Record of the Rheumatology Advisory Committee Meeting held on 24 February 2026

Rheumatology Advisory Committee records are published in accordance with the Terms of Reference for the Specialist Advisory Committees 2021.

Note that this document is not necessarily a complete record of the Rheumatology Advisory Committee meeting; only the relevant portions of the meeting record relating to Rheumatology Advisory Committee discussions about an application or Pharmac staff proposal that contain a recommendation are generally published.

The Rheumatology Advisory Committee may:

(a) recommend that a pharmaceutical be listed by Pharmac on the Pharmaceutical Schedule and the priority it gives to such a listing;

(b) defer a final recommendation, and give reasons for the deferral (such as the supply of further information) and what is required before further review; or

(c) recommend that Pharmac decline to list a pharmaceutical on the Pharmaceutical Schedule.

Pharmac Advisory Committees make recommendations, including priority, within their therapeutic groups of interest.

The record of this Advisory Committee meeting will be reviewed by PTAC at an upcoming meeting.

Specialist Advisory Committees and PTAC may differ in the advice they provide to Pharmac, including recommendations' priority, due to the committees' different, if complementary, roles, expertise, experience, and perspectives.

Pharmac is not bound to follow the recommendations made below. Applications are prioritised by Pharmac against other funding options and progressed accordingly. The relative priority of any one funding choice is dependent on a number of factors, including (but not limited to) the recommendation of PTAC and/or Specialist Advisory Committees, the mix of other applications being assessed, the amount of funding available, the success of commercial negotiations and/or the availability of clinical data.

Table of Contents

1. Attendance

Present
Paul Vroegop
Andrew Harrison
Elizabeth Dennet
Keith Colvine
Priscilla Campbell-Stokes
Sarah McClean-Orsborn
William Taylor

Apologies
Janet Hawyward
Michael Corkill

2. The role of Specialist Advisory Committees and records of meetings

2.1. This meeting record of the Rheumatology Advisory Committee is published in accordance with the Terms of Reference for the Pharmacology and Therapeutics Advisory Committee (PTAC) 2021 and Specialist Advisory Committees 2021.Terms of Reference describe, *inter alia*, the establishment, activities, considerations, advice, and the publication of such advice of Specialist Advisory Committees and PTAC.

2.2. Conflicts of Interest are described and managed in accordance with section 6.4 of the SAC Terms of Reference.

2.3. The Rheumatology Advisory Committee is a Specialist Advisory Committee of Pharmac. The Rheumatology Advisory Committee and PTAC and other Specialist Advisory Committees have complementary roles, expertise, experience, and perspectives. The Rheumatology Advisory Committee and other Specialist Advisory Committees may therefore, at times, make recommendations for treatments for Rheumatology that differ from PTAC's, including the priority assigned to recommendations, when considering the same evidence. Likewise, PTAC may, at

times, make recommendations for treatments for Rheumatology that differ from the Rheumatology Advisory Committee's, or Specialist Advisory Committees may make recommendations that differ from other Specialist Advisory Committees'.

Pharmac considers the recommendations provided by both the Rheumatology Advisory Committee and PTAC and any other relevant Specialist Advisory Committees when assessing applications for treatments for rheumatology.

3. Welcome and introduction

3.1. The Chair welcomed the Committee with a karakia followed by whakawhanaungatanga.

4. Pharmac update

4.1. The Committee noted the Pharmac update.

4.2. The Committee acknowledged the recent changes in Pharmac kaimahi and ongoing leadership and strategic changes, including the new Chief Executive who started at Pharmac in mid-September and the 2025/2026 Letter of Expectations.

4.3. The Committee noted an update about the organisation reset programme and acknowledged that more information can be found on the Pharmac Website.

4.4. The Committee noted the following updates to the record processes:

4.4.1. 30-day provisional recommendation trial update.

4.4.2. The Committee noted the removal of second committee reviews, with targeted reviews to be used as required, and supported the use of direct engagement with Discussion Leads to resolve outstanding issues.

4.4.3. The Committee noted the proposed publishing of agenda summaries for all Advisory Committee meetings.

5. Matters Arising – Biologics procurement update

Discussion

5.1. The Committee noted Pharmac's RFP procurement process allows it to compete biosimilar and generic medicines when there are several suppliers who may be able to supply the market.

5.2. The Committee noted that Pharmac has previously run RFP processes for a number of biologic treatments including adalimumab, rituximab and infliximab.

5.3. The Committee noted the biologic treatments to be included in the 2026 hospital biologics RFP process and the potential outcomes that could occur for each treatment dependant on the bids received.

5.4. The Committee noted that the Pharmacology and Therapeutic Advisory Committee (PTAC) reviewed biosimilar evidence assessing changing from a reference biologic or biosimilar to another biosimilar. The Committee noted that Medsafe were responsible for determining safety and efficacy when approving biosimilar treatments for New Zealand.

5.5. The Committee considered that any increase in rituximab usage for rheumatological indications that would result from a potential open listing could predominantly be for treating interstitial lung disease (ILD). The Committee noted that there are a large number NPPAs for rituximab across a large range of indications that would need to be considered.

5.6. The Committee considered that any change in the brand of rituximab may need to include an exemption allowing people (particularly children) currently on the reference brand of rituximab for the rheumatoid arthritis indication to change back to the reference rituximab if response is lost or deemed clinically unresponsive. The Committee noted that Pharmac intend to have an alternative brand allowance (ABA) pathway for all people currently using the reference rituximab to change back if deemed clinically appropriate.

5.7. The Committee noted that discussions related to a rituximab biosimilar for RA indications and the potential change to subcutaneous presentations for tocilizumab and infliximab would occur later in the meeting.

6. Tocilizumab (subcutaneous) SA criteria for Giant Cell Arteritis (GCA)

Discussion

Background

6.1. The Committee noted that Pharmac was seeking advice from the Committee regarding the Special Authority criteria for subcutaneous (SC) tocilizumab for Giant Cell Arteritis (GCA) and the likely length of treatment with tocilizumab.

6.2. The Committee noted that Pharmac received an application for the funding of SC tocilizumab for GCA in April 2023. This was reviewed by PTAC in August 2023, who recommended it be funded with a medium priority, subject to Special Authority criteria.

6.3. The Committee noted that since 2022 there have been 40 Named Patient Pharmaceutical Assessment (NPPA) applications for tocilizumab for GCA, of which 13 have been approved. The Committee noted that to be considered for approval, patients need to have tried prednisone and at least three funded immunosuppressants.

Health benefit

6.4. The Committee noted the evidence for tocilizumab for GCA considered by PTAC in August 2023, including the Giant-Cell Arteritis Actemra (GiACTA) trial (Stone et al. 2017. N Engl J Med. 2017;377:317-28; Stone et al. Rheumatology (Oxford). 2022;61:2915-22; Adler et al. Rheumatology (Oxford).2019;58:1639-43; Strand et al. Arthritis Res Ther. 2019;21:64), and that since that time the following relevant studies have been published:

6.4.1. Martín-Gutiérrez A, et al.; Semin Arthritis Rheum. 2025

6.4.2. Christ L, et al. Rheumatology (Oxford). 2025 Nov 1;64(11):5616-5621

6.4.3. Matza MA et al., RMD Open. 2023 Apr;9(2) e002923

6.5. The Committee noted that Martín-Gutiérrez A, et al. 2025 was a retrospective multicentre observational study on the frequency and factors associated with relapse in 407 GCA patients treated with tocilizumab in clinical practice. Just over half (53.1%) received tocilizumab intravenous (IV), with the remainder (46.9%) receiving tocilizumab SC. The median time receiving tocilizumab was 18 (8.3-28.8) months. The Committee noted that after a mean follow-up of 25.3 ± 21.7 months, relapses were observed in 15.5% of patients and that the median time to first relapse was 12 (6-24) months.

6.5.1. The Committee considered that it is difficult to interpret the results of the trial without a placebo control, or to know the impact of corticosteroid treatment on the results.

6.6. The Committee noted that Christ L, et al. 2025 was a 3-year follow-up study on the efficacy of tocilizumab monotherapy after a short period of glucocorticoid administration in 18 participants. All patients received an initial treatment of 500 mg methylprednisolone IV for three consecutive days. Subsequently, tocilizumab IV was administered at a dose of 8 mg/kg bodyweight, followed by weekly 162 mg tocilizumab SC injections from day 10 until week 52. Patients in clinical remission stopped tocilizumab at week 52 and entered the follow-up study.

6.6.1. The Committee noted that participants in remission stopped treatment at week 52, and that relapse-free remission was achieved in 13 of 18 (72%) patients at 52 weeks.

6.6.2. The Committee considered that it is uncertain whether the high response rates were partially due to the use of the methylprednisone IV for 3 days at the start of the study period.

6.7. The Committee noted that Matza MA et al. 2023 was a retrospective analysis of 65 patients with GCA who received IV or SC tocilizumab. The mean duration of treatment was 1.9 years and the estimated relapse rate at 18 months on tocilizumab was 15.5%. After stopping tocilizumab, approximately 47% relapsed in the 12 months follow-up period.

6.8. The Committee considered that the optimal length of tocilizumab treatment is uncertain, but that based on the evidence provided, it is likely to be approximately 12-18 months. The Committee considered that patients should be evaluated at 12 months to determine if continued treatment is necessary.

6.8.1. For patients in remission at 12 months, the Committee considered that the majority of patients would gradually be tapered off tocilizumab treatment. Following cessation of tocilizumab, the Committee considered that approximately 50% of patients are likely to relapse in the first 12 months, with rates highest amongst those that have abrupt withdrawal of tocilizumab; those who receive non-biological DMARDs prior to tocilizumab; those who receive IV tocilizumab; or if treatment is delayed following onset of symptoms.

6.8.2. The Committee considered that patients would receive further treatment with tocilizumab following relapse, and that there are good response rates to tocilizumab retreatment following relapse, as evidenced in the clinical studies.

6.8.3. For those who continue to have active disease at 12 months, the Committee considered that many of these patients may continue to receive treatment due to a higher risk of relapsing off-treatment.

6.9. The Committee noted that tocilizumab IV is not Medsafe approved for use in GCA, and that there is limited evidence evaluating the efficacy of tocilizumab IV. The Committee noted that Martín-Gutiérrez A, et al. 2025 indicates that tocilizumab IV is likely to be less effective than tocilizumab SC in GCA. The Committee also considered that tocilizumab IV is less suitable as it requires monthly infusions. However, the Committee considered that if tocilizumab SC was not available, tocilizumab IV would be a desirable option.

Funding criteria

6.10. The Committee noted the draft Special Authority considered by PTAC. The Committee considered that the criteria were broad and potentially a large number of patients would meet the criteria.

6.10.1. The Committee noted the European Alliance of Associations for Rheumatology (EULAR) recommended tocilizumab for those with, or at risk of, glucocorticoid-related adverse events and considered this was appropriate to

include in the Special Authority criteria.

6.11. The Committee considered the following Special Authority criteria was appropriate and would target treatment to those who would benefit:

> **Initial application** (giant cell arteritis) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:
>
> Either:
> 1. Both of the following:
> 1.1. Individual has newly diagnosed with giant cell arteritis; and
> 1.2. Individual is at increased risk of developing glucocorticoid-related side effects or complications, such as osteoporosis, diabetes, hypertension, or glaucoma; or
> 2. Individual has refractory or relapsing disease.
>
> **Renewal** – (giant cell arteritis) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:
>
> 1. The treatment remains appropriate, and the patient is benefiting from continuing tocilizumab therapy

7. Tocilizumab and infliximab subcutaneous

Discussion

7.1. The Committee noted Pharmac's intention to run a procurement process and that there may be bids for a subcutaneous presentation of either tocilizumab or infliximab.

7.2. The Committee noted PTAC's consideration in August 2023 of the funding application and evidence for subcutaneous infliximab for all funded indications.

7.3. The Committee noted PTAC's consideration in November 2025 of the paper and evidence for biosimilar tocilizumab and the subcutaneous presentation.

7.4. The Committee considered that the evidence shows that the subcutaneous presentation is well tolerated and is a reasonable comparison to IV with respect to disease outcomes. The Committee considered some rheumatology patients would benefit from the suitability advantages of subcutaneous presentations.

7.5. The Committee considered that there would be significant uptake (50-75% of adult patients) of a subcutaneous formulation of either treatment if it were available.

7.5.1. The Committee considered Pharmac could reasonably assume similar uptake to studies from other comparable countries.

7.5.2. The Committee also considered that uptake in children is likely to be very unpredictable.

7.6. The Committee noted the Medsafe approved presentation for infliximab and tocilizumab subcutaneous is a pre-filled pen that may be administered by patients or caregivers.

7.7. The Committee considered that information on dosing for subcutaneous vs intravenous tocilizumab and infliximab would need to be communicated clearly to the sector as infusion dosing is weight based but the subcutaneous is likely to be fixed dosing.

7.8. The Committee considered that rheumatology patients are very familiar with using pre-filled pen injections as both adalimumab and etanercept are subcutaneous pens that are used prior to infliximab.

7.9. The Committee considered there may be some patients who would experience a loss of therapeutic effect on moving from weight based IV dosing to fixed dose

subcutaneous dosing. The Committee considered that it would be appropriate to allow patients to change between the IV and SC presentations as required.

7.10. The Committee considered that Pharmac should consider the suitability aspects for a fixed-dose subcutaneous presentation for paediatric patients and should include consideration for paediatric patients within the RFP.

7.11. The Committee considered that Pharmac should request information through the procurement process on the patient support that the suppliers of the subcutaneous presentations can provide as this would be important for patient education.

7.12. The Committee considered that IV treatment would still be necessary for some indications such as treatment of severe COVID, severe Still's disease, and Castleman's disease.

7.13. The Committee considered it would be appropriate for Pharmac to list subcutaneous presentations of any biologic treatments currently funded provided they are Medsafe approved, and patients still have the option of IV treatment as well.

7.14. The Committee considered that there may be a reduction in geographical inequities to treatment access, outpatient infusion resources, patient time and associated costs by changing from IV to SC.

8. Rituximab biosimilar for rheumatoid arthritis

Discussion

8.1. The Committee noted Pharmac's intention to run a procurement process which may result in a biosimilar rituximab being listed for all indications including rheumatoid arthritis.

8.2. The Committee noted that Pharmac previously ran a procurement process in 2019 for rituximab which resulted in a change to a biosimilar rituximab, Riximyo.

8.2.1. The Committee noted that this change did not occur for patients with rheumatoid arthritis due to patents held by the supplier of Mabthera.

8.3. The Committee considered that there would be no concern with patients with rheumatoid arthritis changing to a biosimilar rituximab provided it has Medsafe approval as the comparability to the reference product has been assessed.

8.4. The Committee considered that a nine-month transition period would be practically sufficient if a change in brand was required for these patients.

8.5. The Committee considered that the previous implementation approach for the biosimilar brand change for rituximab was sufficient and appropriate.

8.6. The Committee considered that the same high level of support or training regarding biosimilars generally may not be required given the health sector now has had experience with several treatments changing to biosimilars. However, support will still be required to ensure a successful transition.