Nye metoder - Request for assessment of medicinal product

To request an assessment of a new medicinal product or a new indication for an existing medicinal product through Nye metoder, health technology developers should complete this form. By submitting a request for assessment, the developer signals that it plans to submit documentation for such an assessment.

Please send the completed form to Nye metoder by e-mail: nyemetoder@helse-sorost.no.

A request for assessment may not be submitted prior to day 120 of the European Medicines Agency (EMA) marketing authorisation assessment process for new medicinal products under regular approval procedure, or prior to day 1 for variation/extension assessments and for medicinal products under accelerated assessment.

This form must be completed in its entirety. Nye metoder will plan the assessment process based on the information provided in the request form.

At the time of request for assessment, the health technology developer must have a plan for when it intends to submit documentation for assessment.

Information about Nye metoder can be found online (nyemetoder.no). Please contact Sekretariatet for Nye metoder if you have any questions.

Please note: The form will be published in its entirety.

The submitter is aware that the form will be published in its entirety (**tick**): ☑

1 Contact information	
Date	28.3.2024
Health technology developer	Swedish Orphan Biovitrum AB
Name	Judith Thanner
Position	Associate Director Patient Access
Telephone	+46 76 001 17 42
E-mail	judith.thanner@sobi.com
External representation Name/Organization Phone/E-mail *PLEASE NOTE: For external representation, please attach an authorisation/power of attorney*	N/A

2 Medicinal product overview

Does the request concern a new active substance?	Yes
Trade name	TBA
Generic name	Efanesoctocog alfa
Marketing authorisation in Norway	Sobi
ATC code	B02BD02
Mode of administration	Intravenous infusion
Pharmacotherapeutic group and mechanism of action *Briefly describe*	Pharmacotherapeutic group: Antihemorrhagics Mechanism of action: Clotting factor 8 (FVIII) interacts with von Willebrand factor (VWF) and platelets to generate a normal haemostatic response. VWF acts as a chaperone for FVIII and, under normal conditions, >95% of FVIII circulating in plasma is bound to VWF in a high-affinity non-covalent association, and during clotting, thrombin cleavage releases activated FVIII from VWF. However, the FVIII-VWF interaction imposes a biological limit on the half-life of FVIII replacement products, as the complex is subject to the VWF clearance pathway with a half-life of about 16 hours (VWF half-life ceiling) (Hermans and Pierce 2023, Malec and Matino 2023). Efanesoctocog alfa has a half-life of about 47 hours (observed in Phase 3 XTEND-1 study in patients with haemophilia A [PwHA] aged ≥12 years [NCT04161495]) and overcomes the VWF-imposed half-life ceiling via three mechanisms (von Drygalski et al. 2023): - Fc domain facilitates recycling through the neonatal Fc receptor pathway - Covalent linkage to a VWF D ' D3 FVIII binding domain decouples recombinant FVIII from endogenous VWF - Two XTEN polypeptides shield efanesoctocog alfa from proteolytic degradation and clearance Efanesoctocog alfa thus belong to a new generation of clotting factors with a greatly improved half-life, enabling longer dosing intervals and higher factor trough levels than extended half-life (EHL) products currently on the market. This enables the achievement of normal coagulation and efanesoctocog alfa will thus prevent long term joint damage.
Expected indication relevant to the request *Expected indication must be written in Norwegian*	Behandling og profylakse av blødning hos pasienter med hemofili A (medfødt faktor VIII-mangel). Kan brukes i alle aldersgrupper.

3 Assessment history

Has the medicinal product previously been assessed by Nye metoder for other indications? *If yes, enter the Nye metoder ID number*	No
Are you aware of other medicinal products assessed by Nye metoder for the same indication? *If yes, enter the Nye metoder ID number*	Emicizumab (Hemlibra) - ID2018_066, Indication: Rutineprofylakse ved hemofili A uten antistoff mot faktor VIII In addition, Emicizumab is assessed for the following indications: - ID2017_104, Indication: Behandling av pasienter med hemofili A med utviklet inhibitorer (antistoffer) - ID2023_083, Indication: Rutineprofylakse ved alvorlig hemofili A uten antistoff mot faktor VIII der behandling med FVIII er vurdert som uegnet eller der effekt av behandling med FVII er utilstrekkelig - ID2022_006, Indication: Rutineprofylakse ved mild til moderat hemofili A uten antistoff mot faktor VIII - ID2021_023, Indication: Rutineprofylakse ved alvorlig hemofili A uten antistoff mot faktor VIII Efmoroctocog alfa (Elocta): - ID2015_058, Indication: Behandling av hemofili A Damoctocog alfa pegol (Jivi): - ID2018_020, Indication: Behandling av hemofili A Turoktokog alfa pegol (Esperoct): - ID2018_098. Indication: Behandling og profylakse hos pasienter med hemofili A som er tolv år og eldre Rurioctocog alfa pegol (Adynovate): - ID2016_090, Indication: Behandling av hemofili A

4 Expected timeline

Procedure number for the marketing authorisation assessment in EMA	EMEA/H/C/005968
Expected date (month/year) of CHMP positive opinion	April 2024
Expected date (month/year) of marketing authorisation in Norway	End of July/August 2024 (+30 days from Commission`s decision)
Expected date (quarter/year) for submission of documentation to Norwegian Medicines Agency *Dates must be stated*	July 2024

5 Diagnostics and resource use

Fill inn where relevant

Will the new method require diagnostic testing for biomarker analysis?	No additional testing needed. The disease is typically diagnosed at early age.
Which biomarker(s) are relevant and which publications describe this? *Please refer to publications*	Testing for clotting factor levels is needed to diagnose haemophilia A and to determine the residual plasma concentration of FVIII. FVIII concentration is expressed in IU, where 1 IU is the concentration of FVIII in 1 mL of pooled plasma, or percentages of normal pooled plasma with normal levels ranging between 50 – 150%. Healthy individuals have a plasma FVIII of 0.5 to 1.5 IU/mL. People with moderate haemophilia A have FVIII of 0.01 to 0.05 IU/mL (1% to 5% of normal), and those with severe disease have no measurable FVIII (<0.01 IU/mL / <1%). Haemorrhage frequency and severity correlates with FVIII levels (Srivastava et al. 2020). Laboratory assays for suspected haemophilia include: - Complete blood cell count - Screening coagulation tests such as prothrombin time (PT), and activated partial thromboplastin time (aPTT) - FVIII assay (clot based or chromogenic) - FVIII inhibitor assay (Bethesda assay, Nijmegen modified Bethesda assay)
Do you know whether diagnostics can be performed by the public health service or whether it must be performed by an external supplier?	Hemophilia care is best provided through designated diagnostic and treatment centres with clearly defined treatment protocols, standards of care, and quality and audit activities (Srivastava et al. 2020).
Will introduction of the new method require establishment of other/new infrastructure? *For example, custom analysis machine, digital pathology/ AI-based analysis, proteomics, functional tests etc.?*	No, the disease is already diagnosed and there is already infrastructure in place.
Pre-analytical requirements *For example, biopsies, other sampling, sample processing etc. are required.*	For plasma-based coagulation assays the recommendation is: - Direct venipuncture: Ensure atraumatic phlebotomy and minimal tourniquet. - Collection tube and order of draw: 3.2% (109 mmol/L sodium citrate, light blue stopper) first, or only after a non-additive tube. - Fill tube correctly to the mark (line), proportion blood to citrate 9:1. - Gently and thoroughly mix blood with anticoagulant (invert tube immediately 5-10 times). - Transport the whole-blood tube capped promptly at room temperature (RT). - Centrifuge within 1 hour after phlebotomy at minimum 1500 g, 15 min, RT, to obtain platelet poor plasma (PPP). - If analysis cannot be performed within four hours, the plasma should be transferred to another tube and frozen at -70C for later analysis (Nordic Hemophilia Council 2022).

Test execution: is there a need to establish one specific test or is a biomarker already established in the health service (e.g. in gene panels)?	Not necessary
Description of reading of results including data analysis program if necessary.	Not necessary
Which patient groups need to be tested, and what is the expected proportion of findings that provide treatment options?	Severe haemophilia A often manifests in the first months of life, whereas mild or moderate disease usually presents later in childhood or adolescence, often incidentally or following trauma (Srivastava et al. 2020). In two-thirds of cases, confirmation of the haemophilia diagnosis occurs shortly after the delivery of an affected son to a mother who carries the susceptible gene. However, the diagnosis of disease caused by de novo mutations is usually made after the start of bleeding symptoms. Among women and girls who often have complex genetic causes for their haemophilia phenotype, many are not tested for haemophilia before puberty and heavy menstrual bleeding is often the first symptom to manifest.

6 Description of the disease and current treatments

Description of the disease *<u>Brief</u> description of the pathophysiology and clinical presentation/symptoms, possibly including references*	Haemophilia A is an inherited bleeding disorder associated with the partial or total deficiency of clotting factor VIII (FVIII). Haemophilia A is caused by mutations of the FVIII gene in the X chromosome, meaning that males are affected while female carriers are typically asymptomatic (De Caterina et al. 2013). In normal haemostasis, coagulation is activated when a blood vessel is damaged resulting in the formation of a stable platelet and fibrin clot at the site of injury (De Caterina et al. 2013). In PwHA, there is a deficiency in the plasma glycoprotein FVIII, resulting in a failure to generate adequate thrombin for stable clot formation (Bolton-Maggs and Pasi 2003). This disruption of normal coagulation results in spontaneous bleeding, or severe or excessive bleeding in response to trauma or surgery (Srivastava et al. 2013). Haemorrhage frequency and severity correlates with FVIII levels (Srivastava et al. 2020). There are three degrees of severity in haemophilia. Whereas normal levels of FVIII are between 0.4 and 1.5 IU/mL (40 – 150%), patients with mild, moderate, and severe haemophilia have FVIII levels of 0.05 – 0.4 IU/mL (5 – 40%), 0.01-0.05 IU/mL (1 – 5%) and <0.01 IU/mL (<1%) respectively (World Federation of Hemophilia 2022).
Therapeutic area *Specify which field best describes the method*	Anestesi, smertebehandling og intensivmedisin **Blodsykdommer** Endokrine sykdommer Gynekologiske sykdommer og fødsel Hjerte- og karsykdommer
Cancer *If the method applies to the medical field of cancer, specify which type of cancer is relevant*	*** Ingen Kreftsykdom** Bein- og bløtvevskreft Blod- beinmargs- og lymfekreft Brystkreft Mage- og tarmkreft
Current treatment *Current standard treatment in Norway, including references*	FVIII concentrates are the standard of care replacement therapy for haemophilia A internationally as well as in Norway (Nordic Hemophilia Council 2022, Srivastava et al. 2020). Standard half-life (SHL) FVIII concentrates have half-lives of 10 – 14 hours, meaning that prophylaxis typically requires infusions every other day. Currently licensed EHL FVIII products show a 1.4- to 1.6-fold improvement in half-life compared with SHL FVIIIs, typically requiring infusions every 3-5 days or longer (Marchesini et al. 2021). SHL and EHL are first line choices in prophylactic treatment in Norway, with ranking according to tender outcomes (Sykehusinnkjøp 2023). In the past, the aim of prophylactic treatment of haemophilia A has been to convert a person with severe haemophilia (baseline FVIII level <1 IU/dL [1%]) to a bleeding phenotype typical of moderate or mild haemophilia by maintaining factor trough levels above 1 IU/dL (1%). However, factor trough levels of 1 – 3 IU/dL (1% – 3%) are insufficient to totally prevent bleeds in all people, and this regimen is ineffective in preventing joint damage in the long run. Low factor trough levels allow occasional clinical and subclinical bleeds, resulting in gradual progression of joint disease over a lifespan. The higher the factor trough levels, the less the bleeding, and most clinicians prefer to target higher trough levels (>3%-5%, or higher) (Srivastava et al. 2020, Skinner et al. 2020, Malec and Matino 2023). However, trough levels are limited by the short half-life of currently available FVIII concentrates, and higher trough levels may therefore require higher doses or more frequent infusions of factor concentrates.

Prognosis *Describe the prognosis with current treatment options, including references*	Life expectancy Over the past fifty years, developments in the treatment of bleeding disorders brought the life expectancy in people with haemophilia A and without HIV and/or viral hepatitis near to that of the general population. However, despite improved life expectancy, haemophilia is a life-threatening condition, representing a substantial burden to health (Hay et al. 2021). In a Swedish registry study, the hazard ratio for all-cause mortality was 2.2 (95% CI: 1.8, 2.7) in the total population of PwHA or PwHB, and in the severe haemophilia subgroup 8.2 (95% CI: 3.2, 20.8) when patients with HIV and/or viral hepatitis were excluded (Lovdahl et al. 2013). Intracranial haemorrhage (ICH) is a severe and life-threatening complication in PwHA. The occurrence of ICH in haemophilia was estimated at 0.23% and 0.74% per year for lifetime populations in children and young adults, respectively (Zwagemaker et al. 2021). Haemorrhage is the cause of death in approximately 20% of PwHA, and ICH accounts for approximately 70% of haemorrhage related deaths in PwHA (Hay et al. 2021). Joint bleeds and damage Bleeding frequency and location vary according to age, with the knees and elbows most commonly affected in PwHA aged >30 years, whereas adolescents and young adults usually present with bleeding affecting the ankles (Srivastava et al. 2020). In people with severe disease, 90% of bleeding episodes involve the musculoskeletal system, primarily involving spontaneous joint bleeds (haemarthroses) that occur without any clearly identified cause and usually affecting one joint at a time (Rodriguez-Merchan 2010). Pain onset and local discomfort are the most common signs that bleeding has started (acute joint bleeds), and symptoms usually resolve with FVIII replacement treatment and rehabilitation (Srivastava et al. 2020). However, joint bleedings result in iron deposition leading to chronic synovitis and cartilage damage, which in turn increases the risk of new bleedings (Knobe and Berntorp 2011). A single joint bleed can
The new medicinal product's placement in the treatment algorithm	Efanesoctocog alfa is a once-weekly FVIII replacement therapy, which achieves non-haemophilia activity levels (>40%) for a significant part of the week, with a mean of 15% after 7 days. The first-in-class recombinant FVIII concentrate transforms the treatment paradigm for PwHA, with advantages over current FVIII replacement therapies (von Drygalski et al. 2023). The mean efanesoctocog alfa half-life was up to 4 times longer than that of recombinant FVIII concentrates and mean area under the activity-time curve (AUC) was up to 7 times higher after IV administration of a single dose of either treatment in the single-dose phase I/IIa EXTEN-A study (NCT03205163) in previously treated patients with severe haemophilia A (Konkle et al. 2020). Efanesoctocog alfa is expected to be an important treatment alternative for patients with haemophilia A, who are in need of higher factor levels.
Patient population *Description, incidence and prevalence of the patient population covered by the relevant indication* in Norway, including references.* *Number of Norwegian patients assumed to be relevant for new method* ** The entire patient group covered by the indication in question is to be described*	According to the SLV Esperoct assessment, there were 337 registered patients with haemophilia A in Norway. Of these, 173 had severe haemophilia A. It is further estimated that around 2-3 new patients are diagnosed annually (the number accumulates as a result of lifelong treatment) (Statens legemiddelverk 2020).

7 Comparability to other medicinal products and inclusion in tender

Are there existing procurements or tenders in the therapeutic area?	Factor VIII tender 2212, 01.12.22-31.08.2025
Are there other medicinal products with a similar mechanism of action and/or similar effect (for the same indication)?	The medical products presented below are EHL FVIII products. Although the basic mechanism of action is the same as efanesoctocog alfa, the latter overcomes the VWF-imposed half-life ceiling and thus have the potential to normalize haemostasis. In the XTEND-1 trial we have seen that once-weekly efanesoctocog alfa provides superior bleed protection compared with prior standard of care FVIII prophylaxis, and that patients experienced clinically meaningful improvements in joint health, physical health and pain (ClinicalTrials.gov 2023b, von Drygalski et al. 2023). As to the indication, of the EHLs described below, only Elocta can be used for all ages, whereas other EHLs are pegylated and can only be used from 12 years and older. - Efmoroctocog alfa (Elocta) - Damoctocog alfa pegol (Jivi) - Turoktokog alfa pegol (Esperoct) - Rurioctocog alfa pegol (Adynovi)
Does the supplier consider the medicinal product to be comparable to other medicinal products?	No, FVIII concentrates are the standard of care replacement therapy for haemophilia A internationally as well as in Norway (Nordic Hemophilia Council 2022, Srivastava et al. 2020). Efanesoctocog alfa offers advantages over the EHLs in terms of a dramatically increased half-life – up to four times that associated with FVIII products – signalling a new class of factor VIII replacement therapy (Konkle et al. 2020). Efanesoctocog alfa is a once-weekly FVIII replacement therapy, which achieves non-haemophilia activity levels (>40%) for a significant part of the week, with a mean trough level of 15% after 7 days. The first-in-class recombinant FVIII concentrate transforms the treatment paradigm for PwHA, with advantages over current FVIII replacement therapies (von Drygalski et al. 2023).

8 Relevant clinical trials
(pivotal trial(s) and clinical studies relevant for establishing relative efficacy)

	Study 1	Study 2	Study 3
Study ID *Study name, NCT number, hyperlink*	XTEND-1, NCT04161495, A Phase 3 Open-label Interventional Study of Intravenous Recombinant Coagulation Factor VIII Fc-von Willebrand Factor-XTEN Fusion Protein, Efanesoctocog Alfa (BIVV001), in Patients With Severe Hemophilia A https://clinicaltrials.gov/study/NCT04161495	XTEND kids, NCT04759131, Safety, Efficacy and PK of BIVV001 in Pediatric Patients With Hemophilia A https://clinicaltrials.gov/study/NCT04759131 (ClinicalTrials.gov 2023c)	XTEND-ed, NCT04644575, Long-term Safety and Efficacy of Efanesoctocog Alfa (BIVV001) in Previously Treated Patients With Hemophilia A https://clinicaltrials.gov/study/NCT04644575 (ClinicalTrials.gov 2023a)
Study type and design	Eligible participants (12 years and older) received efanesoctocog alfa 50 IU/kg once-weekly as a prophylaxis regimen for up to 52 weeks (Arm A), or received efanesoctocog alfa 50 IU/kg as an on-demand regimen for bleeding episodes for 26 weeks, and then efanesoctocog alfa 50 IU/kg once-weekly prophylaxis for another 26 weeks (Arm B). Bleeding episodes were treated with a single dose of efanesoctocog alfa 50 IU/kg, and if the bleeding episode did not resolve, additional doses of efanesoctocog alfa 30 or 50 IU/kg could be administered every 2-3 days.	The study comprised two age cohorts of children (<6 years and 6 to <12 years), and consisted of a screening period of up to 8 weeks, a 52-week open-label treatment period, and a 2- to 3-week safety follow-up period only for participants who did not enter the open-label extension study.	Participants will receive efanesoctocog alfa once weekly for a total of at least 100 exposure days to efanesoctocog alfa (including exposure during a efanesoctocog alfa parent study, if applicable). Participants will have the opportunity to continue in this study for up to 4 years, unless efanesoctocog alfa is commercially available in their applicable participating country.
Objective	Primary Objective: - To evaluate the efficacy of efanesoctocog alfa as a prophylaxis treatment in prophylaxis treatment arm. Secondary Objectives: - To evaluate the efficacy of efanesoctocog alfa as a prophylaxis treatment. - To evaluate the efficacy of efanesoctocog alfa in the treatment of bleeding episodes. - To evaluate efanesoctocog alfa consumption for the prevention and treatment of bleeding episodes. - To evaluate the effect of efanesoctocog alfa prophylaxis on joint health	Primary Objective: - To evaluate the safety of efanesoctocog alfain previously treated pediatric subjects with haemophilia A Secondary Objectives: - To evaluate the efficacy of efanesoctocog alfa as a prophylaxis treatment - To evaluate the efficacy of efanesoctocog alfa in the treatment of bleeding episodes - To evaluate efanesoctocog alfa consumption for prevention and treatment of bleeding episodes - To evaluate the effect of efanesoctocog alfa prophylaxis on joint health	Primary Objective: - To evaluate the long-term safety of efanesoctocog alfa in previously treated subjects with haemophilia A Secondary Objectives: - To evaluate the efficacy of efanesoctocog alfa as a prophylaxis treatment. - To evaluate the efficacy of efanesoctocog alfa in the treatment of bleeding episodes. - To evaluate efanesoctocog alfa consumption for prevention and treatment of bleeding episodes. - To evaluate the effect of efanesoctocog alfa prophylaxis on joint health
Population *Important inclusion and exclusion criteria*	Eligibility criteria were severe haemophilia A, defined as <1 IU/dL (<1%) endogenous FVIII or a documented genotype known to produce severe haemophilia A, and had received previous treatment for haemophilia A including any recombinant and/or plasma-derived FVIII concentrate, or cryoprecipitate for at least 150 exposure days.	Participants enrolled in this study were PTPs previously treated patients with severe haemophilia A defined as <1 IU/dL [<1%] endogenous FVIII or a documented genotype known to produce severe haemophilia A. Previous treatment of haemophilia A (prophylaxis or on-demand) was defined as any recombinant and/or plasma-derived FVIII replacement product, or cryoprecipitate for at least 150 exposure days for patients aged 6 to <12 years and for at least 50 exposure days for patients aged <6 years. Participants with a history of a positive inhibitor test or with a positive inhibitor result at study screening were excluded.	Inclusion criteria: - For participants rolling over into Arm A o Participants who have completed the studies EFC16923, EFC16925, Arm B or Arm C of the current study, or any other potential BIVV001 study. - For participants new to BIVV001 (Arm B and C) o Previous treatment for hemophilia A (prophylaxis or on-demand) with any recombinant and/or plasma-derived FVIII, or cryoprecipitate for at least 150 EDs or 50 EDs for participants aged <6 years. o Platelet count ≥100 000 cells/µL at screening. o A participant known to be human immunodeficiency virus (HIV) antibody
Intervention (n) *Dosage, dosing interval, duration of treatment*	Arm A: prophylaxis, efanesoctocog alfa (n=133), 50 IU/kg QW, once weekly, up to 52 weeks Arm B: on-demand, then prophylaxis, efanesoctocog alfa (n=26), 50 IU/kg as needed for treatment of bleeding episodes from week 1 to week 26. At week 26, participants switched to prophylaxis treatment, 50 IU/kg QW, once weekly, until week 52.	The eligible participants received efanesoctocog alfa (n=75), at a dose of 50 IU/kg IV, QW, once weekly for 52 weeks.	Efanesoctocog alfa (n=261), at a dose of 50 IU/kg IV, once weekly, QW, up to 4 years unless efanesoctocog alfa is commercially available in their applicable participating country.
Comparator (n) *Dosage, dosing interval, duration of treatment*	N/A	N/A	N/A
Endpoints *Primary, secondary and exploratory endpoints, including definition, measurement method and, if applicable, time of measurement*	- ABR with efanesoctocog alfa prophylaxis (primary endpoint) - ABR intra-patient comparison of FVIII versus efanesoctocog alfa (key secondary endpoint) - Joint health - HRQoL - Pain - Treatment of bleeds - Perioperative management - PK parameters - Safety, including inhibitor development	- Inhibitor development (primary endpoint) - ABR - Efanesoctocog alfa consumption - Joint health - HRQoL - Treatment of bleeds - Perioperative management - Safety - PK parameters	- ABR - FVIII activity - Joint health - HRQoL - PK parameters - Safety
Relevant subgroup analyses *Description of any relevant subgroup analyses*	Surgery subgroup (efanesoctocog alfa during surgery, n=13)	Surgery subgroup	Surgery subgroup

	Study 1	Study 2	Study 3
Follow up time *If the study is ongoing, indicate the follow-up time for the data expected to be available for assessment by the Norwegian Medicines Agency as well as the expected/planned total follow-up time for the study*	52 weeks	52 weeks	Up to 4 years
Time perspective results *Ongoing or completed study? Available and future data cut-offs*	Completed Data cut-offs not available	Completed Data cut-offs not available	Ongoing Data cut-offs not available
Publications *Title, author, journal, year. Expected date of publication*	Efanesoctocog Alfa Prophylaxis for Patients with Severe Hemophilia A, Von Drygalski et al. N Engl J Med 2023, 388: 310-8 (ClinicalTrials.gov 2023b, von Drygalski et al. 2023)	Safety, Efficacy and PK of BIVV001 in Pediatric Patients With Hemophilia A (XTEND-Kids), National Library of Medicine, N/A, 2023, N/A (ClinicalTrials.gov 2023c)	Long-term Safety and Efficacy of Efanesoctocog Alfa (BIVV001) in Previously Treated Patients With Hemophilia A (XTEND-ed) (ClinicalTrials.gov 2023a)

9 Ongoing and planned studies

Are there ongoing or planned studies for the medicinal product within the same indication that may provide further information in the future? *If yes, state the expected time perspective for data availability*	Yes, XTEND-ed (in the right column in the table above) which is estimated to be completed 2027-01-15.
Are there ongoing or planned studies for the medicinal product for other indications?	N/A

10 Expected health economic documentation

Enter information about the expected health economic analysis

Type of health economic analysis *E.g. cost-per-QALY analysis or cost minimisation analysis* *(Justify the proposal)*	Economic comparative analysis of high sustained FVIII levels.
The patient population on which the health economic analysis is based, including any subgroups. *The main analysis (base case) shall include the entire patient population covered by the indication sought.*	Patients according to indication.
What type of documentation will form the basis for estimating relative efficacy? *(Direct or indirect evidence)*	Indirect treatment comparison
What type of documentation will form the basis for health-related quality of life data?	Not relevant
Expected pharmaceutical budget impact per year, in the 5-year period following a potential approval	Will be provided in full dossier

11 Suitable for FINOSE?

Can the method be appropriate for assessment through FINOSE (yes/no) *If no, why not?*	No, since the relevant comparators differ across the FINOSE markets.

12 Other relevant information

Disclose other aspects that Nye metoder should be aware of.

Have you been in contact with clinicians at Norwegian health trusts about this medicinal product/ indication? Yes/no *If so, who have you been in contact with and what have been their contribution?* *(Relevant information in connection with the recruitment of experts in the field at Nye metoder)*	No
Are there specific circumstances related to the medicinal product implying that a plain discount may not be appropriate for fulfilment of the priority criteria (yes/no)? *If yes, a separate form must be completed and sent nyelegemidler@sykehusinnkjop.no at the same time as documentation is sent to the Norwegian Medicines Agency for a health technology assessment.* *Information and form:* https://www.sykehusinnkjop.no/om-oss/informasjon-og-opplering/	No
Any other relevant information?	No other information. References Bolton-Maggs, P. H. & Pasi, K. J. 2003. Haemophilias A and B. Lancet, 361, 1801-9. Clinicaltrials.Gov. 2023a. Long-term Safety and Efficacy of Efanesoctocog Alfa (BIVV001) in Previously Treated Patients With Hemophilia A (XTEND-ed) [Online]. Available: https://clinicaltrials.gov/study/NCT04644575?term=Nct04644575&rank=1 [Accessed 14 November 2023]. Clinicaltrials.Gov. 2023b. A Phase 3 Open-label Interventional Study of Intravenous Recombinant Coagulation Factor VIII Fc-von Willebrand Factor-XTEN Fusion Protein, Efanesoctocog Alfa (BIVV001), in Patients With Severe Hemophilia A (XTEND-1) [Online]. Available: https://clinicaltrials.gov/study/NCT04161495?term=NCT04161495&rank=1 [Accessed 14 November 2023]. Clinicaltrials.Gov. 2023c. Safety, Efficacy and PK of BIVV001 in Pediatric Patients With Hemophilia A (XTEND-Kids) [Online]. Available: https://clinicaltrials.gov/study/NCT04759131?term=NCT04759131&rank=1 [Accessed 14 November 2023]. De Caterina, R., Husted, S., Wallentin, L., Andreotti, F., Arnesen, H., Bachmann, F., Baigent, C., Huber, K., Jespersen, J., Kristensen, S. D., Lip, G. Y., Morais, J., Rasmussen, L. H., Siegbahn, A., Verheugt, F. W., Weitz, J. I. & European Society of Cardiology Working Group on Thrombosis Task Force on Anticoagulants in Heart, D. 2013. General mechanisms of coagulation and targets of anticoagulants (Section I). Position Paper of the ESC Working Group on Thrombosis--Task Force on Anticoagulants in Heart Disease. Thromb Haemost, 109, 569-79. Hay, C. R. M., Nissen, F. & Pipe, S. W. 2021. Mortality in congenital hemophilia A - a systematic literature review. J Thromb Haemost, 19 Suppl 1, 6-20. Hermans, C. & Pierce, G. F. 2023. Towards achieving a haemophilia-free mind. Haemophilia, 29, 951-953.