Expanding access to monoclonal antibody-based products

A global call to action
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Expanding access to monoclonal antibody-based products

A global call to action
Monoclonal antibodies are one of the most powerful tools in modern medicine. More than 100 of them have been licensed over the past 30 years and they are transforming the way doctors treat, prevent and even cure serious non-communicable diseases, including many cancers and autoimmune disorders. These monoclonal antibody products are significantly more effective than previously available therapies and are often better tolerated and easier to deliver. There’s also a rapidly growing pipeline of monoclonal antibodies to treat and prevent many existing and emerging infectious and neglected diseases.

Millions of people around the world stand to benefit both from existing monoclonal antibody-based products and those in development. Rates of non-communicable diseases are on the rise in many developing countries. In addition, there are numerous existing and emerging infectious disease threats, including COVID-19, Ebola and HIV, for which monoclonal antibodies are poised to play an important role in treatment and prevention. As the COVID-19 pandemic has shown, no country is immune to the threat posed by emerging infectious diseases. If monoclonal antibodies prove to be effective for COVID-19, ensuring prompt, equitable and affordable global access to these products, as well as others, will be imperative.

But as this report details, global access to monoclonal antibody products is now severely limited in many countries. Today, the market for monoclonal antibodies is overwhelmingly in high-income countries. Few, if any, monoclonal antibodies are registered in low-income countries, and those that are registered in many middle-income countries are often unavailable in their public health systems, making them prohibitively expensive. This gap in access will only widen because monoclonal antibodies are an increasingly large proportion of pharmaceutical company pipelines.

For global access to monoclonal antibodies to be a reality, these innovative products have to be both available and affordable. Awareness, but it also requires that regulatory and policy issues are addressed, and that technological advances are applied throughout the process of identifying, optimising, producing and delivering more potent, lower-cost monoclonal antibody products. New business models that promote the availability and affordability of these products are also necessary. Together, these actions will make it possible to address the growing inequity to these products, saving or improving millions of lives in the process.

Progress can’t come soon enough. The goal of this report is to catalyse discussion, collaboration and action. Pharmaceutical companies, global health agencies, public sector entities, philanthropic organisations and ministries of health must join forces to make global access to transformative monoclonal antibody products a priority, and a reality.

The time to act is now.
Reshaping the monoclonal antibody world

Today's global market for monoclonal antibodies is highly unbalanced.

Ensuring equitable access requires four parallel yet vital commitments.

**Increase awareness**
Spread the word that monoclonal antibodies save lives

**Expand availability**
Support broader registration of antibody products across the globe

**Apply innovations**
Invest in and deploy new technologies to lower development costs

**Create new models**
Establish business models that enable different market approaches and promote access

Note: Percentages are approximate
Table of contents

7 Methodology

8 Monoclonal antibodies are transforming human health
   12 Global need, but not global access
   14 Case studies

18 What will it take to make monoclonal antibodies globally accessible?

20 Monoclonal antibodies are only accessible if they are available
   22 Harmonising regulatory pathways
   24 Expand and utilise policy pathways for mAb access
   26 Raise awareness of the health benefits of mAbs
   26 Strengthen healthcare systems and the ability to diagnose disease

28 Making monoclonal antibodies more affordable
   30 Factors influencing global mAb prices
   32 Validate and apply novel technologies to lower costs
   39 Innovative approaches to intellectual property to expand access
   39 Implement new business models that prioritise access
   42 Establish procurement and delivery models to enable greater access

44 A roadmap for expanding global access to monoclonal antibodies

49 References

Appendix (presented separately)
   2 Stakeholders list
   5 Monoclonal antibody products approved or under review in the European Union and United States
   11 Trastuzumab biosimilars
   13 Pipeline of monoclonal antibodies for emerging, neglected and endemic infectious diseases and pathogens
   34 Isolation of antibodies
   38 Biosimilar guidelines in BRICS-TM
Methodology

Scope
The goal of this report is to assess the factors impeding access to mAbs in low- and middle-income countries, particularly within public health systems, and to formulate a series of recommendations for expanding global access to affordable antibody therapies. The classification of low-, middle- and high-income countries is based on World Bank classifications.

The report highlights opportunities for expanding access to monoclonal antibodies for cancers and autoimmune diseases, as well as those for neglected and viral/bacterial infectious diseases that are anticipated to represent a significant percentage of the future antibody market. These include antibodies against SARS-CoV-2, HIV, respiratory syncytial virus (RSV), rabies, Ebola, filoviruses, viral enteric pathogens and gram negative bacterial enteric pathogens, including *Escherichia coli*, *Klebsiella pneumoniae*, *Shigella* and *Salmonella*, which are on the World Health Organization’s (WHO) and the US Centers for Disease Control and Prevention’s lists of critical drug-resistant pathogens, as well as gram-positive bacterial enteric pathogens such as *Clostridium difficile*.

Approach, data collection and analyses were based on two methods. A robust assessment was conducted of peer-reviewed biomedical literature, news sources, organisational websites, drug labels, recognised global and national datasets (including those available from the Institute for Health Metrics and Evaluation), the WHO, clinical trial registries, national regulatory agencies, national patent offices, drug pricing databases and market reports to capture the current state of the innovative and biosimilar mAb markets. Reports on antibody pricing models, with a focus on access to antibodies in public health systems in LMICs were analysed, and Charles River Associates (CRA) was commissioned to extract more detailed information on pricing pressures and models, with a focus on understanding global access challenges.

Additionally, a series of more than 100 interviews were conducted with global-health focused organisations, ministries of health, academic institutions, regulatory authorities, antibody-focused biosimilar/biotechnology companies and multinational pharmaceutical companies with large antibody pipelines. Focused stakeholder meetings were convened in India, where local participants and influencers were invited to discuss the challenges and opportunities for global access to antibodies. Smaller group discussions and individual stakeholder consultations were convened in sub-Saharan Africa (SSA) and in several high-income countries. The list of organisations consulted in this process is on page 2 of the Appendix to this report.

Several case studies were then selected of licensed monoclonal antibodies to illustrate the impact they have had on non-communicable, communicable and neglected diseases, and to evaluate the availability of the products and their impact in high-, middle- and low-income countries for which data are available. Case studies were selected because they cover a broad range of mAbs for non-communicable diseases (cancers and autoimmune diseases), communicable diseases (RSV and *C. difficile* infections) and neglected diseases (rabies). The case studies cover antibodies that were approved more than 15 years ago (e.g. Herceptin®, the first targeted antibody for breast cancer; Humira® and Enbrel®, which are the gold standard treatments for rheumatoid arthritis; and Synagis®, the first licensed preventive antibody for an infectious disease); as well as other more recent approvals (e.g. Keytruda®, Rabishield®, Twinrab®, and Zinplava®). A landscape analyses of emerging, neglected and endemic infectious disease mAbs and more detailed examination of some pipeline monoclonal antibodies for infectious diseases, including COVID-19, HIV, Ebola, Nipah/ Hendra and influenza, are included in supplemental sections of this report. Supplemental sections of this document cover the following topics: the emerging role of monoclonal antibodies in epidemic/pandemic preparedness and response; monoclonal antibodies: a new era in the treatment and prevention of disease; the development of HIV-specific broadly neutralising antibodies; combination monoclonal antibodies and alternate formats; and India’s biopharmaceutical business: an evolving success story.
Monoclonal antibodies are one of the most powerful tools in modern medicine. These proteins act specifically against their targets — anything from viruses and bacteria to cancerous cells — and can safely and effectively prevent or treat a growing number of diseases (Figure 1, next page), some of which were previously difficult, if not impossible, to treat. Millions of people have benefited from mAb-based therapies in the 30 years since the first one was licensed.

The majority of licensed mAbs are used to treat non-communicable diseases, including cancers and autoimmune diseases. Today’s successful cancer immunotherapies — including more than 40 licensed mAbs that directly or indirectly stimulate the immune system to attack and kill tumor cells — are revolutionising cancer treatment and have significantly improved overall and long-term survival.

What are monoclonal antibodies?

Antibodies are proteins generated by the immune system. They are one of the primary ways the body defends itself against disease.

Polyclonal antibodies are mixtures of naturally occurring antibodies expressed from different immune cells. They are extracted from human or animal blood and are used in serum or convalescent plasma-based therapies to treat diseases including COVID-19, rabies and snakebite.

Monoclonal antibodies are single antibodies expressed from identical immune cells that can be manufactured at commercial scale using cell systems. These human-like proteins are a powerful tool in treating and preventing disease.
Expanding access to monoclonal antibody-based products compared to conventional approaches such as chemotherapy (Figure 2).

Only seven mAbs are licensed for infectious diseases. But that is poised to change. There is a growing pipeline of mAbs in development for infectious and neglected diseases as well as antimicrobial-resistant bacteria, all of which are significant and escalating threats to global public health (Figure 3, next page; see Appendix, page 13).

Antibodies are now being explored for treatment and prevention of a wide range of viral diseases including Zika, dengue, Ebola, influenza, HIV and the newly identified coronavirus, SARS-CoV-2, which was first identified in China in late 2019 and was classified as a pandemic by the WHO in March 2020. Recent technological advancements have provided an opportunity to quickly isolate, develop and produce therapeutic or preventative mAbs as a complementary approach to vaccine development as part of preparing for or responding to current and future epidemics/pandemics.

Many efforts are underway to evaluate the potential of using mAbs to treat or prevent COVID-19, and two experimental mAb products against Ebola are already being administered as part of an emergency access programme in the Democratic Republic of the Congo, where several recent Ebola outbreaks have occurred. Clinical data suggest that therapeutic Ebola mAbs, in combination with the recent approval of the first Ebola vaccine (ERVESCO®), could prove a powerful duo in treating and preventing this viral infection.

For more, see the supplement to this report: The emerging role of monoclonal antibodies in epidemic/pandemic preparedness and response.
Emerging and neglected diseases are chikungunya, Crimean Congo hemorrhagic fever, dengue, Ebola, Sudan, Bundibugyo, Marburg, Junin Virus, Lassa, MERS, SARS, Nipah, Hendra, Rift Valley fever, rabies, severe fever with thrombocytopenia syndrome, Zika virus disease.

Priority antimicrobial resistance pathogens are Acinetobacter baumannii, Campylobacter, Enterobacter, Enterococcus faecium, enterovirus, Helicobacter pylori, Klebsiella pneumoniae, Morganella spp, Proteus, Providencia spp, Pseudomonas aeruginosa, Salmonella Typhi, Shigella, Staphylococcus aureus, Streptococcus pneumoniae.

Enteric diseases are adenovirus, astrovirus, cholera, Clostridium difficile, hepatitis A, B and E, norovirus, rotavirus, typhoid.

E. coli and Klebsiella pneumoniae are both enteric and antimicrobial resistance pathogens and are listed separately.

For HIV there are multiple mAbs that are being tested alone or in combination. Repurposed mAbs for SARS-CoV-2 symptomatic treatment not shown. Two anthrax mAbs not shown.

Preclinical numbers represent the number of institutions/programs. The clinical numbers represent numbers of antibodies, unless otherwise stated.

Source: IAVI pipeline analysis.
The use of mAbs to both prevent and treat HIV infection is another flourishing area of research. Several antibodies that can act against the diverse strains of the virus (so-called broadly neutralising antibodies or bnAbs) are in development and may offer new hope in battling HIV, which still newly infects about two million people each year.

Data from the first proof-of-concept trial testing whether a single bnAb can prevent HIV infection is expected in 2020. Meanwhile, researchers are applying technological advances to optimise HIV-specific bnAbs and increase their potency, thereby lowering the dose necessary to provide protection in animal models. Many optimised HIV bnAbs delivered subcutaneously in combination or in a single, multispecific antibody format are in development. These more potent antibodies have the potential to be more affordable globally.

Transforming lives, transforming markets

Given their numerous applications, the development of mAb products is one of the fastest growing segments of biomedical research. Since 1985, over 100 mAbs (Figure 3, previous page; see Appendix, page 5) have been licensed or submitted for regulatory review, with approval rates rapidly increasing. More than 50 mAbs were licensed in the last six years. In 2019, seven of the ten best-selling novel drugs were mAbs for cancer and autoimmune diseases (Figure 4).

Monoclonal antibodies are also the single-largest class of biologic molecules undergoing clinical investigation.
Global need, but not global access

Given the growing number of non-communicable and infectious diseases for which mAbs are or might be an effective treatment or preventive, there is clearly a global need for these products. Yet mAb sales are predominantly in the US, Canada and Europe (see map). Low- and middle-income countries (LMICs), which account for 85 per cent of the global population, lag far behind in mAb sales and access to these innovative products17,20,55.

In low-income countries, few if any mAbs are even registered (see figure below). India represents one of the best-case scenarios with respect to the availability of mAbs in middle-income countries, largely because of its extensive biosimilar manufacturing capacity and the resulting competition among biosimilar products, yet even there, fewer than 22 per cent of the products in the US market are available, and no mAbs for cancer therapy are currently available in the Indian public health system19,56. As the percentage of mAbs in development pipelines are increasing⁸, more and more mAbs will enter the market, and the disparity in access between high-income countries and the rest of the globe will likely only worsen.

Number of registered monoclonal antibodies in selected countries (includes biosimilars)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU</td>
<td>120</td>
</tr>
<tr>
<td>US</td>
<td>112</td>
</tr>
<tr>
<td>Brazil</td>
<td>77</td>
</tr>
<tr>
<td>India</td>
<td>36</td>
</tr>
<tr>
<td>Nigeria</td>
<td>10</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>7</td>
</tr>
</tbody>
</table>

Sources: IAVI registration analysis (chart) Coherent Market Report, 2019 (map)

Estimated global market for monoclonal antibodies, 2018

The majority of deaths from non-communicable diseases occur in low- and middle-income countries.

Clinical investigation. The percentage of biologics in development has doubled in the past two decades (increasing from 20 per cent of pharmaceutical pipelines in 1995 to more than 40 per cent in 2018)⁸. More than 570 mAbs are now in clinical testing—60 per cent of which are for oncology—and hundreds more are in preclinical development for a range of diseases⁹.

Increasingly, combination mAbs are also being developed to address the emergence of drug-resistant strains or escape mechanisms for many diseases, including HIV, antimicrobial resistant infections and cancer. Combining mAb products can increase the breadth of functional activity and improve response rates¹⁰. There is also a growing interest in different types of antibody formats including antibody-drug conjugates (ADCs), antibody-protein fusions, antibody fragments, single-chain antibodies and multispecific formats. Multispecific antibodies offer an alternative to combinations of multiple mAbs, each binding a distinct epitope. All of these alternate antibody formats can expand the therapeutic potential of mAbs and allow for various modes of delivery¹¹–¹³.

For more, see the supplement to this report: Combination monoclonal antibodies and alternate formats
There is also a growing market of biosimilars, which are lower-priced versions of licensed mAbs that have no clinically meaningful differences to the originator product in terms of mechanism of action, safety, purity and potency. While somewhat akin to generic drugs, biosimilars are not identical copies of the originator mAb and, as a result, their development is significantly more complex and costlier. It is on average 50–100 times more expensive to develop and manufacture a biosimilar than a small molecule generic. It also takes eight to ten years to develop biosimilars, compared to only three to five years for generics.14

In many countries, biosimilars enter the market once the 20-year period of patent protection on the originator mAb expires. However, in some cases, inventors can obtain secondary patents based on new uses or formulations of an existing mAb product. These secondary patents are the primary reason the introduction of biosimilars is delayed in some markets, particularly the US, where companies are more likely to file secondary patents to protect market share. Europe, India, Argentina, Brazil, Japan and the Philippines typically allow biosimilars to enter the market earlier than other countries.15

With patent expirations for some blockbuster mAbs expected in the next few years, many companies are now developing both innovative and biosimilar mAbs.16 Biosimilar development is thriving in India, the European Union (EU), the US, South Korea and China, with India a clear leader.

The Indian biosimilar market was evaluated at US$2.7 billion in 2018 and is anticipated to reach approximately US$6.19 billion by 2024.17 More than 100 Indian biopharmaceutical companies are manufacturing and marketing biosimilars, with 36 biosimilar mAb products already on the market and another 37 in the pipeline.19,20 In 2017, Biocon, a leading Indian biosimilar company, successfully registered Ogivri® (a biosimilar of the breast cancer mAb trastuzumab) in the US in partnership with Mylan, making it the first Indian company to have a US Food and Drug Administration (USFDA)-approved biosimilar.21

India is also a leader in developing small molecule generic drugs. Its strength and leadership in developing and manufacturing both biosimilars and generics stems partly from the country’s historical intellectual property laws that did not uphold product patents. In 2005 India amended its patent laws to comply with TRIPS (Trade-Related Aspects of Intellectual Property Rights) obligations, but in the 35-year period prior to that, the country built extensive drug manufacturing capacity. The Indian government also supports the development of both innovative and biosimilar mAbs.

Low-cost/high-volume pharmaceutical and vaccine manufacturers in India, including the Serum Institute of India Private Ltd., Genova Biopharmaceuticals and Sun Pharma, are now investing in both biosimilar and novel mAb development, and are increasingly focused on developing products that address domestic priorities.23,24

Globally innovative and biosimilar mAb products are a large and growing market. In 2018 the global mAb market had an estimated value of US$111.7 billion. Its value is expected to increase to US$319 billion by 2026.17

Despite a global disease burden, access to monoclonal antibody products is predominantly restricted to high-income countries. This imbalance is preventing the vast majority of the world’s population from benefiting from monoclonal antibody treatments and preventives and it is only likely to grow as more monoclonal antibodies enter the market.
Case studies: Factors affecting broader access

An analysis of select licensed mAbs is presented here to illustrate the major factors impeding more equitable global access to these products. The mAbs evaluated are for a range of infectious (RSV, C. diff and rabies) and non-communicable diseases (cancers and autoimmune diseases) and include both older and more recently licensed products. The priority for this analysis was evaluating access to mAbs outside of high-income countries (HICs), but in many cases, access in low-income countries was difficult to assess due to limited data. Data on non-communicable disease (NCD) mAbs are presented first as they represent the vast majority of all licensed products. While there is a rapidly growing pipeline of mAbs for infectious/neglected diseases, antimicrobial-resistant infections and emerging infections, only seven of these products are licensed and therefore access data is more limited.

Monoclonal antibodies for non-communicable diseases

Monoclonal antibody therapies are transforming the treatment of cancers and autoimmune diseases. However, access to these products, even those licensed decades ago, is still predominantly in HICs. The mAb products analysed are largely unavailable in many LMICs, despite a large and growing disease burden in these countries. The majority of deaths from leading NCD-related causes—including 70 per cent of cancer deaths—occur in LMICs, where they are now the leading cause of mortality.

In all cases presented here, lack of availability—either because the product is not registered or it is not available in public health systems—and high prices are the major factor impeding access. Lower-priced biosimilars are helping expand access in some MICs, particularly India, but prices are still too high to make them widely accessible.

HERCEPTIN®
(trastuzumab)

<table>
<thead>
<tr>
<th>Company</th>
<th>Genentech/Roche</th>
</tr>
</thead>
<tbody>
<tr>
<td>First approved</td>
<td>1988, United States</td>
</tr>
<tr>
<td>Primary indication</td>
<td>HER2+ breast cancer</td>
</tr>
</tbody>
</table>

Impact
HER2+ breast cancer has gone from worst to first because of the success of Herceptin in combination with chemotherapy

Notes: Kanjinti® and CanMab® are biosimilars. Herclon® is a “second brand” of Herceptin®—a lower-priced version made by the same company but marketed with a different name and sometimes with unique packaging. Prices are as of February 2020 unless noted.

MONTHLY COST
Price of four weekly doses of 2 mg/kg for a 75 kg patient. In US dollars.

<table>
<thead>
<tr>
<th>Country</th>
<th>HERCEPTIN®</th>
<th>Kanjinti®</th>
<th>Herclon®</th>
<th>CanMab®</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$7,480</td>
<td>$6,340</td>
<td>$2,112</td>
<td>$1,260</td>
</tr>
<tr>
<td>China</td>
<td>$4,356</td>
<td></td>
<td>$580</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>$476</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$2,120</td>
<td>$1,908</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>$3,240</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

ACCESS FACTORS

- Annual costs range from $5,712 to $89,760, based on pricing data listed in different countries.
- Herceptin® global sales were $6.1 billion in 2019.
- 12% of women in the United States and 50% of women in Europe and China did not receive trastuzumab or any other HER2+–targeted agent, with price being the most significant barrier to access.
- A subset of oncologists in high- and upper-middle income countries reported insurance coverage, drug availability and expense were main barriers to access.
- A 2013 survey showed it is available at half of the healthcare facilities in 14 sub-Saharan African countries, but fewer than 5% of patients could afford it.
- Several biosimilars available, including four approved by the USFDA, five by the European Medicines Agency (EMA) and at least three approved products for use in low- and middle-income countries (see Appendix, page 11), but data is limited on how this has expanded access.
Expanding access to monoclonal antibody-based products

Monoclonal antibodies for non-communicable diseases (continued)

**KEYTRUDA® (pembrolizumab)**

- **Company**: Merck
- **First approved**: 2014, United States
- **Primary indication**: Melanoma
- **Impact**: Keytruda® has significantly improved survival rates of melanoma, lung cancer and eight other difficult-to-treat cancers

**MONTHLY COST**

Price of 200 mg every three weeks. In US dollars.

<table>
<thead>
<tr>
<th>Country</th>
<th>Keytruda®</th>
<th>Humira®</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$11,668</td>
<td>$6,208</td>
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<tr>
<td>China</td>
<td>$5,200</td>
<td>$366</td>
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<tr>
<td>United Kingdom</td>
<td>$6,980</td>
<td>$842 Exemptia®</td>
</tr>
<tr>
<td>India</td>
<td>$2,522</td>
<td>$280 Exemptia®</td>
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</tbody>
</table>

**ACCESS FACTORS**

- Annual treatment costs range from $42,874 to $198,356\(^{30-32}\)
- Keytruda® global sales were $11.1 billion in 2019\(^7\)
- Most patients in Brazil are unable to access it through the public health system because of its high price\(^36\)
- An oncologist in India reports “only one in 1,000 of my patients can actually afford to use this drug”\(^37\)
- Access in public health systems and low- and middle-income countries is severely limited because of high treatment costs
- Added to the WHO essential medicines list in 2019, but unclear how this will affect access in low- and middle-income countries\(^38\)
- No biosimilars available

**HUMIRA® (adalimumab)**

- **Company**: AbbVie
- **First approved**: 2002, United States
- **Primary indication**: Rheumatoid arthritis
- **Impact**: In patients who do not respond to conventional treatments, Humira can suppress disease activity, slow or stop progression of joint/radiologic damage and prevent further loss of quality of life

**MONTHLY COST**

Price of two doses of 40 mg every other week. In US dollars.\(^{30-32}\)

<table>
<thead>
<tr>
<th>Country</th>
<th>Keytruda®</th>
<th>Humira®</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$12,000</td>
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<tr>
<td>China</td>
<td>$10,000</td>
<td>$366</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$8,000</td>
<td>$918 Hyrimoz®</td>
</tr>
<tr>
<td>India</td>
<td>$6,000</td>
<td>$2,522 Exemptia®</td>
</tr>
</tbody>
</table>

**ACCESS FACTORS**

- Humira® is the best-selling prescription drug in the world, with sales of approximately $19.2 billion in 2019\(^7\)
- Unavailable in India until the launch of biosimilars in 2014, despite 12 million people in the country having conditions that could benefit from its use\(^42\)
- First available in China in 2010\(^39\)
- Still unregistered in some sub-Saharan African countries including Zimbabwe and Nigeria
- Introduction of biosimilars in Europe in 2018 led to an 80% price reduction of Humira® in some European markets\(^23\)
- As of 2019 there are four USFDA-approved biosimilars in the US, with another three in development, but none of them is expected to launch before 2023 when patent protection expires\(^25\)

Note: Hyrimoz® and Exemptia® are biosimilars.
Monoclonal antibodies for non-communicable diseases (continued)

**ENBREL®** (etanercept)

- **Company**: Amgen/Pfizer
- **First approved**: 1998, United States
- **Primary indication**: Rheumatoid arthritis

**Impact**
In patients who do not respond to conventional treatments, Enbrel can suppress disease activity, slow or stop progression of joint/radiologic damage and prevent further loss of quality of life.

**ACCESS FACTORS**
- Enbrel® global sales were $5.2 billion in 2019.
- A few biosimilars became available after expiration of the Enbrel® European patent in 2015.
- Samsung Bioepia’s biosimilar is approved in 38 countries but there is limited data on access.
- Biosimilars are unavailable in the US despite USFDA approval because of secondary patents extending until 2028 or 2029.

**MONTHLY COST**
Price of four weekly 50 mg doses. In US dollars.

<table>
<thead>
<tr>
<th>Country</th>
<th>United States</th>
<th>United Kingdom</th>
<th>India</th>
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<tbody>
<tr>
<td>Enbrel®</td>
<td>$6,668</td>
<td>$928</td>
<td>$472</td>
</tr>
<tr>
<td>Benepali®</td>
<td></td>
<td>$852</td>
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<tr>
<td>Intacept®</td>
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<td>$392</td>
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</table>

**ZINPLAVA®** (bezlotoxumab)

- **Company**: Merck
- **First approved**: 2016, United States
- **Primary indication**: Prevention of *Clostridium difficile* infection

**Impact**
The only licensed mAb to prevent (in combination with antibiotics) an enteric disease. *C. diff* is the leading cause of healthcare-associated infections.

**ACCESS FACTORS**
- Merck is conducting clinical trials in several middle-income countries, including Colombia, Czechia, Malaysia and South Africa.
- No evidence of access in low- and middle-income countries.
- No biosimilars available.

**MONTHLY COST**

<table>
<thead>
<tr>
<th>Country</th>
<th>United States</th>
<th>United Kingdom (2017 price)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zinplava®</td>
<td>$4,560</td>
<td>$3,221</td>
</tr>
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</table>

Monoclonal antibodies for infectious diseases

Availability of these select mAbs is severely limited, even in countries where the need is greatest. Where available, high prices are the biggest barrier to access, with the exception of Rabishield® and Twinrab®. Another barrier to access for some of these mAb products is that they are not optimised for use by all populations in LMICs. This analysis highlights the importance of designing and delivering infectious/neglected disease mAbs that are aligned with patient, healthcare provider and policy maker preferences. This may include antibodies that are effective against a broad range of strains (e.g., rabies) or provide longer-lasting protection (e.g., RSV).
### SYNAGIS® (palivizumab)

**Company**
MedImmune (AstraZeneca)

**First approved**
1998, United States

**Primary indication**
Prevention of respiratory syncytial virus infection

**Impact**
The only licensed mAb to prevent respiratory syncytial virus infections, the second-leading cause of death in children during the first year of life.

**ACCESS FACTORS**
- Price ranges from about $3,600 to $17,820 per season (five doses), depending on the country.
- Marketed in over 80 countries but, 21 years after its initial approval, access in low- and middle-income countries remains limited.
- Not currently licensed in China or Nigeria, two countries with high RSV incidence.
- No biosimilars available.

**MONTHLY COST**
Price of a 15 mg/kg dose for a 3.5 kg patient. In US dollars.

<table>
<thead>
<tr>
<th>Country</th>
<th>Price</th>
</tr>
</thead>
<tbody>
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<tr>
<td>United Kingdom</td>
<td>$734</td>
</tr>
<tr>
<td>Malaysia (2015)</td>
<td>$965</td>
</tr>
<tr>
<td>Costa Rica (2015)</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

Note: Prices are as of February 2020 unless noted.

### RABISHIELD®

**Company**
Serum Institute of India

**First approved**
2017, India

**Primary indication**
Rabies

**Impact**
Uptake has been modest so far because of competition from treatment with human rabies immune globulins/equine rabies immune globulins and a lack of assurance of a large market.

**ACCESS FACTORS**
- Available in India as well as some other countries, under orphan review by USFDA.
- Doesn’t satisfy WHO’s recommendation that a mix of at least two antibodies with non-overlapping epitopes is needed to protect against escape mutants.
- One of the least expensive marketed mAbs.
- No biosimilars available.

**MONTHLY COST**
A single dose treatment in India is priced at about $20 a vial for an ~0.2 mg/kg dose.

**ACCESS FACTORS**
- Available only in India.
- Efficacy, strain coverage, price and market size will ultimately determine uptake.
- No biosimilars available.

### TWINRAB®

**Company**
Zydus Cadila

**First approved**
2019, India

**Primary indication**
Rabies

**Impact**
A combination of two mAbs expected to protect against resistant rabies strains that are not covered by the single antibody product (Rabishield®).

**MONTHLY COST**
Anticipated price of $20 to $40 vial.

**ACCESS FACTORS**
- Available only in India.
- Efficacy, strain coverage, price and market size will ultimately determine uptake.
- No biosimilars available.

*Consultation with WHO, 29 June 2020*
What will it take to make monoclonal antibodies globally accessible?

To expand global access to mAbs, they must be available and affordable.

The following sections describe the barriers impeding broader access to mAbs as well as solutions to overcoming these barriers, which, if taken, could dramatically increase access and save or improve millions of lives in the process.
availability

Harmonize and expand existing policy and regulatory pathways and explore new ways to encourage wider registration of mAbs in low- and middle-income countries

Raise awareness of the clinical, public health and economic value of mAbs through concerted advocacy efforts

Strengthen healthcare systems and the ability to diagnose disease in low- and middle-income countries to support a more accurate assessment of the market need for mAb products and to enable their implementation

+ affordability

Validate and apply novel technologies to drive down mAb development and manufacturing costs

Implement alternate business models that prioritize access

Identify procurement and delivery models for mAbs similar to those used to increase affordability of vaccines

= access
**Monoclonal antibodies are only accessible if they are available**

**Key findings:**

- Many mAbs are not available in low- and middle-income countries because of long delays in regulatory filing, approval and launch of these products, which creates a huge gap in access.

- Capacity constraints, unclear or undefined regulatory policies and a lack of market incentive are all barriers to companies more broadly registering mAb products.

- Those mAbs that are registered are often still unavailable or have extremely limited availability in the public health systems in low- and middle-income countries.

- Efforts are underway to harmonise regulatory approval pathways across low-income settings.

- Of the harmonisation efforts underway, only the WHO prequalification pilot program has been applied to biosimilar mAbs, and only one mAb has been prequalified so far.

- Incorporating mAbs into WHO policy guidance is one way to support adoption of these products more globally.

- Several mAbs were added recently to the WHO’s Model List of Essential Medicines, but it is too soon to tell how this will expand access.

- Advocacy efforts related to mAb access are limited or non-existent.

- Efforts to demonstrate a public health value proposition—including economic modelling of the impact of mAbs—can help bolster the case for making mAbs more widely available in low- and middle-income countries.

- Health systems strengthening and improving the capabilities to diagnose and treat disease in developing countries can help define the market size and support demand forecasting for mAb products to catalyse investments and access in these countries.

- Engaging communities, healthcare providers and policy makers will help ensure that future products are acceptable and feasible to implement in diverse settings.

---

**One major barrier to global mAb access is that many of these innovative products are not even available in many low- and middle-income countries.**

This is partly because there are long delays for filing, approval and launch of mAb products in many resource-limited settings relative to their introduction in the EU and US$^{14,57}$ (Figure 5, next page). An Access to Medicines Foundation report found that innovative products are not even registered in 43 per cent of priority LMICs, including 13 of 46 sub-Saharan African (SSA) countries.

There are several factors that contribute to these registration delays, or lack of filings altogether. One of the biggest factors is that pharmaceutical companies prioritise commercialisation in more lucrative markets in high and upper middle-income countries. Only 21 per cent of new products are filed broadly in countries identified as having the greatest need within a year of launch$^{55}$. Addressing the...
Expanding access to monoclonal antibody-based products

barriers to wider registration of mAbs in LMICs is a priority given the number of products in development for diseases that predominantly affect individuals in low-income settings.

Harmonising the registration process is one way to accomplish this. Regulatory requirements are often unclear or even undefined (see Appendix, page 38) in many LMICs, and variation in requirements across national medicines regulatory authorities (NMRAs) increases the cost, time and complexity for manufacturers interested in submitting their products for regulatory review58.

Capacity constraints pose an additional challenge. Globally, the WHO estimates that at least 30 per cent of NMRAs have limited capacity to perform core regulatory functions59. This gap is the widest in Africa, where the majority of the continent’s 50 NMRAs are unable to perform core functions. In Kenya, the Pharmacy and Poisons Board lacks the in-house expertise to evaluate mAbs and therefore regulatory review must be outsourced.**

Some countries are taking steps to shorten their regulatory review timelines. The Chinese Food and Drug Administration (CFDA) joined the International Council for Harmonisation in 2017 and has begun to align its regulatory processes with international standards, resulting in a dramatic increase in the number mAbs approved annually. By early 2019, the CFDA had already approved three mAbs from domestic developers and 10 mAbs from multinational pharmaceutical companies, a significant increase from the average two mAbs approved in previous years60.

Some multinational companies are also attempting to address delays in access. Novartis and Takeda have launched strategies to make their mAb products more widely available sooner after their introduction in high-income countries. For example, Novartis’s mAb Lucentis® for wet age-related macular degeneration was approved in India and Brazil within 12 months of approval in the EU57.

Another example is Novartis’s approach to addressing sickle cell disease (SCD). SCD is a global health problem but the highest burden of disease is in Africa, where 50 per cent to 90 per cent of children born with the disease die before age five61. Novartis submitted hydroxyurea, the only USFDA- and EMA-approved drug for the treatment of SCD, to regulators in Ghana, Kenya, Uganda and Tanzania to accelerate access to treatment in communities that are most affected and plans to deliver 60,000 treatments by the end of 2020. The company also plans to file its USFDA-approved SCD mAb Adakveo®/crizanlizumab globally62 and clinical trials are expected to start in Africa in 2020.***

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*Consultation with Utrecht Centre for Affordable Biotherapeutics. 9 August 2019. Phone interview conducted by IAVI. Consultation with African Vaccine Manufacturing Initiative. 3 July 2010. Phone interview conducted by IAVI.

**Consultation with Kenyan Pharmacy and Poisons Board. 17 July 2019. In-person interview conducted by IAVI.

***Consultation with Novartis conducted by IAVI. July 2020

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Figure 5: Regulatory approval dates for monoclonal antibodies

<table>
<thead>
<tr>
<th>Country/ region</th>
<th>Herceptin® (trastuzumab)</th>
<th>Enbrel® (etanercept)</th>
<th>Humira® (adalimumab)</th>
<th>Keytruda® (pembrolizumab)</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>2002</td>
<td>2010</td>
<td>2011</td>
<td>2018</td>
</tr>
<tr>
<td>Egypt</td>
<td>2002</td>
<td>No data</td>
<td>2010</td>
<td>2016</td>
</tr>
<tr>
<td>India</td>
<td>2000</td>
<td>2002</td>
<td>No data</td>
<td>2016</td>
</tr>
<tr>
<td>Mexico</td>
<td>No data</td>
<td>2001</td>
<td>No data</td>
<td>2016</td>
</tr>
<tr>
<td>South Africa</td>
<td>2001</td>
<td>2004</td>
<td>2006</td>
<td>2017</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>2014</td>
<td>Not registered</td>
<td>Not registered</td>
<td>Not registered</td>
</tr>
</tbody>
</table>

Source: IAVI registration analysis
In addition, the company has signed agreements with the governments of Ghana, Kenya, Uganda and Tanzania to jointly develop holistic approaches to improve the diagnosis, management and effective care for SCD patients.

Despite these efforts, there are still long delays or complications to broad registration of innovative medicines and biosimilars in low-income settings. Even the definition of a biosimilar varies or remains undefined in many countries.

The EMA first established biosimilar guidelines in 2005, followed by the introduction of global guidelines through the WHO in 2009, as well as in other countries: Japan (2009), South Korea (2009), Canada (2010), the US (2012) and India (2012) have all established processes for biosimilar approval. But many LMICs still lack a clear pathway for registering biosimilars. Even the BRICS-TM (Brazil, Russia, India, China, South Africa, Turkey and Mexico) nations have less-defined regulations for biosimilar development and comparability (see Appendix, page 38).

As a result, biosimilar approval and introduction can be delayed even beyond the lengthy timeframe it takes to develop these more complicated products. The first biosimilar drug approved in South Africa, Teva’s Filgrastim®, was delayed more than five years due to the backlog of products awaiting scrutiny by the South African Health Products Regulatory Authority. The introduction of mAbs in India is delayed an average of five years, even though biosimilar development there is typically faster than in high-income countries, taking only three to five years compared to eight years in Europe. Some middle-income countries such as Mexico, Nigeria and Vietnam still require in-country clinical trial data for regulatory approval or have undefined regulations, both of which contribute to delays in access.

Addressing these delays and promoting wider registration of innovative and biosimilar medicines is therefore essential. This report explores three potential solutions to expanding the global availability of mAbs:

• harmonise and expand existing policy and regulatory pathways and explore new ways to encourage wider registration of mAbs in LMICs
• raise awareness of the clinical, public health and economic value of mAbs through concerted advocacy efforts
• strengthen healthcare systems and the ability to diagnose disease in LMICs to support a more accurate assessment of the market need for mAb products and to enable their implementation.

There are already some pathways in place to facilitate broader registrations of both innovative and biosimilar products in LMICs. These programmes include the WHO’s prequalification programme, the EMA Article 58 pathway, Swissmedic and the US President’s Emergency Plan for AIDS Relief (PEPFAR) tentative approval (Figure 6, next page). Prequalification has been used primarily for generic drugs and biosimilars, whereas the other programmes are designed to accelerate access to innovative medicines. Each of these efforts are designed to harmonise regulatory procedures and to help manufacturers overcome the barriers to registering their products in LMICs that may lack clear regulatory processes.

But so far these programmes have not been extensively utilised to facilitate access to mAbs. Only WHO prequalification has been used for biosimilar mAbs, and only one mAb has been prequalified to date.

The WHO prequalification system was originally set up to facilitate access to UN-supported health commodities and to address the lack of regulatory capacity in resource-limited settings. This programme aims to ensure the quality, safety and efficacy of priority global health products, while supporting capacity building for national regulatory bodies and facilitating access pathways. The first mAb—a trastuzumab biosimilar for the treatment of breast cancer—was prequalified in 2019 through a pilot procedure developed in 2018. Prequalification of the biosimilar rituximab for the treatment of common lymphomas and leukemias is underway.
To address some of the barriers to access that exist even after prequalification, the WHO also developed a collaborative registration process (Figure 6) with stringent regulatory authorities (SRAs) to accelerate national registration of WHO-prequalified products. More than 20 African national regulatory authorities (NRAs) participate in WHO collaborative registration schemes, and these have resulted in registration of 152 essential medicines, cutting assessment and approval time from several years to an average of 78 days\(^1\). Now that a trastuzumab biosimilar is prequalified, it is eligible for collaborative registration. Most stakeholders from the African continent who were interviewed for this report agreed that products prequalified by the WHO or approved by an SRA such as the EMA or the USFDA would be more likely to be licensed quickly in their countries.

Yet even with prequalification and collaborative registration processes, some stakeholders report there are still delays in access to innovative medicines. A 2016 study showed that vaccines already approved by an SRA still took on average 16 months to complete the prequalification process\(^2\). Generic medicines from emerging markets took even longer—more than two years on average.

Efforts to speed approval timelines for innovative products are therefore underway through the Accelerated Registration of Finished Pharmaceutical Products Approved by SRAs procedure. Through this procedure, the assessment and inspection reports of participating reference SRAs — EMA, Swissmedic, the UK Medicines and Healthcare Products Regulatory Agency and the Swedish Medical Products Agency — and bridging reports that address issues of direct relevance in high-burden settings are shared with NRAs in 21 participating countries and the Caribbean nations in the CARICOM region. The goal is to facilitate national regulatory decisions within 90 days\(^3\). This procedure has resulted in 42 regulatory approvals for five different products in 20 countries, but has not yet been utilized for mAb products. Many other challenges also remain, including addressing inconsistent requirements across NRAs that required supplemental documentation and additional inspections.

One effort to support regional harmonization of NRAs is the African Medicines Agency (AMA). In 2019, 55 African nations signed the treaty to form the AMA, which will promote the adoption and harmonisation of regulatory policies and standards and will

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**Figure 6: Collaborative and expedited regulatory pathways**

<table>
<thead>
<tr>
<th>Regulatory agencies/bodies</th>
<th>Pathways</th>
<th>Potential applications to antibody products</th>
</tr>
</thead>
<tbody>
<tr>
<td>USFDA</td>
<td>FDA’s expedited review of PEPFAR’s innovative HIV products in as short as 6 months and tentative approval of generics for sale outside the US for HIV products still under US market exclusivity(^1)</td>
<td>HIV bnAbs</td>
</tr>
<tr>
<td>USFDA, WHO, NRAs</td>
<td>Collaborative Registration Procedure-Lite (CRP-Lite): facilitated through sharing of redacted assessment reports of FDA-approved products with WHO to accelerate registration of HIV medicines in low- and middle-income countries(^1)</td>
<td>HIV bnAbs</td>
</tr>
<tr>
<td>EMA, WHO, NRAs</td>
<td>Article 58: EMA, in collaboration with the WHO, provides scientific opinions on medicines to prevent or treat diseases of major public health interest that are intended exclusively or initially for markets outside the EU(^2)</td>
<td>Monoclonal antibodies for infectious/neglected diseases mainly in low- and middle-income countries</td>
</tr>
<tr>
<td>EMA, WHO, NRAs</td>
<td>Parallel EU and low- and middle-income country registrations: A promising initiative through which EMA collaborates with sponsors on a parallel approach that integrates elements of the Article 58 process, such as representation from WHO and low- and middle-income country NRAs during the assessment process, as part of a centralised Marketing Authorisation Application for EU registration. This pathway was tested with the recently licenced Ebola vaccine (ERVEBO(^3)).(^4)</td>
<td>Monoclonal antibodies for global health</td>
</tr>
<tr>
<td>Swissmedic, WHO, NRAs</td>
<td>Swissmedic (Switzerland) authorisation procedures involve African NRAs and WHO in the assessment process, building capacity and addressing regional considerations while accelerating marketing authorisations in Switzerland for Africa and elsewhere(^5)</td>
<td>Monoclonal antibodies for global health</td>
</tr>
</tbody>
</table>

\(^*\) Consultation with EMA, 20 September 2019. Phone interview conducted by IAVI
coordinate existing harmonisation efforts. The aim of the AMA is to align fragmented regulatory systems on the continent, reduce the lead time associated with meeting different country requirements and increase the availability of safe, effective and high-quality essential medicines for priority and neglected diseases across the African continent. The AMA will provide an important platform to address some of the regulatory barriers impeding access to biologicals in Africa.

Another effort to support harmonisation is the African Vaccine Regulatory Forum (AVAREF), a regional regulatory network founded by the WHO in 2006 with 23 African member-countries. AVAREF aims to support NRAs in their decision making by providing information on vaccine candidates and timelines for clinical trials, and also to promote communication and collaboration between African NRAs and ethics committees. Although only applicable to vaccines, AVAREF could be a model for supporting regional NRAs for mAb regulatory issues.

Expand and utilise policy pathways for mAb access

WHO policy guidance also plays an important role in the adoption of new technologies and their integration into financing and procurement platforms. Some stakeholders that were interviewed noted that many LMICs will not include a medicine on their national medicine lists or utilise a treatment or therapy unless it is part of WHO guidelines.

It can therefore be beneficial for mAb developers to engage with the WHO early in the process if they are interested in having their products included in WHO policy guidelines and securing prequalification. This engagement allows the WHO to provide guidance on the preferred attributes of an eventual product as well as its potential value proposition and access pathways, all of which can help favorably position products for a policy review that occurs post licensure.

Preferred Product Characteristics (PPCs):
Most companies that develop mAbs design target product profiles based on the needs of individuals in high-income countries. This can result in products that are not as well suited for use in LMICs because of factors such as their dosing regimen, side effects or feasibility constraints. To avoid this, the WHO is developing PPCs to provide strategic guidance on the preferred attributes for new vaccines and antibodies in priority disease areas. PPCs are developed as part of a broad consultation process early in clinical development. Considering the needs of individuals outside of high-income countries early in the mAb development process—when product attributes can be more readily changed—can help ensure that products satisfy end-user preferences and pricing expectations, and that they can be implemented in places with more limited healthcare infrastructure.

Technology Roadmaps and Full Public Health Value Propositions:
Technical documents such as these outline priority activities for researchers, funders and product development partners to consider when developing mAbs for LMICs.
developers to accelerate the availability of products in priority disease areas and to articulate the economic, societal and indirect impact of the intervention at the population level.

Together, these guidance documents can facilitate the inclusion of a mAb product in formal WHO guidelines\(^8\). This approach is primarily used for development of new vaccines, but in recent years the WHO has provided some preliminary guidance on preventative mAbs for RSV and rabies in the context of available vaccines, and the organisation is now involved in drafting the first formal PPCs for HIV and RSV mAb products.

Adding mAbs to the WHO’s Model List of Essential Medicines (EML) is another way to influence national policies and encourage broader uptake of mAbs. Inclusion on the EML can affect eligibility for reimbursement through public health systems\(^82\), and can help ensure these products are integrated into procurement and supply channels.

Avastin\(^8\) (bevacizumab) was the first mAb added to the EML in 2013 for off-label treatment of age-related macular degeneration (Figure 7). In 2015, Rituxan\(^8\) (rituximab) and Herceptin\(^8\) (trastuzumab) became the first two cancer mAbs to be added to the EML. These mAbs were added long after their initial approval, but in the last two years, 18 antibodies were reviewed and six were added to the EML in 2019 alone.*

The growing number of mAbs on the EML is spurring efforts within the WHO, relevant UN agencies and international organisations to facilitate access to these products\(^83\). Inclusion of mAbs on the EML should encourage more countries to add them to their own essential medicine lists—more than 155 countries create national essential medicines lists based on the EML\(^85\).

However, delays are still likely as national lists may not be updated as regularly. Kenya first established its essential medicines list in 1981, but has only updated it four times since then\(^84\). Despite Avastin’s inclusion on the EML in 2013, and Herceptin and Rituxan being added in 2015, there is limited evidence that these mAbs are widely included on national medicine lists and therefore the impact on global access is unclear\(^85\). Addressing the barriers (including patent protection and registration) to nations adding mAbs on the WHO EML to their own essential medicine lists will help raise awareness of the value of mAbs and enhance access in LMICs.

In addition to the EML and other WHO policy pathways, health technology assessment (HTA) bodies that perform value-based assessments of innovative medicines and help determine pricing (see page 30) could also be used to influence which mAbs are included on national medicine lists. HTAs in some LMICs such as China, Thailand and Tanzania are already being utilised this way\(^86-88\).

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*WHO and UNAIDS consultation. 29 May 2019. Phone interview conducted by IAVI.
Raise awareness of the health benefits of mAbs

Advocacy is essential to promoting supportive policy regarding mAbs and to enhance availability. Yet advocacy for mAb products is either limited or nonexistent. The unprecedented advocacy that played a vital role in expanding access to HIV medicines and preventives in developing countries could serve as a model. A similar movement could help bolster the case for global mAb access.

Underpinning all efforts to make mAbs more widely available is the need to increase awareness among governments, ministries of health and patient advocacy groups of their transformative health benefits, both on the individual level and the public health level. As governments struggle to prioritise healthcare interventions, advocacy efforts will be critical to making political leaders and public health officials aware of the broad potential mAbs offer to treat and prevent diseases.

Related to this, advocacy efforts could help dispel the misperception that mAbs are too expensive to ever become widely available in LMICs. Some mAbs are already available at much lower prices, and by implementing a combination of innovative technologies and alternative business models (see page 28), these prices could be even lower, making them more affordable for more of the world. Global access to mAbs will not be easy, but it is possible, and advocacy efforts will be required to deliver that message.

Cost-effectiveness and health economic modelling of the impact of mAbs can also help inform advocacy efforts by establishing a value proposition for introducing mAbs more broadly, particularly within the public health systems of LMICs. For cancer, mAb products could even be introduced before older medical options, “leapfrogging” radiation treatment and chemotherapy, which are more challenging to implement in resource-poor settings89.

Another component of advocacy for mAb access is ensuring that mAbs receive widespread support through their inclusion in UN-backed global public health agendas, such as the Sustainable Development Goals and Universal Health Coverage (UHC). UHC, which was adopted in 2015, calls for all individuals and communities to receive health services without suffering financial hardship. Including mAbs in such agendas can spur government investment and stimulate industry focus on delivering affordable and accessible mAb products. Major public health funders, including Wellcome through their Flagship initiative, the Bill & Melinda Gates Foundation, Unitaid and the Coalition for Epidemic Preparedness Innovations (CEPI) are either already considering or could consider adding mAb development to their portfolios.

Strengthen healthcare systems and the ability to diagnose disease

Improving capabilities to both diagnose and treat disease is another important component of improving global access to mAbs.

Gaps in local health systems and inadequate infrastructure hamper the delivery of medicines to millions of people and delay access to innovative medicines such as mAbs.

This is particularly true for products to treat non-communicable diseases. Most deaths from non-communicable diseases occur in LMICs, where 85 per cent of the global population lives25,26. Cancer services and access to diagnostic medical equipment are limited in these countries (Figure 8, next page) despite a large and growing disease
burden. In many countries there are not enough specialists and/or specialised medical centers for specific diseases\textsuperscript{50}. For example, Zambian cancer patients must travel to South Africa and pay out of pocket to access mAb cancer treatments, an option only viable to wealthy individuals.\textsuperscript{*}

The burden of many diseases is also unknown or measured inaccurately in many LMICs, including Kenya and Zambia, because of limited medical staff, training and diagnostic equipment\textsuperscript{90,91,99}. Strengthening healthcare systems and the ability to diagnose disease will help provide mAb manufacturers with a more accurate assessment of disease burden and the market size for their products in LMICs, which is a critical component of expanding access to mAbs.

For infectious diseases, expanding the availability and rapid use of diagnostic tests confirming the type and strain of pathogen is also critical to ensuring timely and appropriate treatment. To enable broader use of therapeutic mAbs, diagnostic capabilities for infectious diseases will also need to be strengthened.

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*Personal communication with Professor Chipeta at the University of Zambia and IAVI

### Figure 8: Pieces of medical equipment per million population in 2013

<table>
<thead>
<tr>
<th>Country</th>
<th>Magnetic resonance imaging</th>
<th>Radiation therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>45.94</td>
<td>7.17</td>
</tr>
<tr>
<td>Canada</td>
<td>7.99</td>
<td>8.07</td>
</tr>
<tr>
<td>Mexico</td>
<td>1.41</td>
<td>0.54</td>
</tr>
<tr>
<td>Yemen</td>
<td>1.15</td>
<td>0.12</td>
</tr>
<tr>
<td>Honduras</td>
<td>1.11</td>
<td>0.74</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>0.28</td>
<td>0.42</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>0.10</td>
<td>0</td>
</tr>
<tr>
<td>Uganda</td>
<td>0.08</td>
<td>0.05</td>
</tr>
<tr>
<td>Cambodia</td>
<td>0.07</td>
<td>0.07</td>
</tr>
<tr>
<td>Zambia</td>
<td>0.07</td>
<td>0.04</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: WHO (2016) Global Health Observatory data repository
## Making monoclonal antibodies more affordable

### Key findings:

- mAbs are unaffordable for most of the world’s population.
- Companies focused on high-income country markets have little incentive to pursue lower-cost strategies to develop, manufacture and deliver mAbs.
- Competition, regulation and other strategies that can lower mAb prices are not sufficient to make these products affordable globally.
- Advancements in antibody optimisation, manufacturing technologies and packaging and delivery have the potential to lower mAb production costs and increase efficiency.
- Local and mobile manufacturing of mAbs are untested in LMICs but may be an alternative for improving access to affordable mAbs in remote areas.
- Creative intellectual property/licensing frameworks may help expand access to mAbs.
- Alternate business models, including public-private partnerships and industry-led access models, are emerging to support mAb research and development, manufacturing and global access for non-communicable and infectious/neglected diseases.
- Including mAbs in pooled procurement platforms, similar to those used for vaccines, could make them more widely accessible.

### One barrier to achieving global access to innovative mAbs is that they are unaffordable for most of the world’s population.

Biologics, and particularly mAbs, are among the highest priced pharmaceutical products in the world. In the US, biologic drugs represented 2 per cent of all prescriptions in 2017, but 37 per cent of net drug spending. The median price for mAb treatments in the US ranges from approximately $15,000-$200,000 a year (Figure 9, next page). And mAb-based therapies are increasingly prescribed in sequence or in combination, which can result in even higher treatment costs.

The most expensive mAbs are for oncology and hematology, with annual treatment prices approximately $100,000 higher than mAbs for other diseases. Drug prices, including those for mAbs, vary greatly worldwide because of a variety of factors (see page 30). But with few exceptions, existing price-control mechanisms and access strategies are insufficient to make mAbs widely affordable (Figure 10, next page).

The same is true for biosimilars. The introduction of lower-priced biosimilar mAbs can offer significant savings to payers and governments that are struggling to prioritise healthcare interventions and manage already stretched budgets. But, to date, biosimilars have not expanded access substantially. This is because they are still largely unaffordable.

In most countries, generic drugs are typically sold...
at steep discounts—more than 90 per cent off the original price—whereas biosimilars are generally only 10 per cent to 35 per cent less expensive than the originator mAb in most countries. This difference is explained, at least in part, by the fact that biosimilars are much more complicated and costlier to develop than small molecule generics (see page 13).

Even in India, where biosimilar prices are discounted the most because of extensive local production and competition among biosimilar manufacturers, they are discounted by 57 per cent—significantly less than generic drug discounts.\(^{(5,31,57,101)}\)

The WHO estimates that up to 90 per cent of the population in LMICs purchase medicines through out-of-pocket payments.\(^{(102)}\) Therefore, even at a substantial discount, mAbs and biosimilars remain too expensive for many people. Also, few, if any, of the most commonly prescribed mAbs are reimbursed through public health systems even in some middle-income countries, such as Kenya, India and Egypt (Figure 10)\(^{(56,96,97,103)}\).

This report focuses on three potential solutions, which if applied in combination, could make mAbs more affordable:

- validate and apply novel technologies to lower mAb development and manufacturing costs
- implement alternate business models that prioritise access
- identify procurement and delivery models for mAbs similar to those used to increase access to vaccines.

**Figure 9: Median price of monoclonal antibodies by therapy area for one year of treatment**

US prices as of January 2017, in US dollars

<table>
<thead>
<tr>
<th>Therapy Area</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology/hematology</td>
<td>$142,833</td>
</tr>
<tr>
<td>Immunology</td>
<td>$52,969</td>
</tr>
<tr>
<td>Infectious diseases/allergy</td>
<td>$29,808</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>$22,464</td>
</tr>
<tr>
<td>Cardiology/endocrinology</td>
<td>$15,624</td>
</tr>
</tbody>
</table>


**Figure 10: Availability of seven monoclonal antibodies* in selected countries with different levels of universal health coverage, 2018**

<table>
<thead>
<tr>
<th>Country</th>
<th>Available, reimbursed/on national list</th>
<th>Available, not publicly reimbursed</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Sweden</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Brazil</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Mexico</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>China</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Morocco</td>
<td>5</td>
<td>No data</td>
</tr>
<tr>
<td>Kenya</td>
<td>7</td>
<td>No avail.</td>
</tr>
<tr>
<td>India</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Egypt</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

*Adalimumab, cetuximab, ipilimumab, panitumumab, pertuzumab, rituximab, trastuzumab. Note: “not avail.” = not available/not registered

Factors influencing global mAb prices

Several factors influence drug prices, and how they are applied varies in different parts of the world. As a result, drug prices can also vary widely (Figure 11, next page). Some of the most common factors that affect global mAb prices are:

1. **COMPETITION** among products for similar indications or with similar mechanisms of action can impact price, as can competition from biosimilars.

   Competition in the Indian biosimilar market has led to biosimilars that are priced up to 70 per cent lower than the local retail price of the innovator mAb. In some cases, biosimilar competition can even spur manufacturers to lower the price of the originator antibody to retain market share. Dr. Reddy’s Laboratories biosimilar Reditux® (rituximab) was introduced in India at 50 per cent less than the retail price of Roche’s Rituxan/MabThera® (rituximab)104. In response, Roche lowered the price of Rituxan® to promote its brand-name product104.

2. **INTERNATIONAL REFERENCE PRICING (IRP)** is one of the most common price-control mechanisms used by governments. It uses the proposed price of a product in several countries to derive a benchmark or reference price.

   The potential downside of IRP is that it may cause companies to delay or avoid launching new drugs in countries that use IRP, especially if they are small markets referenced by countries with larger markets. One study showed that pharmaceutical companies systematically delayed submission in Belgium because of IRP105.

3. **COST-EFFECTIVENESS THRESHOLDS** are used to determine the acceptable price based on a product's clinical effectiveness.

   Health technology assessment (HTA) mechanisms are increasingly used to make value-based assessments of medicines and to inform both pricing and reimbursement decisions. HTAs are usually conducted by independent government agencies such as the National Institute for Health and Care Excellence in England, the Canadian Agency for Drugs and Technologies in Health or the National Committee for Health Technology Incorporation (CONITEC) in Brazil. One drawback to HTAs is that they are time-consuming processes that can delay patient access, particularly for products that receive conditional regulatory approval based on limited clinical data106. And in some countries, like Spain and Italy, autonomous regions and hospitals sometimes conduct their own HTA and negotiations with manufacturers after national decisions, leading to further delays107,108.

   Risk-sharing agreements between the payer and a company can also be used when there is uncertainty associated with the efficacy of a drug. Risk-sharing agreements allow payments to be determined based on the clinical benefit of a product. Risk-sharing agreements have improved access to select medicines in some European countries, including Sweden, Portugal and Italy109,110.

   More than 25 European countries have a national HTA and the Japanese government recently announced plans to implement one111,112.

   Efforts to establish HTA-like groups are also emerging in some African countries. With the support of the International Decision Support Initiative, the KEMRI-Wellcome Trust Research Programme is supporting the development of an HTA mechanism in Kenya. Most participants in stakeholder meetings convened in Zambia, Uganda, Kenya and South Africa agreed that establishing HTA bodies to assess mAbs would be useful; however, they cautioned that there may not be enough skilled personnel to form these advisory bodies, especially in smaller African countries. As an alternative, they suggested establishing more regional HTAs that could evaluate data from countries with similar disease burdens and demographics.

4. **TIERED PRICING** is a strategy used to set prices for different parts of the world based on macroeconomic indicators, such as the average national gross domestic product per capita. Tiered-pricing levels are often established through direct negotiations between government payers and manufacturers.

   Tiered-pricing arrangements vary across companies, therapy areas and products. They are currently being applied in Kenya to increase patient access and affordability to Roche’s cancer mAb trastuzumab113. In 2016 Roche agreed to provide trastuzumab to the Kenyan government at 50 per cent off its normal price. The Kenyan government then agreed to establish a small fund (initially valued at $195,000) to help patients pay the remaining treatment costs114.
availability + affordability = access

**Figure 11: International comparison of Herceptin® (trastuzumab) prices**

Price per dose of 2 mg/kg for a 75 kg patient, in US dollars

![Price comparison chart]

Sources: 28–32

This programme is attempting to make a cancer mAb more affordable in a country where 75 per cent of the population lacks private health insurance.115

5 **DIRECT PRICE NEGOTIATIONS** between pharmaceutical companies and governments or procurement bodies can provide assurance of significant market volume, which ultimately can be an incentive for manufacturers to lower their prices.

China is increasingly relying on direct price negotiations to determine drug prices for national reimbursement.116 The National Development and Reform Commission now sets a maximum reimbursement for products on the National Reimbursement Drug List (NRDL). Only those products included on the NRDL are eligible for provincial tenders. Manufacturers are therefore incentivised to lower prices to be included on the NRDL, and then to lower prices even further to win provincial tenders. Trastuzumab was launched in China in 2002 and Roche reduced the price of the mAb by roughly 70 per cent to get it included on the NRDL in 2017.117

6 **INTRODUCTION OF SECOND BRANDS** is a way for companies to market lower-priced versions of an originator mAb in a specific market, such as public health systems in LMICs.

Second brands have a different name and use unique supply chains, sometimes including the use of local manufacturers, to further differentiate them from original brands and to prevent lower-priced products from threatening profitability in high-income country markets. Introducing second brands can also increase competition.

In some cases, second brand strategies and alternate supply chains have led to more affordable mAb prices in middle-income countries. In South Africa, Roche sells its breast cancer mAb trastuzumab as both Herceptin®, the original brand, and as a second brand called Herclon®. Herclon® is sold for $145 per dose—a 70 per cent discount off the price of Herceptin®—and is only available within the public health system. In India, Roche sells the lower-priced, second brand Herclon®. This has given rise to increased biosimilar competition. The biosimilar CanMab®, manufactured by the Indian company Biocon, is available in India at a substantially lower price than Herclon® (Figure 11).

In India, Roche partnered with the local manufacturer Emcure to produce and market second brand versions of two of their mAbs: Herclon® and Mabthera®, a second brand of Rituximab®.118

In many instances, these pricing factors are applied in an integrated manner. In Brazil, for example, regulators use both IRP and value-based assessments based on advice from the national HTA agency CONITEC. A manufacturer must prove that a new medicine offers clinical benefits over a comparator to be able to charge a premium price. If deemed innovative, IRP is then used to derive the drug’s list price. The average price of the mAb trastuzumab dropped by 57 per cent after it received CONITEC approval in 2012.119
Validate and apply novel technologies to lower costs

The process of developing new medicines is long and costly. It’s reported to cost on average $2.6 billion to develop a new drug\textsuperscript{121}, although the precise costs associated with developing any specific product are undisclosed. Pharmaceutical R&D is also a high-risk business as many drug and vaccine candidates fail in clinical testing.

In the US, where prescription drug prices are the highest, there is no clear association between research and development costs and drug prices\textsuperscript{122}. Companies that market many of the originator mAbs are primarily focused on markets in high-income countries, where prices are the highest. Given this, there is limited incentive for companies to devise lower cost strategies for developing or manufacturing mAbs in an effort to lower prices\textsuperscript{123}.

It reportedly costs between $95–$200/gram to produce marketed mAbs, with even higher costs for startup companies, and this does not take into account research and development costs\textsuperscript{14}. However, there are several innovative technologies that could be applied across the mAb development continuum—from discovery to delivery—which, if coupled with alternate business models, could substantially reduce mAb development and production costs as well as prices.

Selection and optimisation

Advances in B-cell immortalisation, high-throughput screening, single-cell analysis and display technologies, and humanised animal models (see Appendix, page 34) have made it possible to rapidly identify antibodies—including rare and potent antibodies from currently or previously infected humans—that bind to specific targets.

Technological advances are also making it possible to engineer mAbs to improve their potency, breadth, half-life and biophysical properties\textsuperscript{5,124}. For example, clinical studies of the anti-RSV antibody MED18897-YTE and the anti-HIV antibody VRCO1-LS have demonstrated that slight modifications can lead to four- to fivefold enhancements in half-life, which is anticipated to translate into products that can be delivered less frequently, on average once every three to six months\textsuperscript{5,124}. More recently, an integrated approach of deep sequencing, bioinformatics and directed evolution by yeast display is being utilised to select and optimise antibodies with biophysical characteristics that would make them more amenable to manufacturing\textsuperscript{125}.

For example, Just Biotherapeutics, which was recently acquired by Evotech Inc., uses software to predict how modifying the DNA sequence of a protein could increase its drug-like properties and expression in cell culture, thereby making it easier to purify and manufacture. The company, with support from the Bill & Melinda Gates Foundation, is developing their technology to develop sequence-optimised broadly neutralising HIV mAbs with improved stability that could be manufactured at low cost\textsuperscript{126}.

Manufacturing

Currently, most commercial mAbs are produced in mammalian Chinese Hamster Ovary (CHO) cells that are engineered to produce a large quantity of

“Improvements in mAb potency and reduced manufacturing costs would reduce the dosage and frequency of administration, leading to decreased cost and improved convenience.”

Gary Nabel, CSO and Senior Vice-President, Sanofi Inc.
antibodies (in the 1–5 gram/liter range)\textsuperscript{123}. CHO cell lines expressing the antibody of interest are typically grown in large bioreactors for more than 10–15 days. The resulting antibodies are then purified through multiple-column chromatography methods\textsuperscript{127} and formulated for appropriate administration, a process called “batch production.” CHO cells make fully functional proteins that are generally well tolerated by humans, but they require a long production time and high material costs.

To reduce cost and increase capacity, many manufacturers are therefore exploring alternatives to batch production methods. Continuous biomanufacturing and single-use bioreactors are two technologies that can improve the speed, flexibility and convenience of CHO-based mAb production\textsuperscript{128}. Single-use bioreactors allow for a quicker turnaround, can be used in tandem to produce biopharmaceuticals at scale and require significantly lower capital investment to construct. This technology has enabled the development of global mAb production facilities.

Integrated continuous biomanufacturing processes are also faster and cheaper\textsuperscript{129}, and offer more consistent processing and greater product quality. Economic analyses of continuous biomanufacturing coupled with continuous chromatographic processes (referred to as integrated continuous processing) can reduce costs by 55 per cent compared to conventional batch processing, considering both capital and operating expenses\textsuperscript{128}.

WuXi, a leading mAb manufacturer based in China, runs the world’s largest disposable bioreactor-based biologics manufacturing facility. The facility uses a continuous bioprocess system integrated with single-use bioreactors that is predicted to reduce mAb manufacturing costs from $95–$200 per gram to less than $15 per gram, or $3 for an average 200 mg dose of most mAbs\textsuperscript{130–132}. If these efforts to dramatically lower production costs are coupled with a dramatic reduction in price, it would be a big step towards making mAbs more affordable.

The Serum Institute of India is also investing in more efficient manufacturing processes with multiple modular facility units at a new site in Pune, India, to support their growing investments in both biosimilar and innovative mAb development and manufacturing\textsuperscript{131}.

Many alternatives to CHO-based mAb production are also being explored\textsuperscript{134} (Figure 12). Alternate production platforms, including yeast, fungus, algae and transgenic plants, as well as nucleic acid delivery via DNA or messenger RNA (mRNA; Figure 13, page 35) have the potential to be cheaper and faster than traditional methods. Using genetic constructs—either DNA or mRNA—as a delivery system could reduce production costs by five- to tenfold\textsuperscript{135}.

Packaging and delivery

The way mAb products are packaged and delivered can also help lower mAb production costs. Delivery of mAbs is complicated by their physiochemical and biological properties. Most antibodies are delivered

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**Figure 12: Alternative monoclonal antibody manufacturing methods**

<table>
<thead>
<tr>
<th>Method</th>
<th>Manufacturer</th>
<th>Programmes</th>
<th>Highest status of programmes</th>
<th>Advantages and challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yeast</strong></td>
<td>Alder Biopharmaceuticals</td>
<td>Migraine and chronic autoimmune diseases</td>
<td>Submitted to USFDA for approval</td>
<td>Lower upfront investments and lower cost of production; glycosylation patterns and post translational modifications can be a challenge; however, GlycoFi engineered strains more human-like — but no recent activity reported\textsuperscript{136,137}</td>
</tr>
<tr>
<td>Research Corporation Technologies</td>
<td>Contract work</td>
<td>Available for licence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GlycoFi (Merck)</td>
<td><strong>Unreported</strong></td>
<td>Preclinical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerous groups in research: Genomics Research Center; Academia Sinica Taiwan; Scripps Research; MIT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(table continues on next page)*
### Figure 12: Alternative monoclonal antibody manufacturing methods (continued)

<table>
<thead>
<tr>
<th>Method</th>
<th>Manufacturer</th>
<th>Programmes</th>
<th>Highest status of programmes</th>
<th>Advantages and challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transgenic tobacco</td>
<td>Mapp</td>
<td>Ebola, HIV</td>
<td>Phase II</td>
<td>Lower upfront investments as smaller facilities needed, but variation in quality(^{136-140})</td>
</tr>
<tr>
<td></td>
<td>Biopharmaceutical; LeafBio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PlantForm</td>
<td>Cancer, Ebola HIV, ricin, undisclosed</td>
<td>Preclinical</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planet</td>
<td>Common cold</td>
<td>Discontinued Phase II</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Biotechnology Inc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fraunhofer Institute for Molecular Biology</td>
<td>HIV</td>
<td>Phase I</td>
<td></td>
</tr>
<tr>
<td></td>
<td>iBio</td>
<td>RSV, Ebola</td>
<td>Preclinical</td>
<td></td>
</tr>
<tr>
<td>Fungus</td>
<td>Dyadic with Serum Institute of India</td>
<td>Undisclosed</td>
<td>Undisclosed</td>
<td>Higher yield per liter of media and potential for lower cost; engineering of more human-like strains ongoing(^{141})</td>
</tr>
<tr>
<td>Milk of transgenic cattle</td>
<td>China Agricultural University</td>
<td>Cancer</td>
<td>Preclinical</td>
<td>Lower upfront investments but glycosylation challenges(^{142})</td>
</tr>
<tr>
<td>In vitro cell-free expression systems</td>
<td>Sutro Biopharma</td>
<td>Cancer</td>
<td>Preclinical</td>
<td>Potential for lower cost; however, large-scale production untested(^{143})</td>
</tr>
<tr>
<td>Algae</td>
<td>Institut de Recherche et d’Innovation Biomédicale</td>
<td>Hepatitis B</td>
<td>Preclinical</td>
<td>Low production costs; challenges with heterogeneity and post-translational modification(^{144-147})</td>
</tr>
<tr>
<td></td>
<td>Scripps Research; University of California, San Diego</td>
<td>Cancer, anthrax, HSV, botulism</td>
<td>Preclinical</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Algal Research Group; University College London</td>
<td>No mAb data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baculoviral insect cell</td>
<td>Vienna Institute of Biotechnology; University of Natural Resources and Life Sciences</td>
<td>HIV</td>
<td>Preclinical</td>
<td>Potential for lower cost; however, large-scale production untested(^{148})</td>
</tr>
<tr>
<td>Silkworm baculovirus expression</td>
<td>National Institute of Health Sciences, Kanagawa</td>
<td>Cancer</td>
<td>Preclinical</td>
<td>Potential for lower cost; however, large-scale production untested(^{151})</td>
</tr>
<tr>
<td>Drosophila S2 cell line</td>
<td>Institut Pasteur of Shanghai</td>
<td>Influenza</td>
<td>Preclinical</td>
<td>Potential for lower cost; however, large-scale production untested(^{149})</td>
</tr>
<tr>
<td>In situ vector gene delivery</td>
<td>IAVI</td>
<td>HIV</td>
<td>Phase I</td>
<td>Potential for lower cost; however, undetectable expression in clinical study (lack of proof of concept)(^{150})</td>
</tr>
<tr>
<td></td>
<td>NIAID</td>
<td>HIV</td>
<td>Phase I</td>
<td>Ongoing POC (NCT03374202)</td>
</tr>
</tbody>
</table>

Table doesn’t include data for SARS-CoV-2 mAbs

*availability + affordability = access*
either intravenously, subcutaneously or in some cases through nasal administration if the mAb is susceptible to gut protease degradation. Intravenous (IV) administration has several drawbacks: it is more complicated, it can be more painful and therefore less tolerable for recipients, and it is more expensive as it must be administered by a medical professional. Studies have found that IV administration of trastuzumab is associated with a more than twofold higher administration cost (not including the cost of the mAb)\(^{164}\).

Alternate administration routes are therefore one way to reduce delivery costs. Subcutaneous injection is a less expensive way to administer mAbs. About one-third of all mAbs approved in the past ten years are administered via subcutaneous injection\(^{165}\).

Some manufacturers are also researching more patient-friendly and cost-effective delivery devices, including microneedles and slow-release implants (Figure 14, page 37). Additional investments and innovation are needed to create convenient and affordable devices that are more amenable for global use.

Technologies that enable oral delivery of mAbs are also in development. Most mAbs are of the naturally occurring immunoglobulin G (IgG) subtype\(^1\). This subtype of mAbs is relatively stable and has long half-lives, which makes it suitable for large-scale manufacturing. But the naturally occurring IgA2 mAb subtype is resistant to mucosal proteases and enzymes, making them amenable to oral delivery. In preclinical murine challenge studies, oral delivery of IgA2 mAbs protected against enteric bacteria including *Salmonella*, *Shigella* and *E. coli*\(^{166,167}\). These IgA2 mAbs have shorter half-lives and are more challenging to manufacture\(^{168}\), so new technologies are being developed to address these shortcomings. For example, heavy-chain variable domain nanobodies that are engineered to be
resistant to intestinal and inflammatory proteases have been delivered orally and shown to survive in the intestinal tract of humans with intestinal bowel disease\textsuperscript{169, 170}. For more, see the supplement to this report: Combination monoclonal antibodies and alternate formats.

A proprietary spirulina algae-based production and oral delivery technology is also being tested in preclinical studies for the delivery of single-chain camelid antibodies for diarrheal diseases\textsuperscript{171}. Researchers are isolating antibodies from humans that could be delivered orally for the treatment of serious diarrhea and intestinal inflammation caused by \textit{C. diff} infections\textsuperscript{172}. Other technologies that could allow for oral delivery of antibodies for enteric and liver diseases are also in development\textsuperscript{173}.

In addition to the route of administration, innovative approaches to packaging and storage can also help make mAbs more affordable. Blow-Fill-Seal technology, a form of advanced aseptic packaging in which the container is formed, filled and sealed in one automated system, has recently been used for injectables and biologics, including vaccines and mAbs\textsuperscript{174}. Blow-Fill-Seal technology replaces glass vials or pre-filled syringes—typically used for subcutaneously administered mAbs\textsuperscript{175}—with plastic, which reduces accidental breakage. The low-cost, aseptic design and compact nature of Blow-Fill-Seal tubes, which can be custom made for a wide range of volumes and readily shipped, could help achieve broader access to mAbs.

Shipping and delivering mAbs is also complicated because they are typically less stable at ambient temperatures and therefore require cold storage. Maintaining cold-chain facilities can be challenging in some parts of the world. In Africa, cold-chain systems are primarily used for storing and shipping childhood vaccines and there’s little additional capacity. Cold-storage systems also add to the expense of delivering mAbs, particularly in low-income countries that contend with frequent power outages. Products that require freezing temperatures for transport and storage would pose a challenge in many countries, according to stakeholders. Therefore, technologies that could reduce the cost of monitoring and maintaining cold-chain systems\textsuperscript{a} as well as developing alternate thermostable formulations of mAbs that would enable storage at ambient temperatures could also help make mAbs more affordable and accessible.

**Mobile manufacturing**

More flexible and modular units are also being developed to manufacture biologics. These mobile manufacturing units could be particularly useful in local outbreak situations. However, these technologies have not yet been tested or used for the local production of quality-controlled, affordable biologics in an LMIC setting.

- Univercells’s miniaturised bioreactors are easily transportable and could enable in-country mAb production by deploying low-footprint, multiproduct facilities that are more affordable to build and operate\textsuperscript{162}.

- Emergent BioSolutions Inc. is developing a mobile, small-scale manufacturing site for biologics that is designed to manufacture mAbs in a controlled environment the size of a shipping container that could be deployed wherever an outbreak occurs\textsuperscript{163}.

- Research is also advancing in the field of benchtop manufacturing. Some groups are developing small automated systems capable of producing clinical-grade therapeutic proteins, including mAbs, in a matter of days. These fast and flexible manufacturing processes could be performed in a hospital or a pharmacy and could enable the production of small amounts of mAbs for endemic breakouts, with limited, if any, cold chain storage. The Massachusetts Institute of Technology (MIT) is developing the Integrated Scalable Cyto-Technology, a closed system of producing and purifying biologics using \textit{Pichia pastoris} yeast cells. This platform has the potential to shorten production times by tenfold\textsuperscript{164}.

How all of these technologies are applied—whether it is optimising antibodies to lower the dose, using alternate manufacturing platforms or developing oral formulations—will ultimately determine how much lower mAb costs can be. Alternate business models will also need to be implemented to ensure that lower production costs result in lower prices. Other factors will also need to be considered, including the disease in question, the existing treatments available, what is feasible in various LMIC settings and what is acceptable to the populations that will ultimately use these products. Understanding the preferences of communities, healthcare workers and

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\textsuperscript{a}Consultation with Southern African Programme on Access to Medicines and Diagnostics. 17th July 2019. In person interview conducted by IAVI.
Consultation with CAPRISA. 19 July 2019. Phone interview conducted by IAVI.
Figure 14: Examples of advancements in mAb delivery

<table>
<thead>
<tr>
<th>Advancement</th>
<th>Device or technology</th>
<th>Antibodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large volume subcutaneous delivery</td>
<td>Halozyme ENHANZE: Drug delivery technology based on recombinant human hyaluronidase PH20 enzyme, rHuPH20, which locally degrades hyaluronan in the subcutaneous space; allows for increased dispersion and absorption of co-administered therapies enabling large volume (&gt;5 ml)</td>
<td>Roche with Halozyme has developed two cancer mAbs: Herceptin Hylecta&lt;sup&gt;®&lt;/sup&gt; (trastuzumab) and Rituxan Hylecta&lt;sup&gt;®&lt;/sup&gt; (rituximab)&lt;sup&gt;178&lt;/sup&gt;</td>
</tr>
<tr>
<td>Large volume on-body infusors</td>
<td>Pushtronix System—The device adheres to the body, usually on the abdomen, and patients are hands-free during administration; 420 mg/3.5mL of Repatha&lt;sup&gt;®&lt;/sup&gt; is delivered subcutaneously in nine minutes</td>
<td>Amgen’s Repatha&lt;sup&gt;®&lt;/sup&gt; (evolocumab) single dose monthly dosing for cholesterol lowering&lt;sup&gt;177&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>enFuse is an on-body infusor drug delivery device designed for patient self-administration of high-volume drugs from 5 to 50 mL</td>
<td>Enable Injections is in development partnerships with Genetech, Sanofi, and Apellis Pharmaceuticals for mAb delivery&lt;sup&gt;178&lt;/sup&gt;</td>
</tr>
<tr>
<td>Slow release subdermal</td>
<td>Medici Drug Delivery System: A matchstick-sized osmotic mini-pump designed to deliver a continuous flow of medication placed under the skin for once- or twice-yearly dosing</td>
<td>Intarcia and Numab collaboration focused on the development of once- or twice-yearly mono-specific and multi-specific antibodies addressing diabetes, obesity and autoimmune indications&lt;sup&gt;179&lt;/sup&gt;</td>
</tr>
<tr>
<td>Microneedles</td>
<td>Transdermal alternative for drug delivery using micron-scale needle structures</td>
<td>In preclinical development, testing bevacizumab and PD1 antibodies&lt;sup&gt;180–182&lt;/sup&gt;</td>
</tr>
<tr>
<td>Electroporation</td>
<td>Electroporation uses very short electrical pulses to produce temporary pores of nanometer-range diameters in the intercellular lipid matrix of the skin, which allows for the delivery of large molecules</td>
<td>Inovio’s Dengue/Zika mAb delivered with their CELLECTRA&lt;sup&gt;®&lt;/sup&gt; 2000 device is in Phase I clinical testing NCT03831503</td>
</tr>
<tr>
<td>Jet injectors</td>
<td>Jet injectors are a needle-free drug delivery device that delivers the biologic through a pressurized liquid, clinically shown to be less painful and preferred by patients compared to a standard needle-based injection</td>
<td>Takeda Pharmaceutical and Portal Instruments in development for Entyvio&lt;sup&gt;®&lt;/sup&gt; (vedolizumab)&lt;sup&gt;183&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Policy makers can help guide the development of products that are acceptable, affordable and feasible to implement.

**Local production, local access**

Another way to increase access to mAbs is to expand local or regional manufacturing capacity.

It’s estimated that around 79 per cent of all pharmaceuticals in Africa are imported<sup>184</sup>. Importation can increase costs and lead to delays in access, or even drug shortages. But the economic benefits of local manufacturing are dependent on large volume demand<sup>128</sup>. And maintaining the quality of the facility and mAb product and aligning manufacturing standards with local regulatory expectations can be complicated.

Many MICs are capable of manufacturing small molecules and vaccines<sup>185</sup>, but manufacturing of biologics, including mAbs, mostly occurs in North America and Europe (Figure 15, next page)<sup>186</sup>. However, the number of mAb manufacturing facilities is expanding in Asia and South America. India now has more USFDA-approved manufacturing facilities than any country except the US<sup>187</sup> and their mAb manufacturing capacity is growing.

Africa currently lacks the capacity to produce mAbs locally. Some stakeholders highlighted the need to train and develop personnel required for the production and regulation of biologics before
investment in local manufacturing in Africa could be considered.*

One of the main challenges, according to stakeholders, is that the market size for mAbs in many African countries is largely unknown, and without the guarantee of a large market, local manufacturing is not feasible. “When it comes to antibodies, unless you have a big market it’s really not viable to set up [local manufacturing]. It’s only when you produce very large volumes that you can drop your prices.”**

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*Consultation with KEMRI-Wellcome Trust. 4 June 2019. Phone interview conducted by IAVI. Consultation with African Vaccine Manufacturing Initiative. 3 July 2010. Phone interview conducted by IAVI. Consultation with Clinton Health Access Initiative. 5 July 2019. Phone interview conducted by IAVI. Consultation with Kenyan Pharmacy and Poisons Board. 17th July 2019. In person interview conducted by IAVI. Consultation with Southern African Programme on Access to Medicines and Diagnostics. 17th July 2019. In person interview conducted by IAVI.

**Professor Salim S. Abdool Karim, FRS Director: CAPRISA Professor of Global Health: Department of Epidemiology,
Innovative approaches to intellectual property to expand access

One potential approach for facilitating greater access to mAbs and biosimilars in LMICs is the use of voluntary licences. The Medicines Patent Pool (MPP), founded in 2010 by Unitaid, has successfully utilised voluntary licences from pharmaceutical companies to enhance access in LMICs to drugs to treat HIV, TB and hepatitis C. Upon securing the voluntary licence from a pharmaceutical company for a specific compound, the MPP sublicenses the patent rights to manufacture and commercialise the drug to one or more generic manufacturers to support specified LMIC markets that have been agreed upon with the pharmaceutical company.

MPP undertook a feasibility study with the WHO to assess whether they should expand their mandate to include other infectious and non-infectious diseases that impact LMICs, as well as biological products, including mAbs. They concluded that the MPP mechanism could enhance access to biosimilars in LMICs, particularly for products with sizeable markets, such as for the treatment of breast cancer, provided that the technology transfer could be negotiated together with a licence. MPP plans to release a special report on biologics soon.

TRIPS agreements allow for compulsory licences and exemptions to intellectual property protection for life-saving medicines in low-income countries. But compulsory licensing has mostly been used for procurement of HIV/AIDS therapies in LMICs and has not significantly improved access to other medicines in the least-developed countries. Compulsory licensing has not yet been utilised to broaden access to mAb products and there may be challenges to utilising this approach.

Some public-private partnerships are using intellectual property rights to ensure that any products developed through their collaborations will be promptly registered, manufactured in adequate quantities and distributed at reasonable prices in developing countries. An increasing number of public and philanthropic funders, including Wellcome, are requiring similar access provisions for R&D they support.

Not all mAb products on the market today are priced at thousands of dollars per dose. Biocon’s Canmab® — a biosimilar version of the breast cancer mAb Herceptin®—sells for $100–$200 per dose in India, significantly less than the $1,800 price per dose in the US. Innovative products Rabishield and Twinrab, as illustrated on page 17, are priced at approximately $20–$40 per dose. These examples provide proof of concept that mAbs can be sold at dramatically lower prices while still maintaining a viable, albeit lower-profit business model.

For mAbs to be globally accessible, prices may need to be even lower. How much lower will ultimately vary by country and disease area, but the goal is to ensure that affordability is not a barrier to access for more of the world’s population.

Efforts to lower mAb development and manufacturing costs are essential to making mAbs more affordable. But alone, they are not sufficient. Access-driven, innovative business models are also necessary. By both implementing new technologies and developing sustainable lower-profit business models, mAbs could be made more affordable. Public-private partnerships such as the Utrecht Center for Affordable Biotherapeutics (UCAB) and companies like the Serum Institute of India already aim to reduce mAb production costs, and prices, substantially. UCAB is targeting a price of $50 per dose for palivizumab, more than 20-fold less than the average price of Synagis® in high-income countries, while some low-cost manufacturers are targeting prices as low as $5 per dose.*

Other models of collaboration between multinational pharmaceutical companies, governments, low-cost manufacturers and procurement agencies will also be required to ensure that both existing mAbs and those in development are made more affordable.

*Stakeholder consultation with lost cost Indian manufacturer
Alternate funding models to stimulate research and development for infectious/neglected diseases

For some infectious/neglected diseases and drug-resistant bacterial infections, the burden is overwhelmingly in developing countries and so there is not a strong market incentive for pharmaceutical companies to invest in this research. As a result, alternate funding models are filling the gap. Today, development of new therapies for infectious and neglected diseases is mainly supported by public-sector and philanthropic sources, which are creating alliances with governments, private companies and other public-sector entities to support mAb research and development.

The public sector provided nearly two-thirds of the global infectious/neglected disease R&D funding in 2016, with contributions from the US, UK and European Commission topping the list. The US was by far the largest funder, providing $1.5 billion in funding in 2016, nearly three-quarters of the global total.

Philanthropic entities including the Bill & Melinda Gates Foundation and Wellcome also provide significant levels of R&D funding for infectious and neglected diseases. The Bill & Melinda Gates Medical Research Institute, a non-profit biotech organisation, is focused on advancing products, including mAbs, to fight malaria, tuberculosis and diarrheal diseases. Wellcome, through their Innovations Flagships, is committed to a broad portfolio approach to address neglected, tropical and infectious diseases, and is exploring the affordability of mAbs and their potential role in enteric disease treatment and prevention. Wellcome also has specific initiatives in epidemics, drug-resistant infections and snakebite.

Other funding sources include:

- CARB-X (Combating Antibiotic Resistant Bacteria)—a non-profit partnership financing the development of therapies, prevention and diagnostics that target high-priority drug-resistant bacteria. CARB-X is supported by multiple public and non-governmental organisation (NGO) sources and has supported two mAb projects so far: funding Visterra Inc. to develop VIS705, a novel broad-spectrum antibody-drug conjugate against multiple drug-resistant strains of Pseudomonas, and funding Bravos Biosciences for the preclinical development of antibodies for multidrug resistant E. coli strains.

- The European Commission’s Innovative Medicines Initiative (IMI) supports many research consortia to jointly develop new antibiotics as well as alternatives such as mAbs. The COMBACTE-NET (combating AMR in Europe) network, supported by IMI, is conducting a phase II trial of MEDI3902, an investigational bispecific mAb owned by Medimmune against Pseudomonas aeruginosa.

- Venture capital initiatives, such as the Impact Repair Fund by Novo Ventures and the AMR Diagnostic Challenge.

- LifeArc, a leading UK medical research charity, has partnered with Kymab, a clinical-stage biopharmaceutical company, to develop mAb-based therapeutics for a range of targets.

- Some governments are also exploring a “Netflix”-like subscription-based model to incentivise R&D. The UK’s National Health Service will test the world’s first subscription-style payment model to encourage pharmaceutical companies to develop new drugs for drug-resistant infections. It works like this: Instead of paying companies based on the volume of medicine sold, the government will make upfront payments to pharmaceutical companies for access to their drugs based on their usefulness.

Access-focused alternate business models

A few of the alternative business models currently being used to develop more affordable mAbs are described below.

Utrecht Centre for Affordable Biotherapeutics (UCAB)

The WHO and Utrecht University in The Netherlands initiated a technical collaboration in 2014 to create UCAB. UCAB is pioneering access models to develop high quality and affordable biotherapeutics through an association of distributed manufacturers in MICs.

UCAB’s first pilot project, with technical oversight and in-kind contributions from the WHO, is to develop a low-cost biosimilar version of Synagis® (palivizumab) against RSV with an anticipated estimated price of $250 per child for a full course of five doses. UCAB has created a consortium, including a lead manufacturer (mAbxience) and local manufacturers (Libbs in Brazil, Medigen in Taiwan and Spinaco in Saudi Arabia) to support the project. UCAB anticipates filing the palivizumab biosimilar in 2023; however, determining market size is a key challenge.
NIH is working with partners to launch a set of initiatives to make mAb treatments and preventives affordable and globally accessible. NIH's strategy is to enable wider access to mAbs through innovation and investments in product development and optimisation, low-cost manufacturing and novel business models. NIH, in collaboration with Scripps Research, has been a leader in the discovery and optimisation of potent HIV-specific bnAbs for prevention and treatment. Much of NIH’s work on HIV bnAbs has been supported by the US Agency for International Development.

NIH is also partnering with the Serum Institute of India to produce affordable and accessible HIV bnAbs, as well as other mAb products. With support from the UK Department for International Development, NIH has formed a research consortium on snakebite to identify and engineer antibodies to treat envenoming, a disease caused by snake venom. NIH and its partners are also applying their experience in HIV to the discovery and development of mAbs to prevent and treat a variety of emerging and established infectious diseases including drug-resistant bacteria and COVID-19.

MIT BioACCESS

The development of new health technologies for NCDs is predominantly led by pharmaceutical companies. Although NCDs are now the most common cause of death and disability worldwide, accounting for 70 per cent of global mortality, there has not been a significant expansion of resources or attention from international donors or governments to address this escalating disease burden in developing countries. In 2017, development assistance for health from major funding sources (bilateral assistance, philanthropies, NGOs, etc.) totaled over $37 billion, while funding for NCDs was less than $1 billion.

MIT BioACCESS, part of the MIT’s Center for Biomedical Innovation, is addressing the complex issues surrounding global access to biologics, in particular for NCDs in resource-constrained settings. Through an “Access-by-Design” framework, this group is utilising a systems-based approach to model the impact different innovations could have on manufacturing and delivery of NCD biologics. Such models are anticipated to highlight the factors that directly influence affordability and availability at a local level.

Industry-led access models

Pharmaceutical companies are critical to planning for and supporting access to existing mAbs in developing countries. An important component of industry-led access initiatives in LMICs are patient-access schemes. These schemes between payers (including ministries of health, private insurance companies and procurement agencies) and pharmaceutical companies started out in high-income countries, but are now increasingly being used in middle-income countries in Latin America, Asia and Africa to enable patient access to innovative medicines.

One type of patient access scheme that is more common in developing countries is company-led, patient-assistance programmes. These programmes seek to increase access to innovative medicines and address a lack of healthcare infrastructure.

Both Roche and Takeda have launched patient-assistance programmes to provide mAb therapies to patients who couldn’t otherwise afford them. Roche is partnering with the governments of China, Pakistan and the Philippines to supply their breast cancer mAb Herceptin®. In Pakistan Roche splits 50 per cent of the cost of Herceptin® treatment with the federal government for patients in need.

In China, the company collaborates with the Cancer Foundation (CFC) and the Ministry of Health to donate eight cycles of Herceptin® after the patient has completed the first six cycles. Before this programme fewer than 15 per cent of women in the public health system in China received Herceptin®. Now, more than twice that amount complete the full course of treatment. To date, over 60,000 women...
have accessed Herceptin® through this programme, which has also made Chinese physicians more willing to prescribe the mAb223.

Takeda’s access strategy focuses on providing some of the company’s most innovative medicines as well as strengthening local R&D and healthcare capacity in LMICs. The company offers patient-assistance programmes in 14 countries in Asia, Africa, Latin America, the Middle East and Europe. As a result of these programmes, Takeda has provided more than 125,000 patients with treatment, screened over a million patients for cancer, hypertension and diabetes, and trained over 4,000 healthcare providers and community health workers to improve patient care224.

Nearly 700 patients have been treated with Takeda’s most innovative antibody-based medicines — Adcetris®, an antibody-drug-conjugate for relapsed and refractory Hodgkins lymphoma, and Entyvio®, a mAb product to treat inflammatory bowel disease224—as a result of these patient-assistance programmes.

The affordability of Adcetris® and Entyvio® were assessed by an independent third party, Axios, which created an individualised payment scheme for each patient to ensure they could complete their entire course of treatment even if they could not pay for it in full. This personalised pricing is distinct from standard discounts or tiered pricing. The patient-specific approach takes into consideration what is an affordable price for each individual, rather than determining it more broadly on a country or even community level. This patient assistance programme is a useful case study for access to novel mAb therapies, and if scaled up and applied to other mAbs, could have a significant impact on global access.

Takeda’s Access to Medicines (AtM) R&D initiatives also aim to share knowledge and build skills to strengthen local R&D and healthcare capacity in LMICs. This includes supplying medical and scientific equipment and developing research capabilities224.

Other multinational companies are also starting to recognise the need for access strategies to provide innovative medicines, including mAbs, in LMICs. The Access to Medicines Foundation’s (AMF) recent ten-year analysis noted that companies are gradually changing their business models and are setting access targets for products outside of high-income countries225. However, only a few companies so far are supporting comprehensive access agendas (covering R&D, pricing, manufacturing, distribution, licensing, capacity building and product donations), and only a limited number of diseases and countries are covered.

Establish procurement and delivery models to enable greater access

Access to existing health technologies for infectious diseases in low-income countries and some middle-income countries is largely facilitated by government and philanthropic funding pooled through UN-backed agencies like Gavi (vaccines), The Global Fund (HIV, TB and malaria) and UNICEF (children’s wellbeing), or the US government-supported PEPFAR programme (HIV). Pooled procurement is akin to buying in bulk—these agencies combine several buyers (typically governments of various countries) into a single entity and purchase vaccines or medicines on behalf of those buyers at discounted prices. Pooled procurement has helped make vaccines and medicines available and affordable in the poorest countries in the world226. However, mAbs are not yet included in any of these existing donor-funded procurement agencies.

Gavi, the Vaccine Alliance, which was established in 2000, gathers large-scale donor funding (approximately $9.1 billion from 2016-2020)227 and uses it to fund the purchase and procurement of vaccines for the poorest nations in the world. Gavi considered providing mAb-based post-exposure prophylaxis (PEP) for rabies but instead decided to support rabies vaccines for PEP beginning in 2021228. Gavi also considered supporting mAbs for prevention of RSV, but initially supported RSV vaccines and not mAbs.
Still, a Gavi-like financing model, which has been highly successful for childhood vaccines, could be a viable solution for broadening access to mAbs.* Gavi and The Global Fund are both considering including mAbs in their long-term planning,** and it is anticipated that UN-backed procurement agencies, specifically those involved in vaccines, may eventually support procurement of mAbs.*** However, as UN-backed procurement agencies depend upon prequalification by the WHO, their ability to support procurement of mAbs will be limited unless more mAb products undergo the prequalification process.

Other agencies involved in drug procurement, including The Global Fund, are open to considering including mAbs for infectious/neglected diseases in their long-term planning.**** Other procurement models will likely also be required to widen access to mAbs for non-communicable diseases.

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*Consultation with Churches Health Association of Zambia. 4 July 2019. Phone interview conducted by IAVI
**Consultation with GAVI, 4 July 2019. Consultation with The Global Fund. 17 June 2019. Phone interviews conducted by IAVI
***Consultation with UNICEF 13 September 2019. Phone interview conducted by IAVI. Consultation with The Global Fund 17 June 2019. Phone interview conducted by IAVI
****Consultation with GAVI, 4 July 2019. Consultation with the Global Fund. 17 June 2019. Phone interviews conducted by IAVI
Monoclonal antibody-based therapies are unavailable and unaffordable for millions of people around the world. The goal of this report is to catalyze new ways of thinking, greater collaboration and new ways of doing business to address this inequity.

The following roadmap details specific actions to expand access to existing monoclonal antibodies for both non-communicable and infectious diseases and to pave the way for expeditious development and introduction of future monoclonal antibody products. If the desired outcomes are reached, there will be substantial progress towards advancing global access.
Increase the availability of mAbs in low- and middle-income countries

PART I: ADVOCACY

Monoclonal antibodies save lives: Spread the word

OUTCOMES

- Advocacy networks established that focus on increasing the availability of mAbs in low- and middle-income countries
- Key barriers addressed that prohibit broader availability of mAbs in public health systems
- Value proposition established, using health and economic modeling studies, for the introduction of mAbs in low- and middle-income countries
- Goals related to mAb development and access included in existing global health agendas (examples include: UN-backed Sustainable Development Goals, Universal Health Coverage, Wellcome Flagship Initiatives and the Coalition for Epidemic Preparedness Innovations)
- Commitments secured on calls to action for global access to mAbs at a Key Opinion Leader meeting held by Wellcome and IAVI

Who’s needed

Government agencies, global health organisations, academic and public research institutions, non-governmental organisations (NGOs) and civil society groups

Action

Increase awareness among governments, ministries of health and patients that mAbs have substantial clinical and public health value

Government agencies, global health organisations, academic and public research institutions, non-governmental organisations (NGOs) and civil society groups

Bolster advocacy efforts related to mAb access in low- and middle-income countries

Government agencies, global health organisations, academic and public research institutions, funders, non-profit product developers and bio-pharmaceutical industry, non-governmental organisations (NGOs) and civil society groups

Dispel myths that mAbs can’t be affordable and that production costs can’t be lower by communicating the findings of this report

Global health organisations, academic and public research institutions, manufacturers, non-profit product developers and bio-pharmaceutical industry

Assess the barriers to making mAbs available in public health systems in low- and middle-income countries

Government agencies, health care providers, global health organisations, academic and public research institutions, health technology assessment groups, non-governmental organisations (NGOs) and civil society groups

Conduct studies to model the health and economic impact of introducing mAbs in developing countries

Government agencies, global health organisations, academic and public research institutions, health technology assessment groups

Promote access through global health agendas

Influencers and leaders of global health organisations, including the Bill & Melinda Gates Foundation, Wellcome, Unitaid; policy makers and influencers associated with universal healthcare, non-governmental organisations (NGOs) and civil society groups

Include mAbs in epidemic/pandemic preparedness initiatives as an important complement to vaccines

Government agencies and ministries of health, global health organisations, non-governmental organisations (NGOs) and civil society groups

Convene key opinion leaders from private, public and philanthropic entities to align on access pathways

Wellcome, IAVI, all stakeholders mentioned above

45 | Expanding access to monoclonal antibody-based products
Support broader registration and availability of monoclonal antibodies across the globe

**Action**

Develop disease-specific guidelines for mAbs to ensure products are designed with local population needs in mind

Who’s needed:
Non-profit product developers, bio-pharmaceutical industry, manufacturers; global health organisations (including WHO); governments; national regulatory agencies; stringent regulatory authorities

Harmonise and expand existing policy and regulatory pathways in low- and middle-income countries

Who’s needed:
Non-profit product developers, bio-pharmaceutical industry, manufacturers; global health organisations (including WHO); government agencies; national regulatory agencies; stringent regulatory authorities; African Medicines Agency; African Vaccine Regulatory Forum

Encourage product developers to engage with the WHO early in the development process to clarify pathways for inclusion in policy guidelines and to enable prequalification.

Who’s needed:
WHO, non-profit product developers and bio-pharmaceutical industry

Identify barriers to adding mAbs to the WHO’s Model List of Essential Medicines or in getting more mAbs prequalified by the WHO

Who’s needed:
WHO, global health organisations, government agencies, non-profit product developers and bio-pharmaceutical industry

Identify barriers to mAbs being added to national essential medicines lists following their approval by stringent regulatory authorities, their being prequalified or added to the EML

Who’s needed:
Government agencies, ministries of health, WHO, national regulatory agencies, health technology assessment groups

Expand use of collaborative regulatory initiatives between stringent and national regulatory authorities to address limited regulatory capacity in developing countries

Who’s needed:
WHO, non-profit product developers and bio-pharmaceutical industry, African Medicines Agency, African Vaccine Regulatory Forum, national regulatory authorities

**OUTCOMES**

- More mAbs are registered in more low- and middle-income countries faster and included in public health programmes
- More mAb products are developed based on individual, local and regional preferences
- Initiatives including the African Medicines Agency and the African Vaccine Regulatory Forum help address regulatory barriers to mAb licensure in Africa
- More mAbs are prequalified by the WHO, added to WHO’s EML and added to essential medicines list in developing countries
- Access is expanded to mAbs that are either prequalified or included in essential medicines list
Make mAbs more affordable in low- and middle-income countries

**PART I: INNOVATION**

Invest in and deploy innovative technologies to lower monoclonal antibody development costs

**Action**
Engage public-private partnerships and funders to drive mAb innovation with an end-to-end perspective

**Who’s needed**
- Funders, non-profit product developers and bio-pharmaceutical industry, global health organisations, academic and public research institutions

Develop and refine target product profiles that prioritise affordability and acceptability for low- and middle-income countries at all stages of mAb discovery and development.

**Who’s needed**
- Non-profit product developers and bio-pharmaceutical industry, global health organisations, academic and public research institutions, technology companies

Ensure that appropriate technologies (and companion diagnostics if needed) are integrated early into product development and are responsive to the specific diseases, patient populations and communities in which they will be introduced.

**Who’s needed**
- Non-profit product developers and bio-pharmaceutical industry, technology companies, global health organisations, academic and public research institutions, funders

Develop and apply new technologies and platforms that have the potential to lower costs throughout the production process from antibody isolation to manufacturing to delivery.

**Who’s needed**
- Funders, non-profit product developers and bio-pharmaceutical industry, manufacturers, academic and public research institutions, technology companies, global health organisations

Apply technological lessons learned from developing and producing lower-priced biosimilars and some lower-priced innovative mAbs to further lower prices of marketed mAbs as well as those in development.

**Who’s needed**
- Low-cost LMIC manufacturers, biosimilar companies

**OUTCOMES**

- Increased and diversified funding available for the research and development of mAbs for global health
- Proven technologies and platforms are applied to discovery, optimisation and development of pipeline mAbs that can prevent and treat infectious and neglected diseases, including drug-resistant bacterial infections, epidemics such as Ebola and pandemics such as COVID-19
- Proven technologies and platforms are applied to dramatically lower production and delivery costs of licensed innovative and biosimilar mAb products
PART II: BUSINESS MODELS

Create new business models that enable different market approaches in low-, middle- and high-income countries

Who’s needed: Non-profit product developers, bio-pharmaceutical industry, manufacturers; funders; global health organisations; academic and public research institutions

Action: Establish collaborations between public, private and philanthropic entities to expand access to innovative and biosimilar mAbs in low- and middle-income countries

Expand existing but limited industry-led patient access plans that focus on enhancing access to innovative medicines as well as strengthening health systems, diagnostic capabilities and research capacity in developing countries

Who’s needed: Non-profit product developers, bio-pharmaceutical industry, manufacturers; governments global health organisations; funders

Action: Develop or expand global pricing frameworks for mAbs, including the use of second brands, to introduce existing biosimilar and innovative mAbs in low- and middle-income countries

Who’s needed: Non-profit product developers, bio-pharmaceutical industry, manufacturers; health technology assessment groups; government agencies

Action: Identify donor-funded procurement agencies that can support broader access to mAbs in developing countries

Who’s needed: Global health organisations, funders

Action: Explore alternate manufacturing and supply chains in different regions that enable market differentiation and provision of more affordable mAbs in low- and middle-income countries

Who’s needed: Non-profit product developers, bio-pharmaceutical industry, manufacturers; procurement groups; government agencies

Action: Identify creative solutions to manage intellectual property rights related to mAbs that encourage innovation, while also prioritising access to affordable mAb products

Who’s needed: Unitaid; Medicines Patent Pool; non-profit product developers, bio-pharmaceutical industry, manufacturers; global health organisations

OUTCOMES

✓ Public-private partnerships focused on developing mAbs for infectious/neglected diseases establish comprehensive and innovative plans for global commercialisation of and access to eventual products

✓ More companies establish scalable patient access schemes to expand access to existing mAbs

✓ More affordable products, including second brands and biosimilars, are introduced in low- and middle-income countries

✓ A Gavi-like model of procurement is established for mAbs to enable a lower cost and sustainable supply of antibodies in developing countries

✓ Alternate intellectual property agreements that prioritise access are implemented in developing countries
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