China brings CAR T-cell therapy for lymphoma into basic medical insurance

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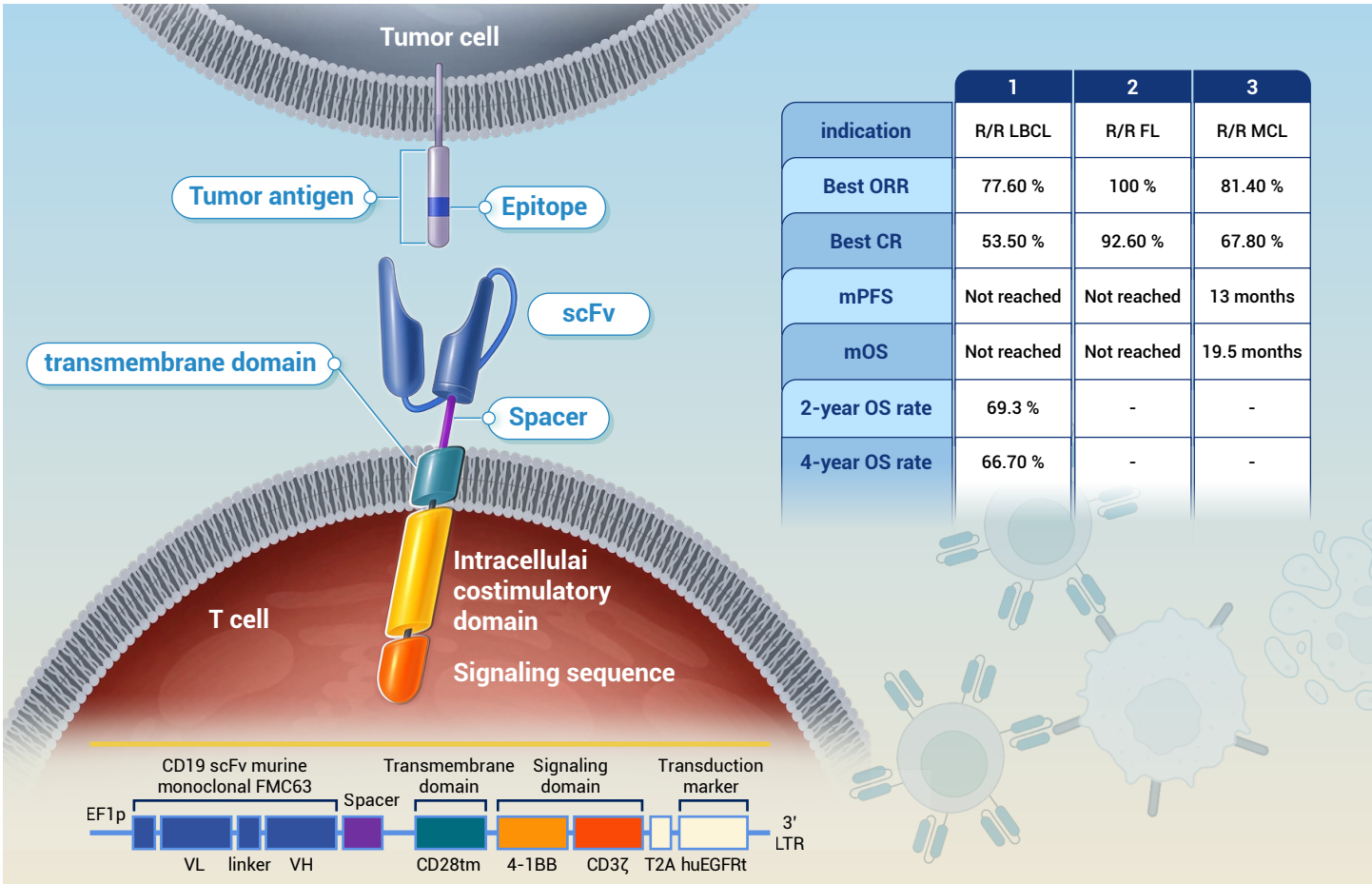
China has included a CAR T-cell therapy in its basic medical insurance drug list for the first time. Relmacabtagene autoleucel (relma-cel, marketed as Carteyva®) is the only product in the class to enter the 2026 National Reimbursement Drug List (NRDL). From January 1, 2027, reimbursement will be available under applicable rules for eligible adults with three types of previously treated lymphoma: large B-cell lymphoma (LBCL), follicular lymphoma (FL), and mantle cell lymphoma (MCL).[1] JW Therapeutics disclosed a negotiated drug reimbursement standard of RMB 288,600, down from RMB 1.29 million, its public list price at launch.[2] This figure is the negotiated drug reimbursement benchmark, not the total cost of treatment or the amount a patient pays out of pocket. It does not cover apheresis, bridging therapy, supportive care, hospitalization, follow-up, or the management of cytokine release syndrome (CRS) and immune effector cell-associated neurotoxicity syndrome (ICANS). Patient out-of-pocket costs differ greatly by local insurance policies and cost-sharing rules.

Juno Therapeutics, now part of Bristol Myers Squibb, and a subsidiary of WuXi AppTec founded JW Therapeutics' Shanghai operation in 2016. Relma-cel uses the same CD19-targeting chimeric antigen receptor (CAR) construct as Juno's lisocabtagene maraleucel (liso-cel, marketed as Breyanzi) (Figure 1). JW optimized the manufacturing process and took relma-cel through clinical development in China. The therapy now entering reimbursement in mainland China is relma-cel, not imported liso-cel.

TREATMENT UPTAKE AND REIMBURSEMENT

CAR T-cell products have been commercially available in China since 2021, but uptake has remained limited. A company investor presentation cited 2025 market research estimating CAR T-cell use at approximately 3.5% in the third-line or later LBCL setting in China; the underlying sample and calculation methods were not publicly disclosed. This estimate should be interpreted cautiously. Low uptake is multifactorial and is not driven by cost alone. It may



	1	2	3
indication	R/R LBCL	R/R FL	R/R MCL
Best ORR	77.60 %	100 %	81.40 %
Best CR	53.50 %	92.60 %	67.80 %
mPFS	Not reached	Not reached	13 months
mOS	Not reached	Not reached	19.5 months
2-year OS rate	69.3 %	-	-
4-year OS rate	66.70 %	-	-

Figure 1. The mechanism diagram of Relma-cel and clinical research data Source: Albertson T. *Presentation to STEM Education Innovation Alliance.* Juno Therapeutics, a Celgene company. May 29, 2019. LBCL: Large B-cell lymphoma, FL: Follicular lymphoma, MCL: Mantle cell lymphoma.

reflect patient selection, referral pathways, center capacity, manufacturing logistics, physician and patient awareness, local reimbursement rules, and out-of-pocket costs. Cross-national comparisons of CAR T-cell penetration should also account for differences in denominators, lines of therapy, data sources, and health-system contexts; such estimates are not directly comparable across countries.

Some patients previously obtained coverage through commercial or supplemental insurance. Relma-cel was included in the inaugural Commercial Health Insurance Innovative Drug Directory released in 2025, but that listing did not confer basic insurance coverage. From January 1, 2027, eligible patients can seek reimbursement under basic medical insurance. The RMB 288,600 reimbursement standard is not the amount a patient pays out of pocket. The patient's share depends on local cost-sharing rules, and the drug is only one part of the total treatment bill. The national implementation notice specifies that prices listed on provincial procurement platforms for negotiated drugs may not exceed the national reimbursement standard.[1] Hospital care and follow-up can add to total costs, and some patients may also incur travel expenses.

The national implementation notice calls on designated hospitals to review the availability of newly listed medicines and permits temporary procurement where necessary. Hospitals can request case-by-case payment review when standard case-based payment is unsuitable. However, case-by-case reimbursement should be regarded as a transitional solution rather than a permanent fix for access. Uneven distribution of qualified infusion centers remains a major barrier to equitable access, and local implementation capacity will materially affect how quickly eligible patients can benefit. For drugs previously listed in the Commercial Health Insurance Innovative Drug Directory, the relevant policy provisions continue to apply for two agreement periods (four years) after inclusion in the basic medical insurance drug list.[1] An individual patient's reimbursement remains subject to applicable local rules.

JW THERAPEUTICS' PERSPECTIVE ON PRICING AND SUPPLY

The lentiviral vector is a key manufacturing input and has been identified as an opportunity to reduce production costs. JW has developed its own suspension lentiviral vector platform to reduce reliance on external suppliers. China's National Medical Products Administration accepted a post-marketing supplemental application in October 2025 to add the in-house vector to relma-cel manufacturing. Acceptance for review does not authorize its use in commercial production, and any such process change is subject to regulatory approval. Any cost reduction from this platform is therefore potential and uncertain; it may take time to materialize, and savings are not guaranteed to translate into lower drug prices.

A lower drug price under basic insurance may allow some patients who would otherwise forgo treatment to consider it. Each year, an estimated 11,000 patients in China newly meet the clinical criteria for one of the indications covered by the listing. This is a theoretical epidemiological estimate of potential clinical need, not the expected number of infusions. It draws on published epidemiological data, expert interviews, and assumptions about patient eligibility. Many patients may be excluded because of comorbidities, poor T-cell quality, CD19 loss, or manufacturing failure. Actual uptake will depend in part on local reimbursement, hospital implementation, and treatment capacity. Autologous CAR T-cell therapy is manufactured separately for each patient. If more patients receive treatment, higher production volumes can spread fixed facility and staffing costs across more treatment courses, but this does not by itself ensure broad or equitable access.

As of October 31, 2026, more than 1,200 patients in China had received relma-cel, and more than 200 treatment centers nationwide had been certified to administer it.[2] These figures predate implementation of basic insurance coverage.

PUBLISHED CLINICAL EVIDENCE

Relma-cel is made from a patient's own T cells (Figure 1)**.** When the engineered receptor binds CD19, the T cells can expand and kill target cells. CD19 is also present on normal B cells, which can be depleted after treatment; this may lead to hypogammaglobulinemia and related long-term adverse events. The efficacy data summarized below are from selected registrational cohorts. Real-world outcomes may be inferior to those observed in clinical trials. In addition, CD19 antigen escape and long-term adverse events such as hypogammaglobulinemia may occur and require monitoring.

Large B-cell lymphoma (Figure 1)**.** RELIANCE enrolled adults with relapsed or refractory LBCL after at least two prior systemic regimens. Fifty-nine received relma-cel and 58 were evaluable for efficacy. In the primary analysis, the investigator-assessed objective response rate (ORR) at three months was 60.3%. Grade 3 or higher cytokine release syndrome (CRS) and neurotoxicity occurred in 5.1% and 3.4% of infused patients, respectively.[3]

Follicular lymphoma (Figure 1)**.** The indication covers adults with grade 1, 2, or 3a FL that is refractory or has relapsed within 24 months, after at least two prior lines of systemic therapy. Among 27 patients evaluable for efficacy in the RELIANCE FL cohort, the investigator-assessed ORR and complete response rate (CRR) at 3 months after infusion were 100% and 85.2%, respectively. In the primary analysis, at a median follow-up of 11.7 months, the investigator-assessed best CRR was approximately 93%, reflecting complete responses achieved at any assessment during follow-up rather than at a fixed time point.[4]

Mantle cell lymphoma (Figure 1)**.** The MCL indication requires at least two prior systemic regimens, including a Bruton tyrosine kinase inhibitor. Of 70 patients enrolled in the phase 2 study, 59 received an infusion. The investigator-assessed ORR at three months, the primary endpoint, was 71.2%. The best CRR was 67.8%. At a median follow-up of 13.3 months, median PFS was 15.5 months and median duration of response was 18.1 months. Grade 3 or higher CRS and neurotoxicity each occurred in 6.8% of patients, and those events resolved. Grade 3 or higher neutropenia occurred in 76.3%.[5]

A CLINICAL PERSPECTIVE ON ACCESS

For many patients with B-cell lymphoma in China, high costs have put CAR T-cell therapy out of reach even when it was clinically indicated and they wanted to proceed. The negotiated drug price for relma-cel is about 22% of its previous list price. Once basic medical insurance coverage begins, the lower price and reimbursement are expected to ease the financial burden for eligible patients. Where the lower drug price is also available to patients paying out of pocket, it could make treatment affordable for some even without reimbursement.

The negotiated price is low relative to publicly listed CAR T-cell drug prices in some other markets. .

Over time, this difference may further strengthen China's position in cell therapy and provide survival benefits to more patients with lymphoma.

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DECLARATION OF INTERESTS

The authors declare no competing interests.