Justification

Gemeinsamer Bundesausschuss

to the Resolution of the Federal Joint Committee (G-BA) on an Amendment of the Pharmaceuticals Directive (AM-RL): Annex XII – Resolutions on the Benefit Assessment of Medicinal Products with New Active Ingredients According to Section 35a SGB V Blinatumomab (new therapeutic indication: acute lymphatic leukaemia, MRD-positive patients)

of 15 August 2019

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1. Legal basis

According to Section 35a, paragraph 1 German Social Code, Book Five (SGB V), the Federal Joint Committee (G-BA) assesses the benefit of reimbursable medicinal products with new active ingredients.

For medicinal products for the treatment of a rare disease (orphan drugs) that are approved according to Regulation (EC) No. 141/2000 of the European Parliament and of the Council of 16 December 1999, according to Section 35a, paragraph 1, sentence 11, 1st half of the sentence SGB V, the additional medical benefit is considered to be proven through the grant of the marketing authorisation. Evidence of the medical benefit and the additional medicinal benefit in relation to the appropriate comparator therapy need not be submitted (Section 35a, paragraph 1, sentence 11, 2nd half of the sentence SGB V). Section 35a, paragraph 1, sentence 11 1st half of the sentence SGB V thus guarantees an additional benefit for an approved orphan drug, although an assessment of the orphan drug in accordance with the principles laid down in Section 35a, paragraph 1, sentence 3, numbers 2 and 3 SGB V in conjunction with the Chapter 5, Sections 5 et seq. of the Rules of Procedure, G-BA (VerfO) has not been carried out. Only the extent of the additional benefit has to be demonstrated.

However, the restrictions on the benefit assessment of orphan drugs resulting from the statutory obligation to the marketing authorisation do not apply if the turnover of the medicinal product with the SHI at pharmacy retail prices including VAT exceeds €50 million in the last 12 calendar months. According to Section 35a, paragraph 1, sentence 12 SGB V, the pharmaceutical company must then, within three months of being requested to do so by the G-BA, submit evidence according to Chapter 5, Section 5, subsection 1–6 VerfO, in particular regarding the additional medical benefit in relation to the appropriate comparator therapy as defined by the G-BA according to Chapter 5, Section 6 VerfO and prove the additional benefit in comparison with the appropriate comparator therapy.

In accordance with Section 35a, paragraph 2 SGB V, the G-BA decides whether to carry out the benefit assessment itself or to commission the Institute for Quality and Efficiency in Health Care (IQWiG). On the basis of the statutory requirement in Section 35a, paragraph 1, sentence 11 SGB V that the additional benefit of an orphan drug is deemed to have been proven through the grant of marketing authorisation, the G-BA modified the procedure for the benefit assessment of orphan drugs at its session on 15 March 2012 to the effect that, in the case of orphan drugs, the G-BA initially no longer independently determines an appropriate comparator therapy as the basis for the legally permissible assessment of the extent of an additional benefit to be assumed by law. Rather, the extent of the additional benefit provided by the G-BA is evaluated exclusively on the basis of the approval studies.

Accordingly, at its session on 15 March 2012, the G-BA amended the mandate issued to the IQWiG by the resolution of 1 August 2011 for the benefit assessment of medicinal products with new active ingredients in accordance with Section 35a paragraph 2 SGB V to that effect that, in the case of orphan drugs, the IQWiG is only commissioned to carry out a benefit assessment in the case of a previously defined comparator therapy when the sales volume of the medicinal product concerned has exceeded the legal limit of €50 million and is therefore subject to an unrestricted benefit assessment (cf. Section 35a paragraph 1, sentence 12 SGB V). According to Section 35a paragraph 2 SGB V, the assessment by the G-BA must be completed within three months of the relevant date for submission of the evidence and published on the internet.

According to Section 35a, paragraph 3 SGB V, the G-BA shall pass a resolution on the benefit assessment within three months of its publication. The resolution is to be published on the internet and forms part of the Pharmaceuticals Directive.

2. Key points of the resolution

The active ingredient blinatumomab was listed for the first time on 15 December 2015 in the "LAUER-TAXE®", the extensive German registry of available drugs and their prices.

On 18 January 2019, blinatumomab received marketing authorisation for a new therapeutic indication (for the treatment of adults with Philadelphia chromosome-negative, CD19-positive B‑precursor ALL in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1%) to be classified as a major type 2 variation as defined according to Annex 2 number 2a to Regulation (EC) No. 1234/2008 of the commission of 24 November 2008 concerning the examination of variations to the terms of marketing authorisations for medicinal products for human use and veterinary medicinal products (OJ L 334, 12 December 2008, p. 7). Blinatumomab for the treatment of acute lymphocytic leukaemia in MRD-positive patients is approved as a medicinal product for the treatment of a rare disease under Regulation (EC) No 141/2000 of the European Parliament and the Council of 16 December 1999.

According to Section 35a, paragraph 1, sentence 10, 1st half of the sentence SGB V, the additional benefit is considered to be already proven by the marketing authorisation. The extent of the additional benefit is assessed on the basis of the approval studies by the G-BA.

On 13 February 2019, the pharmaceutical company has submitted a dossier in accordance with Section 4, paragraph 3, number 2 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV) in conjunction with Chapter 5, Section 8, paragraph 1, number 2 of the Rules of Procedure (VerfO) of the G-BA on the active ingredient blinatumomab with the new therapeutic indication in due time (i.e. at the latest within four weeks after informing the pharmaceutical company about the approval for a new therapeutic indication (treatment of acute lymphatic leukaemia in MRD-positive patients).

The G-BA carried out the benefit assessment and commissioned the IQWiG to evaluate the information provided by the pharmaceutical company in Module 3 of the dossier on treatment costs and patient numbers. The benefit assessment was published on 15 May 2019 together with the IQWiG assessment on the website of the G-BA (www.g-ba.de), thus initiating the written statement procedure. In addition, an oral hearing was held.

The G-BA adopted its resolution on the basis of the dossier of the pharmaceutical company, the dossier evaluation carried out by the G-BA, the assessment of treatment costs and patient numbers (G19-08) prepared by IQWiG, and the statements submitted in the written and oral hearing procedure. In order to determine the extent of the additional benefit, the G-BA has evaluated the studies relevant for marketing authorisation with regard to their therapeutic relevance (qualitative) in accordance with the criteria laid down in Chapter 5, Section 5, paragraph 7, sentence 1 numbers 1 through 4 VerfO. The methodology proposed by the IQWiG in accordance with the General Methods 1 was not used in the benefit assessment of blinatumomab.

In light of the above and taking into account the comments received and the oral hearing, the G-BA has arrived at the following assessment:

1 General Methods, Version 5.0 dated 10 July 2017. Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen [Institute for Quality and Efficiency in Health Care], Cologne.

2.1 Additional benefit of the medicinal product

2.1.1 Approved therapeutic indication of blinatumomab (Blincyto®) in accordance with the product information

BLINCYTO is indicated as monotherapy for the treatment of adults with Philadelphia chromosome-negative, CD19-positive B-precursor ALL in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1%.

2.1.2 Extent of the additional benefit

Adult patients with Philadelphia chromosome-negative, CD19-positive B-precursor ALL in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1%.

To demonstrate the extent of additional benefit, the pharmaceutical company presents the results of the pivotal MT103-203 study in a weighted indirect comparison without bridge comparator, taking into account the results of a historical control population (Study 20120148). In addition, the pharmaceutical company also focuses on the single-arm Phase II MT103-202 study.

The single-arm, multi-centre Phase II MT103-203 (BLAST) study was decisive for the marketing authorisation of blinatumomab in this indication.

It investigated chemotherapeutically pre-treated adult patients with B-precursor ALL in complete haematologic remission (< 5% blasts in bone marrow) but with molecular residual disease (corresponding to ≥ 10^{-3} cells at least two weeks after the last systemic chemotherapy). The study patients had to have adequate bone marrow function, no relevant restriction of kidney and liver function and a good general condition overall (ECOG PS 0/1). Patients with relevant diseases of the central nervous system and patients who had previously received an allogeneic stem cell transplant were excluded from the study.

After a 3-week screening phase, study patients received one to four treatment cycles, each consisting of a 28-day continuous infusion of blinatumomab followed by a two-week non-treatment interval. Patients who were eligible for allogeneic stem cell transplantation and for whom a donor was available were subsequently transplanted. The majority of the study patients (77.6%) underwent allogeneic stem cell transplantation; the median was 3.1 months after the start of treatment with blinatumomab.

Deviations from the finally approved dosage of blinatumomab resulted from the fact that the MT103-203 study used body surface-dependent dosing instead of a fixed dose. Furthermore, according to the product information, patients can receive one cycle of induction therapy followed by up to three further treatment cycles with blinatumomab as consolidation therapy depending on the benefits and risks. However, in the MT103-203 study, four treatment cycles were generally planned independent of the achievement of an interim MRD response. Finally, under certain conditions, patients could receive two more cycles of blinatumomab after the completion of four treatment cycles.

Patients were included in the study as early as November 2010. A total of 211 patients were evaluated for inclusion in the study, but ultimately only 116 patients received at least one infusion of the medicinal product to be evaluated. The final study results are available for the benefit assessment.

The primary endpoint of the study was the achievement of complete MRD emission within one treatment cycle with blinatumomab. Overall survival was assessed as a secondary endpoint as were relapse-free survival, duration of MRD emission, patient reported morbidity and quality of life (EORTC QLQ-C30 and EQ-5D), and certainty.

The supportive single-arm study MT103-202 investigated the efficacy and safety of blinatumomab in 21 adult patients with B precursor acute lymphocytic leukaemia (ALL) with minimal residual disease (MRD). The study will not be considered for assessment because a relevant proportion of the patients included do not comply with the present therapeutic indication. For example, some of the patients were not treated in accordance with the dosage information, whilst others had a positive Philadelphia chromosome status. Furthermore, the CD19 status was not surveyed, and there are differences to the therapeutic indication to be evaluated with regard to limit values for MRD negativity.

The other available studies (20130320, 00103311 (TOWER), 20120216, MT103-205, MT103-206, MT103-208, MT103-211) are also not taken into account because the patient populations do not correspond to the existing therapeutic indication. Patients with relapsed or refractory B precursor ALL but not with haematologic response were included in the aforementioned studies. The patient population of the MT103-206 study also does not correspond to the current therapeutic indication because only relapsed or refractory patients with diffuse large B-cell lymphoma were included.

Because there are no data from directly comparative studies, the pharmaceutical company presents a weighted indirect comparison with a historical control population (study 20120148) in the dossier. The historical control population is based on retrospective observations from several centres in Europe, each in patients older than 15 years with Philadelphia chromosome negative B-precursor ALL in complete haematologic remission but without molecular remission (MRD-positive) after treatment with at least three blocks of intensive chemotherapy. From all data sets available, the pharmaceutical company has extracted a Direct Comparison Analysis Set with 182 patients who are in first remission, are at least 18 years old, and have an MRD level of at least 10^{-3}. For the weighting of the results in the propensity score analysis for the endpoints overall survival and relapse-free survival, 73 patients were considered. The analysis populations to which the weights thus determined were ultimately applied are not clear from the documentation provided.

However, for several reasons, this historical comparison is not sufficiently valid to be used to quantify the additional benefit of blinatumomab.

On one hand, there is a lack of information on relevant criteria for the selection of the study centres considered as well as the selection criteria for the inclusion of patients in the observational study. The nature and extent of antineoplastic treatment received by patients in the control population are also unclear.

The proportion of patients who underwent allogeneic stem cell transplantation following systemic treatment is significantly lower in the control population than in the MT103-203 study (36.8% vs 64.6%). The extent to which the different transplantation rates are solely due to the fact that in study MT103-203, a higher proportion of patients were treated with a stem cell transplant because of the response to blinatumomab or the extent to which differences between the two comparison groups with regard to prognostically relevant baseline characteristics could have been the cause cannot be conclusively assessed based on the information provided. The selection of the adjustment factors taken into account for the propensity score analysis is also not sufficiently justified in the dossier of the pharmaceutical company. It cannot be excluded that relevant factors have not been taken into account. The limitations of the comparison population in the selection of the study centres considered as well as the selection criteria for the inclusion of the patients also remain valid in the propensity score analysis.

Overall, the remaining uncertainties are so serious that the propensity score analysis presented cannot be used for the benefit assessment.

Thus only the results of the non-comparative study MT103-203 (BLAST) remain for the assessment.

Mortality

At the final data cut-off of 7 January 2019, 56.4% of the 110 study patients treated with blinatumomab had died. The median survival time was 36.5 months. The median observation period was 59.8 months. The Kaplan-Meier estimator changes only slightly between Month 48 and Month 60. The estimator at the time of 60 months is 0.43.

Morbidity

MRD negativity

A complete molecular remission after the first treatment cycle, which is defined as the lack of detection of leukaemia-specific conversions of the immunoglobulin or TCR genes by PCR (sensitivity at least 10^{-4}), was achieved by 77.9% of the patients in study MT103-203.

Achieving MRD negativity is considered an important prognostic factor in ALL therapy. Studies have also shown an association between MRD negativity and recurrence or mortality. There is no validation of MRD negativity as a surrogate parameter for overall survival. The endpoint is therefore presented as a supplement. No statement on the extent of the additional benefit is derived from the results.

EQ-5D VAS

The health status data, which was collected using the visual analogue scale of the EQ-5D, changed by an average of 4.33 points for the 103 patients included in the analysis between baseline survey and completion of the first treatment cycle. The absolute median change was 2.00 scale points.

The return rates were only over 70% at baseline and after treatment cycle 1. Further survey time points are therefore not presented.

EORTC QLQ-C30 symptom scales

Here, too, the return rates for baseline and after treatment cycle 1 were over 70% for the EORTC QLQ-C30. With regard to the symptom scales covered by the EORTC QLQ-C30, none of the symptoms (fatigue, nausea and vomiting, pain, shortness of breath, insomnia, loss of appetite, constipation, and diarrhoea) showed a mean change of more than 3 scale points. The median change was 0 points for all symptom scales.

Health-related quality of life

EORTC QLQ-C30 functional scales

None of the functional scales for general health status, physical function, and cognitive function showed a change of more than 4.2 scale points in the mean value in the comparison between baseline survey and survey after completion of the first blinatumomab cycle. The mean change for social function was 10.42 points. The median change was 0 points for all functional scales. Here, too, the return rates for baseline and after treatment cycle 1 were over 70%.

Side effects

In the MT103-203 study, adverse events were assessed from start of treatment to 30 days after the last blinatumomab infusion or end of study.

All study patients experience an adverse event during this period. 61.2% of the patients had an AE with CTCAE grade ≥ 3; 62.9% of the patients had a serious AE (SAE). 17.2% of the patients discontinued the study medication because of an adverse event.

With regard to AE with CTCAE grade ≥ 3, leukopenia and neutropenia, fever, tremor, and increases in alanine aminotransferase with a frequency of more than 5% occurred at the level of preferred terms. For the SAE, this applies to the side effects fever, encephalopathy, tremor, and aphasia

Overall assessment

For the benefit assessment of blinatumomab for the treatment of adults with Philadelphia chromosome-negative, CD19-positive B-precursor ALL in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1%, results on the endpoint categories mortality, morbidity, quality of life, and side effects from the uncontrolled MT103-203 study are available.

The historical data from the 20120148 study submitted by the pharmaceutical company are neither suitable for a naïve historical comparison nor for a historical comparison adjusted by a propensity score analysis. In particular, they are considered unsuitable for demonstrating the additional benefit because of the insufficient information on the study population and the resulting questionable comparability as well as uncertainties regarding the adjustment procedure applied. Because of the one-armed study design and the unsuitable historical control, a comparative assessment of the study results is not possible overall.

Thus, a quantitative assessment of the extent of the effect and a quantification of the additional benefit on the basis of the data submitted is not possible.

As a result, the G-BA classifies the extent of the additional benefit of blinatumomab in the present indication as non-quantifiable because of the limited data basis based on the criteria in Section 5, paragraph 7 of the AM-NutzenV, taking into account the severity of the disease and the therapeutic objective in the treatment of the disease. According to Section 35a, paragraph 1, sentence 11, 1st half of sentence SGB V, there is an additional benefit; however, this is non-quantifiable because the scientific data basis does not allow this.

2.1.3 Summary of the assessment

The present assessment concerns the benefit assessment of the active ingredient blinatumomab in a new therapeutic indication:

“BLINCYTO is indicated as monotherapy for the treatment of adults with Philadelphia chromosome-negative, CD19-positive B-precursor ALL in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1%”.

Blinatumomab is a medicinal product used for the treatment of a rare disease.

For the assessment, the pharmaceutical company presents the results of the single-arm MT103-203 (BLAST) study, which is the basis for marketing authorisation. The results of this study are compared with the results of a historical control population. In particular because of insufficient information on the study population and the resulting questionable comparability as well as uncertainties regarding the adjustment procedure applied, the comparative evaluations are not suitable for quantifying the additional benefit.

Thus, a quantitative assessment of the extent of the effect and a quantification of the additional benefit on the basis of the data submitted are not possible. The extent of the additional benefit of blinatumomab in the present indication is therefore considered non-quantifiable.

2.2 Number of patients or demarcation of patient groups eligible for treatment

The information on the number of patients is based on the target population in statutory health insurance (SHI).

The resolution will be based on the information from the dossier of the pharmaceutical company regarding the number of patients. The information provided there is generally comprehensible; however, there is uncertainty because the limited data basis.

Thus, proportional values from studies were used. Because of the selection of study patients, these are only of limited use for epidemiological questions. Furthermore, patients who received a first or second therapy line in the previous year were not included in the derivation; the number of patients thus tends to be underestimated.

2.3 Requirements for a quality-assured application

The requirements in the product information are to be taken into account. The European Medicines Agency (EMA) provides the contents of the product information (summary of product characteristics, SmPC) for Blincyto® (active ingredient: blinatumomab) at the following publicly accessible link (last access: 10 May 2019):

https://www.ema.europa.eu/documents/product-information/blincyto-epar-product-information_de.pdf

Only specialists in internal medicine, haematology, and oncology experienced in the treatment of patients with acute lymphatic leukaemia may initiate and monitor treatment with blinatumomab.

In accordance with the specifications of the EMA regarding additional measures for risk minimisation, the pharmaceutical company must provide training material for doctors, pharmacists, medical specialists, and patients/nurses as well as a patient reminder card.

The training material contains, in particular, information on the administration of BLINCYTO® and on neurological events.

2.4 Treatment costs

The treatment costs are based on the contents of the product information and the information listed in the LAUER-TAXE® (last revised: 15 July 2019).

In order to improve comparability, the costs of the medicinal products were approximated both on the basis of the pharmacy retail price level and also deducting the statutory rebates in accordance with Sections 130 and 130 a SGB V. To calculate the annual treatment costs, the required number of packs of a particular potency was first determined on the basis of consumption. Having determined the number of packs of a particular potency, the pharmaceutical costs were then calculated on the basis of the costs per pack after deduction of the statutory rebates.

Adult patients with Philadelphia chromosome-negative, CD19-positive B-precursor ALL in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1%.

Treatment period:

Designation of the therapy	Treatment mode	Number of treatments/patient/year	Treatment duration/treatment (days)	Treatment days/patient/year
Medicinal product to be assessed				
Blinatumomab	Induction therapy			
	continuous on day 1–28 of a 42-day cycle	1 cycle	28	28
	Consolidation therapy			
	continuous on day 1–28 of a 42-day cycle	0–3 cycles	28	0–84

Usage and consumption:

Blinatumomab is administered in a dosage of 28 µg per patient per day for 28 days each. According to the product information, four vials of blinatumomab (each containing 38.5 µg) are required for the filling of an infusion pump with an infusion duration of 96 h (corresponds to 4 days) in order to achieve the target dosage of 28 µg/day/patient. Seven such preparations are necessary to treat a patient for 28 days (i.e. for one cycle). For seven preparations, 28 vials of blinatumomab are required. A total of 112 vials are required for the execution of four cycles.

Designation of the therapy	Dosage	Dosage/patient/treatment days	Consumption by potency/treatment day	Treatment days/ patient/ year	Average annual consumption by potency
Medicinal product to be assessed					
Blinatumomab	28 µg	28 µg	28 µg	Induction: 28 days Consolidation: 28 days per cycle	28–112 vials of 38.5 µg each

Costs:

Costs of the medicinal product:

Designation of the therapy	Package size	Costs (pharmacy sales price)	Rebate Section 130 SGB V	Rebate Section 130a SGB V	Costs after deduction of statutory rebates
Medicinal product to be assessed					
Blinatumomab	1 vial	€ 2,773.33	€ 1.77	€ 155.11	€ 2,616.45
Abbreviations: ***					

Pharmaceutical retail price (LAUER-TAXE®) as last revised: 15 July 2019

Costs for additionally required SHI services:

Only costs directly related to the use of the medicinal product are taken into account. If there are regular differences in the necessary medical treatment or the prescription of other services when using the medicinal product to be assessed in accordance with the product information, the costs incurred for this must be taken into account as costs for additionally required SHI services.

Medical treatment costs, medical fee services, and costs incurred for routine examinations (e.g. regular laboratory services such as blood count tests) that do not exceed the usual expenditure in the course of the treatment are not shown.

No additionally required SHI services are taken into account for the cost representation.

Other SHI services:

The special agreement on contractual unit costs of retail pharmacist services (Hilfstaxe; contract on price formation for substances and preparations of substances) is not fully used to calculate costs. Alternatively, the pharmacy retail price publicly accessible in the directory services in accordance with Section 131, paragraph 4 SGB V is a suitable basis for a standardised calculation.

According to the special agreement on contractual unit costs of retail pharmacist services [Hilfstaxe"] (last revised: arbitral award to determine the mg prices for parenteral preparations from proprietary medicinal products in oncology in the Hilfstaxe according to Section 129, paragraph 5c, sentences 2–5 SGB V of 19 January 2018), surcharges for the production of parenteral preparations containing cytostatic drugs of a maximum of € 81 per ready-to-use preparation and for the production of parenteral solutions containing monoclonal antibodies of a maximum of € 71 per ready-to-use unit shall be payable. These additional costs are not added to the pharmacy retail price but rather follow the rules for calculating the Hilfstaxe. The cost representation is based on the pharmacy retail price and the maximum surcharge for production and is only an approximation of the treatment costs. This presentation does not take into account, for example, the discounts on the pharmacy purchase price of the active ingredients, the invoicing of discards, and the calculation of application containers and carrier solutions according to the regulations of Annex 3 of the Hilfstaxe.

3. Bureaucratic costs

The proposed resolution does not create any new or amended information obligations for care providers within the meaning of Annex II to Chapter 1 VerfO and, accordingly, no bureaucratic costs.

4. Process sequence

On 13 February 2019, the pharmaceutical company submitted a dossier for the benefit assessment of blinatumomab to the G-BA in due time in accordance with Chapter 5, Section 8, number 1, sentence 2 VerfO.

The benefit assessment of the G-BA was published on 15 May 2019 together with the IQWiG assessment of treatment costs and patient numbers on the G-BA website (www.g-ba.de), thus initiating the written statement procedure. The deadline for submitting written statements was 5 June 2019.

The oral hearing was held on 24 June 2019.

In order to prepare a recommendation for a resolution, the Subcommittee on Medicinal Products commissioned a working group (Section 35a) consisting of the members nominated by the leading organisations of the care providers, the members nominated by the SHI umbrella organisation, and representatives of the patient organisations. Representatives of the IQWiG also participate in the sessions.

The evaluation of the written statements received and the oral hearing were discussed at the session of the subcommittee on 6 August 2019, and the proposed resolution was approved.

At its session on 15 August 2019, the plenum adopted a resolution to amend the Pharmaceuticals Directive.

Chronological course of consultation

Session	Date	Subject of consultation
Subcommittee Medicinal product	7 May 2019	Knowledge of the benefit assessment of the G-BA
Working group Section 35a	18 June 2019	Information on written statements received; preparation of the oral hearing
Subcommittee Medicinal product	24 June 2019	Conduct of the oral hearing
Working group Section 35a	3 July 2019 17 July 2019 31 July 2019	Consultation on the dossier evaluation by the G-BA, the assessment of treatment costs and patient numbers by the IQWiG, and the evaluation of the statement procedure
Subcommittee Medicinal product	6 August 2019	Concluding discussion of the proposed resolution
Plenum	15 August 2019	Adoption of the resolution on the amendment of Annex XII AM-RL

Berlin, 15 August 2019

Federal Joint Committee (G-BA)
in accordance with Section 91 SGB V
The chair

Prof Hecken