

Cemiplimab (cutaneous squamous cell carcinoma, adjuvant)

Addendum to Project A25-155
(dossier assessment)¹

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List of abbreviations

Abbreviation	Meaning
ACT	appropriate comparator therapy
AE	adverse event
cSCC	cutaneous squamous cell carcinoma
CTCAE	Common Terminology Criteria for Adverse Events
DFS	disease-free survival
EMA	European Medicines Agency
EORTC QLQ-C30	European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire-Core 30
EPAR	European Public Assessment Report
EQ-5D	European Quality of Life-5 Dimensions
IQWiG	Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (Institute for Quality and Efficiency in Health Care)
RCT	randomized controlled trial
SAE	serious adverse event
VAS	visual analogue scale

1 Background

On 29 April 2026, the Federal Joint Committee (G-BA) commissioned the Institute for Quality and Efficiency in Health Care (IQWiG) to conduct supplementary assessments for Project A25-155 (Cemiplimab – Benefit assessment according to §35a Social Code Book V) [1].

The commission comprises the assessment of the analyses presented by the pharmaceutical company (hereinafter referred to as “the company”) in the commenting procedure [2], taking into account the information provided in the dossier [3]:

- Analysis on the second data cut dated 7 April 2025 and presentation of the results
- Sensitivity analysis for the outcome disease-free survival (DFS) including secondary tumours for the second data cut (page 5 of the pharmaceutical company’s comments) and presentation of the results
- Analyses on the outcome DFS from the third data cut of 3 March 2026 and presentation of the results

The responsibility for this assessment and the assessment result lies exclusively with IQWiG. The assessment is forwarded to the G-BA. The G-BA decides on the added benefit.

1.1 Modifications in comparison with Version 1.0

The present Version 1.1 of 27 May 2026 replaces Version 1.0 of the addendum of 15 May 2026. The following change is contained in Version 1.1 compared with Version 1.0:

- Table 2 shows the duration of treatment for the second data cut of 7 April 2025. In this version 1.1, the reference to the underlying data cut shown in Table 2 has been corrected accordingly from data cut 1 to data cut 2.

The change has no impact on the conclusion of the benefit assessment.

2 Assessment

Concurring with the company, the C-POST study that compares cemiplimab as monotherapy with placebo, in each case after surgery and subsequent radiation [4-8] was used in benefit assessment A25-155 [1]. In the C-POST study, three further interim analyses were added with the amendment of the study protocol of 29 June 2021 (Amendment 2) in addition to the originally planned final analysis at approx. 165 DFS events in the total population (according to the study protocol): after approx. 83 DFS events (50% of 165 DFS events), after around 107 (65%) and after around 132 DFS events (80%).

The company presents analyses on 2 data cuts in Module 4A of the dossier [3]. The first data cut of 4 October 2024 represents the prespecified interim analysis after 89 DFS events (50% of 165 DFS events). The second data cut of 7 April 2025 is a non-prespecified data cut at 97 DFS events (approx. 59% of 165 DFS events). In its dossier, the company states that the second data cut was carried out concurring with the European Medicines Agency (EMA) and is therefore relevant to the assessment. On the basis of the publicly available information, it could not be ensured that the EMA had requested this section as part of the marketing authorization procedure. This ensures that the date of the data cut coincides with the submission of the marketing authorization documents. Benefit assessment A25-155 was therefore based on the first data cut. In its comments, the company submitted the minutes of the pre-submission meeting of 20 February 2025 [9], according to which the second data cut was carried out at the EMA's request. It is clear from the minutes of the pre-submission meeting that the rapporteur considered updated efficacy and safety data to be desirable. However, a specific data cut or time point of such an updated analysis is not defined. As such, there is no information to suggest that the data extract was explicitly requested. In the current situation, however, the information provided does not point to the second data cut being carried out in a results-driven manner. The results of the second data cut of 7 April 2025 are set out below taking into account the information in the dossier and the comments.

Furthermore, the company did not record new cutaneous squamous cell carcinoma (cSCC) lesions as recurrence events in its analyses of the DFS, as, according to the company, these represent tumours that occur independently within the framework of a field cancerization. However, in order to assess whether patients have been cured as a result of the treatment, it is necessary to take these events into account when interpreting the outcome failure of the curative treatment approach and to present at least sensitivity analyses that take new cSCC lesions into account for both the DFS and the recurrence rate. In its comments, the company presented sensitivity analyses for the DFS under consideration of newly diagnosed tumours. The analyses of the outcome failure of the curative treatment approach that take these primary tumours into account, are presented in Table 5 as a supplement to the main analysis.

In its comments, the company also presented analyses of the DFS based on a recent extract from the database of 3 March 2026, as well as details of the duration of follow-up for patients for this data cut. 111 DFS events (67% of 165 DFS events) had occurred at the time of these analyses. In the oral hearing [10], the company described that this data set had not been predefined. However, given the current number of 107 DFS events which occurred, it is assumed that this data cut is the originally prespecified second interim analysis at 107 DFS events (65% of 165 DFS events). Furthermore, the study documents do not suggest that the data cuts originally planned should no longer be carried out following the final analysis of the DFS of the first interim data cut. Apart from the analyses on the DFS, the company did not provide any analyses of other outcomes for this data cut. In accordance with the supplement to the oral hearing [11], the company may submit the complete analyses of this data cut by 3 July 2026. The analyses on the outcome failure of the curative treatment approach at the data cut of 3 March 2026 can be found in Table 8 in Appendix B.

2.1 Study characteristics

A detailed description of the C-POST study, including information on study design, characteristics of the intervention and planned duration of follow-up can be found in dossier assessment A25-155 [1].

Information on patient characteristics and on the course of the study

Dossier assessment A25-155 provides details of the patient characteristics and the course of the study at the first data cut of 4 October 2024.

Information on study and treatment discontinuation

Table 1 shows the updated data for the second data cut on study and treatment discontinuation.

Table 1: Study/treatment discontinuation –RCT, direct comparison: cemiplimab versus placebo

Study characteristic category	Cemiplimab N = 209	Placebo N = 206
C-POST		
Treatment discontinuation, n (%) ^{a, b}	44 (21)	62 (30)
Study discontinuation, n (%) ^{c, d}	29 (14)	36 (17)
a. Treatment discontinuations for the randomized phase of the study (Phase 1) until the data cut of 7 April 2025. b. Common reasons for treatment discontinuation in the intervention arm vs. the comparator arm were the following (percentages based on randomized patients): recurrence (5% vs. 24%), AEs (9% vs. 2%). In addition, 4 (2%) vs. 2 (1%) randomized patients never started treatment, and 70% vs. 64% of patients completed treatment as planned. c. Study discontinuations for the entire study duration (including Phase 2). d. A common reason for study discontinuation in the intervention vs. the comparator arm (percentages refer to randomized patients) was withdrawal of consent (2% vs. 4%). The data additionally include patients who died during the course of the study (intervention arm: 7% vs. comparator arm: 8%). AE: adverse event; n: number of patients in the category; N: number of randomized patients; RCT: randomized controlled trial		

Overall, 21% of patients in the intervention arm and 30% in the comparator arm discontinued treatment prematurely. Common reasons for treatment discontinuation in the intervention vs. the comparator arm were: recurrence (5% vs. 24%) and AEs (9% vs. 2%). At the second data cut, 14% versus 17% of patients had discontinued the study. Common reasons for study discontinuation were death (7% vs. 8%) and withdrawal of consent (2% vs. 4%).

Information on the course of the study

Table 2 shows patients' mean and median treatment durations as well as the mean and median observation periods for individual outcomes.

Table 2: Information on the course of the study – RCT, direct comparison: cemiplimab vs. placebo

Study duration of the study phase outcome category / outcome	Cemiplimab N = 205	Placebo N = 204
C-POST		
Treatment duration [months]		
Data cut 2		
Median [Q1; Q3]	11.0 [9.6; 11.0] ^a	11.0 [7.0; 11.0] ^a
Mean (SD)	9.4 (3.2) ^a	9.1 (3.2) ^a
Observation period [months] ^b		
Overall survival	ND	ND
Morbidity		
Recurrence	ND	ND
Symptoms (EORTC QLQ-C30)	ND	ND
Health status (EQ-5D VAS)	ND	ND
Health-related quality of life (EORTC QLQ-C30)	ND	ND
Side effects	ND	ND
a. Institute's calculation from data in weeks. b. It is assumed that the follow-up period reflects the entire follow-up period of the study (including Phase 2 of the study): The median follow-up period up to the second data cut was 30.1 (min: 8.0; max: 70.0) months for the entire study population. The median follow-up period for the intervention group was 30.6 months (min: 8.0, max: 67.0) months; for the comparator group, it was 29.9 months (min: 8.0, max: 70.0) months). EORTC QLQ-C30: European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire-Core 30; max: maximum; min: minimum; N: number of analysed patients; ND: no data; Q1: first quartile; Q3: third quartile; RCT: randomized controlled trial; SD: standard deviation; VAS: visual analogue scale		

The median treatment duration was 11.0 (Q1: 9.6; Q3: 11.0) months in the intervention arm and 11.0 (Q1: 7.0; Q3: 11.0) months in the control arm. This means that at least 75% of patients in both arms had completed the 48-week treatment phase (11 months). Details regarding the outcome-specific observation periods are neither provided in Module 4A nor in the comments. The median observation period up to the second data cut was 30.1 (min: 8.0; max: 70.0) months for the total population, 30.6 [min: 8.0; max: 67.0] for the intervention arm and 29.9 [min: 8.0; max: 70.0] months for the comparator arm. It is assumed that the observation period reflects the entire observation duration of the study (including Phase 2 of the study).

As described in dossier assessment A25-155 [1], a meaningful assessment of the curative treatment approach generally requires a sufficiently long follow-up extending beyond the high-risk period following the end of treatment. This is particularly due to the situation given

in the intervention arm of the C-POST study and, in relation to the experimental intervention, means a sufficiently long follow-up after the end of the 48-month therapy with cemiplimab. This is intended to ensure that, once treatment is discontinued, relapses are actually prevented rather than merely delayed. According to the S3 guideline, most relapses in this therapeutic indication occur within the first two years after the primary diagnosis; intensified follow-up is therefore recommended during this period [12]. Overall, the available information leads to the assumption that the observation periods currently applied in this study do not adequately cover the high-risk period.

Information on subsequent therapies

Table 3 shows the subsequent therapies patients received after discontinuing the study medication.

Table 3: Information on subsequent systemic antineoplastic therapiesa – RCT, direct comparison: cemiplimab versus placebo

Study drug	Patients with subsequent therapy, n (%)	
	cemiplimab N = 209	placebo N = 206
C-POST		
Number of patients with recurrence ^b	22 (10.5)	64 (31.1)
Number of patients with a recurrence who received subsequent treatment ^c	15 (7.2)	62 (30.1)
Surgery	4 (26.7)	13 (21.0)
Radiotherapy	5 (33.3)	9 (14.5)
Systemic therapy	13 (86.7)	59 (95.2)
Cemiplimab (Phase 2)	3 (20.0)	51 (82.3)
Total number of other systemic therapies (not in Phase 2)	11 (73.3)	16 (25.8)
a. 1st subsequent therapy following a relapse. b. This does not include patients for whom the recurrence event was death from any cause. c. The following percentages are based on this population (Institute's calculation). n: number of patients with subsequent therapy; N: number of analysed patients; RCT: randomized controlled trial		

Overall, 22 (10.5%) of patients in the intervention arm of the C-POST study versus 64 (31.1%) patients in the comparator arm had a recurrence at the second data cut, of whom 15 patients in the intervention arm (68.2%) and 62 patients in the comparator arm (96.9%) received follow-up treatment.

With regard to the subsequent therapies used in the C-POST study, the company only submitted aggregated information in the dossier. Drug-related data are not available for the

second data cut in the study documents either. The available information does therefore not permit a more in-depth analysis of the subsequent therapies. More detailed information was available for the first data cut; this is described in benefit assessment A25-155 [1]. In both study arms of the C-POST study, there were no restrictions on the choice of subsequent antineoplastic therapies [1]. However, given the possibility of transition to Phase 2 of the study, there was a tendency to favour the use of cemiplimab as the subsequent therapy.

In the C-POST study, 20% of the patients who received a first subsequent therapy were administered cemiplimab in the intervention arm. In the comparator arm, this proportion amounts to 82.3%. Based on patients with a recurrence in the comparator arm, this proportion amounts to 79.7%. Therefore, cemiplimab was the most commonly used subsequent therapy in the study. Cemiplimab is approved for the treatment of locally advanced or metastatic cSCC when curative surgery or curative radiation are unsuitable [13]. As described in benefit assessment A25-155, there are uncertainties as to whether re-treatment with cemiplimab is appropriate for patients in the intervention arm following the onset of a recurrence, and whether the period of at least 3 months after completion of adjuvant cemiplimab therapy is sufficient to use cemiplimab again in the relapse therapy.

Related to patients with recurrence and subsequent therapy, 33.3% in the intervention arm and 14.5% in the comparator arm received radiotherapy. Surgeries were performed in 26.7% of patients in the intervention arm and 21.0% of patients in the comparator arm.

At the second data cut, 12 (5.7%) patients in the intervention arm and 28 (13.6%) patients in the comparator arm had a distant recurrence. Systemic therapy would therefore, in principle, be suitable for these patients. No information is available on which form of treatment was used in the subsequent therapy for which type of recurrence. However, significantly more patients received systemic therapy with cemiplimab. It can therefore be assumed that patients with a locoregional recurrence have also received systemic therapy. However, as described in dossier assessment A25-155, there is no information available as to the criteria on which the decision for systemic therapy was based. Furthermore, there is no information available on how many patients had an isolated local recurrence. In this regard, the company does not provide any further information in its statement either. It is therefore not possible to assess how many patients were eligible for local treatment forms such as surgery and radiation.

As this assessment includes no suitable data for the benefit assessment (see Section 2.2.3), this uncertainty has no consequences for the benefit assessment at this point in time.

2.2 Results on added benefit

2.2.1 Outcomes included

The following patient-relevant outcomes were to be included in the assessment:

- Mortality
 - overall survival
- Morbidity
 - failure of the curative treatment approach (represented via DFS)
 - symptoms
 - recorded using the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire-Core 30 (EORTC QLQ-C30)
 - health status
 - recorded using the (Visual Analogue Scale of the European Quality of Life-5 Dimensions) EQ-5D VAS
- Health-related quality of life
 - recorded using the EORTC QLQ-C30
- Side effects
 - serious adverse events (SAEs)
 - severe AEs (Common Terminology Criteria for Adverse Events [CTCAE] grade ≥ 3)
 - discontinuation due to adverse events (AEs)
 - immune-mediated SAEs
 - immune-related severe AEs (CTCAE grade ≥ 3)
 - other specific AEs, if any

The selection of patient-relevant outcomes deviated from that of the company, which used further outcomes in the dossier (Module 4).

Table 4 shows for which outcomes data were available in the included study.

Table 4: Matrix of outcomes – RCT, direct comparison: cemiplimab versus placebo

Study	Outcomes										
	Overall survival	Failure of the curative treatment approach ^a	Symptoms (EORTC QLQ-C30)	Health status (EQ-5D VAS)	Health-related quality of life (EORTC QLQ-C30)	SAEs	Severe AEs ^b	Discontinuation due to AEs	Immune-mediated SAEs	Immune-mediated severe AEs	Hypothyroidism (PT, AEs)
C-POST ^c	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
a. Operationalized as recurrence rate and disease-free survival , includes the events local recurrence, regional recurrence, distant metastases, and death from any cause. b. Severe AEs are operationalized as CTCAE grade ≥ 3 . c. No suitable data; for justification see dossier assessment A25-155 [1]. AE: adverse event; CTCAE: Common Terminology Criteria for Adverse Events; EORTC QLQ-C30: European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire-Core 30; EQ-5D: European Quality of Life-5 Dimensions; PT: Preferred Term; RCT: randomized controlled trial; SAE: serious adverse event; VAS: visual analogue scale											

Notes on selected outcomes

Failure of the curative treatment approach

Failure of the curative treatment approach was therefore considered a patient-relevant event in this assessment. In the C-POST study, failure of the curative treatment approach was not directly recorded as an outcome. As an approximation, the present assessment considers the events that were recorded as part of the primary outcome of the C-POST study, i.e. the composite outcome of DFS, as operationalization for the outcome. The proportion of patients with event (hereinafter referred to as the event rate) and, in addition, the time to event (DFS) are relevant for the assessment (see also the explanations on the operationalization in dossier assessment A25-155 [1]).

As already described in dossier assessment A25-155, the company does not record cSCC lesions as recurrence events in Module 4A of the dossier, as, according to the company, these represent tumours that occur independently within the framework of a field cancerization. However, in order to assess whether patients have been cured as a result of the treatment, it is necessary to take these events into account when interpreting the outcome failure of the curative treatment approach and to present at least sensitivity analyses that take new cSCC lesions into account for both the DFS and the recurrence rate. In its comments, the company presented sensitivity analyses for the DFS under consideration of newly diagnosed tumours.

The analyses of the outcome failure of the curative treatment approach that take these primary tumours into account, are presented in Table 5 as a supplement to the main analysis. Taking new primary tumours into account, the extent of the added benefit for the recurrence rate changes. In the present situation, however, this has no consequences, as suitable data are particularly lacking for the outcome failure of the curative treatment approach (see the following section).

As already described in Section 2.1, the follow-up duration does not adequately cover the high-risk period for recurrence following the completion of treatment with cemiplimab for the 2nd data cut either. Thus, there are no suitable data available to carry out an overall assessment of the positive and negative effects across all outcome categories in the current situation. This is justified in Section 2.2.3, taking into account the present data situation.

2.2.2 Risk of bias

There is no difference in the risk of bias across outcomes and the outcome-specific risk of bias between the second and the first data cut of the C-POST study. Therefore, the tables on the risk of bias will not be re-presented.

2.2.3 Results

There are no suitable data available to assess the added benefit of cemiplimab compared with the appropriate comparator therapy (ACT) in adult patients with cSCC at high risk of recurrence after surgery and radiation. There is no hint of an added benefit of cemiplimab in comparison with the ACT; an added benefit is therefore not proven. However, the results are presented below as supplementary information.

Table 5 and Table 6 summarize the results on the comparison of cemiplimab with placebo in patients with cSCC at high risk of disease recurrence following surgery and radiotherapy. Where necessary, calculations conducted by the Institute are provided in addition to the data from the company's dossier.

The analyses of the outcome failure of the curative treatment approach at the data cut of 3 March 2026 can be found in Table 8 in Appendix B.

Table 5: Results (mortality, morbidity, health-related quality of life) – RCT, direct comparison: cemiplimab versus placebo (multipage table)

Study outcome category outcome	Cemiplimab		Placebo		Cemiplimab versus placebo
	N	median time to event in months [95% CI] patients with event n (%)	N	median time to event in months [95% CI] patients with event n (%)	HR [95% CI]; p-value ^a
C-POST					
Mortality					
Overall survival	209	NA 15 (7.2)	206	NA 18 (8.7)	0.78 [0.39; 1.56]; 0.482
Morbidity					
Failure of the curative treatment approach ^b					
Event rate ^c	209	29 (13.9)	206	68 (33.0)	RR: 0.42 [0.28; 0.62]; < 0.001 ^d
Locoregional recurrences	209	10 (4.8)	206	36 (17.5)	–
Distant recurrence ^e	209	12 (5.7)	206	28 (13.6)	–
Death	209	7 (3.3)	206	4 (1.9)	–
Disease-free survival	209	NA 29 (13.9)	206	NA [48.5; NC] 68 (33)	0.35 [0.23; 0.55]; < 0.001
Failure of the curative treatment approach (sensitivity analysis) ^f					
Event rate ^c	209	59 (28.2)	206	100 (48.5)	RR: 0.58 [0.45; 0.75]; < 0.001 ^d
Recurrence ^g	209	17 (8.1)	206	57 (27.7)	–
Death	209	7 (3.3)	206	4 (1.9)	–
New primary tumours	209	35 (16.7)	206	39 (18.9)	–
Disease-free survival	209	53.9 (51.5; NC) 59 (28.2)	206	25.7 [16.0; > 39.2]; 100 (48.5)	0.46 [0.33; 0.64]; < 0.001
Symptoms (EORTC QLQ-C30 – time to first deterioration ^h)					
Fatigue	ND ⁱ	5.65 [5.55; 8.31] 136 (65.1)	ND ⁱ	8.31 [5.72; 8.61] 111 (53.9)	1.12 [0.87; 1.45]; 0.351
Nausea and vomiting	ND ⁱ	NA [40.31; NC] 61 (29.2)	ND ⁱ	48.82 [30.75; NC] 53 (25.7)	0.91 [0.63; 1.32]; 0.625
Pain	ND ⁱ	10.64 [8.34; 13.67] 121 (57.9)	ND ⁱ	13.93 [9.72; 29.57] 97 (47.1)	1.24 [0.94; 1.62]; 0.121
Dyspnoea	ND ⁱ	25.86 [21.22; 33.91] 86 (41.1)	ND ⁱ	33.61 [18.20; NC] 66 (32.0)	1.08 [0.78; 1.50]; 0.644

Table 5: Results (mortality, morbidity, health-related quality of life) – RCT, direct comparison: cemiplimab versus placebo (multipage table)

Study outcome category outcome	Cemiplimab		Placebo		Cemiplimab versus placebo
	N	median time to event in months [95% CI] patients with event n (%)	N	median time to event in months [95% CI] patients with event n (%)	HR [95% CI]; p-value ^a
Insomnia	ND ⁱ	14.98 [10.64; NC] 91 (43.5)	ND ⁱ	21.72 [14.55; 38.70] 79 (38.3)	1.06 [0.78; 1.44]; 0.699
Appetite loss	ND ⁱ	NA [24.08; NC] 70 (33.5)	ND ⁱ	NA [45.83; NC] 47 (22.8)	1.28 [0.88; 1.86]; 0.193
Constipation	ND ⁱ	43.96 [25.13; NC] 71 (34.0)	ND ⁱ	30.69 [22.34; 58.68] 68 (33.0)	0.86 [0.62; 1.21]; 0.397
Diarrhoea	ND ⁱ	62.26 [41.46; NC] 60 (28.7)	ND ⁱ	NA [29.73; NC] 52 (25.2)	0.95 [0.65; 1.38]; 0.793
Health status (EQ-5D VAS – time to first deterioration ^j)	ND ⁱ	28.85 [17.87; 37.06] 84 (40.2)	ND ⁱ	38.90 [22.21; NC] 62 (30.1)	1.30 [0.93; 1.81]; 0.116
Health-related quality of life					
EORTC QLQ-C30 – time to first deterioration ^k					
Global health status	ND ⁱ	14.59 [10.64; 29.31] 105 (50.2)	ND ⁱ	22.21 [8.61; 45.83] 87 (42.2)	1.11 [0.83; 1.48]; 0.469
Physical functioning	ND ⁱ	21.68 [17.58; 39.82] 89 (42.6)	ND ⁱ	34.83 [14.85; NC] 72 (35.0)	1.03 [0.76; 1.42]; 0.834
Role functioning	ND ⁱ	10.84 [8.34; 14.75] 118 (56.5)	ND ⁱ	14.39 [9.69; 25.69] 89 (43.2)	1.17 [0.89; 1.55]; 0.264
Emotional functioning	ND ⁱ	25.63 [14.98; NC] 87 (41.6)	ND ⁱ	22.47 [13.54; 48.82] 80 (38.8)	0.96 [0.70; 1.30]; 0.785
Cognitive functioning	ND ⁱ	13.90 [10.78; 18.40] 107 (51.2)	ND ⁱ	13.93 [10.18; 22.21] 94 (45.6)	0.94 [0.71; 1.25]; 0.699
Social functioning	ND ⁱ	15.38 [10.81; 25.63] 105 (50.2)	ND ⁱ	17.77 [10.68; 45.83] 84 (40.8)	1.04 [0.78; 1.38]; 0.802

Table 5: Results (mortality, morbidity, health-related quality of life) – RCT, direct comparison: cemiplimab versus placebo (multipage table)

Study outcome category outcome	Cemiplimab		Placebo		Cemiplimab versus placebo
	N	median time to event in months [95% CI] patients with event n (%)	N	median time to event in months [95% CI] patients with event n (%)	HR [95% CI]; p-value ^a
a. HR and CI from Cox proportional hazards model, p-value from log-rank test, each stratified by high-risk tumour (HN vs. non-HN) and geographical region (North America vs. Australia/New Zealand vs. rest of the world). b. Newly diagnosed primary tumours were not taken into account in the operationalization (see Section 2.2.1). c. Proportion of patients, individual components are presented in the lines below. d. Logistic regression model, stratified by high-risk tumour (HN vs. non-HN) and geographical region (North America vs. Australia/New Zealand vs. the rest of the world). e. Number of qualifying events for the outcome DFS. Patients with multiple recurrences are counted only once. 6 patients had both locoregional and distant recurrences (1 in the intervention arm and 5 in the control arm) and are shown only under 'distant recurrences'. f. Sensitivity analysis that considers newly diagnosed primary tumours in the operationalization (see Section 2.2.1). g. Information on the proportion of locoregional or distant recurrences is not available. h. A score increase by ≥ 10 points from baseline is considered a clinically relevant deterioration (scale range 0 to 100). i. According to the company, all randomized patients were included in the analysis. At the same time, it can be seen in the PRO-SAP that patients with no baseline value or no value in the course of the study were censored on Day 1. For example, depending on the scale used, baseline data were missing for 8% to 11% of patients. Thus, no times of these patients were actually included in the analysis. The exact number of these patients cannot be calculated. j. A score decrease by ≥ 15 points from baseline is considered a clinically relevant deterioration (scale range: 0 to 100). k. A score decrease by ≥ 10 points from baseline is considered a clinically relevant deterioration (scale range: 0 to 100). CI: confidence interval; EORTC QLQ-C30: European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire-Core 30; HN: head and neck; HR: hazard ratio; n: number of patients with an event; N: number of analysed patients; NA: not achieved; NC: not calculable; ND: no data; PRO-SAP: statistical analysis plan for patient-reported outcomes; RCT: randomized controlled trial; RR: relative risk; VAS: visual analogue scale					

Table 6: Results (side effects) – RCT, direct comparison: cemiplimab versus placebo

Study outcome category outcome	Cemiplimab		Placebo		Cemiplimab versus placebo
	N	patients with event n (%)	N	patients with event n (%)	RR [95% CI]; p-value ^a
C-POST					
Side effects					
AEs (supplementary information)	205	191 (93.2)	204	185 (90.7)	—
SAEs	205	38 (18.5)	204	21 (10.3)	1.78 [1.08; 2.92]; 0.024
Severe AEs ^b	205	52 (25.4)	204	33 (16.2)	1.50 [1.02; 2.22]; 0.042
Discontinuation due to AEs	205	20 (9.8)	204	4 (2.0)	4.93 [1.70; 14.25]; 0.003
Immune-mediated SAEs	205	11 (5.4)	204	1 (0.5)	10.95 [1.43; 84.01]; 0.004 ^c
Immune-mediated severe AEs ^b	205	19 (9.3)	204	1 (0.5)	18.91 [2.55; 139.92]; < 0.001 ^c
Hypothyroidism (PT, AEs) ^d	205	28 (13.7)	204	9 (4.4)	3.07 [1.48; 6.35]; 0.003
a. Unless otherwise labelled, logistic regression model, stratified by high-risk tumour (HN vs. non-HN) and geographical region (North America vs. Australia/New Zealand vs. rest of the world).					
b. Operationalized as CTCAE grade ≥ 3.					
c. Institute’s calculation of RR, CI (asymptotic) and p-value (unconditional exact test, CSZ method according to [14]).					
d. Both symptomatic (CTCAE grade ≥ 2) and asymptomatic events are included in the PT hypothyroidism. The data from the study documents show that the majority of the hypothyroidism events were symptomatic (82% in the intervention arm and 89% in the comparator arm).					
AE: adverse event; CI: confidence interval; CTCAE: Common Terminology Criteria for Adverse Events; HN: head and neck; n: number of patients with (at least one) event; N: number of analysed patients; PT: Preferred Term; RCT: randomized controlled trial; RR: relative risk; SAE: serious adverse event					

For the outcome failure of the curative treatment approach, a statistically significant difference in favour of the intervention was shown both in the time to event (effect measure: HR) and the event rate (effect measure: RR), in both the main analysis and the sensitivity analysis of the outcome failure of the curative treatment approach (Table 5). As described, the sensitivity analysis alters the extent in the recurrence rate. No statistically significant difference between the treatment arms was shown for the outcomes on symptoms, health-related quality of life and overall survival. The outcomes in the side effects category show statistically significant differences to the disadvantage of the intervention.

No suitable data available for the benefit assessment due to the observation period being too short

As already described in Section 2.1, the follow-up duration does not adequately cover the high-risk period for recurrence following the completion of treatment with cemiplimab. Thus, based on the results of the second data cut, there are no suitable data available to carry out an overall assessment of the positive and negative effects across all outcome categories in the current situation. This was already described in dossier assessment A25-155 for the results of the first data cut [1] and also applies to the analyses of the second data cut, which was carried out just eight months after the first one. This is justified below.

Failure of the curative treatment approach is the essential treatment goal in this therapeutic indication. In order to meaningfully assess the failure of the curative treatment approach, it is generally necessary to carry out a sufficiently long follow-up period. This should, on the one hand, cover the high-risk period and, on the other hand, extend for a sufficiently long time beyond the end of treatment. This is intended to ensure that, once treatment is discontinued, relapses are actually prevented rather than merely delayed. As already stated in dossier assessment A25-155, the European Public Assessment Report (EPAR) of the EMA [4] also shows that, for the first two data cuts, uncertainties remain (due to the duration of the follow-up) as to whether recurrences are prevented and not merely delayed. For this reason, the EMA recommends that further descriptive data on DFS be submitted, as well as the final analysis on overall survival after the marketing authorization.

According to the S3 guideline, most relapses in this therapeutic indication occur within the first two years after the primary diagnosis; intensified follow-up is therefore recommended during this period [12]. If, in a specific therapeutic situation or with a particular drug, it can be ruled out with sufficient certainty that the occurrence of relapses is merely being delayed, a follow-up period shorter than the high-risk period extending beyond the treatment may also be sufficient. The presence of such a situation must be supported by data drawn from relevant literature. However, the company does not provide such a justification either in Module 4A of the dossier or in its comments.

In order to assess whether the follow-up period in the C-POST study is sufficient for a meaningful analysis of the outcome failure of the curative treatment approach, the follow-up period for those patients who have not experienced a DFS event by the second data cut is therefore relevant. This information is not included in Module 4A of the dossier or the study documents, nor was it subsequently provided by the company in the comments. The follow-up periods for those patients who had not experienced a DFS event by the second data cut can be roughly categorized based on the following information: The maximum follow-up period was 70 months, and the minimum follow-up period was 8 months. For the total population, the median follow-up duration up to the second data cut was 30.1 months (Q1:

18.2; Q3: 42.8). Overall, based on the available data, it is assumed that the follow-up period after the end of the maximum 48-week adjuvant therapy with cemiplimab is not sufficiently long for a relevant proportion of patients without DFS event to reliably rule out recurrences following the discontinuation of treatment. This assessment is also supported by the fact that a stable plateau has not yet developed in the Kaplan-Meier curves for the second data cut (see Figure 2 in Appendix A.1.2). This becomes particularly clear in the Kaplan-Meier curves of the sensitivity analysis for the outcome DFS, in which newly diagnosed primary tumours were taken into account in the operationalization (see Figure 3 in Appendix A.1.2).

Following the oral hearing, the company stated that the study report on the final analysis for the C-POST study was submitted to the EMA on 31 July 2028, and presented a letter addressed to the EMA [15].

In summary, the data at the time of the second data cut are unsuitable to allow for an overall assessment of the positive and negative effects of cemiplimab compared with the ACT across all outcome categories.

For this reason, subgroup analyses will not be presented below.

Results on the third data cut of 03 March 2026.

In its comments, the company presented analyses of the outcome DFS based on a recent extract from the database of 3 March 2026. As described above, it is assumed that this data cut is the originally prespecified second interim analysis at 107 DFS events (65% of 165 DFS events). Apart from the analyses on the DFS, the company did not provide any analyses of other outcomes for this data cut. According to the study protocol, all outcomes, with the exception of those in the side effects category, are recorded at least until recurrence (or, where applicable, until death or the end of the study). Therefore, it is assumed that relevant new information on other outcomes will be gained between the second and the third data cut.

The results for the DFS cannot be interpreted without the analysis of the other patient-relevant outcomes. Therefore, the analyses on the outcome failure of the curative treatment approach at the data cut of 3 March 2026 can be found in Table 8 in Appendix B in compliance with the commission.

2.3 Summary

The data subsequently submitted by the company in the commenting procedure did not alter the conclusion on the added benefit of cemiplimab drawn in dossier assessment A25-155.

The following Table 7 shows the result of the benefit assessment of cemiplimab, taking into account dossier assessment A25-155 and this addendum.

Table 7: Cemiplimab – probability and extent of added benefit

Therapeutic indication	ACT ^a	Probability and extent of added benefit
Adult patients with cutaneous squamous cell carcinoma at high risk of recurrence after surgery and radiation; adjuvant treatment ^b	Watchful waiting	Added benefit not proven
a. Presented is the ACT specified by the G-BA. b. It is assumed that patients have undergone an R0 resection or have achieved a complete radiological response. ACT: appropriate comparator therapy; G-BA: Federal Joint Committee		

The G-BA decides on the added benefit.

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The reference list contains citations provided by the company in which bibliographical information may be missing.

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Appendix A Kaplan-Meier curves

A.1.1 Mortality

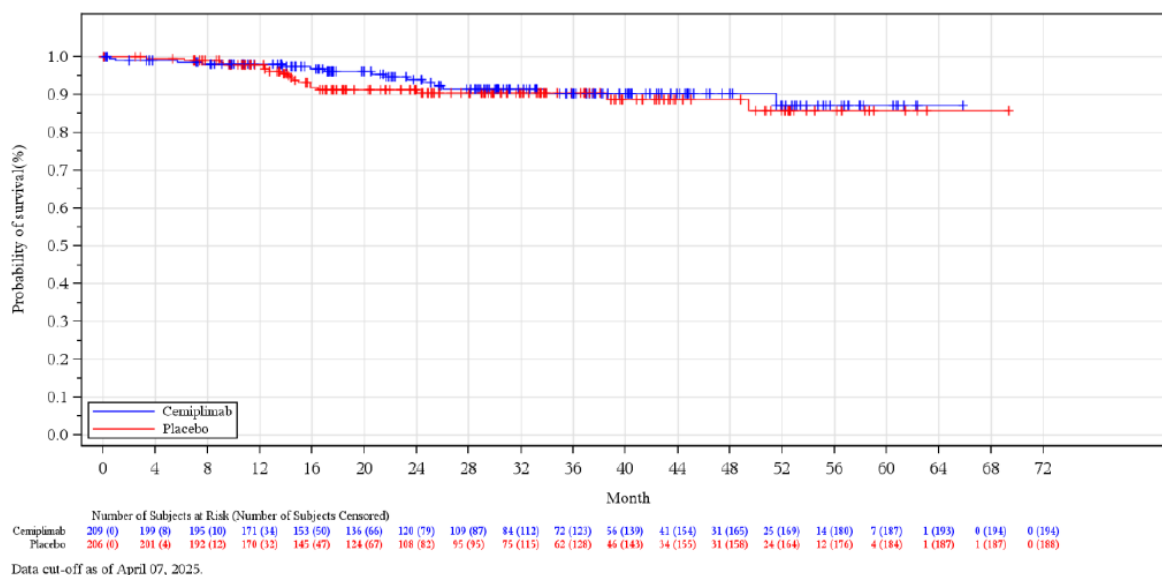


Figure 1: Kaplan-Meier curves for the outcome overall survival – 2nd data cut of 07 April 2025

A.1.2 Morbidity

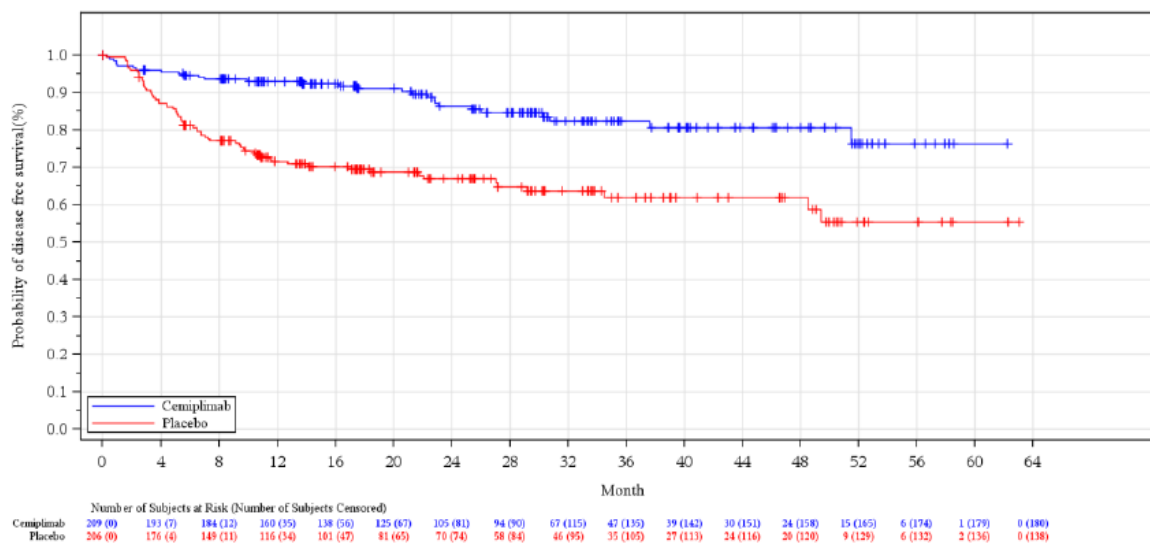


Figure 2: Kaplan-Meier curve for the outcome DFS; second data cut of 07 April 2025

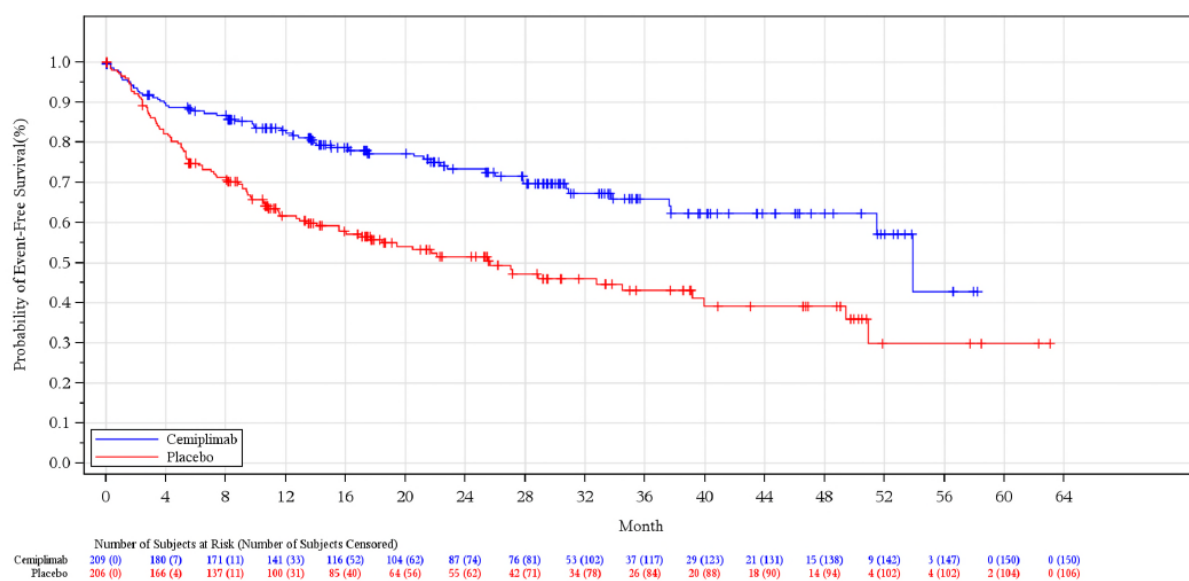


Figure 3: Kaplan-Meier curves of the sensitivity analysis for the outcome DFS, taking into account newly diagnosed primary tumours; 2nd data cut of 7 April 2025

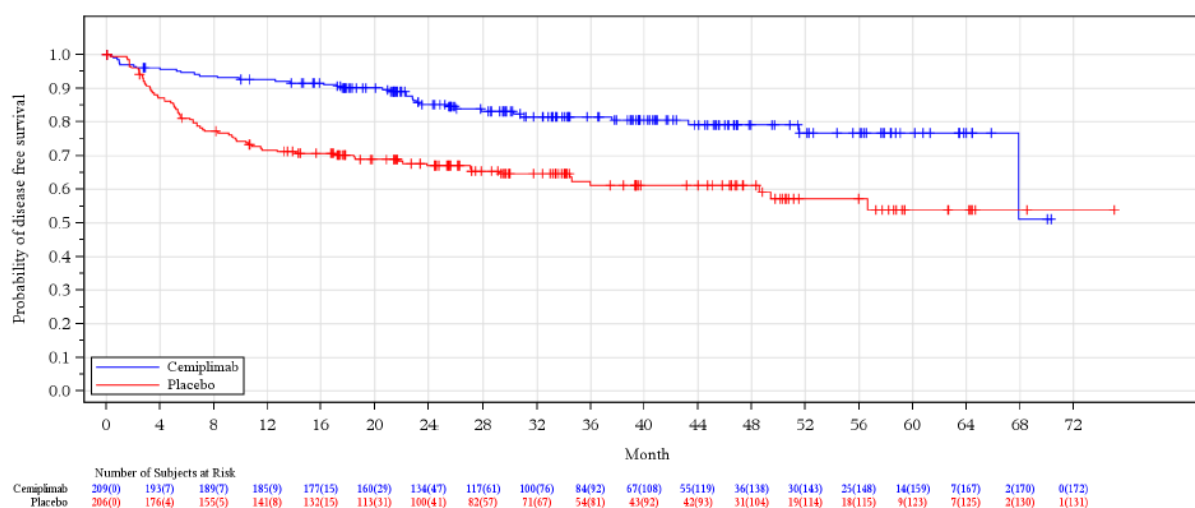


Figure 4: Kaplan-Meier curves for the outcome DFS – 2nd data cut of 03 March 2026

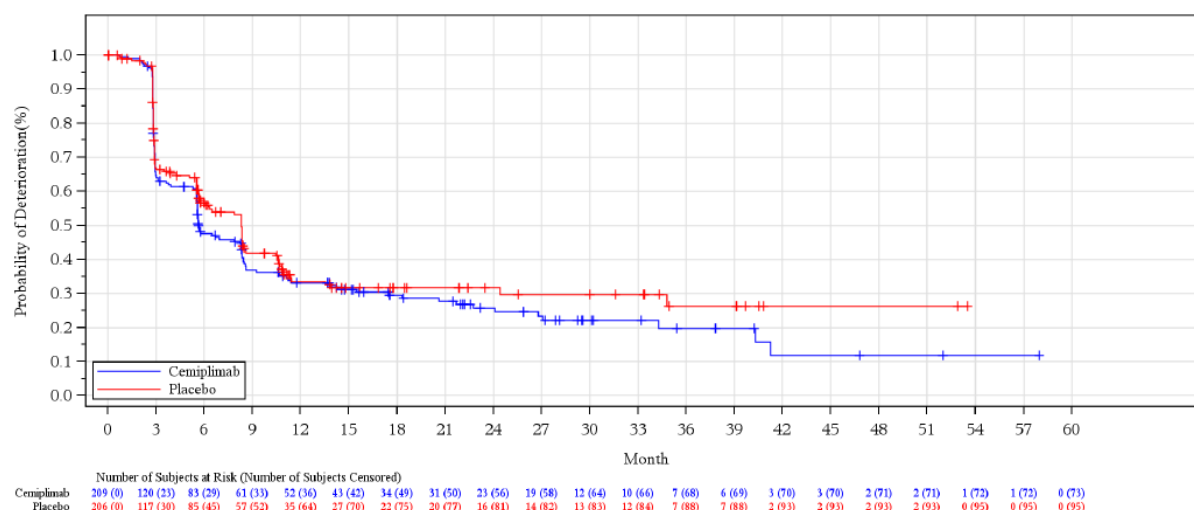


Figure 5: Kaplan-Meier curves for the outcome fatigue (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

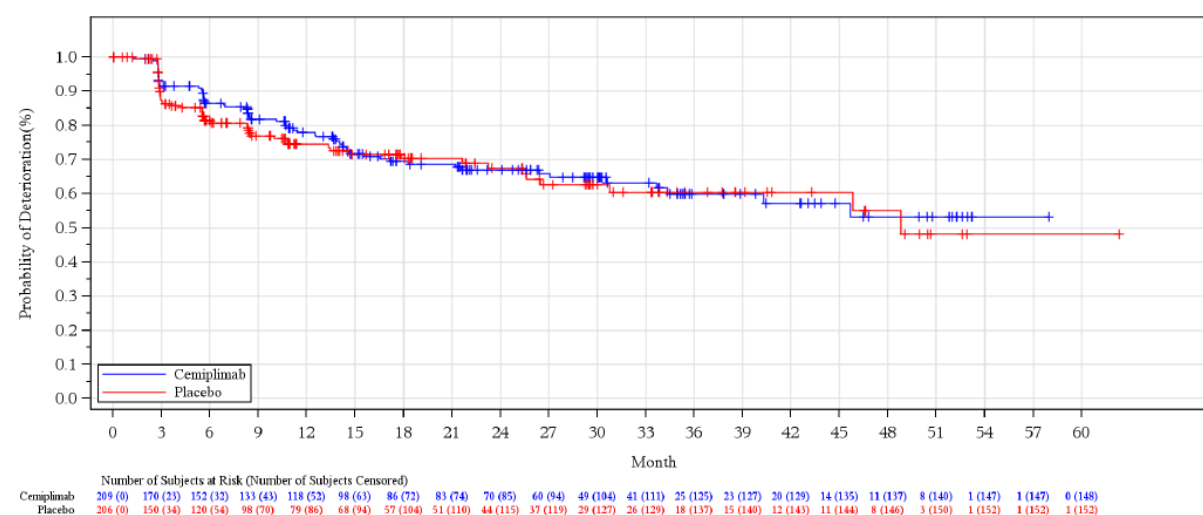


Figure 6: Kaplan-Meier curves for the outcome nausea and vomiting (EORTC QLQ-C30, first deterioration by ≥ 10 points)

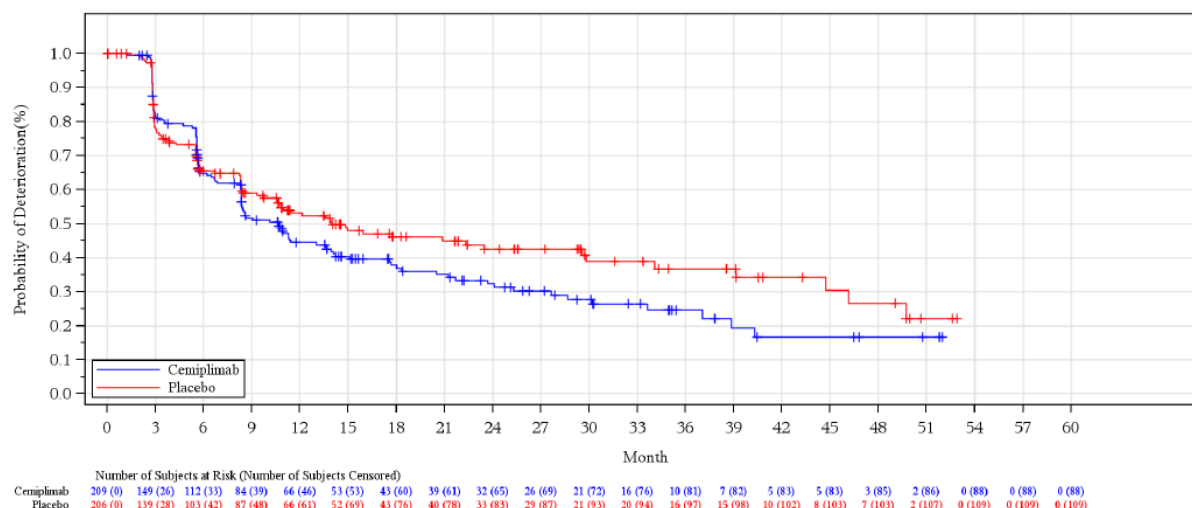


Figure 7: Kaplan-Meier curves for the outcome pain (EORTC QLQ C30, time to first deterioration by ≥ 10 points)

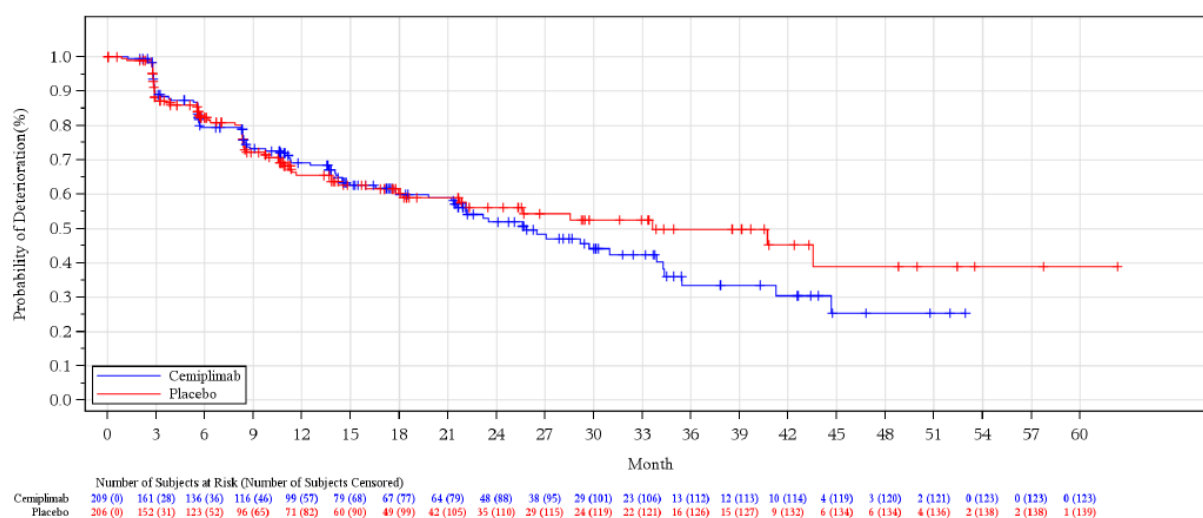


Figure 8: Kaplan-Meier curves for the outcome dyspnoea (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

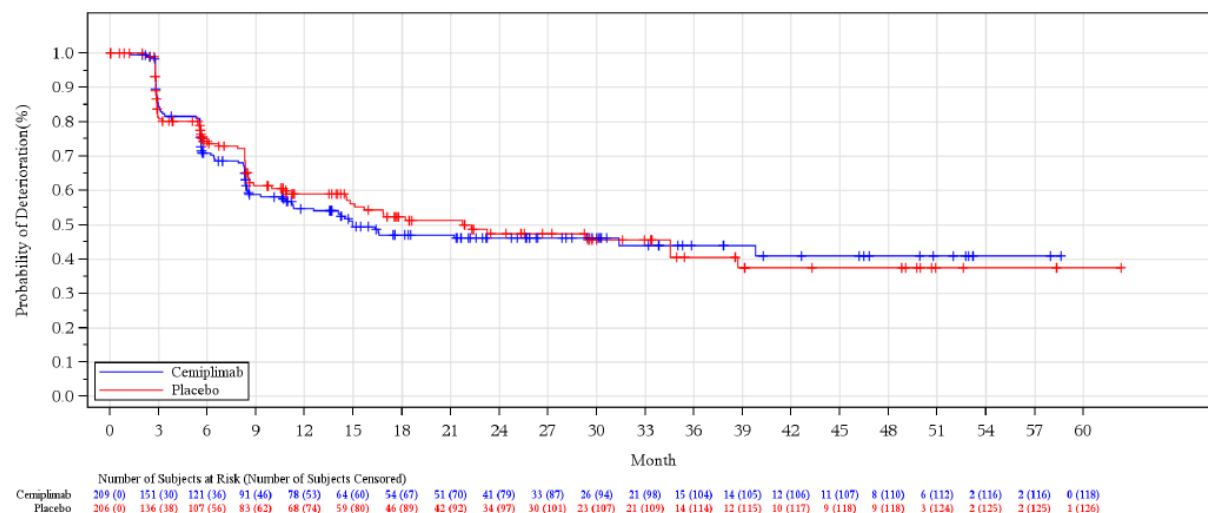


Figure 9: Kaplan-Meier curves for the outcome insomnia (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

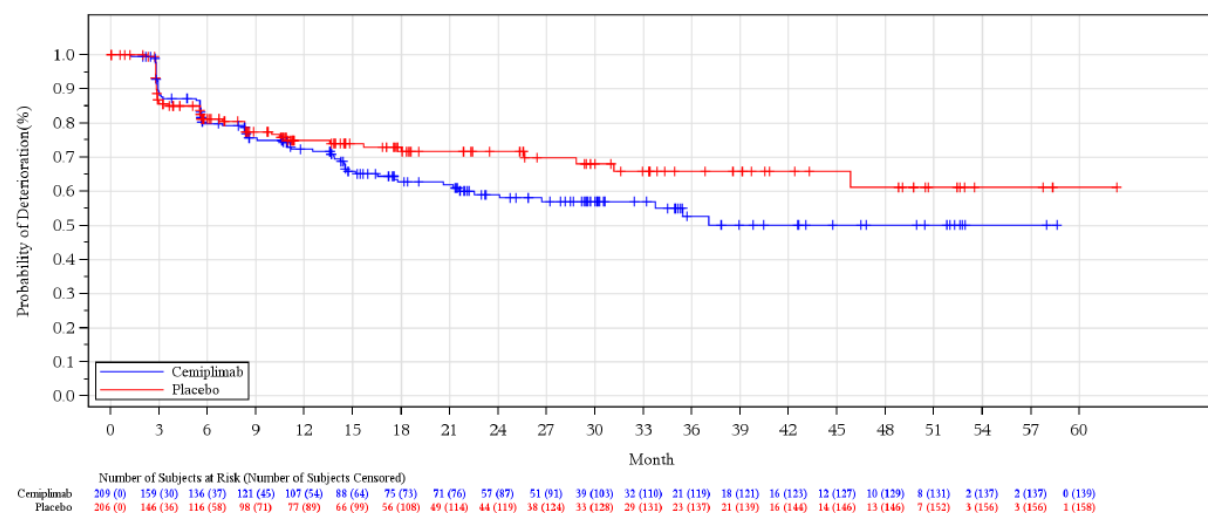


Figure 10: Kaplan-Meier curves for the outcome appetite loss (EORTC QLQ C30, time to first deterioration by ≥ 10 points)

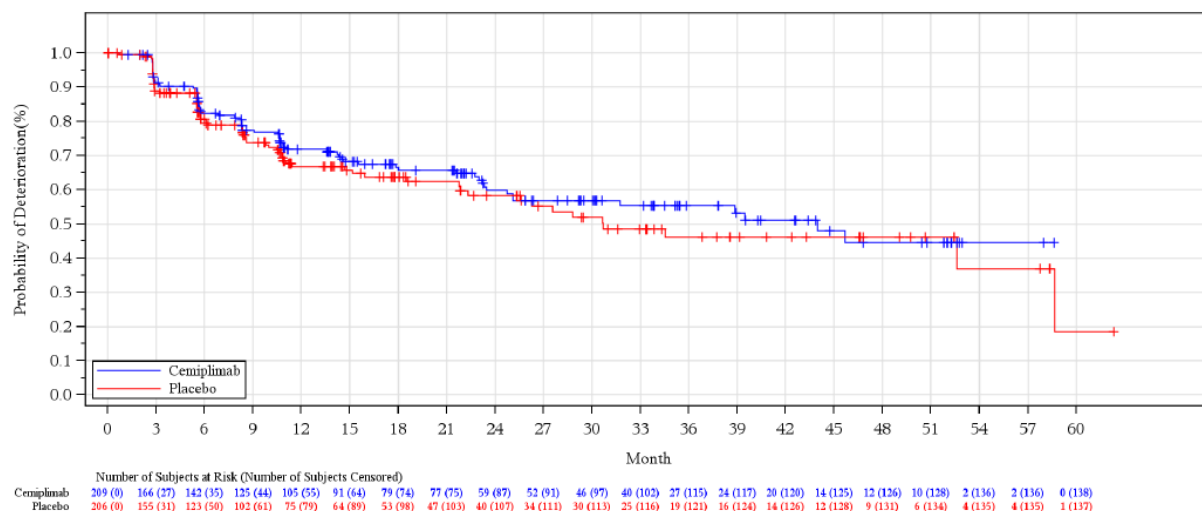


Figure 11: Kaplan-Meier curves for the outcome constipation (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

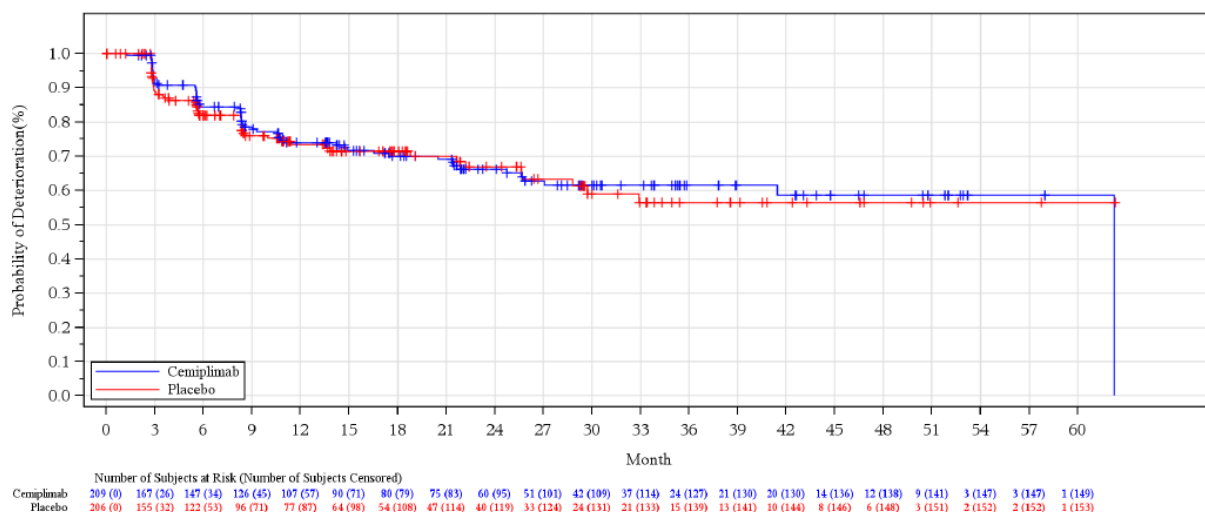


Figure 12: Kaplan-Meier curves for the outcome diarrhoea (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

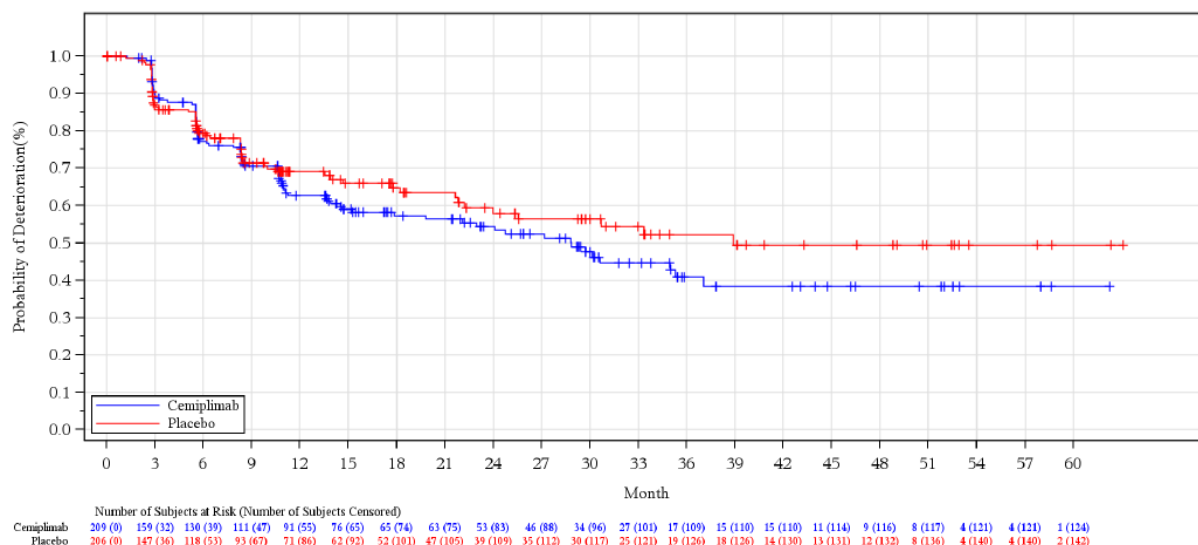


Figure 13: Kaplan-Meier curves for the outcome health status (EQ-5D VAS, time to first deterioration by ≥ 15 points)

A.2 Health-related quality of life

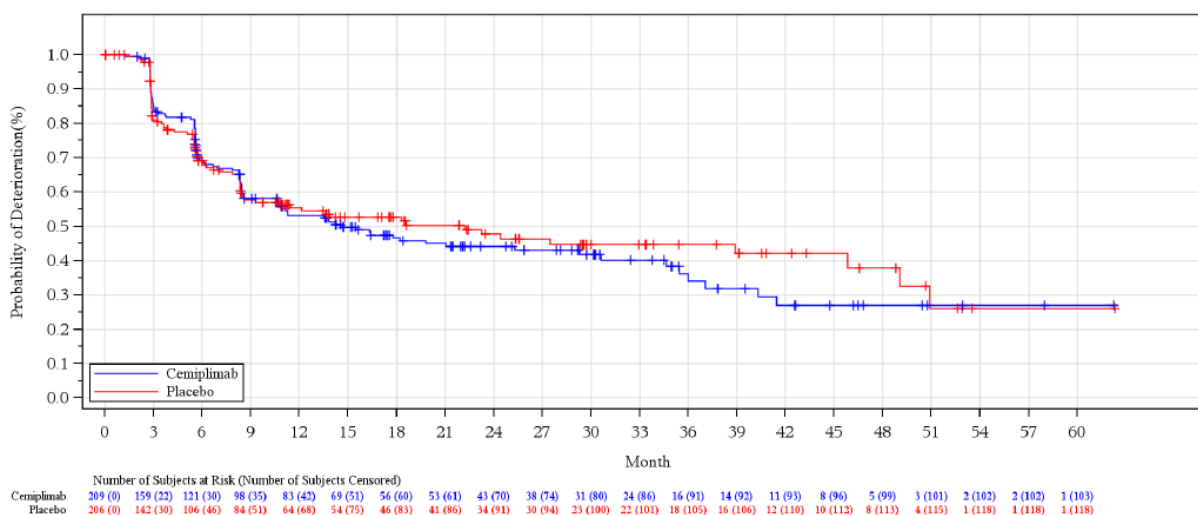


Figure 14: Kaplan-Meier curves for the outcome global health status (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

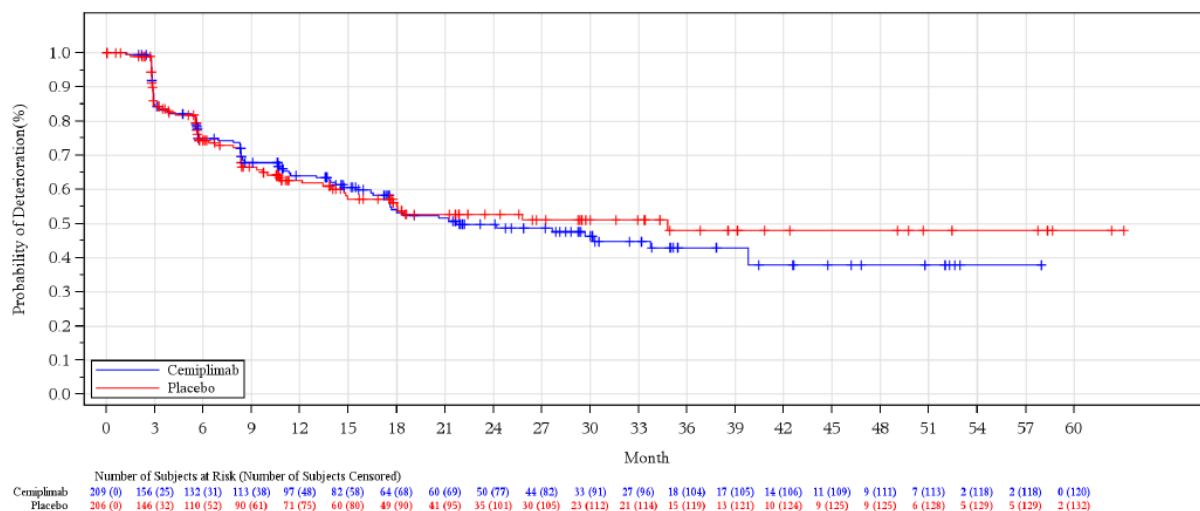


Figure 15: Kaplan-Meier curves for the outcome physical functioning (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

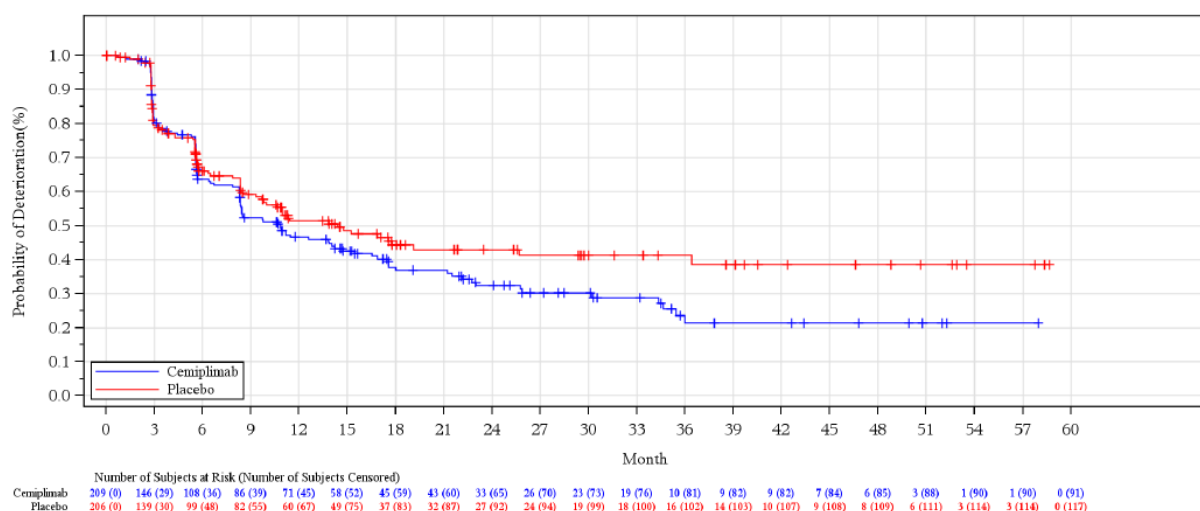


Figure 16: Kaplan-Meier curves on the outcome role functioning (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

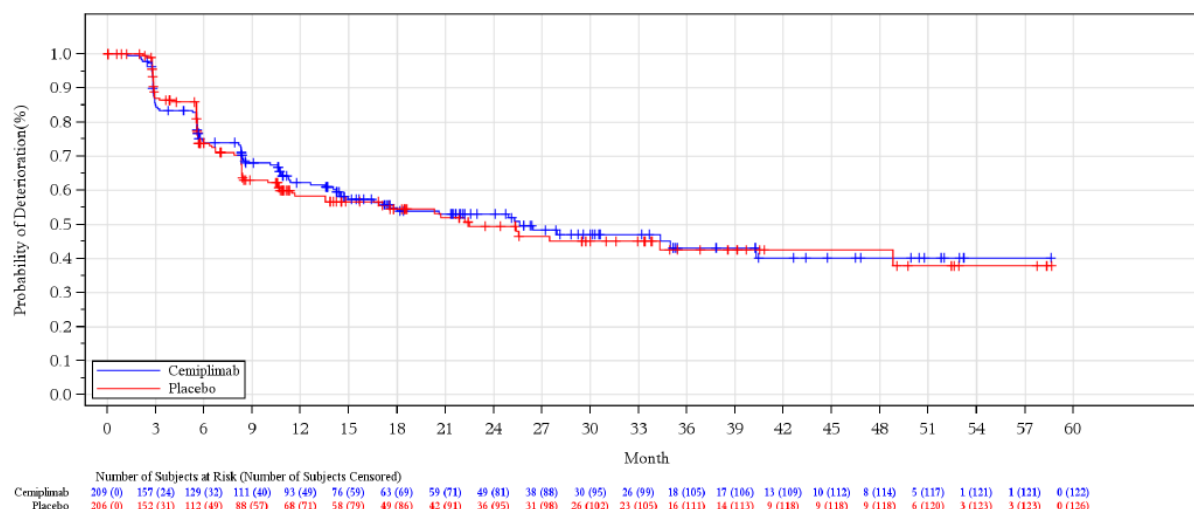


Figure 17: Kaplan-Meier curves on the outcome emotional functioning (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

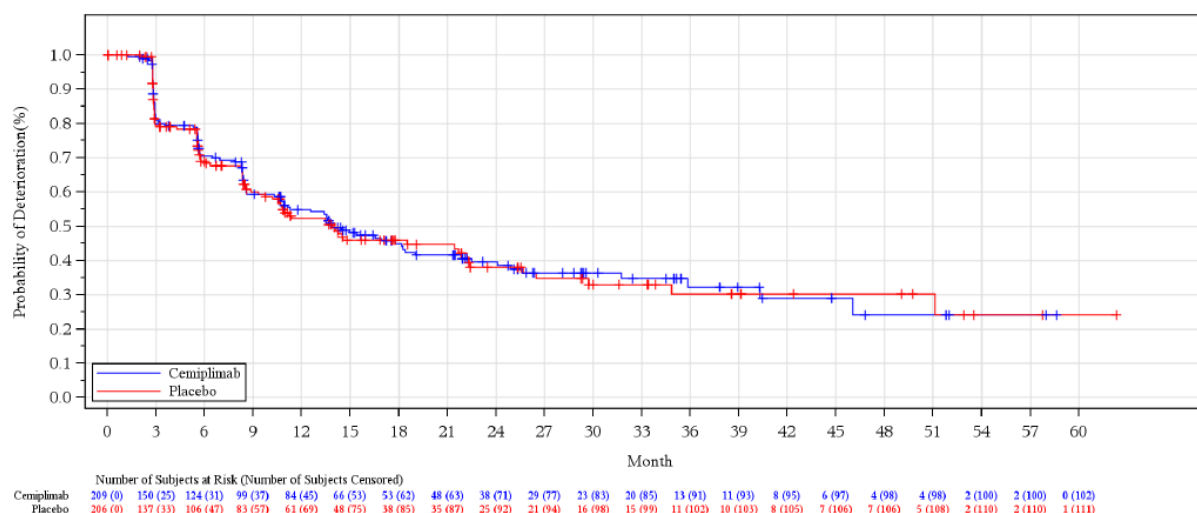


Figure 18: Kaplan-Meier curves for the outcome cognitive functioning (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

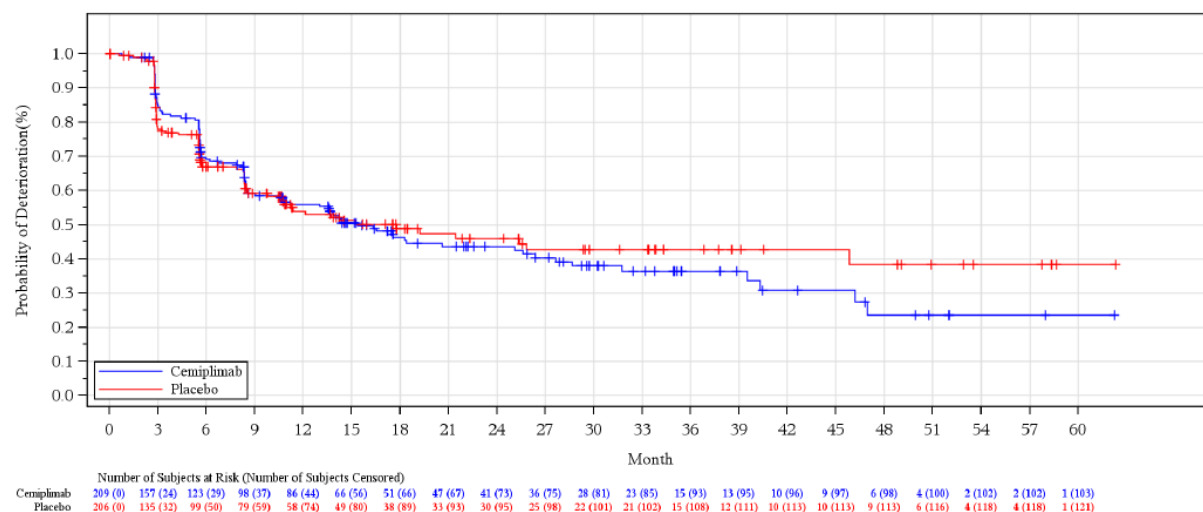


Figure 19: Kaplan-Meier curves on the outcome social functioning (EORTC QLQ-C30, time to first deterioration by ≥ 10 points)

Appendix B Supplementary analyses for DFS

Table 8: Results for the outcome failure of the curative treatment approach (morbidity) – RCT, direct comparison: cemiplimab versus placebo

Study outcome category outcome	Cemiplimab		Placebo		Cemiplimab versus placebo HR [95% CI]; p-value ^a
	N	median time to event in months [95% CI] patients with event n (%)	N	median time to event in months [95% CI] patients with event n (%)	
C-POST					
Morbidity (data cut of 03 March 2026)					
Failure of the curative treatment approach ^b					
Event rate ^c	209	37 (17.7)	206	74 (35.9)	RR: 0.49 [0.35; 0.70]; < 0.001 ^d
Recurrence ^e	209	29 (13.9)	206	68 (33.0)	–
Death	209	8 (3.8)	206	6 (2.9)	–
Disease-free survival	209	NA [67.9; NC] 37 (17.7)	206	NA [49.4; NC] 74 (35.9)	0.40 [0.27; 0.60]; < 0.001
a. HR and CI from Cox proportional hazards model, p-value from log-rank test, each stratified by high-risk tumour (HN vs. non-HN) and geographical region (North America vs. Australia/New Zealand vs. rest of the world)".					
b. Newly diagnosed primary tumours were not taken into account in the operationalization (see Section 2.2.1).					
c. Proportion of patients, individual components are presented in the lines below.					
d. Institute’s calculation of RR, CI (asymptotic) and p-value (unconditional exact test, CSZ method according to [14]).					
e. Information on the proportion of locoregional or distant recurrences is not available.					
CI: confidence interval; HN: head and neck; HR: hazard ratio; n: number of patients with event; N: number of analysed patients; NA: not achieved; NC: not calculable; RCT: randomized controlled trial; RR: relative risk					

Appendix C Side effects

Table 9: Common AEsa – RCT, direct comparison: cemiplimab vs. placebo (multipage table)

Study SOC ^b PT ^b	Patients with event n (%)	
	cemiplimab N = 205	placebo N = 204
C-POST		
Overall AE rate	191 (93.2)	185 (90.7)
Skin and subcutaneous tissue disorders	115 (56.1)	87 (42.6)
Rash	37 (18.0)	19 (9.3)
Pruritus	36 (17.6)	27 (13.2)
Rash maculo-papular	25 (12.2)	12 (5.9)
Actinic keratosis	23 (11.2)	22 (10.8)
Infections and infestations	93 (45.4)	84 (41.2)
COVID-19	16 (7.8)	18 (8.8)
Skin infection	6 (2.9)	12 (5.9)
General disorders and administration site conditions	82 (40.0)	76 (37.3)
Fatigue	50 (24.4)	44 (21.6)
Oedema peripheral	12 (5.9)	6 (2.9)
Asthenia	11 (5.4)	8 (3.9)
Gastrointestinal disorders	75 (36.6)	75 (36.8)
Diarrhoea	32 (15.6)	41 (20.1)
Nausea	16 (7.8)	15 (7.4)
Constipation	14 (6.8)	17 (8.3)
Dry mouth	14 (6.8)	8 (3.9)
Musculoskeletal and connective tissue disorders	65 (31.7)	57 (27.9)
Arthralgia	27 (13.2)	27 (13.2)
Back pain	13 (6.3)	9 (4.4)
Neoplasms benign, malignant and unspecified (incl cysts and polyps)	49 (23.9)	55 (27.0)
Bowen's disease	17 (8.3)	24 (11.8)
Squamous cell carcinoma of skin	17 (8.3)	20 (9.8)
Basal cell carcinoma	14 (6.8)	18 (8.8)
Nervous system disorders	48 (23.4)	47 (23.0)
Headache	14 (6.8)	18 (8.8)
Examinations	42 (20.5)	26 (12.7)
Alanine aminotransferase increased	12 (5.9)	4 (2.0)
Aspartate aminotransferase increased	10 (4.9)	3 (1.5)

Table 9: Common AEsa – RCT, direct comparison: cemiplimab vs. placebo (multipage table)

Study SOC ^b PT ^b	Patients with event n (%)	
	cemiplimab N = 205	placebo N = 204
Endocrine disorders	37 (18.0)	10 (4.9)
Hypothyroidism	28 (13.7)	9 (4.4)
Hyperthyroidism	12 (5.9)	2 (1.0)
Respiratory, thoracic and mediastinal disorders	33 (16.1)	28 (13.7)
Cough	14 (6.8)	7 (3.4)
Injury, poisoning and procedural complications	32 (15.6)	28 (13.7)
Fall	11 (5.4)	6 (2.9)
Metabolism and nutrition disorders	31 (15.1)	17 (8.3)
Vascular disorders	22 (10.7)	19 (9.3)
Hypertension	8 (3.9)	11 (5.4)
Psychiatric disorders	20 (9.8)	14 (6.9)
Insomnia	12 (5.9)	5 (2.5)
Ear and labyrinth disorders	19 (9.3)	19 (9.3)
Renal and urinary disorders	19 (9.3)	10 (4.9)
Eye disorders	15 (7.3)	11 (5.4)
Blood and lymphatic system disorders	13 (6.3)	12 (5.9)
Cardiac disorders	13 (6.3)	8 (3.9)
Hepatobiliary disorders	11 (5.4)	2 (1.0)
a. Events that occurred in ≥ 10 patients in at least one study arm. b. MedDRA version 27.0; SOC and PT notation taken from Module 4 without adaptation. AE: adverse event; MedDRA: Medical Dictionary for Regulatory Activities; n: number of patients with at least one event; N: number of analysed patients; PT: Preferred Term; RCT: randomized controlled trial; SOC: System Organ Class		

Table 10: Common SAEsa – RCT, direct comparison: cemiplimab vs. placebo

Study SOC ^b PT ^b	Patients with event n (%)	
	cemiplimab N = 205	placebo N = 204
C-POST		
Overall SAE rate	38 (18.5)	21 (10.3)
Infections and infestations	10 (4.9)	10 (4.9)
a. Events that occurred in ≥ 10 patients in at least one study arm. b. MedDRA version 27.0; SOC notation taken from Module 4. MedDRA: Medical Dictionary for Regulatory Activities; n: number of patients with at least one event; N: number of analysed patients; PT: Preferred Term; RCT: randomized controlled trial; SAE: serious adverse event; SOC: System Organ Class		

Table 11: Common severe AEs (CTCAE grade ≥ 3)^a – RCT, direct comparison: cemiplimab vs. placebo

Study SOC ^b PT ^b	Patients with event n (%)	
	cemiplimab N = 205	placebo N = 204
C-POST		
Overall rate of severe AEs (CTCAE grade ≥ 3)	52 (25.4)	33 (16.2)
Infections and infestations	10 (4.9)	13 (6.4)
Neoplasms benign, malignant and unspecified (incl cysts and polyps)	3 (1.5)	10 (4.9)
a. Events that occurred in ≥ 10 patients in at least one study arm. b. MedDRA version 27.0; SOC notation taken from Module 4. AE: adverse event; CTCAE: Common Terminology Criteria for Adverse Events; MedDRA: Medical Dictionary for Regulatory Activities; n: number of patients with at least one event; N: number of analysed patients; PT: Preferred Term; RCT: randomized controlled trial; SOC: System Organ Class		

Table 12: Discontinuation due to AEs – RCT, direct comparison: cemiplimab vs. placebo (multipage table)

Study SOC ^a PT ^a	Patients with event n (%)	
	cemiplimab N = 205	placebo N = 204
C-POST		
Overall rate of discontinuations due to AEs	20 (9.8)	4 (2.0)
Skin and subcutaneous tissue disorders	4 (2.0)	0 (0)
Immune-mediated dermatitis	1 (0.5)	0 (0)
Pemphigoid	1 (0.5)	0 (0)
Rash	1 (0.5)	0 (0)
Skin abscess	1 (0.5)	0 (0)
Examinations	3 (1.5)	0 (0)
Alanine aminotransferase increased	3 (1.5)	0 (0)
Aspartate aminotransferase increased	2 (1.0)	0 (0)
Serum alkaline phosphatase increased	2 (1.0)	0 (0)
Gamma-glutamyltransferase increased	1 (0.5)	0 (0)
Endocrine disorders	2 (1.0)	0 (0)
Adrenal insufficiency	2 (1.0)	0 (0)
Gastrointestinal disorders	2 (1.0)	0 (0)
Colitis	1 (0.5)	0 (0)
Immune-mediated enterocolitis	1 (0.5)	0 (0)
Musculoskeletal and connective tissue disorders	2 (1.0)	1 (0.5)
Arthralgia	1 (0.5)	0 (0)
Myositis	1 (0.5)	0 (0)
Polychondritis	0 (0)	1 (0.5)
Cardiac disorders	1 (0.5)	0 (0)
Myocarditis	1 (0.5)	0 (0)
General disorders and administration site conditions	1 (0.5)	0 (0)
Fatigue	1 (0.5)	0 (0)
Hepatobiliary disorders	1 (0.5)	0 (0)
Immune-mediated hepatitis	1 (0.5)	0 (0)
Infections and infestations	1 (0.5)	0 (0)
Urinary tract infection	1 (0.5)	0 (0)
Injury, poisoning and procedural complications	1 (0.5)	0 (0)
Infusion related reaction	1 (0.5)	0 (0)
Neoplasms benign, malignant and unspecified (incl cysts and polyps)	1 (0.5)	3 (1.5)
Dedifferentiated liposarcoma	1 (0.5)	0 (0)
Acute myeloid leukaemia	0 (0)	1 (0.5)

Table 12: Discontinuation due to AEs – RCT, direct comparison: cemiplimab vs. placebo (multipage table)

Study SOC ^a PT ^a	Patients with event n (%)	
	cemiplimab N = 205	placebo N = 204
Hepatocellular carcinoma	0 (0)	1 (0.5)
Lung neoplasm malignant	0 (0)	1 (0.5)
Renal and urinary disorders	1 (0.5)	0 (0)
Acute kidney injury	1 (0.5)	0 (0)
a. MedDRA version 27.0; SOC and PT notation taken unmodified from Module 4. AE: adverse event; MedDRA: Medical Dictionary for Regulatory Activities; n: number of patients with at least one event; N: number of analysed patients; PT: Preferred Term; RCT: randomized controlled trial; SOC: System Organ Class		

Table 13: Common immune-mediated AEs^a – RCT, direct comparison: cemiplimab vs. placebo

Study SOC ^b PT ^b	Patients with event n (%)	
	cemiplimab N = 205	placebo N = 204
C-POST		
Overall rate of immune-mediated AEs	124 (60.5)	67 (32.8)
Skin and subcutaneous tissue disorders	86 (42.0)	39 (19.1)
Pruritus	32 (15.6)	21 (10.3)
Rash	30 (14.6)	14 (6.9)
Rash maculo-papular	25 (12.2)	10 (4.9)
Endocrine disorders	33 (16.1)	8 (3.9)
Hypothyroidism	26 (12.7)	8 (3.9)
Hypothyroidism	11 (5.4)	1 (0.5)
Gastrointestinal disorders	25 (12.2)	19 (9.3)
Diarrhoea	21 (10.2)	17 (8.3)
Examinations	21 (10.2)	9 (4.4)
Alanine aminotransferase increased	11 (5.4)	3 (1.5)
Aspartate aminotransferase increased	10 (4.9)	1 (0.5)
Musculoskeletal and connective tissue disorders	13 (6.3)	12 (5.9)
Arthralgia	10 (4.9)	10 (4.9)
a. Events that occurred in ≥ 10 patients in at least one study arm. b. MedDRA version 27.0; SOC and PT notation taken from Module 5 without adaptation. AE: adverse event; MedDRA: Medical Dictionary for Regulatory Activities; n: number of patients with at least one event; N: number of analysed patients; PT: Preferred Term; RCT: randomized controlled trial; SOC: System Organ Class		

Table 14: Common immune-mediated SAEs – RCT, direct comparison: cemiplimab vs. placebo

Study SOC PT	Patients with event n (%)	
	cemiplimab N = 205	placebo N = 204
C-POST		
Overall rate of immune-mediated SAEs^b	11 (5.4)	1 (0.5)
a. Events that occurred in ≥ 10 patients in at least one study arm. b. Information on SOC and PTs according to MedDRA is neither provided in Module 5 nor in the company's dossier. MedDRA: Medical Dictionary for Regulatory Activities; n: number of patients with at least one event; N: number of analysed patients; PT: Preferred Term; RCT: randomized controlled trial; SAE: serious adverse event; SOC: System Organ Class		

Table 15: Common immune-mediated severe AEs (CTCAE grade ≥ 3)^a – RCT, direct comparison: cemiplimab vs. placebo

Study SOC ^b PT ^b	Patients with event n (%)	
	cemiplimab N = 205	placebo N = 204
C-POST		
Overall rate of immune-mediated severe AEs^b	19 (9.3)	1 (0.5)
a. Events that occurred in ≥ 10 patients in at least one study arm. b. For severe AEs, no MedDRA SOC and PTs met the criterion for presentation.		