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Austrian Institute for
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Lurbinectedin (ZEPZELCA®) in combination with atezolizumab for extensive-stage small cell lung cancer

Health Technology Assessment

Appendix

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List of abbreviations

AE..... Adverse Event
AT..... Atezolizumab monotherapy
BRCA..... Breast cancer gene
BSA..... Body Surface Area
BSC..... Best Supportive Care
CE..... Cost-Effectiveness
CI..... Confidence Interval
CSCO..... Chinese Society of Clinical Oncology
CT..... Computed Tomography
EQ-5D..... EuroQol 5-Dimension
ES-SCLC..... Extensive-Stage Small-Cell Lung Cancer
ESMO..... European Society for Medical Oncology
FDA..... Food and Drug Administration
G-CSF..... Granulocyte Colony stimulating Factor
GDP..... Gross Domestic Product
HTA..... Health Technology Assessment
ICER..... Incremental Cost-Effectiveness Ratio
IV..... Intravenous
JCA..... Joint Clinical Assessment
LALUCA..... Longitudinal Analysis of Lung Cancer Data
LU-AT..... Lurbinectedin + Atezolzumab combination
MRI..... Magneted Resonance Imaging
n.a..... not applicable
NCCN..... National Comprehensive Cancer Network
NRDL..... National Reimbursement Drug List
OECD..... Organisation for Economic Co-operation and Development
OS..... Overall Survival
PD..... Progressive Disease
PFS..... Progression-free Survival
PSA..... Probabilistic Sensitivity Analysis
PICO……..Population, Intervention, Comparator, Outcome
QALY..... Quality-Adjusted Life Year
QoL..... Quality of Life
RECIST..... Response Evaluation Criteria in Solid Tumours
SCLC..... Small Cell Lung Cancer
USA..... United States of America
WTP..... Willingness-To-Pay

1 Introduction

No content.

2 Scope of assessment

No content.

3 Methods

Guiding questions

Table 3-1: Health problems and current use [1]

Element ID	Research question
A0001	For which health conditions, and for what purposes, is the technology used?
A0002	What is the disease or health condition in the scope of this assessment?
A0003	What are the known risk factors for the disease or health condition?
A0004	What is the natural course of the disease or health condition?
A0005	What is the burden of disease for patients with the disease or health condition?
A0006	What are the consequences of the disease or health condition for society?
A0024	How is the disease or health condition currently diagnosed according to published guidelines and in practice?
A0025	How is the disease or health condition currently managed according to published guidelines and in practice?
A0007	What is the target population in this assessment?
A0023	How many people belong to the target population?

Table 3-2: Description of the technology [1]

Element ID	Research question
B0001	What is the technology and the comparator(s)?
A0020	For which indications has the technology received marketing authorisation or CE marking?
B0002	What is the claimed benefit of the technology in relation to the comparators?
B0003	What is the phase of development and implementation of the technology and the comparator(s)?
B0004	Who administers the technology and the comparators, and in what context and level of care are they provided?
B0008	What kind of special premises are needed to use the technology and the comparator(s)?
B0009	What supplies are needed to use the technology and the comparator(s)?
A0018	What are the other typical or common alternatives to the current technology?
A0022	Who manufactures the technology?

Table 3-3: Economic aspects [1]

Element ID	Research question
E0001	What types of resources are used when delivering the assessed technology and its comparators (resource-use identification)?
A0002	What amounts of resources are used when delivering the assessed technology and its comparators (resource-use measurement)?
E0009	What were the measured and/or estimated costs of the assessed technology and its comparator(s)?
G0007	What are the likely budget impacts of implementing the technologies being compared?
E0005	What is (are) the measured and/or estimated health-related outcome(s) of the assessed technology and its comparator(s) (outcome identification, measurement and valuation)?
E0006	What are the estimated differences in costs and outcomes between the technology and its comparator(s)?

Element ID	Research question
E0010	What are the uncertainties surrounding the costs and economic evaluation(s) of the technology and its comparator(s)?
E0013	What methodological assumptions were made in relation to the technology and its comparator(s)?
E0012	To what extent can the estimates of costs, outcomes, or economic evaluation(s) be considered as providing valid descriptions of the technology and its comparator(s)?

Table 3-4: Organisational, ethical and social aspects [1]

Element ID	Research question
G001	How does the technology affect the current work processes?
G002	What kind of involvement has to be mobilised for patients/participants and important others and/or caregivers?
H0200	What are the experiences of living with the condition?
H0100	What expectations and wishes do patients have with regard to the technology, and what do they expect to gain from the technology?
H0002	What is the burden on caregivers?
H0202	How are treatment choices explained to patients?

4 Clinical effectiveness and safety

No content.

5 Price comparisons, treatment costs and budget impact

5.1 Pharmacoeconomic model(s)

5.1.1 Submitted pharmacoeconomic model

No pharmaco-economic model has been submitted by the HTD.

5.1.2 Economic evaluation based on pharmacoeconomic models

Table 5-1: Economic evaluation of lurbinectedin in adults with treatment-naive extensive-stage small-cell lung cancer

Author, year (REF)	Country	Intervention and comparator	Target population (base case)	Economic evaluation	Model	Perspective and time horizon	Utility values	Severity modifier	Discount rate	Model assumptions
Huang Y., Xu Z., Bao L., 2025 [2]	China and United States	Lurbinectedin (3.2 mg/m^2) + atezolizumab (1200 mg) IV every 3 weeks (LU-AT) vs atezolizumab monotherapy (1200 mg) IV every 3 weeks (AT)	Adults (≥18 years) with treatment-naive extensive-stage small-cell lung cancer (ES-SCLC), following 4 cycles of induction therapy with AT + carboplatin + etoposide	Cost-utility analysis; outcomes reported as total costs, QALYs, and ICER ($/QALY)	Partitioned Survival Analysis (PartSA) model built; 3 health states: PFS, progressive disease (PD), and death; cycle length 21 days; 102 cycles (8.5 years); log-logistic distribution for both PFS and OS curves	Payer perspective (China's healthcare system and US healthcare system) Time horizon: 8.5 years (102 cycles of 21 days), with 99% of patients projected to die within this period	PFS: 0.673 (range 0.5384-0.8076); PD: 0.473 (range 0.3784-0.5676); sourced from published literature (You et al., 2024)	Not reported / not applicable	5% annually for both costs and utilities (range 0-8% in sensitivity analysis), per Chinese Pharmacoeconomic Evaluation Guidelines	(1) Topotecan-based chemotherapy as standard second-line treatment for both arms per NCCN/CSCO guidelines (2) 37% of LU-AT and 49% of AT patients received second-line chemotherapy post-progression (3) Second-line treatment duration set at 1.73 months based on Song et al. (4) Remaining patients received BSC (5) Only direct medical costs included

Author, year (REF)	Country	Intervention and comparator	Target population (base case)	Economic evaluation	Model	Perspective and time horizon	Utility values	Severity modifier	Discount rate	Model assumptions
							Disutility decrements applied for grade ≥3 AEs (>5% incidence): anaemia: 0.073, decreased neutrophil count: 0.200, decreased platelet count: 0.050, neutropenia: 0.090, thrombocytopenia: 0.190			(6) Grade ≥3 AEs with >5% incidence accounted for
Zhu J., Li Z., Song D., Liu W., 2026 (in press) [3]	United States	LU+AT vs AT alone	Hypothetical cohort of 65-year-old patients with ES-SCLC, confirmed by histology or cytology, who completed 4-cycle induction with atezolizumab + etoposide/platinum without disease progression, then entered maintenance phase	Cost-effectiveness analysis; Outcomes reported as total costs (USD), QALYs, and ICER ($/QALY); WTP threshold $100,000–$150,000/QALY gained	Partitioned survival model (three health states: PF, PD, death); driven by PFS and OS Kaplan-Meier curves from the IMforte trial; Cycle length 21 days	US healthcare system (direct medical costs only) 10-year base case (scenario analyses at 5, 15, and 20 years)	PF state: 0.75 (range 0.60–0.90) PD state: 0.70 (range 0.56–0.84) Source: EQ-5D-5L data from US NSCLC patients used as proxy (Yang et al. 2023) Disutilities (grade 3–4 AEs, applied as one-time decrements in cycle 1): Anaemia: 0.07 Decreased neutrophil count: 0.20 Decreased platelet count: 0.05 Neutropenia: 0.09	Not reported / not applied	3% per annum for both costs and QALYs (varied 0%–8% in sensitivity analysis)	Proportional hazards assumption was tested and not supported; independent parametric models fitted per treatment arm: OS for lurbinectedin arm: restricted cubic spline (RCS1); OS for atezolizumab arm: log-logistic PFS for lurbinectedin arm: Royston-Parmar hazard spline (RP-hazard-1); PFS for atezolizumab arm: Royston-Parmar normal spline (RP-normal-1) Survival extrapolated over full 10-year horizon using best-fitting models

Author, year (REF)	Country	Intervention and comparator	Target population (base case)	Economic evaluation	Model	Perspective and time horizon	Utility values	Severity modifier	Discount rate	Model assumptions
							Thrombocytopenia: 0.25			Drug wastage explicitly modelled as a cost component in the base case: lurbinectedin supplied in single-dose vials; unused portions discarded per product label; doses rounded up to nearest vial size; no vial sharing or cross-patient pooling assumed in base case; wastage estimated at 2.18 mg/patient-cycle (~$4,496/patient-cycle); wastage rate ~27% Only grade 3–4 AEs included in cost analysis NSCLC utility values used as proxy for ES-SCLC (no ES-SCLC-specific EQ-5D-5L data available) AE disutilities applied as one-time decrements in the first treatment cycle BSC costs applied to patients not receiving subsequent anti-cancer therapy after progression

Author, year (REF)	Country	Intervention and comparator	Target population (base case)	Economic evaluation	Model	Perspective and time horizon	Utility values	Severity modifier	Discount rate	Model assumptions
										Drug costs based on wholesale acquisition costs (RED BOOK); healthcare service costs from 2024 CMS rates; all costs adjusted to 2024 USD using the Consumer Price Index for Medical Care 10,000 Monte Carlo simulations conducted for PSA; beta distributions for utilities, AE incidence, and proportions receiving subsequent treatment; gamma distributions for cost parameters

Abbreviations: AE…Adverse Event, AT…Atezolizumab monotherapy, BSC…Best Supportive Care, CSCO…Chinese Society of Clinical Oncology, ES-SCLC…Extensive-Stage Small-Cell Lung Cancer, ICER…Incremental Cost-Effectiveness Ratio, IV…Intravenous, KM…Kaplan-Meier, LU-AT…Lurbinectedin + Atezolizumab combination, NCCN…National Comprehensive Cancer Network, OS…Overall Survival, PartSA…Partitioned Survival Analysis, PD…Progressive Disease, PFS…Progression-Free Survival, QALY…Quality-Adjusted Life Year, RECIST…Response Evaluation Criteria in Solid Tumours, WTP…Willingness-To-Pay

Table 5-2: Main results of the included economic evaluations of Lurbinectedin in adults with treatment-naive extensive-stage small-cell lung cancer

Author, year (REF)	Country	Incremental costs (base case)	Incremental utilities (base-case)	ICER (base-case) and CE-threshold applied (base-case)	Sensitivity and scenario analyses	Reflection
Huang Y., Xu Z., Bao L., 2025 [2]	China and United States	China: LU-AT total cost $134,590.58 vs AT $55,632.29 → incremental cost $78,958.29 USA: LU-AT total cost $400,754.83 vs AT $174,698.00 → incremental cost $226,056.83	LU-AT: 0.88 QALYs vs AT: 0.67 QALYs → incremental gain of 0.21 QALYs This result was identical for both the China and USA analyses, as the same clinical efficacy data (IMforte trial) and utility values were applied in both models	China ICER: $374,167.43/QALY gained WTP: $40,365/QALY (3× 2024 per capita GDP, per Chinese Pharmacoeconomic Evaluation Guidelines) USA ICER: $1,071,237.82/QALY gained WTP: $150,000/QALY Both ICERs far exceed their respective thresholds → LU-AT deemed not cost-effective in either setting	One-way sensitivity analysis: The four most influential parameters in both countries were: (1) utility of PFS, (2) cost of lurbinectedin, (3) BSA, and (4) cost of AT. Even when the price of lurbinectedin was reduced to zero, LU-AT remained non-cost-effective, attributed to prolonged AT use in the LU-AT arm. The ICER consistently exceeded the WTP threshold across all parameter variations. PSA: 1,000 Monte Carlo simulations: 95% CI: $270,324-$488,936/QALY gained (China); $786,394-$1,446,804/QALY (USA). Probability of LU-AT being cost-effective vs. AT: 0% at both WTP thresholds. Scenario analysis: (1) Model runtime varied to 2, 4, and 6 years - China ICERs: $535,117, $422,205, and $390,617/QALY gained respectively; USA ICERs: $1,543,361, $1,211,656, and $1,119,293/QALY gained, respectively. Longer treatment duration improved but did not achieve cost-effectiveness. (2) Sensitivity analysis on survival curve parameters to adjust for ethnic differences did not alter the conclusion of non-cost-effectiveness.	The study demonstrates that despite a statistically meaningful survival benefit (median PFS 5.4 vs 2.1 months; median OS 13.2 vs 10.6 months), the incremental QALY gain is modest (0.21 QALYs), and the high costs of dual maintenance therapy with LU-AT render the regimen non-cost-effective in both settings. Limitations: (1) Survival extrapolation beyond trial follow-up introduces potential bias (2) Limited Asian patient representation in the IMforte trial may affect generalisability to Chinese populations (3) Second-line treatment assumptions are based on trial data and published literature, which may not reflect real-world practice (4) Only grade ≥3 AEs with >5% incidence were modelled (5) Potential national drug price negotiations (as seen with toripalimab and tislelizumab in China) to reduce ICERs below WTP thresholds, and note that the US "most-favoured-nation" pricing executive order (May 2025) may similarly affect future cost-effectiveness. The study provides a baseline model for re-evaluation following potential price adjustments in both countries

Author, year (REF)	Country	Incremental costs (base case)	Incremental utilities (base-case)	ICER (base-case) and CE-threshold applied (base-case)	Sensitivity and scenario analyses	Reflection
Zhu J., Li Z., Song D., Liu W., 2026 (in press) [3]	United States	+$229,342.16 (LU+AT vs. AT alone): total costs $382,776.03 (LU+AT) vs $153,433.87 (AT); 88% of total costs in LU-group incurred during PF state; drug wastage contributed ~$4,496.25/patient-cycle and increased total LU-group costs by approximately 13%	+0.30 QALYs (1.26 vs. 0.96); 35% of QALYs accumulated in PF state in LU-group; majority of QALYs accumulated in PD state across both groups	ICER: $773,428.44/QALY gained; Combination therapy deemed not cost-effective at current prices. To achieve cost-effectiveness at $150,000/QALY threshold, LU price would need to fall from $8,250/4mg to $1,212.75/4mg, and AT price from $11,589.36/1200mg to $1,703.63/1200mg (reductions of ~85%)	One-way sensitivity analysis: Most influential parameters (in order): utility in PD state, price of LU, price of AT, utility in PF state, post-progression treatment cost in LU-group A 30% reduction in LU price reduced ICER by 24% but did not change the overall conclusion PSA (10,000 Monte Carlo simulations): At current prices: 0% probability of cost-effectiveness at $150,000/QALY At 20% of original price: still not cost-effective at $150,000/QALY At 10% of original price: 97.3% probability of cost-effectiveness at $150,000/QALY; 12.8% at $100,000/QALY At 5% of original price: cost-effective at $100,000/QALY threshold Scenario analyses: Scenario 1 (no drug wastage, 10-year): ICER = $606,228.36/QALY; incremental cost reduced to $179,762.88; 81% joint price reduction required for cost-effectiveness Scenario 2 (5-year horizon + drug wastage): ICER = $1,336,736.33/QALY; incremental QALYs only 0.17 Scenario 3 (15-year horizon + drug wastage): ICER = $554,559.65/QALY; incremental QALYs 0.42	ES-SCLC-specific EQ-5D-5L utility values unavailable; NSCLC proxy values used, interchangeability unvalidated, though sensitivity analyses suggest minimal impact on conclusions Drug wastage and mitigation strategy estimates based on theoretical projections; not externally validated with real-world data Dose reductions due to treatment-related toxicities not incorporated due to limited available data Cross-patient vial sharing not universally permitted (e.g. prohibited in India), limiting generalisability Efficacy and safety tolerance of LU to dose rounding (±10%) not yet confirmed in real-world evidence Indirect comparison approach: model driven by a single RCT (IMforte); no network meta-analysis or head-to-head comparison with other emerging maintenance regimens Societal costs (productivity loss, informal care) excluded given US healthcare system perspective, potentially underestimating true economic burden

Author, year (REF)	Country	Incremental costs (base case)	Incremental utilities (base-case)	ICER (base-case) and CE-threshold applied (base-case)	Sensitivity and scenario analyses	Reflection
					Scenario 4 (20-year horizon + drug wastage): ICER = $444,522.09/QALY; incremental QALYs 0.53 Scenario 5 (20-year horizon, no drug wastage): ICER = $350,360.81/QALY; 65% price reduction required at $150,000/QALY threshold Scenario 6 (10-year + dose rounding ±10%): median total cost Lu+Ate = $349,245.38; ICER = $660,350.41/QALY; 80% price reduction required Scenario 7 (10-year + vial sharing, large cancer centres): wastage reduced from 27.2% to 1.2%; monthly saving $399.72; ICER = $611,600.47/QALY; 82.1% price reduction required at $150,000/QALY Scenario 8 (10-year + vial sharing + Drug Day, outpatient clinics): wastage reduced to 4%; monthly saving $387.00; ICER = $619,593.53/QALY; 82.6% price reduction required at $150,000/QALY Alternative time horizons and parametric survival models tested; conclusions consistent across all	The very large price reductions required (65–85%) to achieve cost-effectiveness are unlikely to be achieved through current negotiation mechanisms alone, raising broader access and affordability concerns for this patient population

Abbreviations: AE…Adverse Event, AT…Atezolizumab monotherapy, BSA…Body Surface Area, CE…Cost-Effectiveness, CI…Confidence Interval, CSCO…Chinese Society of Clinical Oncology, EQ-5D…EuroQol 5-Dimension (preference-based quality of life instrument), ES-SCLC…Extensive-Stage Small-Cell Lung Cancer, GDP…Gross Domestic Product, ICER…Incremental Cost-Effectiveness Ratio, Imforte…Phase III clinical trial of lurbinectedin plus atezolizumab in ES-SCLC, LU-AT…Lurbinectedin + Atezolizumab combination, NCCN…National Comprehensive Cancer Network, NRDL…National Reimbursement Drug List, OECD…Organisation for Economic Co-operation and Development, OS…Overall Survival, OWSA…One-Way Sensitivity Analysis, PD…Progressive Disease, PFS…Progression-Free Survival, PSA…Probabilistic Sensitivity Analysis, QALY…Quality-Adjusted Life Year, QoL…Quality of Life, USA…United States of America, WTP…Willingness-To-Pay

5.1.3 Quality assessment of the included economic evaluation based on pharmaco-economic models

Table 5-3: Check of reporting standards – the CHEERS checklist [4]

#	Domain	Huang Y., Xu Z., Bao L., 2025 [2]	Zhu J., Li Z., Song D., Liu W., 2026 (in press) [3]
TITLE			
1	Title	✅ Reported	✅ Reported
ABSTRACT			
2	Abstract	✅ Reported	✅ Reported
INTRODUCTION			
3	Background & objectives	✅ Reported	✅ Reported
METHODS			
4	Health economic analysis plan	❌ Not reported[1]	❌ Not reported[2]
5	Study population	✅ Reported	✅ Reported
6	Setting and location	✅ Reported	✅ Reported
7	Comparators	✅ Reported	✅ Reported
8	Perspective	⚠️ Partial[3]	✅ Reported
9	Time horizon	✅ Reported	✅ Reported

[1] No pre-registered or published health economic analysis plan referenced.

[2] No pre-registered or separately published health economic analysis plan is referenced. The authors state adherence to CHEERS 2022 guidelines but do not report a prospectively registered analysis plan.

[3] Payer/healthcare system perspective stated for both countries; formal rationale for perspective choice not explicitly provided.

#	Domain	Huang Y., Xu Z., Bao L., 2025 [2]	Zhu J., Li Z., Song D., Liu W., 2026 (in press) [3]
10	Discount rate	✅ Reported	✅ Reported
11	Selection of outcomes	✅ Reported	✅ Reported
12	Measurement of outcomes	⚠️ Partial[4]	⚠️ Partial[5]
13	Valuation of outcomes	⚠️ Partial[6]	⚠️ Partial[7]
14	Measurement & valuation of resources and costs	✅ Reported	✅ Reported
15	Currency, price date & conversion	✅ Reported	✅ Reported
16	Rationale & description of model	✅ Reported	✅ Reported
17	Analytics & assumptions	✅ Reported	✅ Reported
18	Characterising heterogeneity	⚠️ Partial[8]	⚠️ Partial[9]
19	Characterising distributional effects	❌ Not reported[10]	❌ Not reported[11]
20	Characterising uncertainty	✅ Reported	✅ Reported

[4] Utility values sourced from published literature (You et al. 2024) as IMforte trial collected no QoL data; this limitation is acknowledged.

[5] QALYs are used as the primary effectiveness measure and survival data are reconstructed from IMforte trial KM curves using a validated algorithm (Guyot et al.). However, no primary utility data collection was conducted; ES-SCLC-specific utility data are unavailable and NSCLC proxy values are used without formal validation of their transferability to this population.

[6] Source study cited but instrument used (e.g. EQ-5D version, value set) and elicitation method in original source not described in this paper.

[7] Utility values are sourced from published EQ-5D-5L data in US NSCLC patients as a proxy. The authors acknowledge this as a key methodological limitation and test it in sensitivity analyses. However, the absence of condition-specific utility measurement and the unvalidated cross-condition assumption prevents full reporting status.

[8] No formal subgroup analysis by patient characteristics; ethnic variation addressed only via scenario analysis on survival curve parameters.

[9] Subgroup analyses are not conducted. The model simulates a single hypothetical cohort of 65-year-old patients based on the IMforte trial population. BSA variability is incorporated in the dose rounding Monte Carlo simulation, but broader patient-level heterogeneity (e.g. by performance status, prior treatment response, or comorbidity) is not explored.

[10] No equity or distributional analysis across patient subgroups reported.

[11] No equity analysis or assessment of distributional consequences across patient subgroups, socioeconomic strata, or geographic settings is presented.

#	Domain	Huang Y., Xu Z., Bao L., 2025 [2]	Zhu J., Li Z., Song D., Liu W., 2026 (in press) [3]
21	Approach to engagement with patients and others	❌ Not reported[12]	❌ Not reported[13]
RESULTS			
22	Study parameters	✅ Reported	✅ Reported
23	Summary of main results	✅ Reported	✅ Reported
24	Effect of uncertainty	✅ Reported	✅ Reported
25	Effect of engagement with patients and others	❌ Not reported[14]	❌ Not reported[15]
DISCUSSION			
26	Study findings, limitations, generalizability & current knowledge	✅ Reported	✅ Reported
OTHER			
27	Source of funding	✅ Reported	✅ Reported
28	Conflicts of interest	✅ Reported	✅ Reported
OVERALL		✅ **Reported: 20** ⚠️ **Partial: 4** ❌ **Not reported: 4**	✅ **Reported: 21** ⚠️ **Partial: 3** ❌ **Not reported: 4**

Table 5-4: CHEC list quality assessment [5]

[12] No patient, clinician, or stakeholder engagement described; no expert consultation reported.

[13] No patient, caregiver, or stakeholder involvement in model development, outcome selection, or interpretation is described.

[14] Not applicable — no engagement undertaken.

[15] Follows directly from item 21; no results relating to patient or stakeholder engagement are reported.

#	Item	Huang Y., Xu Z., Bao L., 2025 [2]	Zhu J., Li Z., Song D., Liu W., 2026 (in press) [3]
1	Is the study population clearly described?	✅ Yes	✅ Yes
2	Are competing alternatives clearly described?	✅ Yes	✅ Yes
3	Is a well-defined research question posed in answerable form?	✅ Yes	✅ Yes
4	Is the economic study design appropriate to the stated objective?	✅ Yes	✅ Yes
5	Is the chosen time horizon appropriate in order to include relevant costs and consequences?	✅ Yes	✅ Yes
6	Is the actual perspective chosen appropriate?	⚠️ Unclear[16]	✅ Yes
7	Are all important and relevant costs for each alternative identified?	✅ Yes	✅ Yes
8	Are the measurements of outcomes appropriate?	⚠️ Unclear[17]	⚠️ Unclear[18]
9	Is an incremental analysis of costs and outcomes performed?	✅ Yes	✅ Yes
10	Are all future costs and consequences discounted appropriately?	✅ Yes	✅ Yes
11	Are all important uncertain variables subjected to sensitivity analysis?	✅ Yes	✅ Yes
12	Are the costs of the interventions described?	✅ Yes	✅ Yes

[16] Healthcare payer perspective stated for both countries; only direct medical costs included; indirect costs (productivity loss, caregiver burden) excluded without explicit justification for this choice.

[17] Utility values borrowed from a prior study (You et al. 2024) as IMforte trial collected no QoL data; the instrument and value set used in the source are not described; appropriateness for this specific trial population is uncertain.

[18] However, utility values are derived from US NSCLC patients as a proxy for ES-SCLC, as no condition-specific EQ-5D-5L data exist for this population. The cross-condition transferability of these utility weights has not been formally validated, introducing uncertainty into the QALY calculations, and the authors themselves acknowledge this as a key methodological limitation.

#	Item	Huang Y., Xu Z., Bao L., 2025 [2]	Zhu J., Li Z., Song D., Liu W., 2026 (in press) [3]
13	Are all direct and indirect costs and consequences described?	⚠ Unclear[19]	⚠ Unclear[20]
14	Are the costs properly measured and valued?	✅ Yes	✅ Yes
15	Is the effectiveness established based on a systematic review?	❌ No[21]	❌ No[22]
16	Is the model structure described?	✅ Yes	✅ Yes
17	Do the conclusions follow from the data reported?	✅ Yes	✅ Yes
18	Does the study discuss generalisability to other settings or patient groups?	⚠ Unclear	⚠ Unclear[23]
19	Does the article indicate no potential conflict of interest?	✅ Yes	✅ Yes
OVERALL		**✅ Yes: 14** **⚠ Unclear: 4** **❌ No: 1**	**✅ Yes: 15** **⚠ Unclear: 3** **❌ No: 1**

[19] Only direct medical costs included; indirect costs (productivity loss, informal care) and non-medical direct costs excluded; this exclusion is not explicitly justified in the methods.

[20] Direct medical costs are comprehensively identified and described, including drug acquisition (with drug wastage explicitly modelled), intravenous administration, follow-up examinations, adverse event management, best supportive care, and end-of-life care. However, indirect costs, such as productivity losses, informal caregiver burden, and patient out-of-pocket costs, are entirely excluded by virtue of the US healthcare system perspective. While this is consistent with the stated perspective, the absence of any indirect costs means not all costs and consequences relevant to patients and society are captured, warranting an unclear rather than a full yes rating.

[21] Effectiveness data sourced solely from the IMforte Phase III RCT; no systematic review or network meta-analysis conducted to identify all relevant comparators or confirm best available evidence.

[22] Clinical effectiveness data are drawn exclusively from a single RCT, the phase III IMforte trial. No systematic review or network meta-analysis was conducted to identify, appraise, or synthesise the broader evidence base for lurbinectedin plus atezolizumab or to contextualise its efficacy relative to other comparators beyond atezolizumab monotherapy.

[23] The authors acknowledge that findings are specific to the US healthcare system and that cross-patient vial sharing assumptions may not be applicable in other countries where it is prohibited (e.g. India). However, the discussion of generalisability is limited and largely confined to the drug wastage scenarios.

6 Extended perspectives

6.1 Stakeholder perspectives

Table 6-1: Questions for clinical experts

Questions about the relevance of JCA-PICOs	
Question 1	Sind alle 7 PICOs aus österreichischer Versorgungsperspektive relevant, oder können einzelne PICOs als weniger relevant eingestuft werden?
Questions about the standard of care in Austria	
Question 2	Welche Leitlinien werden in Ihrer Einrichtung für diese Indikation angewendet (z.B. ESMO, S3)?
Question 3	Welche Therapieoptionen würden Sie aktuell als Standard- bzw. Vergleichstherapie für diese Indikation in Österreich betrachten?
Questions about the target population in Austria	
Question 4	Gibt es Subgruppen, die in der klinischen Versorgungspraxis tatsächlich nicht für die Therapie infrage kommen, obwohl sie formal von der Zulassung umfasst sind?
Question 5	Einschätzung der Zielpopulation
Questions about resource use and organisational aspects	
Question 6	Wird in Ihrer klinischen Praxis bei Lurbinectedin eine Primärprophylaxe mit G-CSF eingesetzt? Falls ja: welches Präparat, in welcher Dosierung und bei welchen Patient:innen?
Question 7	Werden Lurbinectedin und Atezolizumab in der Praxis voraussichtlich am selben Behandlungstag verabreicht?
Question 8	Welche routinemäßigen Kontrolluntersuchungen werden bei Patient:innen unter Atezolizumab durchgeführt? Sind neben regelmäßigen Schilddrüsenfunktionstests weitere Kontrollen relevant, z. B. Labor, Leberwerte, Nierenfunktion, endokrinologische oder pneumologische Abklärung bei Verdacht auf immunvermittelte Nebenwirkungen?
Question 9	Sind für die sichere Anwendung von Lurbinectedin zusätzliche organisatorische Maßnahmen, Infrastruktur (z.B. MRT, CT) oder Schulungen des medizinischen Personals erforderlich
Questions about further relevant aspects	
Question 10	Ethische Aspekte: Gibt es aus Ihrer Sicht ethische Aspekte im Zusammenhang mit der Anwendung von Lurbinectedin, die in der Bewertung berücksichtigt werden sollten?
Question 11	Falls bereits eigene klinische Erfahrungen mit Lurbinectedin vorliegen: Gibt es weitere Aspekte der klinischen Anwendung oder Versorgungssituation, die aus Ihrer Sicht für die Bewertung relevant sind und bisher nicht angesprochen wurden?
Question 12	Register/Dokumentation: Welche Register gibt es (österreichweit)? Werden neue Therapien in Österreich erfasst? Neben z.B. LALUCA-Register
Question 13	Gibt es zusätzliche relevante Aspekte seitens der klinischen Expert:innen, die im Zuge der HTA-Erstellung berücksichtigt werden sollten?

Abbreviations: CT … Computertomographie, ESMO … European Society for Medical Oncology, G-CSF … Granulozyten-Kolonie-stimulierender Faktor, HTA … Health Technology Assessment, JCA … Joint Clinical Assessment, LALUCA … Longitudinal Analysis of Lung Cancer Data, MRT … Magnetresonanztomographie, PICO … Population, Intervention, Komparator, Outcome

6.2 Patient´s perspective

Table 6-2: Questions asked to patients, carers or members of patient organisations

Question 1	Rolle des Ausfüllenden (einzelne(r) Patient(in)/Angehörige/Andere).
Question 2	Nur für Angehörige/Vertreter:innen einer Patient:innenorganisation: Wie sind Sie an Informationen zu den Erfahrungen von Patient:innen gelangt?
Question 3	In welchem Land befindet sich Ihr Hauptwohnsitz?
Question 4	Sind Sie Mitglied einer Patient:innenorganisation? ■ 4a: Bei welcher Patient:innenorganisation sind Sie Mitglied? ■ 4b: Welche Erkrankung(en) werden von der Patient:innenorganisation vertreten? ■ 4c: Welche Rolle haben Sie in der Patient:innenorganisation?
Question 5	■ 5a: Wie lautet die Diagnose? Bitte geben Sie die Erkrankung an, an der Sie/Ihre Angehöriger/Ihr Angehöriger leiden/leidet. ■ 5b: In welchem Stadium Ihrer Erkrankung befindet befinden Sie sich? Wie würden Sie den Schweregrad aktuell einschätzen? ■ 5c: Welche Symptome haben Sie oder hat Ihre Angehörige/Ihr Angehöriger derzeit? ■ 5d: Krankheitsgeschichte: Seit wann leben Sie/Ihre Angehörige/Ihr Angehöriger mit der Erkrankung? Wann wurde sie diagnostiziert? Welche Behandlungen wurden bisher durchgeführt? ■ 5e: Zusätzliche Informationen, die Ihrer Meinung nach für den HTA-Bericht hilfreich wären.
Question 6	Wie beeinflusst die Erkrankung Ihr tägliches Leben (bzw. das Leben eines Patienten/einer Patient:in)?
Question 7	Wie wirkt sich die Erkrankung auf Ihr familiäres und soziales Umfeld aus?
Question 8	Wie wirkt sich die Erkrankung auf das familiäre und soziale Umfeld der Patient:innen aus?
Question 9	Wie würden Sie die aktuelle Versorgungssituation in Österreich für Ihre Erkrankung beschreiben?
Question 10	Wie geht es Ihnen/Ihrer Angehörigen/Ihrem Angehörigen mit der derzeit angewandten Therapie? Falls keine spezifische Therapie zur Verfügung steht, geben Sie dies bitte an.
Question 11	Was würden Sie oder Ihre Angehörigen oder Ihr Angehöriger im Allgemeinen von einer neuen Therapie erwarten?
Question 12	Kennen Sie das Arzneimittel Lurbinectedin (ZEPZELCA®)?
Question 13	Welche Gedanken haben Sie zum neuen Arzneimittel?
Question 14	Für Personen, die Erfahrung mit ZEPZELCA® im Rahmen klinischer Studien haben: Welche Auswirkungen hatte bzw. Was hat es auf Ihr Leben (positiv und negativ) ausgemacht?
Question 15	Was ist Ihrer Meinung nach noch wichtig? Gibt es weitere Aspekte, z.B. ethische oder soziale Aspekte, die noch nicht besprochen wur-den? Bitte erläutern Sie diese.

Abbreviations: HTA … Health Technology Assessment

6.3 Further considerations

No content.

6.4 Austrian registries and documentation of lurbinecetdin use

No content.

6.5 Interpretation of findings

No content.

7 Development costs and public contributions

7.1 Own development costs, acquisitions and licenses

No content.

7.2 Public contributions to drug development

Table 7-1: Financing/patent deals/licensing/funding rounds of all companies involved in the development of ZEPZELCA®

Type of information	Details on collaboration, financing, and public funding	Year	Amount	Funders/Investors/ Acquiror	Source
Jazz Pharmaceuticals					
Licensing agreement	Exclusive license agreement with PharmaMar pursuant to which they obtained exclusive U.S. development and commercialisation rights to ZEPZELCA®.	2019	n.a.	PharmaMar	2025 10-K SEC-report https://www.sec.gov/Archives/edgar/data/1232524/000123252426000013/jazz-20251231.htm
Licensing agreement	Amended license agreement with PharmaMar to expand to Canada	2020	n.a.	PharmaMar	2025 10-K SEC-report https://www.sec.gov/Archives/edgar/data/1232524/000123252426000013/jazz-20251231.htm
Patent information	One Orange Book listed U.S. patent (expiring in 2029, with granted patent term extension) covers a genus of compounds, including lurbinectedin, and use in treating various cancers. A request for extension has also been filed in Canada. ZEPZELCA® has also been granted orphan drug exclusivity for the treatment of adults with metastatic SCLC with disease progression on or after platinum-based chemotherapy until 2027 and new chemical entity exclusivity, which expired in 2025. Orphan drug exclusivity for the second indication is anticipated, which, if granted, would expire in October 2032.	n.a.	n.a.	n.a.	2025 10-K SEC-report https://www.sec.gov/Archives/edgar/data/1232524/000123252426000013/jazz-20251231.htm

Type of information	Details on collaboration, financing, and public funding	Year	Amount	Funders/Investors/ Acquiror	Source
Licensing agreement details	Licensing agreement between Jazz Pharmaceuticals and PharmaMar. The agreement became effective in January 2020 and Jazz Pharmaceuticals made an upfront payment of $200.0 million. PharmaMar is also eligible to receive milestone payments totalling up to $800.0 million based on regulatory and commercial milestones. PharmaMar is also eligible to receive incremental tiered royalties on future net sales of lurbinectedin ranging from the high teens up to 30 percent.	2020	$200.0 million	Jazz Pharmaceuticals	2019 10-K SEC-report https://www.sec.gov/Archives/edgar/data/1232524/000123252420000016/jazz1231201910k.htm
PharmaMar					
This part includes confidential information!					
Milestone payment	In addition, in October 2025, a regulatory milestone set forth in the license agreement was reached, triggered by the granting of full approval for ZEPZELCA (lurbinectedin) in combination with atezolizumab as a first-line maintenance treatment for adults with SCLC by the U.S. FDA. As a result, PharmaMar received a payment of $50 million (€42,586,000).	2025	$50 million	Jazz Pharmaceuticals	PharmaMar Memorias anuales, Cuentas Anuales Individuales https://pharmamar.com/es/inversores/informacion-financiera/memorias-anuales/ https://pharmaphorum.com/news/pharmamar-and-jazz-sign-1bn-us-deal-for-lung-cancer-drug
Licensing agreement	In April 2025, Pharma Mar entered into an exclusive licensing agreement with the German company Merck Healthcare KGaA for the development and commercialisation of ZEPZELCA (lurbinectedin) in Japan. Under this agreement, Pharma Mar received an upfront payment of 22 million euros. The agreement also includes a series of regulatory and commercial milestones that, if achieved, would generate revenue for Pharma Mar, as well as certain percentages of royalties on sales, when they occur. The commitments assumed by the Group as a result of this agreement are: • Granting of a license for lurbinectedin in Japan, including marketing rights for that territory.	2025	Advance payment of €22 mill	Merck Healthcare KGaA	PharmaMar Memorias anuales, Cuentas Anuales Individuales https://pharmamar.com/wp-content/uploads/2026/02/CUENTAS-ANUALES-INDIVIDUALES-2025.pdf

Type of information	Details on collaboration, financing, and public funding	Year	Amount	Funders/Investors/ Acquiror	Source
Licensing agreement	Pharma Mar received a non-refundable payment of $100 million (€88.5 million) in June 2020, in addition to the $200 million (€181 million) up-front payment it had received in January 2020 upon signing the license agreement. Similarly, it may receive additional payments of up to $150 million once the FDA grants full approval of ZEPZELCA™ within the specified timeframes. Additionally, Pharma Mar may receive up to $550 million for commercial milestones, in addition to royalties on net sales of ZEPZELCA.	2020	$100 million in non-refundable payment of June 2020 $200 million in January 2020 as an upfront payment for the signing of the license agreement.	Jazz Pharmaceuticals	PharmaMar Memorias anuales, Cuentas Anuales Individuales https://pharmamar.com/wp-content/uploads/2021/11/CUENTAS-ANUALES-INDIVIDUALES-2020.pdf
Agreement of marketing	In December 2024, Pharma Mar's partner for China, Hong Kong, and Macau, Luye Pharma Group, received conditional marketing approval from China's National Medical Products Administration for ZEPZELCA® for the treatment of adult patients with metastatic SCLC. In connection with this approval, Pharma Mar received $5 million (€4.409 million).	2024	Payment of $5 mill	Luye Pharma	PharmaMar Memorias anuales, Cuentas Anuales Individuales https://pharmamar.com/wp-content/uploads/2026/02/CUENTAS-ANUALES-INDIVIDUALES-2025.pdf
Public research funding	Efficacy studies in the treatment of selected advanced solid tumours with the marine-origin antitumor compound lurbinectedin Grant ID: IDI-20150006	2022	Not publicly disclosed	Centro para el Desarrollo Tecnológico IndustrialCentro para el Desarrollo Tecnológico Industrial	https://pmc.ncbi.nlm.nih.gov/articles/PMC9588879/ https://www.cdti.es/en/ayudas-subvenciones2
Public research funding	Advances in understanding the physicochemical stability in plasma and aqueous vehicles of four new antitumor molecules currently undergoing preclinical evaluation	2010	€74,045	Agencia Estatal de Investigación	https://www.aei.gob.es/en/awarded-grants/awarded-grants-finder?year=All&convocatory=All&code=INC-FPGS-2010-0653&gender=All&area=&subarea=&title=&keywords=&cif=A78267176&name=&ccaa=All&province=All&granted%5Bmin%5D=&granted%5Bmax%5D=&summary=
Public research funding	Research on the delivery of highly hydrophobic drugs: POLYSFERA: Polymeric nanocapsules for the controlled and targeted release of anticancer drugs (Primary target: docetaxel, but with implications for lurbinectedin)	2010	€2,290,860	Agencia Estatal de Investigación	https://www.aei.gob.es/en/awarded-grants/awarded-grants-finder?year=All&convocatory=All&code=IPT-090000-2010-001&gender=All&area=&subarea=&title=&keywords=&cif=A78267176&name=&ccaa=All&province=All&granted%5Bmin%5D=&granted%5Bmax%5D=&summary=
Texas A&M University					
Public research funding	Structural/ Synthetic Studies of Bioactive Marine Agents	1995-2019	$6,540,193	National Institute of General Medical Sciences	https://reporter.nih.gov/search/aTR9Ms1p8U-VH5KlcJWNDA/project-details/6019071#history

Type of information	Details on collaboration, financing, and public funding	Year	Amount	Funders/Investors/ Acquiror	Source
University of Texas					
Public funding	Lurbinectedin, a selective inhibitor of oncogenic transcription, in patients with pretreated germline BRCA1/2 metastatic breast cancer: results from a phase II basket study (MD Anderson Cancer Center) Grant ID: RP1100584	n.a.	n.a.	Cancer Prevention & Research Institute of Texas	https://pmc.ncbi.nlm.nih.gov/articles/PMC9588879/ https://www.cprit.texas.gov/grants-funded
Public research funding	Informatics to enable routine personalised cancer therapy (University of Texas Health Science Center at Houston)	2013	$335,040	National Cancer Institute	https://reporter.nih.gov/search/-RQvmnzy_0KO2frw1Ej9Rw/project-details/8607017

Abbreviations: BRCA … breast cancer gene, FDA … U.S. Food and Drug Administration, n.a. … not applicable, SCLC … small cell lung cancer, U.S. … United States, SEC…U.S. Securities and Exchange Commission

Table 7-2: Search terms used to identify the development history and public contributions of ZEPZELCA®

Database/News outlet/ clinical trial registry/funding website	Search terms used	Additional search terms	Relevant information found (yes/no)	Search period	Type of information extracted
https://www.ema.europa.eu/en/medicines	JZP-712 Lurbinectedina LY-01017 PM-01183 PM-1183 Tryptamicidin Zepsyre ZEPZELCA Zepzelca		Yes	Earliest mention - 05/2026	Active substance, Medical speciality, Pharmacotherapeutic group, Therapeutic area, Class, Orphan designation, Categorization, Additional monitoring, Conditional approval, Accelerated assessment, PRIME: priority medicines, Marketing authorisation issued
https://www.fda.gov/			Yes		
https://adisinsight.springer.com/			Yes		Alternative names/ Alternative Product identifiers
https://ihsi-horizonscandb.ecri.org/					
https://pubmed.ncbi.nlm.nih.gov/			Yes		Development history, Researchers
https://clinicaltrials.gov/			Yes		Clinical trials
https://euclinicaltrials.eu/			Yes		
https://trialsearch.who.int/			Yes		
https://eudract.ema.europa.eu/			No		

Database/News outlet/ clinical trial registry/funding website	Search terms used	Additional search terms	Relevant information found (yes/no)	Search period	Type of information extracted
https://cordis.europa.eu/			No		
https://reporter.nih.gov/		ADIUM PHARMA	Yes		
https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm		Immedica Jazz Pharmaceuticals plc	No		Basic research. Authors selected based on literature found on PubMed
https://www.sec.gov/		Luye Pharma Group	Yes		Collaborations, funding, financing, Series A-C funding, patent information, acquisitions, development history
https://competition-cases.ec.europa.eu/search		PharmaMar	No		
https://www.ihi.europa.eu/		Roche	No		
https://eismea.ec.europa.eu/index_en		Specialised Therapeutics Asia	No		
https://eit.europa.eu/		Swiss Group for Clinical Cancer Research	No		
https://eic.ec.europa.eu/index_en			No		
https://www.eib.org/en/index		Jazz Pharmaceuticals	No		
https://research-and-innovation.ec.europa.eu/funding/funding-opportunities/funding-programmes-and-open-calls_en		Hoffmann-La Roche MedSIR Merck Sharp & Dohme LLC	No		
https://www.sbir.gov/			No		
https://www.nsf.gov/		Intergroupe Francophone de Cancerologie Thoraciqu	No		
https://www.ukri.org/			No		
https://foerderportal.bund.de/		Groupe Francais De Pneumo-Cancerologie	No		
https://www.health-holland.com/			No		
https://www.cprit.texas.gov/grants-funded		Institut Curie	Yes		
https://www.bpifrance.com/		Luye Pharma Group	No		
https://www.inserm.fr/en/home/		National Cancer Institute	No		
https://innovationsfonden.dk/da		Fundacion Oncosur	No		
https://www.pap.hacienda.gob.es/bdnstrans/GE/es/concesiones/consulta		H. Lee Moffitt Cancer Center and Research Institute	Yes		
https://www.aei.gob.es/en/awarded-grants/		Bristol-Myers Squibb	Yes		
https://www.ucc.ie/en/apc/		Mayo Clinic	No		
https://www.amractionfund.com/about		Misty Shields	No		
https://reporter.nih.gov/		Swiss Cancer Institute	Yes		
https://www.gatesfoundation.org/			No		

Database/News outlet/ clinical trial registry/funding website	Search terms used	Additional search terms	Relevant information found (yes/no)	Search period	Type of information extracted
https://www.google.com/		Emory University	No		
https://www.forbes.com/		Institut Bergonié	No		
https://www.reuters.com/		AstraZenecaAntonio Calles Blanco (Hospital Gregorio Marañon)	No		
https://www.science.org/			No		
https://www.cafepharma.com/		Nicolas Girard (Institut Curie)	No		
https://www.livescience.com/			No		
https://www.biospace.com/		Anish Thomas (NCI)	No		
https://www.bioworld.com/		Alberto A Chiappori (NCI)	No		
https://www.biopharmadive.com/		Andrea B Apolo (NCI)	No		
https://pharmaphorum.com/		Konstantinos Leventakos (Mayo)	No		
https://pharmatimes.com/		Anastasios Dimou (Mayo)	No		
https://pharmafile.com/		Misty D Shields (Indiana University)	No		
https://www.fiercepharma.com/			No		
https://www.businesswire.com/		Federica Grosso (SS. Antonio e C. Arrigo Hospital Alessandria)	No		
https://www.businessinsider.com/			No		
https://www.statnews.com/		Miklos Pless (Kantonsspital Winterthur)	No		
		Roger von Moos (Kantonsspital Graubünden)			
		Yannis Metaxas (Kantonsspital Graubünden)			
		Kristin Higgins (Emory)			

8 Landscape overview

No content.

9 Discussion

No content.

10 References

[1] EUnetHTA. HTA Core Model Handbook. 2025 [cited 03.03.2026]. Available from: https://web.archive.org/web/20181213135915/http:/meka.thl.fi/htacore/ViewHandbook.aspx.

[2] Huang Y., Xu Z. and Bao L. Cost-effectiveness analysis of lurbinectedin plus atezolizumab as first-line treatment for extensive-stage small-cell lung cancer. Front Immunol. 2025;23(16). DOI: 10.3389/fimmu.2025.1658740.

[3] Zhu J., Li Z., Song D. and Liu W. Cost-effectiveness of lurbinectedin with atezolizumab for extensive-stage small-cell lung cancer in the United States: impact of drug wastage reduction on economic outcomes. BMC Health Serv Res. 2026;26(1). Epub 20260504. DOI: 10.1186/s12913-026-14653-5.

[4] Husereau D., Drummond M., Augustovski F., de Bekker-Grob E., Briggs A., Carswell C., et al. Cheers 2022 Checklist. 2022 [cited 03.03.2026]. Available from: https://www.equator-network.org/wp-content/uploads/2013/04/CHEERS-2022-checklist-1.pdf.

[5] Evers S., Goossens M., de Vet H., van Tulder M. and Ament A. Criteria list for assessment of methodological quality of economic evaluations: Consensus on Health Economic Criteria. Int J Technol Assess Health Care. 2005;21(2):240–245.

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