NYE METODER

Anmodning om vurdering av legemiddel i Nye metoder

Skjema for leverandører

En leverandør som ønsker offentlig finansiering av et legemiddel/legemiddelindikasjon i den norske spesialisthelsetjenesten, skal anmode om vurdering i Nye metoder ved å fylle ut dette skjemaet.

Utfylt anmodningsskjema sendes til Nye metoder: nyemetoder@helse-sorost.no

Leverandøren skal på anmodningstidspunktet både ha et forslag til type helseøkonomisk analyse og en plan for når de leverer dokumentasjonen. Merk at dokumentasjon i henhold til oppdraget fra Bestillerforum for nye metoder må leveres inn senest 12 måneder etter anmodningstidspunktet.

Hele anmodningsskjemaet skal fylles ut. Mer informasjon og veiledning finnes i artikkelen For leverandører (nyemetoder.no)

Merk: Skjemaet vil bli publisert i sin helhet på nyemetoder.no.

Innsender er klar over at skjemaet vil bli publisert i sin helhet (må krysses av): ☒

Fyll ut dato for innsending av skjema: 14.04.2025

1 Kontaktopplysninger	
1.1 Leverandør (innehaver/søker av markedsføringstillatelse i Norge)	Novartis Norway AS
1.2 Navn kontaktperson	Thea Halvorsen
1.3 Stilling kontaktperson	Value & Access Manager
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Ekstern representasjon - vedlegg fullmakt	
1.6 Navn/virksomhet	Klikk eller trykk her for å skrive inn tekst.
1.7 Telefon og e-post	Klikk eller trykk her for å skrive inn tekst.

2 Legemiddelinformasjon og indikasjon	
2.1 Hva gjelder anmodningen? *Kryss av for hva anmodningen gjelder*	Et nytt virkestoff ☒ En indikasjonsutvidelse / ny indikasjon ☒ En ny styrke eller formulering ☐
2.2 Hvilken indikasjon gjelder anmodningen?	Fabhalta er indisert til behandling av voksne pasienter med komplement 3-glomerulopati (C3G) i kombinasjon med en renin-angiotensinsystem (RAS)-hemmer, eller hos pasienter som er intolerante for RAS-hemmer, eller hvor en RAS-hemmer er kontraindisert.

Indikasjonen skal oppgis på norsk. Hvis prosess for godkjenning pågår, oppgi også indikasjon på engelsk. *Merk: Leverandør skal anmode om vurdering av hele indikasjonen som de har fått godkjent eller søker om godkjenning for. Dersom leverandør foreslår en avgrensning til undergrupper, må dette begrunnes og leverandør må levere dokumentasjonen som trengs for å foreta en vurdering av undergruppen i tillegg til dokumentasjonen for hele indikasjonen.*	
2.3 Handelsnavn	Fabhalta
2.4 Generisk navn/virkestoff	Iptacopan
2.5 ATC-kode	L04AJ08
2.6 Administrasjonsform og styrke *Oppgi også forventet dosering og behandlingslengde* *Skriv kort*	Iptacopan is an oral formulation, and the recommended dose is 200 mg taken orally, twice per day.
2.7 Farmakoterapeutisk gruppe og virkningsmekanisme. *Skriv kort*	Iptacopan is a proximal complement inhibitor that targets Factor B (FB) to selectively inhibit the alternative pathway. In C3G, overactivation of the complement alternative pathway leads to deposition of C3 within the glomeruli, triggering inflammation, glomerular injury, and kidney fibrosis. Iptacopan selectively blocks the alternative pathway overactivation by inhibiting the alternative pathway related C3 convertase activity, leading to decreased cleavage of C3 and reduced C3 deposition in the kidney (1).

3 Historikk – virkestoff og indikasjon

3.1 Har Nye metoder behandlet metoder med det aktuelle virkestoffet tidligere? *Hvis ja, oppgi ID-nummer til metoden/metodene i Nye metoder*	Ja ☐ Nei ☒ ID-nummer: Klikk eller trykk her for å skrive inn tekst.
3.2 Er du kjent med om andre legemidler/virkestoff er vurdert i Nye metoder til samme indikasjon?	Ja ☐ Nei ☒ ID-nummer:

Hvis ja, oppgi ID-nummer til metoden/metodene i Nye metoder	Klikk eller trykk her for å skrive inn tekst.
3.3 Er du kjent med om det er gjennomført en metodevurdering i et annet land som kan være relevant i norsk sammenheng? *Hvis ja, oppgi referanse*	Ja ☐ Nei ☒ Referanse: Klikk eller trykk her for å skrive inn tekst.

4 Status for markedsføringstillatelse (MT) og markedsføring

4.1 Har legemiddelet MT i Norge for en eller flere indikasjoner? *Hvis ja - skriv inn dato for norsk MT for den første indikasjonen*	Ja ☒ Nei ☐ Dato for MT for første indikasjon: 17.05.2024
4.2 Markedsføres legemiddelet i Norge?	Ja ☐ Nei ☒
4.3 Har legemiddelet MT i Norge for anmodet indikasjon? *For alle metoder: Fyll ut prosedyrenummer i EMA (det europeiske legemiddelbyrået)*	MT i Norge: Ja ☒ Nei ☐ Prosedyrenummer i EMA: EMEA/H/C/005764/II/0001
Hvis metoden ikke har MT i Norge, fyll ut forventet tidspunkt (måned/år) for CHMP opinion i EMA. *Hvis metoden har MT i Norge, fyll ut dato for MT*	**Hvis metoden ikke har MT**: Forventet tidspunkt for CHMP opinion i EMA (måned/år): Klikk eller trykk her for å skrive inn tekst. Forventet tidspunkt for markedsføringstillatelse (MT) for den aktuelle indikasjonen i Norge (måned/år): Klikk eller trykk her for å skrive inn tekst.
	Hvis metoden har MT: Dato for MT i Norge for den aktuelle indikasjonen: 31.03.2025
4.4 Har legemiddelet en betinget markedsføringstillatelse for anmodet indikasjon? *Hvis ja, fyll ut en beskrivelse av hva som skal leveres til EMA og når.*	Ja ☐ Nei ☒ Beskrivelse: Klikk eller trykk her for å skrive inn tekst.
4.5 Har anmodet indikasjon vært i	Ja ☐ Nei ☒

«accelerated assessment» hos EMA?	
4.6 Har legemiddelet «orphan drug designation» i EMA? *Hvis ja, fyll ut dato*	Ja ☒ Nei ☐ Dato for «orphan drug designation»: 31.07.2024

5 Ordning for forenklet vurdering av PD-(L)1-legemidler

5.1 Er legemiddelet registrert i Nye metoders ordning «Forenklet vurdering av PD-(L)1-legemidler"?	Ja ☐ Nei ☒

6 Sammenlignbarhet og anbud

6.1 Finnes det andre legemidler med lignende virkningsmekanisme og /eller tilsvarende effekt til den aktuelle indikasjonen?	Ja ☐ Nei ☒ Kommentar: Klikk eller trykk her for å skrive inn tekst.
6.2 Vurderer leverandør at legemiddelet i anmodningen er sammenlignbart med et eller flere andre legemidler som Nye metoder har besluttet å innføre til den samme indikasjonen? *Hvis ja, hvilke(t)? Oppgi ID-nummer på metoden/metodene i Nye metoder*	Ja ☐ Nei ☒ Legemiddel og ID-nummer: Klikk eller trykk her for å skrive inn tekst.
6.3 Er det eksisterende anbud på terapiområdet som kan være aktuelt for legemiddelet?	Ja ☐ Nei ☒ Kommentar: Klikk eller trykk her for å skrive inn tekst.

7 Nordisk samarbeid JNHB (Joint Nordic HTA-bodies)

7.1 Er anmodet indikasjon aktuell for utredning i det nordiske HTA-samarbeidet JNHB? *Hvis nei, begrunn kort*	Ja ☐ Nei ☒ Begrunnelse: Fabhalta is an oral treatment and will consequently fall into different reimbursement pathways in the Nordic countries, not being fit for a Nordic joint assessment.

8 Europeisk samarbeid om vurdering av relativ effekt og sikkerhet (HTAR)	
8.1 Er anmodet legemiddel/indikasjon omfattet av regelverket for utredning av relativ effekt og sikkerhet i europeisk prosess (HTAR)? *Hvis ja, fyll ut dato for søknad om MT til EMA*	Ja ☐ Nei ☒ Dato for søknad til EMA: Klikk eller trykk for å skrive inn en dato.

9 Helseøkonomisk dokumentasjon og forslag til helseøkonomisk analyse	
9.1 Hvilken type helseøkonomisk analyse foreslår leverandøren? *F.eks. kostnad-per-QALY analyse eller kostnadsminimeringsanalyse.* *Begrunn forslaget*	Because of the rarity of C3G, the limitations & uncertainty related to performing a cost-utility analysis, Novartis suggest a simplified HTA for iptacopan in this indication. The documentation to the Norwegian Medicinal Products Agency would thus be based on a medical assessment and a budget impact analysis. Novartis suggest to further discuss the documentation needed to assess iptacopan for C3G in a dialogue meeting with DMP prior to submission. Clinical trial results shows that iptacopan significantly reduce proteinuria (UPCR), and stabilizes kidney function (eGFR) in patients with C3G. Therefore, iptacopan has potential to delay progression to end stage kidney disease and the need for replacement therapies (dialysis & transplant), with large impact on quality of life & healthcare costs. However, we expect the use of surrogate endpoints to introduce uncertainty into the health economic analysis. The endpoints used in APPEAR-C3G are clinically relevant and validated within renal diseases. While the endpoints are sufficient to assess the clinical value of iptacopan and the risk of kidney disease progression, the most important clinical outcome of chronic kidney disease (CKD) is kidney failure. The natural progression of CKD and C3G occurs over years, often several decades. In the health economic analysis, this would mean to extrapolate the relative risk of progression to end stage kidney disease based on surrogate endpoints over a lifetime horizon, introducing uncertainty into the long term outcomes of the model. According to the guidelines for single technology assessments in Norway, the use of surrogate endpoints in a health economic analysis will be assessed on a case by case basis. Novartis is

	concerned that the expected uncertainty in the analysis could potentially delay access for these patients. Furthermore, the Norwegian Medicinal Products Agency has recently stated that they will look into alternative measures to reduce time to access for rare diseases, including the possibility for simplified assessments. There is a significant unmet need as there are no targeted treatments available for these patients, only supportive care. Iptacopan is the first targeted therapy for C3G, addressing the disease's underlying pathophysiology by specifically binding Factor B, inhibiting the overactivation of the alternative complement pathway. This represents a significant advancement over non-specific therapies and offers unique benefits for patients. Considering the unmet need, that C3G is a rare disease with an incidence of 1-2 patients per million per year, and the expected uncertainty in the health economic model, Novartis suggest an alternative/simplified HTA for Fabhalta in C3G.
9.2 Pasientpopulasjonen som den helseøkonomiske analysen baseres på, herunder eventuelle undergrupper.	Adult patients with complement 3 glomerulopathy (C3G) The APPEAR-C3G study enrolled adult patients with biopsy-confirmed C3G, urine protein-to-creatinine ratio (UPCR) ≥1 g/g, and eGFR ≥30 ml/min/1.73 m2.
9.3 Hvilken dokumentasjon skal ligge til grunn? (H2H studie, ITC, konstruert komparatorarm etc.) *Angi det som er relevant med tanke på hvilken type analyse som foreslås.*	The application will be based on data from the APPEAR-C3G study, a phase 3 study (NCT04817618) in patients with C3G randomized to either iptacopan or standard treatment. Supportive data from a phase 2 study (NCT03832114) will also be included as well as follow-up from an extension study (NCT03955445).
9.4 Forventet legemiddelbudsjett i det året med størst budsjettvirkning i de første fem år.	Novartis expect a limited number of eligible patients due to the rarity of C3G. There is limited knowledge on the epidemiology, however, the internationally estimated incidence is 1-2 cases per million per year (2). There's uncertainty in how many of these patients will be eligible for treatment.

9.5 Forventet tidspunkt (måned og år) for levering av dokumentasjon til Direktoratet for medisinske produkter og/eller Sykehusinnkjøp HF. *Tidspunkt må oppgis*	Novartis plans to submit documentation to DMP during Q3 2025. We suggest to discuss the challenges addressed in this section, as well as the documentation needed to evaluate iptacopan for C3G in a dialogue meeting prior to submission. This will secure a common understanding of the case and enable us to give a more accurate timing for submission.

10 Sykdommen og eksisterende behandling

10.1 Sykdomsbeskrivelse for aktuell indikasjon *Kort beskrivelse av sykdommens patofysiologi og klinisk presentasjon / symptombilde, eventuelt inkl. referanser*	C3G is a pathologic description that defines a group of rare renal diseases characterized by complement dysregulation. The disease is often caused by immunological and/or genetic factors, although in a significant number of patients, current tests are unable to identify disease drivers (5). C3G is caused by overactivation of the complement alternative pathway of the immune system, which leads to the deposition of C3 and its cleavage products within the glomeruli of the kidneys (1). The continued and unchecked complement activity characteristic of C3 glomerulopathy incites glomerular inflammation and subsequent scarring, which leads to chronic and irreversible kidney damage (1). While the natural history of C3G is not well defined, hematuria, proteinuria, and nephrotic syndrome are the most common signs and symptoms (1,5). Individuals with nephrotic syndrome experience a high symptom burden and are at risk of complications such as infection, hyperlipidemia, hypercoagulability, respiratory distress, sepsis and thromboembolism (8). About one-third of adults present with acute kidney failure (1,5)
10.2 Fagområde *Angi hvilket fagområde som best beskriver metoden*	Velg fagområde fra menyen: Sykdommer i nyrer, urinveier og kjønnsorganer
10.3 Kreftområde *Hvis metoden gjelder fagområdet Kreftsykdommer, angi hvilket kreftområde som er aktuelt*	Velg kreftområde fra menyen: Velg et element.

10.4 Dagens behandling *Nåværende standardbehandling i Norge, inkl. referanse*	There are currently no disease-modifying treatments approved in C3G. Due to lack of evidence, an optimal treatment for C3G patients has not been established internationally nor in Norway; however, there are international guideline recommendations to support renal preservation, most recently those published by the KDIGO Glomerular Diseases Work Group (KDIGO), which reflect expert opinion and the collective experience derived from a number of clinical case series (6). These recommendations are followed in Norway. The treatments either act to protect the kidneys and reduce blood pressure (e.g., ACE- and ARB-inhibitors), or to reduce the immune system activation driving the disease (e.g., MMF and corticosteroids/prednisolone). (6)
10.5 Prognose *Beskriv prognosen med nåværende behandlingstilbud, inkl. referanse*	As progression through CKD stages is usually irreversible, the treatment goal in C3G is to slow disease progression, preserving kidney function for longer (1,6). There are currently no disease-modifying treatments for C3G; available treatments either act to protect the kidneys and reduce blood pressure (e.g., ACE- and ARB-inhibitors), or to reduce the immune system activation driving the disease (e.g., MMF and corticosteroids/prednisolone) (6). With these therapies, as the underlying cause of disease has not been addressed, ~50% of people will progress to kidney failure within 10-years (1). If transplantation is offered, histologic disease recurrence is the rule (90%) with allograft loss occurring in about half of the cases (1,5). Consequently, there is a need for targeted treatments which can reduce the risk of disease progression.
10.6 Det nye legemiddelets innplassering i behandlingsalgoritmen	There are no disease modifying treatments available. Novartis expect Fabhalta to be used in patients who do not respond, or are intolerante, to current SoC, ie after RASi and before/after MMF+CS.

10.7 Pasientgrunnlag *Beskrivelse, insidens og prevalens av pasienter omfattet av aktuell indikasjon* i Norge, inkl. referanse.* *Antall norske pasienter antatt aktuelle for behandling med legemiddelet til denne indikasjonen.* ** Hele pasientgruppen som omfattes av aktuell indikasjon skal beskrives*	There is very limited knowledge about the Norwegian C3G-population. The extreme rarity of C3G hampers the collection of precise epidemiological data, and since the sole diagnostic criterion requires interpretation of a renal biopsy sample, incidence and prevalence estimates are affected by regional and national biopsy and referral practices. Despite having a Norwegian Renal & Biopsy Registry since late 80'ties, there's not been any disease specific, -clinical nor -pathology, C3G-coding implemented. ICD-10 codes have been available since October 2023 (7). In a study from the Norwegian Renal Biopsy Registry (NKBR), 158 patients with biopsy verified membranoproliferative glomerulonephritis (MPGN) were identified during the period of 1991-2012. This population included both C3G and Immune-Complex MPGN (3). A recent Finnish study from the Helsinki University Hospital district looking at patients diagnosed between 2006 and 2017, found a 40-60% split of C3G vs IC-MPGN (4). Consequently, based on ~63 C3G patients diagnosed during a period of 11 years in NKBR, we estimate a Norwegian prevalence of ~1 case/million/year. There's uncertainty in how many of these patients will be eligible for treatment.

11 Studiekarakteristika for relevante kliniske studier

	Studie 1	Studie 2	Studie 3
11.1 Studie-ID *Studienavn, NCT-nummer, hyperlenke*	APPEAR-C3G NCT04817618 Study Details | Study of Efficacy and Safety of Iptacopan in Patients With C3 Glomerulopathy. | ClinicalTrials.gov	Phase 2 NCT03832114 Study Details | Study on Efficacy and Safety of LNP023 in C3 Glomerulopathy Patients Transplanted and Not Transplanted | ClinicalTrials.gov	Extension trial NCT03955445 Study Details | Long-term Efficacy, Safety and Tolerability of Iptacopan in C3G or IC-MPGN | ClinicalTrials.gov
11.2 Studietype og -design	Phase 3, pivotal, multicentre, randomised, placebo-controlled trial, comprising a 6-months double-blinded and 6-month open-label period	Open-label, two cohort non-randomized trial	Open-label, non-randomized, extension trial

11.3 Formål	The study is designed to evaluate the efficacy and safety of iptacopan 200 mg b.i.d vs placebo, in addition to standard of care, in patients with C3G disease	The study is designed to evaluate the efficacy, safety, and pharmacokinetics of iptacopan in patients with C3G (Cohort A) and patients who have undergone kidney transplant and have C3G recurrence (Cohort B)	The study is designed to evaluate the long-term efficacy, safety and tolerability of iptacopan in subjects with C3 glomerulopathy or idiopathic immune-complex-membranoproliferative glomerulonephritis
11.4 Populasjon *Viktige inklusjons- og eksklusjonskriterier*	Adult (≥18 years) patients with biopsy-confirmed C3G disease and reduced serum C3 levels Key inclusion critera - Adult patients, 18–60 years of age - Biopsy-confirmed C3G within 12 months prior to enrollment - UPCR ≥1.0 g/g eGFR (CKD-EPI) ≥30 mL/min/1.73 m2 - Serum C3 <77 mg/dL - Stable, maximally recommended or tolerated dose of ACEi/ARB and of other antiproteinuric medications MMF and corticosteroids (prednisolone ≤7.5mg/day or equivalent) were allowed Key exclusion criteria: - Solid organ or cell transplant - Rapidly progressive crescentic glomerulonephritis - Renal biopsy showing interstitial	Inclusion Criteria for Cohort A and B: - Male and female patients between the ages of 18 to 65 (inclusive) at screening - C3G patients with proteinuria Inclusion criteria Cohort A: - Estimated GFR (using the CKD-EPI formula) or measured GFR ≥30 mL/min per 1.73 m2 for patients on a maximum recommended or maximum tolerated dose of an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) - UPCR ≥ 100 mg/mmol (equivalent to ≥ 1 g/24h total urinary protein excretion)	Inclusion Criteria: - Patients must have completed the treatment period of the CLNP023X2202, CLNP023B12301 or CLNP023B12302 study on study drug Exclusion Criteria: - Severe concurrent co-morbidities, e.g. advanced cardiac disease (NYHA class IV), severe pulmonary arterial hypertension (WHO class IV), or any illness or medical condition that in the opinion of the investigator and sponsor is likely to prevent the patient from safely tolerating LNP023 or complying with the requirements of the study - Participants with an active systemic

	fibrosis/tubular atrophy of more than 50% - Post-infectious glomerulonephritis - Monoclonal gammopathy - Active systemic bacterial, viral or fungal infection or the presence of fever - A history of recurrent invasive infections caused by encapsulated organisms - Use of complement inhibitors within 6 months prior to screening - Use of immunosuppressants (except MMF, cyclophosphamide or systemic corticosteroids (prednisolone >7.5 mg/day or equivalent)) within 90 days of randomization	Inclusion criteria Cohort B: - No historical/ Laboratory/ clinical signs of allorejection - If applicable, induction treatment after allotransplatation needs to be completed >30 days before inclusion - Transplantation of kidney allograft >90 days before inclusion Exclusion criteria cohort A and B: - Use of other investigational drugs at the time of enrollment, or within 5 half-lives of randomization, or within 30 days, whichever is longer; or longer if required by local regulations - A history of clinically significant ECG abnormalities, - History of immunodeficiency diseases, or a positive HIV test result. - Chronic infection with Hepatitis B (HBV) or Hepatitis C (HCV).	bacterial, viral or fungal infection within 14 days prior to screening - History or current diagnosis of ECG abnormalities - History of HIV or any other immunodeficiency disease Other protocol-defined inclusion/exclusion criteria may apply
11.5 Intervensjon (n) *Dosering, doseringsintervall, behandlingsvarighet*	Iptacopan 200 mg twice a day (in combination with background medication)	Increasing doses of iptacopan up to 200mg	Iptacopan 200 mg twice a day

11.6 Komparator (n) *Dosering, doseringsintervall, behandlingsvarighet*	Placebo (in combination with background medication)	No comparator	No comparator
11.7 Endepunkter *Primære, sekundære og eksplorative endepunkter, herunder definisjon, målemetode og ev. tidspunkt for måling*	Primary objective at 6 months (double blind period): Reduction of proteinuria (UPCR 24h). Primary objective at 12 month (open label period): effect on UPCR. Key secondary objectives at 6 months (double blind period): improvements in eGFR, the proportion of participants who achieve a composite renal endpoint (≥50% reduction UPCR + ≤15% reduction in eGFR), reducing glomerular inflammation in the kidney (total activity score), improvement of patient-reported fatigue (total FACIT-Fatigue score), evaluate the safety and tolerability of iptacopan vs. placebo. Secondary endpoints at 12 months (open label period): The effect on composite renal endpoint, safety and tolerability.	Primary endpoints: - Cohort A: Change from baseline in UPCR at 12 weeks - Cohort B: Change from baseline in C3 deposit Secondary enpoints: Change from baseline in UPCR, change from baseline in urine protein excretion, change from baseline in UACR excretion, change from baseline change in urinary albumin excretion,change from baseline in eGFR, change from baseline in creatine clearence, number of patients with hematuria, change from baseline in UPCR first morning void, pharmacokinetics of LNP023 area under the plasma-concetraton-time curve AUCtau, observed maximum concentration after drug administration, observed minimum concentration after drug administration, time to reach the max plasma concentration, summary of change from baseline	Primary endpoints: - Cohort A-native C3G: Number of participants who achieve the composite renal endpoint - Cohort B - kidney transplant and recurrent C3G: Change from baseline in the C3 Deposit Score - Number of AEs of special interest for participants from CLNP023X2202, CLNP023B12301 and CLNP023B12302 - Number of participants with study drug discontinuation due to an AE (or any safety issue) for participants from CLNP023X2202, CLNP023B12301 and CLNP023B12302 - Number of participants with abnormal clinically

		complement C3 biomarker in serum, ratio to baseline summary of plasma Bp	significant vital signs,ECGs, and safety laboratory measurements for participants from CLNP023X2202, CLNP023B12301 and CLNP023B12302 Secondary endpoints: CLNP023X2202: Number of participants who achieve the 2-component composite renal endpoint, CLNP023X2202: Change from baseline in log-transformed urine protein/creatinine ratio (UPCR), CLNP023X2202: Change from baseline in log-transformed urine albumin/creatinine ratio (UACR), CLNP023X2202: Change from baseline in serum creatinine concentration, CLNP023X2202: Change from baseline in estimated glomerular filtration rate (eGFR), CLNP023X2202: Status of C3G disease progression, CLNP023X2202: Log-transformed ratio to baseline in serum C3, CLNP023X2202: Number of participants who achieve the composite renal endpoint, CLNP023X2202: Plasma LNP023 concentration up to 12 months at trough, CLNP023B12301 and CLNP023B12302: Change from initiation of iptacopan treatment in the core study in log-transformed UPCR over time, CLNP023B12301

			and CLNP023B12302: Change from initiation of iptacopan treatment in the core study in eGFR over time, CLNP023B12301 and CLNP023B12302: Number of participants who achieve a 2-component composite renal endpoint
11.8 Relevante subgruppeanalyser *Beskrivelse av ev. subgruppeanalyser*	Klikk eller trykk her for å skrive inn tekst.	Klikk eller trykk her for å skrive inn tekst.	Klikk eller trykk her for å skrive inn tekst.
11.9 Oppfølgingstid *Hvis pågående studie, angi oppfølgingstid for data som forventes å være tilgjengelige for vurderingen hos Direktoratet for medisinske produkter samt den forventede/planlagte samlede oppfølgingstid for studien*	6 month double blind period & 6 month open label period (in total 12 months).	12 weeks (84 days)	9 months (beyond initial study period). The study is expected to continue until the drug product becomes commercially available and accessible (anticipated to be up to approximately 168 months from the first patient first visit date), or the benefit-risk profile is no longer positive, or the program is discontinued for business or strategic reasons.
11.10 Tidsperspektiv resultater *Pågående eller avsluttet studie? Tilgjengelige og fremtidige datakutt*	Ongoing. Estimated study completion: January 2026.	Completed 23.04.2021	Estimated: 30.05.2036
11.11 Publikasjoner	Alternative Complement Pathway Inhibition With Iptacopan for the Treatment	Efficacy and Safety of Iptacopan in Patients With C3 Glomerulopathy - PMC	WCN25-1242 UPDATE TO THE LONG-TERM SAFETY AND EFFICACY OF

Tittel, forfatter, tidsskrift og årstall. Ev. forventet tidspunkt for publikasjon	of C3 Glomerulopathy-Study Design of the APPEAR-C3G Trial		IPTACOPAN IN C3G: 33-MONTH EXTENSION STUDY DATA FROM PATIENTS ENROLLED IN A PHASE 2 STUDY - ScienceDirect Iptacopan Reduces Proteinuria and Stabilizes Kidney Function in C3 Glomerulopathy

12 Igangsatte og planlagte studier

12.1 Er det pågående eller planlagte studier for legemiddelet innenfor samme indikasjon som kan gi ytterligere informasjon i fremtiden? *Hvis ja, oppgi forventet tidspunkt*	Ja ☒ Nei ☐ In the APPEAR-C3G study, a separate and independent cohort of adolescent participants (aged 12-17 years) with C3G was initiated later and is still enrolling. Estimated study completion: January 2026. An extension study (NCT03955445) with open label treatment of Iptacopan is ongoing. The study includes patients with C3 glomerulopathy from the phase 2 and 3 studies, as well as patients from the trial program for Iptacopan in patients with idiopathic Immune-complex-membranoproliferative glomerulonephritis. Estimated study completion: March 2033.
12.2 Er det pågående eller planlagte studier for legemiddelet for andre indikasjoner?	Ja ☒ Nei ☐ IgAN: Phase 2, NCT06797518: Study Details | Study to Evaluate the Impact of Iptacopan on Top of SOC on Biopsy Changes in Kidneys of Adult Patients With IgAN | ClinicalTrials.gov Phase 3, NCT040578834 (APPLAUSE-IgAN): Study Details | Study of Efficacy and Safety of LNP023 in Primary IgA Nephropathy Patients | ClinicalTrials.gov Phase 3, NCT04557462: Study Details | A Rollover Extension Program (REP) to Evaluate the Long-term Safety and Tolerability of Open Label Iptacopan/LNP023 in Participants With Primary IgA Nephropathy | ClinicalTrials.gov

	IC-MPGN: Phase 3 (APPARENT), NCT05755386: Study Details | Study of Efficacy and Safety of Iptacopan in Participants With IC-MPGN | ClinicalTrials.gov aHUS: Phase 3, NCT04889430 (APPELHUS): Study Details | Efficacy and Safety of Iptacopan (LNP023) in Adult Patients With Atypical Hemolytic Uremic Syndrome Naive to Complement Inhibitor Therapy | ClinicalTrials.gov Phase 3, NCT05935215: Study Details | Efficacy and Safety of Switching From Anti-C5 Antibody Treatment to Iptacopan Treatment in Study Participants With Atypical Hemolytic Uremic Syndrome (aHUS) | ClinicalTrials.gov Phase 3, NCT05795140: Study Details | Evaluate Long-term Safety, Tolerability and Efficacy of Iptacopan in Study Participants With aHUS | ClinicalTrials.gov AAV: Phase 2, NCT0638841:Study Details | Iptacopan in Patients With ANCA Associated Vasculitis | ClinicalTrials.gov LN: Phase 2, NCT05268289: Study Details | Study of Efficacy and Safety of LNP023 in Participants With Active Lupus Nephritis Class III-IV, +/- V | ClinicalTrials.gov AMD: Phase 2, NCT05230537: Study Details | A Masked, Placebo-controlled Study to Assess Iptacopan in Age-related Macular Degeneration | ClinicalTrials.gov gMG: Phase 3, NCT06517758: Study Details | A Phase III Study to Investigate Efficacy, Safety and Tolerability of Iptacopan Compared With Placebo in Participants Aged 18 to 75 Years With gMG. | ClinicalTrials.gov

13 Diagnostikk	
13.1 Vil bruk av legemiddelet til anmodet indikasjon kreve diagnostisk test for analyse av biomarkør?	Ja ☒ Nei ☐

Hvis ja, fyll ut de neste spørsmålene	
13.2 Er testen etablert i klinisk praksis? *Hvis ja, testes pasientene rutinemessig i dag?*	Ja ☒ Nei ☐ Hvis ja, testes pasientene rutinemessig i dag? Ja ☒ Nei ☐
13.3 Hvis det er behov for en test som ikke er etablert i klinisk praksis, beskriv behovet inkludert antatte kostnader/ressursbruk	The differential diagnosis for glomerulonephritis (GN) is broad and if symptoms (hematuria, proteinuria and/or edema) persist and C3 levels remain low for more than 3 months, a renal biopsy is warranted (5). The evaluation for complement dysregulation should include serum levels of complement proteins and their cleavage products as well as functional assays of Alternative Pathway (AP) and Classical Pathway (CP) integrity and activity. To identify possible drivers of dysregulation, patients could be screened for nephritic factors, autoantibodies, and genetic variants that can lead to dysregulation of the AP (5). However, the tests are not new within the field of GN. It is not expected that testing will change if Fabhalta is implemented in clinical practice.

14 Andre relevante opplysninger

14.1 Har dere vært i kontakt med fagpersoner (for eksempel klinikere) ved norske helseforetak om dette legemiddelet/indikasjonen? *Hvis ja, hvem har dere vært i kontakt med og hva har de bidratt med?* *(Relevant informasjon i forbindelse med rekruttering av fageksperter i Nye metoder)*	Ja ☐ Nei ☒ Klikk eller trykk her for å skrive inn tekst.
14.2 Anser leverandør at det kan være spesielle forhold ved dette legemiddelet som gjør at en innkjøpsavtale ikke kan basere seg på flat rabatt for	Ja ☒ Nei ☐ Klikk eller trykk her for å skrive inn tekst.

at legemiddelet skal kunne oppfylle prioriteringskriteriene? *Hvis ja, begrunn kort.* *Hvis ja, skal eget skjema fylles ut og sendes til Sykehusinnkjøp HF samtidig med at dokumentasjon til metodevurdering sendes til Direktoratet for medisinske produkter.* *Nærmere informasjon og skjema:* Informasjon og opplæring - Sykehusinnkjøp HF	
14.3 Andre relevante opplysninger?	References used in this document: 1. Smith RJH et al. C3 glomerulopathy - understanding a rare complement-driven renal disease. Nat Rev Nephrol. 2019 Mar;15(3):129-143. 2. Schena FP, Esposito P, Rossini M. A Narrative Review on C3 Glomerulopathy: A Rare Renal Disease. Int J Mol Sci. 2020;21(2) 3. Bjoerneklett R, Bostad LS, Knoop T, Bostad LH. Long-Term Risk and Risk Factors for ESKD in Membranoproliferative Glomerulonephritis: SA-PO811. Journal of the American Society of Nephrology. 2024;35(10S):10.1681/ASN.2024kw17k12d. 4. Kovala M, Seppala M, Raisanen-Sokolowski A, Meri S, Honkanen E, Kaartinen K. Diagnostic and Prognostic Comparison of Immune-Complex-Mediated Membranoproliferative Glomerulonephritis and C3 Glomerulopathy. Cells. 2023;12(5). 5. Heiderscheit, A. K., et al. (2022). "C3 glomerulopathy: Understanding an ultra-rare complement-mediated renal disease." Am J Med Genet C Semin Med Genet **190**(3): 344-357. 6. Rovin BH, Adler SG, Barratt J, Bridoux F, Burdge KA, Chan TM, et al. Executive summary of the KDIGO 2021 Guideline for the Management of Glomerular Diseases. Kidney Int. 2021;100(4):753-79. 7. https://icd10cmtool.cdc.gov/?fy=FY2023&query=c3%20glomerulopathy 8. Tapia C, Bashir K. Nephrotic Syndrome. StatPearls. Treasure Island (FL)2025.

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