7.01 OSIMERTINIB, Tablet 40 mg, Tablet 80 mg, Tagrisso®, AstraZeneca Pty Ltd.

1 Purpose

1.1 The early re-entry resubmission sought a Section 85 (General Schedule), Authority Required Pharmaceutical Benefits Scheme (PBS) listing for osimertinib in combination with cisplatin or carboplatin, and pemetrexed for the first-line treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with evidence in tumour material of an activating epidermal growth factor receptor mutation (*EGFRm*) known to confer sensitivity to EGFR tyrosine kinase inhibitors (TKIs).

1.2 The resubmission was based on the PBAC decision to not recommend osimertinib for this indication from May 2025.[1] The PBAC had considered osimertinib in combination with chemotherapy (O+C) was associated with a moderate improvement in progression free survival (PFS) but overall survival (OS) data were immature and it was associated with increased toxicity. The PBAC considered the economic model was based on optimistic assumptions and overestimated the benefit of O+C. The PBAC considered the uptake rate of O+C in the submission to be substantially overestimated given the safety profile of the treatment. The PBAC considered the outstanding issues could be addressed in an early re-entry resubmission. The PBAC indicated the following changes may address these outstanding issues without requiring further re-evaluation:

- Propose a single combined listing for osimertinib monotherapy and O+C
- Reduce price to give an ICER less than $55,000 to < $75,000 per QALY gained using the revised model
- Revision of the financial estimates
- Propose a revised osimertinib risk-sharing arrangement proposal.

1.3 This resubmission addressed the issues raised by PBAC as outlined in the table below.

[1] https://www.pbs.gov.au/industry/listing/elements/pbac-meetings/psd/2025-05/files/osimertinib-psd-may-2025.pdf

Table 1: Summary of key matters to be addressed

Matter of concern	Response	Addressed?
Propose a single combined listing: 7.6 With regards to the restriction criteria, the PBAC considered it would be preferable to have a single, combined listing allowing either osimertinib monotherapy or osimertinib in combination with chemotherapy. The PBAC noted this could be achieved by removing the clinical criterion "The treatment must be the sole PBS-subsidised therapy for this condition" from the current listing. The PBAC noted that this would require a weighted price for osimertinib in the first-line locally advanced/metastatic setting.	The resubmission proposed a single combined listing for continued use allowing osimertinib as monotherapy or in combination with pemetrexed. A weighted price for osimertinib in the first-line locally advanced/metastatic setting (i.e. O+C and osimertinib monotherapy) was proposed.	Y
Reduce price to give an ICER less than $[redacted][1] per QALY gained using the revised model: 7.13 The PBAC considered the ESC respecified base case model (as outlined in paragraph 6.50) with the treatment duration cap for O+C removed provided a reasonable basis for assessing the cost-effectiveness of O+C compared to osimertinib. The PBAC noted the ICER increased from $[redacted][1] per QALY to $[redacted][2] per QALY (based on an average treatment duration of [redacted] months for O+C).	The base case economic model was revised for consistency with the ESC re-specified base case (time horizon of 7.5 years, use of extrapolation functions with the lowest AIC, adjustment to AE costs) and removed the treatment duration cap. The model re-specifications resulted in an ICER of $[redacted][2] at the previously proposed price (effective EMP $[redacted]). An ICER of $[redacted][1]/QALY is achieved with the revised effective EMP of $[redacted] in the O+C indication.	Y
Revision of the financial estimates: 7.14 The PBAC considered the assumed uptake of O+C of [redacted]% of patients eligible for first-line osimertinib monotherapy was overestimated, noting the toxicity of the combination. The PBAC considered the financial estimates would require revision and advised it would be reasonable to consider an uptake rate of 30% to 40%. The PBAC considered the inclusion of some prevalent patients was appropriate; however, the uptake in this population should be less than 30%. The PBAC noted the financial estimates assumed a capped treatment duration of [redacted] months per patient and considered this was not appropriate and the financials should apply a mean treatment duration of [redacted] months.	A revised uptake of [redacted]% for O+C was used. The revised uptake assumption in prevalent patients was [redacted]%. The capped treatment duration of [redacted] months was removed from the updated financial estimates. The updated mean treatment duration of [redacted] months was applied in the financial estimates.	Y
Propose a revised osimertinib risk-sharing arrangement proposal: 7.15 The PBAC considered it would be appropriate for O+C to join the risk sharing agreement for osimertinib that currently includes the PBS listings for first-line, second-line, adjuvant use. An increase in the caps to account for additional net expenditure on osimertinib associated with the extended listing would be reasonable	A revised Risk Sharing Arrangement for osimertinib indications was proposed.	Y

Source: Table 1-1, pp9-10 of the resubmission
EMP = ex-manufacturer price, ICER = incremental cost effectiveness ratio; O+C = osimertinib in combination with chemotherapy, QALY = quality adjusted life year
The redacted values correspond to the following ranges:
[1] *$55,000 to < $75,000*
[2] *$115,000 to < $135,000*

2 Background

2.1 Osimertinib plus chemotherapy (pemetrexed and platinum-based chemotherapy) (O+C) was approved by the Therapeutic Goods Administration (TGA) on 30 October 2024 for "the first-line treatment of patients with locally advanced or metastatic NSCLC whose tumours have EGFR exon 19 deletions or exon 21 L858R mutations."

2.2 The PICO from the previous submission is presented below.

Table 2: Key components of the clinical issue addressed by the submission (as stated in the previous submission)

Component	Description
Population	First-line treatment of patients with locally advanced (Stage IIIB/C) or metastatic (Stage IV) *EGFRm* NSCLC
Intervention	Osimertinib 80 mg once daily, in combination with pemetrexed (500 mg/m^2; with vitamin supplementation) plus either cisplatin (75 mg/m^2) or carboplatin (AUC5), with both treatments administered every three weeks for four cycles, followed by osimertinib 80 mg once daily, plus pemetrexed maintenance (500 mg/m^2) every three weeks.
Comparator	Osimertinib monotherapy 80 mg once daily
Outcomes	Primary outcome: PFS Key secondary outcomes: OS, ORR, DoR, depth of response, DCR, post-progression outcomes, HRQoL Safety
Clinical claim	In patients with locally advanced or metastatic *EGFRm* NSCLC, osimertinib in combination with platinum plus pemetrexed chemotherapy is superior in terms of effectiveness compared with osimertinib monotherapy. In patients with locally advanced or metastatic *EGFRm* NSCLC, osimertinib in combination with platinum plus pemetrexed chemotherapy is associated with inferior but manageable safety compared with osimertinib monotherapy.

Source: Table 1, osimertinib Public Summary Document, May 2025 PBAC meeting
DCR = disease control rate; DoR = duration of response; *EGFRm* = epidermal growth factor receptor-mutated; HRQoL = health related quality of life; NSCLC = non-small cell lung cancer; ORR = objective response rate; OS = overall survival; PFS = progression-free survival; SoC = standard of care; TKI = tyrosine kinase inhibitor.

3 Requested listing

3.1 The criteria proposed in the resubmission for the first line treatment setting are presented below. Suggestions and additions proposed by the Secretariat are added in italics and suggested deletions are crossed out with strikethrough.

MEDICINAL PRODUCT Medicinal Product Pack	**Dispensed Price Max Qty (DPMQ)**	Max qty packs	Max qty units	No. of repeats	Available brands
Osimertinib 80 mg tablet, 30	Published: $7,582.10 Effective: $[redacted] (SPA)	1	30	2	TAGRISSO

Category / Program	GENERAL – General Schedule (Code GE)
Prescriber type	Medical Practitioners
Restriction type	Authority Required (Immediate assessment)
Administrative advice	No increase in the maximum quantity of number of units may be authorised No increase in the maximum number of repeats may be authorised Special Pricing Arrangements apply 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.
Indication	Stage IIIB/IIIC (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)
Treatment phase	Initial treatment as first-line epidermal growth factor receptor tyrosine kinase inhibitor therapy
Clinical criteria	Patient must have a WHO performance status of *2 or less* ~~0 or 1~~, ~~AND~~ ~~The treatment must be in combination with platinum-based chemotherapy (PBC) plus pemetrexed for a maximum of four cycles (12 weeks), unless intolerance of a severity necessitating treatment withdrawal had occurred to any of these agents. The details of intolerance must be documented in the patient's medical record.~~ AND Patient must not have previously received PBS-subsidised treatment with this drug~~,~~ ~~platinum based chemotherapy and pemetrexed for this condition.~~ AND Patient must not have received previous PBS-subsidised treatment with another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI); or Patient must have developed intolerance to another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI) of a severity necessitating permanent treatment withdrawal.
Population criteria	Patient must have evidence in tumour material of an activating epidermal growth factor receptor (EGFR) gene mutation known to confer sensitivity to treatment with EGFR tyrosine kinase inhibitors *AND* *Patient must not have evidence in tumour material of an activating epidermal growth factor receptor (EGFR) exon 20 insertion mutation.*
Prescribing instructions	PBS-subsidised treatment with this drug is restricted to one line of therapy at any disease staging for NSCLC (i.e. if therapy has been prescribed for early disease, subsidy under locally advanced or metastatic disease is no longer available).

MEDICINAL PRODUCT Medicinal Product Pack	**Dispensed Price Max Qty (DPMQ)**	Max qty packs	Max qty units	No. of repeats	Available brands
Osimertinib 80 mg tablet, 30	Published: $7,582.10 Effective: $[redacted] (SPA)	1	30	5	TAGRISSO
Osimertinib 40 mg tablet, 30	Published: $7,582.10 Effective: $[redacted] (SPA)	1	30	5	TAGRISSO

Category / Program	GENERAL – General Schedule (Code GE)
Prescriber type	Medical Practitioners
Restriction type	Authority Required (Immediate assessment)
Administrative advice	No increase in the maximum quantity of number of units may be authorised No increase in the maximum number of repeats may be authorised Special Pricing Arrangements apply 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.
Indication	Stage IIIB/IIIC (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)
Treatment phase	Continuing treatment of first-line EGFR tyrosine kinase inhibitor therapy
Clinical criteria	~~The treatment must be as monotherapy, or~~ ~~Treatment must be in combination with pemetrexed unless intolerance of a severity necessitating treatment withdrawal had occurred. The details of intolerance must be documented in the patient's medical record.~~ Patient must have previously received PBS-subsidised treatment with this drug ~~as monotherapy, or~~ ~~Patient must have previously received PBS-subsidised treatment with this drug in combination with platinum-based chemotherapy and pemetrexed for this condition.~~ Patient must not have developed disease progression while receiving treatment with this drug for this condition.
Prescribing instructions	PBS-subsidised treatment with this drug is restricted to one line of therapy at any disease staging for NSCLC (i.e. if therapy has been prescribed for early disease, subsidy under locally advanced or metastatic disease is no longer available).

3.2 Noting the PBAC preference for a combined single restriction for osimertinib covering all the *EGFR* positive NSCLC patient populations at the July 2025 meeting (see paragraph 4.14), the Secretariat proposed the following criteria:

MEDICINAL PRODUCT medicinal product pack	**PBS item code**	**Max. qty packs**	**Max. qty units**	**№.of Rpts**	**Available brands**
OSIMERTINIB					
osimertinib 40 mg tablet, 30	NEW	1	30	5	Tagrisso
osimertinib 80 mg tablet, 30	NEW	1	30	5	

Category / Program: ☒ GENERAL - General Schedule (Code GE)
Prescriber type: ☒ Medical Practitioners
Benefit type: ☒ Authority Required (Telephone/Online PBS Authorities System)
Prescribing rule level:
Administrative advice: No increase in the maximum quantity or number of units may be authorised.
Administrative advice: No increase in the maximum number of repeats may be authorised.

Administrative advice: Special Pricing Arrangements apply.
Administrative advice: Applications for authorisation under this restriction may be made in real time using the Online PBS Authorities system (see www.servicesaustralia.gov.au/HPOS) or by telephone by contacting Services Australia on 1800 888 333.
Restriction Summary [new1] / Treatment of Concept: [new1A]
Indication: Non-small cell lung cancer (NSCLC)
Clinical criteria:
Patient must be each of: (i) initiating treatment with this drug; (ii) have not previously received PBS-subsidised treatment with this drug for this condition; or
Patient must be continuing treatment with this drug for this condition, with an absence of further disease progression while being treated with this drug.
AND
Clinical criteria:
Patient must have/have had a WHO performance status score of no greater than 2 at treatment initiation with this drug for this condition.
AND
Clinical criteria:
Patient must have evidence of an activating epidermal growth factor receptor (EGFR) gene mutation known to confer sensitivity to treatment with EGFR tyrosine kinase inhibitors in tumour material
AND
Clinical criteria:
Patient must not have evidence in tumour material of an activating epidermal growth factor receptor (EGFR) exon 20 insertion mutation
AND
Clinical criteria:
Patient must not have received previous PBS-subsidised treatment with another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI);
OR
Patient must have developed intolerance to another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI) of a severity necessitating permanent treatment withdrawal.
Prescribing Instruction: PBS-subsidised treatment with this drug is restricted to once per lifetime at any disease staging for NSCLC (i.e. if therapy has been prescribed for early disease, subsidy under locally advanced or metastatic disease is no longer available).
Prescribing Instruction: Prescribers must refer to this drug's approved Therapeutic Goods Administration (TGA) Product Information (PI) for the relevant dosing regimens, treatment duration and mutation type for the specific stage of NSCLC. For patients receiving treatment with this drug as adjuvant therapy, treatment must cease upon disease progression, or after the completion of three years from the first administered dose, whatever comes first.

3.3 The Secretariat proposed draft restriction for the single listing includes the following prescriber instruction: 'Prescribers must refer to this drug's approved Therapeutic Goods Administration (TGA) Product Information (PI) for the relevant dosing regimens, treatment duration and mutation type for the specific stage of NSCLC'. However, this may limit the use of O+C to patients with EGFR exon 19 deletions or exon 21 L858R mutations. The PBAC has previously noted it would be appropriate to remain silent on the EGFR mutation type, as use outside the appropriate mutation

would be unlikely (paragraph 7.5, osimertinib Public Summary Document (PSD), May 2025 PBAC meeting).

3.4 The draft restriction included the clinical criteria 'Patient must not have received previous PBS-subsidised treatment with another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI) OR Patient must have developed intolerance to another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI) of a severity necessitating permanent treatment withdrawal' to allow switching between EGFR TKIs for reasons of intolerance (as per the current listing in the first line setting). However, this will impact patients using osimertinib in the second line treatment setting i.e. after progression on previous EGFR tyrosine kinase inhibitor therapy.

3.5 The PBAC considered it was appropriate to retain the requirement that PBS-subsidised treatment with osimertinib is restricted to once per lifetime at any disease staging for NSCLC (i.e. if therapy has been prescribed for early disease, subsidy under locally advanced or metastatic disease is no longer available).

3.6 With a single listing, the Secretariat noted the current osimertinib item codes could be delisted with a supply only period of 6 months.

3.7 The pre-PBAC response accepted the proposed combined single listing restriction, with deletion of the current osimertinib item codes.

For more detail on PBAC's view, see section 5 PBAC outcome.

4 Consideration of the evidence

Clinical evidence

4.1 There was no new clinical evidence presented in the resubmission.

4.2 The PBAC previously noted the clinical evidence for O+C was based on the FLAURA2 trial (n = 557), which was a head-to-head randomised controlled trial comparing the efficacy and safety of O+C to osimertinib as first-line treatment in patients with locally advanced or metastatic *EGFR*m NSCLC (specifically, exon 19 deletion or exon 21 L858R substitution mutations). The PBAC noted there was a statistically significant improvement in PFS for O+C compared to osimertinib with a hazard ratio (HR) of 0.62 (95% CI: 0.49, 0.79; p-value < 0.0001) and a median incremental PFS gain of 8.8 months (25.5 months median PFS in the O+C arm compared to 16.7 months median PFS in the osimertinib arm). The PBAC noted the OS data was immature with 40.6% of patients having died (paragraph 7.8, osimertinib PSD, May 2025 PBAC meeting).

4.3 The PBAC previously considered the observed toxicity with O+C was an important clinical issue and noted whilst both arms were associated with a high rate of treatment emergent adverse events (TEAEs) the O+C arm was associated with more frequent Grade ≥ 3 TEAEs (O+C 63.8% vs osimertinib 27.3%) and with more severe adverse

events when compared with osimertinib (O+C 37.7% vs osimertinib 19.3%) (paragraph 7.10, osimertinib PSD, May 2025 PBAC meeting).

4.4 The PBAC previously considered that the claim that O+C had superior comparative effectiveness and inferior comparative safety was reasonable (paragraph 6.38 and 6.39, osimertinib PSD, May 2025 PBAC meeting).

Economic analysis

4.5 The resubmission accepted the parameters of the ESC respecified base case and proposed a price reduction to achieve an incremental cost effectiveness ratio (ICER) of $55,000 to < $75,000 per quality adjusted life year (QALY). The PBAC noted this met the requirements of its previous consideration.

Table 33: Results of the economic evaluation

	Incremental cost	Incremental QALY	ICER
ESC respecified base case with EMP $[redacted] as presented in May 2025 PSD	$[redacted]	0.330	$[redacted][1]
ESC respecified base case with EMP $[redacted]	$[redacted]	0.330	$[redacted][2]

Source: Table 12, osimertinib PSD, May 2025 PBAC meeting; Economic Evaluation Excel model.xlsx provided with resubmission
EMP = ex-manufacturer price; ESC = economics subcommittee; ICER = incremental cost effectiveness ratio; QALY = quality adjusted life year
The redacted values correspond to the following ranges:
[1] *$115,000 to < $135,000*
[2] *$55,000 to < $75,000*

Estimated PBS usage & financial implications

4.6 The key inputs for the financial estimates in May 2025 and September 2025 are presented in Table 4.

Table 4: Key inputs for financial estimates

Parameter	May 2025	September 2025
Incident patients treated with osimertinib (monotherapy) in 1st line advanced/ metastatic *EGFRm* NSCLC	[redacted][1] in Yr 1 to [redacted][1] in Yr 6	[redacted][1] in Yr 1 to [redacted][1] in Yr 6
Uptake rate	[redacted]%	[redacted]% for incident patients, [redacted]% for prevalent patients
Eligible incident patients treated with O+C	[redacted][2] in Yr 1 to [redacted][2] in Yr 6	[redacted][2] in Yr 1 to [redacted][2] in Yr 6
Prevalent patients treated with O +C	[redacted][2] in Yr 1	[redacted][2] in Yr 1[a]
Duration of treatment	[redacted] months for O+C and capped duration of [redacted] months for osimertinib	[redacted] months for O+C and capped duration of [redacted] months for osimertinib. Assumed prevalent patients would have received [redacted] months of therapy prior to O+C listing on PBS

O+C = osimertinib in combination with chemotherapy
a. Financial estimates also account for <500 patients who initiated treatment with osimertinib monotherapy in the year prior receiving [redacted] months of treatment in Year 1 at the reduced weighted price
The redacted values correspond to the following ranges:
[1] *500 to < 5,000*
[2] *< 500*

4.7 The number of first line patients treated with osimertinib monotherapy or in combination with chemotherapy is presented in Table 5.

Table 5: Total first-line osimertinib patients

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Total first line incident patients	[redacted]1	[redacted]1	[redacted]1	[redacted]1	[redacted]1	[redacted]1
- Initiating first line OSI + CHEMO ([redacted]%)	[redacted]2	[redacted]2	[redacted]2	[redacted]2	[redacted]2	[redacted]2
- Initiating first line OSI monotherapy ([redacted]%)	[redacted]2	[redacted]2	[redacted]2	[redacted]2	[redacted]2	[redacted]2
Prevalent patients initiating PBS-listed O+C	[redacted]2	-	-	-	-	-

Source: Table 4-2, Table 4-5 of resubmission
The redacted values correspond to the following ranges:
1 500 to < 5,000
2 < 500

4.8 The resubmission proposed a single weighted price, based on the patient market share for osimertinib monotherapy and O+C, as summarised in Table 7.

Table 6: Weighted average price of first-line osimertinib

	AEMP	Market share	Weighted price
Effective price for osimertinib monotherapy	$[redacted]	[redacted]%	$[redacted]
Effective price for osimertinib in combination with chemotherapy	$[redacted]	[redacted]%	$[redacted]
Weighted average price in first line osimertinib	$[redacted]		

Source: Table 4-11 of resubmission

4.9 The Secretariat considered that, given the different treatment duration for the two populations ([redacted] months for O+C, [redacted] months for osimertinib monotherapy), it may be more appropriate to calculate the weighted price based on script numbers. The pre-PBAC response accepted using script numbers to calculate a weighted price.

4.10 A summary of the estimated use and financial implications is presented in Table 7.

Table 7: Estimated use and financial implications

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Estimated extent of use O+C						
Number of patients initiating treatment	[redacted][1,a]	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]
Number of scripts dispensed[b]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]
Estimated financial implications of osimertinib O+C						
Cost to PBS/RPBS less copayments	[redacted][3]	[redacted][4]	[redacted][4]	[redacted][4]	[redacted][4]	[redacted][4]
Estimated financial implications for osimertinib (monotherapy) and chemotherapy (cisplatin/carboplatin, pemetrexed)						
Number of scripts dispensed, osimertinib	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]	[redacted][2]
Cost to PBS/RPBS less copayments, osimertinib	[redacted][3]	[redacted][4]	[redacted][4]	[redacted][4]	[redacted][4]	[redacted][4]
Cost to PBS/RPBS less copayments, chemotherapy	[redacted][6]	[redacted][6]	[redacted][6]	[redacted][6]	[redacted][6]	[redacted][6]
Cost to PBS/RPBS less copayments, total	[redacted][3]	[redacted][4]	[redacted][9]	[redacted][9]	[redacted][4]	[redacted][4]
Net financial implications						
Net cost to PBS/RPBS	[redacted][5]	[redacted][6]	[redacted][6]	[redacted][6]	[redacted][6]	[redacted][6]
May 2025 submission						
Number of patients initiating treatment	[redacted][7,b]	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]	[redacted][1]
Number of scripts dispensed[c]	[redacted][8]	[redacted][2]	[redacted][8]	[redacted][8]	[redacted][8]	[redacted][8]
Net cost to PBS/RPBS	[redacted][6]	[redacted][10]	[redacted][6]	[redacted][6]	[redacted][6]	[redacted][6]

Source: Tables 4-6, 4-14, 4-19 of the resubmission, Economic Evaluation Excel model.xlsx provided with resubmission, Table 15, osimertinib PSD, May 2025 PBAC meeting
Values in italics were calculated during evaluation from Table 107, p167 and Table 112 – 114, p171 of the submission.
PBS = Pharmaceutical Benefits Scheme; RPBS = Repatriation Pharmaceutical Benefits Scheme.
[a] Includes <500 prevalent patients
[b] Includes <500 prevalent patients
[c] Assumed [redacted] months treatment duration

The redacted values correspond to the following ranges
[1] < 500
[2] 10,000 to < 20,000
[3] $30 million to < $40 million
[4] $50 million to < $60 million
[5] net cost saving
[6] $0 to < $10 million
[7] 500 to < 5,000

[8] *5,000 to < 10,000*
[9] *$40 million to < $50 million*
[10] *$10 million to < $20 million*

Financial Management – Risk Sharing Arrangements

4.11 There is a current Deed of Agreement for osimertinib which includes use in first-line, second-line and adjuvant treatment of *EGFRm* positive NSCLC, with [redacted]% rebate for spend above expenditure caps (Table 8).

Table 8: Expenditure cap and Commonwealth spend: first line, second line and adjuvant treatment of EGFRm NSCLC

Year	Expenditure cap	Total Commonwealth Payment	% cap reached
Year 1 (June 24 -May 25)[a]	$[redacted]	$[redacted]	[redacted]%
Year 2 (June 25 -May 26)	$[redacted]		
Year 3 (June 26 -May 27)	$[redacted]		
Year 4 (June 27 -May 28)	$[redacted]		
Year 5 (June 28 -May 29)	$[redacted]		

a. Year 1 contains unadjusted data that is subject to change in the end of financial year reconciliation process

4.12 The resubmission proposed a revised RSA, with an increase in the current caps to account for increased use of osimertinib in the first line setting with the listing of O + C. The resubmission also proposed that the rebate level for use exceeding the caps be reduced from [redacted]% to [redacted]%, which it considered to be equivalent to removing the rebate on the proportion of utilisation attributed to the O + C listing. The resubmission considered this was justified based on the O + C listing being associated with greater certainty in expenditure due to the reduced price, the number of patients, and extended treatment duration assumption. The proportion of O + C use ([redacted]%) was based on 2024 PBS prescription data in which 81% of prescriptions were for osimertinib monotherapy and the assumption that approximately [redacted]% of these would be replaced with O + C (i.e. 0.81 x [redacted] = ~[redacted]).

4.13 The Secretariat noted if additional certainty for the expenditure for the current osimertinib listings was proposed, and the weighted price reflected rebates currently being paid, the RSA may no longer be required, particularly if a broad listing is implemented (see below).

Single broad listing for osimertinib

4.14 At its July 2025 meeting, the PBAC noted that it would be preferable to have a combined single restriction for osimertinib covering all the *EGFR* positive NSCLC patient populations: (1) adjuvant early stage resected; (2) unresectable locally advanced (Stage III); and (3) first- or second line locally advanced or metastatic. The PBAC noted this would require a single weighted price across all indications (paragraph 74, osimertinib PSD, July 2025 PBAC meeting).

4.15 The pre-PBAC response proposed an ex-manufacturer price (EMP) of $[redacted] per pack for Stage III unresectable NSCLC based on the parameters outlined in the July 2025 PABC recommendation (paragraph 7.11, osimertinib PSD, July 2025 PBAC meeting).

The pre-PBAC response disagreed with some of the parameters included in the economic and financial models (i.e., HR = 0.84 for OS, assumption that 64% of patients have no disease progression after chemoradiation therapy). However, the pre-PBAC response stated that, despite concerns regarding the use of highly conservative assumptions, it would accept the requirements outlined by the PBAC in order to progress a single listing for osimertinib.

4.16 The pre-PBAC response proposed a methodology to calculate a weighted price based on estimated script numbers for osimertinib across the different treatment settings. Based on this methodology, the proposed weighted EMP was $[redacted] per pack (Table 9). At this price, the pre-PBAC response proposed a [redacted]% rebate for any spend over expenditure caps. To facilitate a broad listing with no expenditure caps, the pre-PBAC response proposed a weighted average price [redacted]% lower (i.e., $[redacted] per pack).

Table 9: Weighted average price methodology proposed in pre-PBAC response

Treatment setting	Estimated script numbers 2026 to 2029	% use	EMP ($)
Adjuvant	[redacted][1]	34%	[redacted]
Stage III unresectable	[redacted][2]	14%	[redacted][a]
First line, monotherapy	[redacted][1]	26%	[redacted]
First line, combination	[redacted][3]	18%	[redacted]
Second line	[redacted][4]	8%	[redacted]
Weighted EMP			[redacted]

[a] Estimated price based on PBAC outcome for osimertinib Stage III unresectable indication at the July 2025 PBAC meeting, see paragraph 4.15

The redacted values correspond to the following ranges
[1] *30,000 to < 40,000*
[2] *10,000 to < 20,000*
[3] *20,000 to < 30,000*
[4] *500 to < 5,000*

4.17 The PBAC noted the net effective price paid for the currently listed indications (adjuvant use, first line metastatic disease as monotherapy and second line metastatic disease), incorporating the estimated RSA rebates, would be [redacted]% lower than presented in Table 9[2]. The PBAC noted incorporating this into the weighted price calculations would result in a lower price than proposed in the pre-PBAC response.

For more detail on PBAC's view, see section 5 PBAC outcome.

5 PBAC outcome

5.1 The PBAC recommended the listing of osimertinib in combination with cisplatin or carboplatin, and pemetrexed for the first-line treatment of patients with locally

[2] Calculated as ($[redacted] - $[redacted])/$[redacted] from Table 8

advanced or metastatic non-small cell lung cancer (NSCLC) with evidence in tumour material of an activating epidermal growth factor receptor mutation (*EGFRm*) known to confer sensitivity to EGFR tyrosine kinase inhibitors (TKIs). The PBAC considered the early re-entry resubmission had addressed the outstanding issues from its May 2025 consideration. The PBAC considered a single, broad listing for *EGFRm* NSCLC would be appropriate and the methodology for calculating a weighted price proposed in the pre-PBAC response was reasonable.

5.2 The PBAC considered it would be appropriate for osimertinib to be listed with a single restriction covering all EGFRm NSCLC patient populations and noted this approach had been accepted in the pre-PBAC response. The PBAC noted a single listing would require a single weighted price for osimertinib across the current indications (adjuvant use, first line metastatic disease as monotherapy, second line metastatic disease) and recommended indications (first-line metastatic disease in combination with chemotherapy recommended herein and use in unresectable Stage III disease recommended July 2025).

5.3 With regards to the first-line listing in combination with chemotherapy, the PBAC considered that osimertinib would be cost effective for this population at the price proposed (EMP $[redacted] per pack) and that the utilisation estimates provided in the resubmission were reasonable.

5.4 The PBAC considered the single listing criteria proposed by the Secretariat in paragraph 3.2 would be reasonable with the following amendments:

- It would be appropriate to remain silent on specific mutation types in the criteria. The PBAC advised this could be achieved by deleting reference to mutation type in the Prescribing Information: 'Prescribers must refer to this drug's approved Therapeutic Goods Administration (TGA) Product Information (PI) for the relevant dosing regimens, treatment duration and mutation type for the specific stage of NSCLC'.
- The clinical criteria: 'Patient must not have received previous PBS-subsidised treatment with another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI) OR Patient must have developed intolerance to another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI) of a severity necessitating permanent treatment withdrawal' should be deleted to allow use of osimertinib after other TKIs in the second line setting.

5.5 The PBAC noted the pre-PBAC response proposed calculating a weighted price for the single listing based on script use across the indications and considered the methodology and proportion of use across each indication was reasonable (see Table 9). The PBAC noted the calculation incorporated the price for first line use in combination with chemotherapy (as per paragraph 5.3) and a price for use in patients with Stage III unresectable disease consistent with the July 2025 PBAC recommendation. The calculation incorporated the existing prices for the PBS listed

indications, however the PBAC recalled that the prices for the first line metastatic setting (as monotherapy) and second line metastatic setting reflected an artificially low treatment duration and the cost-effective prices were to be achieved though expected rebates as part of the RSA.

5.6 The PBAC noted the pre-PBAC response proposed two options (i) a weighted price of $[redacted] per pack, retention of current RSA (with increase in expenditure caps to account for the two new indications) with a [redacted]% rebate of any use over the caps and (ii) a weighted price of $[redacted] per pack (a [redacted]% price reduction) with no RSA. The PBAC considered that an RSA may not be required with a single listing criteria for all EFGRm populations. However, the PBAC noted that the weighted price did not account for rebates being realised for expenditure over the current RSA caps. The PBAC advised a price reduction was appropriate to minimise any additional expenditure in relation to the current listed indications.

5.7 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 osimertinib:

a) The treatment is not expected to provide a substantial and clinically relevant improvement in efficacy over alternative therapies, as the improvement in PFS was moderate and magnitude of benefit in OS was uncertain due to immaturity of the data;

b) The treatment is not expected to address a high and urgent unmet clinical need because osimertinib is already available on the PBS; and

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.

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

Outcome:
Recommended

6 Recommended listing

6.1 Add new item:

MEDICINAL PRODUCT medicinal product pack	PBS item code	Max. qty packs	Max. qty units	№.of Rpts	Available brands
OSIMERTINIB					
osimertinib 40 mg tablet, 30	NEW	1	30	5	Tagrisso
osimertinib 80 mg tablet, 30	NEW	1	30	5	
Category / Program: ☒ GENERAL - General Schedule (Code GE)					
Prescriber type: ☒ Medical Practitioners					
Benefit type: ☒ Authority Required (Telephone/Online PBS Authorities System)					
Prescribing rule level:					
Administrative advice: No increase in the maximum quantity or number of units may be authorised.					
Administrative advice: No increase in the maximum number of repeats may be authorised.					
Administrative advice: Special Pricing Arrangements apply.					
Administrative advice: Applications for authorisation under this restriction may be made in real time using the Online PBS Authorities system (see www.servicesaustralia.gov.au/HPOS) or by telephone by contacting Services Australia on 1800 888 333.					
Restriction Summary [new1] / Treatment of Concept: [new1A]					
Indication: Non-small cell lung cancer (NSCLC)					
Clinical criteria:					
Patient must be each of: (i) initiating treatment with this drug; (ii) have not previously received PBS-subsidised treatment with this drug for this condition; or					
Patient must be continuing treatment with this drug for this condition, with an absence of further disease progression while being treated with this drug.					
AND					
Clinical criteria:					
Patient must have/have had a WHO performance status score of no greater than 2 at treatment initiation with this drug for this condition.					
AND					
Clinical criteria:					
Patient must have evidence of an activating epidermal growth factor receptor (EGFR) gene mutation known to confer sensitivity to treatment with EGFR tyrosine kinase inhibitors in tumour material					
AND					
Clinical criteria:					
Patient must not have evidence in tumour material of an activating epidermal growth factor receptor (EGFR) exon 20 insertion mutation					
Prescribing Instruction: PBS-subsidised treatment with this drug is restricted to once per lifetime at any disease stage for NSCLC (i.e. if therapy has been prescribed for early disease, subsidy under locally advanced or metastatic disease is no longer available).					
Prescribing Instruction: Prescribers must refer to this drug's approved Therapeutic Goods Administration (TGA) Product Information (PI) for the relevant dosing regimens and treatment duration for the specific stage of NSCLC. For patients receiving treatment with this drug as adjuvant therapy, treatment must cease upon disease progression, or after the completion of three years from the first administered dose, whatever comes first.					

6.2 The following osimertinib item codes may be delisted with a supply only period of 6 months:

- osimertinib 40 mg listings: 11620N, 12233W, 14162J
- osimertinib 80mg listings: 11622Q, 12232T, 14168Q

These restrictions may be subject to further review. Should there be any changes made to the restriction the sponsor will be informed.

7 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.

8 Sponsor's Comment

The sponsor had no comment.