7.01 BELANTAMAB MAFODOTIN, Powder for injection 70 mg, Powder for injection 100 mg, Blenrep®, GlaxoSmithKline Australia Pty Ltd.

1 Purpose of submission

1.1 The standard re-entry resubmission requested a Section 100 (Efficient Funding of Chemotherapy) Authority Required listing of belantamab mafodotin for use in combination with bortezomib and dexamethasone (BmBd), for the treatment of relapsed and/or refractory multiple myeloma in patients who have progressive disease after at least one prior line of therapy.

1.2 Listing was requested on the basis of a cost-effectiveness analysis versus daratumumab in combination with bortezomib and dexamethasone (DBd) and carfilzomib in combination with dexamethasone (Cd). The model was updated in the pre-PBAC response to include costs associated with pomalidomide in combination with bortezomib and dexamethasone (PBd).

Table 1: Key components of the clinical issue addressed in the resubmission

Component	Description
Population	Patients with relapsed or refractory multiple myeloma who have received at least ~~after~~ one prior line of therapy.
Intervention	Belantamab in combination with bortezomib and dexamethasone (BmBd)
Comparator	Main comparators: - Daratumumab in combination with bortezomib and dexamethasone (DBd) - Carfilzomib in combination with dexamethasone (Cd) Supplementary comparators: - Pomalidomide in combination with bortezomib and dexamethasone (PBd) - Selinexor in combination with bortezomib and dexamethasone (SBd)
Outcomes	Progression-free survival, overall survival, duration of response, minimal residual disease negativity, health-related quality of life, adverse events.
Clinical claim	In patients with relapsed or refractory multiple myeloma who have received at least ~~after~~ one prior line of therapy: - BmBd is superior in terms of efficacy, with an inferior safety profile, compared to DBd. - BmBd is superior in terms of efficacy, with a different safety profile, compared to Cd, PBd and SBd.

Source: Table 1-2, p27 of the resubmission; Table 1, p1 of the November 2025 belantamab mafodotin public summary document.
Note: Changes compared to the November 2025 submission are indicated by underlining/strikethrough.

2 Background

Registration status

2.1 Belantamab mafodotin was registered on the Australian Register of Therapeutic Goods on 18 November 2025 for the treatment of adults with relapsed or refractory multiple myeloma:

- In combination with bortezomib and dexamethasone in patients who have received at least one prior therapy; and
- In combination with pomalidomide and dexamethasone in patients who have received at least one prior therapy including lenalidomide. Listing for this population has not been requested in the resubmission.

Previous PBAC consideration

2.2 The PBAC did not recommend BmBd for the treatment of relapsed or refractory multiple myeloma after one prior line of therapy at the November 2025 PBAC meeting. A summary of the key matters of concern is provided in Table 2.

Table 2: Summary of key matters of concern

Matter of concern identified in November 2025 belantamab mafodotin PSD	How the resubmission addresses it
Proposed restriction	
A broader listing of BmBd, for use in the wider relapsed and/or refractory multiple myeloma setting rather than just the second line setting, would be more appropriate (paragraph 7.1).	The place in therapy was broadened from the treatment of patients with one prior line of therapy to treatment of patients with one or more prior lines of therapy.
An Authority Required (telephone/online) listing for both the initial and continuing restrictions would be appropriate (paragraph 7.10).	Authority Required (telephone/online) restrictions were proposed for initial and continuing treatment with belantamab mafodotin.
A cautionary note regarding ocular toxicity should be included and reference the need for eye exams prior to the first four doses of belantamab mafodotin (paragraph 7.10).	The resubmission stated that measures currently in place (including the guidance on ophthalmic examination in the belantamab mafodotin product information and consumer medicines information, and proposed quality use of medicines initiatives) are comprehensive, and therefore an additional cautionary note may not be necessary.
The restriction should prevent use in patients who have received a prior B-cell maturation antigen (BCMA) therapy (paragraph 7.10).	The proposed restriction was updated with a criterion specifying that patients must not have previously received treatment with another BCMA-directed therapy.
Comparator	
A mixed comparator that consisted of daratumumab, carfilzomib, pomalidomide, selinexor and elotuzumab would be reasonable for a broader relapsed and/or refractory multiple myeloma listing (paragraph 7.3).	DBd and Cd were nominated as the main comparators; with PBd and SBd nominated as supplementary comparators (the November 2025 submission nominated DBd as the main comparator). [a]
Clinical evidence	
The dose modifications required to address the high rates of ocular toxicity and the recent listing of DLd in the first line setting could affect the effectiveness of BmBd in clinical practice (paragraph 7.1).	The resubmission presented the results of a *post hoc* analysis of progression-free survival among patients in the BmBd arm with ≥1 dose delay of ≥12 weeks. The resubmission stated that prior daratumumab exposure is not expected to compromise the effectiveness of BmBd.

Matter of concern identified in November 2025 belantamab mafodotin PSD	How the resubmission addresses it
The use of the DREAMM-7 ITT population would have been more robust, as although the majority of first-line therapy in Australia includes lenalidomide, the lenalidomide-exposed subgroup did not reflect the proposed second-line population in terms of prior lines of therapy (paragraph 7.4).	The clinical claim for BmBd versus DBd was based on the results for the ITT population of the DREAMM-7 trial (previously based on the lenalidomide-exposed subgroup). Clinical comparisons were presented for BmBd versus Cd, PBd and SBd (based on the results of a network meta-analysis for progression-free survival and overall survival; and based on an unanchored comparison for safety outcomes).
Economic analysis	
Given the issues with the proposed place in therapy for BmBd (second line only), the PBAC considered that the economic model presented in the submission was largely uninformative. (paragraph 7.7). Additionally, the use of the lenalidomide-exposed subgroup to inform the economic model was not adequately justified (paragraph 7.7).	The target population was revised to patients with relapsed/refractory multiple myeloma after one or more prior lines of therapy. The base case was revised using the ITT population of the DREAMM-7 trial (used to inform population characteristics, health state allocation, initial treatment costs, subsequent treatment costs, health state utilities and adverse event incidence). The model was also updated to include a comparison against Cd, with a weighted overall result based on the nominated main comparators (% DBd, % Cd).
The extrapolation of trial data, from a median follow-up of 37.5 months in the DREAMM-7 trial to 20 years, was associated with a substantial amount of uncertainty. Further, the PBAC considered that a 20-year time horizon was long as the mean age of patients diagnosed with multiple myeloma in Australia was 71.5 years (paragraph 7.7).	The time horizon was reduced to 15 years.
The use of the exponential function (based on the lenalidomide-exposed subgroup) appeared to underestimate overall survival for patients in the DBd arm. Further, the modelled survival of patients in the BmBd arm was implausibly high, with 11% of patients remaining alive at 20 years (paragraph 7.7).	The resubmission used the exponential function for extrapolation of overall survival for BmBd and DBd, stating that the uncertainties associated with modelled survival were addressed by applying a shorter 15 year time horizon in the base case.
The economic model did not adequately capture the costs and quality of life impact associated with severe ocular toxicity events (paragraph 7.8).	Costs associated with ocular toxicity events were updated (increased frequency of regular ophthalmic examination visits, no change to costs associated with ocular adverse events). Quality of life impacts associated with ocular toxicity events were unchanged.
Financial estimates	
A standard market share approach, accounting for increased survival, would have provided more accurate estimates of the initial population than the combined epidemiological/market share approach used, as the submission assumed that BmBd will replace DBd (paragraph 7.9).	The resubmission used a mixed epidemiological/market share approach to estimate the utilisation and financial implications of listing belantamab mafodotin. The proposed population was broadened to include patients with one or more prior lines of therapy (previously limited to patients with one prior line of therapy). Cost offsets were included for second line substitution of BmBd for DBd, and second- and third-line substitution of BmBd for Cd (previously based on substitution for second line DBd only).

Matter of concern identified in November 2025 belantamab mafodotin PSD	How the resubmission addresses it
With the listing of DLd in the first line setting, the use of other drugs, such as BmBd would likely increase in the second and later line settings in approximately 3 to 4 years. Conversely, the potential PBS listing of the near market comparator, elranatamab, which is also an antibody targeting BCMA, may reduce BmBd use (paragraph 7.9).	A proportion of patients were assumed to receive DLd as a first line treatment option. The second line BmBd uptake rate (for patients who would otherwise be eligible for second line treatment with DBd) was reduced. Elranatamab was listed on the PBS on 1 April 2026, for the treatment of patients with relapsed or refractory multiple myeloma after at least 3 prior lines of therapy.

Source: Constructed during the evaluation with reference to the belantamab mafodotin November 2025 Public Summary Document, the belantamab mafodotin November 2025 PBAC minutes and the current belantamab mafodotin resubmission.
Abbreviations: BCMA, B-cell maturation antigen; BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; DBd, daratumumab in combination with bortezomib and dexamethasone; DLd, daratumumab in combination with lenalidomide and dexamethasone; ITT, intention to treat; PBd, pomalidomide in combination with bortezomib and dexamethasone; PSD, Public Summary Document; QALY, quality-adjusted life year; SBd, selinexor in combination with bortezomib and dexamethasone.
[a] The resubmission stated that elotuzumab was not included as a comparator in the current resubmission on the basis that it is only available through the PBS for existing patients on treatment from 1 December 2024.

2.3 A multiple myeloma stakeholder meeting was held in July 2025 to discuss PBS listed therapies for multiple myeloma, including the non-alignment of current PBS medicine restrictions with clinical guidelines, and a future optimal PBS treatment paradigm that would be cost-effective and financially sustainable (p1, Outcome Statement, July 2025 multiple myeloma stakeholder meeting[1]).

2.4 A subsequent meeting with multiple myeloma sponsors was held in February 2026 to respond to the issues raised at the July 2025 meeting, and to discuss opportunities and challenges to moving toward this optimal and preferred treatment landscape for multiple myeloma in Australia (p1, Outcome Statement, February 2026 multiple myeloma stakeholder meeting[2]).

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

3 Requested listing

3.1 Suggested additions are in italics and deletions are in strikethrough.

MEDICINAL PRODUCT Form	Dispensed Price Max Amt	Max. Amount	№.of Rpts
BELANTAMAB MAFODOTIN	Public hospital $[redacted] published price $[redacted] effective price Private hospital $[redacted] published price $[redacted] effective price	300 mg	7

[1] Multiple-Myeloma-Meeting-Outcome-Statement.pdf
[2] Multiple-Myeloma-Sponsor-Outcomes-Statement-February-2026.pdf

Available brands
Blenrep (belantamab mafodotin 70 mg injection, 1 vial) Blenrep (belantamab mafodotin 100 mg injection, 1 vial)
Category / Program: Section 100 – Efficient Funding of Chemotherapy
Prescriber type: ☒Medical Practitioners
Restriction type: ☒Authority Required (telephone/online PBS Authorities system)
Episodicity: Relapsed and/or refractory
Condition: Multiple myeloma
Indication: Relapsed and/or refractory multiple myeloma
Treatment phase: Initial treatment ~~for weeks 1 to 24~~
Clinical criteria:
The condition must be confirmed by a histological diagnosis,
AND
Clinical criteria:
The treatment must be *(or have been) initiated)* in combination with bortezomib and dexamethasone,
AND
Clinical criteria:
Patient must have progressive disease after at least one prior therapy,
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 not have developed disease progression while receiving treatment with this drug for this condition.
Treatment phase: Continuing treatment ~~from week 25 until disease progression~~
Clinical criteria:
Patient must have previously received PBS-subsidised 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.
~~**Treatment Phase:** Grandfathered treatment - transitioning from non-PBS to PBS subsidised supply~~
~~**Clinical criteria:**~~
~~Patient must have received non-PBS-subsidised treatment with this drug for this condition prior to *[insert listing date here]*,~~
~~**AND**~~
~~**Clinical criteria:**~~
~~Patient must have met all initial treatment PBS-eligibility criteria applying to a non-grandfathered patient prior to having commenced treatment with this drug, which are: (i) the condition was confirmed by histological diagnosis, (ii) the treatment is/was being used as part of triple combination therapy with bortezomib and dexamethasone, (iii) the condition progressed (see definition of progressive disease below) after at least one prior therapy, and (iv) patient must not have previously received treatment with another B-cell maturation antigen (BCMA) directed therapy for this condition,~~
~~**AND**~~
~~**Clinical criteria:**~~
~~Patient must not have developed disease progression while receiving treatment with this drug for this condition.~~

~~Prescribing instructions:~~
~~Progressive disease is defined as at least one 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 extraction, 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 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.~~
~~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.~~ ~~Increased maximum amount will be authorised where a patient's weight is greater than 120 kg.~~ ~~No increase in the maximum number of repeats may be authorised.~~ ~~Special Pricing Arrangements apply.~~

3.2 The resubmission requested a special pricing arrangement, with an effective ex-manufacturer price (EMP) for belantamab mafodotin of $[redacted] per 100 mg vial and $[redacted] per 70 mg vial (a reduction of [redacted]% compared to the November 2025 submission). The resubmission stated that the proposed effective prices for belantamab mafodotin in the resubmission are included as a placeholder, as the economic evaluation is based on the published (rather than the effective) prices for daratumumab and carfilzomib. The resubmission stated that, following a PBAC recommendation, the effective price for belantamab mafodotin will be determined based on the recommended incremental cost-effectiveness ratio (ICER) which includes the effective prices of daratumumab and carfilzomib.

3.3 The resubmission proposed an Authority Required (Telephone/Online) listing but stated that an Authority Required (Streamlined) listing may be appropriate, given that the initial and continuing treatment PBS restrictions for carfilzomib are Authority Required (Streamlined) restrictions. The PBAC previously considered that an Authority Required (Telephone/Online) listing for both the initial and continuing restrictions would be appropriate (paragraph 7.10, belantamab mafodotin, Public Summary Document [PSD], November 2025 PBAC meeting).

3.4 The Sub-Committees noted that the proposed initial restriction, which does not require previous treatment with specific prior therapies (e.g. a proteasome inhibitor, immunomodulatory agent or an anti-CD38 monoclonal antibody), allows all patients with relapsed and/or refractory multiple myeloma to receive a BCMA targeted drug regardless of line of therapy.

3.5 The PBAC previously considered that a cautionary note regarding ocular toxicity should be included and reference the need for eye examinations (paragraph 7.10, belantamab mafodotin, PSD, November 2025 PBAC meeting). The resubmission stated that measures currently in place (including the guidance on ophthalmic examination in the belantamab mafodotin product information and consumer medicines information, and proposed quality use of medicines initiatives) are comprehensive, and therefore an additional cautionary note may not be necessary. The Sub-Committees agreed with the PBAC's previous consideration that a cautionary note and reference for the need for eye examinations should be included in the restriction. The Sub-Committees noted that the incidence of ocular adverse events was high and that some patients did not return to baseline function despite dose modification. The pre-PBAC response again stated that a cautionary note was not necessary, but if it was required, proposed the following text:

> "Belantamab mafodotin is associated with an increased risk of ocular events such as changes in vision and dry eyes. Please consult the approved Product Information for information about eye examination requirements before commencing treatment with this drug."

3.6 The resubmission requested grandfathering provisions for patients treated with belantamab mafodotin under a patient access program that commenced in [redacted]. The Secretariat has amended the restriction so the initial restrictions do not exclude patients who've received non-PBS subsidised treatment. Therefore, a grandfather restriction is no longer required.

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

4 Population and disease

4.1 Multiple myeloma is a malignancy characterised by clonal proliferation of plasma B-cells and abnormally high production of monoclonal immunoglobulin. Proliferation of plasma cells in the bone marrow is associated with impairment of haematopoiesis, while deposition of the monoclonal immunoglobulin protein in tissues leads to the development of organ dysfunction. A net increase in osteoclastic activity results in increased bone resorption and the development of lytic bone lesions.

4.2 Common symptoms associated with multiple myeloma include fatigue, weight loss, bone pain and bone fractures. Additionally, patients may develop symptoms related to hypercalcaemia and renal impairment. Patients with multiple myeloma have a higher risk of developing infections. An estimated 2,755 new cases of multiple myeloma were forecast in Australia in 2025 (1,670 males and 1,085 females; AIHW, 2026). The reported median age of patients diagnosed with multiple myeloma in Australia in 2021 was 72.6 years (mean: 71.6 years; AIHW, 2026).

4.3 Belantamab mafodotin is a humanised IgG1 kappa monoclonal antibody targeting B-cell maturation antigen (BCMA), which is conjugated to a cytotoxic agent (maleimidocaproyl monomethyl auristatin F; mcMMAF). BCMA is selectively

expressed on malignant plasma cells. The recommended initial dose of belantamab mafodotin when used as part of the BmBd regimen is 2.5 mg/kg administered by intravenous infusion every 3 weeks. A lower dose of 1.9 mg/kg is recommended for patients experiencing adverse events associated with treatment. Treatment with belantamab mafodotin is ongoing until disease progression or unacceptable toxicity.

4.4 The belantamab mafodotin Product Information includes a black box warning regarding changes in the corneal epithelium associated with treatment. The warning notes that dry eyes, changes in vision (including the potential for severe visual impairment), and corneal ulcers can occur. The Product Information states that ophthalmic examinations that include visual acuity testing and slit lamp examination by an eyecare professional should be conducted prior to each dose of belantamab mafodotin, or more frequently as clinically indicated. If changes in vision or corneal signs are not observed at or before the sixth dose examination, the frequency of examinations may be reduced to approximately every 3 months and whenever clinically indicated.

4.5 The resubmission's proposed clinical management algorithm included two scenarios. In the first scenario (the 'current state'), the resubmission positioned BmBd as an alternative to current PBS listed second and third line multiple myeloma treatments, including DBd (second line only), Cd, carfilzomib in combination with lenalidomide and dexamethasone (CLd), PBd, selinexor in combination with bortezomib and dexamethasone (SBd), pomalidomide in combination with dexamethasone (Pd), selinexor in combination with dexamethasone (Sd), lenalidomide in combination with dexamethasone (Ld), and bortezomib in combination with dexamethasone (Bd).

4.6 The resubmission noted that the PBS listing for DBd limits use to second line treatment. The resubmission stated that the removal of the line of therapy restriction for DBd would provide flexibility for prescribing and allow for optimal sequencing of therapies. The resubmission presented a second scenario (the 'ideal state'), in which the clinical algorithm included DBd as an alternative treatment option in the second- and third-line treatment settings. The PBAC considered that as the 'ideal state' was not currently available under the PBS listings, it was not relevant to this resubmission.

4.7 The population targeted in the resubmission is patients with relapsed or refractory multiple myeloma who have received at least one prior therapy. The proposed population is broader than the population requested in the November 2025 submission, which was limited to patients with one prior line of therapy. The PBAC previously considered that a broader listing of BmBd, for use in the wider relapsed and/or refractory multiple myeloma setting rather than just the second line setting, would be more appropriate (paragraph 7.1, belantamab mafodotin, PSD, November 2025 PBAC meeting).

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

5 Comparator

5.1 The resubmission nominated DBd and Cd as the main comparators, and PBd and SBd as supplementary comparators. The main arguments provided to support the nomination of DBd, Cd, PBd and SBd as comparators were:

- The PBAC previously considered that for the second line listing proposed in the November 2025 submission, the nomination of DBd as the comparator was appropriate (paragraph 7.3, belantamab mafodotin, PSD, November 2025 PBAC meeting).
- The PBAC previously noted that PBS listing of daratumumab in combination with lenalidomide and dexamethasone (DLd) for use in the first line setting for transplant ineligible patients in November 2025 will likely lead to a reduction in DBd use in the second line setting, but considered that it would take a number of years for this change to affect the prevalent patient population (paragraph 7.3, belantamab mafodotin, PSD, November 2025 PBAC meeting). The PBS restriction for DLd specifies use of PBS-subsidised treatment with daratumumab once per lifetime.
- The PBAC previously considered that the PBS listing of DBd for use in the second line setting only would likely displace the other relapsed and/or refractory multiple myeloma treatments (RRMM) to the third and later line settings (paragraph 7.4, ixazomib, PSD, March 2022 PBAC meeting).
- Based on an analysis of the 10% PBS sample data (patients who initiated third line therapy from January to October 2025), Cd was the most commonly initiated third line therapy (38%), with 16% initiating Ld, 16% initiating Pd, 14% initiating CLd, 11% initiating PBd, 3% initiating SBd, and 3% initiating Sd.
- Consultation with Australian clinicians suggests that BmBd is unlikely to substitute for lenalidomide-based regimens (Ld, CLd) or the oral regimens (Ld, Pd, Sd) due to prior treatment-related factors (e.g., sensitivity to lenalidomide) and patient factors (e.g., age, frailty).

5.2 The evaluation considered that DBd, Cd, PBd and SBd were appropriate comparators. The PBAC previously advised that if it were to consider a broader relapsed or refractory multiple myeloma listing for belantamab mafodotin, a mixed comparator that consisted of daratumumab, carfilzomib, pomalidomide, selinexor and elotuzumab would be reasonable (paragraph 7.3, belantamab mafodotin, PSD, November 2025 PBAC meeting). The resubmission stated that elotuzumab was not included as a comparator in the current resubmission on the basis that it is only available through the PBS for existing patients on treatment from 1 December 2024.

5.3 While the resubmission nominated DBd, Cd, PBd and SBd as comparators, the economic evaluation compared BmBd to treatment with DBd and Cd only. The PBAC previously recommended PBd and SBd on a cost-minimisation basis against Cd (paragraph 6.10, pomalidomide, PSD, November 2019 PBAC meeting; paragraph 7.1, selinexor, PSD, November 2022 PBAC meeting); however, pomalidomide was subject

to a first new brand statutory price reduction in October 2022, and a price disclosure reduction in April 2026. The results of the modelled economic evaluation assumed a weighted [redacted]% DBd/[redacted]% Cd split, based on the estimated numbers of patients treated with BmBd rather than DBd and Cd over the initial 6 years of listing. The Sub-Committees noted that the weightings applied in the economic analysis assumed that the majority of BmBd use would be in the second line setting in place of DBd.

5.4 Given that BmBd would be available for use in the second or any later line of treatment, there may also be substitution of BmBd for CLd, Ld, Pd, Sd and elranatamab.

5.5 The Sub-Committees considered that although the nominated comparators were reasonable the weightings of DBd and Cd applied in the economic evaluation needed further consideration. The Sub-Committees, noting the second-line only listing of DBd, considered that for the foreseeable future, the majority (i.e. approximately 70%) of BmBd use would be in the third-or later-line setting. The Sub-Committees noted that BmBd use in the second line setting would increase as DLd use in the first line setting increased but considered that uptake would be gradual as the mean treatment duration for DLd is estimated to be 48 months (Table 21, daratumumab PSD, March 2025 PBAC meeting). In the third line setting the Sub-Committees noted that, although the majority of patients currently receive Cd, a relatively high percentage of patients receive PBd (11%, see paragraph 5.1). Further, the Sub-Committees considered that given the lower cost of pomalidomide, the exclusion of PBd from the economic analysis favoured BmBd. Thus, the Sub-Committees considered that a more reasonable weighting split in the economic evaluation would be 30% DBd; 50% Cd and 20% PBd. The pre-PBAC response stated that consumer input, guidelines and current utilisation observed in the patient access program suggested BmBd would be used as early as possible in the treatment algorithm. Further, the pre-PBAC response stated that PBS utilisation data does not support a 20% comparator split for PBd. Thus, the pre-PBAC response proposed an alternative split of [redacted]% DBd; [redacted]% Cd and [redacted]% PBd and that over the first 6 years of listing, [redacted]% of BmBd use would be in the second-line setting, with [redacted]% of use in the third line setting. Revised economic and financial analyses based on this revised weighting were provided. The PBAC noted the revised split assumed approximately [redacted]% of use of BmBd in Year 1 would be in the 3L setting, decreasing to [redacted]% in Year 6.

5.6 Belantamab mafodotin is also TGA registered for use in combination with pomalidomide and dexamethasone (BmPd), for the treatment of patients with relapsed or refractory multiple myeloma who have received at least one prior therapy including lenalidomide. The resubmission stated that the assessment of overall survival in the pivotal BmPd trial (DREAMM-8) has not been finalised, and that [redacted]. Clinical guidelines include BmPd as a preferred treatment regimen in a number of situations.

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

6 Consideration of the evidence

Sponsor hearing

6.1 The sponsor requested a hearing for this item. The clinician described the current treatment options and survival rates following each line of therapy. The clinician described how they thought BmBd would be used in clinical practice and highlighted the need for new and effective treatments, particularly in patients who have previously been exposed to lenalidomide. The clinician discussed the results of the DREAMM-7 trial, highlighting the progression free and overall survival gains observed compared to DBd. Safety was also discussed with the clinician acknowledging the ocular toxicity associated with belantamab mafodotin, describing it as predictable, manageable and usually reversible with dose modification.

Consumer inputs

6.2 The PBAC noted and welcomed the input from individuals (147), health professionals (6) and organisations (5) via the Office of Health Technology Assessment Consultation Hub. The PBAC recalled that in November 2025 it had received input from individuals (19), health care professionals (2) and organisations (4). The inputs from individuals highlighted the need for additional lines of treatment to increase survival time, improve quality of life and provide psychological hope. The importance of making effective treatments available at the right stage of disease was also highlighted. PBS-listing of belantamab mafodotin was also supported to improve equity of access and accessibility for all Australians. Individuals who have received BmBd described its advantages, including meaningful clinical responses and improved efficacy compared to currently available options. Ocular toxicity was described by individuals who had received belantamab mafodotin as the primary adverse event and it was noted that it could affect daily functioning; however, overall, individuals considered that belantamab mafodotin improved their quality of life.

6.3 The health professionals described belantamab mafodotin as a clinically important additional treatment option for RRMM, noting that it demonstrated superior clinical responses when compared to DBd in the DREAMM-7 trial. The health professionals noted the ocular toxicity effects but described them as manageable. In addition, the health professionals stated that belantamab mafodotin, when used earlier in the disease course, would help maintain quality of life for longer.

6.4 The PBAC noted the advice received from the Australasian Leukaemia and Lymphoma Group (ALLG) and the Myeloma and Related Diseases Registry (MRDR), both of which supported the submission. The ALLG noted the positive results of the DREAMM-7 trial and stated that it was important the Australian patients have access to a BCMA-targeted therapy as early as possible. The ALLG stated that the ocular adverse events associated with belantamab mafodotin were manageable and reversible with dose modifications and its PBS-listing would provide an important treatment option for

patients with RRMM. The MRDR input highlighted the importance of optimising treatment sequencing early and introducing effective therapies at earlier stages of disease.

6.5 Advice was also received from patient support organisations, Rare Cancers Australia, the Leukaemia Foundation and Myeloma Australia and its Medical and Scientific Advisory Group (MSAG). These organisations strongly supported the PBS listing of belantamab mafodotin, highlighting the results of the DREAMM-7 trial. The groups highlighted the financial burden of accessing drugs that are not listed on the PBS and the equity issues this causes. Myeloma Australia and MSAG highlighted the importance of having access to a BCMA-targeted therapy as early as possible in the relapsed setting and considered that the ocular adverse events associated with belantamab mafodotin were manageable.

Clinical trials

6.6 The resubmission was based on the following comparisons between BmBd and the nominated comparators:

- One head-to-head randomised trial comparing BmBd to DBd in patients with relapsed or refractory multiple myeloma after at least one line of therapy (DREAMM-7).
- An indirect comparison of efficacy outcomes for BmBd versus Cd, PBd and SBd based on a network meta-analysis (NMA) of 13 randomised trials comparing a variety of treatment regimens in patients with relapsed or refractory multiple myeloma (DREAMM-7, ARROW, CANDOR, ENDEAVOR, GEM-KyCyDex, IKEMA, BOSTON, CASTOR, LEPUS, OPTIMISMM, PANORAMA-1, NCT01478048 and NCT00813150).
- An unanchored comparison of safety outcomes for BmBd (DREAMM-7) versus Cd (ARROW, CANDOR, ENDEAVOR, GEM-KyCyDex and IKEMA), PBd (OPTIMISMM) and SBd (BOSTON).

6.7 Details of the included trials presented in the resubmission are provided in Table 3.

Table 3: Trials and associated reports presented in the resubmission

Trial ID	Protocol title/ Publication title	Publication citation
BmBd clinical trials		
DREAMM-7 (NCT04246047)	A multicenter, open-label, randomised phase III study to evaluate the efficacy and safety of the combination of belantamab mafodotin, bortezomib, and dexamethasone (B-Vd) compared with the combination of daratumumab, bortezomib and dexamethasone (D-Vd) in participants with relapsed/refractory multiple myeloma (DREAMM-7).	Clinical study report, February 2024, with June 2024 errata Clinical study report, January 2025
	Hungria V, Robak P, Hus M, Zherebtsova V, et al. Belantamab mafodotin, bortezomib, and dexamethasone for multiple myeloma.	*NEJM* 2024; 391(5): 393-407.
	Hungria V, Robak P, Hus M, Zherebtsova V, et al. A multicenter, open-label, randomised phase III study to evaluate the efficacy and safety of the combination of belantamab mafodotin, bortezomib, and dexamethasone (B-Vd) compared with the combination of daratumumab, bortezomib and dexamethasone (D-Vd) in participants with relapsed/refractory multiple myeloma (DREAMM-7).	*The Lancet Oncology* 2025; 26(8): 1067-1080.
	Hungria V, Hus M, Fu C, Zherebtsova V, et al. Patient-reported outcomes with belantamab mafodotin, bortezomib, and dexamethasone versus daratumumab, bortezomib, and dexamethasone in patients with relapsed or refractory multiple myeloma (DREAMM-7): results from a phase 3, open-label, randomised controlled trial.	*The Lancet Haematology* 2025; 12(8): e599-e610.
	Mateos MV, Trudel S, Quach H, Robak P, et al. Modification of belantamab mafodotin dosing to balance efficacy and tolerability in the DREAMM-7 and DREAMM-8 trials.	*Blood Advances* 2025; 9(22): 5708-5719.
Cd clinical trials		
ARROW	Moreau P, Mateos MV, Berenson JR, Weisel K, et al. Once weekly versus twice weekly carfilzomib dosing in patients with relapsed and refractory multiple myeloma (A.R.R.O.W.): interim analysis results of a randomised, phase 3 study.	*Lancet Oncol.* 2018; 19(7): 953-964.
	Mateos MV, Ludwig H, Kumar S, Rosenbaum CA, et al. Safety and efficacy of once-weekly carfilzomib (K) dosing in frail patients (pts): A subgroup analysis from the phase 3 A.R.R.O.W. study.	*J Clin Oncol* 2019; 37(15): 8027-8027.
CANDOR	Dimopoulos M, Quach H, Mateos MV, Landgren O, et al. Carfilzomib, dexamethasone, and daratumumab versus carfilzomib and dexamethasone for patients with relapsed or refractory multiple myeloma (CANDOR): results from a randomised, multicentre, open-label, phase 3 study.	*The Lancet* 2020; 396(10245): 186-197.
	Usmani SZ, Quach H, Mateos MV, Landgren O, et al. Carfilzomib, dexamethasone, and daratumumab versus carfilzomib and dexamethasone for patients with relapsed or refractory multiple myeloma (CANDOR): updated outcomes from a randomised, multicentre, open-label, phase 3 study.	*Lancet Oncol.* 2022; 23(1): 65-76.
	Usmani SZ, Quach H, Mateos MV, Landgren O, et al. Final analysis of carfilzomib, dexamethasone, and daratumumab vs carfilzomib and dexamethasone in the CANDOR study.	*Blood Adv.* 2023; 7(14): 3739-3748.
ENDEAVOR	Dimopoulos MA, Moreau P, Palumbo A, Joshua D, et al. Carfilzomib and dexamethasone versus bortezomib and dexamethasone for patients with relapsed or refractory multiple myeloma (ENDEAVOR): a randomised, phase 3, open-label, multicentre study.	*Lancet Oncol.* 2016; 17(1): 27-38.
	Dimopoulos MA, Goldschmidt H, Niesvizky R, Joshua D, et al. Carfilzomib or bortezomib in relapsed or refractory multiple myeloma (ENDEAVOR): an interim overall survival analysis of an open-label, randomised, phase 3 trial.	*Lancet Oncol.* 2017; 18(10): 1327-1337.

Trial ID	Protocol title/ Publication title	Publication citation
	Orlowski RZ, Moreau P, Niesvizky R, Ludwig H, et al. Carfilzomib-dexamethasone versus bortezomib-dexamethasone in relapsed or refractory multiple myeloma: updated overall survival, safety, and subgroups.	*Clin Lymphoma Myeloma Leuk.* 2019; 19(8): 522-530.
	Moreau P, Joshua D, Chng WJ, Palumbo A, et al. Impact of prior treatment on patients with relapsed multiple myeloma treated with carfilzomib and dexamethasone vs bortezomib and dexamethasone in the phase 3 ENDEAVOR study. Chng WJ, Goldschmidt H, Dimopoulos MA, Moreau P, et al. Carfilzomib-dexamethasone vs bortezomib-dexamethasone in relapsed or refractory multiple myeloma by cytogenetic risk in the phase 3 study ENDEAVOR. Dimopoulos M, Siegel D, White DJ, Boccia R, et al. Carfilzomib vs bortezomib in patients with multiple myeloma and renal failure: a subgroup analysis of ENDEAVOR. Moreau P, Joshua D, Chng WJ, Palumbo A, et al. Impact of prior treatment on patients with relapsed multiple myeloma treated with carfilzomib and dexamethasone vs bortezomib and dexamethasone in the phase 3 ENDEAVOR study.	*Leukemia* 2017; 31(1): 115-122. *Leukemia* 2017; 31(6): 1368-1374. *Blood* 2019; 133(2): 147-155. *Leukemia* 2017; 31(1): 115-122.
GEM-KyCyDex	Puertas B, González-Calle V, Sureda A, Moreno MJ, et al. Randomized phase II study of weekly carfilzomib 70 mg/m^2 and dexamethasone with or without cyclophosphamide in relapsed and/or refractory multiple myeloma patients.	*Haematologica* 2023; 108(10): 2753-2763.
IKEMA	Moreau P, Dimopoulos MA, Mikhael J, Yong K, et al. IKEMA study group. Isatuximab, carfilzomib, and dexamethasone in relapsed multiple myeloma (IKEMA): a multicentre, open-label, randomised phase 3 trial. Martin T, Dimopoulos MA, Mikhael J, Yong K, et al. Isatuximab, carfilzomib, and dexamethasone in patients with relapsed multiple myeloma: updated results from IKEMA, a randomized Phase 3 study.	*The Lancet* 2021; 397(10292): 2361-2371. *Blood Cancer J.* 2023; 13(1): 72.
SBd clinical trials		
BOSTON	Grosicki S, Simonova M, Spicka I, Pour L, et al. Once-per-week selinexor, bortezomib, and dexamethasone versus twice-per-week bortezomib and dexamethasone in patients with multiple myeloma (BOSTON): a randomised, open-label, phase 3 trial. Mateos M, Jagannath S, Delimpasi S, Simonova M, et al. Impact of prior therapies on the safety and efficacy of once weekly selinexor, bortezomib, and dexamethasone compared with twice weekly bortezomib and dexamethasone in relapsed or refractory multiple myeloma: results from the Boston study. Auner HW, Gavriatopoulou M, Delimpasi S, Simonova M, et al. Effect of age and frailty on the efficacy and tolerability of once-weekly selinexor, bortezomib, and dexamethasone in previously treated multiple myeloma. Richard S, Chari A, Delimpasi S, Simonova M, et al. Selinexor, bortezomib, and dexamethasone versus bortezomib and dexamethasone in previously treated multiple myeloma: Outcomes by cytogenetic risk.	*The Lancet* 2020; 396(10262): 1563-1573. *Blood* 2020; 136(Supplement 1): 50-52. *Am J Hematol.* 2021; 96(6): 708-718. *Am J Hematol.* 2021; 96(9): 1120-1130.
DBd clinical trials		
CASTOR	Palumbo A, Chanan-Khan A, Weisel K, Nooka AK, et al. Daratumumab, bortezomib, and dexamethasone for multiple myeloma. Spencer A, Lentzsch S, Weisel K, Avet-Loiseau H, et al. Daratumumab plus bortezomib and dexamethasone versus bortezomib and dexamethasone in relapsed or refractory multiple myeloma: updated analysis of CASTOR.	*N Engl J Med.* 2016; 375(8): 754-66. *Haematologica* 2018; 103(12): 2079-2087.

Trial ID	Protocol title/ Publication title	Publication citation
	Weisel K, Spencer A, Lentzsch S, Avet-Loiseau H, et al. Daratumumab, bortezomib, and dexamethasone in relapsed or refractory multiple myeloma: subgroup analysis of CASTOR based on cytogenetic risk.	*J Hematol Oncol*. 2020; 13(1): 115.
	Mateos MV, Sonneveld P, Hungria V, Nooka AK, et al. Daratumumab, bortezomib, and dexamethasone versus bortezomib and dexamethasone in patients with previously treated multiple myeloma: three-year follow-up of CASTOR.	*Clin Lymphoma Myeloma Leuk*. 2020; 20(8): 509-518.
	Weisel K, Sonneveld P, Mateos MV, Hungria V, et al. Efficacy and safety of daratumumab, bortezomib, and dexamethasone (D-Vd) versus bortezomib and dexamethasone (Vd) in first relapse patients (pts) with multiple myeloma (MM): four-year update of CASTOR.	*Blood* 2019; 134(Suppl 1): 3192.
	Sonneveld P, Chanan-Khan A, Weisel K, Nooka AK, et al. Overall survival with daratumumab, bortezomib, and dexamethasone in previously treated multiple myeloma (CASTOR): a randomized, open-label, phase III trial.	*J Clin Oncol*. 2023; 41(8): 1600-1609.
LEPUS	Lu J, Fu W, Li W, Hu J, et al. Daratumumab, bortezomib, and dexamethasone versus bortezomib and dexamethasone in Chinese patients with relapsed or refractory multiple myeloma: phase 3 LEPUS (MMY3009) study.	*Clin Lymphoma Myeloma Leuk*. 2021; 21(9): e699-e709.
	Fu W, Li W, Hu J, An G, et al. Daratumumab, bortezomib, and dexamethasone (D-VD) versus bortezomib and dexamethasone (VD) alone in Chinese patients with relapsed or refractory multiple myeloma (RRMM): updated analysis of LEPUS.	*HemaSphere* 2022; 6(Suppl): 786-787.
	Fu W, Li W, Hu J, An G, et al. Daratumumab, bortezomib, and dexamethasone versus bortezomib and dexamethasone in Chinese patients with relapsed or refractory multiple myeloma: updated analysis of LEPUS.	*Clin Lymphoma Myeloma Leuk*. 2023; 23(1): e51-e58.
PBd trials		
OPTIMISMM	Richardson PG, Oriol A, Beksac M, Liberati AM, et al. OPTIMISMM trial investigators. Pomalidomide, bortezomib, and dexamethasone for patients with relapsed or refractory multiple myeloma previously treated with lenalidomide (OPTIMISMM): a randomised, open-label, phase 3 trial.	*Lancet Oncol*. 2019; 20(6): 781-794.
	Beksac M, Richardson P, Oriol A, Lindsay J, et al. Pomalidomide, bortezomib, and dexamethasone vs bortezomib and dexamethasone in relapsed or refractory multiple myeloma (OPTIMISMM): final survival outcomes from a randomized, open-label, phase 3 trial.	*Clinical Lymphoma, Myeloma and Leukemia* 2023; 23: S27-S28.
Panobinostat plus bortezomib and dexamethasone trials		
PANORAMA-1	San-Miguel JF, Hungria VT, Yoon SS, Beksac M, et al. Panobinostat plus bortezomib and dexamethasone versus placebo plus bortezomib and dexamethasone in patients with relapsed or relapsed and refractory multiple myeloma: a multicentre, randomised, double-blind phase 3 trial.	*Lancet Oncol*. 2014; 15(11): 1195-206.
	San-Miguel JF, Hungria VT, Yoon SS, Beksac M, et al. Overall survival of patients with relapsed multiple myeloma treated with panobinostat or placebo plus bortezomib and dexamethasone (the PANORAMA 1 trial): a randomised, placebo-controlled, phase 3 trial.	*Lancet Haematol*. 2016; 3(11): e506-e515.
	Richardson PG, Hungria VTM, Yoon SS, Beksac M, et al. Panobinostat plus bortezomib and dexamethasone in previously treated multiple myeloma: outcomes by prior treatment.	*Blood* 2016; 127(6): 713-721.
	San-Miguel JF, Hungria VTM, Yoon SS, Beksac M, et al. Panobinostat plus bortezomib and dexamethasone: impact of dose intensity and administration frequency on safety in the PANORAMA 1 trial.	*Br J Haematol*. 2017; 179(1): 66-74.
EBd trials		

Trial ID	Protocol title/ Publication title	Publication citation
NCT01478048	Jakubowiak A, Offidani M, Pégourie B, De La Rubia J, et al. Randomized phase 2 study: elotuzumab plus bortezomib/dexamethasone vs bortezomib/dexamethasone for relapsed/refractory MM. Palumbo A, Offidani M, Pégourie B, De La Rubia J, et al. Elotuzumab plus bortezomib and dexamethasone versus bortezomib and dexamethasone in patients with relapsed/refractory multiple myeloma: 2-year follow-up.	*Blood* 2016; 127(23): 2833-2840. *Blood* 2015; 126(23): 510.
Cyclophosphamide plus bortezomib and dexamethasone trials		
NCT00813150	Kropff M, Vogel M, Bisping G, Schlag R, et al. Bortezomib and low-dose dexamethasone with or without continuous low-dose oral cyclophosphamide for primary refractory or relapsed multiple myeloma: a randomized phase III study.	*Ann Hematol*. 2017; 96(11): 1857-1866.

Source: Table 2-3, pp65-67 of the resubmission; Table 9, pp10-17 of Attachment 2.3 of the resubmission.
Note: Selected citations relating to conference abstracts omitted.

6.8 The key features of the included trials are summarised in Table 4.

Table 4: Key features of the included evidence

Trial	N	Design/ duration	Risk of bias	Patient population	Key outcomes	Use in modelled evaluation
DREAMM-7 (BmBd versus DBd)	494 [a]	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up of up to 39.4 months	Unclear [b]	- Adults with RRMM - ≥1 prior lines of therapy - ECOG ≤2 - Disease progression during or after the most recent therapy - Excluded patients refractory to bortezomib or daratumumab	- PFS - OS - Response rates - MRD rate - HRQoL - AEs	- PFS - OS - AEs - EQ-5D-3L - Use of subsequent treatments
ARROW (Cd versus Cd) [c]	478	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up of 12 months	Unclear [b]	- Adults with RRMM - 2-3 prior lines of therapy - ECOG ≤1 - Previous exposure to a PI (except carfilzomib or oprozomib) - Refractory to most recent therapy (including bortezomib or ixazomib)	- PFS - OS - Response rates - AEs	- PFS and OS (hazard ratios for BmBd versus Cd derived from NMA)
CANDOR (DCd versus Cd)	466	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up of 50 months	Unclear [b]	- Adults with RRMM - 1-3 prior lines of therapy - Partial response or better to at least 1 previous therapy line - At least a partial response and no relapse within 60 days for most recent carfilzomib regimen	- PFS - OS - Response rates - MRD rate - AEs	- PFS and OS (hazard ratios for BmBd versus Cd derived from NMA)
ENDEAVOR (Cd versus Bd)	929	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up of 44 months	Unclear [b]	- Adults with RRMM - 1-3 prior lines of therapy - ECOG ≤2 - Previous PI permitted if at least a partial response was achieved	- PFS - OS - Response rates - AEs	- PFS and OS hazard ratios for BmBd versus Cd (derived from NMA) - AEs

Trial	N	Design/ duration	Risk of bias	Patient population	Key outcomes	Use in modelled evaluation
GEM-KyCyDex (Cyclophosphamide + Cd versus Cd)	197	Phase 2, multicentre, open label, randomised controlled trial. Median follow-up of 37 months	High	- Adults with RRMM - 1-3 prior lines of therapy - ECOG ≤2 - At least a partial response with prior therapy - Excluded patients refractory to a PI	- PFS - OS - Response rates - AEs	- PFS and OS hazard ratios for BmBd versus Cd (derived from NMA)
IKEMA (Isatuximab + Cd versus Cd)	302	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up of 44 months	Unclear [b]	- Adults with RRMM - 1-3 prior lines of therapy - ECOG ≤2 - Excluded patients with primary refractory disease, prior treatment with carfilzomib, or refractory to an anti-CD38 therapy	- PFS - OS - Response rates - MRD rate - HRQoL - AEs	- PFS and OS hazard ratios for BmBd versus Cd (derived from NMA)
BOSTON (SBd versus Bd)	402	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up of 17 months	Unclear [b]	- Adults with RRMM - 1-3 prior lines of therapy - ECOG ≤2 - Evidence of progressive disease on/after most recent treatment - Refractory to most recent treatment regimen - At least a partial response to PI therapy (if previously used)	- PFS - OS - Response rates - MRD rate - HRQoL - AEs	- PFS and OS hazard ratios for BmBd versus Cd (derived from NMA)
CASTOR (DBd versus Bd)	498	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up of 72 months	Unclear [b]	- Adults with RRMM - ≥1 prior lines of therapy - At least a partial response to a prior treatment - Excluded patients refractory to bortezomib or another PI (ixazomib or carfilzomib following a protocol amendment)	- PFS - OS - Response rates - AEs	- PFS and OS hazard ratios for BmBd versus Cd (derived from NMA)
LEPUS (DBd versus Bd)	211	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up of 37 months	Unclear [b]	- Adults with RRMM - ≥1 prior lines of therapy - ECOG ≤2 - At least a partial response to a prior multiple myeloma regimen - Progressive disease on or after their last regimen - Excluded patients refractory to a PI and with previous anti-CD38 therapy	- PFS - OS - Response rates - HRQoL - AEs	- PFS and OS hazard ratios for BmBd versus Cd (derived from NMA)

Trial	N	Design/ duration	Risk of bias	Patient population	Key outcomes	Use in modelled evaluation
OPTIMISMM (PBd versus Bd)	559	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up of 65 months	Unclear [b]	- Adults with RRMM - 1-3 previous regimens (including 2+ cycles of lenalidomide) - ECOG ≤2 - Progressive disease during or after their last anti-myeloma regimen - Excluded patients with progressive disease during or within 60 days of the last dose of a bortezomib-containing regimen	- PFS - OS - Response rates - HRQoL - AEs	- PFS and OS hazard ratios for BmBd versus Cd (derived from NMA)
PANORAMA-1 (Panobinostat + Bd versus Bd)	768	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up NR [c]	Low	- Adults with RRMM - 1-3 prior lines of therapy - ECOG ≤2 - Excluded patients with primary refractory or bortezomib refractory myeloma	- PFS - OS - Response rates - AEs	- PFS and OS hazard ratios for BmBd versus Cd (derived from NMA)
NCT01478048 (Elotuzumab + Bd versus Bd)	152	Phase 2, multicentre, open label, randomised controlled trial. Median follow-up of 24 months	High	- Adults with RRMM - 1-3 prior lines of therapy - ECOG ≤2 - Disease progression during or after the most recent therapy - Prior PI therapy allowed if previously achieved a partial response, and not refractory to a PI	- PFS - OS - Response rates - AEs	- PFS and OS hazard ratios for BmBd versus Cd (derived from NMA)
NCT00813150 (Cyclophosphamide + Bd versus Bd)	90	Phase 3, multicentre, open label, randomised controlled trial. Median follow-up NR	High	- Adults with RRMM - 1-3 prior lines of therapy - Karnofsky performance status ≥60% - Excluded patients with progressive or stable disease while on prior bortezomib therapy, or experienced Grade ≥2 peripheral neuropathy	- PFS - OS - Response rates - AEs	- PFS and OS hazard ratios for BmBd versus Cd (derived from NMA)

Source: Section 2, pp59-140 of the resubmission, and respective trial publications: Moreau et al. (2018; ARROW trial); Dimopoulos et al. (2020; CANDOR trial); Dimopoulos et al. (2017; ENDEAVOR trial); Puertas et al. (2023; GEM-KyCyDex trial); Moreau et al. (2021; IKEMA trial); Grosicki et al. (2020; BOSTON trial); Palumbo et al. (2016; CASTOR trial); Lu et al. (2021; LEPUS trial); Richardson et al. (2019; OPTIMISMM trial); San-Miguel et al. (2014; PANORAMA-1 trial); Jakubowiak et al. (2016; NCT01478048); Kropff et al. (2017; NCT00813150 trial).

Abbreviations: 3L, 3-level; AE, adverse event; Bd, bortezomib in combination with dexamethasone; BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; CD, cluster of differentiation; DBd, daratumumab in combination with bortezomib and dexamethasone; DCd, daratumumab in combination with carfilzomib and dexamethasone; EBd, elotuzumab in combination with bortezomib and dexamethasone; ECOG, Eastern Cooperative Oncology Group; HRQoL, health-related quality of life; MRD minimal residual disease; NMA, network meta-analysis; NR, not reported; OS, overall survival; PBd, pomalidomide in combination with bortezomib and dexamethasone; PI, proteasome inhibitor; PFS, progression-free survival; RRMM, relapsed or refractory multiple myeloma; SBd, selinexor in combination with bortezomib and dexamethasone.

[a] Two subjects in the intention to treat analysis of the DREAMM-7 trial were randomised, not treated, re-screened and re-randomised and are counted as 4 unique subjects in the analyses.
[b] Open-label trial with a high risk of performance bias. Assessments by the blinded independent review committee had a low risk of performance bias; assessments by study investigators had a high risk of bias open label trial design.
[c] The ARROW trial compared carfilzomib 27 mg/m^2 twice weekly (in combination with dexamethasone) with carfilzomib 70 mg/m^2 once weekly (in combination with dexamethasone).
[d] The median duration of follow-up was not reported in the latest results publication.

6.9 The clinical claim for BmBd versus DBd was based on the results of the DREAMM-7 trial. The DREAMM-7 trial is an ongoing trial with continuing follow-up of study participants until the accrual of 355 deaths or 5 years from the first visit of the last patient, whichever occurs first. Results in the resubmission were based on the first (October 2023 data cut; median follow-up 28.2 months) and second (October 2024 data cut; median follow-up 39.4 months) interim analyses of the trial. The pre-PBAC response presented data from a January 2026 data-cut with median follow-up of 52.9 months.

6.10 The open-label trial design has the potential to introduce bias, as knowledge of treatment assignment may affect disease management decisions and assessment of outcomes that are not centrally assessed. The risk of detection bias was minimised by the inclusion of a blinded independent review committee for response and disease progression assessments.

6.11 No new efficacy or safety data for the DREAMM-7 trial were presented in the resubmission compared to the November 2025 submission. However, the clinical claim and economic evaluation were based on data from the intention to treat (ITT) population of the DREAMM-7 trial (the clinical claim in the November 2025 submission was based on the results for the subgroup of patients with prior lenalidomide exposure, with the results for the ITT population included as supportive evidence).

6.12 Table 5 summarises treatment exposure to belantamab mafodotin over different time intervals based on the October 2023 data cut and the October 2024 data cut (presented in the Pre-Sub-Committee Response [PSCR]).

Table 5: Exposure to belantamab mafodotin in DREAMM-7 ITT population (October 2023 and October 2024 data cuts)

		Time intervals							
		0-6 months		6-12 months		12+ months		Overall	
Data cut		Oct 2023	Oct 2024	Oct 2023	Oct 2024	Oct 2023	Oct 2024	Oct 2023	Oct 2024
Number of patients		242	242	162	161	132	132	242	242
Infusions per patient	Mean	4.4	4.4	3.8	3.8	8.9	11.7	11.7	13.2
	Median (IQR)	4 (3, 6)	4 (3, 6)	3 (2, 6)	3 (2, 6)	6.5 (4, 13)	9 (5,16)	9 (4, 16)	9 (4, 18)
Total doses		1,133	1,133	577	577	1,122	1,485	2,832	3,195
Number of doses by dose level, n (%)	2.5 mg/kg	768 (68)	767 (68)	198 (34)	199 (34)	201 (18)	243 (16)	1,167 (41)	1,209 (38)
	1.9 mg/kg	365 (32)	366 (32)	379 (66)	378 (66)	921 (82)	1,242 (84)	1,665 (59)	1,986 (62)
Time between doses, weeks	N	231	231	130	130	124	124	231	231
	Mean	4.8	4.8	6.8	6.8	10.9	11.5	7.2	7.5
	Median (IQR)	3.6 (3, 6)	3.6 (3, 6)	4.7 (3, 8)	4.7 (3, 9)	9.5 (5, 15)	9.6 (5, 16)	5.7 (3, 10)	5.9 (3, 10)

Source: Table 2-12, p77 of the resubmission and Table 8, p9 of the PSCR

Abbreviations: IQR, interquartile range; ITT, intention to treat

Note that the results presented in Table 5 are derived from ad-hoc analyses conducted by the applicant specifically for the purposes of informing the PBAC consideration. Interpretation of the results and their application should therefore be limited to seeking to understand the basis for the PBAC outcome and should not be used for any other purpose.

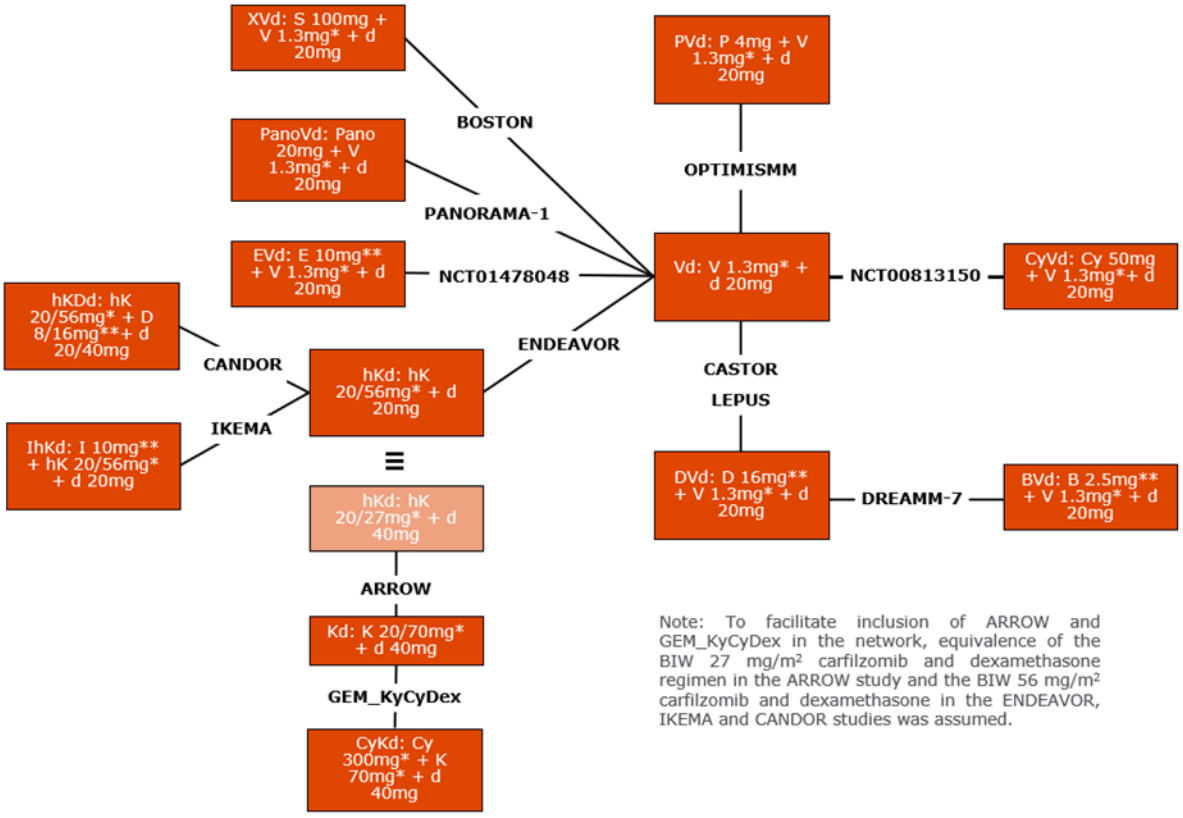
6.13 Based on the October 2023 data cut, over a median follow-up period of 29.2 months, the actual observed mean dose per patient was 2.2 mg/kg (median 2.1 mg/kg; as compared to a recommended starting dose of 2.5 mg/kg) and the average dosing interval per patient was 7.2 weeks (median 5.7 weeks; as compared to a recommended interval of 3 weeks). The data show that over time, an increasing proportion of patients received a reduced dose of belantamab mafodotin (1.9 mg/kg) with increasing time between doses (mean time of 4.8 weeks during the first 6 months increasing to 10.9 weeks from 1 year onwards). The data from the October 2024 data cut indicated a continued increase in the proportion of patients receiving a dose of 1.9 mg/kg and an increasing length of time between doses. Overall, the evaluation considered that it was unclear whether the circumstances of use of belantamab mafodotin in the trial would be applicable to clinical practice given the protocol-driven nature of dosing in the trial with regards to dose reductions and delays, and the known issues with ocular toxicity. The PSCR stated that the circumstances of use of belantamab mafodotin in the DREAMM-7 trial were largely consistent with the recommendations included in the Product Information. The Sub-Committees considered that the use of belantamab mafodotin in the trial with respect of dose reductions and delays would likely reflect its use in clinical practice.

6.14 The resubmission presented estimates of comparative efficacy for BmBd versus Cd, PBd and SBd derived from an NMA. The resubmission stated that the NMA was based

on the NMA published by Richter et al. (2025[3]), with updated data for the DREAMM-7 trial based on the October 2024 data cut.

6.15 Figure 1 illustrates the network of studies included in the NMA.

Figure 1: Network of studies identified in the NMA literature search



Source: Figure 2-16, p104 of the resubmission.

Abbreviations: *, mg/m²; **, mg/kg; B, belantamab mafodotin; BIW, twice weekly; BVd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cy, cyclophosphamide; CyKd, cyclophosphamide in combination with carfilzomib once weekly and dexamethasone; d, dexamethasone; CyVd, cyclophosphamide in combination with bortezomib and dexamethasone; D, daratumumab; DVd, daratumumab in combination with bortezomib and dexamethasone; E, elotuzumab; EVd, elotuzumab in combination with bortezomib and dexamethasone; hK, twice weekly carfilzomib; hKd, twice weekly carfilzomib in combination with dexamethasone; hKDd, daratumumab in combination with twice weekly carfilzomib and dexamethasone; I, isatuximab; IhKd, isatuximab in combination with twice weekly carfilzomib and dexamethasone; K, carfilzomib once weekly; Kd, carfilzomib once weekly in combination with dexamethasone; Pano, panobinostat; PVd, pomalidomide in combination with bortezomib and dexamethasone; V, bortezomib; Vd, bortezomib in combination with dexamethasone; XVd, selinexor in combination with bortezomib and dexamethasone.

[3] Richter, J., Nooka, A., Rodríguez-Otero, P., et al. (2025). Belantamab Mafodotin Plus Proteasome Inhibition Efficacy Versus Comparators in Early Relapsed Myeloma: A Systematic Review and Network Meta-Analysis. Am J Hematol, 100(6), 998-1009. https://doi.org/10.1002/ajh.27661

6.16 There were no identified common reference arms to facilitate single-step indirect comparisons for BmBd versus Cd, PBd or SBd. With the exception of the DBd versus Bd comparison, which included 2 trials (CASTOR and LEPUS), links in the network were limited to single studies. There were no closed loops in the network to facilitate alternative estimates of indirect treatment effect.

6.17 The included studies were Phase 3 trials, with the exception of the GEM-KyCyDex and NCT01478048 trials, which were Phase 2 trials. Trial enrolment start dates ranged from 2008 for the NCT00813150 trial to 2020 for the DREAMM-7 trial.

6.18 There were differences in the carfilzomib treatment regimens included in the trials. Carfilzomib treatment in the ENDEAVOR, CANDOR and IKEMA trials was based on a 56 mg/m^2 twice weekly regimen, whereas the Cd arm of the GEM-KyCyDex trial was based on a carfilzomib 70 mg/m^2 once weekly regimen. The ARROW trial compared carfilzomib 70 mg/m^2 once weekly with a lower dose (27 mg/m^2) twice weekly regimen. The inclusion of the ARROW trial in the network relied upon an assumption of equivalence of the carfilzomib 56 mg/m^2 twice weekly treatment regimen included in the ENDEAVOR, CANDOR and IKEMA trials, with the carfilzomib 27 mg/m^2 twice weekly treatment regimen included in the ARROW trial. This assumption may not be reasonable. Further, this assumption particularly impacts the results of the NMA for BmBd versus once weekly carfilzomib, as the comparison of BmBd versus Cd once weekly relies on the equivalence of the 56 mg/m^2 and 27 mg/m^2 twice weekly regimens to allow inclusion in the network.

6.19 The BOSTON and CASTOR trials allowed patients to cross over to receive the investigational treatment regimen following confirmed disease progression.

6.20 Apart from the PANORAMA-1 trial, which was a double-blind placebo-controlled trial, all of the included trials were open-label. The DREAMM-7, ARROW, CANDOR, ENDEAVOR, IKEMA, BOSTON and OPTIMISMM trials included response and disease progression assessments by a blinded independent review committee and therefore had a lower risk of detection bias.

6.21 There were differences in the sample sizes of the included trials, with total sample sizes ranging from 90 patients in the NCT00813150 trial, to 929 in the ENDEAVOR trial.

6.22 There were large differences in trial follow-up durations across the included trials, ranging from a median of 13 months in the ARROW trial to a median of 73 months in the CASTOR trial. Overall survival results were relatively immature for some of the included trials (particularly the ARROW, LEPUS and BOSTON trials.

6.23 The resubmission stated that the median age, proportion of male patients, and distribution of ECOG scores, were broadly similar between trials. The resubmission noted that there was variability across studies in the International Staging System (ISS) stage, the proportion with high cytogenetic risk, the number of prior lines of prior therapy, prior immunomodulator exposure, and the median time since diagnosis. There were also differences in the proportions of patients enrolled with prior

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autologous stem cell transplant, and the proportion of patients with prior bortezomib treatment.

6.24 The resubmission identified the following as potential treatment effect modifiers: age, gender, ethnicity, comorbidities, ECOG performance status, prior lines of therapy, refractory status to the specific agents in the trial, ISS stage, cytogenetic risk profile, extramedullary disease, creatine clearance, the time from diagnosis and prior immunomodulatory drugs/lenalidomide-refractory status.

6.25 Although the resubmission stated that the networks of evidence met the assumption of transitivity, given the differences between the included trials in enrolment periods, trial design (Phase 2 versus Phase 3 studies, sample size differences, inclusion of crossover), patient characteristics (including potential treatment effect modifiers) and follow-up durations, this assumption did not appear reasonable.

6.26 Comparisons were presented for progression-free survival and overall survival based on the ITT populations for each trial. The resubmission stated that Bayesian fixed and random effects models were conducted based on the National Institute for Health and Care Excellence Decision Support Unit recommended methodology. The NMAs were conducted using hazard ratios reported for the included trials and relied upon the assumption of proportional hazards within each trial. For the DREAMM-7 trial comparison of BmBd and DBd, the resubmission considered that the proportional hazards assumption may not be met.

6.27 The resubmission selected the fixed effects model for the base case, with results based on the random effects models included as a secondary analysis. The 95% credible intervals for the fixed effects model are unlikely to adequately account for the heterogeneity across the included trial network.

Comparative effectiveness

DREAMM-7 trial

6.28 Table 6 and Figure 2 present the results for independent review committee-assessed progression free survival for the ITT population of the DREAMM-7 trial.

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Table 6: Results for IRC-assessed progression-free survival in the DREAMM-7 trial (ITT population)

Outcome	BmBd (N=243)	DBd (N=251)
IRC-assessed progression-free survival (October 2023 data cut)		
Median duration of follow-up, months (range)	29.2 (0.2, 40.0)	27.6 (0.1, 39.7)
Participants with event, n (%) - Disease progression, n (%) - Death, n (%)	91 (37) 67 (28) 24 (10)	158 (63) 139 (55) 19 (8)
Censored - Follow-up ended - Follow-up ongoing	152 (62) 44 (18) 108 (44)	93 (37) 41 (16) 52 (21)
Median PFS, months (95% CI)	36.6 (28.4, NE)	13.4 (11.1, 17.5)
Hazard ratio (95% CI)	**0.41 (0.31, 0.53)**	
IRC-assessed progression-free survival (October 2024 data cut)		
Median duration of follow-up, months (range)	40.2 (0.2, 52.3)	38.2 (0.1, 51.3)
Participants with event, n (%) - Disease progression, n (%) - Death, n (%)	109 (45) 81 (33) 28 (12)	167 (67) 147 (59) 20 (8)
Censored - Follow-up ended - Follow-up ongoing	134 (55) 54 (22) 80 (33)	84 (33) 45 (18) 39 (16)
Median PFS, months (95% CI)	33.8 (28.4, 45.8)	13.4 (11.1, 17.5)
Hazard ratio (95% CI)	0.46 (0.35, 0.59) [a]	
Progression-free survival rate (95% CI) - 6 months - 12 months - 18 months - 24 months	 0.88 (0.83, 0.91) 0.78 (0.72, 0.83) 0.69 (0.62, 0.75) 0.65 (0.58, 0.71)	 0.77 (0.71, 0.82) 0.53 (0.47, 0.60) 0.43 (0.36, 0.49) 0.34 (0.28, 0.41)

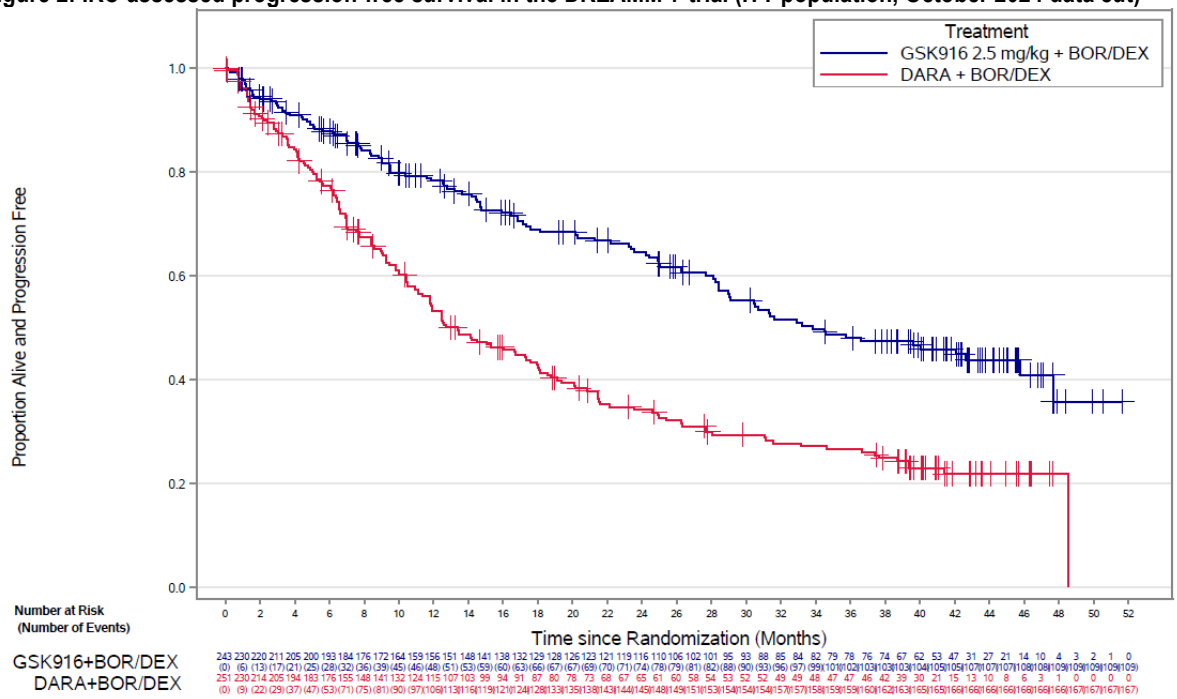
Source: Table 2-9, p75; Table 2-19, p82 of the resubmission; Table 2.0007, pp435-436 of the DREAMM-7 IA1 clinical study report; Table 1, p5 of the DREAMM-7 IA2 clinical study report; Table 2.0007, pp1-2 of the DREAMM-7 IA2 supplementary data.

Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; CI, confidence interval; DBd, daratumumab in combination with bortezomib and dexamethasone; IA1, interim analysis 1 (October 2023 data cut); IA2, interim analysis 2 (October 2024 data cut); IRC, independent review committee; ITT, intention-to-treat; NE, not estimable; PFS, progression-free survival.

Bolded results indicate statistical significance.

[a] Results are descriptive and were not formally re-tested at the October 2024 data cut, given statistical significance for PFS was achieved based on the October 2023 data cut.

Figure 2: IRC-assessed progression-free survival in the DREAMM-7 trial (ITT population, October 2024 data cut)



Source: Figure 2-4, p84 of the resubmission; Figure 2.0037, p1 of DREAMM-7 IA2 supplementary data.
Abbreviations: BOR, bortezomib; DARA, daratumumab; DEX, dexamethasone; GSK916, belantamab mafodotin; IA2, interim analysis 2 (October 2024 data cut); IRC, independent review committee.
Note that the results presented in Figure 2 is derived from ad-hoc analyses conducted by the applicant specifically for the purposes of informing the PBAC consideration. PFS was not formally re-tested at IA2 given statistical significance was achieved at IA1 in DREAMM-7. Interpretation of the results and their application should therefore be limited to seeking to understand the basis for the PBAC outcome and should not be used for any other purpose.

6.29 At the October 2023 data cut, based on a median follow-up of 29.2 months in the BmBd arm and 27.6 months in the DBd arm, treatment with BmBd was associated with a statistically significant improvement in progression-free survival compared to DBd (HR = 0.41; 95% CI: 0.31, 0.53). Median progression-free survival was 36.6 months in the BmBd arm versus 13.4 months in the DBd arm. Results based on the October 2024 data cut also favoured BmBd, with a smaller numerical benefit compared to the October 2023 data cut.

6.30 Table 7 and Figure 3 present the results for the key secondary outcome of overall survival for the ITT population of the DREAMM-7 trial. Longer term data from the DREAMM-7 trial was presented in the pre-PBAC response (January 2026 data-cut).

Table 7: Results for overall survival in the DREAMM-7 trial (ITT population)

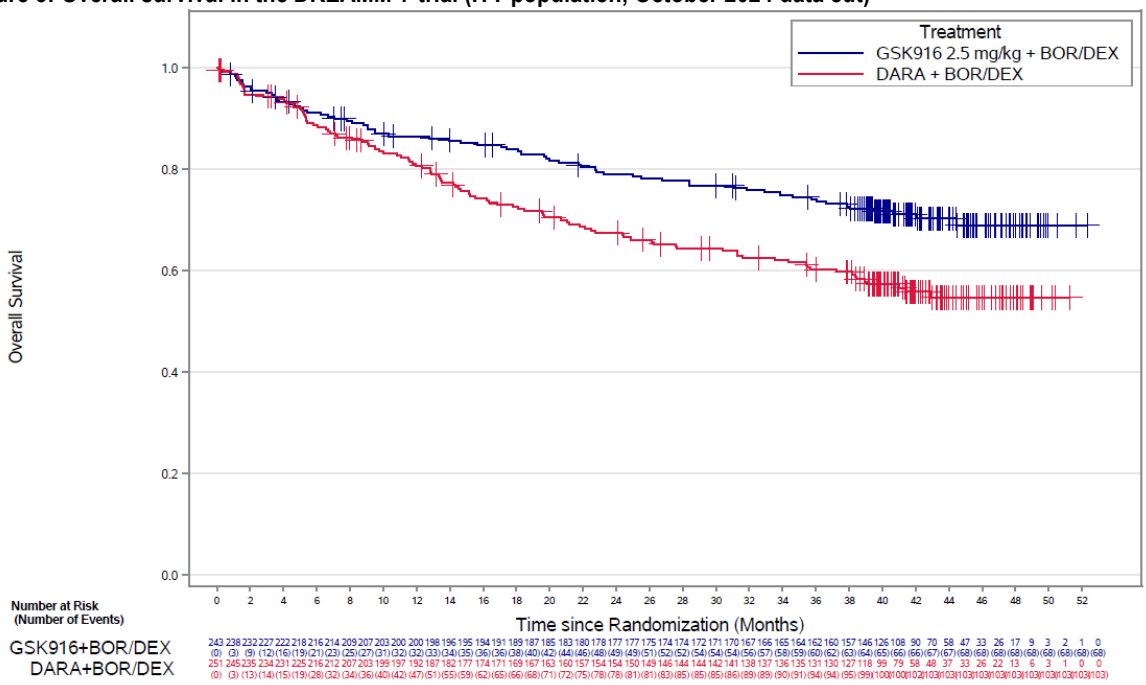
Outcome	BmBd (N=243)	DBd (N=251)
Median duration of follow-up, months (range)	40.2 (0.2, 52.3)	38.2 (0.1, 51.3)
October 2024 data-cut		
Deaths, n (%)	68 (28)	103 (41)
Censored, n (%) - Follow-up ended - Follow-up ongoing	175 (72) 26 (11) 149 (61)	148 (59) 33 (13) 115 (46)
Median OS, months (95% CI)	NE (NE, NE)	NE (41.0, NE)
Hazard ratio (95% CI)	**0.58 (0.43, 0.79)**	
Overall survival rate (95% CI) - 6 months - 12 months - 18 months - 24 months - 36 months	 0.91 (0.87, 0.94) 0.87 (0.81, 0.90) 0.84 (0.79, 0.88) 0.79 (0.73, 0.84) 0.74 (0.68, 0.79)	 0.89 (0.84, 0.92) 0.81 (0.75, 0.85) 0.73 (0.67, 0.78) 0.67 (0.61, 0.73) 0.60 (0.54, 0.66)
January 2026 data-cut (provided in pre-PBAC response)		
Median duration of follow-up, months	52.9	
Median OS, months (95% CI)	NR (63.0. NR)	58.3 (41.4, NR)
Hazard ratio (95%CI)	0.62 (0.46, 0.82)	
Landmark survival - 6 months - 12 months - 18 months - 24 months - 36 months - 48 months	 0.91 (0.87, 0.94) 0.87 (0.81, 0.90) 0.84 (0.79, 0.88) 0.79 (0.73, 0.84) 0.74 (0.68, 0.79) 0.68 (0.62, 0.74)	 0.89 (0.84, 0.92) 0.81 (0.75, 0.85) 0.73 (0.67, 0.78) 0.67 (0.61, 0.73) 0.60 (0.54, 0.66) 0.54 (0.48, 0.60)

Source: Table 2-9, p75; Table 2-20, p83 of the resubmission; Table 2.0024, pp12-13 of the DREAMM-7 IA2 clinical study report and Table 7 and Table 2.0024 of the pre-PBAC response.

Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; CI, confidence interval; DBd, daratumumab in combination with bortezomib and dexamethasone; IA2, interim analysis 2 (October 2024 data cut); ITT, intention-to-treat; NE, not estimable; OS, overall survival.

Bolded results indicate statistical significance.

Figure 3: Overall survival in the DREAMM-7 trial (ITT population, October 2024 data cut)



Source: Figure 2-5, p84 of the resubmission; Figure 1, p7 of the DREAMM-7 IA2 clinical study report.
Abbreviations: BOR, bortezomib; DARA, daratumumab; DEX, dexamethasone; GSK916, belantamab mafodotin; IA2, interim analysis 2 (October 2024 data cut).

6.31 At the October 2024 data cut, based on a median follow-up of 40.2 months in the BmBd arm and 38.2 months in the DBd arm, treatment with BmBd was associated with a statistically significant improvement in overall survival compared to DBd (HR = 0.58; 95% CI: 0.43, 0.79). Median overall survival was not reached in either treatment arm.

6.32 Results for other key secondary outcomes of the DREAMM-7 trial demonstrated a longer duration of response, and a higher rate of MRD negativity (based on a sensitivity of 10^{-5}) for the BmBd arm compared to the DBd arm at both data cuts.

Based on the October 2023 data cut, trial participants had a mean utility (based on EQ-5D-3L indexed using the Australian value set) of 0.77 at baseline, and mean utility scores remained broadly similar between the BmBd and DBd arms across study visits, with a gradual increase in utilities from Week 31. Utilities at the end-of-treatment visit showed a slight decrease relative to baseline across the 2 treatment arms.[4]

[4] *Note that the results presented are derived from post-hoc analyses conducted by the applicant specifically for the purposes of informing the PBAC consideration. These analyses were not part of the prespecified statistical plan for DREAMM-7. Interpretation of the results and their application should therefore be limited to seeking to understand the basis for the PBAC outcome and should not be used for any other purpose.*

6.33 Patient-reported outcomes related to visual function, measured by the Ocular Surface Disease Index (OSDI) were presented in the DREAMM-7 study report (October 2023 data cut). In the BmBd arm, deterioration of vision-related functioning scores became notable starting at Week 7; however, 20% of participants reported a meaningful deterioration in vision-related functioning as early as Week 4. Levels of deterioration in vision-related functioning appeared to peak between Weeks 10 and 13 (74% and 70% of participants with meaningful deterioration) then slightly decrease and remain stable. Deteriorated scores from baseline persisted through to Week 130. A similar pattern was observed for OSDI total score by study visit.

6.34 The DREAMM-7 study report (October 2023 data cut) also reported that, of the participants who were able to read with little or no difficulty at baseline, more participants in the BmBd arm than in the DBd arm stopped reading due to eyesight issues at some point on treatment (27% versus 2%). Of the participants who were able to drive with little or no difficulty at baseline, more participants in the BmBd arm than in the DBd arm stopped driving due to eyesight issues at some point on treatment (40% versus 3%) – see Comparative harms section.

Network meta-analysis (NMA)

6.35 Results of the fixed effects and random effects NMAs for progression-free survival and overall survival for BmBd versus Cd, PBd and SBd are summarised in Table 8 below.

Table 8: Summary of results of the fixed effects and random effects NMAs for progression-free survival and overall survival for BmBd versus Cd, PBd and SBd

Comparison	Fixed effects NMA HR (95% CrI)	Random effects NMA HR (95% CrI)
Progression-free survival		
BmBd vs Cd twice weekly	0.28 (0.19, 0.40)[a]	0.28 (0.10, 0.72)
BmBd vs Cd once weekly	0.40 (0.26, 0.63)	0.40 (0.13, 1.22)
BmBd vs PBd	0.26 (0.18, 0.38)	0.27 (0.10, 0.70)
BmBd vs SBd	0.21 (0.14, 0.32)	0.21 (0.08, 0.56)
Overall survival		
BmBd vs Cd twice weekly	0.53 (0.35, 0.80)[a]	0.47 (0.09, 1.89)
BmBd vs Cd once weekly	0.66 (0.38, 1.14)	0.59 (0.08, 3.11)
BmBd vs PBd	0.53 (0.35, 0.81)	0.47 (0.09, 1.86)
BmBd vs SBd	0.48 (0.28, 0.81)	0.42 (0.08, 1.77)

Source: Figures 2-18 to 2-19, pp108-109; and Figures 2-21 to 2-22, pp112-113 of the resubmission.

Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; CrI, credible interval; HR, hazard ratio; NMA, network meta-analysis; PBd, pomalidomide in combination with bortezomib and dexamethasone; SBd, selinexor in combination with bortezomib and dexamethasone.

[a] BmBd vs Cd twice weekly fixed effect model results were applied in the economic evaluation

Note that the results of the NMA are derived from post-hoc analyses specifically for the purposes of informing the PBAC consideration. These analyses were not part of the prespecified statistical plan for DREAMM-7. Interpretation of the results and their application should therefore be limited to seeking to understand the basis for the PBAC outcome and should not be used for any other purpose.

6.36 For progression-free survival, statistically significant benefits were observed for BmBd versus Cd twice weekly, PBd and SBd in both the fixed and random effects models, while the comparison versus Cd once weekly was statistically significant only in the fixed effects model.

6.37 For overall survival, statistically significant benefits were observed in the fixed effects model for BmBd versus Cd twice weekly, PBd and SBd; but not for BmBd versus Cd once weekly. Overall survival results from the random effects model for BmBd versus Cd twice weekly, Cd once weekly, PBd, and SBd were not statistically significant.

6.38 The results for the comparison of BmBd versus once weekly Cd should be interpreted with caution, given that the assumed equivalence of the carfilzomib 56 mg/m^2 twice weekly and carfilzomib 27 mg/m^2 twice weekly treatment regimens has not been established, and the immaturity of the overall survival results in the ARROW trial.

6.39 Based on the results of the NMA, the resubmission claimed that the Cd is non-inferior to PBd and SBd. Comparative efficacy estimates for Cd versus PBd and SBd were not presented in the resubmission; however, the PBAC has previously accepted that PBd and SBd were non-inferior in terms of effectiveness compared to Cd.

Comparative harms

DREAMM-7 trial

6.40 Table 9 presents a summary of safety outcomes for the DREAMM-7 trial based on the October 2024 data cut. Adverse event data were based on patient incidence only, which does not capture the occurrence of multiple events of the same type in individual patients.

Table 9: Summary of adverse events in the DREAMM-7 trial (safety population; October 2024 data cut)

	BmBd (N=242)	DBd (N=246)
Median duration of follow-up, months (range)	40.2 (0.2, 52.3)	38.2 (0.1, 51.3)
Any adverse event, n (%) - Treatment related	242 (100) 242 (100)	246 (100) 234 (95)
Serious adverse event, n (%) - Treatment related	129 (53) 50 (21)	94 (38) 32 (13)
Grade 3/4 adverse event, n (%) - Treatment related	230 (95) 222 (92)	191 (78) 166 (67)
Fatal serious adverse event - Treatment related	26 (11) 7 (3)	20 (8) 2 (<1)
AEs leading to treatment discontinuation, n (%) - Treatment related	77 (32) 67 (28)	47 (19) 36 (15)
AEs leading to dose reduction, n (%)	181 (75)	146 (59)
AEs leading to dose interruption/delay, n (%)	229 (95)	186 (76)

Source: Table 2-27, p82; Table 2-28, p83; Table 2-29, p84 of the submission; Table 3.0003, pp1-31; Table 3.1016, pp1-2; Table 3.0108100, pp1-2; Table 3.0046, pp1-2; Table 3.0049, pp1-4; Table 3.0048, p1; Table 3.0050, pp1-10 of the DREAMM-7 IA2 Supplementary data.
Abbreviations: AE, adverse event; BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; CI, confidence interval; DBd, daratumumab in combination with bortezomib and dexamethasone; IA2, interim analysis 2 (October 2024 data cut).

6.41 All patients in the BmBd arm and 95% of patients in the DBd arm experienced at least one treatment-related adverse event. Adverse events reported in at least 20% of patients in either treatment arm and in at least 10% more patients in the BmBd arm than in the DBd arm included thrombocytopenia, blurred vision, dry eye, photophobia, eye irritation, foreign body sensation in eyes, eye pain, cataract and pneumonia.

6.42 A higher proportion of patients in the BmBd arm experienced a Grade ≥3 adverse event compared to the DBd arm (95% versus 78%). The most commonly reported Grade ≥3 adverse events in the BmBd arm were thrombocytopenia (56%), blurred vision (24%), and decreased platelet count (18%); and in the DBd arm were thrombocytopenia (35%), decreased platelet count (11%) and anaemia (10%).

6.43 Fatal serious adverse events occurred in 26 (11%) patients in the BmBd arm and 20 (8%) patients in the DBd arm. Of these, 9 deaths (7 in the BmBd arm and 2 in the DBd arm) were considered treatment-related, with the major causes being pneumonia, COVID-19, COVID-19 pneumonia and sepsis.

6.44 A higher proportion of patients in the BmBd arm discontinued treatment (32% versus 19%), had a dose reduction (75% versus 59%), and had at least one treatment interruption (95% versus 76%) compared to the DBd arm. Thrombocytopenia and blurred vision were the main adverse events leading to dose reduction, interruption or delay in the BmBd arm.

6.45 Table 10 summarises the ocular adverse events of special interest with an incidence of at least 10% in the DREAMM-7 trial, based on the October 2024 data cut.

Table 10: Summary of adverse events (CTCAE grade) of special interest in the DREAMM-7 trial (safety population; October 2024 data cut)

Ocular AE category, n (%)	BmBd (N=242)		DBd (N=246)	
	Any grade	Grade ≥3	Any grade	Grade ≥3
Any ocular adverse event	194 (80)	85 (35)	76 (31)	8 (3)
Vision blurred	165 (68)	58 (24)	27 (11)	3 (1)
Dry eye	129 (53)	17 (7)	19 (8)	0
Photophobia	120 (50)	7 (3)	6 (2)	0
Foreign body sensation in eye	111 (46)	9 (4)	12 (5)	0
Eye irritation	110 (45)	12 (5)	14 (6)	0
Eye pain	81 (33)	2 (<1)	9 (4)	1 (<1)
Visual impairment	26 (11)	12 (5)	4 (2)	1 (<1)
Lacrimation increased	24 (10)	2 (<1)	8 (3)	0

Source: Table 2-25, p91 of the resubmission; Table 3.0034, pp1-5 of the DREAMM-7 IA2 supplementary data.
Abbreviations: AE, adverse event; BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; CTCAE, Common Terminology Criteria for Adverse Events; DBd, daratumumab in combination with bortezomib and dexamethasone; IA2, interim analysis 2 (October 2024 data cut).

6.46 More patients in the BmBd arm experienced ocular adverse events of special interest compared to patients in the DBd arm (80% versus 31%). The most commonly reported ocular adverse events of special interest in the BmBd arm were blurred vision, dry eye, photophobia, foreign body sensation in the eye and eye irritation.

6.47 The trial reported investigator-assessed ocular adverse events for the BmBd arm graded using the Keratopathy and Visual Acuity (KVA) scale. The KVA scale has two components, the first grading corneal findings from the ocular exam (e.g., presence of microcysts, corneal haze, etc.) and the second grading changes in vision based on best corrected visual acuity (BCVA). The overall KVA grade is determined by the more severe grade of the 2 components.

6.48 At the October 2024 data cut, 83% of patients in the BmBd arm experienced treatment-related corneal adverse events based on KVA scale grading. Based on the 81% of patients with Grade ≥2 KVA scale events, the median time to onset of the first occurrence was 58.0 days, the median duration of the first occurrence was 106.0 days, and 58% of patients had 3 or more events. Results indicated that 154 (64%) patients in the BmBd arm had unresolved corneal events at the end of treatment, with 94 (61%) of these patients having symptoms unresolved at the end of follow-up/time of the data cut. The longer-term impacts of belantamab mafodotin on the cornea and vision are unclear.

6.49 The resubmission presented a pooled analysis of reading and driving outcomes for patients included in the DREAMM-7 and DREAMM-8 trials (based on a post hoc analysis published by Mateos et al., 2025[5]). This analysis was previously included in the November 2025 pre-subcommittee response. Among 238 patients with baseline reading and no, little, or some difficulty due to eyesight issues, 58 stopped reading at some point. Among 150 patients with baseline driving and no, little, or some difficulty due to eyesight issues, 50 stopped driving at some point. The median number of days patients stopped reading or driving was 29 and 32 days, respectively. The resubmission noted that the majority of patients returned to reading and driving with no, little, or some difficulty.

Unanchored comparison of safety outcomes

6.50 The resubmission presented unanchored comparisons of adverse events for the BmBd arm of the DREAMM-7 trial, with the Cd arms of the CANDOR, ENDEAVOR, IKEMA, ARROW and GEM-KyCyDex trials, the PBd arm of the OPTIMISMM trial, and the SBd arm of the BOSTON trial. Comparisons were presented for summary level adverse events and Grade ≥3 adverse events. The resubmission noted that there were large differences in the durations of follow-up between the trials.

6.51 Table 11 presents a comparison of summary level adverse events for BmBd, Cd, PBd and SBd.

[5] Mateos, M. V., Trudel, S., Quach, H., et al (2025). Modification of belantamab mafodotin dosing to balance efficacy and tolerability in the DREAMM-7 and DREAMM-8 trials. Blood Adv, 9(22), 5708-5719. https://doi.org/10.1182/bloodadvances.2025016949

Table 11: Unanchored comparison of summary level adverse events for BmBd, Cd, PBd and SBd

	BmBd	Cd twice weekly			Cd once weekly		PBd	SBd
	DREAMM-7 N=242	CANDOR N=153	ENDEAVOR N=463	IKEMA N=122	ARROW N=238	GEM-KyCyDex N=100	OPTIM-ISMM N=278	BOSTON N=195
Median follow-up, months (range)	40.2 (0.2-52.3)	50.1 (0-58)	44 (NR)	44 (NR)	12.6 (NR)	37 (4.7-50.2)	64.5 (NR)	13.2 (6.2-19.8) [a]
Any AE	242 (100)	149 (97)	457 (99)	119 (98)	227 (95)	NR	278 (100)	194 (100)
Any Grade 3-4 AE	230 (95)	120 (78)	379 (82)	89 (73)	161 (68)	43 (43)	259 (93)	154 (79)
AE leading to discontinuation	77 (32)	41 (27)	137 (30)	22 (18)	30 (13)	7 (8)	92 (33)	41 (21)
AE leading to dose reduction	181 (75)	59 (39)	138 (30)	NR	25 (11)	NR	NR	141 (72)
Any serious AE	129 (53)	80 (52)	279 (60)	73 (60)	103 (43)	NR	177 (64)	101 (52)
Any fatal AE	26 (11)	9 (6)	32 (7)	6 (5)	22 (9)	4 (4)	29 (10)	12 (6)

Source: Table 2-44, p119 of the resubmission.

Abbreviations: AE, adverse event; BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; NR, not reported.

[a] Median follow-up (interquartile range).

Note that the results of the unanchored comparison are derived from post-hoc analyses specifically for the purposes of informing the PBAC consideration. These analyses were not part of the prespecified statistical plan for DREAMM-7. Interpretation of the results and their application should therefore be limited to seeking to understand the basis for the PBAC outcome and should not be used for any other purpose.

6.52 The resubmission stated that, based on the unanchored comparison, the incidence of treatment-emergent adverse events, serious adverse events and adverse events leading to death were generally similar for BmBd, Cd, PBd and SBd. The resubmission noted that the incidence of Grade ≥3 adverse events was numerically higher for BmBd (95%) compared to Cd (43-82%) and SBd (79%), but was similar to PBd (93%); the incidence of adverse events leading to a dose reduction was numerically higher for BmBd (75%) compared to Cd (11-39%), but was similar to SBd (72%; not reported for PBd); and the proportion of patients who discontinued treatment due to adverse events was numerically higher for BmBd (32%) compared to SBd (21%), but generally similar to Cd (8-30%) and PBd (33%).

6.53 Table 12 presents an unanchored comparison of Grade ≥3 adverse events for BmBd, Cd, PBd and SBd.

Table 12: Unanchored comparison of Grade ≥3 adverse events for BmBd, Cd, PBd and SBd

	BmBd	Cd twice weekly			Cd once weekly		PBd	SBd
	DREAMM-7 N=242	CANDOR N=153	ENDEAVOR N=463	IKEMA N=122	ARROW N=238	GEM-KyCyDex N=100	OPTIMIS-MM N=278	BOSTON N=195
Median follow-up, months (range)	40.2 (0.2-52.3)	50.1 (0-58)	44 (NR)	44 (NR)	12.6 (NR)	37 (4.7-50.2)	64.5 (NR)	13.2 (6.2-19.8) [a]
Thrombocytopenia	135 (56)	25 (16)	58 (13)	29 (24) [b]	17 (7)	8 (8)	78 (28)	77 (39)
Blurred vision	58 (24)	NR	NR	NR	NR	NR	NR	NR
Neutropenia	30 (12)	10 (7)	12 (3)	9 (7) [b]	14 (6)	5 (5)	131 (47)	17 (9)
Dry eyes	17 (7)	NR	NR	NR	NR	NR	NR	NR
Anaemia	21 (9)	25 (16)	80 (17)	26 (21) [b]	42 (18)	11 (11)	43 (16)	31 (16)
Hypertension	13 (5)	27 (18)	69 (15)	28 (23)	13 (6)	10 (10)	NR	8 (4)
Diarrhoea	10 (4)	1 (1)	19 (4)	3 (2)	2 (1)	0	22 (8)	12 (6)
Fatigue	9 (4)	7 (5)	32 (7)	1 (1)	11 (5)	NR	27 (10)	26 (13)
Peripheral neuropathy	3 (1)	1 (1)	11 (2)	NR	0	0	23 (8)	9 (5)
Nausea	2 (1)	1 (1)	NR	NR	1 (<1)	0	1 (<1)	15 (8)
Cardiac failure	2 (<1)	13 (9)	28 (6)	5 (4)	7 (3)	1 (1)	NR	1 (<1)

Source: Table 2-45, p119 of the resubmission.

Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; NR, not reported; PBd, pomalidomide in combination with bortezomib and dexamethasone; SBd, selinexor in combination with bortezomib and dexamethasone.

[a] Median follow-up (interquartile range).

[b] Laboratory abnormalities were reported as treatment-emergent adverse events (in addition to laboratory results in the case report forms) only when they led to action taken on study treatment (dose modification or drug withdrawn) and/or when they were serious.

Note that the results of the unanchored comparison are derived from post-hoc analyses specifically for the purposes of informing the PBAC consideration. These analyses were not part of the prespecified statistical plan for DREAMM-7. Interpretation of the results and their application should therefore be limited to seeking to understand the basis for the PBAC outcome and should not be used for any other purpose.

6.54 The resubmission noted that ocular adverse events (Grade ≥3 blurred vision and dry eyes) associated with BmBd occurred in the DREAMM-7 trial, but were not reported for Cd, PBd and SBd. The incidence of cardiovascular events (Grade ≥3 hypertension and cardiac failure) was higher for Cd (6-23% and 1-9%) than for BmBd (5% and <1%) and SBd (4% and <1%; not reported for PBd). The incidence of Grade ≥3 thrombocytopaenia was higher for BmBd (56%) compared to Cd (11-21%), PBd (28%) and SBd (39%); the incidence of Grade ≥3 anaemia was generally lower for BmBd (9%) compared to Cd (11-21%), PBd (16%) and SBd (16%); and the incidence of Grade ≥3 neutropenia was 12% for BmBd, compared to 3-8% for Cd, 47% for PBd and 9% for SBd.

6.55 The resubmission stated that the reported incidences of Grade ≥3 peripheral neuropathy and fatigue for BmBd (1% and 4%) were comparable to Cd (0-2% and 1-7%), and were numerically lower compared to PBd (8% and 10%) and SBd (5% and 13%); the incidence of Grade ≥3 nausea reported for BmBd (1%) was similar to Cd (0-1%) and PBd (<1%), and was numerically lower compared to SBd (8%); and the incidence of Grade ≥3 diarrhoea reported for BmBd (4%) was comparable to Cd (0-4%), PBd (8%) and SBd (6%).

6.56 The results of the unanchored comparisons should be interpreted with caution due to differences in follow-up durations, patient characteristics, reliance on reported incidence data to inform the comparisons (rather than rates given that adverse events can occur more than once) and given selective reporting of adverse event data in some trial publications. Comparisons were presented for summary level adverse events and Grade ≥3 adverse events only and may not adequately capture the ocular adverse events associated BmBd treatment.

Benefits/harms

6.57 On the basis of direct evidence presented in the resubmission, after a median duration of follow-up of 39.4 months (October 2024 data cut), for every 100 patients treated with BmBd compared to DBd:

- Approximately 31 additional patients would remain progression-free after 24 months.
- Approximately 12 additional patients would remain alive after 24 months.
- Approximately 15 more patients would experience serious adverse events that are life-threatening or required hospitalisation.
- Approximately 49 more patients would experience ocular adverse events, such as blurred vision, photophobia, and dry eye.
- In patients with little or no difficulty reading or driving, approximately 25 more patients would stop reading and approximately 37 more patients would stop driving due to eyesight issues at some point while on treatment.

6.58 A comparison of benefits and harms for BmBd versus Cd, PBd and SBd was not presented, as the benefits and harms could not be reliably quantified from the indirect comparisons.

Clinical claim

6.59 The resubmission described BmBd as superior in terms of effectiveness and inferior in terms of safety compared to DBd.

6.60 The Sub-Committees considered that this claim was adequately supported. In November 2025, the PBAC considered that the claims of superior comparative effectiveness and inferior comparative safety versus DBd were reasonable (paragraphs 6.47 and 6.48, belantamab mafodotin, PSD, November 2025 PBAC meeting).

6.61 The resubmission described BmBd as superior in terms of effectiveness to Cd, PBd and SBd. The resubmission did not make an explicit comparative safety claim but described BmBd as having a different safety profile to Cd, PBd and SBd.

6.62 The Sub-Committees considered that the claim of superior effectiveness was reasonable. However, noted that the following issues should be considered:

- There were no head-to-head trials comparing BmBd with Cd, PBd or SBd, and there were no identified trials with common reference arms to allow single-step indirect

comparisons to be performed. Therefore, the clinical claim was based on the results of an NMA. While the comparisons of progression-free survival and overall survival for BmBd versus Cd, PBd and SBd favoured BmBd, the NMA network was relatively sparse, and there were no closed loops to facilitate alternative estimates of indirect treatment effect. A number of transitivity issues were identified, including differences in trial enrolment periods (trial enrolment start dates ranging from 2008 to 2020), trial design (Phase 2 versus Phase 3 studies, sample size differences, inclusion of crossover in some trials), patient characteristics (including differences in potential treatment effect modifiers) and large differences in follow-up durations. As a result, the magnitude of difference in progression-free survival between BmBd and Cd, PBd and SBd is considered uncertain.

- The resubmission presented the results of fixed and random effects models, with the results of the fixed effects models used in the base case of the economic evaluation, and the results of the random effects models included as a secondary analysis. The 95% credible intervals for the fixed effects model are unlikely to adequately account for the heterogeneity across the included trial network.
- The overall survival comparisons were impacted by immaturity of the overall survival data for a number of trials, and potential differences in post-progression treatments.

6.63 In terms of comparative safety, the Sub-Committees noted that the following issues should be considered:

- Due to the lack of available head-to-head clinical trials comparing BmBd with Cd, PBd and SBd, comparative safety was based on a series of unanchored comparisons of adverse event incidences reported across clinical trials for BmBd, Cd, PBd and SBd.
- The results of the unanchored comparisons should be interpreted with caution due to differences in follow-up durations, patient characteristics, and the reliance on reported adverse event incidences rather than event rates. Additionally, comparisons were presented for summary level adverse events and Grade ≥3 adverse events only, which may not adequately capture the ocular adverse events associated BmBd treatment. Based on the unanchored comparison, treatment with BmBd appeared to be associated with higher rates of Grade ≥3 adverse events compared to Cd, PBd and SBd.

6.64 The PBAC considered that the claim that BmBd was superior in terms of comparative effectiveness compared to DBd, Cd, PBd and SBd was reasonable.

6.65 The PBAC considered that the claim that BmBd was inferior in terms of comparative safety compared to DBd, Cd, PBd and SBd was reasonable.

Economic analysis

6.66 The resubmission presented a modelled economic evaluation of BmBd versus DBd and Cd for the treatment of patients with relapsed or refractory multiple myeloma after

one or more prior lines of therapy. The economic evaluation was based on the DREAMM-7 trial ITT population, results from an indirect comparison of BmBd and Cd and additional modelled data. The economic evaluation was presented as a cost-effectiveness/cost-utility analysis.

6.67 Key components of the economic evaluation are summarised in Table 13.

Table 13: Key components of the economic evaluation

Component	Description
Treatments	BmBd versus DBd and Cd (and PBd as per the revised model in the pre-PBAC response).
Time horizon	15 years in the model base case versus a median follow-up of 39.4 months in the DREAMM-7 ITT population.
Outcomes	Life years; quality-adjusted life years.
Methods used to generate results	Partitioned survival analysis
Health states	Progression-free (on- and off-treatment); progressed disease; dead.
Cycle length	1 week.
Allocation to health states	The proportions of patients who were progression-free (on- and off-treatment), progressed and dead were informed by modelled overall survival (OS), progression-free survival (PFS) and time to treatment discontinuation (TTD) curves. Kaplan-Meier estimates for OS, PFS and TTD for BmBd and DBd were derived from the DREAMM-7 ITT population and were used directly in the model up to the median duration of follow-up for each arm, then extrapolated to 15 years using standard parametric functions. For Cd, OS and PFS were modelled assuming proportional hazards by applying hazard ratios from an indirect comparison of BmBd and Cd twice weekly to the modelled survival outcomes for BmBd from the BmBd vs DBd model. The resubmission used modelled PFS as a proxy for time to treatment discontinuation for Cd. Australian life tables were used to ensure that the risk of death in any model cycle was no lower than general population mortality. Adjustments were incorporated into the model to ensure that TTD did not exceed PFS, and PFS did not exceed OS in any model cycle.
Health related quality of life	Health state utilities were derived from DREAMM-7 EQ-5D-3L utility data analysed using a mixed-effects linear regression model including coefficients for progression status and treatment status, indexed using the Australian value set (Viney 2011). Progression-free on treatment: 0.7831[a] Progression-free off treatment: 0.7837[a] Progressed disease: 0.7568[a] The QALY loss associated with adverse events in each arm was based on the incidence of Grade ≥3 adverse events occurring in ≥5% of patients and grade ≥2 KVA scale ocular adverse events in the DREAMM-7 (BmBd and DBd arms) and ENDEAVOR (Cd arm) trials, and disutilities and durations of adverse events derived from various published sources and assumptions.
Costs	BmBd treatment: Belantamab mafodotin costs were derived from an analysis of individual patient data (IPD) of weekly dosing in the DREAMM-7 ITT population and assumed beyond the median duration of follow-up. Bortezomib and dexamethasone costs were derived based on recommended doses with adjustments for trial-based relative dose intensities. Treatment persistence was based on trial-based time to treatment discontinuation for the BmBd arm up to the median duration of follow-up then extrapolated using standard parametric functions. DBd treatment: costs were derived based on recommended doses with adjustments for trial-based relative dose intensities. Treatment persistence was based on trial-based time to treatment discontinuation for the DBd arm up to the median duration of follow-up then extrapolated using standard parametric functions.

Component	Description
	Cd treatment: costs were derived based on recommended doses with adjustments for relative dose intensities (based on assumptions), assuming a 60%/40% split between the once weekly and twice weekly regimens. Treatment persistence was assumed based on modelled progression-free survival. The cost of administration for parenteral treatments was based on MBS item 13950 (administration of one or more antineoplastic agents). Grade ≥3 non-ocular adverse events with an incidence of ≥5% in the DREAMM-7 trial (BmBd and DBd arms) and the ENDEAVOR trial (Cd arm only) (Orlowski 2019) were mapped to AR-DRGs. Costs were derived using 2022/23 National Hospital Cost Data Collection admitted acute cost weights for AR-DRG Version 11.0 and the 2025/26 National Efficient Price. Costs associated with Grade ≥2 KVA events were based on MBS Item 10918 (optometrical services) and were included for patients with 2 or more occurrences (57%), from Week 18 in the model until treatment discontinuation. Costs associated with subsequent therapies were based on published PBS prices, with the distribution of therapies based on DREAMM-7 trial data (for BmBd and DBd arms) and a 10% PBS sample analysis (for the Cd arm). The proportion of patients who initiate subsequent therapy was based on data from the DREAMM-7 trial (47.5% BmBd, 61.0% DBd) and assumed for Cd (61.0%, same as DBd). Disease management costs were based on MBS costs associated with haematologist visits (MBS Item 104), full blood count (MBS Item 65070), biochemistry (MBS Item 66500), protein electrophoresis (MBS Item 71057) and immunoglobin and serum free light chain excretion (MBS Items 71066, 71068, 71072, 71074 and 71075), with assumed frequency based on Tomlinson et al. (2018); the cost of artificial tears (BmBd arm) was based on the advertised pharmacy cost; ophthalmic assessments (BmBd arm) were based on MBS Item 10918 (optometrical services assuming 1 visit every 3 weeks for the first 18 weeks then one visit every 12 weeks thereafter); and the cost of a baseline blood type and antibody screen (DBd arm) was based on MBS Item 65090. Terminal care costs were based on an analysis of the 45 and Up Study conducted by Goldsbury et al. (2018).
Software package	Microsoft Excel

Source: Table 3-3, p145 of the resubmission

Abbreviations: AR-DRG, Australian Refined Diagnosis Related Groups; BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; DBd, daratumumab in combination with bortezomib and dexamethasone; IPD, individual patient data; ITT, intention to treat; KVA, Keratopathy Visual Acuity; MBS, Medicare Benefits Schedule; OS, overall survival; PBS, Pharmaceutical Benefits Scheme; PFS, progression-free survival; QALY, quality adjusted life year; TTD, time to treatment discontinuation

[a] *Note that the utility values were provided for the purposes of informing the PBAC consideration. Interpretation of the results and their application should therefore be limited to seeking to understand the basis for the PBAC outcome and should not be used for any other purpose.*

6.68 A partitioned survival approach was used to allocate patients between model health states. The progression-free health state was further partitioned into on- and off-treatment, based on time to treatment discontinuation curves.

6.69 The resubmission applied a 15-year time horizon for the economic model. The PBAC previously considered extrapolation of the trial data, from a median follow-up of 37.5 months in the DREAMM-7 trial to 20 years, was associated with a substantial amount of uncertainty, and the 20-year time horizon was long as the mean age of patients diagnosed with multiple myeloma in Australia was 71.5 years (paragraph 7.7, belantamab mafodotin PSD, November 2025 PBAC meeting). The Sub-Committees considered that the 15-year time horizon was appropriate.

6.70 The PBAC previously considered that the economic model did not adequately capture the costs and quality of life impacts associated with severe ocular toxicity events (paragraph 7.8, belantamab mafodotin PSD, November 2025 PBAC meeting).

6.71 Costs associated with ocular adverse events were largely unchanged except for updated MBS item fees. However, the resubmission included additional ophthalmic monitoring costs as part of disease management costs. The previous submission applied the cost of ophthalmic examinations for the first 12 weeks of the model only (as a proxy for the first 4 doses, one visit prior to each dose). The frequency of ophthalmic examinations was updated in the resubmission with costs of ophthalmic examinations applied to all patients who remain on treatment throughout the model duration. The resubmission applied weekly costs which were higher for the first 18 weeks of the model (as a proxy for the first 6 doses, one visit prior to each dose) and reduced weekly costs for the remaining model duration based on one visit every 12 weeks thereafter. It is unclear whether all patients on treatment would have reduced ophthalmic exam frequency after 6 doses given belantamab mafodotin was associated with a high frequency of eye related adverse events (80%), and a long duration of occurrence post treatment exposure (average 132 days) in the DREAMM-7 trial. The Sub-Committees noted that the model was not sensitive to changes in the costs associated with ocular adverse events.

6.72 The QALY loss associated with severe ocular toxicity events was unchanged from the previous submission. While disutilities were applied to model adverse events including Grade ≥2 overall KVA scale events, dry eyes and eye irritation, these were assumed to be transient in nature with an overall disutility per event of <0.05. The Sub-Committees again considered this substantially underestimated the quality of life impact of more severe ocular toxicity, which may persist over a longer period of time (paragraph 6.58, belantamab mafodotin PSD, November 2025 PBAC meeting). However, the Sub-Committees noted that the model was not overly sensitive to changes in the disutility per event applied.

6.73 Table 14 summarises the key drivers of the economic model.

Table 14: Key drivers of the model

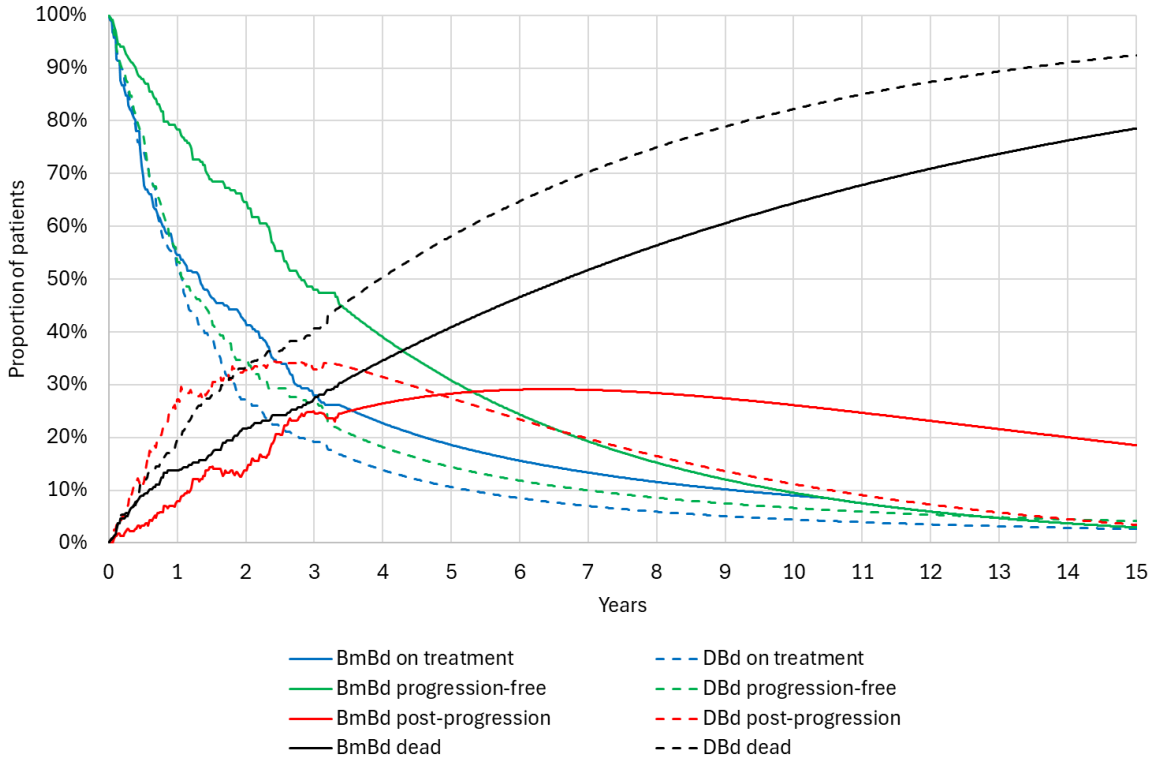
Description	Method/Value	Impact
BmBd and DBd overall survival extrapolation	The resubmission used an exponential function for extrapolation of overall survival in the BmBd and DBd arms in the base case. This was unchanged from the previous submission. While goodness of fit statistics indicated that the lognormal function (for BmBd) and Gompertz function (for DBd) were optimal, the resubmission claimed that the exponential function produced the lowest survival estimates for BmBd and it was the only function that produced clinically plausible estimates for DBd. The resubmission noted that the PBAC previously considered the modelled survival of patients in the BmBd arm was implausibly high with 11% of patients remaining alive at 20 years (paragraph 7.7, belantamab mafodotin PSD, November 2025 PBAC meeting). To address this issue, the resubmission used a 15 year time horizon in the base case. While a shorter time horizon limits the extent of extrapolation, the clinical plausibility of the survival estimates remains uncertain with 21.4% of BmBd patients alive at 15 years. For DBd, the proportion of patients alive at 15 years in the current model was 7.5% (based on the DREAMM-7 ITT population extrapolated using the exponential function. The resubmission stated that all other parametric functions overestimated survival for DBd with more than 10% of patients alive at 15 years. The current model applies a 15 year time horizon but assumes no overall survival convergence at the end of the model duration. The Sub-Committees recalled that the economic model for DBd applied linear convergence of the DBd OS curve to the Bd OS curve from 10 to 15 years (paragraph 6.7, daratumumab PSD, July 2020 PBAC meeting). The Sub-Committees considered that convergence of the BmBd OS curve to the DBd curve from Year 10 to Year 15 would be appropriate and would help to mitigate the uncertainty relating to the longer term OS benefit in the BmBd arm of the model.	High, favours BmBd
BmBd versus Cd treatment effects on overall survival and progression-free survival	Overall survival and progression-free survival in the Cd arm were modelled assuming proportional hazards by applying hazard ratios from an indirect comparison of BmBd and Cd twice weekly based on the sponsor's NMA to modelled survival outcomes for BmBd. Results based on the fixed effects model for BmBd versus Cd twice weekly were used in the base case for PFS (HR: 0.28, 95% CrI: 0.19, 0.40) and OS (HR: 0.53, 95% CrI: 0.35, 0.80). Comparative survival outcomes for BmBd versus Cd are uncertain given limitations with the results based on the NMA presented in the resubmission including substantial heterogeneity between the included trials and lack of closed loops in the network to allow consistency to be assessed.	Unclear impact

Description	Method/Value	Impact
Subsequent treatments	Costs associated with subsequent therapies were applied to 47.5% of patients in the BmBd arm and 61.0% of patients in the DBd arm based on data from the DREAMM-7 trial. The proportion of patients receiving subsequent therapies in the Cd arm was assumed to be the same as the DBd arm. Subsequent treatment distributions for the BmBd and DBd arms were based on DREAMM-7 trial data and re-distributed based on treatments available on the PBS; and for the Cd arm based on a 10% PBS sample analysis. The resubmission estimated the cost of each subsequent treatment based on an assumed treatment duration of 8 months. The resubmission applied the weighted cost of subsequent treatments to the estimated proportion of patients with newly progressed disease in any given cycle. However, this was calculated based on the reduction in the proportion of patients remaining progression-free between cycles, which does not account for patients dying therefore overestimating the proportion of patients who initiate subsequent therapy. The weighted cost was applied as a one-off cost, which effectively attributes the full cost of 8 months of treatment in a single model cycle. The approach lacks face validity but may be necessary given the model structure is based on a partitioned survival analysis that is unable to track changes in disease or treatment status beyond the first occurrence of disease progression. Due to the partitioned survival structure of the model, alternative assumptions for subsequent therapy use (e.g., lines of therapy, distribution of therapies, duration of therapies) affected costs only (and not outcomes).	Moderate impact, favours BmBd

Source: Constructed during the evaluation with reference to Section 3, pp193-197 of the resubmission.
Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; DBd, daratumumab in combination with bortezomib and dexamethasone; NMA, network meta-analysis; OS, overall survival; PFS, progression-free survival

6.74 Figure 4 presents model traces for the comparison of BmBd with DBd in the economic model.

Figure 4: Model traces for BmBd and DBd arms of the economic model



Source: Figures 3-8 and 3-9, pp184-185 of the resubmission and the Section 3 economic model Excel workbook
Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; DBd, daratumumab in combination with bortezomib and dexamethasone
Note that the modelled traces in Figure 4 are presented specifically for the purposes of informing the PBAC consideration. Their interpretation and application should therefore be limited to seeking to understand the basis for the PBAC outcome and should not be used for any other purpose.

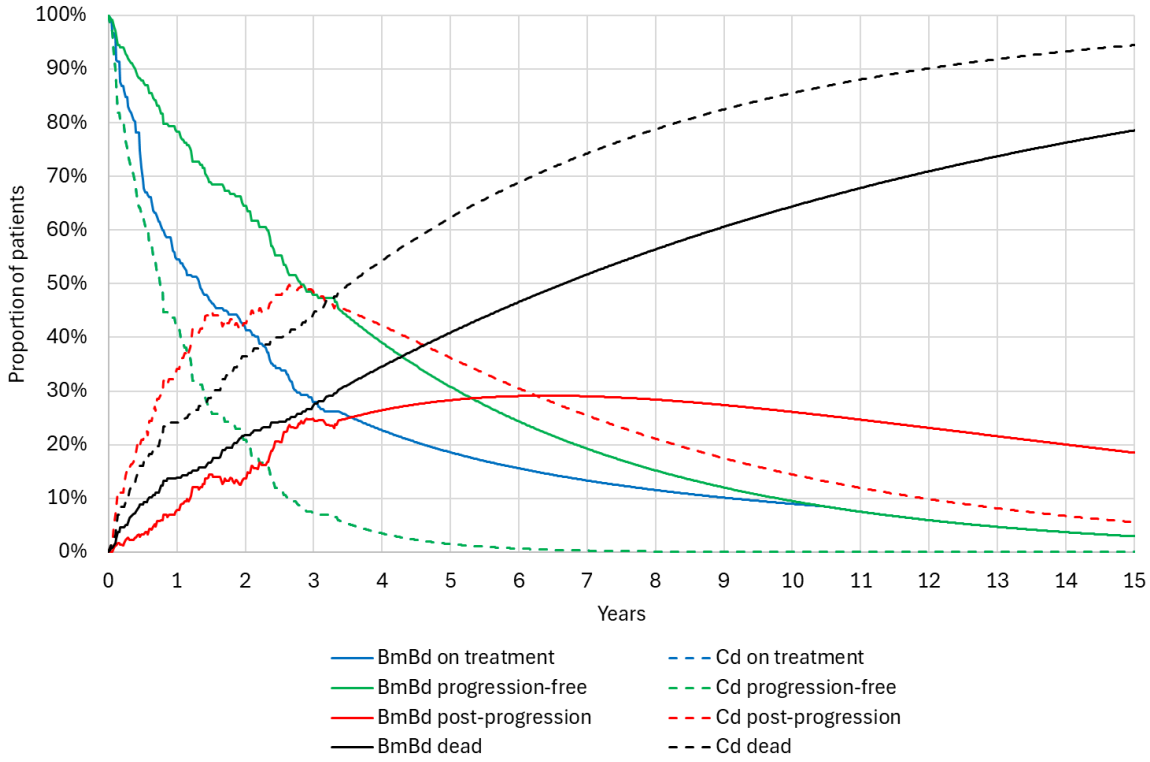
6.75 The model traces show a survival benefit for BmBd compared to DBd that persists over the 15-year time horizon. A difference in mortality between treatment arms is observed from 8 weeks in the model, with a peak difference in mortality at 7.6 years, after which the curves slowly converge over time. The proportion of patients remaining alive in the BmBd arm at 15 years was 21.4% compared to 7.5% in the DBd arm. The Sub-Committees considered that convergence of the BmBd overall survival curve to the DBd curve from Year 10 to Year 15 would be appropriate and would help mitigate the uncertainty relating to the overall incremental survival benefit in the model.

6.76 The traces also show a difference in progression-free survival, in favour of BmBd compared to DBd. The progression-free traces separate from 4 weeks in the model, with a peak difference at 1.8 years, after which the curves converge, and then cross at 12.7 years, after which the proportion of patients who are progression-free is higher in the DBd arm than the BmBd arm. There were 2.9% patients who were progression-free at 15 years in the BmBd arm and 4.1% in the DBd arm.

6.77 There was a relatively large difference between the proportion of patients who were progression-free on treatment versus off treatment, particularly for the BmBd arm, suggesting that a large proportion of patients discontinued treatment despite not having experienced disease progression. Based on the October 2024 data cut of the trial, the primary reasons for treatment discontinuation in the BmBd arm were progressive disease (30%), adverse event (21%) and physician decision (13%); and in the DBd arm were progressive disease (64%), adverse event (9%), and withdrawal by subject (5%).

6.78 Figure 5 presents model traces for the comparison of BmBd with Cd in the economic model. Modelled overall survival, progression-free survival and time to treatment discontinuation in the BmBd arm were the same as for the comparison with DBd above.

Figure 5: Model traces for BmBd and Cd arms of the economic model



Source: Figures 3-9 and 3-10, p185 of the resubmission and the Section 3 economic model Excel workbook
Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone
Note: For Cd, time on treatment was assumed to be the same as time spent progression-free (green dashed curve)
Note that the modelled traces in Figure 4 are presented specifically for the purposes of informing the PBAC consideration. Their interpretation and application should therefore be limited to seeking to understand the basis for the PBAC outcome and should not be used for any other purpose.

6.79 The model traces show a survival benefit for BmBd compared to Cd that persists over the 15-year time horizon. A difference in mortality between treatment arms is observed from the first model cycle, with a peak difference in mortality at 7 years,

after which the curves slowly converge over time. The proportion of patients remaining alive in the BmBd arm at 15 years was 21.4% compared to 5.6% in the Cd arm.

6.80 The traces also show a difference in progression-free survival, in favour of BmBd compared to Cd. The progression-free traces separate from the first model cycle, with a peak difference at 2.2 years, after which the curves slowly converge over time. There were 2.9% patients who were progression-free at 15 years in the BmBd arm and none in the Cd arm.

6.81 The Sub-Committees noted that when linear convergence from Year 10 to Year 15 was applied to OS in the economic models, the proportion of patients alive at 15 years was approximately 7.5% in the BmBd and DBd arms and less than 1% in the Cd arm (noting a HR was applied to the converged BmBd curves to generate an OS curve for Cd).

6.82 The resubmission stated that a time to treatment discontinuation curve for Cd was not available from published literature. Therefore, the resubmission used modelled progression-free survival as a proxy for time on treatment for Cd. The resubmission noted that the PBAC previously considered a mean treatment duration of 15 cycles for Cd based on the ENDEAVOR trial (equivalent to 62.53 weeks or 13.8 months) was reasonable when used in a cost-minimisation analysis between Cd and CLd, and is consistent with the cap applied in the risk sharing arrangement for carfilzomib (paragraphs 6.55 and 7.10, carfilzomib PSD, March 2022 PBAC meeting). In the base case of the resubmission, modelled mean treatment duration for Cd was 60.52 weeks, which is similar to estimates previously accepted by the PBAC.

6.83 Table 15 presents a comparison of modelled survival estimates for the comparator arms, DBd and Cd, against a retrospective analysis of data from the Myeloma and Related Diseases Registry (MRDR December 2025) and key trials of DBd versus Bd (CASTOR, Sonneveld 2023) and Cd versus Bd (ENDEAVOR, Orlowski 2019).

Table 15: Comparison of modelled survival estimates for DBd and Cd with external sources

	DBd			Cd		
	Model	**MRDR**	**CASTOR**	**Model**	**MRDR**	**ENDEAVOR**
Median OS	47 months	30.9 months	49.6 months	42 months	15.9 months	47.8 months
OS at 2 years	67%	~60%	~71%	64%	~37%	~70%
OS at 3 years	59%	~50%	~61%	55%	~27%	~58%
OS at 5 years	42%	-	~44%	38%	-	-

Source: Table 3-39, p183 of the resubmission

Abbreviations: Cd, carfilzomib in combination with dexamethasone; DBd, daratumumab in combination with bortezomib and dexamethasone; MRDR, Myeloma and Related Diseases Registry; OS, overall survival

6.84 The resubmission noted that modelled overall survival for DBd was comparable to estimates from the CASTOR trial but higher compared to real world outcomes reported in the MRDR analysis. The resubmission claimed that the difference is likely due to the high proportion of lenalidomide use in clinical practice which could be affecting survival outcomes in patients receiving DBd. The evaluation noted that this claim may not be reasonable given the relatively small difference in prior lenalidomide exposure between the CASTOR trial (42%) and MRDR analysis (47%). Moreover,

patient age was similar between the model (median 65 years) and the CASTOR trial (median 64 years) but notably lower than in the MRDR analysis (median 72 years).

6.85 The resubmission noted that modelled overall survival for Cd was comparable to estimates from the ENDEAVOR trial but higher compared to outcomes reported in the MRDR analysis. The resubmission claimed that the difference may be due to patients using Cd in a later line of therapy (mainly third or fourth line) compared to the trial (mainly second or third line). While differences in line of therapy are likely to affect the applicability of survival outcomes, there were also differences in terms of modelled patient age (median 65 years, similar to ENDEAVOR) with the MRDR analysis (median 71 years).

6.86 Table 16 presents the results of the economic evaluation based on published prices for daratumumab, carfilzomib and subsequent therapies. The pre-PBAC response presented a revised base case which included subsequent treatment costs for elranatamab and CAR-T, updated prices for daratumumab, lenalidomide and pomalidomide and the updated comparator weighting of [redacted]% DBd, [redacted]% Cd and [redacted]% PBd (see paragraph 5.5). The revised model resulted in a weighted ICER of $55,000 to < $75,000 per QALY. The PBAC noted the revised model included estimated costs for elranatamab and CAR-T and did not include any benefits.

Table 16: Results of the economic evaluation

	BmBd	Comparators	Increment
BmBd versus DBd			
Costs	$[redacted]	$[redacted]	$[redacted]
Life years	5.819	4.262	1.557
QALYs	4.445	3.276	1.169
Incremental cost per life year gained			$[redacted][1]
Incremental cost per QALY gained			$[redacted][2]
BmBd versus Cd			
Costs	$[redacted]	$[redacted]	$[redacted]
Life years	5.819	3.897	1.922
QALYs	4.445	2.974	1.471
Incremental cost per life year gained			$[redacted][3]
Incremental cost per QALY gained			$[redacted][4]
Weighted [redacted]% for BmBd versus DBd and [redacted]% for BmBd versus Cd			
Incremental costs			$[redacted]
Incremental QALYs			–
Weighted incremental cost per QALY gained			$[redacted][3]

Source: Table 3-43 and Table3-49, p189 and p191 of the resubmission; and Section 3 economic model Excel workbook
Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; DBd, daratumumab in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; QALY, quality adjusted life year.
The redacted values correspond to the following ranges:
[1] *$35,000 to < $45,000*
[2] *$45,000 to < $55,000*
[3] *$55,000 to < $75,000*
[4] *$95,000 to < $115,000*

6.87 Treatment with BmBd compared to DBd was associated with an incremental cost per QALY gained of $45,000 to < $55,000. In the model, 85% of incremental QALYs were accrued in the extrapolated period beyond the median duration of follow-up of 39.4

months (3.3 years) in the DREAMM-7 trial. Incremental costs in the model shifted from negative during the trial-based period to positive in the extrapolated period, driven primarily by the continued accrual of initial treatment costs (higher for BmBd compared to DBd), 83% of which occurred during the extrapolated period.

6.88 For every patient treated with BmBd versus DBd and followed for up to 15 years, the economic model (without discounting) estimated that there would be:

- An additional 2.3 years of life lived.
- An additional 1.5 years spent progression-free.
- Additional second-line therapy and administration costs of $[redacted].
- Additional disease management costs of $[redacted] and additional adverse event costs of $[redacted].
- Reduced subsequent therapy costs of $[redacted] and reduced terminal care costs of $[redacted].

6.89 Treatment with BmBd compared to Cd was associated with an incremental cost per QALY gained of $95,000 to < $115,000. In the model base case, 82% of incremental QALYs and 78% of incremental costs were accrued in the extrapolated period beyond the median duration of follow-up of 39.4 months (3.3 years) in the DREAMM-7 trial.

6.90 For every patient treated with BmBd versus Cd and followed for up to 15 years (without discounting) estimated that there would be:

- An additional 2.8 years of life lived.
- An additional 3.0 years spent progression-free.
- Additional second line therapy and administration costs of $[redacted].
- Additional disease management costs of $[redacted] and additional adverse event costs of $[redacted].
- Reduced subsequent therapy costs of $[redacted] and reduced terminal care costs of $[redacted].

6.91 The resubmission presented a weighted ICER per QALY gained of $55,000 to < $75,000 based on the average proportion of patients treated with BmBd who would otherwise be treated with DBd and Cd over the first 6 years of listing, based on the budget impact model of the resubmission ([redacted]% DBd, [redacted]% Cd). The Sub-Committees noted that the second-line only listing of DBd meant that the majority of BmBd use would be displaced to the third- and later-line setting. The Sub-Committees noted that use of BmBd in the second line setting would increase as the use of DLd in the first line setting increased but considered that this change would be gradual (due to the long treatment duration of DLd). The Sub-Committees considered that the majority of patients in the third line setting would receive Cd but noted that a proportion would receive other therapies. Additionally, the Sub-Committees considered that the exclusion of pomalidomide, which has a lower cost than carfilzomib, favoured BmBd. Therefore, the Sub-Committees considered that a more reasonable weighting split in the economic evaluation would be 30% DBd, 50% Cd and 20% PBd. This weighting resulted in an ICER of $95,000 to < $115,000 per QALY (this was achieved by adjusting the cost of the Cd arm as Cd and PBd had previously been considered non-inferior by

the PBAC, see Table 17). The PBAC noted applying the revised weighting proposed in the pre-PBAC response ([redacted]% DBd, [redacted]% Cd, [redacted]% PBd) resulted in an ICER of $75,000 to < $95,000 per QALY.

6.92 The results of key univariate sensitivity analyses for the weighted comparison against DBd and Cd are summarised in Table 17.

Table 17: Results of sensitivity analyses for the weighted comparison against DBd and Cd

Analysis	Incremental cost	Incremental QALYs	ICER	% change
Base case	$[redacted]	[redacted]	$[redacted]	-
Discount rate (base case: 5% costs and outcomes)				
0%	$[redacted]	1.884	$[redacted]	-[redacted]%
3.5%	$[redacted]	1.436	$[redacted]	-[redacted]%
Time horizon (base case: 15 years)				
10 years	$[redacted]	0.934	$[redacted]	+[redacted]%
20 years	$[redacted]	1.488	$[redacted]	-[redacted]%
BmBd overall survival extrapolation (base case: exponential function)				
Lognormal	$[redacted]	1.786	$[redacted]	-[redacted]%
DBd overall survival extrapolation (base case: exponential function)				
Gompertz	$[redacted]	0.690	$[redacted]	+[redacted]%
BmBd time to treatment discontinuation extrapolation (base case: lognormal function)				
Generalised gamma	$[redacted]	–	$[redacted]	-[redacted]%
Gompertz	$[redacted]	–	$[redacted]	+[redacted]%
Loglogistic	$[redacted]	–	$[redacted]	-[redacted]%
DBd time to treatment discontinuation extrapolation (base case: loglogistic function)				
Gompertz	$[redacted]	–	$[redacted]	+[redacted]%
Lognormal	$[redacted]	–	$[redacted]	+[redacted]%
BmBD versus Cd treatment effects on OS, PFS, and TTD for Cd based on PFS (base case: based on treatment effects for Cd twice weekly in the network meta-analysis, fixed effects hazard ratio of 0.53 for OS and 0.28 for PFS)				
Cd twice weekly, random effects, point estimates for OS (HR 0.47) and PFS (HR 0.28)	$[redacted]	1.391	$[redacted]	-[redacted]%
Cd once weekly, fixed effects, point estimates for OS (HR 0.66) and PFS (HR 0.40)	$[redacted]	1.087	$[redacted]	-[redacted]%
Cd once weekly, random effects, point estimates for OS (HR 0.59) and PFS (HR 0.40)	$[redacted]	1.188	$[redacted]	-[redacted]%
Ocular adverse event prophylaxis, monitoring and management costs (base case: all patients receive artificial tears ($16 every 25 days); all patients undergo regular ophthalmic examinations once every 3 weeks for the first 18 weeks then once every 12 weeks thereafter; beyond 18 weeks, patients with multiple ocular adverse events (57% each cycle) are assumed to require additional ophthalmic examinations once every 3 weeks; ophthalmic examination cost of $39 based on MBS item 10918)				
Double monitoring and management costs	$[redacted]	–	$[redacted]	+[redacted]%
Remove monitoring and management costs	$[redacted]	–	$[redacted]	-[redacted]%
Disutility associated with ocular adverse events (base case: disutility per AE - dry eyes = 0.046, eye irritation = 0.046, Grade ≥ 2 KVA scale events = 0.041)				
Double the disutility per event	$[redacted]	1.249	$[redacted]	+[redacted]%
Carfilzomib drug cost (base case: recommended dosing regimen at 91% dose intensity, weighted based on 60% once weekly and 40% twice weekly, treatment duration based on modelled progression-free survival)				
100% once weekly	$[redacted]	–	$[redacted]	+[redacted]%
100% twice weekly	$[redacted]	–	$[redacted]	-[redacted]%
Convergence for OS, PFS and TTD extrapolations (base case: no convergence)				
Convergence from 10 to 15 years **#1**	$[redacted]	–	$[redacted]	+[redacted]%
Weighting of DBd vs Cd (base case: DBd = [redacted]%, Cd = [redacted]%)				

Analysis	Incremental cost	Incremental QALYs	ICER	% change
Base case	$ [redacted]	[redacted]	$ [redacted] [1]	-
DBd = 30%, Cd = 70% **#2**	$ [redacted]	1.380	$ [redacted] [2]	+ [redacted]%
DBd = 30%, Cd = 50%, PBd = 20% **#3**	$ [redacted]	1.380	$ [redacted] [5]	+ [redacted]%
DBd = [redacted]%, Cd = [redacted]%, PBd = [redacted]% **#4**	$ [redacted]	[redacted]	$ [redacted] [2]	+ [redacted]%
Multivariate sensitivity analyses				
#1 + #2	$ [redacted]	[redacted]	$ [redacted] [2]	+ [redacted]%
#1 + #3	$ [redacted]	[redacted]	$ [redacted] [5]	+ [redacted]%
#1 + #4	$ [redacted]	[redacted]	$ [redacted] [2]	+ [redacted]%

Source: Table 3-51, p196 and Section 3 economic model Excel workbook of the resubmission

Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; DBd, daratumumab in combination with bortezomib and dexamethasone; DPMA, dispensed price for maximum amount; DPMQ, dispensed price for maximum quantity; HR, hazard ratio; ICER, incremental cost-effectiveness ratio; OS, overall survival; PBd, pomalidomide in combination with bortezomib and dexamethasone; PFS, progression-free survival; QALY, quality adjusted life year; TTD, time to treatment discontinuation

The redacted values correspond to the following ranges:

[1] *$55,000 to < $75,000*

[2] *$75,000 to < $95,000*

[3] *$45,000 to < $55,000*

[4] *$135,000 to < $155,000*

[5] *$95,000 to < $115,000*

Drug cost/patient/course

Table 18: Drug cost per patient for BmBd, DBd and Cd

	Clinical evidence	Economic model	Financial estimates
BmBd			
Mean relative dose intensity	Belantamab mafodotin: 55.1% [a] Bortezomib: 75.4% Dexamethasone: 81.3%	Belantamab mafodotin: NE based on IPD analysis Bortezomib: 79.3% [b] Dexamethasone: 81.7% [b]	Belantamab mafodotin: NE based on IPD analysis Bortezomib: 79.0% [b] Dexamethasone: 82.0% [b]
Mean treatment duration	1.71 years (median follow-up 3.35 years)	2.94 years [c] (15-year time horizon)	2.19 years [d] (initial 6 years)
Cost per script	-	Belantamab mafodotin 2.5 mg/kg: $ [redacted] [e] Bortezomib: $143 [f] Dexamethasone: $19 [g]	Belantamab mafodotin 2.5 mg/kg: $ [redacted] [h] Bortezomib: $143 [f] Dexamethasone: $19 [g]
Cost/patient/course	-	Initial 6 years [i] Belantamab mafodotin: $ [redacted] Bortezomib: $3,990 Dexamethasone: $144 Extrapolated to 15 years [i] Belantamab mafodotin: $ [redacted] Bortezomib: $3,990 Dexamethasone: $144	Initial 6 years Belantamab mafodotin: $ [redacted] Bortezomib: $3,152 Dexamethasone: $143
DBd			
Mean relative dose intensity	Daratumumab: Cycles 1-3: 88.8% Cycles 4-8: 95.8% Cycles 9+: 97.1% Bortezomib: 83.2% Dexamethasone: 82.1%	Daratumumab: 97.1% [j] Bortezomib: 79.3% [k] Dexamethasone: 81.7% [k]	Daratumumab: 97.0% [l] Bortezomib: 79.0% [l] Dexamethasone: 82.0% [l]

	Clinical evidence	Economic model	Financial estimates
Mean treatment duration	1.46 years (median follow-up 3.18 years)	2.14 years [m] (15-year time horizon)	1.73 years [n] (initial 6 years)
Cost per script	-	Daratumumab: $7,186 [o] Bortezomib: $143 [p] Dexamethasone: $19 [q]	Daratumumab: $7,775 [r] Bortezomib: $139 [s] Dexamethasone: $19 [q]
Cost/patient/course	-	Initial 6 years [i] Daratumumab: $218,508 Bortezomib: $4,059 Dexamethasone: $147 Extrapolated to 15 years [i] Daratumumab: $256,978 Bortezomib: $4,059 Dexamethasone: $147	Initial 6 years Daratumumab: $226,216 Bortezomib: $3,074 Dexamethasone: $146
Cd			
Mean relative dose intensity	No direct trial data for BmBd versus Cd	Carfilzomib: 91% [t] Dexamethasone: 82% [u]	Carfilzomib: 91% [t] Dexamethasone: 82% [u]
Mean treatment duration		1.16 years [v] (15-year time horizon)	1.15 years [v] (initial 6 years)
Cost per script	-	Carfilzomib 20 mg/m^2: $928 [w] Carfilzomib 56 mg/m^2: $2,144 [w] Carfilzomib 70 mg/m^2: $2,752 [w] Dexamethasone: $19 [x]	Carfilzomib 20 mg/m^2: $928 [y] Carfilzomib 56 mg/m^2: $2,346 [y] Carfilzomib 70 mg/m^2: $2,954 [y] Dexamethasone: $19 [x]
Weighted cost	-	Based on 60% once weekly, 40% twice weekly [z]	Based on 60% once weekly, 40% twice weekly [z]
Cost/patient/course	-	Initial 6 years [i] Carfilzomib: $153,156 Dexamethasone: $292 Extrapolated to 15 years [i] Carfilzomib: $154,144 Dexamethasone: $294	Initial 6 years Carfilzomib: $148,062 Dexamethasone: $456

Source: Table 3.0011, Table 3.0012, Table 3.0013, Table 3.0014, Table 3.0015 of the DREAMM-7 IA2 trial report; Section 3 economic model Excel workbook and Section 4 financial model Excel workbook

Abbreviations: BmBd, belantamab in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; DBd, daratumumab in combination with bortezomib and dexamethasone; IPD, individual patient data; NE, not estimable

[a] Based on overall dose intensity (mg/kg/cycle) calculated as cumulative actual dose divided by duration of exposure in days divided by planned cycle length. Relative dose intensity was calculated based on overall dose intensity divided by planned dose intensity × 100%

[b] Mean relative dose intensity for bortezomib in the overall trial population (i.e. both treatment arms). Estimates in the budget impact model were rounded to the nearest whole percentage

[c] Based on time to treatment discontinuation in the trial up to 3.3 years, then extrapolated to 15 years using a lognormal function

[d] Based on modelled time to treatment discontinuation in the economic model for the first 6 years

[e] Weighted DPMAs in the economic model were variable based on average number of vials required for doses ranging from 1.7 mg/kg ($[redacted]) to 2.7 mg/kg ($[redacted]) and mean body weight of 77.2 kg. In the model, the drug cost was estimated based on weekly utilisation data from the IPD analysis of the trial, incorporating dose delays and dose reductions

[f] Weighted DPMA based on published prices assuming 1 × 2.5 mg vial per dose based on the recommended dose in the trial, mean body surface area of 1.90 m^2, and mean relative dose intensity

[g] DPMQ based on the published price, the recommended dose in the trial and mean relative dose intensity

[h] Weighted DPMA based on average number of vials required for the recommended dose of 2.5 mg/kg and mean body weight of 77.2 kg. In the budget impact model, the drug cost was estimated based on weekly utilisation data from the IPD analysis of the trial, incorporating dose delays and dose reductions

[i] Costs based on the economic model were undiscounted

[j] Based on mean relative dose intensity from Cycles 9+ in the trial

[k] Mean relative dose intensity in the overall trial population (i.e. both treatment arms)

[l] As per estimates used in the economic model, rounded to the nearest whole percentage

[m] Based on time to treatment discontinuation in the economic model for 3.3 years, extrapolated to 15 years using a loglogistic function

[n] Based on time to treatment discontinuation in the economic model for the first 6 years
[o] Weighted DPMA based published prices, 1,200 mg per dose, based on the recommended dose in the trial, mean body weight of 77.2 kg and a relative dose intensity of 97%
[p] Weighted DPMA based on published prices assuming 1 × 2.5 mg vial per dose based on the recommended dose in the trial, mean body surface area of 1.90 m^2, and mean relative dose intensity
[q] DPMQ based on the published price, the recommended dose in the trial and mean relative dose intensity
[r] Weighted DPMA based published prices, 1,300 mg per dose, based on the recommended dose in the trial, mean body weight of 77.2 kg and relative dose intensity applied to scripts rather than the average dose
[s] The financial implications workbook included incorrect dispensed public ($111.70) and private hospital ($157.66) prices for bortezomib when used as part of the DBd regimen. The correct prices ($116.15 and $162.17) result in a weighted dispensed price of $143.18 per script.
[t] Source unclear based on documentation in the resubmission
[u] Based on mean relative dose intensity for dexamethasone in the DREAMM-7 trial
[v] Assumed based on modelled progression-free survival for Cd in the economic model
[w] Weighted DPMAs based on published prices for 40 mg, 100 mg and 130 mg doses, based on recommended doses in eviQ, mean body surface area of 1.90 m^2 and mean relative dose intensity
[x] DPMQ based on the published price, the recommended dose in eviQ and mean relative dose intensity
[y] Weighted DPMAs based on published prices for 40 mg, 110 mg and 140 mg doses, based on recommended doses in eviQ, mean body surface area of 1.90 m^2 and relative dose intensity applied to scripts rather than the average dose
[z] Based on assumptions used in a cost-minimisation analysis of carfilzomib in combination with lenalidomide and dexamethasone (CLd) compared to Cd for treatment of relapsed or refractory multiple myeloma (paragraph 7.12, carfilzomib PSD, March 2022 PBAC meeting)
Note: Weighted DPMAs were calculated using a 41%/59% public/private hospital split based on 2025 PBS utilisation data for bortezomib

Estimated PBS usage & financial implications

6.93 This submission was considered jointly by DUSC and ESC.

6.94 The resubmission used a mixed epidemiological/market share approach to estimate the utilisation and financial implications of listing belantamab mafodotin for the treatment of patients with relapsed or refractory multiple myeloma who have received at least one prior line of therapy. The Sub-Committees noted that the submission did not use a market share model as recommended by the PBAC in November 2025.

6.95 The Sub-Committees noted that the eligible patient population each year was derived from the following steps:

i. Estimate the number of incident patients being treated with first line treatment;
ii. Estimate the number of patients progressing from first to second line treatment, accounting for progression rates and death;
iii. Estimate the number of eligible patients treated with BmBd;
iv. Estimate the number of patients progressing from second to third line treatment, accounting for progression rates and death;
v. Estimate the number of eligible patients treated with third line BmBd.

6.96 Table 19 presents the key inputs relied on in the financial estimates.

Table 19: Key inputs for financial estimates

Data	Value applied and source	Comment
Population: First line patients		
Prevalent 1L MM patients in Year 1	[redacted][1] patients. Based on a 10% PBS sample data analysis of prevalent 1L MM patients from 2000 to 2024. An average annual growth rate of 7.16% was applied.	Unchanged from the November 2025 submission. The Sub-Committees noted the paper by Luo et al. 2024 which provides estimates and projections of multiple myeloma incidence, mortality and prevalence in Australia between 1982-2043. The Sub-Committees considered that the prevalence and incidence estimates from the paper could be used to triangulate 2L+ patient numbers.
Number of prevalent 1L patients treated with DLd in Year 1	[redacted][2] patients. Based on the number of dispensed PBS scripts for 1L daratumumab in December 2025.	The resubmission assumed that all initial treatment scripts of daratumumab in the DLd regimen reflected weekly dosing and all grandfathered scripts reflected monthly dosing. It was unclear whether the derived number of patients accurately reflected the number of treated patients given the changes in dosing frequency of the DLd regimen.
Number of prevalent 1L patients treated with LBd/Ld in Year 1	[redacted][1] patients. The number of prevalent patients in Year 1 of listing minus patients treated with DLd	While some patients may receive other treatments, this appeared to be a reasonable simplifying assumption.
Incident MM patients receiving 1L treatment for Year 1 to Year 6	Y1: [redacted][1]; Y2: [redacted][1]; Y3: [redacted][1]; Y4: [redacted][1]; Y5: [redacted][1]; Y6: [redacted][1]. The number of transplant eligible and transplant ineligible incident MM patients in 2022 to 2024 were estimated based on an analysis of 10% PBS sample data. Incident 1L patient growth rate for 2025 to 2031 was estimated from 2024 cases and annual projected cases of incident MM reported by the AIHW.	Unchanged from the November 2025 submission.
% of ASCT ineligible patients	[redacted]%. The total number of transplant ineligible patients in 2022-2024 was divided by the total number of incident patients in 2022-2024. The complement ([redacted]%) was assumed to reflect transplant eligible patients.	Unchanged from the November 2025 submission. Used to determine 1L treatment utilisation.
Annual death rate on 1L LBd, Ld and DLd	7.4%. Assumption based on the proportion of patients remaining alive at 5 years (69%) in the LBd arm of the SWOG S0777 trial (Durie et al., 2020). An exponential function was used to derive an annual death rate. The same death rate was assumed for Ld and DLd.	Deaths were inappropriately estimated by applying a death rate, rather than an annual probability of death to patients remaining on 1L treatment. The PSCR provided updated financial estimates (see paragraph 6.99). The use of a constant hazard (exponential function) may not reflect the natural history of the disease.

Data	Value applied and source	Comment
Annual progression rates on 1L treatment	LBd: 13.0%; Ld: 21.3%; DLd: 6.0%. An exponential function was used to derive annual PFS hazard rates from median PFS estimates reported for the LBd and Ld arms of the SWOG S0777 trial (Durie et al., 2020), and the DLd arm of the MAIA trial (Facon et al., 2025). Annual progression rates were derived from the PFS rates by subtracting the assumed death rate of 7.4%.	The number of patients progressing to 2L treatment was inappropriately estimated by applying the assumed progression rate to patients remaining on 1L treatment. An annual probability of progression in each year derived from the progression rate should have been applied. The constant hazard rate associated with the exponential function (used to derive the PFS and death rates) may not reflect the natural history of the disease and may not be applicable to the older and frailer PBS population. Additionally, the application of the survival data from the trial to patients in the prevalent PBS population who may have already initiated treatment in a prior year may overestimate survival for these patients.
1L treatment utilisation among transplant ineligible prevalent patients	LBd: 68%; Ld: 32%. Based on an analysis of MRDR data included in the March 2023 daratumumab resubmission.	Unchanged from the November 2025 submission.
1L DLd uptake rate among transplant ineligible incident patients	Y1: [redacted]%; Y2: [redacted]%; Y3: [redacted]%; Y4-6: [redacted]%. Based on the uptake rates included in the March 2025 daratumumab submission for 1L treatment of MM (p47, daratumumab, PSD, March 2025 PBAC meeting). Used to derive the proportion of transplant ineligible patients treated with DLd and LBd/Ld.	The PBAC previously considered that the overall uptake (65% in Year 1 increasing to 80% in Years 4-6) to be too high.
Population: Second line patients		
Prevalent 2L MM patients in Year 1	[redacted][1]patients. Based on a 10% PBS sample data analysis of prevalent 2L MM patients from 2000 to 2024. The average annual growth rate (4.32%) was applied to the 2024 prevalent patient estimate ([redacted][1]).	The pre-PBAC response updated the 2L prevalent patient population to correspond with the 2L DBd PBS data ([redacted][1] patients in 2025, see Table 22).
Annual death rates on 2L treatment	DBd: 17.0%; BmBd: 10.0%. An exponential function was used to derive an annual death rate from the proportion of patients remaining alive at 3 years in the DBd and BmBd arms of the DREAMM-7 trial.	Deaths were inappropriately estimated by applying a death rate, rather than an annual probability of death to patients remaining on second line treatment. The PSCR provided updated financial estimates (see paragraph 6.99). The use of a constant hazard (exponential function) may not reflect the natural history of the disease. The applicability of the trial data to the PBS population was unclear.

Data	Value applied and source	Comment
Annual disease progression rate on 2L treatment	DBd: 45.0%; BmBd: 14.6%. An exponential function was used to derive an annual progression-free survival hazard rate from the median PFS for DBd and BmBd reported for the DBd arm BmBd arms of the DREAMM-7 trial. An annual progression rate was derived from the PFS rate by subtracting the assumed death rates of 17.0% for DBd and 10.0% for BmBd.	See above comments relating to annual progression rates on 1L treatment. The applicability of the trial data to the PBS population was unclear.
2L treatment utilisation of DBd among patients treated with first line LBd/Ld	[redacted]%. In the absence of BmBd, [redacted] patients were assumed to receive 2L treatment with DBd.	It is unlikely that [redacted] patients in clinical practice would receive 2L treatment with DBd.
2L BmBd uptake rate among patients not treated with first line DLd	Y1: [redacted]%; Y2: [redacted]%; Y3-6: [redacted]%. Assumption based on expert opinion. The resubmission stated the current limitation of DBd to use as a second line treatment creates challenges for clinicians to optimally sequence treatments, given prior anti-CD38 exposure is a prerequisite for future therapies (elranatamab, CAR-T) and clinical trials. The resubmission stated that the current limitation of DBd to second line only treatment will impact the uptake of BmBd as a second line treatment.	Reduced from the November 2025 submission (previously Year 1: [redacted]%, Year 2: [redacted]%, Years 3-6: [redacted]%). The Sub-Committees considered that the uptake of BmBd remains uncertain, and would likely be lower than assumed, given that DBd is only PBS-listed for use as a 2L agent, the proposed listing allows BmBd to be used as a 2L+ therapy, and given high rates of ocular adverse events associated with belantamab mafodotin treatment. Uptake was revised in the pre-PBAC response to [redacted]% in Year 1, increasing to [redacted]% in Years 5 and 6.
2L BmBd uptake rate among patients treated with first line DLd	Y1: [redacted]%; Y2: [redacted]%; Y3-6: [redacted]%. Assumption based on expert opinion.	The assumed uptake rates were considered uncertain. While the DREAMM-7 trial demonstrated improvements in PFS and OS for BmBd versus DBd, the high rates of ocular adverse events associated with BmBd treatment may lead to lower uptake of BmBd.
Population: Third line patients		
3L BmBd uptake rate among patients treated with 2L DBd	Y1: [redacted]%; Y2: [redacted]%; Y3-6: [redacted]%. Assumption based on expert opinion. The resubmission stated that uptake of BmBd in 3L is expected to be lower than 2L due to treatment-related factors (duration of response, toxicities), disease factors (tempo of relapse, risk-group stratification) and other patient factors (age, frailty, performance status).	Uptake rates were considered uncertain. Some patients may delay treatment with BmBd to a later line of therapy due to the ocular adverse events associated with treatment.
3L BmBd utilisation after 2L Cd	[redacted]%. Assumption. The resubmission stated that patients who receive 2L treatment with Cd rather than BmBd are unlikely to receive 3L treatment with BmBd due to patient-related factors.	This claim was considered uncertain. Some patients may delay treatment with BmBd to a later line of therapy due to the ocular adverse events associated with treatment.
Proposed medicine: BmBd		
Belantamab mafodotin		

Data	Value applied and source	Comment
Belantamab mafodotin 100 mg and 70 mg vial utilisation	Derived from an analysis of weekly belantamab mafodotin utilisation data for the ITT population of the DREAMM-7 trial (including the number of patients remaining on treatment who received a dose, and the dose received in mg/kg). Doses of ≤ 2.1 mg/kg were assumed to reflect an average dose of 1.9 mg/kg; doses of ≥ 2.2 mg/kg were assumed to reflect an average dose of 2.5 mg/kg. The number of vials used each week was estimated by multiplying the number of patients receiving a dose by the average number of 100 mg and 70 mg vials required. The estimated number of vials was multiplied by the proportion of patients remaining on treatment, based on extrapolated time to treatment discontinuation data for the BmBd arm included in the economic model. A fixed dose distribution and frequency was assumed from 173 weeks (corresponding to the point at which fewer than [redacted][3]patients remained on treatment in the patient level analysis). The fixed dose distribution and frequency were based on utilisation during Weeks 173 to 225 of the DREAMM-7 trial.	While the use of the utilisation data from the DREAMM-7 trial allowed dose reductions and dose delays to be captured, the approach used to derive the underlying number of vials in each treatment period was complex, and it is unclear if the derived number of 100 mg and 70 mg vials accurately represented utilisation. The fixed dose distribution and frequency were derived from sparse data, and it is unclear whether the resulting weekly drug cost adequately reflects costs associated with longer-term treatment with BmBd.
Administration cost	$100.80. MBS Item 13950 (administration of an antineoplastic agent), based on 80% of the Schedule fee. One service was assumed for each 70 mg vial of belantamab mafodotin dispensed.	The resubmission based the number of administrations on the number of 70 mg vials, which was higher than the estimated number of 100 mg vials required.
Eye care professional visits	$31.20. MBS Item 10918 (professional attendance, being the second or subsequent in a course of attention and being unrelated to the prescription and fitting of contact lenses), based on 80% of the Schedule fee. One service every 3 weeks for the first 18 weeks, followed by one service every 12 weeks thereafter.	Costs associated with monitoring and management of eye toxicity may be higher in clinical practice given the frequency of eye related adverse events among patients in the DREAMM-7 trial. Additionally, the submission only included costs associated with optometrist consultations. In clinical practice, some patients may be managed by an ophthalmologist, or by an optometrist and an ophthalmologist.
Grandfathered patients	An estimate of grandfathered patients was not provided in the resubmission.	The November 2025 submission estimated that there would be [redacted][3] grandfathered patients (based on a 2L only listing).
Bortezomib and dexamethasone		
Bortezomib treatment	Adherence = 79% (based on mean relative dose intensity in DREAMM-7 in both treatment arms; Persistence = 20.9 weeks (based on the economic model); Administration costs = Nil	Based on treatment discontinuation data of BmBd rather than bortezomib individually; Bortezomib administration costs were likely.
Dexamethasone treatment	Adherence = 82% (based on mean relative dose intensity in DREAMM-& in both treatment arms; Persistence = 20.9 weeks (based on the economic model)	- Based on treatment discontinuation data of BmBd rather than bortezomib individually
Affected medicine: DBd		

Data	Value applied and source	Comment
Daratumumab		
Daratumumab treatment adherence	97%. Based on the mean relative dose intensity for daratumumab reported in the DREAMM-7 trial for Cycle 9+ (ITT population).	The reported mean relative dose intensities for daratumumab in Cycles 1-3 (88.8%) and Cycles 4-8 (95.8%) were lower than the dose intensities reported Cycle 9+ (97.1%). The resubmission included the alternative dose intensities in a sensitivity analysis.
Daratumumab treatment persistence	90.09 weeks. Based on an analysis of time to treatment discontinuation for DBd in the economic model.	The full cost of daratumumab treatment was applied to initiating patients over the first two years (i.e., 90.09 weeks) of treatment. This differed from the method used for belantamab mafodotin treatment costs, which were spread over 6 years. The use of the different approaches did not appear reasonable, as it resulted in a temporal misalignment between costs and cost offsets. This was amended in the PSCR.
Daratumumab administration cost	$100.80. MBS Item 13950 (administration of an antineoplastic agent), based on 80% of the Schedule fee. One service was assumed for each dispensed daratumumab script.	The subcutaneous formulation is administered over 3-5 minutes and may be associated with lower administration costs than the intravenous formulation.
Daratumumab blood group and screen	$9.12. MBS Item 65090 (Blood grouping – ABO and Rhesus), based on 80% of the Schedule fee. Assumed one service for each patient initiating treatment with daratumumab.	The product information for daratumumab states that patients should receive a blood type and screen prior to starting treatment (due to daratumumab binding to CD38 on red blood cells, which may mask detection of antibodies to minor antigens in the patient's serum). MBS Item 65093 ($18.04; 80% of Schedule fee) may have been more appropriate as it includes assessment of minor antigens other than or in addition to the ABO and Rhesus antigens.
Bortezomib and dexamethasone		
Bortezomib treatment	Adherence = 79% (based on mean relative dose intensity in DREAMM-7 in both treatment arms; Persistence = 21.04 weeks (based on the economic model); Administration costs = Nil	- Based on treatment discontinuation data of DBd rather than bortezomib individually; Bortezomib administration costs were likely.
Dexamethasone treatment	Adherence = 82% (based on mean relative dose intensity in DREAMM-& in both treatment arms; Persistence = 21.04 weeks (based on the economic model)	- Based on treatment discontinuation data of DBd rather than bortezomib individually
Affected medicine: Cd		
Carfilzomib		
% of once weekly versus twice weekly Cd use	Once weekly: 60%; Twice weekly: 40%. Based on assumptions used in a cost-minimisation approach between CLd and Cd for treatment of RRMM (paragraph 7.12, carfilzomib PSD, March 2022 PBAC meeting).	It is unclear whether the weighting would reflect current utilisation of these regimens, with no data provided to support this assumption in the resubmission.
% of displaced versus substituted Cd	[redacted]% displaced. The resubmission assumed that [redacted]% of patients would receive Cd in a subsequent line of therapy.	Given that Cd is used as a proxy for other available treatments, the displacement of therapies by BmBd may be higher than estimated.

Data	Value applied and source	Comment
Carfilzomib treatment adherence	91%. Applied to carfilzomib when used as part of the once weekly and twice weekly treatment regimens.	The source of the assumed dose intensity was unclear.
Carfilzomib treatment persistence	59.97 weeks. Derived based on an analysis of time to treatment discontinuation for Cd in the economic model (accrued time on Cd treatment over the initial 6 years of the model).	The full cost of carfilzomib treatment was applied to initiating patients over the first two years (i.e., 59.97 weeks) of treatment. This differed from the method used for belantamab mafodotin treatment costs, which were spread over 6 years. The use of the different approaches did not appear reasonable, as it resulted in a temporal misalignment between costs and cost offsets. This was amended in the PSCR.
Administration cost	$100.80. MBS Item 13950 (administration of an antineoplastic agent), based on 80% of the Schedule fee. One service was assumed for each dispensed carfilzomib script.	-
Dexamethasone		
Dexamethasone treatment	Adherence = 82% (based on an analysis of time to treatment discontinuation in the Cd arm of the economic model); Persistence = 60.37 weeks (based on the economic model)	Source of the estimate was unclear, but appeared to be based on mean relative dose intensity of dexamethasone in the DREAMM-7 population; Overestimated for the once weekly regimen.

Source: Section 4, pp198-252 of the resubmission; Section 4 financial implications Excel workbook.
Abbreviations: 1L, first line; 2L, second line; 3L, third line; AIHW, Australian Institute of Health and Welfare; ANZ, Australia and New Zealand; ASCT, autologous stem cell transplant; Bd, bortezomib in combination with dexamethasone; BmBd, belantamab in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; CD, cluster of differentiation; DBd, daratumumab in combination with bortezomib and dexamethasone; DLd, daratumumab in combination with lenalidomide and dexamethasone; DUSC, Drug Utilisation Sub Committee; ITT, intention to treat; LBd, lenalidomide in combination with bortezomib and dexamethasone; Ld, lenalidomide in combination with dexamethasone; MBS, Medicare Benefits Schedule; MM, multiple myeloma; MRDR, Myeloma and Related Diseases Registry; OS, overall survival; PBAC, Pharmaceutical Benefits Advisory Committee; PBS, Pharmaceutical Benefits Scheme; PFS, progression-free survival; PSD, Public Summary Document; RRMM, relapsed and/or refractory multiple myeloma; S100, Section 100; Y, Year.
The redacted values correspond to the following ranges:
[1] 5,000 to < 10,000 [2] 500 to < 5,000
[3] < 500

6.97 Table 20 presents the estimated utilisation and financial implications of listing belantamab mafodotin on the PBS/RPBS. The PSCR provided revised financial estimates that updated the proportion of patients experiencing disease progression and death, applied the cost of DBd and Cd based on treatment curves from the economic model (i.e. does not frontload these costs into the first available year) and included the daratumumab 5-year anniversary price reduction (1 April 2026). The pre-PBAC response further revised the estimates, adjusting the second-line prevalent population to align with the second-line DBd population (based on PBS data), reduced uptake of second line BmBd in place of DBd and assuming that < 500 PBd patients currently receiving treatment would receive BmBd.

Table 20: Estimated use and financial implications

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Estimated extent of use						
Second line, substituting for DBd	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Second line, substituting for Cd	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Third line, substituting for Cd	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total patients initiating BmBd	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Number of scripts dispensed for BmBd						
Dispensed belantamab mafodotin 100 mg vials	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Dispensed belantamab mafodotin 70 mg vials	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Bortezomib scripts	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Dexamethasone scripts	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Estimated financial implications of BmBd						
Cost of belantamab mafodotin less copayments	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Cost of bortezomib less copayments	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Cost of dexamethasone less copayments	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Estimated financial implications for DBd and Cd						
Cost to PBS/RPBS less copayments	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]
Net financial implications						
Net cost to PBS/RPBS	-$[redacted]	-$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Net cost to MBS	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]
Net cost to PBS/RPBS/MBS	-$[redacted]	-$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Revised estimates presented in the PSCR						
BmBd treated patients	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Cost to PBS/RPBS	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Cost offsets for DBd and Cd	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]
Net cost to PBS/RPBS	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Net cost to MBS	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]
Net cost to health budget	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Revised estimates presented in the pre-PBAC response						
BmBd treated patients	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Cost to PBS/RPBS	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Cost offsets for DBd and Cd	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]
Net cost to PBS/RPBS	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Net cost to MBS	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]	-$[redacted]
Net cost to health budget	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
November 2025 submission						
Net cost to PBS/RPBS	-$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]

Source: Section 4 financial implications Excel workbook; Table 14, p36 of the November 2025 belantamab mafodotin Commentary document.
Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone; Cd, carfilzomib in combination with dexamethasone; DBd, daratumumab in combination with bortezomib and dexamethasone; MBS, Medicare Benefits Schedule; PBS, Pharmaceutical Benefits Scheme; RPBS, Repatriation Pharmaceutical Benefits Scheme.
The redacted values correspond to the following ranges:
[1] *500 to < 5,000*
[2] *< 500*
[3] *5,000 to < 10,000*
[4] *10,000 to < 20,000*
[5] *20,000 to < 30,000*
[6] *$100 million to < $200 million*
[7] *$200 million to < $300 million*
[8] *$0 to < $10 million*
[9] *net cost saving*
[10] *$10 million to < $20 million*
[11] *$30 million to < $40 million*
[12] *$60 million to < $70 million*
[13] *$80 million to < $90 million*
[14] *$20 million to < $30 million*
[15] *$40 million to < $50 million*
[16] *$70 million to < $80 million*
[17] *$50 million to < $60 million*
[18] *$90 million to < $100 million*

6.98 The resubmission estimated a net saving to the PBS/RPBS in Years 1 and 2, a net cost of $80 million to < $90 million in Year 6 and a total net cost over the initial 6 years of $100 million to < $200 million. The cost saving in Years 1 and 2 was due to the different methods used to apply BmBd costs and DBd and Cd cost offsets (see paragraph 6.99). The revised estimates presented in the PSCR, which applied the cost offsets for DBd and Cd consistently over the 6 years, rather than in the first 2 years only, resulted in a net cost to the PBS/RPBS of $10 million to < $20 million in Year 1, increasing to $70 million to < $80 million in Year 6 and totalling $200 million to < $300 million over the first 6 years of listing. The estimates presented in the pre-PBAC response resulted in a cost to the PBS/ RBS of > $1 billion for BmBD and a net cost of > $1 billion over the first 6 years.

6.99 The Sub-Committees noted that the estimated net cost to the PBS/RPBS was considered uncertain due to the following reasons:

- A large number of steps and assumptions were required to model the multiple lines of multiple myeloma treatment, which increased the uncertainty associated with the financial estimates.
- There was limited information provided regarding the methodology used to identify the numbers of prevalent patients receiving first and second line therapy from the 10% PBS sample.

  Given the uncertainty in the methodology used to derive prevalent first- and second-line patient numbers, the Sub-Committees considered the multiple

myeloma prevalence estimates from Luo et al. (2024)[6] could be used, in combination with the DBd PBS data in
Table 22, to triangulate the patient numbers estimated in the resubmission. The pre-PBAC response provided revised estimates that were triangulated and validated as suggested.

- The estimates inappropriately applied annual progression and death rates (derived from reported survival in clinical trials), to patients remaining on treatment in each year, rather than applying an annual probability of progression or death derived using the assumed progression/death rates. The PSCR provided updated financial estimates in which the proportion of patients experiencing death and disease progression in each year was based on the probability of death/disease progression at Year 1 from the overall and progression free survival rates. The Sub-Committees noted that the revised estimates applied the same probability of progression or death to each year, based on the 1-year event probability. It would have been more appropriate to calculate separate probabilities for each year.
- The financial estimates only included costs associated with BmBd when used as a second or third line treatment. The pre-PBAC response stated that this was conservative.
- The assumed uptake rates for BmBd among patients who are eligible for second line DBd were reduced compared to the November 2025 submission, but remained uncertain. Uptake may be lower than assumed given that DBd treatment is limited to second line only treatment, whereas BmBd would be available to use as a third or later line treatment. The Sub-Committees agreed with the commentary and considered that the uptake rates for belantamab use in 2L would be smaller in initial years and rise significantly in subsequent years as daratumumab first line patients relapse. This was amended in the pre-PBAC response.
- Uptake rates for BmBd among patients who receive first line DLd are considered uncertain, and may be overestimated, given the risk of ocular adverse events associated with BmBd treatment, which may result in patients delaying treatment to a later line of therapy.
- While the utilisation data from the DREAMM-7 trial allowed dose reductions, dose interruptions and changes in administration frequency to be captured, the approach used to derive treatment costs for belantamab mafodotin from the

[6] Luo O, et al. Multiple myeloma incidence, mortality, and prevalence estimates and projections, Australia, 1982-2043: a statistical modelling study. *Medical Journal of Australia.* 2024;221(2):75-118.

utilisation data was complex, and it is unclear if the derived number of 100 mg and 70 mg vials accurately represented the utilisation of belantamab mafodotin in the trial. A fixed dose distribution and frequency for belantamab mafodotin was assumed from 173 weeks (corresponding to the point at which < 500 patients remained on treatment in the patient level analysis). The fixed dose distribution and frequency were derived from sparse data, and it is unclear whether the resulting weekly drug cost adequately reflects costs associated with longer-term treatment with BmBd.

- The Sub-Committees noted that the model splits the initiating population into cohorts receiving 100 mg and 70 mg vials and applies dose intensity adjustments to derive the persistent population over the treatment duration. This approach may not reflect clinical practice. The Sub-Committees further noted that this approach produces a partial number of vials (1.25 and 1.17 vials for the 100 mg and 70 mg strengths, respectively) per cycle. The current method also overestimates associated fees and mark-ups per script.
- Cost offsets for DBd and Cd were derived based on an analysis of dose intensity and treatment persistence, which differed from the method used to estimate utilisation of BmBd (based on an analysis of weekly vial utilisation). This was corrected in the PSCR.
- Cd was assumed to be a proxy for all other third line treatments substituted by BmBd. This was revised in the pre-PBAC response with [redacted]% of patients assumed to receive PBd.

6.100 The pre-PBAC response revised the estimate expected substitution as provided in Table 21.

Table 21: Expected substitution of DBd, Cd and PBd by BmBd, provided in pre-PBAC response

N (%)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total	
							N	%
BmBd instead of DBd	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][2] ([redacted]%)	[redacted][2] ([redacted]%)	[redacted][2] ([redacted]%)	[redacted][2]	[redacted]%
BmBd instead of Cd	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][2]	[redacted]%
BmBd instead of PBd	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][1] ([redacted]%)	[redacted][1]	[redacted]%
Total	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][3]	
2L/3L split (%)	[redacted]%/[redacted]%	[redacted]%/[redacted]%	[redacted]%/[redacted]%	[redacted]%/[redacted]%	[redacted]%/[redacted]%	[redacted]%/[redacted]%	2L: [redacted]%, 3L: [redacted]%	

Source: Table 3, pre-PBAC response

Abbreviations: 2L: second line; 3L: third line; BmBd: belantamab mafodotin, bortezomib, dexamethasone; DBd: daratumumab, bortezomib, dexamethasone; Cd: carfilzomib, dexamethasone; PBd: pomalidomide, bortezomib, dexamethasone.

The redacted values correspond to the following ranges:

[1] *< 500*

[2] *500 to < 5,000*

[3] *5,000 to < 10,000*

6.101

6.102 Table 22 compares the number of patients initiating treatment with daratumumab based on an analysis of PBS data with the estimated number of patients initiating BmBd in the resubmission, PSCR and pre-PBAC response.

Table 22: Comparison of estimated BmBd utilisation with daratumumab utilisation based on an analysis of PBS data

Year	Prevalent Patients	Initiating patients			
	Daratumumab (2L)	Daratumumab (2L)	BmBd (+2L)		
			Resubmission	PSCR	Pre-PBAC response
2021	824	824	-	-	-
2022	1,424	835	-	-	-
2023	1,781	825	-	-	-
2024	2,142	908	-	-	-
2025	2,425	977	-	-	-
Year 1		-	[redacted][1]	[redacted][1]	[redacted][1]
Year 2		-	[redacted][1]	[redacted][1]	[redacted][1]
Year 3		-	[redacted][1]	[redacted][1]	[redacted][1]
Year 4		-	[redacted][1]	[redacted][1]	[redacted][1]
Year 5		-	[redacted][1]	[redacted][1]	[redacted][1]
Year 6		-	[redacted][1]	[redacted][1]	[redacted][1]

Source: Data for second-line daratumumab utilisation provided by the DUSC secretariat (PBS Items 12220E, 12221F, 12225K, 12226L, 12228N, 12229P, 12230Q, 12231R, 12673B, 12682L, 12683M, 12704P, 12725R, 12745T, 12746W, 12755H); Section 4 financial implications Excel workbook.

Abbreviations: BmBd, belantamab mafodotin in combination with bortezomib and dexamethasone.

The redacted values correspond to the following ranges:

[1] 500 to < 5,000

Quality Use of Medicines

6.103 The proposed activities to support the quality use of medicines were largely unchanged from the November 2025 submission:

- Medical education for health care professionals and formation of a team providing education for eye care professionals.
- Support materials for health care professionals, including an ophthalmic examination guide and findings materials, an eye-related side effects guide for health care professionals, and local guidelines on dosing and management of ocular adverse events for haematologists and eye care professionals.
- Support materials for patients, including a patient wallet card and an eye-related side effects guide.
- Support of patient organisations, including consultation with Myeloma Australia, sponsorship of patient advocacy groups for educational activities, and delivery of a patient education workshop.

6.104 The resubmission noted that haematologists would be the clinical lead in shared decision making, including for the assessment of patient responses, and for the reviewing of ocular findings from eye care professionals to determine belantamab mafodotin dose adjustments. The resubmission stated that Australia's network of optometrists would provide nationwide access to standard practice ocular tests,

including slit lamp and visual acuity testing. The resubmission claimed that, given the ease of access to optometrists and the typically gradual, noticeable progression of corneal ulcers ensuring early detection, only advanced Grade 4 corneal ulcers (with an incidence of <1% in the DREAMM-7 trial) may require ophthalmologist consultation.

Financial Management – Risk Sharing Arrangements

6.105 The resubmission noted that the sponsor anticipates a risk-sharing arrangement (RSA) will be required for the proposed listing.

6.106 The pre-PBAC response proposed that if use of BmBd exceeds that estimated in the revised estimates (Table 23), a rebate of [redacted]% that reverts the cost of BmBd to the weighted cost per patient of DBd, Cd and PBd would be applied.

Table 23: Proposed RSA expenditure caps for belantamab mafodotin, as per the pre-PBAC response

	Year 1	Year 2	Year 3	Year 4	Year 5
Cost to PBS of Bm	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]

Source: Revised financial estimates workbook provided with the pre-PBAC response
Bm: belantamab mafodotin; RSA: risk sharing arrangement

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

7 PBAC Outcome

7.1 The PBAC recommended the listing of belantamab mafodotin, in combination with bortezomib and dexamethasone (BmBd), for the treatment of relapsed and/or refractory multiple myeloma on the basis that it should be made available only under special arrangements under Section 100 (Efficient Funding of Chemotherapy). The PBAC considered that the proposed use in patients who have received at least one prior therapy was appropriate. The PBAC noted that the evidence presented in the resubmission supported the claims that BmBd was associated with benefits in terms of progression free and overall survival compared to the nominated main comparators, daratumumab (in combination with bortezomib and dexamethasone, DBd) and carfilzomib (in combination with dexamethasone, Cd). The PBAC again noted the ocular adverse events associated with belantamab mafodotin and considered that BmBd was inferior in terms of safety compared to the comparators. The PBAC considered the economic model should apply linear convergence of the BmBd overall survival curve to the DBd curve from Year 10 to Year 15 and that belantamab mafodotin would be cost-effective with a price reduction. The PBAC considered the utilisation estimates and proposed risk sharing arrangement included in the pre-PBAC response were reasonable.

7.2 The PBAC acknowledged the strong support received for this resubmission from individuals, health professionals and medical and consumer organisations via the consumer comments portal and the sponsor hearing. The PBAC noted that the comments highlighted the efficacy of BmBd over currently available treatments and

the associated quality of life benefits. The ocular adverse effects were noted, with most consumers stating that they were manageable.

7.3 The PBAC noted that the resubmission proposed BmBd for use in patients who have progressive disease after at least one prior line of therapy. The PBAC noted that this aligned with the clinical trial, DREAMM-7, and with how multiple myeloma therapies are used in clinical practice. Further, the PBAC noted that the positioning of BmBd would increase patient choice and access, compared to limiting use to second line only (as was proposed in the submission considered in November 2025).

7.4 The PBAC noted that the resubmission nominated DBd and Cd as main comparators, with pomalidomide, in combination with bortezomib and dexamethasone (PBd), and selinexor, in combination with bortezomib and dexamethasone (SBd), as supplementary comparators. The PBAC recalled it had previously considered a mixed comparator was appropriate if BmBD was proposed for use in a broad RRMM population (paragraph 7.3, BmBd PSD, November 2025 PBAC meeting). The PBAC noted that the resubmission assumed a comparator split of [redacted]% DBd and [redacted]% Cd (as a proxy for Cd, PBd and SBd), but that the Sub-Committees considered that, as DBd would continue to be the primary therapy used in the second line setting and noting the relatively high use of PBd in the third line setting (see paragraph 5.5), a more reasonable split would be 30% DBd, 50% Cd and 20% PBd. The PBAC noted that the pre-PBAC response stated that PBS utilisation data did not support a 20% comparator split for PBd and proposed an alternative split of [redacted]% DBd, [redacted]% Cd and [redacted]% PBd (based on revised financial estimates, see Table 21). The PBAC considered that this split would be reasonable to inform the revised economic analyses.

7.5 The PBAC noted that the comparison with DBd was based on the DREAMM-7 trial, which directly compared BmBd and DBd. The resubmission also presented indirect comparisons of efficacy outcomes for BmBd versus Cd, PBd and SBd based on a network meta-analysis of 13 randomised trials.

7.6 For the direct comparison with DBd, the PBAC noted that BmBd resulted in statistically significant improvements in progression free survival (HR = 0.41; 95% CI: 0.31, 0.53; October 2023 data cut) and overall survival (HR = 0.58; 95% CI: 0.43, 0.79, October 2024 data cut). The PBAC noted the OS benefit was maintained in the longer-term data presented in the pre-PBAC response (see Table 7).

7.7 For the indirect comparisons with Cd, PBd and SBd, the PBAC noted that BmBd was associated with statistically significant benefits in terms of progression free and overall survival (see Table 8).

7.8 Overall, the PBAC considered that BmBd was superior in terms of effectiveness compared to DBd, Cd, PBd and SBd.

7.9 Based on the results of the DREAMM-7 trial, the PBAC noted that BmBd was associated with more serious adverse events, Grade 3 or 4 adverse events and more adverse events that resulted in treatment discontinuation, dose reduction and dose interruption compared to DBd (see Table 9). The PBAC noted that unanchored

comparisons of adverse events (Table 11) and Grade ≥ 3 adverse events (Table 12) were presented for the comparisons versus Cd, PBd and SBd. These comparisons indicated that whilst the incidence of treatment-emergent adverse events, serious adverse events and adverse events leading to death were generally similar, BmBd was associated with numerically higher rates of Grade ≥ 3 adverse events. The PBAC again noted that BmBd was associated with ocular events (any Grade) that resulted in blurred vision, visual impairment, dry eye and photophobia. The PBAC noted that it was recommended in the TGA Product Information that patients be assessed by an optometrist or ophthalmologist before commencing treatment and then again before the next 5 doses and that dose modifications were recommended to manage ocular adverse events. Overall, the PBAC considered that BmBd was inferior in terms of safety compared to DBd, Cd, PBd and SBd.

7.10 The PBAC noted that the resubmission presented a weighted incremental cost effectiveness ratio (ICER) which was based on economic models comparing BmBd to DBd and BmBd to Cd/PBd. The PBAC noted that the economic models had a time horizon of 15 years and included revisions to the costs associated with ocular toxicity events as recommended by the PBAC in November 2025, although the quality of life impacts of severe ocular toxicity events remained unchanged. As noted in paragraph 7.4, the pre-PBAC response proposed a revised comparator split of [redacted]% DBd, [redacted]% Cd and [redacted]% PBd. The PBAC considered this split was reasonable, noting that it was difficult to predict the exact weighting as treatment is highly individualised.

7.11 The PBAC noted that the resubmission applied the exponential function to extrapolate overall survival in the BmBd and DBd arms. The PBAC noted that this resulted in 21.4% of BmBd and 7.5% of DBd patients alive at 15 years. The PBAC considered that this was optimistic and advised that linear convergence of the BmBd overall survival curve to the DBd curve from Year 10 to Year 15 would provide more confidence in the results from the economic model.

7.12 The PBAC noted that the resubmission presented a base case ICER of $55,000 to < $75,000 per quality-adjusted life year (QALY) (using published prices of daratumumab, carfilzomib and subsequent treatments). The PBAC noted the ICER using the revised comparator split (see paragraph 7.10) and assuming convergence of the BmBD and DBd overall survival curves (see paragraph 7.11) was $75,000 to < $95,000 per QALY (see Table 17). The PBAC considered BmBd would be cost effective with a price reduction to achieve an ICER of approximately $55,000 to < $75,000 per QALY using this economic model and applying effective prices.

7.13 The PBAC noted that the financial estimates presented in the resubmission relied on a number of steps and assumptions to model the multiple lines of multiple myeloma treatment. The PBAC noted that a number of changes were made to the estimates in both the PSCR and the pre-PBAC response (see Table 19 and paragraph 6.97). The PBAC noted that the utilisation estimates presented in the pre-PBAC response adjusted the second-line prevalent BmBd population to align with the DBd PBS

utilisation data and applied a more conservative uptake profile for BmBd. The PBAC noted for these estimates the number of patients initiating treatment in Year 1 would be 500 to < 5,000 (with [redacted]% of use in the third line setting), increasing to 500 to < 5,000 in Year 6 (with [redacted]% of use in the third line setting) and considered that, on balance, this was reasonable, noting the use of daratumumab in the 2L only setting (Table 22).

7.14 Given the high cost and uncertainty in the treatments that will be replaced (and hence the cost effectiveness), the PBAC considered that a risk sharing arrangement (RSA) would be required. The pre-PBAC response proposed a rebate ([redacted]%, see paragraph 6.106) that would reduce the price of BmBd to the weighted price of DBd, Cd and PBd for any use beyond that estimated in the pre-PBAC response. However, the PBAC considered it was uncertain if this level of rebate adequately addressed the risk of non-cost effective use and the risk of expenditure beyond the estimates, noting the high cost. The PBAC advised that a rebate of less than [redacted]% above the expenditure caps may be appropriate, noting any rebate would need to rebate a majority of the cost over the expenditure caps (consistent with other high-cost multiple myeloma treatments).

7.15 In terms of the restrictions, the PBAC advised that:

- a cautionary note regarding ocular toxicity and reference the need for eye exams prior to the first six doses of belantamab mafodotin should be included in the initial supply restriction. The PBAC considered that the note proposed in the pre-PBAC response was reasonable (see paragraph 3.5);
- belantamab mafodotin should be given in combination with bortezomib and dexamethasone; therefore, the clinical criterion 'The treatment must be (or have been) initiated in combination with bortezomib and dexamethasone' is appropriate and should be included in initial restriction;
- a telephone/online authority level was appropriate for the initial and continuing restrictions and aligned with the restrictions for daratumumab and elranatamab;
- as belantamab mafodotin is administered once every 3 weeks, the references to the weeks/cycles could be removed from the initial and continuing restrictions; (as proposed by the Secretariat in Section 3) and
- the proposed grandfather restriction was not required. The PBAC noted that although a grandfather restriction was requested, the Secretariat had appropriately amended the initial restriction so that it did not exclude patients who have received prior non-PBS subsidised treatment.

7.16 The PBAC advised that belantamab mafodotin should not be treated as interchangeable with any other drugs.

7.17 The PBAC advised that belantamab mafodotin is not suitable for prescribing by nurse practitioners.

7.18 The PBAC advised that the Early Supply Rule should not apply.

7.19 The PBAC found that the criteria prescribed by the *National Health (Pharmaceuticals and Vaccines – Cost Recovery) Regulations 2022* for Pricing Pathway A were not met. Specifically, the PBAC found that in the circumstances of its recommendation for belantamab mafodotin:

a) The treatment is expected to provide a substantial and clinically relevant improvement in efficacy over alternative therapies;

b) The treatment is not expected to address a high and urgent unmet clinical need because other therapies are PBS listed for the treatment of relapsed and/or refractory multiple myeloma;

c) It was not necessary to make a finding in relation to whether it would be in the public interest for the subsequent pricing application to be progressed under Pricing Pathway A because one or more of the preceding tests had failed.

7.20 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:

MEDICINAL PRODUCT **Form**	**PBS item code**	**Max. Amount**	**№.of Rpts**
BELANTAMAB MAFODOTIN Injection	NEW (Public) NEW (Private)	300mg	7
Available brands			
Blenrep (Belantamab mafodotin 70 mg injection, 1 vial)			
Blenrep (Belantamab mafodotin 100 mg injection, 1 vial)			
	Category / Program: Section 100 – Efficient Funding of Chemotherapy Public/Private hospitals		
	Prescriber type: ☒Medical Practitioners		
	Restriction type: ☒Authority Required (telephone/online PBS Authorities system)		
	Episodicity: Relapsed and/or refractory		
	Condition: Multiple myeloma		
Restriction Summary NEW1 / Treatment of Concept: NEW1A			
	Indication: Relapsed and/or refractory multiple myeloma		
	Treatment Phase: Initial treatment		
	Clinical criteria:		
	The condition must be confirmed by a histological diagnosis		

	AND
	Clinical criteria:
	The treatment must be (or have been) initiated in combination with bortezomib and dexamethasone,
	AND
	Clinical criteria:
	Patient must have progressive disease after at least one prior therapy,
	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 not have developed disease progression while receiving treatment with this drug for this condition.
	Prescribing Instructions: Progressive disease is defined as at least one 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 extraction, 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 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: Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein.
	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.
	Administrative Advice: Increased maximum amount will be authorised where a patient's weight is greater than 120 kg
	Administrative Advice: No increase in the maximum number of repeats may be authorised.
	Administrative Advice: Special Pricing Arrangements apply.
	Caution: Belantamab mafodotin is associated with an increased risk of ocular events such as changes in vision and dry eyes. Refer to the approved Product Information for information about eye examination requirements before commencing treatment with this drug.
Restriction Summary NEW2 / Treatment of Concept: NEW2A	
	Indication: Relapsed and/or refractory multiple myeloma
	Treatment Phase: Continuing treatment
	Clinical criteria:
	Patient must have previous*ly* received PBS-subsidised 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.
	Prescribing Instructions: Progressive disease is defined as at least one 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 extraction, 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 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: Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein.
	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.
	Administrative Advice: Increased maximum amount will be authorised where a patient's weight is greater than 120 kg
	Administrative Advice: No increase in the maximum number of repeats may be authorised.
	Administrative Advice: Special Pricing Arrangements apply.

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

GSK welcomes the PBAC's recommendation of belantamab mafodotin (Blenrep®), in combination with bortezomib and dexamethasone, for the treatment of relapsed and/or refractory multiple myeloma (RRMM). GSK recognises the substantial input from clinicians, patients and their associated organisations, which has informed this recommendation. GSK looks forward to working with the Department of Health to make belantamab mafodotin available on the PBS in a timely manner.