HPR150

OPTIMISING PRICING MODELS FOR WEIGHT-BASED AND MULTI-STOCK-KEEPING UNIT (SKU) THERAPIES IN THE EU4

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BACKGROUND

Products with different dosing requirements across patients and indications often have multiple SKUs, creating challenges in modelling consumption and projecting total costs for payers. As such, manufacturers face the challenge of selecting the right pricing model for these products, which has implications on patient access, commercial viability, and payer acceptability in launch markets. Commonly used pricing models for multi-SKU products include linear (i.e., price increases with dose), flat (i.e., one price for different doses), and hybrid linear-flat models.

This research aims to explore the factors influencing the choice of pricing model from a manufacturer perspective and outline the advantages and disadvantages of each pricing model from an EU4 (France, Germany, Italy and Spain) **payer perspective.**

METHODOLOGY

Six multi-SKU drugs authorised by the European Medicines Agency between 2015 and 2024, covering both adult and paediatric indications, were **identified**. **Secondary research** was then performed to extract the following information for each drug: pricing model applied, Health Technology Assessment (HTA) outcomes, launch prices, and reimbursement restrictions in in the EU4. Findings from the secondary research were **validated through interviews with fourteen ex-payers** in the EU4: DE (4), ES (5), FR (3), IT (2). **Insights from both the primary and secondary research** were synthesised to identify the key factors guiding pricing model selection as well as the advantages and disadvantages of each model.

RESULTS

TABLE 1. HTA AND REIMBURSEMENT OUTCOMES FOR PRODUCTS AT INITIAL INDICATION

	Drug	Product attributes (SKUs)	Indication at launch (year)	Reimbursement (EUR) and annual treatment cost			
				🇫🇷	🇩🇪	🇮🇹	🇪🇸
Flat	**Praluent** (alirocumab)	Fixed dose (75,150,300)	HcH[1] (150mg - 2015)	Restricted, 3L[2]	Restricted[a] no added benefit[3]	Reimbursed with strict registries[4]	Restricted[5]
				~€6k	~€5k	~€6k	~€5k
	Jyseleca (filgotinib)	Fixed dose (100,200)	RA[6] (2020)	Restricted, women's only[7]	Reimbursed no added benefit[8]	Reimbursed (Class H)[9]	Restricted[10]
				~€7k	~€13k	~€9k	~€12k
	Briviact (brivaracetam)	Fixed dose (10,25,75,100)	Epilepsy[11] (2016)	Reimbursed[12]	Reimbursed[13]	Reimbursed[14]	Reimbursed[15]
				<€1k	~€1k	~€1.5k	<€1k
Hybrid	**Cosentyx** (secukinumab)	Weight-based dose (75,150,300)	PsA[16] (2015) (Adults + Paediatrics)	Restricted, 3L[17]	Reimbursed no added benefit[18]	Restricted (Class H)[19]	Restricted[20]
				~€17k	~€23k	~€18k	~€20k
Linear	**Ultomiris** (ravulizumab)	Weight-based dose (300,1100)	PNH[21] (2018) (Adults + Paediatrics)	Reimbursed[22]	Reimbursed no added benefit[23]	Reimbursed (Class H)[24]	Reimbursed[25]
				~€335k	~€335k	~€340k	~€340k
	Bylvay (odevixibat)	Weight-based dose (200,400,600,1200)	PFIC[26] (2024) (Adults + Paediatrics)	Restricted, 2L[27]	Reimbursed[28]	Reimbursed[29]	Reimbursed[30]
				~€630k	~€630k	~€624k	~€630k

Reimbursed with restrictions | Reimbursed without restrictions

Across the EU4, pricing architecture shaped implementation restrictions rather than HTA outcomes. Products that adopted flat pricing achieved reimbursement in the EU4; however, access was frequently restricted (except Briviact) where clinical differentiation to comparators was modest or potential budget impact due to population variability implied higher spend. In contrast, products with linear pricing experienced minimal reimbursement restrictions, reflecting their positioning in rare disease indications with smaller patient populations and lower budget impact. (Table 1)

TABLE 2. ADVANTAGES AND DISADVANTAGES OF THE DIFFERENT PRICING MODELS RAISED BY PAYERS

	Advantages	Disadvantages
Flat	✓ **Cost predictability per patient:** Easier budgeting per patient ✓ **Easier to manage:** Streamlined contracting and negotiations	× **Risk of overpaying for some patients:** Higher cost for low-dose patients × **Comparison challenges:** Hard to benchmark vs. linear priced comparators
Linear	✓ **Alignment with consumption:** Price scales with dose ✓ **Familiarity for payers:** Standard approach in most markets	× **Complexity:** Complicated weight distribution modelling × **Variable cost based on dosing frequency:** Dosing frequency adds uncertainty
Hybrid	✓ **Balance of models:** Potential fairness across doses ✓ **Flexibility:** Ability tailor to market needs	× **Admin burden:** Multiple contracts and SKUs × **Limited uptake:** Viewed as impractical by payers

Findings from primary research highlighted distinct advantages associated with each pricing model from a payer perspective. Flat pricing was valued by payers for its operational simplicity and straightforward dose-mix forecasting. Meanwhile, hybrid pricing was perceived to balance price simplicity with dose equity, offering a middle ground between predictability and fairness. Lastly, payers noted the value of linear pricing in offering per-mg equity and alignment with actual product consumption. **Overall, payers expressed a stronger preference for flat pricing, reflecting its ease of implementation and administrative efficiency.** (Table 2)

CONCLUSION

In selecting the appropriate pricing model, manufacturers should consider factors including operational complexity, payer needs, local precedents, dose variability, and revenue implications. Results indicate that flat models offer operational simplicity and cost predictability per patient, hybrid models align with real-world dose distributions, while linear models are most suitable for weight-based dosing and rare diseases requiring per-mg equity. Pricing strategies that reflect both market realities and product value will enable manufacturers to balance clinical, commercial, and access goals.

Notes: a. Praluent is only reimbursed when other, more cost-effective lipid-lowering agents are insufficient or not tolerated. Only non-familial hypercholesterolaemia / mixed dyslipidaemia with persistent LDL-C elevation, and ASCVD patients or very-high/high-risk patients with persistent LDL-C elevation are eligible for Praluent in Germany. **Abbreviations:** 2L: Second Line; 3L: Third Line; DE: Germany; ES: Spain; EU4: France, Germany, Italy, and Spain; EUR: Euro; FR: France; HcH: Hepatocellular Carcinoma; HTA: Health Technology Assessment; IT: Italy; PFIC: Progressive Familial Intrahepatic Cholestasis; PNH: Paroxysmal Nocturnal Hemoglobinuria; PsA: Psoriatic Arthritis; RA: Rheumatoid Arthritis; SKU: Stock Keeping Unit. **References:** 1. EMA: Praluent EPAR. 2. Praluent HAS (2021). 3. G-BA: Drug Directive, Appendix III. 4. Praluent AIFA (2024). 5. Praluent CIPM (2016). 6. EMA: Jyseleca EPAR. 7. Jyseleca HAS (2021). 8. Filgotinib (RA) G-BA (2021). 9. Gazetta Ufficiale (2023). 10. Jyseleca CIPM (2021). 11. EMA: Briviact EPAR. 12. Briviact HAS (2016). 13. Brivaracetam G-BA (2016). 14. Gazzetta Ufficiale (2023). 15. Briviact CIPM (2016). 16. EMA: Cosentyx EPAR. 17. Cosentyx HAS (2016). 18. Secukinumab (PsA) G-BA (2020). 19. Gazzetta Ufficiale (2020). 20. Cosentyx IPT: AEMPS (2015). 21. EMA: Ultomiris EPAR. 22. HAS: Ultomiris (2020). 23. Ravulizumab G-BA (2020). 24. Gazzetta Ufficiale (2021). 25. Ultomiris CIPM (2022). 26. EMA: Bylvay (EPAR). 27. Bylvay HAS (2021). 28. Bylvay G-BA (2022). 29. AIFA Bylvay (2022). 30. Bylvay CIPM (2023)