Medicinrådet

Instructions for pharmaceutical companies

This is the dossier for submitting documentation to the Danish Medicines Council as part of the assessment process for a new drug or an indication extension.

Please note the following requirements:

- The Danish Medicines Council's secretariat carries out a technical validation of all submissions. This means that the application must comply with all requirements specified in *the checklist for formal requirements* on the Danish Medicines Council's website before the assessment process can begin (day 0).
- Companies must always use the current version of the checklist, dossier, standard Excel sheets and method guidelines.
- All applications must comply with data protection regulations. Find out more about the Danish Medical Council's data policy here .
- Text in gray and [in brackets] is provided for illustrative purposes only and must be deleted.
- All sections in the dossier must be completed. If a section or appendix is not applicable, indicate "N/A" and a brief explanation of the reason.
- If a joint European assessment has been prepared under the EU HTA Regulation (JCA), the company should not submit the same information that is already included in the dossier to the JCA. Instead, the company should refer to the specific section of the JCA report where the information is presented. Please note that it may be relevant to submit data from the same studies or updates of analyses that are included in the JCA report, e.g. if data have become available from a later data cut-off than the one used in the JCA report, or if new data for comparators change the results of a relevant comparative analysis from the JCA report.

The assessment process will not begin until all requirements have been met.
The application can be submitted in both Danish and English.

Documentation to be submitted

The following documentation must be sent to the Danish Medicines Council's e-mail address: ansogning@medicinraadet.dk.

- Submission dossier in Word format
- Submission dossier in PDF format
- One Excel file containing both a health economic analysis and a budget impact analysis. The analyses must be linked to the standard Excel sheets from the Danish Medicine Council's Excel template "Standard sheets".
- The European Public Assessment Report (EPAR) must be attached. Please include a draft if the final version has not been published at the time of application and submit the final version as soon as possible thereafter.

Companies are encouraged to submit an importable reference list as a RIS file.

Medicinrådet

Confidential information in the application and any attachments and notes

The Danish Medicines Council publishes the application (including any annexes and notes) on its website together with the assessment report and recommendation.

The Danish Medicines Council must ensure the highest possible degree of transparency in the assessment of new drugs, in accordance with the Council´s terms of reference and the general principles of administrative law. The application must therefore be as transparent as possible (including any annexes and notes). The Danish Medicines Council may redact (black out) specific information if it is considered confidential and of significant importance to the company. Any redactions must always be limited to individual words/values and shall not cover entire sentences or sections of text.

Confidential information must be marked in the first version of the application. If the application, annexes or any subsequent notes contain confidential information, the companies must submit two versions:

- one version for the Danish Medicines Council's case processing, in which the confidential information is marked with turquoise marking (Hex: #00FFFF).
- one version for publication on the Danish Medicines Council's website, in which the confidential information is redacted using black masking. The Danish Medicines Council will publish this version.

It is the company's responsibility to ensure that the redactions is sufficient so that the confidential information cannot be read when published on the Danish Medicines Council's website. This can be done, for example, by covering the information to be redacted with black markings and simultaneously replacing the underlying text with placeholder characters (e.g., "XXX"), ensuring that the original text/information cannot be read when editing the document. Further information about confidential information and redaction is available on the Danish Medicines Council's website.

When redacting specific information, the company must provide concrete and specific justifications explaining why each redacted element is of significant importance to the company and why it should not be disclosed to the public. The justifications must be stated in Appendix K. If the application contains confidential information, completion of Appendix K is a requirement in the technical validation.

Please note that the company's redaction of information on the grounds of confidentiality does not necessarily result in corresponding 1:1-redactions in the context of request for access to documents. The Danish Medicines Council may only withhold information or documents from disclosure to the extent permitted by the provisions of the Danish Access to Public Administration Files Act. When processing a request for access to documents, the Danish Medicines Council therefore conducts an independent and specific assessment in accordance with the provisions of the Act. As a general rule, the Council will initially obtain a statement from the company for the purposes of the specific assessment.

About macros in Excel

Due to IT security requirements, Excel files containing macros must be signed with a certificate by the company before submission to the Danish Medicines Council. Find out more here.

Version log

Version	Date	Revision
2.0	February 20, 2026	New English version approved and published.
1.0	September 1, 2023	The application form in is posted on the Danish Medicines Council's website.

Language: Danish
Format: PDF
Published by the Danish Medicines Council February 20 2026

Application for assessment of <drug(s)> for <indication>

Contact information

Contact information	
Business	**[Name of the applicant company]**
Name	
Title	
Telephone number (incl. country code)	
Email	
External representation	**[Name/Company]**
Title	
Telephone number (incl. country code)	
Email	

[If a company wishes to use external representation in connection with the application for assessment of a new drug/indication extension, this power of attorney must be completed and sent to ansogning@medicinraadet.dk .]

Table of Contents

Tables and figures

[Insert a list of all tables and figures with page references].

Abbreviations

[Insert a list of all abbreviations used in this application].

1. Information about the drug

Drug information	
Trade name	
Generic name	
Indication as formulated by the European Medicines Agency (EMA)	
Marketing Authorization Holder in Denmark	
ATC code	
Combination therapy and/or concurrent treatment	[Yes/No. If yes, please specify medications]
Expected date of EU approval (marketing authorisation)	[Yes/no]
Has the drug received a conditional marketing authorisation?	[Yes/No. If yes, please specify specific obligations for the conditional marketing authorisation, including expiry date]
Has the drug been in 'accelerated' assessment' at EMA?	[Yes/no]
Does the drug have orphan drug designation?	[Yes/No. If yes, please provide date of award]
Other indications approved by the EMA	[Yes/no]
Other indications that have been evaluated by the Danish Medicines Council	[Yes/no]
Joint Nordic Assessment (JNHB): **Is current treatment practice comparable across the Nordic countries (DK, FI, IS, NO, SE)?**	[Yes/No. Please provide a brief explanation]
Joint Nordic Assessment (JNHB): **Is the drug suitable for a joint Nordic assessment?**	[Yes/No. Please provide a brief explanation]

Has a joint European assessment (JCA) been carried out via the EU HTA Regulation?	[Yes/No. If yes, please provide date of approval by the EU-HTA Coordination Group and link to published JCA for the relevant indication, if available]
Delivery	[BEGR/NBS]
Packaging – types, sizes/number of units and concentrations	

2. Summary table

Complete the table below, maximum 2 pages.

Overview	
Indication relevant to the assessment	[Specify indication as well as any deviations from the EMA indication and brief justification]
Dosage regimen and administration route	
Comparator selection	
Prognosis with current standard treatment (comparator(s))	[Briefly describe the expected prognosis in terms of disease progression, mortality and quality of life. Report median survival or survival rates from the Danish population unless the disease has mortality comparable to the background population]
Type of documentation for the clinical evaluation	[E.g., *Head-to-head* study or indirect comparison (ITC, NMA, MAIC, other)]
Main outcomes including at least one outcome for health-related quality of life (difference/improvement compared to comparator(s))	[Insert results for a maximum of 4 outcomes that are most important to the assessment]
Serious adverse events for the intervention and comparator	[Indicate the most frequent serious adverse events and the frequency for both intervention and comparator(s)]
Type of health economic analysis	[Specify cost-utility analysis or cost-minimization analysis]
Health economic model	[Specify model type, e.g., Markov model or partitioned survival model]

Outcomes and sources for extrapolating patient transitions	[E.g., Outcome 1 (data source A), Outcome 2 (data source B)]
Instrument and sources for health-related quality of life	[E.g., Instrument 1 (data source A), Instrument 2 (data source B)]
Life years gained (discounted, corrected for half-cycle and background mortality)	[X years]
QALYs gained (discounted, corrected for half-cycle and background mortality)	[X QALYs]
ICER (DKK/QALY) (discounted, corrected for half-cycle and background mortality)	[XX DKK/QALY]
Company's assessment of uncertainty	[Describe the most important uncertainties in the health economic analysis]

3. Patient population, intervention, choice of comparator(s) and outcome(s)

Applicable documentation standards are stated in the Danish Medicines Council's methodological guideline and associated guideline regarding population, intervention, choice of comparator(s) and outcome(s). Section numbering and tables must not be changed. Rows may be deleted/added in Table 6 *and* Table 7*.*

3.1 Patient population

3.1.1 The disease

[Describe the disease, including:

- The pathophysiology
- The clinical presentation/symptoms of the disease
- The impact of the disease on patients' functional ability and health-related quality of life

Maximum 1-3 pages including figures]

3.1.2 Selected patient population

[Table 1 must be completed. Describe and justify the following in maximum 1-3 pages (including figures and tables):

- Selection of the patient population, including justification for any restriction to a subpopulation within the indicated population.
- The calculation of the expected number of patients in Table 1, including relevant Danish references. Supplement the description with a flowchart clearly showing which patients are included and excluded relative to the EMA indication, and the reason(s) for the choices.
- Whether the incidence has been stable, increasing or decreasing over the past five years. If the incidence has not been relatively stable, supplement with a table illustrating the development
- Whether diagnostic tests and examinations are used for patient selection

For small patient groups, the company must also describe the global disease picture with prevalence and incidence.]

Table 1. Expected number of patients and patient uptake when implementing the intervention

Year	Year 1	Year 2	Year 3	Year 4	Year 5
Expected number of patients*	[E.g., 100]	[E.g., 60]	[E.g., 60]	[E.g., 60]	[E.g., 60]
Patient uptake**	*[Enter %]*	*[Enter %]*	*[Enter %]*	*[Enter %]*	100%

*The number of patients in Denmark eligible for the new treatment, cf. the EMA indication, minus the number of patients who are not considered suitable for treatment with the intervention (e.g. due to age or comorbidity), and minus those who are expected to opt out of the treatment. As a general rule, the number of patients should be based on the expected number of new (incident) patients. However, if prevalent patients are expected to be offered treatment, these should be included in year 1.
** Patient uptake is defined relative to the expected number of patients. If full patient uptake is not expected from year 1 (100%) due to gradual implementation, this must be specified together with the corresponding uptake percentages. Once the new treatment is expected to be fully implemented, patient uptake must reach 100%, no later than in year 5. See the Danish Medicines Council's guideline for budget impact analysis for the definition of patient number and patient uptake.

3.2 Intervention

- [Table 2 and Table 3 must be completed
- If the drug has received conditional approval, explain the conditions
- Briefly describe the intervention, including the mechanism of action
- Insert a table showing the dose distribution from the latest pre-specified data cut in the clinical study(ies). The dose distribution must also be included in the health economic model, as this will form the basis for calculating drug costs, *see the Danish Medicines Council's guideline for calculating costs.*
- Briefly describe any potential differences between the dose distribution from the clinical study(ies) and the dose expected in Danish clinical practice, and the expected implications for efficacy, safety and costs.]

Table 2. Overview of the intervention

Therapeutic indication relevant to the assessment	
Generic name	
ATC code	
Mechanism of action	
Administration method	
Packaging type, pack sizes, shelf life and strengths	
Package size(s)	
If vials: Can these be shared?	
Pre-medication: Should pre-medication be administered? Which one?	
Co-administration: Should the drug be administered with other drugs? Which ones?	
Need for diagnostics, monitoring or other tests (e.g., *companion diagnostics*)	

Table 3. The intervention in the study and the health economic model

	Study	Health economic model
Dosage and frequency **[if weight-based, please state weight in brackets and any criteria for transition to flat-dose]**	E.g., 5 mg/kg on day 1 and 8 every 3 weeks.	E.g., 5 mg/kg on day 1 and 8 every 3 weeks. Max 400 mg (flat dose from 80 kg)
Average dose	E.g., 400 mg	E.g., 350 mg
Criteria for treatment discontinuation	E.g., max 6 series	E.g., max 6 series

	Study	Health economic model
Treatment duration	[Report median and, if possible, average]	[Report modeled average from the health economic model]
Dose adjustment: Report if/how dose adjustment is made*	E.g., the treatment can be dose adjusted down to 3 mg/kg in case of toxicity.	E.g., the dose distribution from [study name] forms the basis for calculating drug costs.
Dose pause: Specify if/how pause(treatment interruption) is performed*	E.g., the treatment cannot be paused.	E.g., pausing is not included in the calculation.

* If the Relative Dose Intensity (RDI) for dose adjustment and/or pause is used, include definition of RDI, see the Danish Medicines Council's guideline for calculating costs.

3.2.1 The intervention in the context of Danish clinical practice

[Describe the current treatment algorithm and expected placement of the intervention within it, as well as any changes to the overall treatment algorithm.

If the intervention is associated with diagnostic tests and methods for patient selection that are not routinely used in Danish clinical practice, provide an explanation here.]

3.2.2 ATMP

[For ATMP: Describe the technology, e.g., vector type, expected duration of effect, risk of immune reactions, cross-reactivity, integration into the host cell's DNA, risk of transmitting vector to partner or to fetus during pregnancy, special precautions, etc.

If a JCA has been prepared for the drug, please refer to the section in the JCA where the technology is described.]

3.3 Selection of comparator(s)

- [Complete Table 4 and Table 5. If more than one comparator is included in the application, copy/paste the tables for each comparator
- Justify the choice of comparator(s)
- Report whether the comparator is used without having an EMA indication for the disease in question (off-label)
- Insert a table showing the dose distribution from the latest pre-specified data cut in the clinical study(s). The dose distribution must also be included in the health economic model, as it forms the basis for calculating drug costs, *see the Danish Medicines Council's guideline for calculating costs*
- Briefly describe any potential differences between the dose distribution from the clinical study(ies) and the dose expected in Danish clinical practice, and the expected implications for efficacy, safety and costs.]

Table 4. Comparator overview

Therapeutic indication relevant to the assessment	
Generic name	
ATC code	
Mechanism of action	
Administration method	
Packaging type, pack sizes, shelf life and strengths	
Package size(s)	
If vials: Can these be shared?	
Pre-medication: Should pre-medication be administered? Which one?	
Co-administration: Should the drug be administered with other drugs? Which ones?	
Need for diagnostics, monitoring or other tests (e.g., *companion diagnostics*)	

Table 5. Comparator in the study and the health economic model

	Study	Health economic model
Dosage and frequency **[if weight-based, please state weight in brackets and any criteria for transition to flat-dose]**	E.g., 5 mg/kg on day 1 and 8 every 3 weeks.	E.g., 5 mg/kg on day 1 and 8 every 3 weeks. Max 400 mg (flat dose from 80 kg)
Average dose	E.g., 400 mg	E.g., 350 mg
Criteria for treatment discontinuation	E.g., max 6 series	E.g., max 6 series
Treatment duration	[Report median and, if possible, average]	[Report modeled average from the health economic model]

	Study	Health economic model
Dose adjustment: Report if/how dose adjustment is made*	E.g., the treatment can be dose adjusted down to 3 mg/kg in case of toxicity.	E.g., the dose distribution from [study name] forms the basis for calculating drug costs.
Dose pause: Specify if/how pause(treatment interruption) is performed*	E.g., the treatment cannot be paused.	E.g., pausing is not included in the calculation.
Dosage and frequency **[if weight-based, please state weight in brackets and any criteria for transition to flat-dose]**	E.g., 5 mg/kg on day 1 and 8 every 3 weeks.	E.g., 5 mg/kg on day 1 and 8 every 3 weeks. Max 400 mg (flat dose from 80 kg)

* If RDI for dose adjustment and/or pause is used, include definition of RDI, see the Danish Medicines Council's guideline for calculating costs.

3.4 Subsequent treatment

[Describe whether patients in Danish clinical practice are expected to be treated with a subsequent line of treatment after the intervention and/or comparator, including the proportion in each treatment arm, e.g. 80% of patients with progressed disease. Describe differences and similarities between the subsequent treatment given in the clinical study and Danish clinical practice and any implications for the transferability of the results from the clinical study.

If one or more subsequent lines of treatment can be given after the intervention and/or comparator:

- Insert table in Appendix C showing the distribution of subsequent treatment in the clinical study.
- Complete Table 6 **Fejl! Henvisningskilde ikke fundet.**regarding assumptions in the health economic analysis.]

Table 6. Assumptions regarding subsequent treatment in the health economic analysis

Subsequent treatment	[Intervention] %	[Comparator] %	Average treatment duration including source	Dosage (Dose, frequency and form of administration including source)	Any assumptions regarding dose adjustment and pause including source
Proportion of patients receiving a	[x% of e.g. patients with	…			

Subsequent treatment	[Intervention] %	[Comparator] %	Average treatment duration including source	Dosage (Dose, frequency and form of administration including source)	Any assumptions regarding dose adjustment and pause including source
subsequent line of treatment	progressive disease]				
[Name of subsequent treatment 1]	[% of patients receiving subsequent treatment]	..			
[Name of subsequent treatment 2]	..	..			
…					

3.5 Relevant outcomes

[If a JCA has been prepared, please refer to the section in the JCA report where the outcomes are defined and described. The rest of this section, including tables, should be filled in with N/A.]

3.5.1 Definition of outcomes

[Table 7 must be completed. Define the outcomes considered relevant and necessary to evaluate the effect of the intervention compared to the comparator. Describe the rationale for the selected outcomes.

All outcomes included in the application must be defined in Table 7.

In the case of indirect comparisons, clearly state any differences in the definition of outcomes across the studies. State how differences are handled in the comparison and their implications for interpretating the results.]

Table 7. Outcomes

Outcome	Follow-up time	Definition
Overall survival (OS)		OS is defined as the time from randomization to death from any cause.

Outcome	Follow-up time	Definition
[Included study 1]		OS is defined as the time from first treatment recorded in registry X to the date of death from any cause.
ASAS40 [Included study 1]	Week 12	Proportion of patients achieving ASAS40. An ASAS40 response was defined as a ≥ 40% improvement and an absolute improvement from baseline of ≥ 2 units (range 0-10) in ≥ 3 of the following four domains: Patient Global Assessment of Disease Activity (0-10 cm VAS), Pain (Total Back Pain, 0-10 cm VAS), Function (BASFI (Bath Ankylosing Spondylitis Index), Spondylitis Functional Index), 0-10 cm VAS [source XX] and inflammation/morning stiffness (mean score for items 5 and 6 in BASDAI) (0-10 cm VAS)) without worsening in the remaining domain [source YY].

3.5.2 Relevance of outcomes

When intermediate or surrogate endpoints are used, the relationships between these endpoints and health-related quality of life and/or survival must be documented. Describe the evidence demonstrating the relationship between the surrogate endpoint and the patient-relevant endpoint and specify which sources have been used and how they were identified, e.g., through a systematic literature review (SLR).]

3.5.3 The validity of outcomes

[As a general rule (with exceptions such as survival and progression-free survival), it must be stated whether the validity of the outcomes has been investigated and how. Provide references. Previous assessments from the Danish Medicines Council are accepted as references. If an instrument or scale is used, it must be described whether it has been validated for the relevant population, and the scale and the minimal clinically relevant difference must be described with reference to the validation.

If composite outcomes are used, the rationale for grouping these measures must be clearly described, including whether there is international consensus on the composite outcomes and whether information is available on the individual outcomes.]

4. Health economic analysis

[Applicable documentation standards are specified in the Danish Medicines Council's methodological guideline and associated guideline on health economic analysis and extrapolation. Section numbering and tables must not be changed. Rows and/or columns must not be added.]

4.1 Basic assumptions

[Table 8 must be completed.]

Table 8. Basic assumptions in the health economic analysis

Assumption regarding	Assumption	Justification
Patient population	[Specify patient population in the health economic analysis]	[Describe any deviations from the section on relative effect, e.g. subgroups]
Intervention	[Specify intervention in the health economic analysis]	[Describe any deviations from the section on relative effect]
Comparator(s)	[Specify comparator in the health economic analysis]	[Describe any deviations from the section on relative effect]
Clinical outcomes	[List all outcomes used in the analysis]	[Add justification e.g., if surrogate outcomes are used]
Analysis type	[E.g., Cost-utility]	[Add justification]
Model type	[E.g., Partitioned survival]	[Add justification]
Average age at entry into the model	[E.g., 60 years]	[Add justification]
Time horizon	[E.g., 40 years]	[Add justification, e.g., lifetime perspective]
Cycle length	[E.g., 1 month]	[Add justification]
Half-cycle correction	[Yes/no + elaborate if some costs are not half-cycle corrected]	[If no: Add justification, e.g., if administration of drug on day 1 of cycle]

4.2 Model type and model structure

[Table 9 must be completed. Justify the choice of analysis (cost-utility analysis or cost-minimization analysis) and the choice of model type (e.g., partitioned survival model, semi-Markov model or Markov model).

Describe the model structure and include a graphic illustration of health states and possible patient transitions between health states. For each treatment arm, explain how the model structure reflects the disease and treatment pathway in Danish clinical practice. In the column “Assumptions”, briefly state whether the model contains other relevant assumptions related to the patient transitions in the model]

Table 9. Choice of health economic analysis, model and model structure

Health economic analysis	Model type	Model structure	Assumptions
[E.g., cost-utility analysis]	[E.g., partitioned survival model]	[E.g., 3 health states (state A, state B, state C)]	[E.g., assumptions regarding cure, waning effect, or use of surrogate outcomes]

5. Literature overview

[*Applicable documentation standards are specified in the Danish Medicines Council's methodological guidelines and associated guideline regarding literature. Section numbering and tables must not be changed. Rows may be added to the tables.]*

5.1 Literature used to assess clinical efficacy and safety

List all references used in the assessment of clinical efficacy and safety in Table 10. The table must clearly state the source on which the individual efficacy and safety measures is based.

If a JCA has been prepared, the table must be completed by referring to the relevant section of the JCA report, if this is comprehensive. If additional literature is included that is not part of the JCA report, references to these specific sources must also be provided.]

Table 10. Relevant literature included in the assessment of efficacy and safety

Reference	Study name	NCT number	Study dates (Start date and expected end date, data cut-off and expected data cut-offs)	Used when comparing*
Author. Title of the article. Journal. Year; volume (edition): pp. [ref. no.] … Data on file: Title etc. [ref. no.] EMA EPAR [ref. no.]			Start: DD/MM/YY End: DD/MM/YY Data *cut-off* DD/MM/YY Future *data cut-offs* DD/MM/YY	<efficacy/ safety endpoint > for <intervention> vs. <comparator> for <population>

*List all study publications and state for each which comparison they are used for.

5.2 Literature used to assess health-related quality of life

[List all references used in the assessment of health-related quality of life in Table 11.

If a JCA has been prepared, the table must be completed with reference to the relevant section of the JCA report, if this is comprehensive. If literature is included that is not part of the JCA report, references to the specific sources must also be provided.]

Table 11. Relevant literature included in the assessment of health-related quality of life

Reference	Instrument and purpose	Identification method (documented in appendix)	Used in paragraph
Author. Title of the article. Journal. Year; volume (edition): pp. [ref.nr]	E.g., EQ-5D-5L for estimating utility values in health state "C"	E.g., Systematic literature search (Appendix I) Focused literature search (Appendix I) Head-to-head study	E.g., 10.3
Data on file: Title etc. [ref. no.]		Head-to-head study	

5.3 Literature used for input into the health economic model

[List the literature used in the health economic model in Table 12.

If a JCA has been prepared, the table is completed with reference to the relevant section of the JCA report, if this is comprehensive. If literature is included that is not part of the JCA report, references to the specific sources must also be provided]

Table 12. Relevant literature used in the health economic model

Reference (Full citation including reference number)	Input/estimate	Identification method (documented in appendix)	Used in paragraph
Author. Title of the article. Journal. Year; volume (edition): pp. [ref. no.]		E.g., Systematic literature search (Appendix J) Focused literature search (Appendix J) Head-to-head study	

Reference (Full citation including reference number)	Input/estimate	Identification method (documented in appendix)	Used in paragraph
Data on file: Title etc. [ref. no.]		Head-to-head study	

6. Clinical studies

[*Applicable documentation standards are specified in the Danish Medicines Council's methodological guidelines and associated guideline regarding clinical effectiveness and safety. Section numbering and tables must not be changed. Rows and/or columns in Table 14 and rows in Table 13 and Table 15 may be deleted/added.*

If more than one comparison is included in the application, section 6.1 must be copied and pasted for each comparison/population.]

6.1 [intervention] compared to [comparator] for [patient population]

6.1.1 Relevant studies

- [List all studies used in the comparison in Table 13. This applies to both studies of the company's drugs and comparators, including real-world evidence (RWE) studies. All studies must be described in detail in Appendix A, and the corresponding study protocols must be submitted as supplementary annexes.
- Indicate whether the population in the application is a subpopulation from the study and, if so, whether the subpopulation was predefined in the study protocol.
- All clinical data used in the application must be from the latest available predefined data cut. Enter the date of the latest available predefined data cut used and the median follow-up time. Also state when data from the next planned data cut is expected to be available.
- Report the proportion of patients who dropped out of the study in each study arm and the reason for dropout.
- Report the proportion of patients in each study arm who did not receive the treatment to which they were randomised.
- For each included study, the internal and external validity must be discussed.

If a JCA has been prepared, please refer to the section in the JCA report where the relevant clinical studies are described. If data are available from a later data cut from the included studies than those used in the JCA, this must be described.]

Table 13. Overview of study characteristics for all studies included in the comparison

Study name, NCT number (reference)	Studio design	Duration of study	Patient population	Intervention	Comparator	Outcomes and follow-up time
Study 1	Randomized phase III/unblinded/placebo-controlled/active comparator			Treatment, administration, dosage	Treatment, administration, dosage	[All primary and secondary endpoints in the study must be reported. Specify the follow-up periods for each endpoint or median follow-up time for time-to-event endpoints. State whether the follow-up period was predefined.]
Study name, NCTxxxx (reference to publication(s))	Randomized, double-blind, placebo-controlled, phase III study of drug X versus placebo	12-week double-blind period followed by 40-week unblinded period (total 52 weeks). Patients randomised to placebo crossed over to drug X without blinding after week 12	Treatment-naïve patients with active disease and incomplete response to conventional therapy	Drug X (subcutaneous administration), 90 mg weeks 0, 4, 8, 12, then every 12 weeks	Drug X matching placebo (subcutaneous) weeks 0, 4, 8, 12, then every 12 weeks	ACR20 response (week 24), ACR50 response (week 24), ACR70 response (week 24), PASI75 response (week 24), PASI90 response (week 24), PASI100 response (week 24), body area affected by psoriasis (week 24), HAQ-DI score (week 24), SF-36 PCS score (week 24), mTSS score (week 24), Leeds Enthesistis Index (LEI) score (week 24), Leeds Dactylitis Index-Basic (LDI_B) score (week 24), Nail Psoriasis Severity Index (NAPSI) (week 24)

6.1.2 Comparability of studies

[Address any differences between the included studies and describe how the differences are handled in the comparison between the studies (not relevant for RCTs with direct comparison between intervention and comparator). If a JCA has been prepared, refer to the section in the JCA report where the comparability of the relevant studies is described.]

6.1.2.1 Comparability of patients across studies

[Complete Table 11 with baseline characteristics of patients included in all studies for the population used in the comparative and health economic analysis, including all prognostic and effect-modifying variables. Adjust the number of columns in the table to match the number of included studies and study arms (flip the page horizontally to include more studies). Briefly explain the most important differences in baseline characteristics.

If a JCA has been prepared, refer to the section in the JCA report where comparability of patients across studies is described. In that case, Table 11 should not be filled in with baseline characteristics. Instead, enter "N/A" into the table and provide a reference to the table(s) with baseline characteristics in the JCA report.

Table 14. Baseline characteristics of patients in included studies for the comparative analysis of efficacy and safety

	[Study name]		[Study name]		[Study name]	
	[int ./ comp .]	[int ./ comp .]	[int./comp .]	[int ./ comp .]	[int ./ comp .]	[int./comp .]
Age						
Sex						
[characteristics]						
…						

6.1.3 Comparability of study population(s) with Danish patients eligible for treatment

[Address the comparability between the study population and the population in the health economic model, and Danish patients eligible for treatment. Complete Table 12 with information on characteristics of the relevant population in Danish clinical practice and the corresponding values used as input parameters in the health economic model. Adjust the number of rows as needed to include all relevant baseline characteristics.]

Table 15. Characteristics of the relevant Danish population and input parameters in the health economic model

	Danish population (source)	Study population	Health economic model (source)
Age			
Sex			
Body weight			
[characteristics]			
…			

6.1.4 Analysis method

[Data must be presented in accordance with the intention-to-treat principle whenever possible. Any supplementary presentations (e.g., subgroup and sensitivity analyses) of data be justified, e.g., analyses that increase the comparability between the study and Danish clinical practice.

The method used for each analysis must be clearly described (or referenced if described elsewhere,). This includes model type, adjustment variables, weighting, stratification factors, correlation structure (repeated measures), transformations of outcomes and/or adjustment variables, handling of missing values, handling of intercurrent events, censoring rules and exceptions. The proportion of missing measurement(s) in each study arm must be reported for each outcome.

For hazard ratios, a graphical assessment of the proportional hazards assumption must be provided, e.g., Schoenfeld residuals. In the case of competing risks, appropriate methods, e.g., the Aalen -Johansen estimator, must be used to estimate cumulative incidences.]

6.1.5 Effect – results per study [study name 1]

[Provide a summary of the most important efficacy results for each study included in the comparative analysis, excluding effects on health-related quality of life, which should be reported in Section 10.

Clearly explain any discrepancies between published data and EMA's scientific discussion (EPAR).

Report the event rates for both intervention and comparator(s) from each study, and present both the absolute (e.g., difference in median OS or OS rate) and relative differences (e.g., HR or RR) for the outcomes. All effect estimates must be accompanied by confidence intervals. For composite outcomes, the frequency (and missing

measurements) of each individual components/events must be reported for all treatment arms, when possible.

For time-to-event outcomes, present survival curves, which show censoring and the number of patients at risk at relevant time points. In addition, report the estimated median survival, as well as the estimated hazard ratio (HR) and the estimated survival at relevant time points.

Effect estimates must always be presented for the outcomes included in the health economic model.

If a JCA has been prepared, refer to the section in the JCA report where the results for each individual outcome for the relevant PICO(s) have been reviewed. In this case, separate subsections for each outcome should not be created. If data are available from a later data cut-off than used in the JCA report, the company must refer to the relevant section in the JCA report and present data from the same analyses relevant to the assessment, updated with the new data cut.]

6.1.6 Effect – results per [study name 2]

[Fill in a section for each study in the comparison as described in Section 6.1.5.]

7. Comparative analyses

[*Applicable documentation standards are specified in the Danish Medicines Council's methodological guideline and associated guideline regarding clinical effectiveness and safety. Section numbering and tables must not be changed. Rows in Table 16 may be deleted/added.*

The subsections should be marked as "N/A" if the relative effect is derived from a single head-to-head study that directly compares the intervention and the comparator.

If a JCA has been prepared with a comparative analysis of the intervention against the comparator, please refer to the relevant sections of the JCA in the subsections. Table 16 should be populated with the relevant outcomes. Instead of entering data, references to the corresponding sections of the JCA report should be provided. As a general rule, the comparative analysis from the JCA should be used. If new data are available for the intervention and/or comparator, the analysis from the JCA should be updated accordingly, but based on the same patients and adjustments as used in the JCA.]

7.1 Method of analysis

[Describe and justify the choice of method used for the comparative analysis. Instructions on reporting the analytical method described in Section 6.1.4 also apply to comparative analyses.

If evidence of efficacy and safety is derived from an indirect comparison, provide a brief description of the method here, and include a detailed description of the method in Appendix D. Use tables and figures where necessary. Always provide effect data for the raw study data (naive comparison) and for any adjusted analysis.

If weighting techniques are used, e.g., matching-adjusted indirect comparisons (MAIC), the weights used (e.g., in the form of a histogram) and the effective sample size must be reported. For inverse probability weighting the model for estimating probabilities of treatment with intervention (propensity scores) must be described, along with the choice of weights (e.g., average treatment effect among people corresponding to the population in the intervention study, *average treatment effect among treated* (ATT)). Baseline characteristics before and after weighting must be presented, and standardized mean differences (SMD) should reported both before and after weighting.]

7.2 Results from the comparative analysis

[Instructions on reporting effect estimates described in Section 6.1.4 also apply to comparative analyses. Data should be presented in accordance with the intention-to-treat principle whenever possible. Supplementary analyses (e.g., subgroup and sensitivity analyses) of data should be justified, e.g., analyses that increase the comparability between the study and Danish clinical practice.

Table 16 must be populated with absolute and relative results. If weighting techniques hare used, a figure must be provided showing survival curves for both the unweighted and the weighted population and corresponding hazard ratios. Effect estimates must always be presented for all outcomes included in the health economic model.]

Table 16. Results from the comparative analysis of [intervention] vs. [comparator] for [patient population]

Outcome	[Intervention] (N=x)	[Comparator] (N=x)	Result
US	Median: X months (95% CI: X;Y)	Median: X months (95% CI: X;Y)	X months HR: X (95% CI: X;X)
Proportion achieving ASAS40 (week 12)	n/N, % (95% CI: X;Y)	n/N, % (95% CI: X;Y)	Absolute risk difference: X %-points (95% CI: X;Y) Relative risk: X (95% CI: X;Y)

7.3 Effect – results per [outcome]

[Fill in a section for each outcome as described in Section 6.1.5]

8. Safety

[*Applicable documentation standards are specified in the Danish Medicines Council's methodological guidelines and associated guideline regarding clinical effectiveness and safety.*

Section numbering and tables must not be changed. Rows/columns in the tables may be deleted/added.]

[Table 17 must be populated with estimates regarding overall safety,e.g., the proportion of serious adverse events, for both intervention and comparator, including the absolute and relative differences. The data source and the time period covered by the data and/or median follow-up time must be reported. It must be clear how the safety population is defined. For indirect comparisons, the tables must include data for the intervention and comparator arms from each individual study.

If a JCA has been prepared, please refer to the section in the JCA report where the relevant data is described. If data are available from a later data cut-off than used in the JCA report, the company must refer to the relevant section in the JCA report and present data from the same analyses relevant to the assessment, updated based on the new data cut-off.]

Table 17. Overview of adverse events [specify data source and time period]

	[Intervention] (N = [x])	[Comparator] (N =[x])	Difference , % points	Difference , RR (95% CI)
All adverse events (AE), n (%)				
Serious AE (SAE), n (%) [1]				
AE grade ≥ 3, n (%) [2]				
Dose reduction due to AE, n (%)				
Treatment discontinuation due to AE, n (%)				

AE = adverse event; CI = confidence interval; RR = risk ratio; SAE = serious adverse event. 1 See ICH definition . 2 CTCAE v. 5.0 is preferred.

[Complete Table 18 for all adverse events with a frequency of ≥ 10%, regardless of grade/severity recorded in the study(s), as well as all adverse events grade ≥ 3, which occurred in ≥ 3% in neither of the treatment arms (if the events are not common terminology criteria for adverse events (CTCAE) graded, indicate serious adverse event (SAE)). The company may use *lower* frequency thresholds if necessary to adequately

illustrate the comparative safety profile. A lower threshold value may be relevant, e.g., to illustrate the occurrence of rare adverse events of significant importance.

If more than two studies are included in the comparison, the results may be presented in separate tables. A list of all serious adverse events that occurred in ≥ 1% of patients should be provided in Appendix F.]

Table 18. Proportion of patients with adverse events [specify data source and time period]

	[Intervention] (N = [x])		[Comparator] (N = [x])	
	All [1]	Grade ≥ 3 or SAE [2]	All [1]	Grade ≥ 3 or SAE [2]
[Adverse Event A], n (%)				
[Adverse Event B], n (%)				
…				

SAE = serious adverse event; 1 List all adverse events with a frequency of ≥ 10%. 2 Report SAEs if adverse events are not CTCAE graded and indicate events with a frequency of ≥ 3% in either arm.

9. Extrapolation of patient transitions

[Applicable documentation standards are specified in the Danish Medicines Council's methodological guideline and associated guideline regarding health economic analysis and extrapolation.

Section numbering and tables must not be changed. Rows in Table 20 and Table 22 may be deleted/added, and rows and/or columns in Table 21 may be deleted/added.]

9.1 Clinical data for extrapolation of patient transitions

[Briefly describe the clinical outcome (including source) used for extrapolations, and the types of extrapolations (parametric extrapolation models and/or transition probabilities). Provide a table that clearly shows which clinical outcome and data sources inform the individual transitions in the model. When surrogate endpoints are used, include a description of the underlying structural assumptions about the relationship between the surrogate endpoint and the clinical outcome(s) of primary interest, including a review of evidence for clinical plausibility of this relationship.

The individual extrapolations are described in Section 9.2 and Appendix E.1 for parametric extrapolation models, and in Section 9.3 and Appendix E.2 for extrapolations with transition probabilities.]

9.2 Extrapolation using parametric extrapolation models

9.2.1 Extrapolation of [clinical endpoint 1]

[Table 19 must be completed. Detailed justification for choice of parametric extrapolation model, including supporting figures and tables, must be provided in Appendix E.1. In this section, please present:

- A figure for each treatment arm showing the extrapolated data for all model candidates alongside the observed data (including confidence intervals for Kaplan-Meier data), adjusted for background mortality and any other assumptions (e.g., cure assumptions).
- A combined figure containing both treatment arms, in which only the selected extrapolation models for the intervention and the comparator are shown together with the observed data, adjusted for background mortality and any other assumptions (e.g., cure assumptions).

If a joint extrapolation model estimated on data from both treatment arms is used, e.g., based on the assumption of proportional hazards, Appendix E.1 should also be completed for the same outcome using separate (independent) extrapolation models for each arm. This also applies if these models are not included in the company's primary analysis. The corresponding figures and data must be available in the submitted model, and it must be possible to use separate (independent) extrapolation models within the model.

The model must include tables reporting relevant annual rates (e.g., 1-, 3-, 5- and 10-year) for each treatment arm and each extrapolated outcome for all extrapolation models examined. All rates must be adjusted for background mortality and any other assumptions (e.g., cure assumptions).]

Table 19. Overview of assumptions regarding extrapolation of [clinical endpoint]

Method/approach	Description/assumption
Data	[Study name, source]
Selected distribution	[Intervention: X distribution] [Comparator: X distribution]
Models investigated	[Describe which parametric extrapolation models have been investigated]
Assumptions	
Proportional hazards between intervention and comparator	[Yes/No/Not applicable] If 'Yes': Briefly describe modeling (joint vs. separate)
Flexible parametric models	[Yes/No/Not applicable] If 'Yes': Briefly describe model

Method/approach	Description/assumption
Cure point and/or share	[Yes/No] If 'Yes': Briefly describe the assumption/method
Treatment waning	[Yes/No] If 'Yes': Briefly describe the assumption/method
Any other assumptions	[Yes/No] If 'Yes': Briefly describe the assumption/method
Internal validity	
Distribution with best AIC fit	[Intervention: X distribution] [Comparator: X distribution]
Distribution with best BIC fit	[Intervention: X distribution] [Comparator: X distribution]
Distribution(s) with best visual fit on probability scale (e.g., Kaplan-Meier data)	[Intervention: X distribution] [Comparator: X distribution]
Distribution(s) with best visual fit according to evaluation of smoothed hazards	[Intervention: X distribution] [Comparator: X distribution]
External validity	
References for validating external validity	[References]
Distribution with highest external validity	[Intervention: X distribution] [Comparator: X distribution]

9.2.2 Extrapolation of [clinical endpoint 2]

[Complete as Section 9.2.1.]

9.3 Extrapolation using transition probabilities

[Table 20 and Table 21 must be completed. Provide explanation of the internal validity of the selected transition probabilities. This should include a description of the relevance, representativeness and clinical plausibility of the individual transition probabilities, including differences between health states and treatment arms. Supporting tables and figures must be included in Appendix E.2, e.g., comparisons of observed data and modeled data in the study period. Results from literature searches should be provided in Appendix J.

Provide explanation of the external validity with a focus on clinical plausibility including relevant references. Include supporting tables and figures in Appendix E.2, e.g., comparisons of external data and modeled data.]

Table 20. Transition probabilities in the health economic model

From health state	To health state	Transition probability, including calculation	Assumption	Reference
A	*A*	*E.g., S(t+Δt)/S(t)*	*E.g., time-dependent, and different between arms as …*	*[study name]*
	B	*E.g., 1− S(t+Δt)/S(t)*	*…*	
	C	*…*		
B	*B*	*E.g., 0.05* $1 - e^{-\lambda t}$*, where λ is the hazard rate and* t *is the cycle length*	*E.g., constant over time and the same in both arms*	
	…	*…*		

Table 21. Transition matrix for [intervention/comparator]

Off/On	State A	State B	State C	…
State A	*S(t+Δt)/S(t)*	*1− S(t+Δt)/S(t)*	*…*	
State B	*…*	*0.05*	*…*	
State C				
…				

9.4 Summary and validity of extrapolated patient transitions

[Table 22 must be completed. Provide a Markov trace for each treatment arm, i.e. a stacked chart that shows the proportion of patients in each health state over time.

Describe the table and figures, and explain whether the sum of choices regarding extrapolation of patient transitions yields logical and clinically plausible transitions over time and across states and treatment arms both during and after the observation period.

If the primary outcome (e.g., OS) is modeled indirectly through other patient transitions in the model, including the use of a surrogate endpoints (e.g., PFS), this section must include a figure comparing observed and modelled data for the primary outcome during the observation period.]

Table 22. Modeled averages in years, undiscounted estimates, half-cycle corrected and adjusted for background mortality

	[Intervention]	[Comparator]	Difference
Total life years			
Life years in [health state A]			
Life years in [health state B]			

Duration of treatment [Drug A]			
Duration of treatment [Drug B]			
...			

10. Health-related quality of life

[*Applicable documentation standards are specified in the Danish Medicines Council's methodological guidelines and associated guideline regarding health-related quality of life.*

Section numbering and tables must not be changed. Rows in the tables may be deleted/added.

If a JCA has been prepared, please refer to the relevant sections of the JCA report. Please refer to the individual subsections for more details.

All included instruments must be reviewed individually in Section 10.2, and the same documentation standards apply to all instruments. This also applies to instruments whose main purpose is to contribute to calculation of utility values. It does not apply to instruments that are solely used to estimate disutilities associated with adverse events.

If mapping is applied, the mapping study should be described in Appendix G, while the justification for using mapping and the choice of mapping algorithm must be described under the respective instrument in Section 10.2 (for indirect mapping) or under the relevant utility calculation in Section 10.3 (for direct mapping).

If a cost minimization analysis is performed, Section 10.3 does not need to be completed. Section 10.2 must still be completed, as a cost minimization analysis assumes that the drugs are equivalent with respect to health-related quality of life.

If the evidence for an instrument and/or the calculated utility values is too limited to complete parts of Sections 10.2 and 10.3, this must be explicitly stated and justified in the relevant sections.]

10.1 Overview

[Complete Table 23 with all included instruments in the submission, including instruments for the calculation of utility values and any instruments based on external sources. Complete Table 24, including utility values based on external sources. Indicate whether additional data is expected from future data-cuts.]

Table 23. Overview of included instruments for health-related quality of life

Instrument	Median follow-up time and data cut	Application	Source	Reference to description
Instrument 1 (e.g. EQ-5D-5L)	16 months (June 22, 2023)	E.g., effect, utility values	Study x	E.g., Section 10.1.1
Instrument 2				E.g., Section 10.1.2
...				

Table 24. Basis for estimating utility values

Instrument	Preference weights	Source	Short description
E.g., EQ-5D-5L	DK		E.g., from the same study that informs clinical efficacy and safety
..	..		E.g., identified in focused literature search

Instrument	Preference weights	Source	Short description
..	..		E.g., mapping from [instrument] to [instrument]

10.2 Instruments

[Complete section 10.2.1 for each instrument in Table 23. The first instrument should be presented in a subsection corresponding to Section 10.2.1, the second instrument in Section 10.2.2, and so forth. Additional corresponding sections should be created after Section10.2.2, if more than two instruments are included.

10.2.1 ["Instrument 1"]

10.2.1.1 Study design and instrument ["instrument 1"]

[If a JCA has been prepared, please refer to the relevant sections of the JCA report. The company must ensure that all of the questions below can be fully addressed through reference to the JCA. If not, the company must provide the necessary supplementary information for the relevant questions.

Describe and justify the choice and use of instrument and study design. If the reporting on an instrument is not based on the study that informed clinical efficacy and safety, any differences in study populations (inclusion and exclusion criteria) must be described. The company must also justify why the external sources are appropriate despite these differences.]

10.2.1.2 Data collection ["instrument 1"]

[If a JCA has been prepared, please refer to the relevant sections of the JCA report. The company must ensure that all of the questions below can be fully addressed through reference to the JCA. If not, the company must provide the necessary supplementary information for the relevant questions.

Table 25 must be completed for all measurement time points and must be accompanied by a description of the data collection, including any reasons for differences in response rates across treatment arms (e.g., differences in adverse event profiles) and implications of these differences. If Table 26 becomes very large, it may be placed in Appendix G.1 rather than in this section. If the instrument forms the basis for calculating utility values, Table 27 must also be completed. Note that the number of responses must be calculated based on the number of fully completed questionnaires.]

Table 25. Overview of responses [create a table for both intervention and comparator]

Time	Number of patients "at risk "* at time t (expected number of responses) N	Number of responses at time t N	Proportion of responses out of the number of patients "at risk " at time t** %	Proportion of responses out of the number of patients at randomisation*** %
Measurement time point 1	99	90	91% (i.e., 90/99)	90% (i.e., 90/100 if 100 patients at randomisation)
Measurement time point 2	85	80	94% (i.e., 80/85)	80% (i.e., 80/100)
Measurement time point 3	80	60	75% (i.e., 60/80)	60% (i.e., 60/100)
...	...	...	...	...

* Number of patients "at risk": Patients who have not died or been censored before time *t*, and who are therefore expected to complete the questionnaire. Patients who have discontinued treatment must be counted.

**Proportion of responses out of patients "at risk" at time *t* = number of responses at time *t*/number of patients "at risk" at time *t*.

***Proportion of responses since randomization = number of responses at time *t*/number of patients at randomisation.

Table 26. Overview of responses by health state [create a table for both intervention and comparator]

Health state	Number of responses in health state N	Number of patients who have provided at least one response in the health state N
State 1	500	99
State 2	100	60
Etc.	...	...

10.2.1.3 Results ["instrument 1"]

[If a JCA has been prepared, please refer to the relevant sections of the JCA report. Please note that, for preference-based instruments (e.g., EQ-5D-5L), the Danish Medicines Council needs the results calculated with Danish preference weights. These results must be reported in this section if they are not already provided in the JCA report.

Complete table 7 for all measurement time points, and insert a graph showing the mean change (with 95% confidence intervals) since baseline for both the intervention and the comparator, see example in graph below. When reporting an instrument that forms the basis for calculating utility values, the development in index scores (with preference weights) must also be reported. For EQ-5D-5L, for example, both index scores calculated with Danish preference weights and EQ-VAS results must be reported. Results for individual domains must be provided in Appendix G.]

Example of a figure showing average change over time in a given measure of health-related quality of life:

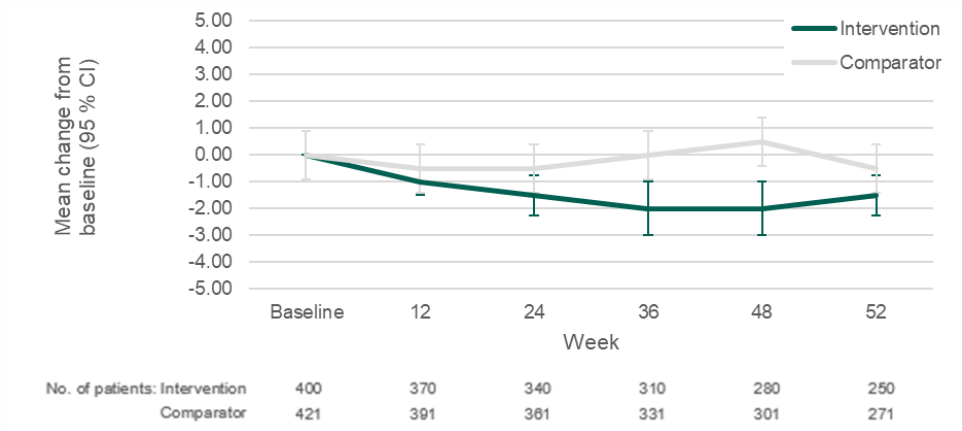

Table 27. Results for [instrument 1]

Time	Intervention	Comparator	Difference
	Average (SE)	Average (SE)	Difference (95%CI)
Baseline			
Time point 1			
Time point 2			
Etc.			

10.2.2 ["Instrument 2"]

10.2.2.1 Study design and instrument ["instrument 2"]

[See Section 10.2.1.1]

10.2.2.2 Data collection ["instrument 2"]

[See Section 10.2.1.2]

10.2.2.3 Results ["instrument 2"]

[See Section 10.2.1.3]

10.2.3 Summary when reporting multiple instruments

[If several different instruments are used, a summary of the advantages and disadvantages of the individual instruments must be provided here, as well as any explanations for differences in reported health-related quality of life between the instruments. Any differences in populations (inclusion and exclusion criteria and patient characteristics) and differences between instruments must also be briefly summarized.]

10.3 Utility values

10.3.1 Dataset(s)

[Describe the dataset(s), including which of the instruments reported in Section 10.2 forms the basis for the calculation of utility values. Indicate whether age adjustment has been performed in accordance with the Danish Medicines Council's methodological guidelines. If there are factors limiting the validity of the comparison of utility values across states, e.g., different sources, instruments or preference weights, these must be described in this section.]

10.3.2 Calculation of utility values

[Describe the choice of regression model, including the underlying assumptions, e.g., regarding correlation between observations within the same individual and handling of missing data. Justify the relationship between the model structure in the health economic model and the regression equation used, including how the explanatory variables reflect the mechanisms (treatment and disease development) driving changes in health-related quality of life of each treatment arms.

All information required to calculate the final utility values, including statistical details on the choice of regression model, the exact specification of regression equations, and the resulting outputs, must be provided in Appendix G.4.]

10.3.3 Adverse events, comorbidity and other state-specific adjustments to the utility values

[If, in certain health states or model cycles, adjustments to the stated utility values are used, e.g., due to comorbidity or adverse events, these must be presented in tabular form in this section, and their inclusion must be justified. Relevant formulas used for the adjustment must also be provided.]

10.3.4 Results for utility values

[Complete Table 28. Present and describe any sensitivity analyses conducted using alternative utility values.]

Table 28. Utility values used in the health economic model

	Utility value [95% CI]	Instrument, preference weight	Source and reference
Main analysis			
State A	0.761 [0.700-0.810]	EQ-5D-5L, UK	Study 1, Section 10.3.2
State B			
...			
Decrease in health-related quality of life			
...			
State A			
...			

11. Cost calculations

[Applicable documentation standards are specified in the Danish Medicines Council's methodological guideline and associated guideline regarding the cost calculations. Section numbering and tables must not be changed. Rows in the tables may be deleted/added.]

11.1 Drug costs

11.1.1 Drug costs for intervention and comparator

[All information regarding dosage must be provided in Sections 3.2 and 3.2.2. The respective dose distributions must form the basis for the calculations. All available packages must be included in the health economic model. Briefly describe how drug costs are calculated.]

11.1.2 Drug costs for subsequent treatment

[All information regarding subsequent treatment and dosage must be provided in Section 3.4. The respective dose distributions must form the basis for the calculations. All available packages must be included in the health economic model. Briefly describe how the drug costs for subsequent treatment are calculated and implemented in the trace in the health economic model.]

11.2 Hospital costs

11.2.1 Administration

[Complete Table 29.]

Table 29. Assumptions regarding administrative costs

Route of administration	Diagnosis and procedure codes*	DRG group	Unit cost, DKK
[E.g., intravenous administration of drug X)]	[E.g., DC679M (A)]	[E.g., 11MA98: 1-dagsgruppe, pat. mindst 7 år]	[DRG tariff in DKK]

*Include other patient information if relevant for the selection of DRG group; A = action diagnosis

11.2.2 Disease management

[Complete Table 30.]

Table 30. Assumptions regarding costs for disease management

Activity/Pathway	Frequency	Duration	Diagnosis and procedure codes*	DRG group	Unit cost
[E.g., visit to oncologist]	[E.g., every 3 weeks]	[E.g., until progression]	[E.g., DC679M (A)]	[E.g., 11MA98: 1-dagsgruppe, pat. mindst 7 år]	[DRG tariff in DKK]
[E.g., CT scan + outpatient visit]	[E.g., every 2 months]	[E.g., first 12 months]	[E.g., DC679M (A) UXCD75 (P)]	[E.g., 30PR06: : CT-scanning, kompliceret]	[DRG tariff in DKK]
[E.g., CT scan + outpatient visit]	[E.g., every 6 months]	[E.g., from 12 to 36 months after	[E.g., DC679M (A) UXCD75 (P)]	[E.g., 30PR06: : CT-	[DRG tariff in DKK]

Activity/Pathway	Frequency	Duration	Diagnosis and procedure codes*	DRG group	Unit cost
		treatment initiation]		scanning, kompliceret]	

*Include other patient information if relevant to the selection of DRG group; A = action diagnosis; P = procedure

11.2.3 Treatment monitoring

[Complete Table 31.]

Table 31. Assumptions regarding costs for treatment monitoring

Activity/Pathway	Frequency	Duration	Diagnosis and procedure codes*	DRG group	Unit cost
[E.g., visit to oncologist]	[E.g., every 3 weeks]	[E.g., until progression]	[E.g., DC679M (A)]	[E.g., : 1-dagsgruppe, pat. mindst 7 år]	[DRG tariff in DKK]
[E.g., CT scan + outpatient visit]	[E.g., every 2 months]	[E.g., first 12 months]	[E.g., DC679M (A) UXCD75 (P)]	[E.g., 30PR06: : CT-scanning, kompliceret]	[DRG tariff in DKK]
[E.g., CT scan + outpatient visit]	[E.g., every 6 months]	[E.g., from 12 to 36 months after treatment initiation]	[E.g., DC679M (A) UXCD75 (P)]	[E.g., 30PR06: CT-scanning, kompliceret]	[DRG tariff in DKK]

*Include other patient information if relevant to the selection of DRG group; A = action diagnosis; P = procedure.

11.2.4 Management of adverse events

[Complete Table 32. As a general rule, only costs for management of adverse events of grade ≥ 3 should be included, and only if the difference between intervention and comparator is ≥ 3 percentage points. If the events are not CTCAE-graded, SAEs may be used instead. Any deviations must be justified. Briefly describe how costs are incorporated into the health economic model.]

Table 32. Assumptions regarding costs for management of adverse events

Adverse event	Proportion		Diagnosis codes*	DRG group	Unit cost
	[Intervention]	[comparator]			
[Admission due to adverse event A, %]	[18%]	[10%]	[E.g., DN179 (A) and DC679M (B), duration ≥ 12 hours (long)]	[11MA01: Akutte medicinske nyresygdomme uden dialyse og uden plasmaferese]]	[DRG tariff in DKK]
[Outpatient visits due to unwanted event B, %]					

*Include relevant procedure codes and other patient information if relevant for the selection of DRG group; A = action diagnosis; B = secondary diagnosis.

11.2.5 Other hospital costs

[Briefly describe all assumptions and sources used if additional hospital costs are included.]

11.3 Patient costs

[Complete Table 33. Briefly explain whether any of the activities occur during the same visit to avoid double-counting.]

Table 33. Assumptions regarding patient time

Activity	Frequency of activity	Time spent on activity	Transport time	Note
[E.g., intravenous administration of drug X]	[E.g., every 2 weeks]	[E.g., 1 hour]	[90 minutes]	
[E.g., visit to oncologist]	[E.g., every 3 weeks]	[E.g., 1 hour]	[0]	E.g., no separate transport time, as it takes place on the same day as IV administration

11.4 Other costs

[Briefly describe all assumptions and sources used if other costs are included.]

12. Results

[Applicable documentation standards are specified in the Danish Medicines Council's methodological guideline and associated guideline regarding uncertainties and sensitivity analyses. Section numbering and tables may not be changed. Rows may be deleted/added in the tables, but the cost categories in Table 34 must not be changed.

Table 34 and Table 35 must be completed. If analyses are conducted as scenarios rather than one base case, please duplicate the tables below for each scenario.]

Table 34. Results, discounted estimates, half-cycle corrected (where relevant) and adjusted for background mortality

	[Intervention]	[Comparator]	Difference
Drug costs			
Drug costs for subsequent treatment			
Administration			
Disease management			
Treatment monitoring			
Management of adverse events			
Patient costs			
Other costs, e.g., co-medication			
...			
Total costs			
Life years in health state A			
Life years in health state B			

	[Intervention]	[Comparator]	Difference
...			
Total life years			
QALYs in health state A			
QALYs in health state B			
...			
Total QALYs			
Incremental costs per life year gained			
Incremental costs per QALY gained (ICER)			

Table 35. Results per drug if combination treatments (more than one drug)

	Drug costs
Intervention: Drug A	
Intervention: Drug B	
…	
Comparator: Drug C	
Comparator: Drug D	
...	

12.1 Sensitivity analyses

12.1.1 Deterministic sensitivity analyses

[Complete Table 36].

Table 36. Results of deterministic sensitivity analyses

Deterministic sensitivity analysis	Incremental costs	Incremental QALYs	ICER
[Sensitivity Analysis 1			

[Sensitivity Analysis 2]
…

12.1.2 Probabilistic sensitivity analyses (PSA)

[Presentation of PSA must include:

- A scatterplot of incremental costs versus incremental QALYs with the average PSA result marked in the plot. For cost minimization analyses, the PSA should be presented as a histogram of incremental costs.
- A brief description of the scatterplot, including the overall pattern and distribution of points (e.g., whether all points lie in the northeast quadrant, or whether, e.g., 20% of the points lie in the northwest quadrant and the remaining 80% in the northeast quadrant).
- A cost-effectiveness acceptability curve (CEAC) plot.
- A convergence plot showing the cumulative average ICER as a function of the number of PSA simulations.

13. Budget impact analysis

[Applicable documentation standards are specified in the Danish Medicines Council's methodological guidelines and associated guideline regarding budget impact analysis. Section numbering and tables must not be changed.

If the health economic analysis is a cost-utility analysis. Table 37 must be completed. Please note that the budget impact must be calculated based on the expected number of patients and patient uptake provided in Section 3.1.2.]

Table 37. Budget impact (non-discounted estimates), DKK

	Year 1	Year 2	Year 3	Year 4	Year 5
Regional costs of recommendation					
Drug costs	[x]	[x]	[x]	[x]	[x]
Other regional hospital costs	[x]	[x]	[x]	[x]	[x]
Total by recommendation	[x]	[x]	[x]	[x]	[x]

	Year 1	Year 2	Year 3	Year 4	Year 5
Regional costs of non-recommendation					
Drug costs	[x]	[x]	[x]	[x]	[x]
Other regional hospital costs	[x]	[x]	[x]	[x]	[x]
Total for non-recommendation	[x]	[x]	[x]	[x]	[x]
Total budget impact	[x]	[x]	[x]	[x]	[x]

14. List of experts

[Provide names, job title, and workplace of clinicians consulted during submission of this application]

15. References

[Insert reference list.]

Appendix A. Study characteristics

[Table 38 must be completed for each included study. If a JCA has been prepared, instead provide a reference to the section in the JCA report where the clinical study is described, without providing further information about the study.]

Table 38. Main characteristics of included studies

Study name	NCT number:
Purpose	[Briefly state the overall purpose of the study]
Publications – title, author, journal, year	[List all publications (including upcoming publications) regarding the study.]
Study type and design	[Report the phase of the study and describe the randomization method , degree of blinding, extent of crossover, status (ongoing or completed), etc. For example: Double-blind randomized placebo-controlled phase 3 study. Included patients were randomly assigned 1:1 using a stratified permuted block randomization system via an interactive response system. Crossover was not permitted. Study officers, patients, and sponsor were blinded during treatment allocation.]
Number of trial participants (N)	
Primary inclusion criteria	
Primary exclusion criteria	
Intervention	[Specify the intervention, including dose, dosing schedule, and number of patients receiving the intervention]
Comparator(s)	[Specify comparator(s), including dose, dosing schedule and number of patients receiving the comparator]
Follow-up time	[Report for primary and secondary endpoints included in the application as well as for safety and HRQoL. For example: Median follow-up for OS of 7.3 months (range 0.5-16.5)]
Is the study used in the health economic model?	[Yes/No. Regarding studies that are not included in the health economic model, but are considered relevant to the submission, the rationale for this must be stated.]

Study name	NCT number:
Primary, secondary and exploratory endpoints	[State all primary, secondary and exploratory endpoints for the trial, regardless of whether the results are disclosed in this application. The definition of included outcomes and results must be stated in E.1.] **Outcomes included in this application :** [For example: The primary endpoint was progression-free survival as assessed by the study director according to RECIST, version 1.1. Secondary efficacy endpoints were overall survival, confirmed objective response according to RECIST, version 1.1, duration of response, progression-free survival assessed by an independent review committee, health-related quality of life (HRQoL) as assessed with the QLQ-C30 and safety. **Other outcomes:** For example: Time to next treatment and objective response rate were included as secondary endpoints in the study, but results are not included in this application.]
Analysis method	[Specify the analysis method. For example: All efficacy analyses were *intention-to-treat* analyses. We used the Kaplan-Meier method to estimate progression-free survival and overall survival rates and a stratified log-rank test for treatment comparisons. Hazard ratios adjusted for XX and YY were estimated using a Cox proportional hazards regression model. The proportional hazards assumption was assessed by looking for trends in the scaled Schoenfeld residuals.]
Subgroup analyses	[Provide the following information for each analysis: - characteristics of the included population - analysis method - was it specified in advance or post hoc? - validity assessment, including statistical power for pre-specified analyses.]
Other relevant information	

Appendix B. Results regarding effectivness per study

[Complete the table for all included studies, regardless of whether they are used in the health economic model or not. Explain how all estimates, e.g. CIs and p-values, have been estimated, including the method used, adjustment variables, stratification variables, weights, corrections (in cases with 0 counts), correlation structure (mixed effects model for repeated measures) and methods used for imputation in connection with missing data. Indicate how assumptions were checked. Survival rates: Indicate the time point for which these were calculated. Relevant subgroup and sensitivity analyses for the individual studies are also inserted here. If a JCA has been prepared, reference is instead given to the section in the JCA report where data from the individual clinical studies are described. If there is a newer data cut from the studies included in the JCA report, the results from the newest data cut are inserted, while the reference to the relevant section in the JCA report is inserted in the "references" column. Table 38 must also be completed for studies that are not included in the JCA report.]

Table 39. Results per study

Results of [study name (NCT number)]											
				Estimated absolute difference in effect			**Estimated relative difference in effect**			**Analysis methods**	**References**
Outcome	**Study arm**	**N**	**Result (CI)**	**Difference**	**95% CI**	***P*- value**	**Difference**	**95% CI**	***P*- value**		
Example: overall median survival (time point)	XXX	247	22.3 (20.3-24.3) months	4.9	1.79-8.01	0.002	HR: 0.70	0.55-0.90	0.005	Median survival is based on the Kaplan-Meier estimator. HR is based on a Cox proportional hazards model adjusting for the variables used for stratification for	
	ZZZ	248	17.4 (15.0-19.8) months								

Results of [study name (NCT number)]											
				Estimated absolute difference in effect			Estimated relative difference in effect			Analysis methods	References
Outcome	**Study arm**	**N**	**Result (CI)**	**Difference**	**95% CI**	***P*- value**	**Difference**	**95% CI**	***P*- value**		
										randomization and study arm.	
Example: 1-year survival	XXX	247	74.5% (68.9-80.2)	10.7	2.39-19.01	0.01	HR: 0.70	0.55-0.90	0.005	Survival rates are based on the Kaplan-Meier estimator. HR is based on a Cox proportional hazards model adjusting for stratification and study arm.	
	ZZZ	248	63.8% (57.6-70.0)								
Insert outcome 3	Intervention										
	Comparator										

Appendix C. Subsequent treatment

[Insert a table with the distribution of subsequent treatment from the clinical trial(s). For each treatment arm, the table should include the proportion of patients who received a subsequent line of treatment and the distribution of subsequent treatments. For example, 80% of patients with progressive disease received a subsequent line of treatment, with 50% receiving drug A and 50% receiving drug B as subsequent treatment.]

Appendix D. Comparative analyses

[For comparative analyses, the table below should be used if no direct comparison is available. For any type of comparative analysis (i.e. paired indirect comparison, network meta-analysis or MAIC analysis), the method, assumptions and results are described here in an appropriate format (text, tables and/or figures, e.g. network meta-diagram for network meta-analyses). Subgroup and sensitivity analyses for comparative analyses are also included here. If a JCA has been prepared, reference should be made instead to the section in the JCA report where the results of the comparative analysis are reviewed. In such cases, Table 40 should only be completed if the analysis has been updated in relation to the JCA, for example if a newer data cut-off is included.]

Table 40. Comparative analysis of studies comparing [intervention] with [comparator] for patients with [indication]

Outcome		Absolute difference			Relative difference			Analysis method	Are results used in the health economic analysis?
	Studies included in the analysis	Difference	CI	P-value	Difference	CI	P-value		
Example: Median overall survival		REACH	REACH	REACH	HR: 0.70	0.55-0.90	0.005	HRs for the included studies were synthesized using random effects meta - analysis (DerSimonian-Laird).	Yes/No
Example: 1-year survival		10.7	2.39-19.01	0.01	HR: 0.70	0.55-0.90	0.005	HRs for the included studies were synthesized using random effects - meta -analysis (DerSimonian-Laird). The absolute difference was estimated by applying the	

Outcome		Absolute difference			Relative difference			Analysis method	Are results used in the health economic analysis?
	Studies included in the analysis	Difference	CI	P-value	Difference	CI	P-value		
								posterior HR to an assumed 1-year survival rate of 64.33% in the comparator group.	
Outcome 3									

Appendix E. Extrapolation of patient transitions

E.1 Parametric extrapolation models

[When extrapolating multiple clinical outcomes, use the same order when presenting the outcomes as in Section 9.2.**Fejl! Henvisningskilde ikke fundet.**]

E.1.1 Extrapolation of [clinical endpoint 1]

[Justifications for the choice of extrapolation models must be done systematically, which implies:

- a review of log-cumulative hazard plots and (Schoenfeld) residual plots to support arguments for whether the treatment arms should be modeled separately (independently) or joint, and to investigate whether there are structural shifts that supports the use of more flexible models will be relevant (Section E.1.1.1).
- an assessment of both internal and external validity by comparing several different models (Sections E.1.1.2 and E.1.1.3).]

E.1.1.1 Log-cumulative hazard plots and residual plots

[Include log-cumulative hazard plots and (Schoenfeld) residual plots, and describe what these show and what conclusions are drawn from them.]

E.1.1.2 Internal validity

E.1.1.2.1 Assessment of statistical and visual fit (AIC and BIC)

[Include table with AIC and BIC for each treatment arm and discuss statistical and visual fit within the observation period.]

E.1.1.2.2 Assessment of smoothed hazard functions

[Include a plot of the hazard function of the outcome. The plots should be presented in separate figures for the intervention and comparator, respectively, and should include the estimated hazard for the observed data. The plot should be discussed in connection with the chosen distribution.]

E.1.1.3 External validity

[Explain the external validity with a focus on clinical plausibility and in relation to evidence from external sources. Include figures and tables that support the external validity, including comparison of modelled data and external data.]

E.1.1.4 Other assumptions

[This section is used if there are assumptions that require an in-depth and longer description]

E.1.2 Extrapolations of [clinical endpoint 2]

[To be completed as E.1.1]

E.2 Transition probabilities

E.2.1 Internal validity

[Supporting tables and figures can be inserted here.]

E.2.2 External validity

[Supporting tables and figures can be inserted here.]

E.2.3 Other assumptions

[This section is used if there are assumptions that require an in-depth and longer description.]

Appendix F. Serious adverse events

[Indicate all serious adverse events with a frequency of ≥ 1% observed in the study(s) on which the assessment is based. If a JCA has been prepared, reference should be made instead to the section of the JCA report where the serious adverse events are described.]

Appendix G. Health-related quality of life

G.1 Data collection – overview of responses

[If a JCA has been performed, please refer to the relevant sections of the JCA report.]

G.2 Reporting of domains

[For each measurement, frequencies and proportions are presented for each domain and each level. The development over time (and possibly across treatment arms) is presented in figures.

If a JCA has been performed, reference is made to the relevant sections of the JCA report.]

G.3 Mapping

[Description of mapping study.]

G.4 Calculation of utility values

[Applicant must describe and justify how the utility values for the individual health states are calculated, including all necessary formulas to calculate the final utility values. The description should cover the choice of regression model, choice of explanatory variables, presentation of final model and regression results (parameter estimates, standard errors and confidence intervals), validation of final model, uncertainties and sensitivity analyses.]

Appendix H. Literature searches for the clinical assessment

H.1 Effect and safety of intervention and comparators

[Describe the literature search, including purpose and search strategy. Explain the concepts used, any search filters and limitations.

Insert tables with databases and other sources used. Name, platform/website and date(s) of the searches must be provided. See examples of tables below.]

Example of table. Bibliographic databases

Database	Platform/Website	Date of search
PubMed/Medline	Ovid/https://pubmed.ncbi.nlm.nih.gov	dd.mm.yyyy
Embase	Ovid/www.embase.com	dd.mm.yyyy

Example of table. Other sources

Source	Website	Search strategy/ keywords used	Date of search
NICE	www.nice.org.uk	'non-small cell lung cancer'	dd.mm.yyyy

[The searches must be documented with search strings line by line, including the number of hits. They can be inserted into tables in this section or submitted as supplementary attachments in any format (e.g. Word or PDF).]

H.2 Systematic selection of studies and references

[Describe the selection process, including number of reviewers, and how disagreements were resolved.

Complete Table 41. with inclusion and exclusion criteria (PICOS) or replace with a corresponding table. If a broader SLR is used, it must be stated whether there are changes in the criteria for Danish conditions, e.g. in relation to (smaller) population or (fewer) comparators.

Table 41 must be populated with studies/references that are included in the assessment, and Table for the studies/references that are excluded. These must also be submitted in supplementary annexes.]

Table 41. Inclusion and exclusion criteria [must be deleted/replaced]

Clinical effect	Inclusion criteria	Exclusion criteria	Change, local adaptation
Population			
Intervention			
Comparators			
Outcome			
Study design/ publication type			
Limitations, e.g. language			

[Complete the PRISMA diagram below or replace with an equivalent one. If a broader SLR is used, the boxes for 'Local adaptation' must indicate how many studies/publications are transferred to and omitted from the Danish assessment.]

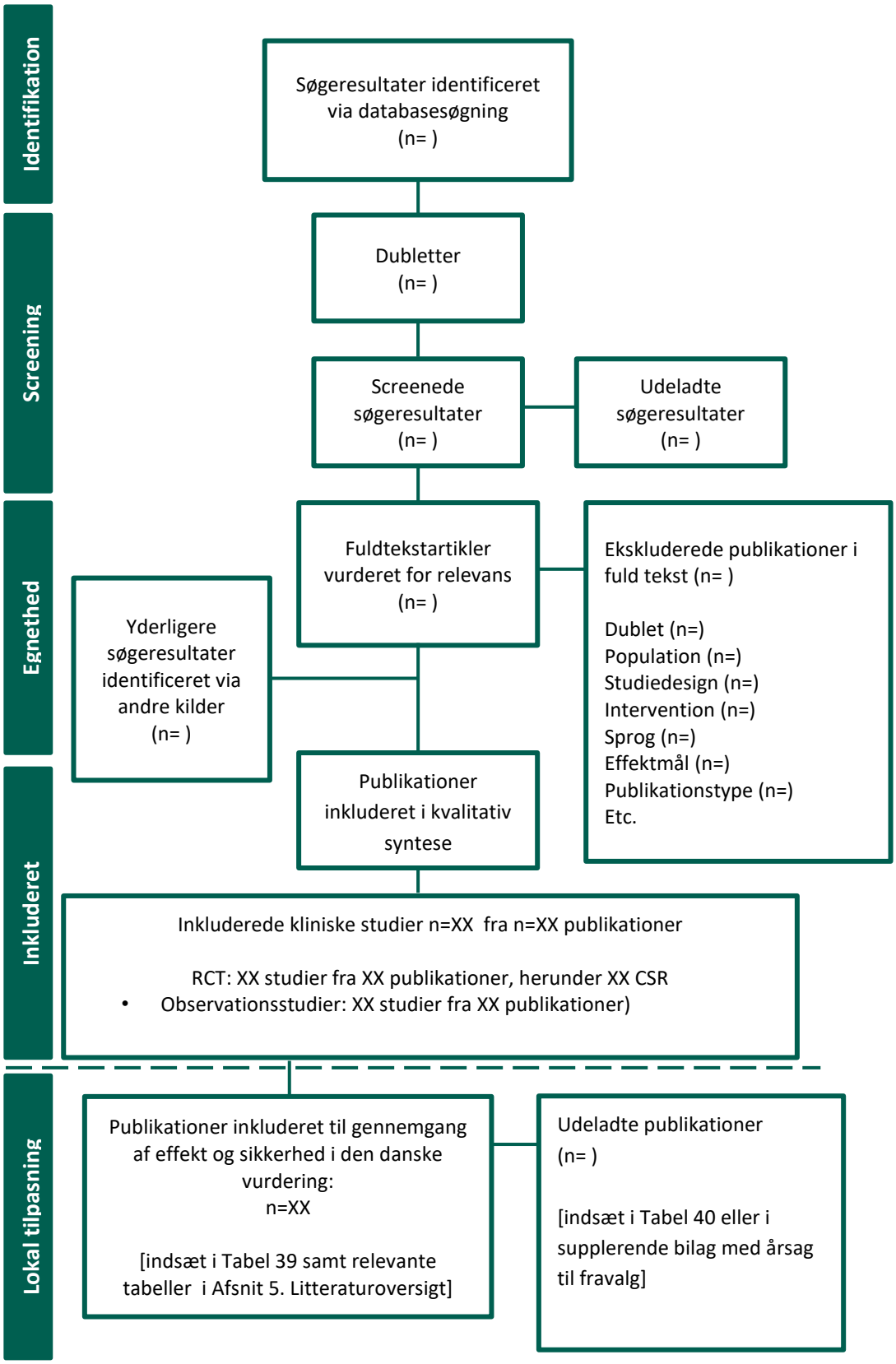
Identifikation
Screening
Egnethed
Inkluderet
Lokal tilpasning
Søgeresultater identificeret via databasesøgning (n=)
Dubletter (n=)
Screenede søgeresultater (n=)
Udeladte søgeresultater (n=)
Fuldtekstartikler vurderet for relevans (n=)
Ekskluderede publikationer i fuld tekst (n=)
Dublet (n=)
Population (n=)
Studiedesign (n=)
Intervention (n=)
Sprog (n=)
Effektmål (n=)
Publikationstype (n=)
Etc.
Yderligere søgeresultater identificeret via andre kilder (n=)
Publikationer inkluderet i kvalitativ syntese
Inkluderede kliniske studier n=XX fra n=XX publikationer
RCT: XX studier fra XX publikationer, herunder XX CSR
Observationsstudier: XX studier fra XX publikationer)
Publikationer inkluderet til gennemgang af effekt og sikkerhed i den danske vurdering: n=XX
[indsæt i Tabel 39 samt relevante tabeller i Afsnit 5. Litteraturoversigt]
Udeladte publikationer (n=)
[indsæt i Tabel 40 eller i supplerende bilag med årsag til fravalg]

Table 42. Studies/references included in the Danish assessment

Study	Reference(s)
Study 1	
Study 2	

Table 43. Excluded studies/references [may alternatively be submitted as a supplementary appendix]

Study	Reference(s)
Study 1	
Study 2	

Appendix I. Literature searches for health-related quality of life

I.1 Systematic search

[Follow instructions/structure for appendix H. The tables can be copy-pasted as needed.]

I.2 Focused search

[Describe the purpose of the search and which sources were used, as well as the date of execution. The search must be documented/described to the fullest extent possible, including the search technique and keywords used, and criteria for relevance assessment.

Insert a table with identified references, and transfer the references included in the assessment to the relevant table in the Literature overview section.]

Appendix J. Literature searches for supplementary input to the health economic model

J.1 Systematic search

[Follow instructions/structure for appendix H. The tables can be copy-pasted as needed.]

J.2 Focused search

[Describe the purpose of the search and which sources were used, as well as the date of execution. The search must be documented/described to the fullest extent possible, including the search technique and keywords used, and criteria for relevance assessment. Insert a table with identified references, and transfer the references included in the assessment to the relevant table in the Literature overview section.]

Appendix K. Reasons for confidential information

[The company must provide concrete and specific justifications explaining why each redacted element is of significant importance to the company and why it should not be disclosed to the public. This applies, among other things, to unpublished data from the study, estimated health gains (life years and QALYs), utility values, treatment duration, expected patient numbers, use of non-confidential data to extrapolate patient transitions, and name, job title and workplace of clinical experts. The justifications for confidential information must be provided in Table 44].

Table 44. Justifications regarding confidential information

Parameter	Justification
[Confidential information 1]	[Concrete and specific justification]
[Confidential information 2]	[Concrete and specific justification]
….	

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