Relapsing Remitting Multiple Sclerosis (RRMS) Stakeholder Meeting

Outcome Statement

Monday 31 August 2026

Attendees

The meeting was attended by people living with multiple sclerosis (MS) and representatives of MS Australia; the Australian and New Zealand Association of Neurologists (ANZAN); MS Nurses Australasia; pharmaceutical companies; the Department of Health, Disability and Ageing; and the Pharmaceutical Benefits Advisory Committee (PBAC). Participants included neurologists, MS nurses, researchers, advocates and people with lived experience of MS. One neurologist provided written input.

Non-departmental participants completed confidentiality declarations prior to the meeting.

Purpose

The purpose of the meeting was to inform a rapid review of Pharmaceutical Benefits Scheme (PBS) medicines for relapsing-remitting multiple sclerosis (RRMS) being undertaken at the request of the PBAC. The meeting sought stakeholder views on the appropriateness of PBS listings for RRMS medicines based on current evidence, patient preferences, clinical guidelines and clinical practice. This included consideration of access issues, switching between treatments, suitability of treatments for different patient populations, and the clinical justification for current higher- and lower-efficacy tiering of medicines.

Discussion

A representative from the department presented findings from a PBS utilisation analysis of RRMS medicines, including prescription volumes, prevalence estimates, patient demographics, geographic patterns of use and commonly observed treatment sequences. Participants noted that it was important to consider patient numbers and dose intervals for the different therapies, as this would be more informative than prescription volumes. One participant noted that extended interval dosing may be used for some treatments.

Stakeholder responses were captured through online written comments (Slido platform) and facilitated discussion addressing the research questions for the rapid review. Written comments were also accepted from stakeholders who were unable to attend the meeting. The following sections summarise the key themes and perspectives raised across all formats.

<u>What are the patient preferences for RRMS treatments? Are there practical barriers that could make a medicine harder to use, such as travel, monitoring requirements, side effects, or how it is administered?</u>

Stakeholders consistently emphasised that treatment preferences and responses to therapy are highly individual and that no single treatment approach is suitable for all people living with MS. Participants highlighted the importance of maintaining subsidised access to a

broad range of therapies with different modes of action and administration. Participants also emphasised the need for informed treatment choice.

Clinicians and consumers highlighted the benefits of access to higher-efficacy disease-modifying therapies (DMTs) in reducing disease activity, maintaining independence, and supporting participation in work, family life and community activities. Participants described access to higher-efficacy DMTs for people living with MS as life changing.

Participants noted that preferences regarding administration methods vary between individuals and may influence whether a treatment is accessible and sustainable in practice. Stakeholders identified a range of practical factors that can influence treatment choice, including travel requirements, monitoring requirements, service availability, disability, employment, caring responsibilities, side effects and safety considerations. Pregnancy, breastfeeding and family planning were frequently identified as important considerations when selecting treatment. Stakeholders noted ongoing research into therapies for paediatric use.

Limited access to infusion centres and state health system capacity constraints were highlighted as barriers for some patients, particularly those living in regional and remote areas. Participants noted the value of self-administered therapies, such as subcutaneous (SC) injections and oral therapies, where access to specialist services and infusion centres may be limited. Access to specialist care, MRI imaging and ongoing clinical monitoring were also identified as important considerations for some patients.

Are some RRMS medicines more suitable for certain population groups than others?

Stakeholders broadly agreed that treatment should be tailored to individual clinical and personal circumstances, including consideration of: disease activity and severity, age, sex, reproductive planning, breastfeeding, comorbidities, John Cunningham (JC) virus status, geographic location, disability, treatment history including previous adverse effects and mode of action of prior therapy, safety and tolerability, treatment adherence, and patient preference. Participants noted that patients who were JC virus seropositive may not be able to use natalizumab due to the risk of progressive multifocal leukoencephalopathy (PML).

Pregnancy, breastfeeding and family planning were discussed, with participants noting that some therapies have stronger evidence supporting their use in these circumstances. Participants noted that natalizumab and ocrelizumab have established registry data supporting use in pregnancy. Participants noted that safety data may not be generalisable to other medicines with a similar mode of action. Stakeholders also highlighted the importance of maintaining a range of treatment options for people with comorbidities, as some therapies may be unsuitable or may worsen other health conditions.

Regional and remote access was identified as an important consideration, particularly for therapies requiring attendance at infusion centres. Participants noted the value of oral and self-administered therapies for people living long distances from treatment centres or specialist services. One participant also highlighted distance, cultural safety and trust as access considerations for Aboriginal and Torres Strait Islander people. Participants noted

that for people living with disability, additional factors such as fatigue, mobility limitations and cognitive capacity may make complex treatment regimens difficult.

Many stakeholders emphasised the importance of early and fast access to highly effective treatment. Participants noted that disease-related damage and loss of function may not be recoverable and considered that earlier access to effective treatment could reduce cumulative disease burden and long-term disability.

One clinician considered that it was essential that at least one therapy within each class, including intravenous (IV) and SC options, remain accessible through the PBS. The clinician considered that otherwise the current therapies within the anti-CD20 class (e.g. ocrelizumab, ofatumumab and ublituximab) seemed interchangeable; however, this was not the consensus position of the group.

Are there important medicines for the treatment of RRMS that are not available in Australia or not PBS-listed?

Stakeholders acknowledged that Australians currently have the best access to RRMS medicines in the world through the PBS. This access was considered to have contributed to improved outcomes for people living with MS, including reductions in disability and improvements in quality of life. One stakeholder noted that research by the Menzies Institute for Medical Research, University of Tasmania, and MS Australia indicated that the introduction of higher-efficacy DMTs in Australia had led to significant reductions in disability progression for people living with RRMS.[1] Participants highlighted the importance of maintaining access to effective therapies and supporting access to new, innovative treatments as the treatment landscape evolves.

Participants suggested that the greatest unmet need may be in progressive forms of MS, where treatment options remain limited and disability may continue to accumulate despite treatment. Emerging therapies, particularly Bruton Tyrosine Kinase (BTK) inhibitors, were identified as an area of interest for future MS management, particularly for progressive forms of the disease. Participants specifically identified the following BTK inhibitors: fenebrutinib, remibrutinib and tolebrutinib. It was noted that these are oral therapies, which would improve access to treatment across Australia. One clinician noted that BTK inhibitors would best be used in combination with other therapies in patients with severe disease involving both relapses and progression.

Participants identified the following medicines as important for RRMS management but not currently available in Australia or PBS-listed for RRMS, noting that some of these medicines are used for symptom management or treatment of relapses: rituximab, fampridine, mirabegron, tizanidine, oral methylprednisolone and modafinil.

One clinician considered that Australian Government funding should be made available for autologous haematopoietic stem cell transplant (AHSCT) for people with aggressive forms of MS presenting with uncontrolled relapses despite higher-efficacy treatment, under strict

[1] Campbell JA, Henson G, van der Mei I, and Taylor B, University of Tasmania Menzies Institute for Medical Research and MS Australia, 'Multiple Sclerosis Prevalence and Health Economic Impacts in Australia 2025'.

access criteria. Chimeric antigen receptor (CAR) T-cell therapy was also noted as an experimental therapy for patients where conventional therapies have failed to control disease activity.

What PBS restrictions for RRMS medicines don't align with the medicines' TGA indications, clinical guidelines or contemporary clinical practice in Australia?

Stakeholders discussed whether current PBS restrictions are aligned with contemporary evidence, diagnostic criteria and clinical practice. Stakeholders emphasised the need for early treatment with higher-efficacy therapies. Some participants considered that existing restrictions are based on older approaches to MS diagnosis and do not reflect contemporary diagnostic criteria and clinical practice.

Clinicians considered that the PBS restrictions for RRMS therapies were based on the 1983 Poser criteria or 2010 McDonald Diagnostic Criteria. Clinicians considered that current clinical practice was based on the 2024 McDonald Diagnostic Criteria which allows diagnosis of MS after a single clinical episode with supportive paraclinical evidence, or in people presenting with features diagnostic of MS, creating a gap between those diagnosed with MS under current criteria and those eligible for PBS-funded treatment. Some clinicians considered that the PBS restrictions supported access for people with radiological evidence of disease activity, while others considered that the PBS criteria only allowed for treatment in the case of clinical attack/relapse. One clinician noted that the PBS criteria did not take account of the severity of attacks. Clinicians requested that the PBS restrictions be updated to reflect contemporary clinical guidelines, currently the 2024 McDonald Diagnostic Criteria, noting that relapses are now defined as both clinical and radiological.

Participants also discussed the evolving understanding of MS disease as a continuum. Some clinicians considered that the traditional disease classifications (e.g. relapsing-remitting MS, primary progressive MS, secondary progressive MS) were no longer clinically meaningful. Clinicians noted that it may be difficult to accurately allocate patients into these traditional categories. Some clinicians suggested that changing the PBS listings to allow treatment for MS, rather than specifying RRMS, would provide greater flexibility and better reflect the current understanding of the biological basis of MS. It was noted that pharmaceutical companies were still undertaking clinical trials using these categories which may complicate the use of broader PBS listings.

Participants noted that the PBS criteria for RRMS DMTs require treatment discontinuation for patients with disease progression. Participants noted that higher-efficacy therapies may continue to provide benefit even where progression occurs. One participant cited a study by Muller J et al 2025[2] which found that switching to a lower-efficacy treatment (de-escalation) is associated with an increased risk of relapse. One clinician noted that current immunotherapies control relapses better than disability progression and therefore disability progression in the absence of relapse is common among treated patients. Some participants

[2] Muller J et al (2025), 'Treatment De-escalation in Relapsing-Remitting Multiple Sclerosis: An Observational Study', *CNS Drugs*, 39:403-416.

considered that access to subsidised medication should not be limited by disability or based on Expanded Disability Status Scale (EDSS) score.

Stakeholders noted that ocrelizumab is TGA-registered for the treatment of primary progressive MS but not PBS-listed for this indication.

The Chair noted that the review may provide an opportunity to update the PBS restrictions for RRMS therapies and requested that the neurologists and/or ANZAN develop and provide preferred wording for the PBS restrictions.

Questions regarding treatment continuation and cessation in an ageing MS population were raised. Several stakeholders emphasised that decisions about treatment continuation or cessation should remain individualised and made between patients and clinicians, rather than being determined by PBS criteria. Participants noted concerns that discontinuing treatment may increase the risk of renewed disease activity for some patients. Clinicians considered that current guidelines did not provide adequate criteria on when to stop treatment that could be used to inform PBS restrictions. Participants also discussed the need for further evidence regarding treatment duration, switching and cessation in older patients, particularly as the MS population ages and the management of comorbidities, side effects and infection risk becomes increasingly important.

One stakeholder noted that rituximab was not TGA-registered for the treatment of MS and considered that it would be inappropriate for PBS restrictions to require prior use of a medication that did not have an indication for MS. It was noted that rituximab had an unrestricted benefit listing on the PBS, allowing subsidised access for any use deemed clinically appropriate by the prescriber, including use for MS treatment. One clinician noted that in South-East Asian countries where rituximab is more commonly used for RRMS treatment than in Australia, its use may be associated with higher rates of hypogammaglobulinemia, hypertension, infection and cancer. In some cases, hypogammaglobulinemia will require lifelong replacement therapy with IV/SC immunoglobulin. One stakeholder noted that the OVERLORD study comparing rituximab to ocrelizumab in patients with newly diagnosed relapsing MS showed an increased rate of infections in the rituximab group and considered this would be an important factor in treating elderly patients.

<u>What evidence or clinical guidance is available to inform switching between RRMS medicines?</u>

Stakeholders described treatment switching as a routine but complex component of contemporary MS care. Participants with lived experience noted that switching is generally undertaken for specific clinical reasons rather than convenience alone. There was broad agreement that decisions regarding treatment switching should be individualised and based on clinical need. Reasons for switching included breakthrough clinical or radiological disease activity, lack of treatment effectiveness, adverse effects, safety concerns, pregnancy planning, emerging comorbidities and changes in individual patient circumstances.

Participants frequently referred to real-world evidence, international MS registries, post-marketing evidence, and Australian and New Zealand clinical guidance as important sources to informing switching decisions. Participants noted that this evidence generally supported switching to higher-efficacy treatment when there was breakthrough disease activity. It was noted that the Australian and New Zealand guidelines recommend switching therapy if there is evidence of breakthrough clinical or radiological disease activity after being on, and adherent to, the therapy for a sufficient time for it to be fully effective.

Clinicians noted that RRMS therapies are not interchangeable and that switching decisions must consider differing mechanisms of action, efficacy profiles, administration requirements, mode of action of the prior therapy, and safety considerations. Stakeholders supported clinically justified switching that aimed to improve disease control, safety or treatment suitability, and did not support non-medical switching of patients stable on an effective therapy as this was considered to expose the patient to potential risk of harm without an expected clinical benefit. Participants noted that patients using natalizumab required monitoring for JC virus seroconversion and may require switching to another treatment if this occurred, based on an individualised benefit-risk assessment.

Stakeholders noted that treatment de-escalation and discontinuation may be considered in some circumstances and should be guided by clinical evidence and individual patient needs. One clinician noted that a current summary of recommended practices for sequencing MS therapies based on evidence was provided in Dersch RS et al 2026.[3] The clinician noted this summary concluded that:

- Early initiation of high-efficacy treatment prevents disability more than delayed initiation.
- Clinical and sub-clinical radiological disease activity should be treated with escalation to a more potent therapy.
- Break-through disease activity on higher-efficacy DMT warrants switching to another higher-efficacy DMT with a different mode of action.
- Progressive forms of disease with evidence of episodic localised inflammatory activity benefit from higher-efficacy DMT.
- Pregnancy and breastfeeding may require switching to a therapy with an appropriate safety profile.
- Groups of patients for whom de-escalation of therapy is safe, and appropriate therapies to use after de-escalation, are yet to be established.

One stakeholder noted the ENHANCE, ENAMOR and ENABLE studies demonstrated successful switching of patients (primarily due to lack of prior treatment efficacy) from other DMTs to ublituximab.

[3] Dersch RS et al. (2026), 'The Art of Sequencing Disease-Modifying Therapies in Multiple Sclerosis', *Neurol Neuroimmunol Neuroinflamm*, 13(5):e200621.

Is the current tiering of RRMS medicines into 'higher' and 'lower' efficacy clinically justified and supported by clinical guidelines? What are the clinically justified options for grouping RRMS medicines?

Several participants suggested that the current two-tier framework may no longer adequately reflect the contemporary treatment landscape, clinical guidelines or evolving evidence base. Several stakeholders supported consideration of a three-tier framework comprising higher-, moderate- and lower-efficacy therapies. Participants considered that a three-tier framework may better reflect current clinical practice, and trial and real-world evidence, including Australian and New Zealand consensus recommendations.

Views differed regarding the classification of some medicines into specific efficacy tiers. At least one stakeholder suggested that the following medicines may be better placed in a moderate-efficacy tier: fingolimod, cladribine, dimethyl fumarate, diroximel fumarate, teriflunomide, siponimod, ozanimod and ponesimod. One participant considered cladribine to be higher-efficacy. Stakeholders raised that fingolimod may no longer be an appropriate comparator for higher-efficacy treatments, and that therapies should only be compared with other therapies within their class (e.g. anti-CD20 therapies). Participants considered that medicines within a tier were not clinically interchangeable at the individual patient level.

Stakeholders including clinicians and participants with lived experience, generally supported the importance of maintaining access to lower-efficacy medicines for some patient groups, particularly oral and self-administered treatments. Reasons cited included patient preference, safety considerations, comorbidities, pregnancy planning, and the needs of patients who have remained stable on these treatments for extended periods. Participants noted that some patients prefer lower-efficacy therapies because of their safety profile, such as pregnant patients, while others may require access to therapies that are less immunosuppressive due to comorbidities such as active malignancy.

The Chair asked participants to reflect on how potential medicine shortages or delistings may be handled by clinicians and patients. Several stakeholders emphasised that treatment changes should not occur solely because alternative therapies are available if patients are stable and doing well on their existing treatment. Participants highlighted the importance of maintaining a range of treatment options to support individual patient circumstances and risk preferences. Some participants noted that treatment switching could trigger disease activity. Participants with lived experience noted that it may be distressing for patients who are stable on therapies to be forced to switch treatments without clinical justification.

Clinicians noted that a lack of subsidised access to SC ofatumumab would be difficult to manage given the likely increased need for access to IV infusion services and access issues this may create particularly for regional and remote patients. One clinician suggested that the cost of increasing infusion capacity, including at regional healthcare services, to accommodate all patients switching from SC ofatumumab to an IV anti-CD20 therapy would likely exceed savings on the cost of the medication.

Conclusion

The Chair thanked participants for their time, contributions and constructive engagement throughout the stakeholder meeting. The Chair reassured participants with lived experience and advocacy groups that input had been clearly heard on the importance of maintaining treatment choice and allowing patients who are stable on therapy to continue their current treatment. The Chair noted that the group had clearly distinguished between treatment options for patients stable on current therapy and those newly diagnosed. The better alignment of PBS indications with clinical practice guidelines would support more "individualised" prescribing.

The Department noted that the rapid review would include further opportunities for input, including through public consultation and pre-PBAC responses invited from pharmaceutical sponsors and key stakeholder groups. Updates on the review would continue to be provided through the PBS Reviews website.