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6.09 BLINATUMOMAB, Powder for I.V. infusion 38.5 micrograms, Blincyto®, Amgen Australia Pty Ltd

1 Purpose of Submission

1.1 The Category 3 submission requested to vary the existing blinatumomab Risk Sharing Arrangement (RSA) to recalibrate the subsidisation caps for minimum residual disease (MRD)-negative paediatric B-precursor acute lymphoblastic leukemia (B-ALL).

1.2 This request was based on the sponsor's assumption of increased paediatric MRD-negative uptake and usage of blinatumomab due to closure of paediatric B-ALL trials AALL1731 and AALL1732, conducted by the Children's Oncology Group (COG). The submission also included an update to underlying Australian Institute of Health and Welfare (AIHW) incidence inputs to reflect the most recently published B-ALL epidemiology.

2 Background

2.1 Blinatumomab is currently listed on the PBS via the Section 100 Efficient Funding of Chemotherapy Program for the treatment of relapsed or refractory B-ALL, and newly diagnosed B-ALL.

2.2 The blinatumomab/inotuzumab ozogamicin (herein referred to as 'inotuzumab') RSA has been previously considered by the PBAC. See Table 1 for an overview of recommendations.

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Table 1: Relevant PBAC considerations of blinatumomab/inotuzumab RSA

Drug	Indication	Key RSA advice	RSA outcome
Blinatumomab Nov' 2016	R/R Ph negative B-ALL	Due to the highly uncertain financial estimates, the PBAC recommended financial caps based on the estimated treated population and less than 42 vials per patient. However, given the significant uncertainty around several aspects of the estimates and the high ICER, the PBAC did not consider that this was sufficient grounds for any upward revision of the expenditure cap (para 6.17, Nov 16 PSD).	RSA established
Inotuzumab Nov' 2018	R/R CD22 positive Ph negative B-ALL	The PBAC considered that inotuzumab would need to join the existing RSA terms in place for blinatumomab, and that the associated financial caps could only be increased by the number of additional treatment courses expected with sequential use permitted. The PBAC considered that the number of treatment courses with blinatumomab or inotuzumab would increase by no more than 50% with sequential use permitted (para 7.18, Nov 18 PSD).	Variation with increase in caps
Inotuzumab May 2019	Expanded R/R to include Ph positive B-ALL	The PBAC considered that the existing RSAs for blinatumomab and inotuzumab would need to be updated to include the estimated cost of treatment of new patients with Ph+ disease. The PBAC noted that any increase to the associated financial caps should only be based on the number of additional treatment courses expected with the extension of the existing listing to patients with Ph+ disease based on the financial estimates. The PBAC considered that the financial estimates should account for no more than 50% of patients receiving sequential therapy with these agents consistent with its previous advice (para 4.17, inotuzumab May 19 PSD & para 5.9, blinatumomab May 19 PSD).	Variation with increase in caps
Blinatumomab May 2019	Expanded R/R to include Ph positive B-ALL		
Blinatumomab July 2019	Newly diagnosed B-ALL in haematological complete remission with minimal residual disease (MRD) following chemotherapy	The PBAC noted that the resubmission indicated the sponsor's preference for a single set of caps for blinatumomab to encompass use in both the MRD and relapsed/refractory setting. The PBAC considered that if a single RSA subsidy cap was to be enacted, the cost of both blinatumomab and inotuzumab and a [redacted]% decrease in use in the relapsed/refractory setting would need to be accounted for when calculating a total cap for both medicines across both settings. On this basis, the PBAC considered that an alternative arrangement which would have the same effect of maintaining overall caps for blinatumomab across both populations would also be appropriate (para 5.9, July 19 PSD).	Variation with increase in caps
Blinatumomab Nov' 2024	Expanded newly diagnosed listing to include MRD-negative following induction chemotherapy	The PBAC advised that an RSA would be appropriate to address the uncertainty regarding the magnitude of benefit in the proposed PBS population, which is broader than the E1910 trial (e.g. in age and Ph chromosome status), and around the cost offsets associated with the reduced use of blinatumomab and inotuzumab ozogamicin in the relapsed/refractory setting. The PBAC advised that blinatumomab for MRD-negative B-ALL should join the existing RSA for blinatumomab and inotuzumab ozogamicin. The PBAC advised that the expenditure caps should be adjusted to incorporate (i) the cost offsets associated with reduced use of blinatumomab and	New RSA with increase in caps

Drug	Indication	Key RSA advice	RSA outcome
		inotuzumab ozogamicin in the relapsed/refractory setting, and (ii) the increased use of blinatumomab in the MRD-negative setting. Noting that the revised RSA would account for all populations (i.e. MRD-positive and MRD-negative and relapsed/refractory disease), the PBAC considered that a rebate for use above the expenditure caps would be reasonable (para 12.4, Nov 24 PSD).	
Blinatumomab Dec' 2025	Recommended amendments to the newly-diagnosed listing: to include consolidation treatment for Ph+ patients who have achieved complete haematological response to induction treatment with a TKI and corticosteroids, without requiring prior combination with chemotherapy; and to remove the requirement for all patients to be MRD negative in order to be eligible for continuing treatment.	The PBAC considered that the proposed changes were clinically appropriate and that the expanded listing would remain cost-effective given the expected clinical outcomes for patients. The PBAC advised that the expansion to include Ph+ patients previously treated with a TKI (who are intolerant to chemotherapy) was likely captured in previous financial estimates for blinatumomab, but that the removal of the MRD-based continuation criteria would be expected to result in a financial impact, which should be incorporated into the expenditure caps under the existing RSA, accounting for offsets in the relapsed or refractory setting (blinatumomab, Web Outcomes, December 2025 PBAC meeting).	Variation with increase in caps (effective 1 June 2026)
Inotuzumab March 2026	Request to terminate the RSA for inotuzumab for the treatment of ALL	The PBAC advised that the RSA for inotuzumab for the treatment of acute lymphoblastic leukaemia can be removed (inotuzumab, Web Outcomes, March 2026 PBAC meeting).	
Blinatumomab July 2026 (current submission)	Request to vary expenditure caps for paediatric MRD-negative B-ALL	The PBAC was asked to advise whether varying the expenditure caps for this population is reasonable, and by how much the caps should change.	

Source: constructed by the Secretariat.

3 Recent RSA changes

3.1 Based on the November 2024 PBAC recommendation, new subsidisation caps (commencing 1 March 2025) were agreed with the sponsor of blinatumomab to reflect its expanded listing inclusive of newly diagnosed B-ALL patients who are MRD-negative following induction chemotherapy (with the shared caps inclusive of sequential use with inotuzumab in the relapsed/refractory setting).

3.2 At its March 2026 meeting, the PBAC advised that the RSA for inotuzumab for the treatment of acute lymphoblastic leukaemia (ALL) can be removed. The PBAC considered that the original rationale for including inotuzumab in a shared RSA with blinatumomab, which was to manage uncertain financial estimates and a high incremental cost-effectiveness ratio, had diminished over time (Inotuzumab, Web Outcomes, March 2026 Meeting).

3.3 The recent amendment to the PBS listing of blinatumomab for newly diagnosed patients with B-cell precursor acute lymphoblastic leukaemia (Pre-B-cell ALL) resulted

in increased subsidisation caps (based on the December 2025 PBAC recommendation).

3.4 Table 2 outlines the subsidisation caps for blinatumomab prior to 1 June 2026 and the revised subsidisation caps from 1 June 2026. The revised RSA subsidisation caps account for the expanded population as the requirement for all patients to be minimal residual disease (MRD) negative for continuing treatment has been removed. A rebate of [redacted]% applies for use exceeding caps.

Table 2: Subsidisation caps prior to 1 June 2026 versus subsidisation caps from 1 June 2026

Deed Year	Subsidisation Caps (prior to 1 June 2026 and as per the submission)	Revised subsidisation Caps (from 1 June 2026) taking into account December 2025 PBAC recommendation
1 (Mar 2025 – Feb 2026)	$[redacted]	–
2 (Mar 2026 – Feb 2027)	$[redacted]	$[redacted]
3 (Mar 2027 – Feb 2028)	$[redacted]	$[redacted]
4 (Mar 2028 – Feb 2029)	$[redacted]	$[redacted]
5 (Mar 2029 – Feb 2030)	$[redacted]	$[redacted]

Source: Compiled by the Secretariat during evaluation

3.5 The estimated expenditure for the drug blinatumomab (not including inotuzumab expenditure) in Deed Year 1 is $[redacted] (draft amount, subject to finalisation).

4 Requested Change

Sponsor hearing

4.1 There was no hearing for this item.

Consumer inputs

4.2 The PBAC noted that no consumer inputs were received.

Request

4.3 The submission requested a variation to the existing blinatumomab subsidisation caps based on two changes to the utilisation and cost model (UCM) used to establish the current component of the caps attributable to use in MRD-negative patients:

- increase assumed paediatric MRD-negative uptake from [redacted]% to [redacted]% of eligible patients, reflecting observed PBS use following clinical trial closures; and
- update underlying AIHW incidence inputs to reflect the most recent published B-ALL epidemiology.

4.4 The submission stated that all other assumptions underpinning the current caps remain unchanged.

Utilisation assumptions for MRD-negative B-ALL population (July and Nov 2024 PBAC meetings)

4.5 At its July 2024 meeting when considering the MRD-negative B-ALL submission, the PBAC noted that the uptake rate for paediatric patients was assumed to be [redacted]% based on the assumption that most of these patients would be offered treatment in a clinical trial. The PBAC considered this assumption uncertain and noted it may be marginally underestimated due to the recent closure of some paediatric clinical trials for this indication (paragraph 7.8, blinatumomab, Public Summary Document [PSD], July 2024 PBAC Meeting).

4.6 The submission noted that a marginal increase from [redacted]% to [redacted]% was agreed [at the November 2024 PBAC meeting], combined with a [redacted]% rebate above caps, which it claimed was a mechanism to manage residual uncertainty around future paediatric trial activity. The submission also stated that at the time of agreeing to these assumptions, it was assumed that new frontline paediatric trials could reopen within the deed term.

4.7 In consideration of the MRD-negative B-ALL population, the PBAC had considered that an RSA would be appropriate to address the uncertainty regarding the magnitude of benefit in the proposed PBS population, which is broader than the E1910 trial (e.g. in age and Ph chromosome status), and around the cost offsets associated with the reduced use of blinatumomab and inotuzumab ozogamicin in the relapsed/refractory setting. Noting that the revised RSA would account for all populations (i.e. MRD-positive and MRD-negative and relapsed/refractory disease), the PBAC considered that a rebate of [redacted]% for use above the expenditure caps would be reasonable (paragraph 10.4, blinatumomab Minutes, November 2024 PBAC meeting).

Current situation

4.8 The submission stated that, in practice, paediatric clinical trial activity has not resumed as anticipated and there are currently no frontline paediatric B-ALL trials providing blinatumomab in Australia, and the sponsor's understanding is that none are likely to be running until sometime beyond 2028.

4.9 The submission stated that the PBS is now the primary access route for paediatric MRD-negative patients, with PBS data showing that approximately 90% of all paediatric PBS use of blinatumomab has occurred since 1 August 2024 when AALL1731 closed. Details of utilisation can be found in Table 3.

Table 3: Utilisation of items 11850Q and 11867N

	2021	2022	2023	2024	2025
Initiating patients					
Paediatric	8	3	3	41	105
Scripts					
Paediatric	15	3	7	62	165

Source: Table 5 of the submission

Updated AIHW data

4.10 The submission stated that the AIHW has released updated cancer incidence data ('Cancer Data in Australia 2025') since the budget impact model for blinatumomab in MRD-negative B-ALL was evaluated by the PBAC and that this updated AIHW data has been added to the UCM workbook for re-evaluating the financial impact of blinatumomab use among paediatric patients in the MRD-negative B-ALL setting on the PBS.

4.11 The submission stated that the incidence of B-ALL among the paediatric population was previously estimated to be 202 in 2025 and 209 by 2030. Based on the updated AIHW data, this increases to 204 patients in 2025 and 224 patients by 2030.

4.12 The submission claimed that changes to these AIHW incidence inputs will have a minor impact on expenditure.

Utilisation and financial implications

4.13 A comparison of the financial impact at [redacted]% versus [redacted]% uptake is provided in Table 4. During preparation of the submission overview, the sponsor submitted a revised UCM workbook that modelled the incremental cost of increasing uptake by [redacted]% (i.e. [redacted]%-[redacted]%), updated the PBS Service volumes, and presented a revised paediatric-specific approach to estimating the downstream offsets in the relapsed/refractory setting. The submission had initially costed the offsets in line with adult-equivalent relapse costs, but the updated model applied a paediatric-specific offset, resulting in reduced offsets.

Table 4: Comparison of the net cost to PBS/RPBS at [redacted]% versus [redacted]% paediatric uptake in MRD-negative B-ALL

	Year 1 (Mar 2025 – Feb 2026)	Year 2 (Mar 2026 – Feb 2027)	Year 3 (Mar 2027 – Feb 2028)	Year 4 (Mar 2028 – Feb 2029)	Year 5 (Mar 2029 – Feb 2030)
Number of eligible patients (AIHW 2024)	112	113	113	114	115
Uptake	[redacted]%				
Number of patients in caps	–	–	–	–	–
Net cost PBS / RPBS at [redacted]% uptake (informing expanded caps following inclusion of MRD-negative patients per the Nov 2024 PBAC recommendation)	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Number of eligible patients (AIHW 2025)	114	117	119	121	123
Additional uptake	[redacted]%				
Proposed number of patients in caps	–	–	–	–	–
Cost PBS/RPBS at [redacted]% uptake	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Net cost PBS/RPBS at [redacted]% uptake	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]

Source: Table 7 of the submission, and updated Utilisation and Cost Model (Attachment 2 Blinatumomab - 07-26 UCM paediatric MRD-negative B-ALL 2 June update FINAL.xlsx)
Note: inotuzumab offsets are based on an assumed effective price.

Proposed new RSA caps

4.14 The new caps as proposed by the sponsor are summarised in Table 5.

Table 5: Sponsor's proposed new subsidisation caps

	Year 1 (Mar 2025 – Feb 2026)	Year 2 (Mar 2026 – Feb 2027)	Year 3 (Mar 2027 – Feb 2028)	Year 4 (Mar 2028 – Feb 2029)	Year 5 (Mar 2029 – Feb 2030)
Increase in net cost to PBS/RPBS	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Current caps (i.e. revised caps taking into account Dec 2025 recommendation)	$[redacted]	$[redacted]	$[redacted]	$[redacted]	$[redacted]
Proposed caps as per this submission	–	$[redacted]	$[redacted]	$[redacted]	$[redacted]
% increase	[redacted]%	[redacted]%	[redacted]%	[redacted]%	[redacted]%

Source: Based on Table 1 of the submission and updated Utilisation and Cost Model (Attachment 2 Blinatumomab - 07-26 UCM paediatric MRD-negative B-ALL 2 June update FINAL.xlsx)

5 PBAC Outcome

5.1 The PBAC advised that it would be appropriate to increase the subsidisation caps under the existing blinatumomab Risk Sharing Arrangement (RSA) to account for

additional utilisation of blinatumomab to treat minimum residual disease (MRD)-negative paediatric B-precursor acute lymphoblastic leukemia (B-ALL).

5.2 The PBAC noted the closure of paediatric B-ALL trials AALL1731 and AALL1732, conducted by the Children's Oncology Group (COG), and the impact on PBS utilisation. The PBAC noted that 87% of lifetime blinatumomab usage of item codes 11850Q and 11867N for B-ALL in the paediatric population has occurred after 1 August 2024, aligning with the forementioned trial closures.

5.3 The PBAC advised that increasing the uptake assumptions from [redacted]% to [redacted]% of eligible patients in paediatric MRD-negative B-ALL populations was reasonable. The PBAC requested that, should the blinatumomab trials for the treatment of paediatric B-ALL reopen, the sponsor inform the PBAC at the earliest opportunity.

5.4 The PBAC agreed that Australian Institute of Health and Welfare cancer incidence data from 2025 would not have a significant impact on utilisation estimates.

5.5 The PBAC considered that the updated approach used to derive the estimated utilisation and financial impact was reasonable, noting that increases to the subsidisation caps would need to account for effective price offsets in the relapsed/refractory setting.

Outcome:
Advice provided

6 Context for Decision

The PBAC helps decide whether and, if so, how medicines should be subsidised through the Pharmaceutical Benefits Scheme (PBS) in Australia. It considers applications regarding the listing of medicines on the PBS and provides advice about other matters relating to the operation of the PBS in this context. A PBAC decision in relation to PBS listings does not necessarily represent a final PBAC view about the merits of the medicine or the circumstances in which it should be made available through the PBS. The PBAC welcomes applications containing new information at any time.

7 Sponsor's Comment

The sponsor had no comment.