EE461

The total cost of care and budget impact of introducing mosunetuzumab plus polatuzumab vedotin for second-line or later (2L+) treatment of relapsed/refractory large B-cell lymphoma (LBCL) to a United States (US) health plan

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Summary

We conducted an **economic analysis to assess the total cost of care** (TCC) among 2L+ treatment options **and the budget impact** of introducing subcutaneous mosunetuzumab plus intravenous polatuzumab vedotin (**Mosun-Pola**) as a treatment for relapsed/refractory (R/R) LBCL to a US health plan

Over 3 years, the **TCC for Mosun-Pola was lower** compared with treat-to-progression epcoritamab, tafasitamab plus lenalidomide (Tafa-Len) and chimeric antigen receptor (CAR) T-cell therapies

The eligible and treated population is small at 17 patients in a 1-million-member plan. The addition of **Mosun-Pola** resulted in a 3-year average **per-member per-month (PMPM) net budget impact of $0.016**

The one-way sensitivity analyses (OWSA) found that the **model results were robust**

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Background

- The Phase III SUNMO trial (NCT05171647), that evaluated Mosun-Pola versus rituximab (R) with gemcitabine and oxaliplatin (R-GemOx) in patients with R/R LBCL, met its primary endpoints of progression-free survival and objective response rates, and demonstrated low cytokine release syndrome (CRS) rates with the regimen (Grade 1: 21%; Grade 2: 4%; Grade 3: 1%).[1]
- An economic analysis was conducted to assess the TCC among 2L+ treatment options, and the budget impact of introducing Mosun-Pola to a US health plan as a treatment for R/R LBCL.
- The study enrolled patients with R/R LBCL who had previously received ≥1 line of therapy.

Methods

- A 3-year budget impact model was developed for a hypothetical cohort of 1 million individuals enrolled in a mixed commercial/Medicare health plan.
- LBCL incidence rates were sourced from the SEER database (22 registries, November 2022 Submission) and the proportions of patients who received first-line (1L), 2L, and third-line (3L) treatment were derived from projected incidence rates based on physician surveys[2] (**Table 1**).
- Average sales price (ASP) for 2L+ regimens was obtained from The Centers for Medicare and Medicaid Services pricing (Quarter 1 [Q1] 2026) and used for the Medicare population.
- Wholesale acquisition cost (WAC) was obtained from AnalySource® 2026 and used for the commercial population.

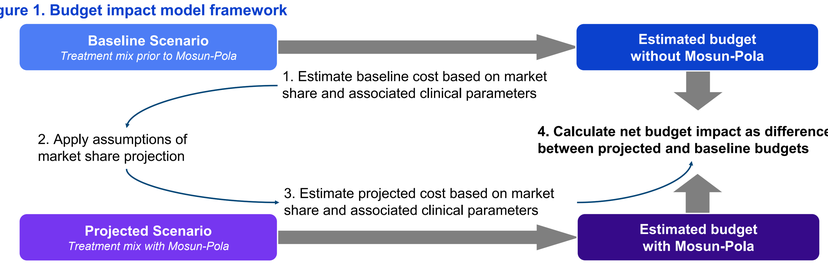
Table 1. Sources for population age and LBCL incidence and treatment for the blended commercial/Medicare population

	Blended commercial/ Medicare proportion	Blended commercial/ Medicare population (n)	Source
Plan size		1,000,000	Assumption
Population age 18–64 years | ≥65 years	57.3% | 18.6%	573,000 | 186,000	US Census (https://www.census.gov/data.html)*
LBCL incidence 18–64 years | ≥65 years	0.0047% | 0.0337%	27 | 63	Adult LBCL incidence (SEER Research Limited-Field Data; 22 Registries, November 2022 Submission)
Received 1L LBCL treatment 18–64 years | ≥65 years	91.0% | 91.0%	25 | 57	Kanas et al. (2022)[2]
Received 2L LBCL treatment 18–64 years | ≥65 years	30.8% | 30.8%	8 | 18	Kanas et al. (2022)[2]
2L ASCT-ineligible 18–64 years | ≥65 years	**50.0% | 50.0%**	**4 | 9**	Sehn et al. (2021)[3]
Received 3L+ LBCL treatment 18–64 years | ≥65 years	**34.9% | 34.9%**	**1 | 3**	Kanas et al. (2022)[2]
Total eligible for treatment (annually)		**5 | 12**	

*We used age distributions from US census data for insured individuals and assumed patients <65 years had commercial coverage and patients ≥65 years had Medicare coverage.
ASCT, autologous stem cell transplant.

- Net budget impact was estimated as the difference in costs between the projected scenario with Mosun-Pola and the current scenario without Mosun-Pola (**Figure 1**)
  - PMPM costs were calculated by dividing the total healthcare expenses incurred by the total number of members covered and by a specific time period (e.g. 12 months for a 1-year time period).

Figure 1. Budget impact model framework



- Total cost per treated patient was calculated as the sum of all direct medical costs over the model time horizon of 3 years based on the mean duration of treatment (number of cycles) from pivotal clinical trials (**Table 2**)
  - Where applicable, costs were inflated to 2026 US dollars (USD) using the Bureau of Labor Statistics Medical Care component of the consumer price index and were based on published US sources.

Table 2. Budget impact model overview

Population	R/R LBCL	• Adults aged ≥18 years with R/R LBCL
Comparators	R/R LBCL regimens	• **Bispecifics**: Mosun-Pola, glofitamab, Glofit-GemOx, epcoritamab* • **CAR T-cell therapies**: axi-cel, liso-cel, tisa-cel • **Others**: Tafa-Len, Lonca, Pola-BR, R-chemo (R-GemOx)
Perspective	US payers	• US payer perspective; blend of Medicare (70%) and commercial (30%) patients
Time horizon	3 years	• 3-year time horizon as base-case, flexible to explore 1–3 years
Costs	Direct medical costs	• Cost inputs include drug†, administration‡, routine care (office visits and tests), CRS management§, and AE management¶

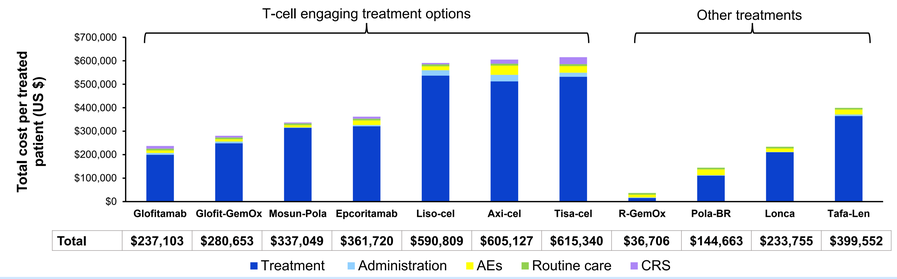
*Epcoritamab plus GemOx was included in the market share for epcoritamab monotherapy. †Sourced from the average WAC reported in AnalySource® (2026) or Medicare ASP (Q1 2026). ‡Based on treatment duration in pivotal trials (medians were converted to means using published methods);[4] mean durations for all therapies were under 1 year, except Tafa-Len. §Unit costs of CRS events by grade ($12,414 for Grades 1–2 and $101,699 for Grade 3+ in 2026 USD) were obtained from Badaracco et al (2023)[5] and inflated to 2026 US dollars. ¶Costs associated with the management of Grade ≥3 AEs occurring in ≥5% of patients in any regimen; AE incidence rates were sourced from each regimen's US package insert or pivotal trial. AE, adverse event; axi-cel, axicabtagene ciloleucel; Glofit-GemOx, glofitamab plus gemcitabine and oxaliplatin; liso-cel, lisocabtagene maraleucel; Lonca, loncastuximab tesirine; Pola-BR, polatuzumab vedotin + bendamustine + rituximab; R-chemo, rituximab-based chemotherapy; tisa-cel, tisagenlecleucel.

- OWSA varied inputs by ±20% to test the robustness of model results.

Results

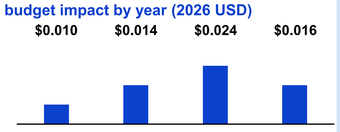
- Of the 1 million individuals in the hypothetical health plan, approximately 17 were projected to be eligible annually for treatment of R/R LBCL after 1L therapy and ASCT-ineligible or after ≥2L therapy (**Table 1**).
- Over the model time horizon, the TCC for Mosun-Pola was lower versus 2L+ treatments, including axi-cel, liso-cel and Tafa-Len, but higher than Glofit-GemOx (**Figure 2**).
- Among 3L treatments, the TCC for Mosun-Pola was lower than epcoritamab and tisa-cel, but higher than Lonca, glofitamab and Pola-BR. Mosun-Pola is projected to have lower administration, AE, and CRS costs compared with other bispecific antibodies and CAR T-cell therapies (**Figure 2**).
- Over 3 years, the addition of Mosun-Pola resulted in an estimated cumulative budget impact of $580,444 ($18,386,377 with Mosun-Pola vs $17,805,934 without); the PMPM net budget impact was $0.016 (**Figure 3**).
- The minimal net budget impact was driven primarily by drug acquisition costs, with cost-offsets in administration, AEs, CRS, and routine care (**Table 3**).
- The OWSA showed robust results; the most influential variables were population inputs and patient characteristics that influence dosing, varying the budget impact from $0.0129 to $0.0193 (**Figure 4**).

Figure 2. The total cost per treated patient over 3 years by regimen and cost category (2026 USD)



	Glofitamab	Glofit-GemOx	Mosun-Pola	Epcoritamab	Liso-cel	Axi-cel	Tisa-cel	R-GemOx	Pola-BR	Lonca	Tafa-Len
Total	**$237,103**	**$280,653**	**$337,049**	**$361,720**	**$590,809**	**$605,127**	**$615,340**	**$36,706**	**$144,663**	**$233,755**	**$399,552**

Figure 3. PMPM budget impact by year (2026 USD)

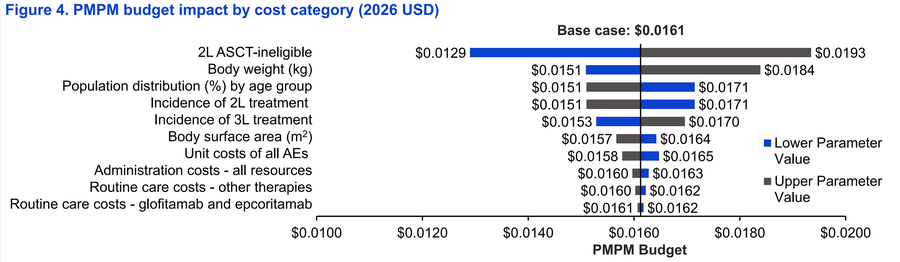


Budget	Year 1	Year 2	Year 3	Overall
Current scenario	$5,550,080	$6,099,693	$6,156,161	$17,805,934
Projected scenario	$5,668,714	$6,268,914	$6,448,749	$18,386,377
Net budget impact	$118,635	$169,221	$292,588	$580,444
Average PMPM budget impact	$0.010	$0.014	$0.024	**$0.016**

Table 3. Budget impact by cost category (2026 USD)

Cost Category	Net Budget Impact Year 1	Year 2	Year 3	Overall
Treatment	$142,861	$203,041	$333,740	$679,642
Administration	-$7,773	-$11,417	-$11,243	-$30,434
AE	-$14,461	-$20,243	-$23,857	-$58,561
CRS	-$1,831	-$1,984	-$5,909	-$9,724
Routine care	-$161	-$175	-$143	-$479
Total	**$118,635**	**$169,221**	**$292,588**	**$580,444**
Average incremental treatment cost	**2.9%**	**3.8%**	**6.2%**	**4.4%**

Figure 4. PMPM budget impact by cost category (2026 USD)



Limitations

- Inputs based on clinical trials may not always be generalizable to the real world.
- Treatment landscape projections are based on internal market research and clinical expert opinions.
- In this 3-year model, no patients are assumed to have additional treatment after discontinuing their initial 2L+ treatment, and no patients are assumed to have died.
- This model is primarily a cost-comparison tool, no comparative efficacy or safety conclusions can be drawn from its outputs.

Conclusions

- The addition of Mosun-Pola, a fixed-duration outpatient therapy, to a US payer formulary is projected to result in a minimal budget impact that remains robust in OWSA.
- The TCC of Mosun-Pola is projected to be lower compared with treat-to-progression bispecific antibodies, such as epcoritamab, and CAR T-cell therapies.
- The addition of Mosun-Pola is projected to have lower administration, AE, and CRS costs compared with other bispecifics and CAR T-cell therapies, resulting in cost-offsets to the health plan in the model.
- These results support the use of Mosun-Pola as a meaningful option for 2L+ R/R LBCL.

Presented at the 2026 ISPOR Annual Meeting | May 17–20, 2026 | Philadelphia, PA, USA

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Acknowledgements

This analysis was sponsored by Genentech, Inc. Third-party editorial assistance, under the direction of all authors, was provided by Berta Fatás, PhD, of Ashfield MedComms, an Inizio company, and was funded by Genentech, Inc.

Disclosures

JW: consultancy: AbbVie/GenMab, AstraZeneca, Nurix, Janssen, Morphosys/Incyte, ADC Therapeutics, Bristol Myers Squibb, Genentech, Inc., Kite/Gilead, Allogene, Novartis, Regeneron, Pfizer, Lyell; research funding: AstraZeneca, Nurix, Janssen, Morphosys/Incyte, ADC Therapeutics, Bristol Myers Squibb, Genentech, Inc., Kite/Gilead, Allogene, Novartis, Regeneron. **DE:** current employment: Genentech, Inc. **KLR:** current employment: Genentech, Inc. **AM:** current employment: Genentech, Inc. **AL-R:** current employment: Genentech, Inc. **DL:** current employment: Genentech, Inc. **CF:** consultancy: AbbVie, Bayer, BeiGene, Celgene, Denovo Biopharma, Foresight Diagnostics, Genentech, Inc./Roche, Genmab, Gilead, Karyopharm, N-Power Medicine, Pharmacyclics/Janssen, SeaGen, Spectrum; stock options: Foresight Diagnostics, N-Power Medicine; research funding: 4D, AbbVie, Acerta, Adaptimmune, Allogene, Amgen, Bayer, BostonGene, Celgene, Cellectis EMD, Gilead, Genentech, Inc./Roche, Guardant, Iovance, Janssen Pharmaceutical, Kite, Morphosys, Nektar, Novartis, Pfizer, Pharmacyclics, Sanofi, Takeda, TG Therapeutics, Xencor, Ziopharm, Burroughs Wellcome Fund, Eastern Cooperative Oncology Group, National Cancer Institute, V Foundation, Cancer Prevention and Research Institute of Texas (RR190079): CPRIT Scholar in Cancer Research.

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