PUBLIC SUMMARY DOCUMENT

Product: Rituximab, solution for I.V. infusion 500 mg in 50 mL, Mabthera®

Sponsor: Roche Products Pty Ltd

Date of PBAC Consideration: March 2007

1. Purpose of Application

To extend the listing of rituximab to include use as a Section 100 pharmaceutical benefit for patients with severe active rheumatoid arthritis (RA) who have received prior treatment with a tumour necrosis factor antagonist (anti-TNF).

2. Background

Rituximab is listed as an authority required benefit for some manifestations of non-Hodgkin's lymphoma.

3. Registration Status

Rituximab is TGA registered for treatment of patients with:

- CD20 positive, previously untreated, Stage III/IV follicular, B-cell non-Hodgkin's lymphoma, in combination with chemotherapy.
- CD20 positive, relapsed or refractory low grade or follicular, B-cell non-Hodgkin's lymphoma.
- CD20 positive, diffuse large B-cell non-Hodgkin's lymphoma, in combination with chemotherapy.
- Severe active rheumatoid arthritis who have had an inadequate response or intolerance to at least one tumour necrosis factor (TNF) antagonist therapy, in combination with methotrexate (MTX)

4. Listing Requested and PBAC's View

Authority required:
Application for an initial course of PBS-subsidised treatment with rituximab, by a rheumatologist or clinical immunologist with expertise in the management of rheumatoid arthritis, of adults who:
(a) have severe active rheumatoid arthritis; and
(b) have received prior PBS-subsidised anti-TNF treatment for this condition in this treatment cycle; and
(c) have failed to achieve an adequate response to at least one prior anti-TNF therapy.

If treatment with an anti-TNF is contraindicated according to the TGA-approved Product Information, or intolerance of a severity necessitating permanent treatment withdrawal develops during the relevant period of use, the patient is exempted from demonstrating an inadequate response to that particular agent(s) only. Details of the contraindications or intolerance, including the degree of toxicity, must be provided at the time of application.

The above requested restriction is an abbreviated version of the complete requested restriction.

See Recommendation and Reasons for the PBAC's view

5. Clinical Place for the Proposed Therapy

Rituximab would provide an alternative treatment to patients with rheumatoid arthritis who have failed one or more tumour necrosis factor antagonists (anti-TNF).

6. Comparator

The submission nominated etanercept and adalimumab as the comparators. The PBAC considered this appropriate.

7. Clinical Trials

Indirect comparisons of rituximab versus etanercept and versus adalimumab, using methotrexate or placebo (for standard care) as a common reference, formed the basis of the submission. The indirect comparisons were based on evidence from:

- three rituximab trials: WA17042, Emery et al (2006) and Edwards et al (2004),
- three etanercept trials: Weinblatt et al (1999), Klareskog et al (2004) and Moreland et al (1999),
- four adalimumab trials: Weinblatt et al (2003), Keystone et al (2004), Furst et al (2003) and Van de Putte (2004).

These trials had been published at the time of submission, as follows:

Trial/First author	Protocol title/Publication title	Publication citation
Cohen SB et al (WA17042)	Rituximab for rheumatoid arthritis refractory to anti-tumour factor therapy: results of a multi-centre, randomized, double-blind, placebo-controlled phase III trial evaluating primary efficacy and safety at twenty-four weeks.	Arthritis & Rheumatism 2006; 54 (9): 2793-2806
Emery P et al.	The efficacy and safety of rituximab in patients with active rheumatoid arthritis despite methotrexate treatment: results of a phase IIB randomized, double-blind, placebo-controlled, dose-ranging trial.	Arthritis & Rheumatism. 2006; 54(5):1390-400.
Edwards JC et al.	Efficacy of B-cell-targeted therapy with rituximab in patients with rheumatoid arthritis.	New England Journal of Medicine. 2004; 350(25): 2572-81.
Strand et al.	Sustained benefit in rheumatoid arthritis following one course of rituximab: improvements in physical function over 2 years.	Rheumatology. 2006; 45(12):1505-13.
Weinblatt ME et al.	A trial of etanercept, a recombinant tumour necrosis factor receptor: Fc fusion protein, in patients with rheumatoid arthritis receiving methotrexate.	New England Journal of Medicine 1999; 340: 253-259
Klareskog L et al.	Therapeutic effect of the combination of	Lancet 2004; 363:675-681

Trial/First author	Protocol title/Publication title	Publication citation
	etanercept and methotrexate compared with each treatment alone in patients with rheumatoid arthritis: double-blind randomised controlled trial.	
Moreland et al.	Etanercept therapy in rheumatoid arthritis. A randomized, controlled trial.	Annals of Internal Medicine. 1999; 130(6):478-86.
Weinblatt et al	Adalimumab, a fully human anti-tumour necrosis factor alpha monoclonal antibody, for the treatment of rheumatoid arthritis in patients taking concomitant methotrexate: the ARMADA trial.	Arthritis and Rheumatism 2003; 48: 35-45.
Furst DE et al	Adalimumab, a fully human anti tumour necrosis factor-alpha monoclonal antibody, and concomitant standard antirheumatic therapy for the treatment of rheumatoid arthritis: results of STAR (Safety Trial of Adalimumab in Rheumatoid Arthritis).	The Journal of Rheumatology 2003 ; 30: 2563-2571
Keystone EC et al.	Radiographic, clinical and functional outcomes of treatment with adalimumab (a human anti-tumour necrosis factor monoclonal antibody) in patients with active rheumatoid arthritis receiving concomitant methotrexate therapy: a randomised, placebo-controlled, 52-week trial.	Arthritis and Rheumatism 2004; 50:1400-1411.
Van de Putte et al	Efficacy and safety of adalimumab as monotherapy in patients with rheumatoid arthritis for whom previous disease modifying antirheumatic drug treatment has failed.	Annals of the Rheumatic Diseases. 2004; 63(5):508-16.

8. Results of Trials

The American College of Rheumatology (ACR) 50 result was presented because this outcome was considered the most clinically relevant and was the end point incorporated into the definition of response in the PBS restriction for biological disease modifying anti-rheumatic drugs (bDMARDS).

Indirect comparisons of pooled results from the trials, including monotherapy studies and studies where the patient population did not include anti-TNF failures, were considered.

The point estimates of the comparisons (excluding the trial reported by Klareskog et al 2004) favoured etanercept compared with rituximab. No significant difference was observed for the pairwise comparison between rituximab and adalimumab. The confidence intervals around the estimate of incremental effect of rituximab versus adalimumab/etanercept were all wide.

The data suggest that rituximab may be equivalent to another TNF inhibitor in a patient who has had an inadequate response to a TNF inhibitor.

Analysis of time to second rituximab treatment course (after an initial course consisting of treatment on day 1 and day 15) showed that the mean time to re-treatment was 449.18

days (standard error 16.19). For those patients receiving rituximab re-treatment, the time between the second and the third course was a mean of 312.41 days (standard error 12.68 days).

9. Clinical Claim

The submission claimed that rituximab (+MTX) was no worse than etanercept 25mg twice weekly (+MTX) and adalimumab 40mg once every two weeks (+MTX) in terms of both efficacy and safety.

See Recommendation and Reasons for PBAC's views.

10. Economic Analysis

A series of preliminary economic evaluations were presented using a cost-minimisation approach. The resources included in the evaluations were drug costs, specialist costs and administration costs.

A modelled economic evaluation was not presented.

11. Estimated PBS Usage and Financial Implications:

The submission estimated that the likely number of patients per year would be < 10,000 in year 4 of listing, while the financial savings per year to the PBS was estimated to be < $10 million in Year 4 of listing, based on the assumption rituximab will substitute for other bDMARDS.

12. Recommendation and Reasons

The PBAC considered that, although the trial data presented in the submission, apart from trial WA17042, were not representative of the requested restriction, rituximab is an effective agent in patients with rheumatoid arthritis including those patients who have previously not responded to at least one TNF inhibitor.

The PBAC accepted that the nominated comparators, etanercept and adalimumab were appropriate and that the data suggest that rituximab may be equivalent to another TNF inhibitor in a patient who has had an inadequate response to a TNF inhibitor.

The PBAC recommended listing as an authority required benefit, in combination with methotrexate, on a cost-minimisation basis as compared to etanercept and adalimumab for patients who have failed to demonstrate a response to at least one TNF inhibitor. The equi-effective doses are rituximab 1000 mg on Days 1 and 15 being equivalent to etanercept 25 mg twice weekly and adalimumab 40 mg once every second week.

The PBAC requested that the restriction be developed in consultation with the sponsor, Australian Rheumatology Association and other relevant stakeholders. The restriction should include the requirement for rituximab to be co-prescribed with methotrexate and should be incorporated into the current interchangeability arrangements for the bDMARDs in the treatment of rheumatoid arthritis, allowing for two treatment courses of rituximab per year (i.e. 4 infusions of 1g). The initiation and response criteria should be

the same as those applying to the current bDMARDs with demonstration of response to treatment required at 3 months

Recommendation
RITUXIMAB, solution for I.V. infusion 500 mg in 50 mL,

Authority required
Note:
Any queries concerning the arrangements to prescribe rituximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority to prescribe rituximab should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Further prescribing information is on the Medicare Australia website at www.medicareaustralia.gov.au.

Note:
TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying anti-rheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, etanercept, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab) and the interleukin-1 inhibitor (anakinra).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.
PBS-subsidised infliximab, anakinra and rituximab must be used in combination with methotrexate at a dose of at least 7.5 mg weekly. Where a patient cannot tolerate 7.5mg of methotrexate weekly, they are only eligible to receive PBS-subsidised etanercept and adalimumab.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

From 1 August 2007, under the PBS, all patients will be able to commence a Treatment Cycle where they may trial PBS-subsidised bDMARD agents without having to experience a disease flare when swapping to an alternate agent. Under these interchangeability arrangements, within a single Treatment Cycle, a patient may continue

to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

A patient who received PBS-subsidised bDMARD treatment prior to 1 August 2007 is considered to be in their first Cycle as of 1 August 2007.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next Cycle.

For patients who have failed PBS-subsidised treatment with 3 bDMARDs prior to 1 August 2007 please contact Medicare Australia on 1800 700 270.

The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent Cycle to the date of the first application for initial treatment with a bDMARD under the new Treatment Cycle.

A patient who has failed less than 3 bDMARDs in a Treatment Cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same Treatment Cycle.

A patient who has failed less than 3 bDMARDs in a Treatment Cycle and who has a break in therapy of more than 5 years, may commence a new Treatment Cycle.

There is no limit to the number of Treatment Cycles a patient may undertake in their lifetime.

If patients fail to respond to a particular bDMARD within a single Treatment Cycle, they are not eligible to receive further PBS-subsidised treatment with that drug until they commence the next Cycle.

1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2007

a) Initial treatment:

Applications for initial treatment should be made where:

i) a patient has received no prior PBS-subsidised bDMARD treatment in this Treatment Cycle and wishes to commence such therapy, excluding rituximab (Initial 1); or

ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under ‘Swapping therapy’ below]; or

iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for etanercept, adalimumab and anakinra, 22weeks of therapy for infliximab and 2 infusions of rituximab.

From 1 August 2007, a patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy

and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to Medicare Australia within 4 weeks.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD excluding rituximab treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Rituximab patients: A further application may be submitted to Medicare Australia 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

b) Continuing treatment:

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to Medicare Australia within these time frames, the patient will be deemed to have failed to respond to treatment with that bDMARD.

2) Swapping therapy

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same Treatment Cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non

bDMARD therapy requirements. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same Treatment Cycle.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

3) Baseline measurements to determine response

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a Treatment Cycle and Medicare Australia will assess response according to these revised baseline measurements.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response.

4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy

A patient who wishes to trial a second or subsequent Treatment Cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received

treatment with at least 1 non-biological DMARD, at an adequate dose, for a minimum of 3 months at the time the ESR and/or CRP levels and the active joint count are measured.

5) Patients 'grandfathered' onto PBS-subsidised treatment with rituximab.
From 1 August 2007, a patient who commenced treatment with rituximab for severe rheumatoid arthritis prior to 7 March 2007 and who was grandfathered on to PBS-subsidised therapy, and who continues to receive treatment in the same Treatment Cycle, will have further applications for treatment with rituximab assessed under the continuing treatment restriction.

Grandfather arrangements will only apply for the first Treatment Cycle. For the second and subsequent Cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that applies to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below for further details.

Public and private hospital authority required
Initial 2 (change or re-commencement)
Application for an initial course of PBS-subsidised treatment with rituximab, in combination with methotrexate at a dose of at least 7.5 mg weekly, by a rheumatologist or clinical immunologist with expertise in the management of rheumatoid arthritis, of an adult who:
(a) has a documented history of severe active rheumatoid arthritis; and
(b) has failed to respond to at least 1 PBS-subsidised TNF alfa antagonist in this Treatment Cycle, and
(c) has not previously failed to respond to PBS-subsidised rituximab in the current Treatment Cycle.

Applications for patients who have demonstrated a response to PBS-subsided rituximab treatment within this Treatment Cycle and who wish to recommence rituximab treatment within the same Cycle following a break in therapy, will only be approved where evidence of a response to the patient's most recent course of PBS-subsidised rituximab treatment has been submitted to Medicare Australia.

A patient may qualify to receive a further course of treatment (one infusion at week 0 and one infusion at week 2) every 24 weeks with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. The demonstration of response must be submitted to Medicare Australia within 4 weeks of assessment.

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial application must be used for assessment of all continuing applications.

The authority application must be made in writing and must include:
(1) a completed authority prescription form; and
(2) a completed Rheumatoid Arthritis PBS Authority Application- Supporting Information Form (www.medicareaustralia.gov.au).

Patients who fail to demonstrate a response to treatment with rituximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug,

in this Treatment Cycle. Patients may re-trial rituximab after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this Cycle and the date of the first application under the new Cycle.

Patients who fail to demonstrate a response to rituximab treatment and who qualify to trial an alternate bDMARD according to the interchangeability arrangements for bDMARDs for the treatment of severe rheumatoid arthritis, may do so without having to have a 22 week treatment free period.

Patients who fail to demonstrate a response to treatment to 3 bDMARDs are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new bDMARD Treatment Cycle after a minimum of 5 years has elapsed from the date the last prescription for a PBS-subsidised bDMARD was approved in this Cycle and the date of the first application under the new Cycle.

Solution for I.V. infusion 500 mg in 50 mL Pack Size: 1

Public and private hospital authority required

Initial 3 (grandfather patients)
Initial PBS-subsidised supply for continuing treatment with rituximab, in combination with methotrexate at a dose of at least 7.5 mg weekly, by a rheumatologist or clinical immunologist with expertise in the management of rheumatoid arthritis, of an adult who:
(a) has a documented history of severe active rheumatoid arthritis; and
(b) was receiving treatment with rituximab prior to 7 March 2007; and
(c) has demonstrated a response as specified in the criteria for continuing PBS-subsidised treatment with rituximab.

The authority application must be made in writing and must include:
(1) a completed authority prescription form; and
(2) a completed Rheumatoid Arthritis PBS Authority Application- Supporting Information Form (www.medicareaustralia.gov.au) which includes the signed patient acknowledgement form.

The same indices of disease severity used to establish baseline at the commencement of treatment with a bDMARD must be used for assessment of all continuing applications.

Patients who fail to demonstrate a response to treatment to 3 bDMARDs are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new bDMARD Treatment Cycle after a minimum of 5 years has elapsed from the date the last prescription for a PBS-subsidised bDMARD was approved in this Cycle and the date of the first application under the new Cycle.

Patients can qualify for PBS-subsidised treatment under this criteria once only.

Solution for I.V. infusion 500 mg in 50 mL Pack Size: 1

Public and private hospital authority required
Continuing treatment
Continuing PBS-subsidised treatment with rituximab, in combination with methotrexate at a dose of at least 7.5 mg weekly, by a rheumatologist or clinical immunologist with expertise in the management of rheumatoid arthritis, of an adult:
(a) who has a documented history of severe active rheumatoid arthritis; and

(b) who has demonstrated an adequate response to treatment with rituximab; and
(c) whose most recent course of PBS-subsidised bDMARD treatment in this Treatment Cycle was with rituximab.

An adequate response to treatment is defined as:
an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; AND either of the following:
(i) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or
(ii) a reduction in the number of the following major active joints, from at least 4, by at least 50%:
— elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
— shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The authority application must be made in writing and must include:
(1) a completed authority prescription form; and
(2) a completed Rheumatoid Arthritis PBS Authority Application- Supporting Information Form (www.medicareaustralia.gov.au).

Patients may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. The demonstration of response must be submitted to Medicare Australia within 4 weeks of assessment.

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial application must be used for assessment of all continuing applications.

Patients who fail to demonstrate a response to treatment to 3 bDMARDs are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new bDMARD Treatment Cycle after a minimum of 5 years has elapsed from the date the last prescription for a PBS-subsidised bDMARD was approved in this Cycle and the date of the first application under the new Cycle.

Solution for I.V. infusion 500 mg in 50 mL Pack Size: 1

13. Context for Decision

The PBAC helps decide whether and, if so, how medicines should be subsidised in Australia. It considers submissions in this context. A PBAC decision not to recommend listing or not to recommend changing a listing does not represent a final PBAC view about the merits of the medicine. A company can resubmit to the PBAC or seek independent review of the PBAC decision.

14. Sponsor's Comment
The sponsor has no further comment.