

# **Technology Guidance**

# Update of MOH List of Subsidised Drugs to include treatments for various cancer conditions

**Recommendations from the MOH Drug Advisory Committee** 

### **Guidance Recommendations**

The Ministry of Health's Drug Advisory Committee has reviewed all available treatments for cancer to update the MOH List of Subsidised Drugs in line with local clinical practice and medical advancements. As part of this review, Technology Guidances<sup>1</sup> have been prepared which describe the subsidy recommendations for many cancer drugs for specific clinical conditions. The remaining treatments which have been considered by the Committee are included in this document.

Based on the available evidence, the Ministry of Health's Drug Advisory Committee has recommended:

- ✓ Abemaciclib 50 mg, 100 mg and 150 mg tablets;
- ✓ Abiraterone acetate 250 mg tablets;
- Afatinib 20 mg, 30 mg and 40 mg tablets;
- ✓ Alectinib 150 mg capsule;
- ✓ Anagrelide 0.5 mg capsule;
- ✓ Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion;
- ✓ Avelumab 200 mg/10 mL concentrate for solution for infusion;
- Axitinib 1 mg and 5 mg tablets;
- Azacitidine 100 mg injection;
- ✓ Bendamustine 25 mg and 100 mg concentrate for infusion;
- ✓ Bicalutamide 50 mg tablet;
- ✓ Bortezomib 3.5 mg injection;
- ✓ Brentuximab vedotin 50 mg powder for concentrate for solution for infusion;
- ✓ Brigatinib 30 mg, 90 mg and 180 mg tablets;
- Cabozantinib 20 mg, 40 mg and 60 mg tablets;
- ✓ Ceritinib 150 mg capsule;
- Cetuximab 100 mg/20 mL solution for infusion;

**Updated: 2 January 2024** 

<sup>&</sup>lt;sup>1</sup> Technology guidances will be published on the ACE website between 4 January 2022 and 1 September 2022.



- ✓ Cisplatin 100 mg/100 mL concentrate for infusion;
- Cyproterone 50 mg tablet;
- ✓ Dabrafenib 50 mg and 75 mg capsules;
- ✓ Dasatinib 20 mg, 50 mg and 70 mg tablets;
- ✓ Durvalumab 120 mg/2.4 mL and 500 mg/10 mL concentrate for solution for infusion;
- ✓ Epirubicin 50 mg/25 mL injection;
- ✓ Eribulin mesylate 1 mg/2 mL solution for injection;
- ✓ Erlotinib 100 mg and 150 mg tablets;
- ✓ Exemestane 25 mg tablet;
- ✓ Fludarabine phosphate 50 mg injection;
- ✓ Fulvestrant 250 mg/5 mL solution for injection;
- ✓ Gefitinib 250 mg tablet;
- ✓ Gilteritinib fumarate 40 mg tablet;
- ✓ Goserelin 3.6 mg and 10.8 mg depot injections;
- ✓ Imatinib 100 mg and 400 mg tablets;
- ✓ Ipilimumab 50 mg/10 mL concentrate for solution for infusion;
- ✓ Lapatinib 250 mg tablets;
- ✓ Lenalidomide 5 mg, 10 mg, 15 mg and 25 mg capsules;
- ✓ Leuprorelin acetate 3.75 mg and 11.25 mg depot injection;
- ✓ Lorlatinib 25 mg and 100 mg tablets;
- ✓ Megestrol 40 mg and 160 mg capsules;
- ✓ Midostaurin 25 mg capsule;
- ✓ Nilotinib 50 mg, 150 mg and 200 mg capsules;
- ✓ Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion;
- ✓ Obinutuzumab 1000 mg/40 mL concentrate for solution for infusion;
- ✓ Olaparib 100 mg and 150 mg tablets;
- ✓ Oxaliplatin 200 mg/40 mL concentrate for infusion;
- ✓ Paclitaxel-albumin bound nanoparticles 100 mg injectable suspension;
- ✓ Palbociclib 75 mg, 100 mg and 125 mg capsules/tablets;
- ✓ Pazopanib 200 mg and 400 mg tablets;
- ✓ Pegylated liposomal doxorubicin 20 mg concentrate for infusion;
- ✓ Pembrolizumab 100 mg/4 mL solution for infusion;
- ✓ Pemetrexed 100 mg and 500 mg injections;
- ✓ Ponatinib 15 mg tablet;
- ✓ Ribociclib 200 mg tablet;
- ✓ Ruxolitinib 5 mg, 15 mg and 20 mg tablets;
- ✓ Somatropin 5 mg/1.5 mL and 10 mg/1.5 mL prefilled pens and solution for injection;
- ✓ Somatropin 4 mg and 5.3 mg/mL powder and solvent for solution for injection;
- ✓ Somatropin 5.83 mg/mL and 8 mg/mL solution for injection;
- ✓ Sunitinib 12.5 mg capsules;
- ✓ Trametinib 0.5 mg and 2 mg tablets; and
- √ Vinorelbine 50 mg/5 mL injection



for inclusion on the MOH Standard Drug List (SDL) or Medication Assistance Fund (MAF) in line with their registered indications or specific clinical criteria for treating cancer, in view of clinical need, and acceptable clinical and cost effectiveness.

Drugs that have not been recommended for subsidy are listed in the Annex.

For all drugs, the clinical indications, subsidy class, subsidy implementation dates (if applicable), and MediShield Life claim limits are provided in the Annex.



# **ANNEX**

# **Recommendations by the MOH Drug Advisory Committee**

Drug preparation (Brand)	Clinical indications	Subsidy class (implementation date)	MediShield Life claim limit per month (implementation date)
Acute myeloid leukaemia			
Gilteritinib fumarate 40 mg tablet	Treatment of FLT3 mutation-positive relapsed or refractory AML. Gilteritinib is not recommended as maintenance therapy for patients after HSCT.	MAF (1 Sep 2022)	\$9200 (1 Sep 2022)
Idarubicin 5 mg/5 mL and 10 mg/10 mL solution for injection	Treatment of patients with acute myeloid leukaemia for remission induction.	Not recommended for subsidy	\$400 (1 Sep 2022)
Midostaurin 25 mg capsule	Treatment of FLT3 mutation-positive AML in combination with standard intensive induction and consolidation chemotherapy. Standard induction chemotherapy must include cytarabine and an anthracycline. Midostaurin is not recommended for maintenance therapy.	MAF (1 Sep 2022)	\$2400 (1 Sep 2022)
Venetoclax 10 mg, 50 mg and 100 mg tablets	Treatment of newly diagnosed AML in combination with a hypomethylating agent or low-dose cytarabine in patients who are ineligible for intensive chemotherapy.	Not recommended for subsidy	\$3000 (1 Sep 2022)
Advanced systemic maste	ocytosis		
Midostaurin 25 mg capsule	Treatment of aggressive systemic mastocytosis, systemic mastocytosis with associated haematological neoplasm or mast cell leukaemia.	Not recommended for subsidy	\$2400 (1 Sep 2022)
Anaplastic large cell lymp	homa		
Crizotinib 200 mg and 250 mg capsules	Paediatric patients 1 year of age and older and young adults with relapsed or refractory, systemic anaplastic large cell lymphoma that is ALK-positive.	Not recommended for subsidy	\$3000 (1 Sep 2022)
Breast cancer	Abone sielik in eenskingtien with en	NAA E	<b>#000</b>
Abemaciclib 50 mg, 100 mg and 150 mg tablets	Abemaciclib in combination with an aromatase inhibitor as initial endocrine-based therapy for HR-positive, HER2-negative, advanced or metastatic breast cancer. Pre/perimenopausal women treated with this combination could also receive a luteinizing hormone-releasing hormone agonist according to local clinical practice. <sup>‡</sup>	MAF (1 Sep 2022)	\$800 (1 Sep 2022)
	Abemaciclib in combination with fulvestrant for treating HR-positive, HER2-negative, advanced or metastatic breast	MAF (1 Sep 2022)	\$800 (1 Sep 2022)



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	cancer in patients who have received prior endocrine therapy. Pre/perimenopausal women treated with this combination could also receive a luteinizing hormonereleasing hormone agonist according to local clinical practice. <sup>‡</sup>		
Alpelisib 150 mg, 200 mg and 200 mg + 50 mg tablets	Alpelisib in combination with fulvestrant for treating HR-positive, HER2-negative, advanced breast cancer in patients with a PIK3CA mutation after disease progression following an endocrine-based regimen.	Not recommended for subsidy	\$800 (1 Sep 2022)
Atezolizumab 840 mg/14mL and 1200 mg/20mL concentrate for solution for infusion plus paclitaxel-albumin bound nanoparticles 100 mg injectable suspension	Atezolizumab in combination with nab- paclitaxel for treating patients with unresectable, locally advanced, or metastatic triple negative breast cancer whose tumours have PD-L1 expression ≥1% and who have not received prior chemotherapy for metastatic disease. <sup>β</sup>	Not recommended for subsidy	\$1800 (1 Sep 2022)
Eribulin mesylate 1 mg/2 mL solution for injection	Treatment of locally advanced or metastatic breast cancer in patients whose disease has progressed after 2 or more chemotherapy regimens for advanced disease.	MAF (1 Sep 2022)	\$1200 (1 Sep 2022)
Everolimus 2.5 mg, 5 mg and 10 mg tablets	Everolimus in combination with exemestane for HR-positive, HER2-negative advanced breast cancer, in postmenopausal women without symptomatic visceral disease after recurrence or progression following a non-steroidal aromatase inhibitor.	Not recommended for subsidy	\$1200 (1 Sep 2022)
Fulvestrant 250 mg/5 mL solution for injection	For cancer treatment.	SDL# (1 Apr 2022)	\$200 (1 Sep 2022)
Goserelin acetate 3.6 mg and 10.8 mg depot injections	Treatment of breast cancer where hormone therapy is specified. ‡	MAF (4 Jan 2022)	\$200 (1 Sep 2022)
Lapatinib 250 mg tablet	Lapatinib in combination with an aromatase inhibitor for postmenopausal women with HR-positive, HER2-positive metastatic breast cancer.	MAF (1 Sep 2022)	\$800 (1 Sep 2022)†
	Lapatinib in combination with capecitabine for HER2-positive, advanced or metastatic breast cancer in patients whose disease has progressed after treatment with an anthracycline and, a taxane, and on prior trastuzumab in the metastatic setting.	MAF (1 Sep 2022)	\$800 (1 Sep 2022)†
Leuprorelin acetate 3.75 mg and 11.25 mg depot injection *	Treatment of breast cancer where hormone therapy is specified.‡	MAF (3.75 mg 4 Jan 2022; 11.25 mg 1 Sep 2022)	\$200 (1 Sep 2022)
Paclitaxel-albumin bound nanoparticles 100 mg injectable suspension	Monotherapy for metastatic breast cancer in patients who have failed first-line treatment for metastatic disease and for whom standard, anthracycline-containing	MAF (1 Sep 2022)	\$1000 (1 Sep 2022)



	therapy is not indicated.		
Palbociclib 75 mg, 100 mg	Palbociclib in combination with an	MAF	\$800
and 125 capsules/tablets	aromatase inhibitor as initial endocrine- based therapy for HR-positive, HER2- negative, advanced or metastatic breast cancer. Pre/perimenopausal women	(1 Sep 2022)	(1 Sep 2022)
	treated with this combination could also receive a luteinizing hormone-releasing hormone agonist according to local clinical practice.‡		
	Palbociclib in combination with fulvestrant for treating HR-positive, HER2-negative, advanced or metastatic breast cancer in patients who have received prior endocrine therapy. Pre/perimenopausal women treated with this combination could also receive a luteinizing hormone-releasing hormone agonist according to local clinical practice.‡	MAF (1 Sep 2022)	\$800 (1 Sep 2022)
Pembrolizumab 100 mg/4mL solution for infusion	Pembrolizumab in combination with chemotherapy for the treatment of patients with locally recurrent unresectable or metastatic triple negative breast cancer whose tumours express PD-L1 (CPS ≥10) and who have not received prior chemotherapy for metastatic disease. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup>	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)
Ribociclib 200 mg tablet	Ribociclib in combination with an aromatase inhibitor as initial endocrine-based therapy for HR-positive, HER2-negative, advanced or metastatic breast cancer. Pre/perimenopausal women treated with this combination could also receive a luteinizing hormone-releasing hormone agonist according to local clinical practice. <sup>‡</sup>	MAF (1 Sep 2022)	\$800 (1 Sep 2022)
	Ribociclib in combination with fulvestrant for treating HR-positive, HER2-negative, advanced or metastatic breast cancer in patients who have received prior endocrine therapy. Pre/perimenopausal women treated with this combination could also receive a luteinizing hormone-releasing hormone agonist according to local clinical practice. <sup>‡</sup>	MAF (1 Sep 2022)	\$800 (1 Sep 2022)
Vinorelbine 20 mg and 30 mg capsules	Treatment of advanced breast cancer.	Not recommended for subsidy	\$400 (1 Sep 2022)



B-cell lymphoma			
Rituximab 1400 mg/11.7 mL solution for subcutaneous injection	Rituximab (subcutaneous) in combination with cyclophosphamide, doxorubicin, vincristine and prednisone (CHOP), for the treatment of CD20+ diffuse large B-cell non-Hodgkin lymphoma.	Not recommended for subsidy	\$1000 (1 Sep 2022)
	Rituximab (subcutaneous) in combination with cyclophosphamide, vincristine, prednisone (CVP), for the treatment of previously untreated patients with stage III-IV follicular lymphoma.	Not recommended for subsidy	\$1000 (1 Sep 2022)
	Rituximab (subcutaneous) for maintenance treatment of patients with follicular lymphoma who have responded to induction therapy.	Not recommended for subsidy	\$1000 (1 Sep 2022)
Obinutuzumab 1000 mg/40 mL concentrate for solution for infusion	Obinutuzumab in combination with chemotherapy, for previously untreated stage II bulky, III or IV follicular lymphoma. Patients achieving at least a partial remission may continue to receive maintenance treatment with obinutuzumab monotherapy. Maintenance treatment with obinutuzumab should be stopped after 2 years, or earlier if disease progresses.	Not recommended for subsidy	\$1800 (1 Sep 2022)
	Obinutuzumab in combination with bendamustine, for the treatment of follicular lymphoma that has not responded to or progressed within 6 months after treatment with rituximab or a rituximab-containing regimen. Patients must not have received obinutuzumab for follicular lymphoma. Maintenance treatment with obinutuzumab should be stopped at 2 years, or earlier if disease progresses.	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)
Pembrolizumab 100 mg/4mL solution for infusion	Treatment of patients with refractory primary mediastinal B-cell lymphoma (PMBCL), or who have relapsed after 2 or more prior lines of therapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for PMBCL. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup>	Not recommended for subsidy	\$1800 (1 Sep 2022)
Chronic myeloid leukaem	ia		
Dasatinib 20 mg, 50 mg, 70 mg tablets	Treatment of adults with treatment- resistant or treatment-intolerant chronic myeloid leukaemia (CML) in chronic phase, accelerated phase, or myeloid or lymphoid blast phase or children with	MAF (1 September 2022)	\$1200 (1 September 2022)



	treatment-resistant or treatment-intolerant CML in chronic phase.		
	Treatment of newly diagnosed Philadelphia chromosome-positive (Ph+)		
	chronic myeloid leukaemia (CML) in chronic phase.		
Nilotinib 50 mg, 150 mg, 200 mg capsules	Treatment of adults with treatment- resistant or treatment-intolerant chronic myeloid leukaemia (CML) in chronic phase or accelerated phase; or children with treatment-resistant or treatment- intolerant CML in chronic phase.  Treatment of newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukaemia (CML) in chronic phase.	MAF (1 September 2022)	\$1200 (1 September 2022)
Ponatinib 15 mg tablets	Treatment of chronic, accelerated, or blast phase chronic myeloid leukaemia (CML) in patients:  • whose disease is resistant to imatinib or dasatinib or nilotinib, and who have the T315I mutation OR  • whose disease is resistant to both nilotinib and dasatinib OR  • whose disease is resistant to nilotinib or dasatinib and who are intolerant of/contraindicated to the other drug.	MAF (1 September 2022)	\$1200 (1 September 2022)
Endometrial cancer			
Pembrolizumab 100 mg/4 mL solution for infusion plus lenvatinib 4 mg and 10 mg capsules	Pembrolizumab in combination with lenvatinib for the treatment of patients with advanced endometrial carcinoma (EC) that is not microsatellite instability-high (non-MSI-H) or mismatch repair deficient (non-dMMR), who have disease progression following prior platinum chemotherapy and are not candidates for curative surgery or radiation. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for advanced EC. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment, with or without lenvatinib, is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup>	Not recommended for subsidy	\$3000 (1 Sep 2022)
Essential thrombocythaer		MAC	\$200
Anagrelide 0.5 mg capsule	Reduction of elevated platelet counts in patients with essential thrombocythaemia who intolerant to their existing therapy are or for whom other therapies are not	MAF (1 Sep 2022)	\$200 (1 Sep 2022)



Growth hormone deficience	cy associated with neoplasms		
Somatropin 5 mg/1.5 mL and 10 mg/1.5 mL prefilled pens, 4 mg and 5.3 mg/mL powder and solvent for solution for injection, 5.83 mg/mL and 8 mg/mL solution for injection	Replacement therapy in adults with growth hormone deficiency associated with benign or malignant hypothalamic or pituitary neoplasms.	MAF (1 Sep 2022)	\$600 (1 Sep 2022)
Head and neck cancer			
Cetuximab 100 mg/20 mL solution for infusion	Cetuximab in combination with radiation therapy for patients with locally advanced squamous cell cancer of the head and neck (LASCCHN) who have contraindications or intolerance to platinum-based chemoradiation therapy.  Cetuximab in combination with platinum-based chemotherapy for patients with unresectable, recurrent, or metastatic squamous cell cancer of the head and neck (RMSCCHN).	SDL (1 Sep 2022)	\$1000 (1 Sep 2022)
Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion	For patients with recurrent or metastatic squamous cell cancer of the head and neck whose disease progressed within six months of starting platinum-based chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for this condition in the recurrent or metastatic setting. Nivolumab should be given as a weight-based dose up to a maximum of 240 mg every two weeks or 480 mg every four weeks. <sup>‡</sup>	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)
Pembrolizumab 100 mg/4 mL solution for infusion	Monotherapy for untreated unresectable, recurrent or metastatic squamous cell cancer of the head and neck (RMSCCHN) with PD-L1 CPS≥1. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup> Pembrolizumab in combination with platinum-based chemotherapy, for untreated unresectable, recurrent or metastatic squamous cell cancer of the head and neck (RMSCCHN) with PD-L1 CPS≥1. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup>	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)



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Hepatocellular carcinoma		NA E	#0000m
Atezolizumab 840 mg/14	Atezolizumab in combination with	MAF	\$3000~
mL and 1200 mg/20 mL	bevacizumab biosimilar (subsidised	(1 Sep 2022)	(1 Sep 2022)
concentrate for solution for	brand) for treating advanced unresectable		
infusion plus bevacizumab	hepatocellular carcinoma in patients who		
biosimilar concentrate for	have not received prior systemic therapy,		
solution for infusion (100	and who have adequate liver function as		
mg/4 mL, 400 mg/16 mL)	assessed by the Child-Pugh scoring		
	system.		
Atezolizumab 840 mg/14	Atezolizumab in combination with	Not recommended	\$3000∞
mL and 1200 mg/20 mL	bevacizumab (non-subsidised brand) for	for subsidy	(1 Sep 2022)
concentrate for solution for	treating advanced unresectable	,	, ,
infusion plus bevacizumab	hepatocellular carcinoma in patients who		
concentrate for solution for	have not received prior systemic therapy,		
infusion (100 mg/4 mL,	and who have adequate liver function as		
400 mg/16 mL)	assessed by the Child-Pugh scoring		
400 mg/10 mL)	, , , , , , , , , , , , , , , , , , , ,		
Hodgkin lymphoma	system.		
Brentuximab vedotin 50	Brentuximab vedotin in combination with	MAF	\$1800
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mg powder for	doxorubicin, vinblastine and dacarbazine	(1 Sep 2022)	(1 Sep 2022)
concentrate for solution	(AVD), for treating patients with previously		
for infusion	untreated CD30+ advanced classic		
	Hodgkin lymphoma (cHL) who are		
	intolerant or have contraindications to		
	bleomycin.		
Brentuximab vedotin 50	Brentuximab vedotin in combination with	Not recommended	(\$1800
mg powder for	doxorubicin, vinblastine and dacarbazine	for subsidy	(1 Sep 2022)
concentrate for solution	(AVD), for treating patients with previously		
for infusion	untreated CD30+ advanced classic		
	Hodgkin lymphoma (cHL).		
Brentuximab vedotin 50	Consolidation treatment of patients with	MAF	\$1800
mg powder for	CD30+ Hodgkin lymphoma (HL) who are	(1 Sep 2022)	(1 Sep 2022)
concentrate for solution	at increased risk of relapse or progression		, ,
for infusion	following an autologous stem cell		
	transplant (ASCT). Treatment should be		
	stopped at 16 cycles, or earlier if disease		
	progresses.		
Brentuximab vedotin 50	Treatment of patients with relapsed or	MAF	\$1800
mg powder for	refractory CD30+ Hodgkin lymphoma	(1 Sep 2022)	(1 Sep 2022)
concentrate for solution	(HL):	(1 000 2022)	(1 Ocp 2022)
for infusion	1. following autologous stem cell		
IOI IIIIUSIOII			
	transplant (ASCT) or		
	2. following at least two prior therapies		
	when ASCT or multi-agent chemotherapy		
	is not a treatment option. Treatment		
	should be stopped at 16 cycles, or earlier		
	if disease progresses.		
Nivolumab 40 mg/4 mL	Treatment of patients with relapsed or	MAF	\$1800
and 100 mg/10 mL	refractory classical Hodgkin lymphoma	(1 Sep 2022)	(1 Sep 2022)
concentrate for solution for	(cHL) after an autologous stem cell		
infusion	transplant (ASCT) and treatment with		
	brentuximab vedotin. Patients must not		
	have received prior treatment with a PD-		
	1/PD-L1 inhibitor for this condition in the		
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relapsed or refractory setting. Nivolumab should be given as a weight-based dose up to a maximum of 240 mg every four weeks. P  Pembrolizumab 100 mg/4 ml. solution for infusion put ferractory classical Hodgkin (mpmbma cHL), who have failed autologous stem cell transplant (ASCT) or following at least two prior therapies when ASCT is not a treatment option. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for this condition in the relapsed or refractory setting. Treatment with pembrolizumab should be stopped at 2 years, or earlier if the person has a stem cell transplant or the disease progresses. Pembrolizumab should be stopped to reasons other than disease progresses. Pembrolizumab perteatment its allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. P  Lung cancer  Afatinib 20 mg, 30 mg and 40 mg tablets  Alezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion  At a concentrate for solution for infusion with a platinum agent and etoposide, for untreated extensive-stage small-cell lung cancer.  At a colizumab in combination with a platinum agent and etoposide, for untreated extensive-stage small-cell lung cancer.  At a colizumab in combination with platinum-doublet chemotherapy, for untreated metastatic non-squamous non-small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations. P  For untreated metastatic non-small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations. P  For untreated metastation from small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations. P  For untreated metastation from small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations. P  For untreated metastation from small-cell lung cancer (NSCLC) who have disease progression during or following platinum-coubler trement with a PD-1/PD-1 in hinblior for metastation NSCLC. P  Atezo				1
Pembrolizumab 100 mg/4 mL solution for infusion  Responsibility of the property of the propert				
weeks or 480 mg every four weeks. \$   Pembrolizumab 100 mg/4 mL solution for infusion				
Pembrolizumab 100 mg/4 mL solution for infusion  Treatment of patients with relapsed or refractory sclassical Hodgkin lymphoma (cHL), who have falled autologous stem cell transplant (ASCT) or following at least two prior therapies when ASCT is not a treatment option. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for this condition in the relapsed or refractory setting. Treatment with pembrolizumab should be stopped at 2 years, or aeriler if the person has a stem cell transplant or the disease progresses. Pembrolizumab should be stopped at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression.  Treatment of locally advanced or metastatic EGFR mutation-positive non-small-cell lung cancer.  Alectinib 150 mg capsule  Alectinib 150 mg capsule  Alezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion  Alezolizumab 840 mg/14 mc. Alezolizumab in combination with a platinum-doublet chemotherapy, for untreated extensive-stage small-cell lung cancer.  Alezolizumab in combination with platinum-doublet chemotherapy and the understatic non-squamous non-small-cell lung cancer (NSCLC), in patients whose tumour sepress PD-L1 with a tumour proportion score ±50%, with no EGFR or ALK genomic tumour abertations.  Treatment of patients with metastatic non-squamous non-small-cell lung cancer (NSCLC), in patients whose tumour sepress PD-L1 with a tumour proportion score ±50%, with no EGFR or ALK genomic tumour abertations.  Treatment of patients with metastatic non-small-cell lung cancer (NSCLC), in patients whose tumour sepress PD-L1 with a tumour proportion score ±50%, with no EGFR or ALK genomic tumour abertations.  Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 hinhibitor for metastatic NSCLC.  Atezolizumab 840 mg/14 he vacicumab bi				
mL solution for infusion    Ceffactory classical Hodgkin lymphoma (cHL), who have failed autologous stem cell transplant (ASCT) or following at least two prior therapies when ASCT is not a treatment option. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for this condition in the relapsed or refractory setting. Treatment with pembrolizumab should be stopped at 2 years, or earlier if the person has a stem cell transplant or the disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progresses. Pembrolizumab retreatment as stopped for reasons other than disease progression. If the progression of the progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. If the progression of the progression. If the progression of the progressi	Danah zalim za ah 400 za z/4		N 4 A 🗁	<b>#</b> 4000
(cHL), who have failed autologous stem cell transplant (ASCT) or following at least two prior therapies when ASCT is not a treatment option. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for this condition in the relapsed or refractory setting. Treatment with pembrolizumab should be stopped at 2 years, or earlier if the person has a stem cell transplant or the disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>§</sup> Lung cancer  Afatinib 20 mg, 30 mg and 40 mg tablets  Alectinib 150 mg capsule  Alectinib 150 mg capsule  Alectinib 150 mg capsule  Alectinib 150 mg capsule  Atezolizumab 840 mg/14  Atezolizumab 840 mg/14  Concentrate for solution for infusion  Atezolizumab in combination with a platinum agent and etoposide, for untreated extensive-stage small-cell lung cancer.  Atezolizumab in combination with platinum-doublet chemotherapy, for untreated metastatic non-squamous non-small-cell lung cancer (NSCLC), in patients whose tumour aberrations. <sup>§</sup> Treatment of patients with netastatic non-small-cell lung cancer (NSCLC), in patients whose tumour aberrations. <sup>§</sup> Treatment of patients with metastatic non-small-cell lung cancer (NSCLC), in patients whose tumour sexpress PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations. <sup>§</sup> Treatment of patients with metastatic non-small-cell lung cancer (NSCLC), in patients whose tumour sexpress PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour with a PD-1/PD-1 inhibitor for metastatic NSCLC. <sup>§</sup> Atezolizumab 840 mg/14  Atezolizumab biosimilar (subsidised breatment of solution for infusion plus beveacizumab biosimilar (subsidised breatment of solution for infusion plus beveacizumab biosimilar (subsidised breatment of solution for infusion plus beveacizumab biosimilar (subsidised breatment of solution for infusion plus beveacizumab biosimilar (subs				-
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mL and 1200 mg/20 mL concentrate for solution for infusion    Platinum agent and etoposide, for untreated extensive-stage small-cell lung cancer.    Atezolizumab in combination with platinum-doublet chemotherapy, for untreated metastatic non-squamous non-small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations.β   For untreated metastatic non-small-cell lung cancer (NSCLC), in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations.β   Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β    Atezolizumab 840 mg/14   MAF   \$3200°     Atezolizumab 840 mg/20 mL concentrate for solution for infusion plus bevacizumab biosimilar (subsidised chemotherapy, for the treatment of   MAF   \$3200°     (1 Sep 2022)   (2 Sep 2022)   (3 Sep 2022)   (4 Sep 2022)     (2 Sep 2022)   (3 Sep 2022)   (4 Sep 2022)     (3 Sep 2022)   (4 Sep 2022)   (5 Sep 2022)     (4 Sep 2022)   (5 Sep 2022)   (5 Sep 2022)     (5 Sep 2022)   (6 Sep 2022)   (7 Sep 2022)     (6 Sep 2022)   (7 Sep 2022)   (8 Sep 2022)     (7 Sep 2022)   (8 Sep 2022)   (8 Sep 2022)   (8 Sep 2022)     (8 Sep 2022)				
terested extensive-stage small-cell lung cancer.  Atezolizumab in combination with platinum-doublet chemotherapy, for untreated metastatic non-squamous non-small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations. <sup>β</sup> For untreated metastatic non-small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations. <sup>β</sup> For untreated metastatic non-small-cell lung cancer (NSCLC), in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations. <sup>β</sup> Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy.  Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC. <sup>β</sup> Atezolizumab 840 mg/14 ML and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab biosimilar (subsidised chemotherapy, for the treatment of				-
infusion    Cancer.			(1 Sep 2022)	(1 Sep 2022)
Atezolizumab in combination with platinum-doublet chemotherapy, for untreated metastatic non-squamous non-small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations.βMAF (1 Apr 2023)Ω\$1800 (1 Sep 2022)For untreated metastatic non-small-cell lung cancer (NSCLC), in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations.βMAF (1 Sep 2022)\$1800 (1 Sep 2022)Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.βMAF (1 Sep 2022)\$1800 (1 Sep 2022)Atezolizumab 840 mg/14 ML and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumabAtezolizumab biosimilar (subsidised brand) and platinum-doublet chemotherapy, for the treatment ofMAF (1 Sep 2022)\$3200° (1 Sep 2022)				
platinum-doublet chemotherapy, for untreated metastatic non-squamous non-small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations.β  For untreated metastatic non-small-cell lung cancer (NSCLC), in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations.β  Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab of the devacizumab of the treatment in the treatment of the	infusion			
untreated metastatic non-squamous non-small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations.β  For untreated metastatic non-small-cell lung cancer (NSCLC), in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations.β  Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab biosimilar (subsidised chemotherapy, for the treatment of				-
small-cell lung cancer (NSCLC), in patients with no EGFR or ALK genomic tumour aberrations.β         For untreated metastatic non-small-cell lung cancer (NSCLC), in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations.β       (1 Sep 2022)       (1 Sep 2022)         Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β       (1 Sep 2022)       (1 Sep 2022)         Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab       Atezolizumab in combination with bevacizumab biosimilar (subsidised chemotherapy, for the treatment of       MAF       \$3200°		1 .	(1 Apr 2023) <sup>Ω</sup>	(1 Sep 2022)
patients with no EGFR or ALK genomic tumour aberrations. <sup>β</sup> For untreated metastatic non-small-cell lung cancer (NSCLC), in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations. <sup>β</sup> Treatment of patients with metastatic nonsmall-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC. <sup>β</sup> Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab  Atexa with no EGFR or ALK genomic tumour should at tumour proportion score ≥50%, with no EGFR or (1 Sep 2022)  MAF  (1 Sep 2022)  (1 Sep 2022)  (1 Sep 2022)  (1 Sep 2022)  MAF  (1 Sep 2022)  (1 Sep 2022)				
tumour aberrations. <sup>β</sup> For untreated metastatic non-small-cell lung cancer (NSCLC), in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations. <sup>β</sup> Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC. <sup>β</sup> Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab biosimilar (subsidised chemotherapy, for the treatment of				
For untreated metastatic non-small-cell lung cancer (NSCLC), in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations.β  Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab  For untreated metastatic non-small-cell (1 Sep 2022)  (1 Sep 2022)  MAF  (1 Sep 2022)  (1 Sep 2022)  (1 Sep 2022)  MAF  (1 Sep 2022)  (1 Sep 2022)  (1 Sep 2022)				
lung cancer (NSCLC), in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations.β    Treatment of patients with metastatic nonsmall-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy.   Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β    Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab   Land 1200 mg/20 mL chemotherapy, for the treatment of   Land 1200 mg/20 mL chemotherapy, for the treatment of   Land 1202 mg/20 mL chemotherapy, for the treatment of   Land 1202 mg/20 mL chemotherapy, for the treatment of   Land 1202 mg/20 mL chemotherapy, for the treatment of   Land 1202 mg/20 mL chemotherapy, for the treatment of   Land 1202 mg/20 mL chemotherapy, for the treatment of   Land 1202 mg/20 mL chemotherapy, for the treatment of   Land 1202 mg/20 mL chemotherapy, for the treatment of   Land 1202 mg/20 mL chemotherapy, for the treatment of   Land 1202 mg/20 mL chemotherapy   Land 1202 mg/20 mL c			N 4 A 🗁	<b>#</b> 4000
tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations.β  Treatment of patients with metastatic nonsmall-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab in combination with chemotherapy, for the treatment of				· ·
proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations.β  Treatment of patients with metastatic non- small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab  ALK genomic tumour aberrations.β  MAF (1 Sep 2022) (1 Sep 2022)  (1 Sep 2022)  MAF (1 Sep 2022) (1 Sep 2022)			(1 Sep 2022)	(1 Sep 2022)
ALK genomic tumour aberrations.β  Treatment of patients with metastatic nonsmall-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab biosimilar (subsidised chemotherapy, for the treatment of				
Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab  Treatment of patients with metastatic non-small shall sha				
small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab biosimilar (subsidised chemotherapy, for the treatment of (1 Sep 2022) (1 Sep 2022)			MAE	\$1800
disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 Atezolizumab in combination with bevacizumab biosimilar (subsidised concentrate for solution for infusion plus bevacizumab biosimilar (subsidised chemotherapy, for the treatment of				-
platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 mL and 1200 mg/20 mL bevacizumab biosimilar (subsidised concentrate for solution for infusion plus bevacizumab biosimilar (subsidised chemotherapy, for the treatment of solution for infusion plus bevacizumab platinum-doublet chemotherapy, for the treatment of solution for infusion plus bevacizumab platinum-doublet chemotherapy.  platinum-containing chemotherapy. Patients must not have received prior treatment of solution for infusion plus bevacizumab in combination with bevacizumab biosimilar (subsidised (1 Sep 2022) (1 Sep 2022)			(1 OCP 2022)	(1 OCP 2022)
Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 Atezolizumab in combination with mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab biosimilar (subsidised chemotherapy, for the treatment of				
treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab 840 mg/14 ME and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumab treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC.β  Atezolizumab in combination with MAF (1 Sep 2022)  bevacizumab biosimilar (subsidised (1 Sep 2022)  brand) and platinum-doublet chemotherapy, for the treatment of				
Metastatic NSCLC.βMAF\$3200°Atezolizumab 840 mg/14 mL and 1200 mg/20 mL concentrate for solution for infusion plus bevacizumabAtezolizumab in combination with bevacizumab biosimilar (subsidised brand) and platinum-doublet chemotherapy, for the treatment of(1 Sep 2022)				
Atezolizumab 840 mg/14 Atezolizumab in combination with mL and 1200 mg/20 mL bevacizumab biosimilar (subsidised concentrate for solution for infusion plus bevacizumab biosimilar (subsidised chemotherapy, for the treatment of solution with mAF (1 Sep 2022) (1 Sep 2022)				
mL and 1200 mg/20 mL bevacizumab biosimilar (subsidised concentrate for solution for infusion plus bevacizumab biosimilar (subsidised brand) and platinum-doublet chemotherapy, for the treatment of (1 Sep 2022)	Atezolizumab 840 mg/14		MAF	\$3200∞
concentrate for solution for infusion plus bevacizumab brand) and platinum-doublet chemotherapy, for the treatment of				
infusion plus bevacizumab chemotherapy, for the treatment of		· ·	(	



solution for infusion (100	non-small-cell lung cancer (NSCLC) who		
mg/4 mL, 400 mg/16 mL)	had not received prior chemotherapy.		
	Patients must not have received prior		
	treatment with a PD-1/PD-L1 inhibitor for		
	metastatic NSCLC. <sup>β</sup>		
Atezolizumab 840 mg/14	Atezolizumab in combination with	Not recommended	\$3000∞
mL and 1200 mg/20 mL	bevacizumab (non-subsidised brand) and	for subsidy	(1 Sep 2022)
concentrate for solution for	platinum-doublet chemotherapy, for the	101 Substay	( 1 dop 2022)
infusion plus bevacizumab	treatment of patients with metastatic non-		
concentrate for solution for			
	squamous non-small-cell lung cancer		
infusion (100 mg/4 mL,	(NSCLC) who had not received prior		
400 mg/16 mL)	chemotherapy. Patients must not have		
	received prior treatment with a PD-1/PD-		
	L1 inhibitor for metastatic NSCLC. <sup>β</sup>		
Brigatinib 30 mg, 90 mg	Treatment of locally advanced or	MAF	\$2000
and 180 mg tablets	metastatic ALK mutation-positive non-	(4 Jan 2022)	(1 Sep 2022)
	small-cell lung cancer		
Ceritinib 150 mg capsule	Treatment of locally advanced or	SDL	\$1000
	metastatic ALK mutation-positive non-	(4 Jan 2022)	(1 Sep 2022)
	small-cell lung cancer.	,	( 1 - )
Crizotinib 200 mg and 250	Treatment of locally advanced or	Not recommended	Not
mg capsules	metastatic ALK mutation-positive non-	for subsidy	recommended
Ing capsules	small-cell lung cancer.	101 Subsidy	for MediShield
	Small-cell lung cancer.		
	To describe the all and a second	Network	Life claims
	Treatment of locally advanced or	Not recommended	\$3000
	metastatic ROS1 mutation-positive non-	for subsidy	(1 Sep 2022)
	small-cell lung cancer. Patients must not		
	have received prior treatment with other		
	ROS1 inhibitors.		
Dabrafenib 50 mg and 75	Dabrafenib in combination with trametinib	MAF	\$3800
mg capsules plus	for the treatment of advanced non-small-	(4 Jan 2022)	(1 Sep 2022)
trametinib 0.5 mg and 2	cell lung cancer in patients with a BRAF		
mg tablets	V600 mutation.		
Durvalumab 120 mg/2.4	Durvalumab in combination with a	MAF	\$1800
mL and 500 mg/10 mL	platinum agent and etoposide, for	(1 Sep 2022)	(1 Sep 2022)
concentrate for solution for	untreated extensive-stage small-cell lung	(: 356 2522)	( · • • • • • • • • • • • • • • • • • •
infusion	cancer.		
Illusion	Consolidation treatment of patients with	MAF	\$1800
	locally advanced, unresectable NSCLC	(1 Sep 2022)	
		(1 Sep 2022)	(1 Sep 2022)
	whose disease has not progressed		
	following platinum-based chemoradiation		
	therapy. Treatment should be continued		
	until disease progression or unacceptable		
	toxicity or for a maximum of 12 months.		
	Durvalumab retreatment is allowed at time		
	of progression for up to 1 additional year if		
	the initial treatment was stopped for		
	reasons other than disease progression. <sup>β</sup>		
Entrectinib 100 mg and	Treatment of locally advanced or	Not recommended	\$3000
200 mg capsules	metastatic ROS1 mutation-positive non-	for subsidy	(1 Sep 2022)
	small-cell lung cancer. Patients must not	121 23.00.07	( )
	have received prior treatment with other		
	ROS1 inhibitors.		
Erlotinib 100 mg and 150	Treatment of locally advanced or	SDL#	\$200
Enount 100 mg and 130	Treatificiti of locally duvaliced of	JDL"	ΨΖΟΟ



mg tablets	metastatic EGFR mutation-positive non-	(1 Feb 2022)	(1 Sep 2022)
	small-cell lung cancer.	,	, ,
Gefitinib 250 mg tablet	Treatment of locally advanced or metastatic EGFR mutation-positive non-small-cell lung cancer.	SDL# (1 Feb 2022)	\$200 (1 Sep 2022)
Lorlatinib 25 mg and 100 mg tablets	Treatment of locally advanced or metastatic ALK mutation-positive non-small-cell lung cancer.	MAF (1 Sep 2022)	\$2000 (1 Sep 2022)
Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion plus ipilimumab injection concentrate (50 mg/10 mL)	Nivolumab in combination with ipilimumab and 2 cycles of platinum-based chemotherapy, for untreated metastatic or recurrent non-small-cell lung cancer (NSCLC) in patients with no EGFR or ALK genomic tumour mutations. Treatment with nivolumab and ipilimumab should be stopped at 2 years, or earlier if disease progresses.	Not recommended for subsidy	\$1800 (1 Sep 2022)
Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion	Treatment of patients with metastatic non-small-cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for metastatic NSCLC. Nivolumab should be given as a weight-based dose up to a maximum of 240 mg every two weeks or 480 mg every four weeks.β	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)
Paclitaxel-albumin bound nanoparticles 100 mg injectable suspension	Nab-paclitaxel in combination with carboplatin, for previously untreated locally advanced or metastatic non-small-cell lung cancer in patients who are not candidates for curative surgery or radiation therapy.	MAF (1 Sep 2022)	\$1000 (1 Sep 2022)
Pembrolizumab 100 mg/4 mL solution for infusion	For untreated metastatic non-small-cell lung cancer (NSCLC) in patients whose tumours express PD-L1 with a tumour proportion score ≥50%, with no EGFR or ALK genomic tumour aberrations.  Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup>	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)
	Pembrolizumab in combination with platinum-doublet chemotherapy for untreated metastatic squamous nonsmall-cell lung cancer (NSCLC).  Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)



	stopped for reasons other than disease		
	progression. <sup>β</sup>		
	Pembrolizumab in combination with	MAF	\$1800
	platinum-doublet chemotherapy, for	(1 Sep 2022)	(1 Sep 2022)
	untreated metastatic non-squamous non-	(1 GCP 2022)	(1 OCP 2022)
	small-cell lung cancer (NSCLC) in patients		
	with no EGFR or ALK genomic tumour		
	aberrations. Treatment with		
	pembrolizumab should be stopped at 2		
	years, or earlier if disease progresses.		
	Pembrolizumab retreatment is allowed at		
	time of progression for up to 1 additional		
	year if the initial treatment was stopped for		
	reasons other than disease progression. <sup>β</sup>		
I have	Treatment of patients with metastatic non-	MAF	\$1800
	small-cell lung cancer (NSCLC), whose	(1 Sep 2022)	(1 Sep 2022)
	tumours express PD-L1 with a tumour	(1 Sep 2022)	(1 3ep 2022)
	proportion score ≥1% and had disease		
	progression during or following platinum-		
	containing chemotherapy. Patients must not have received prior treatment with a		
	PD-1/PD-L1 inhibitor for metastatic		
	NSCLC. Treatment with pembrolizumab		
	should be stopped at 2 years, or earlier if		
	disease progresses. Pembrolizumab		
	retreatment is allowed at time of		
	progression for up to 1 additional year if		
	the initial treatment was stopped for		
	reasons other than disease progression. <sup>β</sup>		
	Treatment of non-small-cell lung cancer.	Not recommended	\$400
mg capsules	riodanioni or non ornan con lang cancon.	for subsidy	(1 Sep 2022)
Merkel cell cancer			
		,	
	Treatment of patients with metastatic		
Avelumab 200 mg/ 10 mL	Treatment of patients with metastatic  Merkel cell carcinoma, Avelumab may be	MAF	\$1800
Avelumab 200 mg/ 10 mL concentrate for solution for	Merkel cell carcinoma. Avelumab may be		
Avelumab 200 mg/ 10 mL concentrate for solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a	MAF	\$1800
Avelumab 200 mg/ 10 mL concentrate for solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup>	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell	MAF (1 Sep 2022)  Not recommended	\$1800 (1 Sep 2022) \$1800
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2	MAF (1 Sep 2022)  Not recommended	\$1800 (1 Sep 2022) \$1800
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with	MAF (1 Sep 2022)  Not recommended	\$1800 (1 Sep 2022) \$1800
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at	MAF (1 Sep 2022)  Not recommended	\$1800 (1 Sep 2022) \$1800
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks.β  Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional	MAF (1 Sep 2022)  Not recommended	\$1800 (1 Sep 2022) \$1800
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at	MAF (1 Sep 2022)  Not recommended	\$1800 (1 Sep 2022) \$1800
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks.β  Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for	MAF (1 Sep 2022)  Not recommended for subsidy	\$1800 (1 Sep 2022) \$1800
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion  Microsatellite instability-high	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup>	MAF (1 Sep 2022)  Not recommended for subsidy	\$1800 (1 Sep 2022) \$1800
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion  Microsatellite instability-hig Nivolumab	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup> gh (MSI-H) or mismatch repair deficient (displayed and displayed a	MAF (1 Sep 2022)  Not recommended for subsidy	\$1800 (1 Sep 2022) \$1800 (1 Sep 2022)
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion  Microsatellite instability-hig Nivolumab 40 mg/4 mL and 100	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup> gh (MSI-H) or mismatch repair deficient (d)  Treatment of unresectable or metastatic	MAF (1 Sep 2022)  Not recommended for subsidy  MMR) tumour  Not recommended	\$1800 (1 Sep 2022) \$1800 (1 Sep 2022)
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion  Microsatellite instability-hig Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup> gh (MSI-H) or mismatch repair deficient (do Treatment of unresectable or metastatic microsatellite instability-high (MSI-H) or	MAF (1 Sep 2022)  Not recommended for subsidy  MMR) tumour  Not recommended	\$1800 (1 Sep 2022) \$1800 (1 Sep 2022)
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion  Microsatellite instability-hig Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup> gh (MSI-H) or mismatch repair deficient (d Treatment of unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)	MAF (1 Sep 2022)  Not recommended for subsidy  MMR) tumour  Not recommended	\$1800 (1 Sep 2022) \$1800 (1 Sep 2022)
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion  Microsatellite instability-hig Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup> gh (MSI-H) or mismatch repair deficient (d)  Treatment of unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer (CRC) that has	MAF (1 Sep 2022)  Not recommended for subsidy  MMR) tumour  Not recommended	\$1800 (1 Sep 2022) \$1800 (1 Sep 2022)
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion  Microsatellite instability-hig Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup> gh (MSI-H) or mismatch repair deficient (d)  Treatment of unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer (CRC) that has progressed following treatment with a	MAF (1 Sep 2022)  Not recommended for subsidy  MMR) tumour  Not recommended	\$1800 (1 Sep 2022) \$1800 (1 Sep 2022)
Avelumab 200 mg/ 10 mL concentrate for solution for infusion  Pembrolizumab 100 mg/4 mL solution for infusion  Microsatellite instability-hig Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion	Merkel cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup> Treatment of metastatic Merkel cell carcinoma. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup> gh (MSI-H) or mismatch repair deficient (d Treatment of unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer (CRC) that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and	MAF (1 Sep 2022)  Not recommended for subsidy  MMR) tumour  Not recommended	\$1800 (1 Sep 2022) \$1800 (1 Sep 2022)



	MSI-H or dMMR CRC.β		
Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion plus ipilimumab injection concentrate (50 mg/10 mL)	Nivolumab in combination with ipilimumab for treatment of unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer (CRC) that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for unresectable or metastatic MSI-H or dMMR CRC. The doses of nivolumab and ipilimumab should not exceed: 3mg/kg nivolumab and 1mg/kg ipilimumab every 3 weeks for 4 doses, followed by nivolumab 240mg every 2 weeks or 480mg every 4 weeks as a single agent. <sup>β</sup>	Not recommended for subsidy	\$1800 (1 Sep 2022)
Pembrolizumab 100 mg/4 mL solution for infusion	For untreated metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer.  Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression. <sup>β</sup>	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)
	Treatment of patients with unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) solid tumours that have progressed following prior treatment and who have no satisfactory alternative treatment options. Patients must not have received prior treatment with a PD-1/PD-L1 inhibitor for the same MSI-H or dMMR solid tumour in the unresectable or metastatic setting. Treatment with pembrolizumab should be stopped at 2 years, or earlier if disease progresses. Pembrolizumab retreatment is allowed at time of progression for up to 1 additional year if the initial treatment was stopped for reasons other than disease progression.	Not recommended for subsidy	\$1800 (1 Sep 2022)
Multicentric Castleman's of Siltuximab 100 mg powder for infusion	Treatment of patients with multicentric Castleman's disease (MCD) who are human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV- 8) negative.	Not recommended for subsidy	\$3000 (1 Sep 2022)
Multiple myeloma Lenalidomide 5 mg, 10	Treatment of multiple myeloma.	SDL#	\$1400
Lonandonnide o mg, 10	Treatment of mainple myeloma.	ODL	ΨΙΨΟΟ



mg, 15 mg and 25 mg		(4 Jan 2022)	(1 Sep 2022)
capsules		(4 Jan 2022)	(1 Sep 2022)
Bortezomib 3.5 mg	Treatment of multiple myeloma	SDL#	\$1400
injection	, ,	(1 Sep 2022)	(1 Sep 2022)
Myelofibrosis			
Ruxolitinib 5 mg, 15 mg	Treatment of patients with intermediate-1	MAF	\$2000
and 20 mg tablets	risk myelofibrosis with severe disease-	(1 Sep 2022)	(1 Sep 2022)
	related symptoms or splenomegaly that		
	are resistant, refractory or intolerant to		
	available therapy.		
	Treatment of patients with intermediate-2		
	or high-risk myelofibrosis with disease-		
	related splenomegaly or symptoms.		
Neurotrophic tyrosine red	eptor kinase (NTRK) gene fusion tumour		
Entrectinib 100 mg and	Treatment of patients with solid tumours	Not recommended	\$3000
200 mg capsules	that:	for subsidy	(1 Sep 2022)
	- have a NTRK gene fusion without a		
	known acquired resistance mutation,		
	- are metastatic or where surgical		
	resection is likely to result in severe		
	morbidity, and		
	- have no satisfactory alternative treatments or that have progressed		
	following treatment.		
Larotrectinib 25 mg and	Treatment of patients with solid tumours	Not recommended	\$3000
100 mg capsules and 2	that:	for subsidy	(1 Sep 2022)
g/100 mL oral solution	- have a NTRK gene fusion without a	,	, ,
	known acquired resistance mutation,		
	- are metastatic or where surgical		
	resection is likely to result in severe		
	morbidity, and		
	- have no satisfactory alternative treatments or that have progressed		
	following treatment.		
Ovarian cancer	Tollowing treatment.		
Pegylated liposomal	Treatment of advanced ovarian cancer in	SDL#	\$1400
doxorubicin 20 mg	patients who have failed a first-line	(1 Feb 2022)	(1 Sep 2022)
concentrate for infusion	platinum-based chemotherapy regimen.	,	, ,
Pancreas Cancer			
Olaparib 100 mg and 150	Maintenance treatment of patients with	MAF	\$1600
mg tablets	deleterious or suspected deleterious	(1 Sep 2022)	(1 Sep 2022)
	germline BRCA mutated metastatic		
	pancreatic adenocarcinoma whose		
	disease has not progressed on at least 16		
	weeks of a first-line platinum-based chemotherapy regimen.		
Paclitaxel-albumin bound	Nab-paclitaxel in combination with	MAF	\$1000
nanoparticles 100 mg	gemcitabine, for treatment of locally	(1 Sep 2022)	(1 Sep 2022)
injectable suspension	advanced or metastatic adenocarcinoma	(1.30) = 322)	( )
,	of the pancreas.		
Pegylated liposomal	Liposomal irinotecan in combination with	Not recommended	\$1000
irinotecan concentrate for	fluorouracil and leucovorin, for patients	for subsidy	(1 Sep 2022)
dispersion for infusion (43	with metastatic adenocarcinoma of the		



mg/10 mL)	pancreas after disease progression following gemcitabine-based therapy.		
Prostate Cancer	Tollowing gernellabilite-based therapy.		
Abiraterone acetate 250 mg tablets	For cancer treatment.	SDL#	\$400 (1 Sep 2022)
Abiraterone 500 mg and 1000 mg tablets	For cancer treatment.	Not recommended for subsidy	\$400 (1 Sep 2022)
Bicalutamide 50 mg tablet	Treatment of prostate cancer.	SDL (4 Jan 2022)	\$200 (1 Sep 2022)
Cyproterone 50 mg tablet	Treatment of prostate cancer.	SDL (4 Jan 2022)	\$200 (1 Sep 2022)
Triptorelin 3.75 mg, 11.25 mg and 22.5 mg injections	Treatment of locally advanced or metastatic prostate cancer.	Not recommended for subsidy	\$200 (1 Sep 2022)
Radium-223 solution for injection (1100 kBq/mL)	Treatment of patients with castration- resistant prostate cancer with symptomatic bone metastases and no known visceral metastatic disease.	Not recommended for subsidy	\$1400 (1 Sep 2022)
Renal cell cancer			<b>***</b>
Avelumab 200 mg/ 10 mL concentrate for solution for infusion plus axitinib 1 mg and 5 mg tablets	Avelumab in combination with axitinib for untreated advanced renal cell carcinoma. Avelumab may be given at a dose of 10 mg/kg up to a maximum of 800 mg, every 2 weeks. <sup>β</sup>	MAF (1 Sep 2022)	\$3000 (1 Sep 2022)
Axitinib 1 mg and 5 mg tablets	For previously treated advanced renal cell carcinoma.	MAF (1 Sep 2022)	\$1000 (1 Sep 2022)
Cabozantinib 20 mg, 40 mg, 60 mg tablets	For untreated intermediate- or poor-risk advanced renal cell carcinoma.  For previously treated advanced renal cell carcinoma.	MAF (1 Sep 2022) MAF (1 Sep 2022)	\$1800 (1 Sep 2022) \$1800 (1 Sep 2022)
Everolimus 2.5 mg, 5 mg and 10 mg tablets	For previously treated advanced renal cell carcinoma.	Not recommended for subsidy	\$1200 (1 Sep 2022)
Lenvatinib 4 mg and 10 mg capsules plus everolimus 2.5 mg, 5 mg and 10 mg tablets	Lenvatinib in combination with everolimus for previously treated advanced renal cell carcinoma.	Not recommended for subsidy	\$ 1800° (1 Sep 2022)
Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion plus ipilimumab 50 mg/10 mL concentrate for solution for infusion^	Nivolumab in combination with ipilimumab for untreated intermediate- or poor-risk advanced renal cell carcinoma. The doses of nivolumab and ipilimumab should not exceed: 3 mg/kg nivolumab and 1 mg/kg ipilimumab every 3 weeks for 4 doses. <sup>β</sup>	MAF (1 Sep 2022)	\$5200 (1 Sep 2022)
Nivolumab 40 mg/4 mL and 100 mg/10 mL concentrate for solution for infusion	For intermediate- or poor-risk advanced renal cell carcinoma, following induction treatment with nivolumab in combination with ipilimumab. Nivolumab should be given as a weight-based dose up to a maximum of 240 mg every two weeks or 480 mg every four weeks. <sup>β</sup>	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)
Nivolumab 40 mg/4 mL and 100 mg/10 mL	For previously treated advanced renal cell carcinoma (RCC). Patients must not have	MAF (1 Sep 2022)	\$1800 (1 Sep 2022)



concentrate for solution for	received prior treatment with a PD-1/PD-		
infusion	L1 inhibitor for advanced RCC. Nivolumab		
	should be given as a weight-based dose		
	up to a maximum of 240 mg every two		
	weeks or 480 mg every four weeks. ‡		
Pembrolizumab 100 mg/4	Pembrolizumab in combination with	Not recommended	\$3000
mL solution for infusion	axitinib for untreated advanced renal cell	for subsidy	(1 Sep 2022)
plus axitinib 1 mg and 5	carcinoma. Treatment with		
mg tablets	pembrolizumab should be stopped at 2		
	years, or earlier if disease progresses.		
	Pembrolizumab retreatment is allowed at		
	time of progression for up to 1 additional		
	year if the initial treatment was stopped for		
	reasons other than disease progression. <sup>β</sup>		
Pazopanib 200 mg and	Treatment of advanced renal cell	SDL	\$1600
400 mg tablets	carcinoma.	(4 Jan 2022)	(1 Sep 2022)
Soft tissue sarcoma		( 1 00 = 0 = 2,	(1 3 3 2 2 2 2 )
Eribulin mesylate 1 mg/2	Treatment of patients with unresectable	MAF	\$1200
mL solution for injection	liposarcoma who have received prior	(1 Sep 2022)	(1 Sep 2022)
ing conductives injection	anthracycline containing therapy (unless	(: 33p 2322)	(1 dop 2022)
	unsuitable) for advanced or metastatic		
	disease.		
Pazopanib 200 mg and	Treatment of patients with selective	SDL	\$1600
400 mg tablets	subtypes* of soft tissue sarcoma who	(4 Jan 2022)	(1 Sep 2022)
400 mg tablets	have received prior chemotherapy for	(+ <b>J</b> an 2022)	(1 OCP 2022)
	metastatic disease or whose disease has		
	progressed within 12 months after		
	(neo)adjuvant therapy.		
	*as per subtypes listed in the product		
	insert		
Pegylated liposomal	Treatment of soft tissue sarcoma.	SDL#	\$1400
doxorubicin 20 mg	Treatment of soft tissue sursonia.	(1 Feb 2022)	(1 Sep 2022)
concentrate for infusion		(11 CD 2022)	(1 OCP 2022)
Trabectedin 1 mg powder	Treatment of advanced or metastatic soft	Not recommended	\$1200
for injection	tissue sarcoma, after failure of	for subsidy	(1 Sep 2022)
ioi injection	anthracyclines and ifosfamide (unless	101 Subsidy	(1 Sep 2022)
	unsuitable).		
Waldenstrom's Macroglob			
		Not recommended	\$2000
Ibrutinib 140 mg capsule,	Ibrutinib as a single agent, or in combination with rituximab, for the		
and 140 mg, 280 mg, 420	· ·	for subsidy	(1 Sep 2022)
mg tablets plus rituximab	treatment of Waldenstrom's		
concentrate for infusion	Macroglobulinaemia.		
(100 mg/10 mL, 500			
mg/50 mL)			
Various types of cancer		25:	<b>*</b>
Azacitidine 100 mg	For cancer treatment.	SDL	\$600
injection		(4 Jan 2022)	(1 Sep 2022)
Bendamustine 25 mg and	For cancer treatment.	SDL	\$1000
100 mg concentrate for		(4 Jan 2022)	(1 Sep 2022)
infusion			
Cisplatin 100 mg/100 mL	For cancer treatment.	SDL	\$200
concentrate for infusion		(4 Jan 2022)	(1 Sep 2022)
Epirubicin 50 mg/25 mL	For cancer treatment.	SDL	\$800
injection		(4 Jan 2022)	(1 Sep 2022)



Exemestane 25 mg tablet	For cancer treatment.	SDL	\$200
		(4 Jan 2022)	(1 Sep 2022)
Fludarabine phosphate 50	For cancer treatment.	SDL	\$600
mg injection		(4 Jan 2022)	(1 Sep 2022)
Imatinib 100 mg and 400	For cancer treatment.	SDL#	\$200
mg tablets		(1 Feb 2022)	(1 Sep 2022)
Megestrol 40 mg and 160	For cancer treatment.	SDL	\$200
mg capsules		(4 Jan 2022)	(1 Sep 2022)
Oxaliplatin 200 mg/40 mL	For cancer treatment.	SDL	\$200
concentrate for infusion		(4 Jan 2022)	(1 Sep 2022)
Paclitaxel-albumin bound	For cancer treatment in patients who are	MAF	\$1000
nanoparticles 100 mg	intolerant to paclitaxel.	(1 Sep 2022)	(1 Sep 2022)
injectable suspension			
Pemetrexed 100 mg and	For cancer treatment.	SDL	\$200
500 mg injections		(4 Jan 2022)	(1 Sep 2022)
Somatropin solution for	For cancer treatment.	SDL	\$400
injection (5 mg/1.5 mL and		(1 Mar 2024)	(1 Mar 2024)
10 mg/1.5 mL) (SciTropin			
A)			
Sunitinib 12.5 mg	For cancer treatment.	SDL	\$1600
capsules		(1 Mar 2024)	(1 Sep 2022)
Tegafur+gimeracil+oteracil	For cancer treatment.	Not recommended	\$200
potassium 20 mg/5.8		for subsidy	(1 Sep 2022)
mg/19.6 mg and 25			
mg/7.25 mg/24.5 mg			
capsules			
Vinorelbine 10 mg/mL	For cancer treatment.	Not recommended	\$400
injection		for subsidy	(1 Feb 2023)
Vinorelbine	For cancer treatment.	SDL	\$400
50 mg/5 mL injection		(4 Jan 2022)	(1 Sep 2022)

Abbreviations: ALK, Anaplastic Lymphoma Kinase; AML, Acute Myeloid Leukaemia; CPS, Combined Positive Score; FLT3, FMS-like Tyrosine Kinase 3; HSCT; Haemopoietic stem cell transplantation; HR, Hormone Receptor; HER2, Human Epidermal Growth Factor Receptor; PHI, Public Healthcare Institution; PIK3CA, Phosphatidylinositol 3-kinase Catalytic Subunit Alpha; PD-1/PD-L1, Programmed Cell Death (Ligand) 1; SDL, Standard Drug List; MAF, Medication Assistance Fund.

<sup>\*</sup>MAF assistance does not apply to other formulations and/or strengths of leuprorelin for treating breast cancer. ^ipilimumab 200 mg/40 mL concentrate for infusion for solution is not marketed in Singapore.

<sup>\*</sup>removal of brand-specific listing for subsidy with effect from 1 Feb 2023.

<sup>‡</sup>revised clinical indication with effect from 1 Feb 2023.

<sup>†</sup>change in MSHL claim limit with effect from 1 Feb 2023.

<sup>&</sup>lt;sup>Ω</sup>change in subsidy status with effect from 1 Apr 2023.

<sup>&</sup>quot;change in MSHL claim limit with effect from 1 Aug 2023.

<sup>&</sup>lt;sup>β</sup>revised clinical indication with effect from 1 Mar 2024.



#### **VERSION HISTORY**

# Update of MOH List of subsidised drugs to include treatments for various cancer conditions

This Version History is provided to track any updates or changes to the guidance following the first publication date. It is not part of the guidance.

1. Publication of guidance

Date of Publication 4 Jan 2022

2. Guidance updated to include more drugs

Date of Publication 1 Apr 2022

3. Guidance updated to include more drugs

Date of Publication 31 Aug 2022

- 4. Guidance updated with the following changes:
  - added vinorelbine 10 mg/mL injection and abiraterone 250 mg, 500 mg and 1000 mg tablets
  - revised clinical indication for abemaciclib, goserelin, leuprorelin, palbociclib and ribociclib
  - revised clinical indication for nivolumab for head and neck cancer, Hodgkin lymphoma, non-small-cell lung cancer and renal cell carcinoma
  - revised clinical indication and subsidy class for atezolizumab and pembrolizumab for non-small-cell lung cancer
  - MSHL claim limit for lapatinib increased from \$600/month to \$800/month
  - removal of brand-specific listing for subsidy for bortezomib, erlotinib, fulvestrant, gefitinib, imatinib, lenalidomide and pegylated liposomal doxorubicin

Date of Publication 19 Dec 2022

- 5. Guidance updated with the following changes:
  - revised clinical indication for triptorelin and nab-paclitaxel
  - MSHL claim limit increased for several drug combinations

Date of Publication 1 Aug 2023

- 6. Guidance updated with the following changes:
  - revised clinical indication for atezolizumab, avelumab, durvalumab, nivolumab, and pembrolizumab
  - revised subsidy status for sunitinib
  - added new formulation of somatropin

Date of Publication 2 Jan 2024



Agency for Care Effectiveness - ACE

in Agency for Care Effectiveness (ACE)

#### **About the Agency**

The Agency for Care Effectiveness (ACE) was established by the Ministry of Health (Singapore) to drive better decision-making in healthcare through health technology assessment (HTA), clinical guidance, and education.

As the national HTA agency, ACE conducts evaluations to inform government subsidy decisions for treatments, diagnostic tests and vaccines, and produces guidance for public hospitals and institutions in Singapore.

This guidance is not, and should not be regarded as, a substitute for professional or medical advice. Please seek the advice of a qualified healthcare professional about any medical condition. The responsibility for making decisions appropriate to the circumstances of the individual patient remains with the healthcare professional.

Find out more about ACE at www.ace-hta.gov.sg/about

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