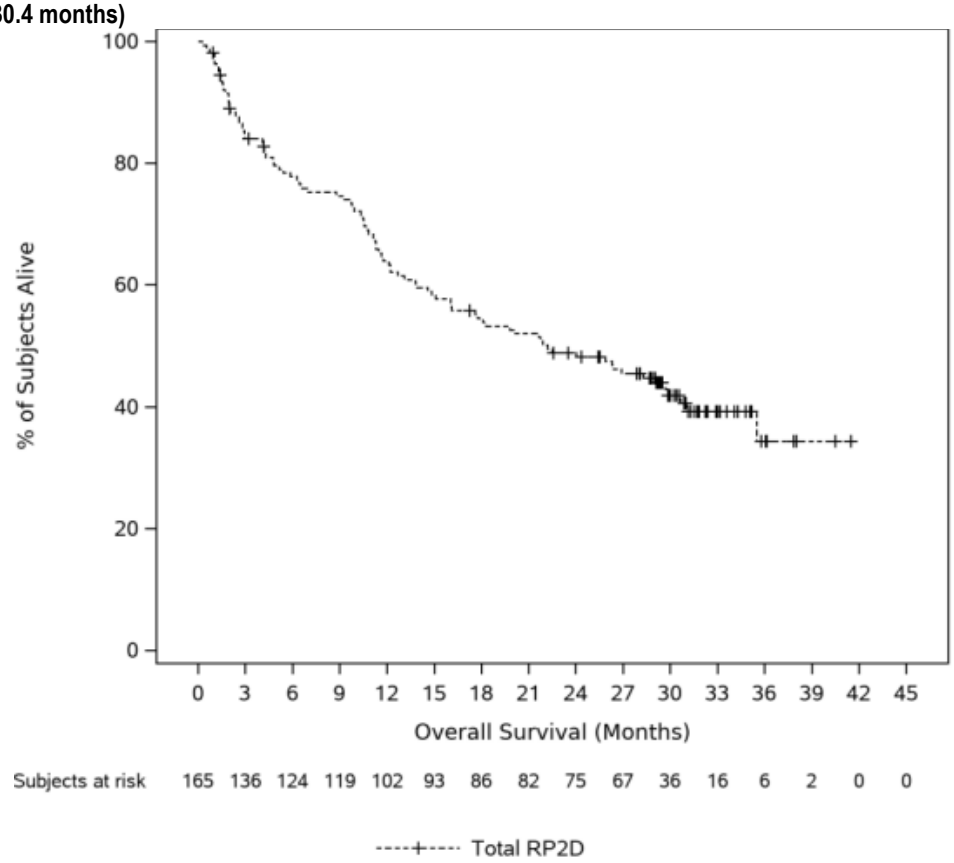
Source: Table 2.36, p146 and Table 2.34, p143 of the submission.
Abbreviations: CI = confidence interval; IRC = independent central review; NE = not estimable; PFS = progression free survival; RP2D = recommended phase 2 population; OS = overall survival.

Figure 1: Progression-free survival by IRC in the MajesTEC-1 RP2D population (all-treated analysis sets, unadjusted analysis; median follow-up: 30.4 months)



Source: Figure 2.10, p143 of the submission.
Abbreviations: IRC = independent central review; RP2D = recommended phase 2 dose population

Figure 2: Overall survival in MajesTEC-1 RP2D population (all-treated analysis sets, unadjusted analysis; median follow-up: 30.4 months)



Source: Figure 2.13, p146 of the submission.
Abbreviations: RP2D = recommended phase 2 dose population.

Indirect Comparison: ORR

6.28 The results of the unanchored MAIC base case and sensitivity analyses for ORR are shown in Table 6. Prior to adjusting for covariates and removing patients who died from COVID (unadjusted results), the ORR was higher for teclistamab versus elranatamab (64.9% versus 61%). Excluding COVID-19 deaths had little impact on the ORR for teclistamab (64.5%). Adjusting for the chosen covariates versus the MagnetisMM-3 cohort and removing COVID deaths (base-case matching set) resulted in a decrease in ORR for teclistamab compared to the unadjusted analysis (63.1% vs 64.9%). The comparison of MajesTEC-1 versus MagnetisMM-3 for the base-case matching set resulted in an odds ratio (OR) of 1.10 (95% CI: 0.65, 1.84). When considering the MajesTEC-1 RP2D population without the China Cohort and with COVID-19 deaths included (Sensitivity Analysis 1), the ORR was numerically lower for teclistamab compared to elranatamab (59.0% vs 61.0%), resulting in an OR of 0.92 (95% CI: 0.54, 1.55). For each analysis where the patient characteristics were matched to MagnetisMM-3, the ORR decreased, indicating the impact of the differences between the patient populations. The ESC noted that there were no statistically significant differences between teclistamab and elranatamab in terms of ORR in any of the analyses presented.

Table 6: Results of the unanchored MAIC provided in the submission for ORR

	Teclistamab			Elranatamab		OR (95% CI)[a]	p-value
	N (ESS)	Events/N or Events/ESS	ORR	Events/N	ORR		
Submission base-case: RP2D population + China Cohort, excluding RP2D patients who died due to COVID-19							
Unadjusted	191 (NA)	124/191	64.9%	75/123	61.0%	1.18 (0.74, 1.89)	0.479
Excluding COVID deaths	172 (NA)	111/172	64.5%			1.16 (0.72, 1.88)	0.532
Base-case matching set	172 (123)	78/123	63.1%			1.10 (0.65, 1.84)	0.731
Full matching set	172 (97)	62/97	64.1%			1.14 (0.66, 1.97)	0.635
Sensitivity 1: RP2D population only, including RP2D patients who died due to COVID-19							
Unadjusted	165 (NA)	104/165	63.0%	75/123	61.0%	1.09 (0.67, 1.76)	0.722
Base case matching set	165 (115)	68/115	59.0%			0.92 (0.54, 1.55)	0.752
Full matching set	165 (65)	37/65	57.5%			0.87 (0.47, 1.59)	0.643
Sensitivity 2: RP2D population only, excluding RP2D patients who died due to COVID-19							
Unadjusted	165 (NA)	104/165	63.0%	75/123	61.0%	1.09 (0.67, 1.76)	0.722
Excluding COVID deaths	146 (NA)	91/146	62.3%			1.06 (0.65, 1.73)	0.82
Base case matching set	146 (103)	61/103	59.3%			0.93 (0.54, 1.60)	0.796
Full matching set	146 (62)	36/62	58.1%			0.89 (0.48, 1.65)	0.706

Source: Table 2.58, p 188 of the submission.

Abbreviations: CI = confidence interval; ESS = effective sample size; NA = not applicable; ORR = overall response rate; OR = odds ratio; RD = risk difference; RP2D = recommended phase 2 dose; RR = relative risk.

[a] An OR greater than 1 favours teclistamab over elranatamab.

Notes:

Unadjusted: observed (pooled) study results:

Excluding COVID-19 deaths: RP2D patients who died from COVID-19 (n =19) are removed from analysis

Base-case matching set: patients in MajesTEC-1 were reweighted for refractory status, R-ISS stage, cytogenetic profile, presence of extramedullary disease, and number of prior lines of therapy.

Full matching set: patients reweighted for all identified comparable covariates between MajesTEC-1 and MagnetisMM-3

Indirect Comparison: PFS

6.29 The results of the unanchored MAIC base case and sensitivity analyses for PFS are shown in Table 7. Prior to adjusting for covariates and removing patients who died from COVID-19 (unadjusted results), the median PFS for teclistamab was 13.1 months compared to 17.3 months for elranatamab. Excluding COVID-19 deaths increased median PFS for teclistamab only marginally to 13.8 months and adjusting for the chosen covariate's vs MagnetisMM-3 (base case matching set) reduced the median PFS to 13.1 months. The comparison of MajesTEC-1 versus MagnetisMM-3 for the base case matching set resulted in a HR of 1.14 (95% CI: 0.80, 1.61). Excluding COVID-19 related deaths led to a more favourable PFS estimate for teclistamab across all scenarios; however, median PFS for elranatamab remained numerically higher.

6.30 The ESC noted that when considering the MajesTEC-1 RP2D population without the China cohort and with COVID-19 deaths included (Sensitivity Analysis 1), the median PFS for teclistamab decreased from 13.1 months (unadjusted observed data) to 10.1 months. The median PFS for elranatamab in MagnetisMM-3 was 17.3 months, resulting in a HR of 1.40 (95% CI: 0.99, 1.98).

Table 7: Results of the unanchored MAIC for PFS

	Teclistamab		Elranatamab (N=123)	HR (95% CI)*	p-value
	N (ESS)	Median PFS, months (95% CI)	Median PFS, months (95% CI)		
Submission base-case: RP2D population + China Cohort, excluding RP2D patients who died due to COVID-19					
Unadjusted	191 (NA)	13.1 (9.7, 17.6)	17.3 (10.0, NA)	1.24 (0.91, 1.69)	0.175
Excl COVID deaths	172 (NA)	13.8 (9.9, 21.7)		1.14 (0.83, 1.57)	0.421
BC matching set	172 123)	13.5 (8.8, 22.8)		1.14 (0.80, 1.61)	0.476
Full matching set	172 (97)	14.4 (9.2, NA)		1.07 (0.73, 1.55)	0.735
Sensitivity 1: RP2D population only, including RP2D patients who died due to COVID-19					
Unadjusted	165 (NA)	11.4 (8.8, 16.4)	17.3 (10.0, NA)	1.31 (0.96, 1.80)	0.09
BC matching set	165 (115)	10.1 (6.4, 16.0)		1.40 (0.99, 1.98)	0.057
Full matching set	165 (65)	8.8 (4.2, 17.2)		1.43 (0.96, 2.15)	0.082
Sensitivity 2: RP2D population only, excluding RP2D patients who died due to COVID-19					
Unadjusted	165 (NA)	11.4 (8.8, 16.4)	17.3 (10.0, NA)	1.31 (0.96, 1.80)	0.09
Excl COVID deaths	146 (NA)	13.1 (8.8, 20.2)		1.21 (0.87, 1.68)	0.254
BC matching set	146 (103)	10.8 (7.6, 20.2)		1.27 (0.89, 1.82)	0.19
Full matching set	146 (62)	9.2 (4.2, 19.4)		1.36 (0.90, 2.06)	0.14

Source: Table 2.59, p193 of the submission.
Abbreviations: BC = base-case; CI = confidence interval; ESS = effective sample size; HR = hazard ratio; NA = not applicable; PFS = progression-free survival; RD = risk difference; RP2D = recommended phase 2 dose; RR = relative risk.
* A HR greater than 1 favours elranatamab over teclistamab.
Unadjusted: observed (pooled) study results
Excluding COVID-19 deaths: RP2D patients who died from COVID-19 (n =19) are removed from analysis
Base-case matching set: patients in MajesTEC-1 were reweighted for refractory status, R-ISS stage, cytogenetic profile, presence of extramedullary disease, and number of prior lines of therapy.
Full matching set: patients reweighted for all identified comparable covariates between MajesTEC-1 and MagnetisMM-3

Indirect Comparison: OS

6.31 Across all OS analyses, excluding COVID-19 deaths consistently resulted in higher median OS for patients treated with teclistamab relative to the unadjusted analyses (Table 8). In the comparative results for OS presented in the submission, several of the HRs were inconsistent with the direction of the underlying absolute event rates. The PSCR stated that this was due to the proportional hazard assumption being violated. The OS Kaplan Meier curves for teclistamab and elranatamab followed a similar trajectory with some crossover points, therefore it was expected that the medians and HRs did not move in the same direction for all analyses.

6.32 The ESC noted that there were no statistically significant differences between teclistamab and elranatamab in terms of OS in any of the analyses presented.

Table 8: Results of the unanchored MAIC for OS

	Teclistamab		Elranatamab (N=123)		
	N (ESS)	Median OS, months (95% CI)	Median OS, months (95% CI)	HR (95% CI)	p-value
Submission base-case: RP2D population + China Cohort, excluding RP2D patients who died due to COVID-19					
Unadjusted	191 (NA)	26.3 (18.1, 35.5)	23.6 (13.6, NA)	0.98 (0.71, 1.33)	0.874
Excluding COVID deaths	172 (NA)	30.7 (23.2, NA)		0.85 (0.61, 1.17)	0.321
Base-case matching set	172 (123)	29.9 (21.7, NA)		0.88 (0.62, 1.26)	0.502
Full matching set	172 (97)	29.7 (18.3, NA)		0.91 (0.63, 1.32)	0.623
Sensitivity 1: RP2D population only, including RP2D patients who died due to COVID-19					
Unadjusted	165 (NA)	22.2 (15.1, 29.9)	23.6 (13.6, NA)	1.08 (0.78, 1.48)	0.647
Base-case matching set	165 (115)	19.8 (12.7, 29.7)		1.16 (0.82, 1.63)	0.405
Full matching set	165 (65)	18.3 (12.2, 31.0)		1.16 (0.78, 1.73)	0.453
Sensitivity 2: RP2D population only, excluding RP2D patients who died due to COVID-19					
Unadjusted	165 (NA)	22.2 (15.1, 29.9)	23.6 (13.6, NA)	1.08 (0.78, 1.48)	0.647
Excluding COVID deaths	146 (NA)	29.1 (18.3, NA)		0.93 (0.67, 1.30)	0.68
Base-case matching set	146 (103)	26.9 (15.1, NA)		0.99 (0.69, 1.43)	0.969
Full matching set	146 (62)	26.3 (13.6, NA)		1.09 (0.72, 1.63)	0.69

Source: Table 2.60, p198 of the submission.
Abbreviations: BC = base-case; CI = confidence interval; ESS = effective sample size; HR = hazard ratio; NA = not applicable; OS = overall survival; RD = risk difference; RR = relative risk.
Unadjusted: observed (pooled) study results
Excluding COVID-19 deaths: RP2D patients who died from COVID-19 (n =19) are removed from analysis
Base-case matching set: patients in MajesTEC-1 were reweighted for refractory status, R-ISS stage, cytogenetic profile, presence of extramedullary disease, and number of prior lines of therapy.
Full matching set: patients reweighted for all identified comparable covariates between MajesTEC-1 and MagnetisMM-3

MoI 2024-2025

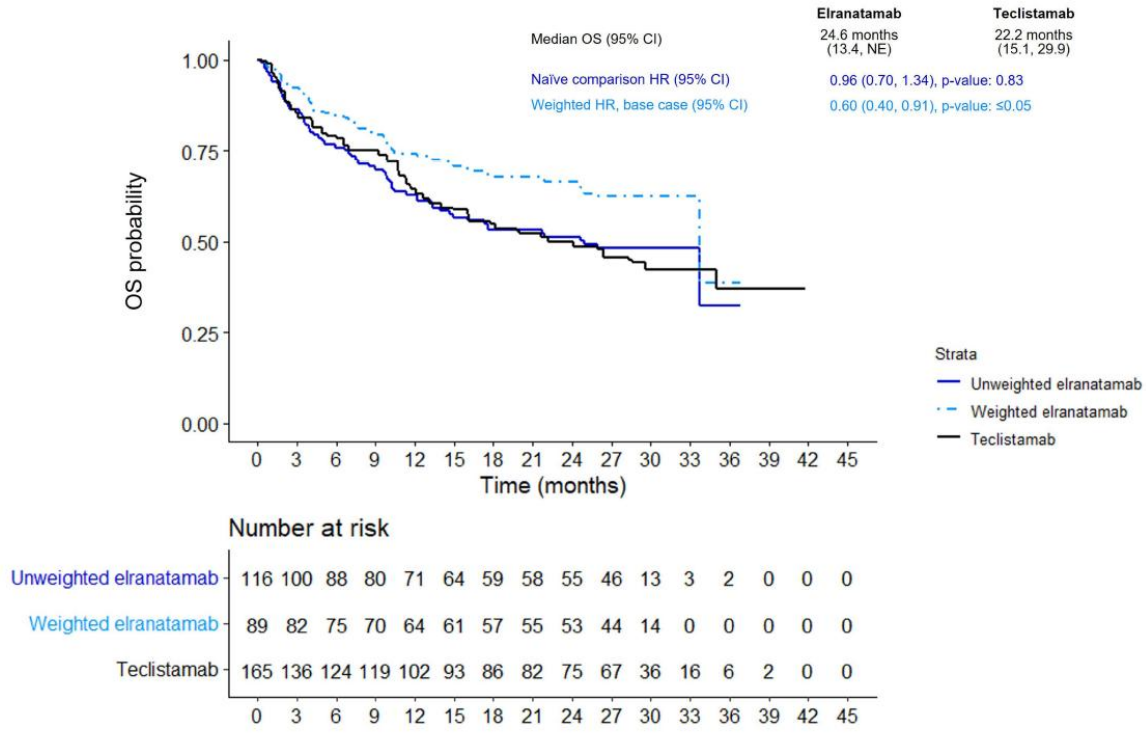
6.33 Results reported in MoI 2025 (OS, PFS and DoR) comparing elranatamab versus teclistamab are shown in Table 9 and Figure 3. The results showed that when adjusted for the identified covariates (see paragraph 6.20), the outcome of ORR favoured elranatamab and reached statistical significance. MoI 2024 acknowledged that the inclusion of COVID-19 deaths constituted a potential limitation in this analysis that could have impacted the efficacy results, but the direction of the impact was not discussed. The PSCR noted that MoI 2024-2025 did not include the China cohort and did not adjust for COVID-19 deaths in the MajesTEC-1 study. The ESC noted that the adjusted analyses resulted in results that statistically significantly favoured elranatamab.

Table 9: Results reported in MoI 2025 for OS, PFS and DoR (median follow-up: 28.4 months for elranatamab and 30.4 months for teclistamab)

Outcome and Analysis	ESS (n)	HR (95% CI)[a]	p-value
PFS (All patients)			
Unadjusted comparison	116	0.77 (0.55, 1.06)	0.11
Base case adjusted	76	**0.55 (0.37, 0.81)**	**<0.05**
OS (All patients)			
Unadjusted comparison	116	0.96 (0.70, 1.34)	0.83
Base case adjusted	74	**0.60 (0.40, 0.91)**	**<0.05**
DoR (All patients)			
Unadjusted comparison	116	0.63 (0.39, 1.03)	0.07
Base case adjusted	76	**0.56 (0.31, 0.99)**	**<0.05**

Source: Table 2, MoI 2025.
Abbreviations: CI = confidence interval; DoR = duration of response; ESS = effect size statistic; OS = overall survival; PFS = progression-free survival.
[a] HR < 1 indicates better survival for patients treated with elranatamab.
Bolded text refer to statistically significant results as reported in MoI 2025.

Figure 3: KM of OS from MajesTEC-1 RP2D (median follow-up of 28.4 months, data cut-off March: 2024) and MagnetisMM-3 Cohort A (median follow-up 30.4 months, data cut-off: August 2023)



Source: Figure 3, Mol 2025.
Abbreviations: CI = confidence interval; HR = hazard ratio; NE = not estimable; OS = overall survival.

Comparative harms

6.34 The submission presented an unadjusted, unanchored comparison of safety outcomes for teclistamab (MajesTEC-1 RP2D and China Cohort) versus elranatamab. The submission's approach likely biases the safety comparison in favour of teclistamab, given the patients enrolled in MajesTEC-1 were generally fitter with less severe disease than patients enrolled in MagnetisMM-3 (see paragraph 6.18).

6.35 Due to the paucity of publicly reported safety data for elranatamab, safety data from the September 2024 MagnetisMM-3 CCO (median follow-up: 33.9 months) was not used to inform the indirect safety ITC. Treatment emergent adverse events (TEAEs) and the summary of any Grade adverse events (AEs) were informed by MagnetisMM-3 data with a median follow-up of 14.7 months and the reports of Grade 3 and 4 AEs were informed from MagnetisMM-3 data with a median follow-up of 28.4 months. The submission presented data from MajesTEC-1 CCOs with comparable median durations of follow-up (March 2022 CCO, median follow-up: 14.1 months; and August 2023 CCO, median follow-up: 30.4 months).

Summary of AEs

6.36 A comparison of AEs reported in the teclistamab and elranatamab studies is shown in Table 10. The ESC noted that there was a higher proportion of CRS in teclistamab patients (75.4%) compared to elranatamab (57.7%). CRS has direct implications for ongoing treatment administration and healthcare resource use. Patients who experience CRS require premedication prior to every subsequent dose of the intervention, not only during the step-up phase (approved Product Information, p21).

In addition, CRS patients might need subsequent hospitalisation and treatment interruption. In MajestTEC-1, patients who experienced Grade 2 CRS or limited Grade 3 CRS were mandated to be hospitalised for at least 48 hours with the next scheduled dose. At the final CCO (2 years of follow-up), 35 teclistamab patients (21.2%) had experienced Grade 2 CRS. The ESC noted the cost of hospitalisation due to CRS was not captured in the CMA.

6.37 Higher rates of haematological toxicities were observed in MajesTEC-1 compared with MagnetisMM-3, including lymphopenia (45.0% vs 26.8%), neutropenia (63.4% vs 49.6%), and thrombocytopenia (44.0% vs 31.7%).

6.38 Patients in MagnetisMM-3 had a higher discontinuation rate due to TEAE compared to patients in MajesTEC-1 (25.2% vs 4.8%); however, reported similar TEAEs and Grade ≥3 events. This suggested different approaches towards discontinuation and AE management between the 2 studies.

Table 10: Summary of AEs and TEAEs in MajesTEC-1 and MagnetisMM-3

	Teclistamab	Elranatamab
	RP2D (N=165) mFU 30.4 months	(N=123) mFU 28.4 months
AEs of any Grade		
Anaemia	91 (55.2%)	48.8%
CRS	119 (72.1%)	57.7%
ICANs	4 (2.4%)	4.9%
Lymphopenia	60 (36.4%)	26.8%
Neutropenia	118 (71.5%)	49.6%
Thrombocytopenia	69 (41.8%)	31.7%
Any TEAE	165 (100.0%)	123 (100.0%)
Study-drug related [a]	154 (93.3%)	112 (91.1%)
Maximum toxicity Grade		
Grade 3 or 4 [b]	121 (73.3%)	89 (72.4%)
Grade 5	35 (21.2%)	25 (20.3%)
Any serious TEAE	114 (69.1%)	94 (76.4%)
Study-drug related [a]	55 (33.3%)	47 (38.2%)
TEAE leading to study-drug discontinuation	8 (4.8%)	31 (25.2%)
Death due to COVID-19 TEAE	18 (10.9%)	2 (1.6%) [c]

Source: Table 2.62, p208 and Table 2.63, p210 of the submission.

Abbreviations: CCO = clinical cutoff; CRS = cytokine release syndrome; ICANS = immune effector cell neurotoxicity syndrome; mFU = median follow-up (in months); NR = not reported; RP2D = recommended phase 2 population; TEAE = treatment-emergent adverse event.

[a] TEAEs related to study drug

[b] Calculated for MajesTEC-1 cohorts by summing maximum toxicity Grade 3 and maximum toxicity Grade 4 values. This was necessary as the data reported for elranatamab in MagnetisMM-3 relate to maximum toxicity Grade of 3 or 4, rather than Grade ≥3 (i.e., including Grade 5 TEAEs).

[c] Two deaths due to COVID-19 were reported at a CCO with a median follow-up of 14.7 months. Publications for the MangetisMM-3 study with more mature CCOs (up to a median follow-up duration of 33.9 months) do not indicate there were any additional COVID-19-related deaths that occurred in the MagnetisMM-3 study. Therefore, it is assumed that two patients had died due to COVID-19 at the later CCO.

Benefits/harms

6.39 A benefits and harms table is not presented as the submission made a claim of non-inferiority.

Clinical claim

6.40 The submission described teclistamab as non-inferior in terms of effectiveness compared to elranatamab. The ESC considered that the claim of non-inferior effectiveness was uncertain, as:

- The clinical effectiveness estimates derived from the unanchored MAIC were associated with limitations that undermined the robustness of the comparison. The selection of covariates used for the base case matching set appeared to be arbitrary and were not justified. Significantly more covariates could be matched as demonstrated by the full matching set, e.g. ECOG performance status.
- The base case MAIC relied on a pooled population that included the MajesTEC-1 RP2D cohort plus the China Cohort. The population in the China Cohort differed with respect to baseline characteristics, clinical management practices, and possibly treatment pathways. Notably, the China Cohort demonstrated higher AEs and improved response and survival outcomes despite having poorer prognostic features, suggesting potential unmeasured confounding which undermined the validity of the pooled analysis.
- All outcomes in the base case MAIC were adjusted for COVID-19–related deaths in MajesTEC-1 RP2D population only. The exclusion of these COVID-19 deaths may have introduced selection bias, disproportionately removing more frail or comorbid patients who are less likely to respond to treatment, thereby artificially inflating the estimated effectiveness of teclistamab.
- Across outcomes, the results of the MAIC were variable and sensitive to the exclusion of COVID-19 related deaths and the inclusion of the China Cohort. The wide confidence intervals across analyses indicate large variability in the results. This limited the robustness of the submissions therapeutic claim of non-inferior efficacy. A published MAIC demonstrated a similar trend with results numerically favouring elranatamab versus teclistamab and some outcomes were statistically significant (Mol 2024, 2025).

6.41 On balance, the PBAC considered that the claim of non-inferior comparative effectiveness was reasonable.

6.42 The submission described teclistamab as similar in terms of safety compared to elranatamab. The ESC considered that this claim was uncertain, noting that the adverse event profiles of teclistamab and elranatamab were different, with teclistamab exhibiting higher rates of haematological toxicities (any Grade and Grade 3–4) and pneumonia (Grade 3-4) than elranatamab. Despite this, discontinuations due to TEAEs were considerably lower in MajesTEC-1. The reason for this discrepancy was unclear.

6.43 The PBAC considered that teclistamab was non-inferior compared to elranatamab in terms of safety.

Economic analysis

6.44 The submission presented a CMA comparing teclistamab to elranatamab. This was consistent with the clinical claim of non-inferiority. Table 11 presents the summary of the CMA.

Table 11: Key components and assumptions of the cost-minimisation approach

Component	Claim or assumption
Therapeutic claim: effectiveness	Based on the MAIC presented in the submission, teclistamab monotherapy is non-inferior in terms of efficacy when compared to elranatamab monotherapy for the treatment of patients with TCE RRMM in the 4L+ setting.
Therapeutic claim: safety	Based on the unanchored, unadjusted indirect treatment comparison presented in the submission, teclistamab monotherapy has a similar safety profile to elranatamab monotherapy when used for the treatment of patients with TCE RRMM in the 4L+ setting.
Evidence base	Teclistamab monotherapy (MajesTEC-1 study), elranatamab monotherapy (MagnetisMM-3 study), Australian haematologist insights and real-world evidence on treatment practices (Chunara et al. 2025)
Equi-effective doses	The total cumulative dose of teclistamab monotherapy per patient per average course of treatment (71 weeks) is 5,114 mg and is equivalent to a total cumulative dose of elranatamab monotherapy per patient per average course of therapy (71 weeks) of 3,191 mg
Direct medicine costs[a]	It is proposed that teclistamab be listed at an effective AEMP per vial that reflects the equi-effective doses for teclistamab and elranatamab for the treatment of 4L+ TCE RRMM
Other costs or cost offsets	Administration costs ($126.00 [MBS13950]). Hospitalisation costs for step-up dosing of elranatamab (based on DRG for Pharmacotherapy for Neoplastic Disorders (AR-DRG v11.0, 2022-23, code R63Z; a cost per day of $2,353 total, which reduces to $714 per day when excluding pharmacy costs).

Source: Table 3.1 p229 of the submission

Abbreviations: AR-DRG = Australian Refined Diagnosis Related Groups; MAIC = matched-adjusted indirect comparison; MBS = Medicare Benefits Schedule; RRMM = relapsed or refractory multiple myeloma; SPA = special pricing arrangement; TCE = triple class exposed; 4L+ = fourth line plus

[a] At time of submission to the PBAC, elranatamab was not listed on the PBS, and thus a public price was not available to the sponsor. The approach in the economic evaluation focused on establishing the relevant equi-effective doses and cost-minimisation methodology for teclistamab and elranatamab

6.45 A cost-minimised price for teclistamab was not provided as the price of elranatamab was not available at the time of submission. The submission presented the methodology for calculating the equi-effective dosing and the effective AEMP for teclistamab using a CMA to elranatamab for 4L+ TCE RRMM (Table 13).

6.46 The dosing and time to switch assumptions for teclistamab and elranatamab applied in the CMA are presented in Table 12.

Table 12: Dosing of the proposed treatment and comparator

Treatment regimen	Dosing applied in the CMA	Source
Elranatamab	Dosing assumptions: Elranatamab is administered as a SC injection as a flat dose Step-up doses of 12 mg on Day 1 and 32 mg on Day 4, followed by the full treatment dose of 76 mg once a week, from Week 2 to Week 24. For patients who have received at least 24 weeks of treatment, and have maintained a response, the dosing interval should transition to a bi-weekly (once every two weeks) schedule. For patients who have received at least 24 weeks of treatment at the bi-weekly schedule and maintained a response, the dose interval should transition to an every four-week schedule. Due to the risk of severe reactions (including CRS and ICANS), the TGA PI recommends hospitalisation for 48 hours after administration of the first step-up dose, and for 24 hours after administration of the second step-up dose. Time to switch assumptions: QW: 100% Week 2 to Week 27 QW to Q2W: 47.2% at Week 28 Q2W to Q4W: 22.8% at Week 52	Elranatamab, TGA PI MagnetismMM-3 (Prince et al. 2024; Lesokhin et al. 2023)
Teclistamab	Dosing assumptions: Teclistamab is administered as a SC injection, with weight-based dosing Step-up doses of 0.06 mg/kg on Day 1 and 0.3 mg/kg on Day 3 followed by 1.5 mg/kg on Day 5 and thereafter 1.5 mg/kg once weekly. In patients who have a complete response or better for a minimum of 6 months, a reduced dosing frequency of 1.5 mg/kg every two weeks until disease progression or unacceptable toxicity may be considered Due to the risk of CRS, the TGA PI instructs patients to remain within proximity of a healthcare facility and that they should be monitored for CRS signs and symptoms daily for 48 hours after administration of all [three] doses within the step-up dosing schedule. Time to switch assumptions: QW: 100% Week 2 to Week 26 QW to Q2W: 39% at Week 27, increasingly linearly to 64.5% at Week 53	Teclistamab, TGA PI Australian clinician survey Chunara et al 2025[a, 9]

Source: Table 3.2 p 232, Table 3.3 p236 of the submission

Abbreviations: CMA = Cost Minimisation Analysis; CRS = cytokine release syndrome; ICANS = immune effector cell-associated neurotoxicity syndrome; QW = weekly; Q2W = fortnightly; Q4W = monthly; SC = subcutaneous; TGA PI = Therapeutic Goods Administration product information

Note: a. A real-world study in the United States reporting on the treatment patterns with teclistamab monotherapy (n=501) use in clinical practice.

6.47 Both medicines are administered weekly in the first instance but allow for less frequent dosing depending on response. The switch to less frequent dosing regimens was incorporated in the CMA; however, the time to switching for teclistamab was not consistent with the MajesTEC-1 study or the TGA PI.

6.48 The timepoint for switching between weekly (QW) dosing to fortnightly dosing (Q2W) for elranatamab was at Week 28.2, based on the mean time of switching to less frequent dosing reported in Lesokhin et al. 2023. This was consistent with the elranatamab TGA PI which recommended switching to less frequent dosing after 24 weeks of treatment assuming maintained response.

6.49 The submission assumed patients treated with elranatamab would switch from Q2W to every 4 weeks (Q4W) dosing from 52 weeks (i.e. 24 weeks after switching to Q2W).

[9] Chunara F, et al. Real-world treatment patterns for teclistamab and talquetamab in multiple myeloma (MM): experience from 609 patients. Blood Cancer J. 2025 Apr 8;15(1):61. doi: 10.1038/s41408-025-01254-4.

This was reasonable and consistent with the recommendation in the elranatamab TGA PI and the median time since the dose switch from Q2W to Q4W (6.5 months) reported in MagnetismMM-3 (Prince et al. 2024).

6.50 The submission assumed 30% of patients would receive elranatamab QW dosing over 71 weeks treatment duration , while 47.2% of patients would switch from QW dosing to Q2W at Week 28.2, and 22.8% would switch to Q4W dosing at Week 52, based on the results from MagnetisMM-3 (Prince et al., 2024).

6.51 The timepoint for switching from teclistamab QW dosing to Q2W used in the CMA was 6 months (i.e. from Week 27). This was based on input from Australian haematologists and the mean time to CR or better as observed in MajesTEC-1, RP2D population (6.47 months). This was inconsistent with the approach used to inform switching for elranatamab (study based) and the recommendation in teclistamab TGA PI, which recommended switching to Q2W dosing in patients who have maintained CR or better for a minimum of 6 months. The mean time to CR or better in MajesTEC-1 (6.47 months) was considerably shorter than the mean time to switching of 12.3 months in MajesTEC-1, RP2D population. The time to switching to teclistamab Q2W at 12.3 months observed in MajesTEC-1 RP2D should have been used to inform the CMA, rather than the time to CR or better. The PSCR stated that although not consistent with the TGA PI or the MajesTEC-1 study, the dosing schedule applied in the CMA was reflective of how teclistamab will be used in clinical practice. The ESC considered that the dosing schedule used in the MajesTEC-1 study and outlined in the PI should be applied in the CMA. The ESC advised that for an alternate dosing schedule to be considered, a submission to the TGA should be made.

6.52 The submission assumed that 39.0% of teclistamab patients would switch from QW to Q2W at Week 27. This was based on the proportion of patients on less frequent dosing (≥ Q2W) between Days 91 and 180 of treatment in Chunara et al, 2025. This proportion also included patients who switched to ≥ Q4W dosing, which was not consistent with dosing recommendations in the teclistamab TGA PI.

6.53 The submission assumed that the proportion of teclistamab patients on Q2W dosing would increase linearly to 64.5% by Week 53. This was based on an assumption that patients would continue to switch to less frequent dosing of teclistamab over time based on depth of response and not the length of time on treatment (as per the input from Australian haematologists). The ESC considered that the number of patients changing dose frequency from QW to Q2W should align with the MajesTEC-1 study in which 40.8% of patients switched at any timepoint.

6.54 The submission assumed that the proportion of patients switching from QW to Q2W was maintained at 64.5% from Week 53 to Week 71. However, the proportion of patients who switched from QW to Q2W at any timepoint in MajesTEC-1 was 40.8%. The submission presented Sensitivity Analysis 2, based on the proportion of patients switching to Q2W (40.8%) and mean time of switching from QW to Q2W (53.3 weeks) from MajesTEC-1 (Table 13). The pre-PBAC response stated that should a trial-based approach be applied, Sensitivity Analysis 2 was the most appropriate for establishing the equi-effective doses as it was reflective of both the MajesTEC-1 and MagnetisMM-3 trials.

6.55 The mean patient weight in MajesTEC-1, including the Chinese cohort, was 72.83 kg (N=191) and was used in the base case CMA to estimate the dose of teclistamab in the

step-up and treatment phases. The submission presented Sensitivity Analysis 3, based on mean patient weight in MajesTEC-1 R2PD population (i.e. excluding the China Cohort).

6.56 The calculated equi-effective doses presented by the submission were based on the mean relative dose intensity (RDI) reported in MajesTEC-1, including the China Cohort (88.8%), and a median relative dose intensity reported for elranatamab in RP2D of the MagnetisMM-3 study (79.1%). The evaluation considered the use of the mean RDI from MajesTEC-1 RP2D (92.9%) was considered more appropriate, noting that MajesTEC-1 China Cohort was not considered suitable for inclusion in the evidence base (see paragraph 6.11).

6.57 The treatment duration applied in the CMA for both teclistamab and elranatamab patients was 71 weeks (16.3 months), based on a previous PBAC recommendation for elranatamab (Table 18, elranatamab, PSD March 2025 PBAC meeting). Instead of assuming the treatment duration for teclistamab was equal to that of elranatamab, a more appropriate approach may have been to determine the treatment duration for teclistamab by extrapolating the time-to-treatment discontinuation (TTD) curve from the MajesTEC-1 study. This would allow for a comparison of treatment duration, rather than relying on the duration of treatment utilised in an elranatamab economic model. The PSCR stated that an equal treatment duration was appropriate considering that both teclistamab and elranatamab were BCMA targeted bispecific antibodies and the evidence supported a claim of non-inferior efficacy. On balance, the ESC considered that assuming the same duration of therapy for teclistamab and elranatamab was reasonable.

6.58 The evaluation identified an error relating to the estimation of equi-effective doses, and which resulted in an underestimation of the number of doses over the 71-weeks treatment duration. Correction of the error resulted in a higher number of average doses per course of treatment for teclistamab (60.47 doses) and elranatamab (60.49 doses) and the following equi-effective doses:

5,694 mg of teclistamab is equivalent to 3,552 mg of elranatamab.

A revised base case and Sensitivity Analyses with this error corrected are presented. The PSCR noted the correction made by the evaluation relating to the estimation of equi-effective doses was appropriate.

6.59 The ESC considered that the average number of doses for teclistamab was underestimated given that the recommendation for treatment switching applied in the CMA differed to that outlined in the TGA PI and the MajesTEC-1 study. As noted above (see paragraph 6.51), the ESC advised that the dosing schedule for teclistamab should align with the MajesTEC-1 study and the TGA PI, which recommends switching to Q2W after achieving and maintaining a CR or better for a minimum of 6 months.

6.60 The submission included additional costs associated with the cost of administration for teclistamab and elranatamab and the cost of hospitalisation for elranatamab. The submission applied an inpatient hospitalisation cost of $714.19 for three days to all patients receiving elranatamab in the CMA for the step-up phase. This was consistent with the TGA PI for elranatamab. Based on the recommendations in the TGA PI for teclistamab, no cost of hospitalisation for the teclistamab step-up dosing phase was applied in the CMA. However, all patients in MajesTEC-1 were hospitalised for safety monitoring for at least 48 hours after each step-up dose and the first treatment dose.

The ESC noted the TGA PIs state patients should be closely monitored for the first two elranatamab doses and the first three teclistamab doses. The ESC considered that, on balance, the cost of monitoring treatment initiation is likely to be similar for elranatamab and teclistamab and advised that it would be appropriate to remove hospital costs for all patients. The pre-PBAC response stated that the exclusion of hospital costs for all patients was reasonable.

6.61 The costs related to AE management were excluded from the CMA. The submission considered that there were no significant differences between teclistamab and elranatamab in the rate of any AE, any AE Grade 3 or 4, or any SAE, and, therefore, listing teclistamab on the PBS was not expected to incur any additional AE costs.

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

	Teclistamab	Elranatamab
Clinical data	MajesTEC-1 plus Chinese cohort (N=191) ; Chunara et al. (2025)	MagnetisMM-3 (N=123)
Route of administration	Subcutaneous	Subcutaneous
Mean weight, kg	72.83 kg	N/A
Mean duration of treatment (weeks)	71 weeks	71 weeks
Dose intensity	88.81% (mean)	79.12% (median; mean NA)
Switching to less frequent dosing	Q2W: 39.0% from Week 27, increasing to 64.5% at Week 53	Q2W: 47.2% from Week 28.2 Q4W: 22.8% from Week 52
Estimated mg per dose	Step-up dose 1: 3.88 mg Step-up dose 2: 19.48 mg Treatment dose: 97.02 mg	Step-up dose 1: 9.49 mg Step-up dose 2: 25.32 mg Treatment dose: 60.13 mg
Proposed equi-effective doses	5,694 mg (corrected during evaluation) of teclistamab being equivalent to 3,552 mg (corrected during evaluation) of elranatamab.	
Drug cost per mg	A Special Pricing Arrangement (SPA) for teclistamab is requested, consistent with that proposed for elranatamab for 4L+ RRMM. It is proposed that teclistamab be listed at an effective AEMP per vial that reflects the agreed equi-effective doses for teclistamab and elranatamab for the treatment of 4L+ RRMM.	
Total cost of hospitalisation during step-up phase per patient	$0.00	$2,142.57
Number of doses administered	60.5	60.5
Total cost of drug administration per patient	$7,618.90	$7,621.46
Total cost/patient/course	Based on estimated dosing as per CMA approach above at an effective price established in relation to the equi-effective dosing vs elranatamab, and the cost-offsets (administration)	Based on estimated dosing as per CMA approach above at the agreed effective price for elranatamab, and the cost-offsets (hospitalisation, administration)

Source: Table 3.8 p241 of the submission, Section 3 Workbook, Sheets 'Input' and 'Results'

Abbreviations: AEMP = approved ex-manufacturer price; AR-DRG = Australian Refined Diagnosis Related Groups; CMA = cost-minimisation analysis; MBS = Medicare Benefits Schedule; N = number; N/A = not applicable; NR = not reported; Q2W = every 2 weeks; Q4W = every 4 weeks; RDI = relative dose intensity; RRMM = Relapsed refractory multiple myeloma; SPA = special pricing arrangement; TGA PI = Therapeutic Goods Administration product information

6.62 The results of sensitivity analyses presented by the submission and conducted during the evaluation are presented in Table 14. Treatment duration, the timepoint of transition to less frequent dosing, and the proportion of patients switching from QW to Q2W had the greatest impact on the proposed equi-effective doses and number of administrations. The ESC suggested Sensitivity Analysis 5, which assumed 100% of teclistamab patients achieved a CR at 6 months and could therefore switch from

weekly to fortnightly dosing at 53 weeks after maintaining CR for at least 6 months (dosing schedule as per the TGA PI and MajesTEC-1 study).

Table 14: Sensitivity analyses provided in submission and conducted during the evaluation (with all analyses based on revised base case)

	Equi-effective dosing (mg)			Number of administrations		
	TEC	ELR	% change vs base	TEC	ELR	% change vs base
Revised base case[a]	5,694	3,552	-	60.5	60.5	-
Sensitivity Analysis 1: 100% of patients switch to less frequent dosing at the earliest opportunity for both medicines (100% Q2W at 27 weeks for TEC, and 100% Q2W at 28 weeks and 100% Q4W at 52 weeks for ELR[b])	4,776	2,620	-16.1% (TEC) -26.2% (ELR)	51.0	45.0	-17.4% (TEC) -28.4% (ELR)
Sensitivity Analysis 2: Proportion, and time of switch, to fortnightly dosing of teclistamab based on MajesTEC-1 (40.8% switch to fortnightly dosing from Week 53.3)	6,553	3,552	+15.1% (TEC) 0% (ELR)	69.3	60.5	+14.7% (TEC) 0% (ELR)
Sensitivity Analysis 3: Mean weight from Majestec-1 (ph1+2; 75.02kg [SD 16.73])	5,865	3,552	+3.0% (TEC) 0% (ELR)	60.5	60.5	0% (TEC) 0% (ELR)
Sensitivity Analysis 4: Mean RDI (89.63%), based on MajesTEC-1 RP2D only	5,748	3,552	+1.0% (TEC) 0% (ELR)	60.5	60.5	0%(TEC) 0%(ELR)
Sensitivity Analysis 5: Patients switch to less frequent dosing assuming it takes 6 months for TEC patients to achieve a CR and at the earliest opportunity for ELR (100% Q2W at 53 weeks for TEC, and 100% Q2W at 28 weeks and 100% Q4W at 52 weeks for ELR)	6,037	2,620	+6.0% (TEC) -26.2% (ELR)	64.0	45.0	+5.8% (TEC) -28.4% (ELR)

Source: Table 3.9 p242 of the submission
Abbreviations: ELR = elranatamab; FE = financial estimates; RDI = relative dose intensity; TEC = teclistamab
Note:
[a] Refers to calculations conducted during the evaluation based on revised base case including correction of errors (sheet 'Input' Cell C8; corrected to weighted average RDI of 88.78% based on MajesTEC-1 RP2D (89.63%) and Majes-TEC-1 China Cohort (83.6%); Sheet 'Engine' Cell A3: A100: treatment duration indexed sequentially by week; UCM = utilisation and cost model
[b] Aligns with the assumptions applied in the elranatamab cost effectiveness model (Table 2, elranatamab PSD, March 2025 PBAC meeting).

6.63 To facilitate interpretation of the CMA, the evaluation used the proposed published EMP price of teclistamab ($[redacted] per 153 mg vial) to calculate the price of elranatamab that results in the same cost per patient ($[redacted], Table 15) and ran the above sensitivity analyses using these prices (Table 16).

Table 15: CMA assuming published price of teclistamab proposed in financial estimates

	Teclistamab	Elranatamab
EMP per vial	$[redacted] (153 mg)	$[redacted] (76 mg)
Total mg	5,694	3,552
Number of administrations	60.5	60.5
Drug cost	$[redacted]	$[redacted]
Inpatient costs	-	$2,143
Admin costs	$7,619	$7.621
Total cost per patient	$[redacted]	$[redacted]

Source: calculated using corrected CMA spreadsheet provided with submission
Abbreviations: CMA = cost minimisation approach; EMP = ex-manufacturer price

Table 16: Sensitivity analyses based on CMA presented in Table 15

	Cost per patient	Teclistamab EMP	% change in teclistamab EMP
Base case	$[redacted]	$[redacted]	-
Sensitivity Analysis 1	$[redacted]	$[redacted]	-12.1%
Sensitivity Analysis 2	$[redacted]	$[redacted]	-13.5%
Sensitivity Analysis 3	$[redacted]	$[redacted]	-2.9%
Sensitivity Analysis 4	$[redacted]	$[redacted]	-0.9%
Sensitivity Analysis 5	$[redacted]	$[redacted]	-31.1%
Sensitivity Analysis 5 PLUS removal of hospitalisation costs	$[redacted]	$[redacted]	-31.9%

Source: calculated using corrected CMA spreadsheet provided with submission
Abbreviations: CMA = cost minimisation approach; EMP = ex-manufacturer price

6.64 Should the PBAC accept the clinical claim of overall non-inferior effectiveness and safety, the cost-minimisation approach must establish that the cost per patient for treatment with teclistamab would be no more than the cost per patient of elranatamab. Where these cost per patient calculations are uncertain, the guiding principle is that the Australian Government should not bear the financial risk of this uncertainty because the Australian population already has access to therapy that is at least as effective and safe. In this case, the PBAC should consider the following parameters: treatment duration, timepoint for change and proportion of patients changing dose frequency.

6.65 The PBAC recalled that when considering elranatamab in March 2025, the economic and financial model assumed that all patients would switch to less frequent dosing at the earliest opportunity (see paragraph 6.73) according to the TGA PI[10]. . Therefore, for the CMA, the PBAC considered that:

- All patients should switch to less frequent dosing for teclistamab and elranatamab at the earliest opportunity according to the relevant TGA PI documents (teclistamab patients switch to Q2W at 53 weeks; elranatamab patients switch to Q2W at 25 weeks, and to Q4W at 49 weeks;
- It would be appropriate to apply the same relative dose intensity applied to elranatamab (79.12%) to teclistamab as there was no evidence to suggest it may be different in clinical practice; and
- Hospital costs should be removed for all patients (as discussed in paragraph 6.60).

Table 17: PBAC's revised CMA scenario

	Cost per patient	EMP	# doses	mg over 71 weeks
Teclistamab	$[redacted]	$[redacted] (-[redacted]%)	64	5,380 mg
Elranatamab		$[redacted]	43	2,500 mg

Source: Prepared during preparation of the minutes
EMP = ex-manufacturer price

Drug cost/patient/course

6.66 The evaluation calculated a drug cost per patient per course of $[redacted] based on the proposed published price of teclistamab (as presented in Table 15).

[10] At the time of consideration, the Q4W dose of elranatamab was not approved (see paragraph 7.17, elranatamab PSD, March 2025 PBAC meeting) but could be included in modelling if it was approved by the TGA

Estimated PBS usage & financial implications

6.67 This submission was not considered by DUSC.

6.68 The submission used an epidemiological approach to estimate the utilisation and financial implications of listing teclistamab for the treatment of patients with RRMM who have received at least three prior lines of therapy that include a PI, IMiD, and an anti-CD38 antibody. As elranatamab, which was nominated as the main comparator, was not listed on the PBS at the time of submission, a market share approach was not possible.

6.69 The key inputs to the financial estimates are presented in Table 18.

Table 18: Key inputs for financial estimates

Data	Value applied and source	Comment
Eligible population		
Number of MM patients that are TCE	PBS 100% dataset 2021 to 2025 (July to June) inclusive with a linear extrapolation to estimate patient numbers from 2025/2026 onwards: Yr 1: 1,075 Yr 2: 1,181 Yr 3: 1,286 Yr 4: 1,392 Yr 5: 1,498 Yr 6: 1,604	Linear extrapolation may overestimate patient numbers.
Proportion initiating 4L therapy	72% Based on MRDR data (September 2022) adjusted to age reclassification of study demographics from the MajesTEC-1 study to weight these attrition rates across all patient subgroups aged 65 years and over. The age distribution was based on the combined pivotal (RP2D cohort, N =165) and Chinese (N = 26) cohort.	The PBAC considered 72% was an overestimate, noting the elranatamab resubmission assumed 40% in Year 1, increasing over time (Table 18, elranatamab PSD, March 2025 PBAC meeting).
Total TCE patients initiating 4L therapy	Yr 1: 774 Yr 2: 850 Yr 3: 926 Yr 4: 1,002 Yr 5: 1,078 Yr 6: 1,155	-
Treatment utilisation		
BCMA utilisation in 4L setting	Yr 1: [redacted]% Yr 2: [redacted]% Yr 3: [redacted]% Yr 4: [redacted]% Yr 5: [redacted]% Yr 6: [redacted]%	The submission justified this based on claim that the 4L TCE RRMM population is expected to be large and to increase over time; 4L+ TCE RRMM patients will likely be refractory to most PBS options, so the availability of a new class of medicine will address a high unmet need.
Uptake rate	Assumption (source not provided) Yr 1: [redacted]%; Yr 2: [redacted]%; Yr 3: [redacted]%; Yr 4: [redacted]%; Yr 5: [redacted]%; Yr 6: [redacted]%;	Submission claimed that the high uptake rates for teclistamab was due to weight-based dosing regimen, which ensured a consistent therapeutic exposure across a diverse patient population, and as teclistamab does not require hospitalisations during the step-up dosing phase. Noting the clinical claim of non-inferiority, the PBAC considered a maximum market share of [redacted]% would be appropriate.
Teclistamab treatment adherence	88.81%; based on the mean RDI reported for teclistamab in MajesTEC-1.	-

Data	Value applied and source	Comment
Elranatamab treatment adherence	79.12%; based on the RDI reported for elranatamab in MagnetisMM-3	-
Treatment duration	71 weeks; based on the mean treatment duration for elranatamab in the March 2025 submission (Table 18, elranatamab PSD, March 2025 PBAC meeting).	This was in line with the clinical claim of non-inferiority and the CMA approach to the submission.
Costs		
Teclistamab	Requested published price: DPMQ / EMP 30 mg: $[redacted] / $[redacted] 153 mg: $[redacted] / $[redacted]	Effective price was not presented as elranatamab was not PBS listed at time of the submission. Special Pricing Arrangements for teclistamab are requested
Elranatamab	Not PBS listed: In the interim it is assumed that the published DPMQ for elranatamab is equivalent to that of teclistamab: Assumed published price: DPMQ / EMP 44 mg: $[redacted] / $[redacted] 76 mg: $[redacted] / $[redacted]	Neither the published nor effective price for elranatamab were available. The price assumed is higher than the cost minimised price calculated using the proposed published price of teclistamab (EMP $[redacted] for 76 mg, see Table 15)

Source: Section 4, of the submission; Section 4 financial implications Excel workbook.
Abbreviations: BCMA = B-cell maturation antigen; CAR-T = Chimeric Antigen Receptor T-cell; CMA = cost-minimisation analysis; DUSC = Drug Utilisation Sub-Committee; DPMQ = Dispensed Price for Maximum Quantity; MBS =Medicare Benefits Schedule; MM= multiple myeloma; MRDR = Myeloma and Related Disease Registry; PBAC = Pharmaceutical Benefits Advisory Committee; PBS = Pharmaceutical Benefits Scheme; PSD = public summary document; RDI = relative dose intensity; RRMM = relapsed refractory multiple myeloma; TCE = Triple-class exposed; Yr = Year; 4L = fourth-line

6.70 The estimated number of scripts for teclistamab and elranatamab reflected the change in dosing frequencies over the average course of therapy (71 weeks) as per the assumptions applied in the CMA.

6.71 The proportion of patients and timing of switching from QW to Q2W for teclistamab was consistent with the estimates applied in the CMA. However, the financial estimates model did not apply a linear increase in fortnightly dosing between Weeks 27 and 53 as per the assumption applied in the CMA. Instead, the financial estimates model was based on switching to less frequent dosing at discrete time points (i.e. Week 27 and Week 53). This resulted in the lower number of teclistamab doses estimated in the CMA (60.5) compared to the number of doses applied in the financial estimates model (61.8).

6.72 The net change in the number of prescriptions was likely underestimated as the submission applied the timepoint for switching from teclistamab QW to Q2W based on time to CR or better (6.47 months) which was substantially lower than the mean time to switch in MajesTEC-1 (12.3 months) and was inconsistent with the recommendation for switching in the TGA PI (see Table 1 and paragraph 6.51).

6.73 The proportion of patients and timing of switching to less frequent dosing for elranatamab was consistent with the estimates applied in the CMA. However, the economic model and financial estimates considered by the PBAC in March 2025 assumed that all patients receive elranatamab weekly in the first 24 weeks, every 2 weeks from Week 25 to Week 48, and every 4 weeks from Week 49 onwards (see Tables 2 and 18, elranatamab PSD, March 2025 PBAC meeting).

6.74 The mean number of elranatamab doses (60.5) was less than the number of doses of teclistamab (61.5). The submission stated that the number of elranatamab scripts affected by the proposed listing was lower than the increase in teclistamab scripts, due to the less frequent dosing of elranatamab (Q4W), and lower compliance rate (79.12%) compared to teclistamab.

Table 19: 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, total market	[redacted][1]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]
Number of patients treated, teclistamab	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]
Teclistamab scripts	[redacted][3]	[redacted][4]	[redacted][4]	[redacted][5]	[redacted][5]	[redacted][5]
Elranatamab scripts	-[redacted][3]	-[redacted][4]	-[redacted][4]	-[redacted][4]	-[redacted][5]	-[redacted][5]
Estimated financial implications of teclistamab						
Cost to PBS/RPBS less copayments	$[redacted][5]	$[redacted][6]	$[redacted][7]	$[redacted][7]	$[redacted][7]	$[redacted][7]
Estimated financial implications for elranatamab						
Cost offset to PBS/RPBS less copayments	-$[redacted][8]	-$[redacted][8]	-$[redacted][8]	-$[redacted][8]	-$[redacted][8]	-$[redacted][8]
Net financial implications						
Net cost to PBS/RPBS	**$[redacted][9]**	**$[redacted][9]**	**$[redacted][10]**	**$[redacted][10]**	**$[redacted][10]**	**$[redacted][11]**
Net cost to MBS	$[redacted][9]	$[redacted][9]	$[redacted][9]	$[redacted][9]	$[redacted][9]	$[redacted][9]
Net cost to the PBS/RPBS/MBS	$[redacted][9]	$[redacted][9]	$[redacted][10]	$[redacted][10]	$[redacted][10]	$[redacted][11]

Table 4.10 p260 of the submission, Section 4 Workbook, Sheet 5. Impact-net
Abbreviations: PBS = Pharmaceutical Benefits Scheme; RPBS = Repatriation Schedule of Pharmaceutical Benefits
The redacted values correspond to the following ranges:
[1] *< 500*
[2] *500 to < 5,000*
[3] *5,000 to < 10,000*
[4] *10,000 to < 20,000*
[5] *$40 million to < $50 million*
[6] *$80 million to < $90 million*
[7] *$100 million to < $200 million*
[8] *net cost saving*
[9] *$0 to < $10 million*
[10] *$10 million to < $20 million*
[11] *$20 million to < $30 million*

6.75 The estimated net cost to the PBS/RPBS was $0 to < $10 million in Year 1, increasing to $20 million to < $30 million in Year 6, and totalling $80 million to < $90 million over the first 6 years of listing (Table 19).

6.76 The estimated financial implications associated with listing teclistamab on the PBS provided in the submission were considered uncertain due to the following reasons:

- The number of TCE patients initiating 4L therapy may be overestimated, based on the linear extrapolation of the PBS 100% dataset to estimate the number of TCE patients and the use of the MRDR dataset to estimate the proportion of patients that would initiate 4L therapy.
- Uptake rates associated with teclistamab were considered uncertain and may be high in the context of a fourth or later RRMM treatment and the potential availability of elranatamab and CAR-T therapy for 4L+ TCE RRMM.
- The utilisation estimates for teclistamab relied on assumptions regarding the proportion of patients and time of switching to Q2W dosing which were informed by feedback from clinicians and Chunara et al. 2025. However, these were not consistent with the recommendations in TGA PI or the MajesTEC-1 study.

Quality Use of Medicines

6.77 The submission proposed activities to support the quality use of medicines including:

- Holding hospital-based training for clinics administering teclistamab. This includes tailored education for haematologists, pharmacists, and nursing teams to ensure safe and effective administration, particularly during the step-up dosing phase.
- Educational materials for health care professionals (HCPs) to support the safe administration of teclistamab and the management of adverse events.
- Patient and carer support: In line with the teclistamab Risk Management Plan (RMP), patient wallet cards will be distributed to support emergency identification and management of CRS. Additionally, patient and carer educational materials are provided to promote awareness of potential side effects and encourage early reporting and intervention. These resources are currently in use under the self-pay program'.
- The Sponsor is planning to partner with Myeloma Australia to co-develop a teclistamab factsheet and deliver training to the Myeloma Australia nurse team. This initiative will help ensure consistent, high-quality information is available to patients and support staff across the country.
- Planned medical education events and video content to further support best practice in teclistamab administration and adverse event management. These materials will be designed to reinforce key safety messages and practical guidance for clinical teams.

6.78 The DUSC previously considered that CRS and Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS) are novel complications that are not well understood outside specialist centres, and that education of both patients and health care practitioners would be needed (paragraph 6.73, elranatamab, PSD, July 2024 PBAC meeting). The ESC noted experience in managing CRS and ICANS has increased.

Financial Management – Risk Sharing Arrangements

6.79 The ESC noted that when recommending elranatamab in March 2025, the PBAC considered that, due to uncertainties with the financial estimates, a risk sharing arrangement (RSA) would be required. The ESC considered that if recommended, teclistamab should join the RSA for elranatamab.

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

7 PBAC Outcome

7.1 The PBAC recommended teclistamab for the treatment of patients with relapsed or refractory multiple myeloma (RRMM) who have received at least 3 prior lines of therapy, including a proteasome inhibitor (PI), an immunomodulatory agent (IMiD) and an anti-CD38 monoclonal antibody, on the basis that it should be available only under special arrangements under the Section 100 (Efficient Funding of Chemotherapy – Related Benefits) and as a General Schedule listing. The PBAC considered that teclistamab was non-inferior in terms of efficacy and safety compared to the nominated comparator, elranatamab. The PBAC considered that teclistamab would be acceptably cost effective if it were cost minimised to elranatamab. The PBAC considered the impact of listing teclistamab on the PBS should be approximately cost neutral and advised that teclistamab should join the risk sharing arrangement (RSA) for elranatamab with no increase in the expenditure caps.

7.2 The PBAC acknowledged the input received from individuals, health care professionals and organisations supporting the submission. The PBAC noted that the input highlighted the continued need for new and effective therapies for patients with RRMM. The PBAC noted the positive responses to treatment for patients who have accessed teclistamab via clinical trials and the substantial improvements that treatment offered to their quality of life.

7.3 The PBAC considered that the positioning of teclistamab, as a fourth-line therapy for use in patients who have progressed on, or are refractory to at least 3 prior lines of therapy including a PI, and IMid and an anti-CD38 monoclonal antibody was appropriate.

7.4 The PBAC considered that the nominated comparator, elranatamab, was appropriate, noting that it was recommended for use in the same clinical setting in March 2025.

7.5 The PBAC considered that the proposed restrictions were reasonable, noting that the amendments made by the Secretariat to align the restrictions with the elranatamab restrictions were appropriate. The PBAC agreed that a grandfather restriction was not required. The PBAC stated that the restrictions should allow for switching between elranatamab and teclistamab in the absence of disease progression e.g. in cases of intolerance. The PBAC advised that this would require flow-on changes to the elranatamab restrictions.

7.6 The PBAC noted that the submission was based on an unanchored, matched adjusted indirect comparison (MAIC) between the results from the open-label, single arm MajesTEC-1 (teclistamab) and MagnetisMM-3 (elranatamab) studies.

7.7 The PBAC noted that there were some uncertainties with the MAIC (see paragraph 6.40). The PBAC noted that for all the analyses presented in the submission, there were no statistically significant differences between teclistamab and elranatamab (see Table 6, Table 7 and Table 8). The PBAC noted that the adjusted analyses from a published indirect comparison, Mol 2025, statistically significantly favoured elranatamab but noted that this analysis, which adjusted for additional prognostic factors, more than halved the population included in the analysis (see Table 9). The PBAC considered that on balance, it was likely that teclistamab was non-inferior in terms of effectiveness compared to elranatamab.

7.8 The PBAC noted that there were some differences in the adverse event profiles of teclistamab and elranatamab but, noting the common mechanism of action, considered that teclistamab was non-inferior in terms of safety compared to elranatamab.

7.9 The PBAC noted that the submission presented a CMA versus elranatamab. The PBAC advised the following assumptions for the CMA would be reasonable (as discussed in paragraph 6.65):

- all patients should switch to less frequent dosing at the earliest opportunity;
- the relative dose intensity applied to elranatamab should be applied to teclistamab;
- hospital administration costs should be removed; and

- the same duration of therapy for teclistamab and elranatamab should be applied.

7.10 Over 71 weeks, the PBAC considered that the equi-effective doses were:

5,380 mg of teclistamab = 2,500 mg of elranatamab (see Table 17)

7.11 The PBAC considered the estimated number of patients with TCE (based on linear extrapolation of PBS data) and the proportion initiating 4L treatment (based on the MRDR database) were overestimated. However, on balance, the PBAC considered that if the utilisation reflected the dosing applied in the CMA (see paragraph 7.9), the addition of teclistamab to the PBS would be approximately cost neutral as the eligible population would already be accounted for by the elranatamab listing.

7.12 The PBAC advised that teclistamab should join the RSA for elranatamab with no increase to expenditure caps.

7.13 The PBAC recommended that teclistamab should not be treated as interchangeable with any other drugs.

7.14 The PBAC advised that teclistamab is not suitable for prescribing by nurse practitioners.

7.15 The PBAC advised that teclistamab should not be exempt from the Early Supply Rule.

7.16 The PBAC noted that its recommendation was on a cost-minimisation basis and advised that, because teclistamab is not expected to provide a substantial and clinically relevant improvement in efficacy, or reduction of toxicity, over elranatamab, or not expected to address a high and urgent unmet clinical need given the presence of an alternative therapy, the criteria prescribed by the *National Health (Pharmaceuticals and Vaccines – Cost Recovery) Regulations 2022* for Pricing Pathway A were not met.

7.17 The PBAC noted that this submission is not eligible for an Independent Review as it received a positive recommendation.

Outcome:
Recommended

8 Recommended listing

8.1 Add new item:

Initial/induction doses:

MEDICINAL PRODUCT medicinal product pack		PBS item code	Max. qty packs	Max. qty units	№.of Rpts	Available brands
TECLISTAMAB						
Teclistamab 30 mg/3 mL injection, vial		NEW (CT)	1	1	1	Tecvayli
Teclistamab 30 mg/3 mL injection, vial		NEW (GE)	1	1	1	Tecvayli
Concept ID (for internal Dept. use)	Category / Program: ☒ GENERAL – General Schedule (Code GE) ☒ Section 100 – Efficient Funding of Chemotherapy – Related Benefits (Code CT)					
	Prescriber type: ☒Medical Practitioners					
	Restriction type: ☒Authority Required (Telephone/Online)					
	Authority type: ☒ Non-complex Authority Required (non-CAR)					
	Episodicity: [Blank]					
	Severity: Relapsed or refractory					

	Condition: Multiple myeloma
	Indication: Relapsed or refractory multiple myeloma
	Treatment Phase: Induction treatment (step-up dosing)
	Clinical criteria:
	The condition must be confirmed by a histological diagnosis
	AND
	Clinical criteria:
	Patient must have had progressive disease after receiving at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, and (iii) an anti-CD38 monoclonal antibody; or
	Patient must have been refractory to, at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, (iii) an anti-CD38 monoclonal antibody
	AND
	Clinical criteria:
	Patient must have a WHO performance status of 2 or less
	AND
	Clinical criteria:
	Patient must not have previously received treatment with another B-cell maturation antigen (BCMA) directed therapy for this condition; or
	Patient must have received elranatamab for this PBS indication and are switching treatment due to intolerance
	AND
	Clinical criteria:
	The treatment must be the sole PBS-subsidised systemic anti-cancer therapy for this condition
	Prescribing instruction: According to the TGA-approved Product Information, patients should be instructed to remain within proximity of a healthcare facility for 48 hours after all doses within the induction treatment phase.
	Prescribing instruction: Patients who require restarting therapy due to dose delays may access step-up dosing through this induction treatment restriction.
	Prescribing instruction: This drug is not PBS-subsidised if it is administered to an in-patient in a public hospital setting.
	Prescriber Instructions: Progressive disease is defined as at least 1 of the following: (a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or (b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or (c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase in the difference between involved free light chain and uninvolved free light chain; or (d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or (e) an increase in the size or number of lytic bone lesions (not including compression fractures); or (f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or (g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause). Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein. Details of: the histological diagnosis of multiple myeloma; prior treatments including name(s) of drug(s) and date of most recent treatment cycle; the basis of the diagnosis of progressive disease or failure to respond; and which disease activity parameters will be used to assess response, must be documented in the patient's medical records. Confirmation of eligibility for treatment with current diagnostic reports of at least one of the following must be documented in the patient's medical records: (a) the level of serum monoclonal protein; or

	(b) Bence-Jones proteinuria - the results of 24-hour urinary light chain M protein excretion; or (c) the serum level of free kappa and lambda light chains; or (d) bone marrow aspirate or trephine; or (e) if present, the size and location of lytic bone lesions (not including compression fractures); or (f) if present, the size and location of all soft tissue plasmacytomas by clinical or radiographic examination i.e. MRI or CT-scan; or (g) if present, the level of hypercalcaemia, corrected for albumin concentration. As these parameters must be used to determine response, results for either (a) or (b) or (c) should be documented for all patients. Where the patient has oligo-secretory or non-secretory multiple myeloma, either (c) or (d) or if relevant (e), (f) or (g) must be documented in the patient's medical records. Where the prescriber plans to assess response in patients with oligo-secretory or non-secretory multiple myeloma with free light chain assays, evidence of the oligo-secretory or non-secretory nature of the multiple myeloma (current serum M protein less than 10 g per L) must be documented in the patient's medical records. Refractory disease is defined as less than or equal to a 25% response to therapy, or progression during or within 60 days after completion of therapy
	Administrative advice: No increase in the maximum number of repeats may be authorised
	Administrative advice: Special pricing arrangements apply
	Administrative Advice: Applications for authorisation under this restriction may be made in real time using the Online PBS Authorities system (see www.servicesaustralia.gov.au/HPOS) or by telephone by contacting Services Australia on 1800 888 333.

Continuing treatment:

MEDICINAL PRODUCT medicinal product pack	PBS item code	Max. qty packs	Max. qty units	№.of Rpts	Available brands
ELRANATAMAB					
Teclistamab 153 mg/1.7 mL injection, vial	NEW (CT)	2	2	5	Tecvayli
Teclistamab 153 mg/1.7 mL injection, vial	NEW (GE)	2	2	5	Tecvayli

Concept ID (for internal Dept. use)	Category / Program: ☒ GENERAL – General Schedule (Code GE) ☒ Section 100 – Efficient Funding of Chemotherapy – Related Benefits (Code CT)
	Prescriber type: ☒Medical Practitioners
	Restriction type: ☒Authority Required (Telephone/Online) – Immediate Assessment
	Authority type: ☒ Non-complex Authority Required (non-CAR)
	Episodicity: [Blank]
	Severity: Relapsed or refractory
	Condition: Multiple myeloma
	Indication: Relapsed or refractory multiple myeloma
	Treatment Phase: Continuing treatment
	Clinical criteria:
	Patient must have had progressive disease after receiving at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, and (iii) an anti-CD38 monoclonal antibody; or
	Patient must have been refractory to, at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, (iii) an anti-CD38 monoclonal antibody
	AND
	Clinical criteria:
	Patient must have a WHO performance status of 2 or less prior to initiating treatment with this drug for this condition
	Clinical criteria:
	Patient must not have previously received treatment with another B-cell maturation antigen (BCMA) directed therapy for this condition; or
	Patient must have received elranatamab for this PBS indication and are switching treatment due to intolerance
	AND

	Clinical criteria:
	Patient must not have developed disease progression while receiving treatment with a BCMA directed therapy for this condition
	AND
	Clinical criteria:
	The treatment must be the sole PBS-subsidised systemic anti-cancer therapy for this condition
	Prescribing Instructions: According to the TGA-approved Product Information, patients should be instructed to remain within proximity of a healthcare facility for 48 hours after the first full treatment dose in the continuing treatment phase.
	Prescribing Instructions: Prescribers may request the number of vials in line with the dosing requirement for each stage of treatment with the intention of providing the number of vials for each 4-weeks of treatment (24-weeks of treatment including repeats). Up to a maximum of 8 vials for each 4-weeks of treatment, with 5 repeats, may be requested for a patient undergoing treatment.
	Prescribing Instructions: Progressive disease is defined as at least 1 of the following: (a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or (b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or (c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase in the difference between involved free light chain and uninvolved free light chain; or (d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or (e) an increase in the size or number of lytic bone lesions (not including compression fractures); or (f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or (g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).
	Prescribing instruction: This drug is not PBS-subsidised if it is administered to an in-patient in a public hospital setting.
	Administrative advice: No increase in the maximum number of repeats may be authorised
	Administrative advice: Special pricing arrangements apply
	Administrative Advice: Applications for authorisation under this restriction may be made in real time using the Online PBS Authorities system (see www.servicesaustralia.gov.au/HPOS) or by telephone by contacting Services Australia on 1800 888 333.

8.2 Flow-on changes to elranatamab to allow treatment switching in the absence of disease progression (additions are in italics and deletions are in strikethrough):

Initial/induction – Elranatamab:

MEDICINAL PRODUCT medicinal product pack	PBS item code	Max. qty packs	Max. qty units	№.of Rpts	Available brands
ELRANATAMAB					
Elranatamab 44 mg/1.1 mL injection, 1.1 mL vial	15301H (CT)	1	1	1	Elrexfio
Elranatamab 44 mg/1.1 mL injection, 1.1 mL vial	15300G (GE)	1	1	1	Elrexfio
Concept ID (for internal Dept. use)	Category / Program: ☒ GENERAL – General Schedule (Code GE) ☒ Section 100 – Efficient Funding of Chemotherapy – Related Benefits (Code CT)				
	Prescriber type: ☒Medical Practitioners				
	Restriction type: ☒Authority Required (Telephone/Online)				

	Episodicity: [Blank]
	Severity: Relapsed or refractory
	Condition: Multiple myeloma
	Indication: Relapsed or refractory multiple myeloma
	Treatment Phase: Induction treatment (step-up dosing)
	Clinical criteria:
	The condition must be confirmed by a histological diagnosis
	AND
	Clinical criteria:
	Patient must have had progressive disease after receiving at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, and (iii) an anti-CD38 monoclonal antibody; or
	Patient must have been refractory to, at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, (iii) an anti-CD38 monoclonal antibody
	AND
	Clinical criteria:
	Patient must have a WHO performance status of 2 or less
	AND
	Clinical criteria:
	Patient must not have previously received treatment with another B-cell maturation antigen (BCMA) directed therapy for this condition; *or*
	Patient must have received teclistamab for this PBS indication and are switching treatment due to intolerance
	AND
	Clinical criteria:
	The treatment must be the sole PBS-subsidised systemic anti-cancer therapy for this condition
	Prescribing instruction: According to the TGA-approved Product Information, patients should be instructed to remain within proximity of a healthcare facility for 48 hours after all doses within the induction treatment phase.
	Prescribing instruction: Patients who require restarting therapy due to dose delays may access step-up dosing through this induction treatment restriction.
	Prescribing instruction: This drug is not PBS-subsidised if it is administered to an in-patient in a public hospital setting.
	Prescriber Instructions: Progressive disease is defined as at least 1 of the following: (a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or (b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or (c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase in the difference between involved free light chain and uninvolved free light chain; or (d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or (e) an increase in the size or number of lytic bone lesions (not including compression fractures); or (f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or (g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause). Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein. Details of: the histological diagnosis of multiple myeloma; prior treatments including name(s) of drug(s) and date of most recent treatment cycle; the basis of the diagnosis of progressive disease or failure to respond; and which disease activity parameters will be used to assess response, must be documented in the patient's medical records.

	Confirmation of eligibility for treatment with current diagnostic reports of at least one of the following must be documented in the patient's medical records: (a) the level of serum monoclonal protein; or (b) Bence-Jones proteinuria - the results of 24-hour urinary light chain M protein excretion; or (c) the serum level of free kappa and lambda light chains; or (d) bone marrow aspirate or trephine; or (e) if present, the size and location of lytic bone lesions (not including compression fractures); or (f) if present, the size and location of all soft tissue plasmacytomas by clinical or radiographic examination i.e. MRI or CT-scan; or (g) if present, the level of hypercalcaemia, corrected for albumin concentration. As these parameters must be used to determine response, results for either (a) or (b) or (c) should be documented for all patients. Where the patient has oligo-secretory or non-secretory multiple myeloma, either (c) or (d) or if relevant (e), (f) or (g) must be documented in the patient's medical records. Where the prescriber plans to assess response in patients with oligo-secretory or non-secretory multiple myeloma with free light chain assays, evidence of the oligo-secretory or non-secretory nature of the multiple myeloma (current serum M protein less than 10 g per L) must be documented in the patient's medical records. Refractory disease is defined as less than or equal to a 25% response to therapy, or progression during or within 60 days after completion of therapy
	Administrative Advice: No increase in the maximum quantity or number of units may be authorised.
	Administrative Advice: No increase in the maximum number of repeats may be authorised
	Administrative Advice: Special pricing arrangements apply
	Administrative Advice: Applications for authorisation under this restriction may be made in real time using the Online PBS Authorities system (see www.servicesaustralia.gov.au/HPOS) or by telephone by contacting Services Australia on 1800 888 333.

Continuing treatment – Elranatamab:

MEDICINAL PRODUCT medicinal product pack	PBS item code	Max. qty packs	Max. qty units	№.of Rpts	Available brands
ELRANATAMAB					
Elranatamab 76 mg/1.9 mL injection, 1.9 mL vial	15331X (CT)	1	1	5	Elrexfio
Elranatamab 76 mg/1.9 mL injection, 1.9 mL vial	15293X (GE)	1	1	5	Elrexfio

Concept ID (for internal Dept. use)	Category / Program: ☒ GENERAL – General Schedule (Code GE) ☒ Section 100 – Efficient Funding of Chemotherapy – Related Benefits (Code CT)
	Prescriber type: ☒Medical Practitioners
	Restriction type: ☒Authority Required (Telephone/Online) – Immediate Assessment
	Episodicity: [Blank]
	Severity: Relapsed or refractory
	Condition: Multiple myeloma
	Indication: Relapsed or refractory multiple myeloma
	Treatment Phase: Continuing treatment
	Clinical criteria:
	Patient must have had progressive disease after receiving at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, and (iii) an anti-CD38 monoclonal antibody; or
	Patient must have been refractory to, at least 3 prior lines of therapy, including each of the following therapies: (i) a proteasome inhibitor, (ii) an immunomodulatory agent, (iii) an anti-CD38 monoclonal antibody
	AND
	Clinical criteria:
	Patient must not have previously received treatment with another B-cell maturation antigen (BCMA) directed therapy for this condition; or
	Patient must have received teclistamab for this PBS indication and are switching treatment due to intolerance
	AND

	Clinical criteria:
	Patient must have a WHO performance status of 2 or less prior to initiating treatment with this drug for this condition
	AND
	Clinical criteria:
	Patient must not have developed disease progression while receiving treatment with *a B-cell maturation antigen (BCMA) directed therapy* for this condition
	AND
	Clinical criteria:
	The treatment must be the sole PBS-subsidised systemic anti-cancer therapy for this condition
	Prescribing Instructions: Progressive disease is defined as at least 1 of the following: (a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or (b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or (c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase in the difference between involved free light chain and uninvolved free light chain; or (d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or (e) an increase in the size or number of lytic bone lesions (not including compression fractures); or (f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or (g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).
	Prescribing Instructions: According to the TGA-approved Product Information, patients should be instructed to remain within proximity of a healthcare facility for 48 hours after the first full treatment dose in the continuing treatment phase.
	Prescribing Instructions: Prescribers may request the number of vials in line with the dosing requirement for each stage of treatment with the intention of providing the number of vials for each 4-weeks of treatment (24-weeks of treatment including repeats). Up to a maximum of 8 vials for each 4-weeks of treatment, with 5 repeats, may be requested for a patient undergoing treatment.
	Prescribing instruction: This drug is not PBS-subsidised if it is administered to an in-patient in a public hospital setting.
	Administrative Advice: No increase in the maximum number of repeats may be authorised
	Administrative Advice: Special pricing arrangements apply
	Administrative Advice: Applications for authorisation under this restriction may be made in real time using the Online PBS Authorities system (see www.servicesaustralia.gov.au/HPOS) or by telephone by contacting Services Australia on 1800 888 333.

These restrictions 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

The sponsor had no comment.